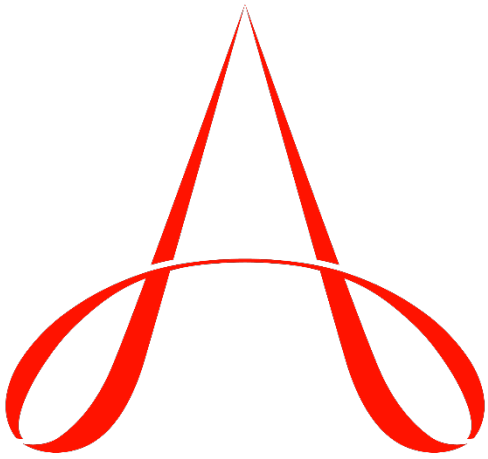
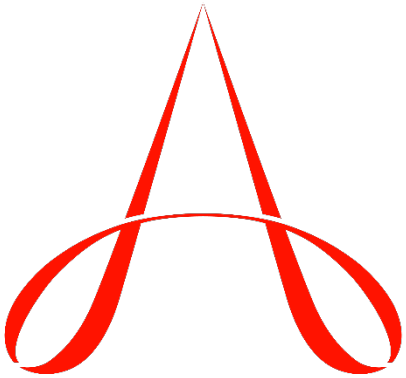


ACGME

Accreditation Council for Graduate Medical Education

The Program Director Guide to the Common Program Requirements (Residency)

(Version 3.0; revised March 2023)



Accreditation Council for Graduate Medical Education

ACGME Mission

The mission of the ACGME is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education.

ACGME Vision

We envision a health care system in which the Quadruple Aim* has been realized. We aspire to advance a transformed system of graduate medical education with global reach that is:

- Competency-based with customized professional development and identity formation for all physicians;
- Led by inspirational faculty role models overseeing supervised, humanistic, clinical educational experiences;
- Immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost-effectiveness, professionalism, and diversity, equity, and inclusion;
- Located in health care delivery systems equitably meeting local and regional community needs; and,
- Graduating residents and fellows who strive for continuous mastery and altruistic professionalism throughout their careers, placing the needs of patients and their communities first.

** The Quadruple Aim simultaneously improves patient experience of care, population health, and health care practitioner work life, while lowering per capita cost.*

ACGME Values

- Honesty and Integrity
- Accountability and Transparency
- Equity and Fairness
- Diversity and Inclusion
- Excellence and Innovation
- Stewardship and Service
- Leadership and Collaboration
- Engagement of Stakeholders

Program Director Guide to the Common Program Requirements Contents
(Residency)

The Program Directors' Guide to the Common Program Requirements (Residency)

The Program Directors' Guide to the Common Program Requirements is a living document that will be updated as the Common Program Requirements change. In addition to this Residency version, the ACGME has developed a Fellowship and One-Year Fellowship version as well.

This guide is available in a **PDF version** that is downloadable and can be printed. If referring to a printed version, periodically check the website for any version updates.
The Guide should serve as a resource, and the content within it is designed to serve as helpful guidance and not to be interpreted as additional requirements. It is also not meant to be read cover to cover in one sitting, but to be referenced as needed throughout the academic year.

If there are any conflicts between the Guide and the Common Program Requirements, as interpreted and implemented by the Review Committees, the interpretation and implementation of the Review Committees shall control.

Note that every set of specialty-specific Program Requirements includes content specific and unique to the specialty. Specialty Program Requirements are not addressed in this Guide. The specialty-specific FAQs and other resource documents provided by the respective Review Committee should be consulted; these are available on the respective specialty section of the ACGME website. Contact Review Committee staff members with specific questions.

Format:

a. Requirement text is included on the pages with a blue background.
    - *Fonts in italics are "philosophic" statements; they are not program requirements and therefore are not citable*
    - Text in boxes provides Background and Intent and is not citable
    - Review Committees may further specify only where bracketed notes indicate that the Review Committee may/must further specify.
b. Guidance is included on the pages with a white background.
c. Table of contents entries are links that can be used to jump to a specific topic area in the Guide.
d. The search function allows users to enter key words to quickly locate information.
e. Where appropriate, screenshots of what data entry looks like within the ACGME's Accreditation Data System (ADS) are included. Many of these may change as Common Program Requirements change. The Guide will be updated periodically as these changes occur.

The ACGME encourages feedback, comments, and questions about the Guide via **this survey.**

COMMON PROGRAM REQUIREMENTS

Introduction

Int.A. *Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.*

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

Int.B. Definition of Specialty

[The Review Committee must further specify]

Int.C. Length of educational program

[The Review Committee must further specify]

GUIDANCE

Introduction A (Int.A.) is not a requirement but is a philosophic statement that embodies the meaning and purpose of graduate medical education. It describes why graduate medical education is important and why programs must ensure that residents and fellows are provided with the best education possible.

Introduction B (Int.B.) and Introduction C (Int.C.) address the definition of a specialty and the length of the educational program for that specialty. These requirements must be further specified in the specialty-specific Program Requirements.

To review the specialty-specific Program Requirements, go to:
https://www.acgme.org/specialties/

- Select the specialty
- Click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- Select the currently in effect specialty program requirements.

For example, to locate the Program Requirements for Orthopaedic Surgery,

- go to: https://www.acgme.org/specialties/
- click on Orthopaedic Surgery
- go to Program Requirements and FAQs and Applications on the right-hand menu.
- a PDF version of the current Program Requirements for Orthopaedic Surgery can be accessed in the “Currently in Effect” section.

As Program Requirements are revised and approved by the ACGME Board of Directors, Program Requirements that are approved but not yet effective can be found in the “Future Effective Date” section of the same page.

COMMON PROGRAM REQUIREMENTS

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the healthcare needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

GUIDANCE

Sponsorship and Sponsoring Institution Accreditation

ACGME Common Program Requirement I.A.1. corresponds with Institutional Requirement I.A.1.: “Residency and fellowship programs accredited by the ACGME must function under the ultimate authority and oversight of one Sponsoring Institution. Oversight of resident/fellow assignments and of the quality of the learning and working environment by the Sponsoring Institution extends to all participating sites.”

Sponsorship of a program includes responsibility for oversight of the Sponsoring Institution’s and all accredited programs’ compliance with the applicable ACGME requirements, and the assurance of the resources necessary for graduate medical education.

The ACGME Board of Directors delegates authority for accrediting Sponsoring Institutions to the Institutional Review Committee. The ACGME’s primary point of contact with each Sponsoring Institution is the designated institutional official (DIO).

For more information about Sponsoring Institutions, refer to the ACGME Institutional Requirements and Frequently Asked Questions.

COMMON PROGRAM REQUIREMENTS

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]

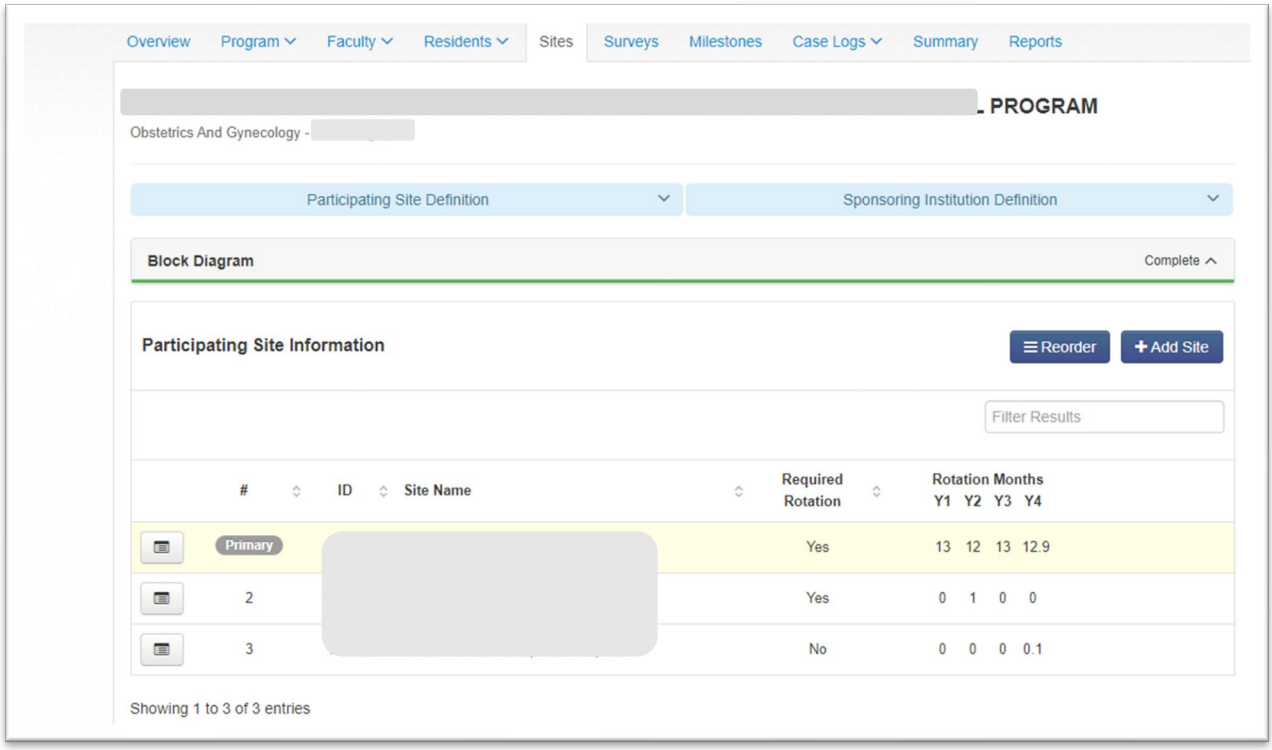
GUIDANCE

I.B.1. Primary Clinical Site Designations and Sponsoring Institution Approval

The Common Program Requirements define a program's primary clinical site as "the most commonly utilized site of clinical activity for the program" (Common Program Requirement I.A.). A program should follow its Sponsoring Institution's methods for identifying the primary clinical site. Typically, the "most commonly utilized" participating site is that which has the highest count of resident FTEs in a program over an academic year, assuming a full and evenly distributed resident complement.

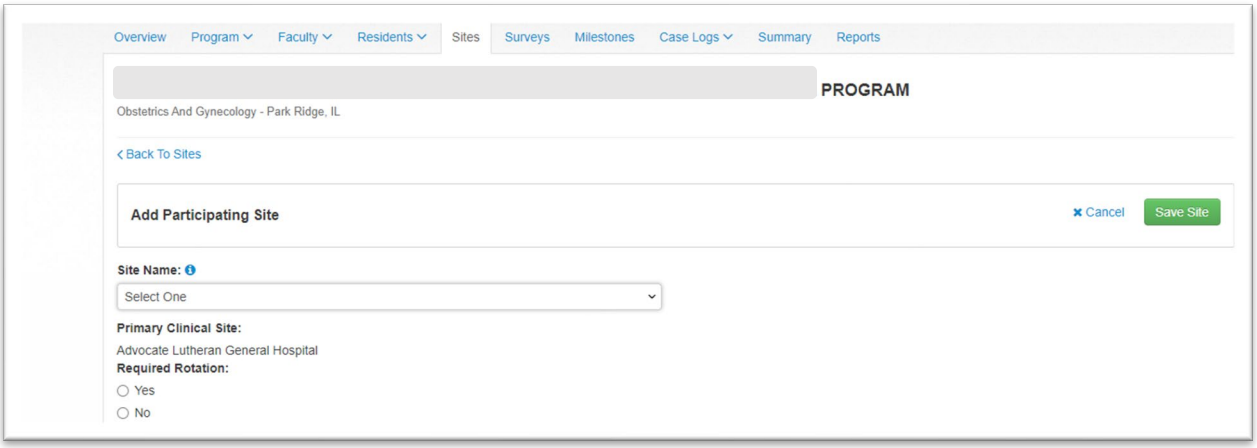
ADS Screenshot: Primary Clinical Site

In a program's Accreditation Data System (ADS) profile, the designated primary clinical site can be found in the "Sites" tab. It is marked as "Primary" in the list of participating sites (# column) and it appears first on the list.



ADS Screenshot: Identifying the Primary Clinical Site in Applications

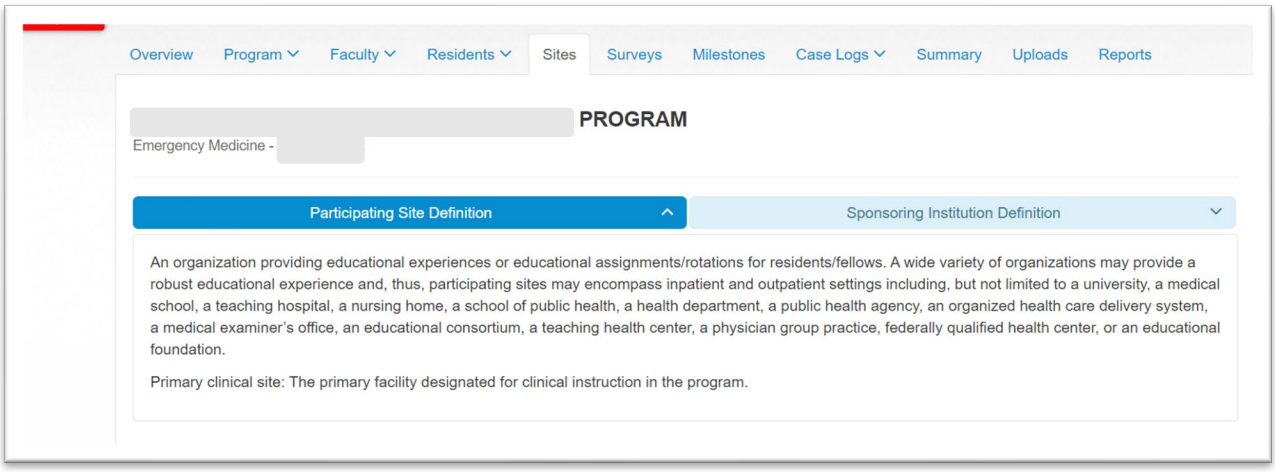
In applications for ACGME accreditation, when adding participating sites, programs are directed to identify one of the participating sites as the primary clinical site. Only one site can be identified as the primary clinical site.



Participating site information listed in ADS, including the designation of the primary clinical site, implies the Sponsoring Institution's approval. The ACGME does not provide a standardized format for documenting institutional approval of these designations. Refer to specialty-specific Program Requirements for additional information.

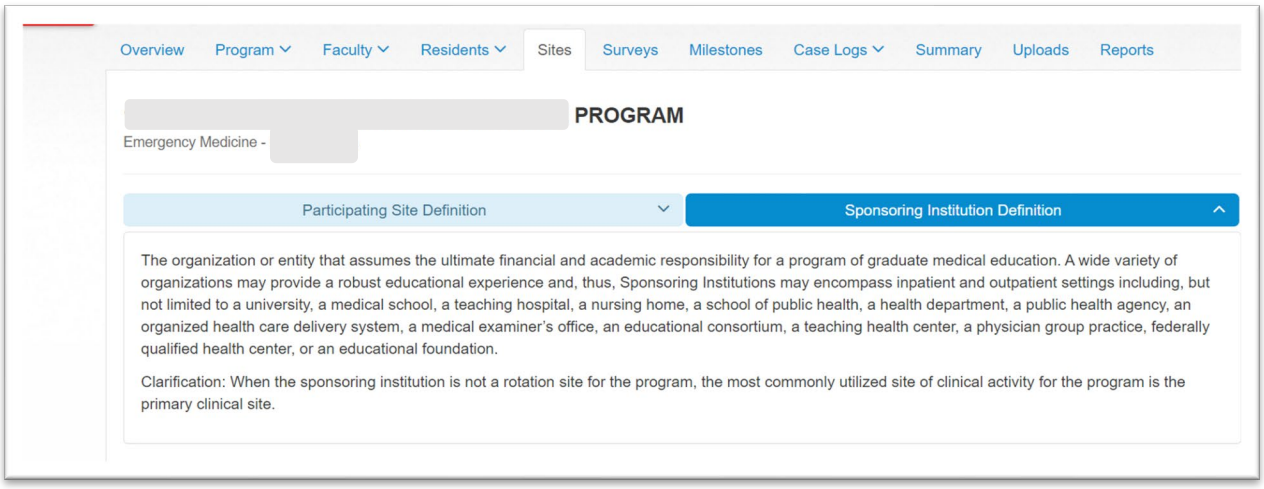
ADS Screenshot: Participating Site Definition

For the definition of a participating site or additional instructions, click the arrow on the "Participating Site Definition" blue bar to expand it.



ADS Screenshot: Sponsoring Institution Definition

For the definition of a Sponsoring Institution or additional instructions, click the arrow on the "Sponsoring Institution Definition" blue bar to expand it.



[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]

Since Review Committees may specify which other specialties/programs must be present at the primary clinical site, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty requirements or expectations for the primary clinical site should be directed to specialty Review Committee staff members.

COMMON PROGRAM REQUIREMENTS

I.B. Participating Sites

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a).(1) be renewed at least every 10 years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs include:

- Identifying the faculty members who will assume educational and supervisory responsibility for residents
- Specifying the responsibilities for teaching, supervision, and formal evaluation of residents
- Specifying the duration and content of the educational experience
- Stating the policies and procedures that will govern resident education during the assignment

[The Review Committee may further specify]

GUIDANCE

The program letter of agreement (PLA) is a written document that addresses graduate medical education (GME) responsibilities between a program and a participating site at which residents have required educational experiences.

The Association of American Medical Colleges (AAMC) has developed a program letter of agreement template which programs can use and modify according to their specific needs.

Important notes:

1. Program directors are responsible for PLAs. Designated institutional officials (DIOs) are required to review and approve all PLAs.
2. A change in program director or DIO does not require updating a PLA with new signatures.
3. PLAs must be updated and renewed at least every 10 years.
4. PLAs are required only for sites providing required educational experiences.
5. Although the ACGME does not require PLAs for sites providing elective rotations, an institution or GME office may require a PLA for those sites.
6. PLAs are between a program and the participating site and include all rotations taking place at that participating site.
7. PLAs are not required for participating sites under the governance of the sponsoring institution.

The purpose of a PLA is to ensure a shared understanding of expectations for the educational experience, the nature of the experience, and the responsibilities of the program and the participating site.

As specified in the Background and Intent under I.B.3.a), suggested elements for a PLA include:

- Identifying the faculty members who will assume educational and supervisory responsibility for residents
- Specifying the responsibilities for teaching, supervision, and formal evaluation of residents
- Specifying the duration and content of the educational experience (e.g., rotation name, educational objectives)
- Stating the policies and procedures that will govern resident education during the assignment

Additionally the Background and Intent under I.B.3.a) identifies other considerations for PLAs:

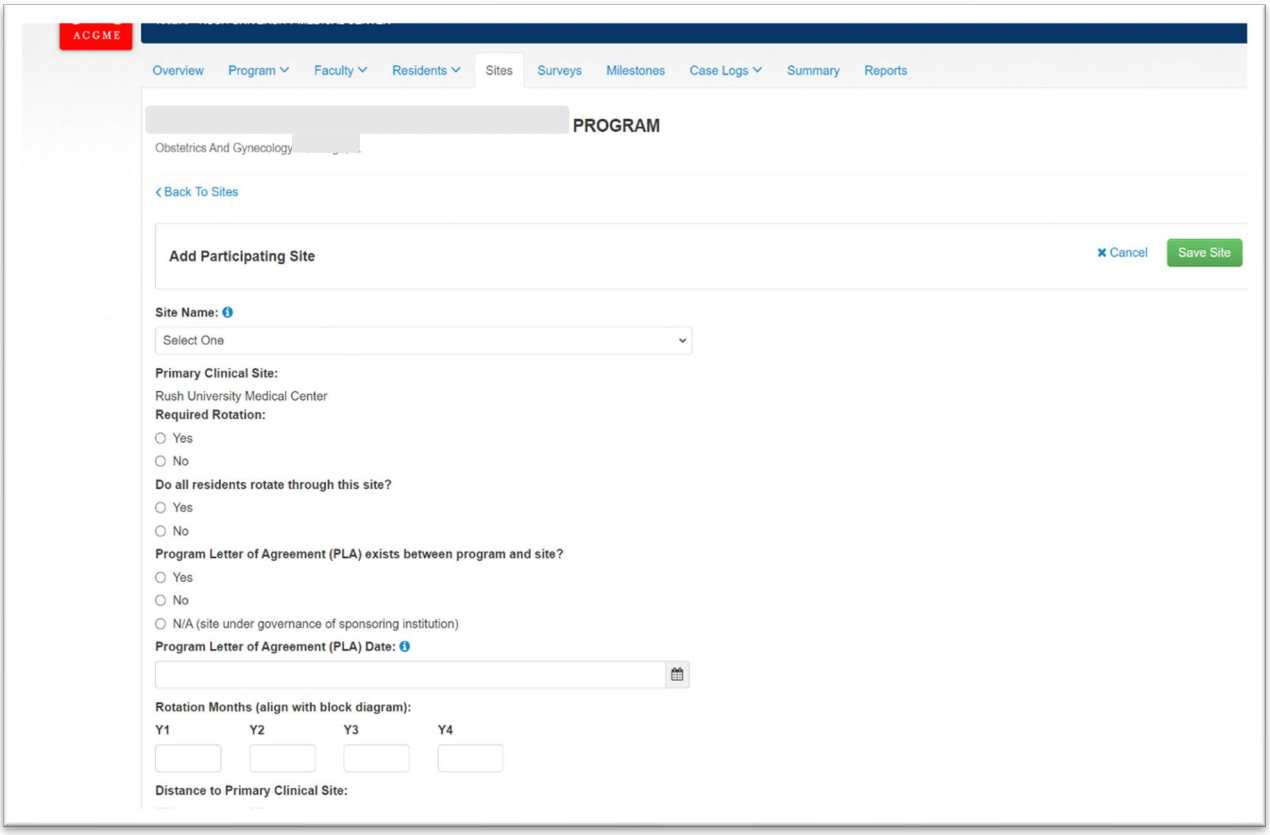
- Designated site director: The site director may be the program director in some cases, but the program director is not usually the site director at all participating sites.
- Travel time and distance to the participating site: If the site is distant, the program should consider providing the residents with accommodation proximate to the participating site.

The ACGME requires copies of PLAs to be uploaded in the Accreditation Data System (ADS) for new program applications and updated applications. Accreditation Field Representatives request copies of and verify PLAs during site visits for applications, initial accreditation, and other types of site visits. For programs with a status of Continued Accreditation, the PLA is not

requested when a new participating site is added in ADS. However, the program must provide confirmation that a PLA is in place and list the effective date. If the effective date is not available, the signature date may be documented as the effective date.

ADS Screenshot: Adding a Participating Site and PLA Details

When entering a new participating site in ADS, programs are asked to confirm that a PLA exists and provide its effective date.



Examples of rotations that require a PLA:

1. One-month required rotation in a pediatric inpatient unit in a children's hospital in a family medicine program
2. One-month required rotation in rheumatology in an internal medicine program
3. Two-month required rotation in an emergency department with a Level 1 trauma center at a site that is not the Sponsoring Institution
4. Required osteopathic neuromusculoskeletal medicine inpatient rotation
5. Longitudinal required geriatric experience in a long-term care facility in a family medicine program
6. Two-week required retina rotation with a community physician who is not a member of the medical staff of one of the participating sites in an ophthalmology program

Potential Areas for Improvement (AFIs) or Citations:

1. Failure to have a PLA signed by the DIO, the program director, and the site director for each site at which residents rotate for a required educational experience

2. Failure to renew a PLA every 10 years
3. Incorrect/incomplete participating site information in ADS

In addition to the guidance included here, the Common Program Requirements FAQs address multiple questions from the GME community about PLAs.

I.B.3. requires that the program must monitor the clinical learning and working environment at all participating sites. The Background and Intent further explains the rationale for this requirement and is worth repeating: "While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case."

Examples of how programs can monitor the experience at all participating sites include but are not limited to:

- Resident evaluations of rotations at each participating site
- Participation of the site director in faculty meetings
- Inclusion of the site director on the Clinical Competency Committee (CCC), and/or on the Program Evaluation Committee (PEC)

[The Review Committee may further specify]

Since Review Committees may specify other requirements related to participating sites, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to participating sites should be directed to specialty Review Committee staff.

COMMON PROGRAM REQUIREMENTS

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)

[The Review Committee may further specify]

GUIDANCE

Requirement I.B. defines a participating site as “an organization providing educational experiences or educational assignments/rotations for residents.” In addition to the primary clinical site, per requirement I.B.4. the program director must add all participating sites routinely providing a required educational experience of one month or more in ADS.

Adding participating sites that provide elective experiences and/or experiences that are shorter than one month in length to ADS is not required by the ACGME but may be helpful for some specialties.

Programs should consult the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

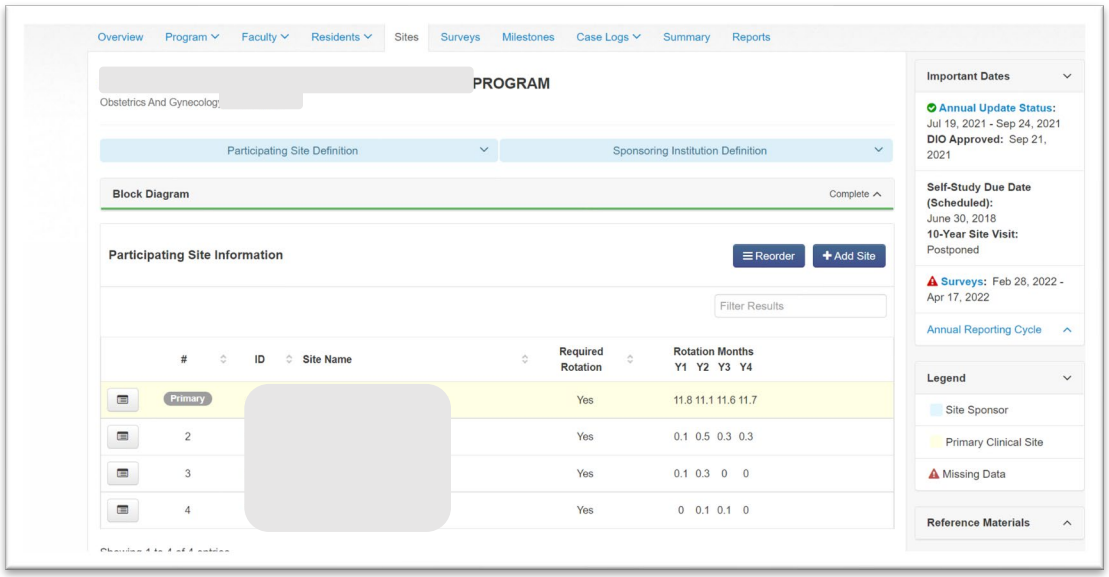
- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Programs can also access the Common Program Requirements FAQs for additional information on participating sites.

When applying for accreditation or recognition of a new program, or when a change occurs in the educational structure of a program and a new participating site at which a required educational experience of one month or more will occur, the program director must add the new site in ADS. All sites added in ADS will be visible to both the program and the Review Committee.

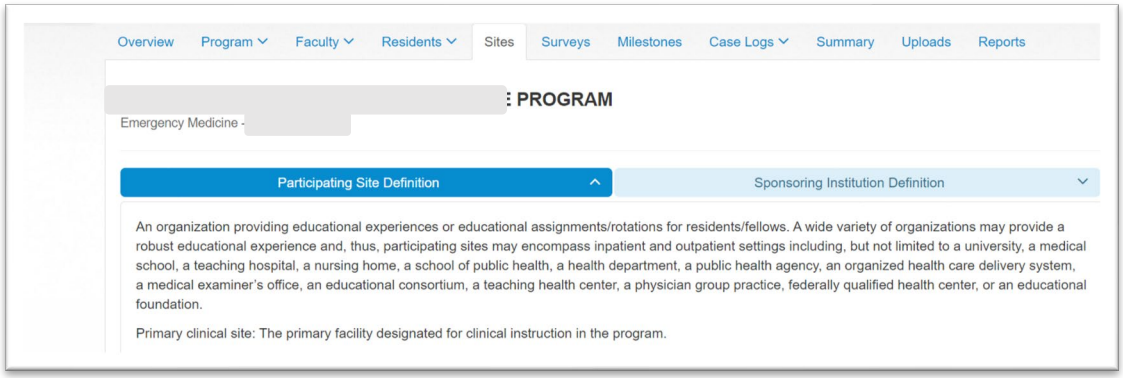
ADS Screenshot: Adding a Participating Site

To add a site in ADS, log into the program’s ADS profile, then go to the Sites tab on the top navigation bar and click the “Add Site” blue button.



ADS Screenshot: Participating Site Definition

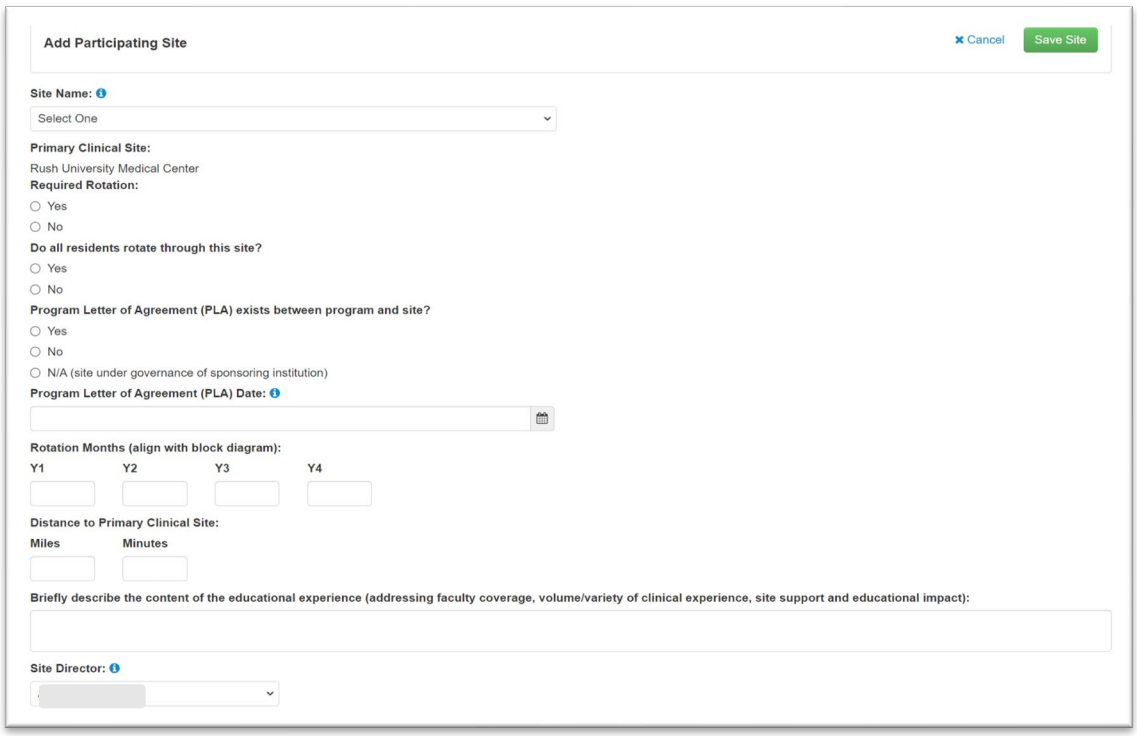
For the definition of a participating site or additional instructions, click the arrow on the "Participating Site Definition" blue bar.



The program director should contact the designated institutional official (DIO) to review any additions/deletions of participating sites in advance of making changes in ADS to ensure appropriate oversight.

ADS Screenshot: Adding Participating Site Details

On the "Add Site" screen, the program will select a site name from the pre-populated dropdown menu. If the site is not on the list, contact the DIO to have the site added. Programs may only enter sites that the Sponsoring Institution has approved and added to ADS. Complete all other information and click the "Save Site" button.



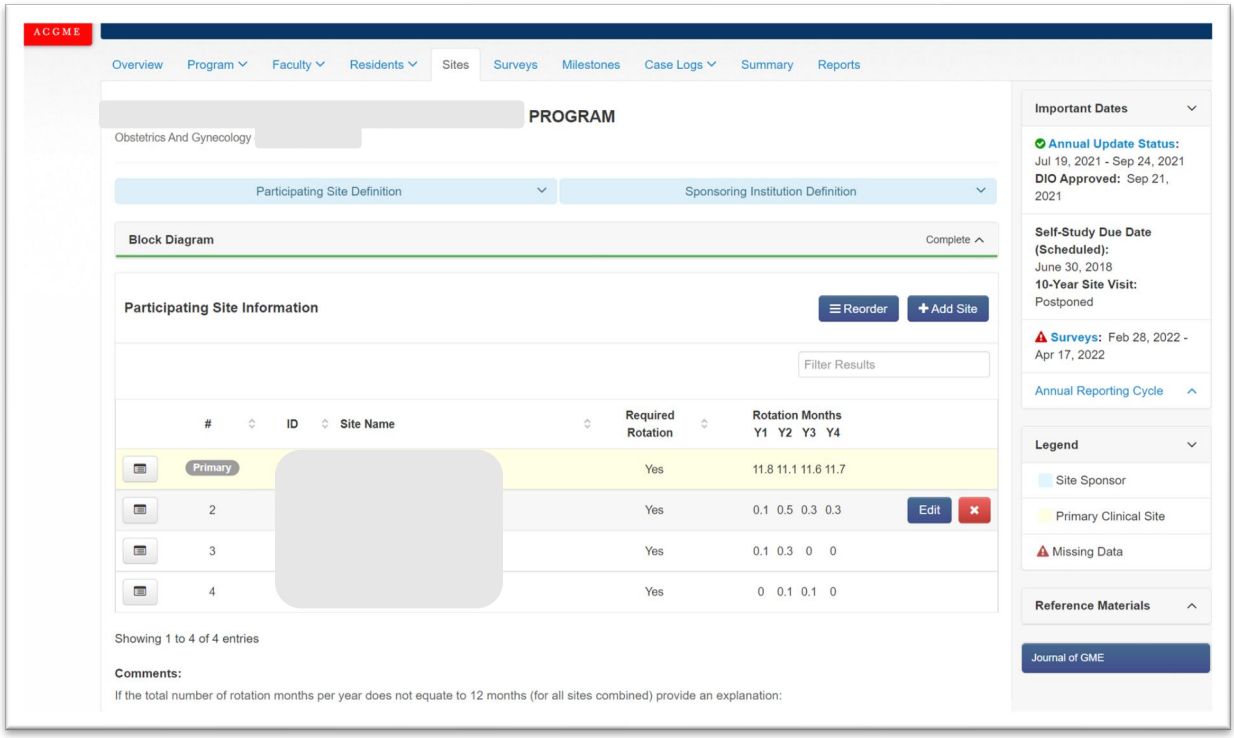
NOTE: Programs should complete all requested information. The ACGME may request additional information from the program if the information submitted is incomplete or inaccurate. For example:

- Rotation months for each post-graduate year listed for that participating site do not align with the rotation months on the block diagram.
- The description of the content of the educational experience does not include a rationale for the addition of the site, faculty coverage, volume/variety of clinical experience, site support, and/or educational impact.

While copies of Program Letters of Agreement (PLAs) are not required when adding a new participating site, programs should ensure that a PLA is in place. A copy may be requested by the ACGME as needed.

ADS Screenshot: Deleting a Participating Site

If the program no longer uses a participating site, the site should be removed from ADS. To remove a site, on the Sites tab hover over the site in the list of participating sites and click the "X" button.



Once all participating sites have been added to or deleted from ADS, programs should review the list of participating sites and ensure that they are ordered based on the number of months residents spend at each site, with the most-used site listed as primary and all other sites listed in descending order. Programs should also ensure that the number of months for each year of training totals 12. If the number of months for each year of education and training do not total 12, the "Comments" box should be used to provide an explanation to the Review Committee. Programs should also ensure that the participating sites listed in ADS match the participating sites listed on the block diagram, including the number of months residents rotate at each site. This is a common discrepancy Review Committees identify.

Review Committee Notification and Approval of Participating Site Additions and Deletions

Once a site is added to or removed from ADS, the Review Committee staff members are notified of the change. The change is reviewed per the Review Committee process and programs will receive notification of approval or follow-up from the Review Committee and ACGME staff members if needed.

Common Areas for Improvement (AFIs) or Citations

Some of the most common areas for which programs receive an AFI or citation include:

- The listing of participating sites in ADS does not match information on the program block diagram.
- The number of months for each year of education and training listed for each participating site in ADS is different from the block diagram.
- The number of months for each year of education and training does not total 12 and the program does not provide an explanation.
- A site director is not identified or is incorrectly identified on the participating site profile in ADS and/or the PLA.

COMMON PROGRAM REQUIREMENTS

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

GUIDANCE

The ACGME is interested in the diversity of the physician workforce because it is essential to addressing health care access and health equity. While most, if not all, Sponsoring Institutions have mission statements pertaining to diversity and policies regarding diversity, these serve as a starting point, and there are aspects of this requirement that may take considerable time to produce quantifiable results. Common Program Requirement I.C. states that programs must engage in mission-driven, ongoing, systematic efforts to recruit and retain individuals of diverse backgrounds as residents and fellows. It is important to also consider that the ability to alter the number of such individuals appreciably will require years of effort to expand the pool of diverse graduate medical education (GME) applicants. This will require cooperative efforts among programs within Sponsoring Institutions, cities, and specialties. Therefore, the initial emphasis is on process, not numerical outcomes.

The definition of diversity is intended to parallel that of the Association of American Medical Colleges' (AAMC) philosophy on Underrepresented in Medicine, which permits flexibility in defining the target groups for diversity based on the service demographic of the program that is underrepresented relative to the workforce for a given role. The population of individuals considered underrepresented in medicine will include racial and ethnic minority individuals reflective of the program's service area, but may also include others the program deems underrepresented in medicine in the service area, or in the discipline in general. As noted in V.C.1.c).(5).(c), workforce diversity is a core element of a program's annual evaluation. Evaluation of workforce diversity should include an assessment of the demographic population in the area served by the program and the program's efforts to recruit and retain a diverse workforce of individuals who are underrepresented in medicine, reflective of the service area population, in the roles clarified in I.C. (i.e., residents, fellows, faculty members, senior GME administrative staff members, and other relevant members of the program's academic community).

Each program is asked to present the demographic information for all GME learners on the Resident Roster in the ACGME's Accreditation Data System (ADS). This information provides important baseline data on the number of individuals as a function of race/ethnicity and gender. With time, as efforts to enhance the pool of diverse learners lead to improvements, ACGME assessment may shift to include the actual increase in the number of diverse learners. To assess meaningful change, it is essential to track these numbers annually to reveal continued progress.

It is important that the best possible data are entered in the Resident Roster. The gold standard for obtaining the race and ethnicity for each resident is for the program staff to have a conversation about the subject and to ask directly how each resident would choose to be represented on the roster. An alternative approach for obtaining this information is to import the race/ethnicity and gender information from the electronic application used at the time of residency selection. This is primary data supplied by the residents themselves and transfer of this information is perhaps the most efficient way of supplying the ACGME with this information.

In 2020, the ACGME introduced the Resident Portal. Individual residents can update their own demographic information as they choose during their educational program. Because the Resident Portal is not currently used by all residents, the ACGME will continue to ask for this information on the Resident Roster.

The demographic categories used by the ACGME reflect race/ethnicity as White, Black or African American, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native; and Hispanic, Latino, or of Spanish origin. Programs will select one of these categories. There are three additional categories: Other, Unknown, and Prefer not to report. Since multiple races cannot currently be selected, if a resident prefers to identify as multiracial, to the exclusion of a single race choice, “Other” is the suggested category. If any residents truly do not know their race/ethnicity (e.g., the resident was adopted or the child of an adopted individual, or the program was not able to obtain any information pertaining to demographics), only then should the “Unknown” category be selected.

For gender, the ACGME currently offers four options for programs to report on the Resident Roster: Male, Female, Non-Binary, and Prefer not to report. For individuals who choose to identify as male, select “Male,” and for those who choose to identify as female, select “Female.” Those who choose not to identify as solely male or female should select “Non-Binary.”

The ACGME has designed a new initiative, *ACGME Equity Matters*™, to assist programs in enhancing their diversity, equity, and inclusion. Among other resources, it includes a toolkit of approaches that address many of the barriers diverse individuals face in the GME environment. Some ideas employed by the most inclusive programs include: having a chief diversity officer position; creating and supporting a diversity committee; and actively engaging minority individuals in the learning environment to help eliminate barriers to success in recruitment and retention.

The AAMC has a helpful tool, the Diversity Engagement Survey , which may be used to assess the climate in a program with respect to diversity.

COMMON PROGRAM REQUIREMENTS

I.D Resources

I.D.1 The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

[The Review Committee must further specify]

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family as outlined in VI.C.1.d).(1).

I.D.2.d) security and safety measures appropriate to the participating site; and, (Core)

I.D.2.e) accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

I.D.3. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

I.D.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

[The Review Committee may further specify]

GUIDANCE

I.D.1. Availability of Adequate Resources for Resident Education

[The Review Committee must further specify]

Since requirement I.D.1. requires that Review Committees further specify about the "availability of adequate resources," programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

The ACGME monitors compliance with requirements in I.D.2. in various ways, including:

- Questions program leadership must answer as part of an application or during the ADS Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys;
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section I.D.2. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

I.D.2.a) and I.D.2.b) Access to Food and Sleep/Rest Facilities

Programs are expected to partner with their Sponsoring Institutions to ensure residents have adequate access to food and sleep/rest facilities at all participating sites. Interpretations of the requirements for space may depend on the attributes of a participating site and the needs of residents when they are assigned to that site.

Depending on the type of participating site and the type of educational experience (e.g., overnight call, outpatient clinic) occurring at that site, there may be differences in the types of resources provided. Because of site-, program-, and resident-specific factors, the ACGME does not provide uniform specifications for access to food and the physical space of sleep/rest facilities beyond the qualities indicated in the requirements and the associated guidance in the associated Background and Intent. It is important for Sponsoring Institutions and programs to obtain resident input when evaluating these aspects of clinical learning environments.

I.D.2.c) Access to Lactation Facilities

It is critical to acknowledge that the timing of residency often overlaps with the timing of starting and raising families. Therefore, residents must have access to lactation facilities.

Rooms for lactation must be clean, provide privacy and refrigeration, and be close enough to the clinical setting to be of use for residents who need them. Simply using a restroom as a facility for lactation or for medication administration would not meet the standard of cleanliness. Refrigeration capabilities are essential for storage. In addition, the availability of a computer and telephone will allow residents and fellows, if necessary, to provide continued attention to patient care while attending to their personal health care needs.

Interpretation of the requirement for "proximity appropriate for safe patient care" is left to the program and the Sponsoring Institution. The requirements do not dictate a specific distance or a time element for the resident to get from the lactation facility or room for personal health care needs to the clinical location. Instead, institutions and programs are urged to consider the circumstances. For example, a busy, high-intensity clinical location, such as the intensive care unit, might require that the lactation room is in a location that allows immediate access to the patient care area, whereas a clinical location that is less busy or intense will not require such proximity. In addition, it is not necessary for the lactation facility to be solely dedicated to resident use.

I.D.2.e) Accommodations for Residents with Disabilities

Programs must work with their Sponsoring Institutions to ensure compliance with institutional policies related to resident requests for accommodation of disabilities. Common Program Requirements I.D.2. and I.D.2.e) are companions of Institutional Requirement IV.I.4., which states, "The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations."

Laws and regulations concerning requests for accommodation of disabilities include Title I of the Americans with Disabilities Act and related enforcement guidance published by the US Equal Employment Opportunity Commission. Other federal, state, and local laws and regulations may also apply. It is common for program directors, coordinators, residents, faculty members, and designated institutional officials to collaborate with their institution's human resources and legal departments and/or institutional officers/committees to manage requests for accommodation.

I.D.3. Reference Material

Sponsoring Institutions and programs must ensure that residents have access to medical literature that supports their clinical and educational work. Common Program Requirement I.D.3. is parallel to ACGME Institutional Requirement II.E.2., which states, "Faculty members and residents/fellows must have ready access to electronic medical literature databases and specialty-/subspecialty-specific and other appropriate full-text reference material in print or electronic format."

Review Committee members are aware that the availability of a computer or mobile device with internet access alone may provide access to a wide range of relevant reference material. Many Sponsoring Institutions and programs purchase subscriptions to information resources and

services to supplement open access materials. As with other programmatic resources, interpretation of the requirement may depend on unique circumstances of participating sites, programs, faculty members, and residents. Residents and faculty members may provide valuable input to Sponsoring Institutions and programs regarding the adequacy of available medical literature resources.

I.D.4. Resources to Support the Number of Residents

Programs, in partnership with their Sponsoring Institutions, must ensure there are resources to support the number of residents appointed to the program. If a program fails to demonstrate that it has the capacity to provide each resident with a sufficient educational experience, the Review Committee may reduce that program's approved complement (ACGME Policies and Procedures - 19.500 Reduction in Resident/Fellow Complement) or will not approve a request for a resident complement increase.

[The Review Committee may further specify]

Programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

COMMON PROGRAM REQUIREMENTS

I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)

I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

GUIDANCE

Although other learners and other care providers can, and frequently do, enhance resident education, there are certainly circumstances in which they interfere with that process. Examples include:

- The interference of a subspecialty fellow or another care provider in the communication between a faculty member and the resident (or resident team) in such a manner that the resident does not gain the educational benefit of direct communication with the attending physician faculty member;
- A fellow repeatedly performing procedures in which the resident is expected to develop competence when there is a limited pool of procedures available;
- Too many learners for the amount of educational experience or excessive rotators (e.g., medical students, residents from other specialties, advanced practice provider students);
- Lack of opportunity for peer teaching (e.g., senior resident to junior resident, PGY-1 to medical student); and,
- Certified Registered Nurse Anesthetists (CRNA) or CRNA students interfering with residents performing and gaining competence in certain procedures.

Situations of this type frequently involve a degree of intra- or inter-departmental disagreement on educational responsibilities and priorities. In the case of other care providers, they may also impact decisions made by the administration of the clinical site. The designated institutional official and Graduate Medical Education Committee (GMEC) may be very helpful in supporting the program(s) and in arriving at equitable and mutually beneficial solutions.

The ACGME monitors compliance with requirements I.E.- I.E.1 in various ways, including:

- Questions program leadership must answer as part of an application or during the ADS Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys;
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section I.E. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

ADS Screenshot: The Presence of Other Learners

The question below is part of the program ADS Annual Update Questionnaire.

Programs are encouraged to monitor any concerns identified in the Resident/Fellow Survey and address these concerns proactively in the major changes section in ADS as part of their ADS Annual Update.

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core).

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) Final approval of the program director resides with the Review Committee. (Core)

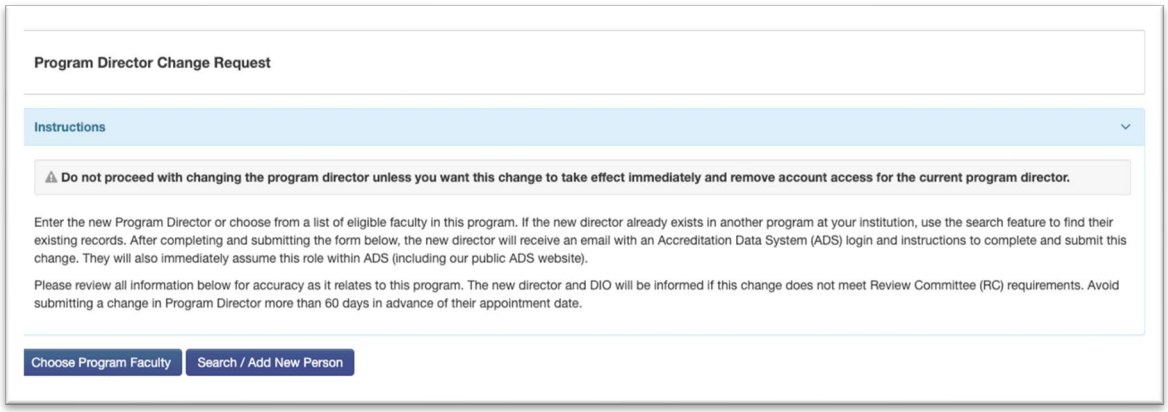
Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

GUIDANCE

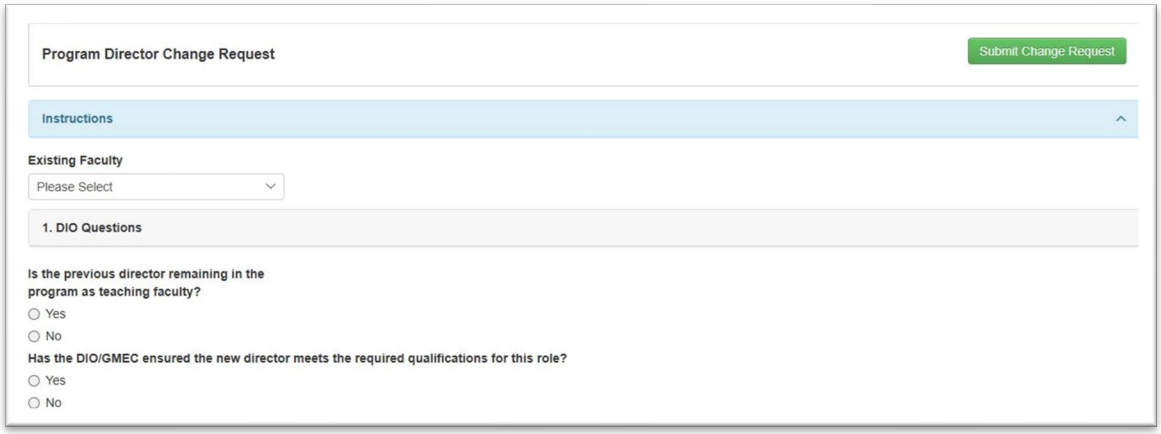
Requirement II.A.1. specifies that each program must have one faculty member appointed as program director. For new programs, the program director is selected in the Accreditation Data System (ADS) by the designated institutional official (DIO). For existing programs, the program director is already designated and appears first on the faculty roster, or a new program director can be designated when the DIO initiates a change in ADS. For appointment of a new program director, the Graduate Medical Education Committee (GMEC) must first approve the change. Following GMEC approval, the DIO will enter the recommendation into ADS. Final approval rests with the Review Committee.

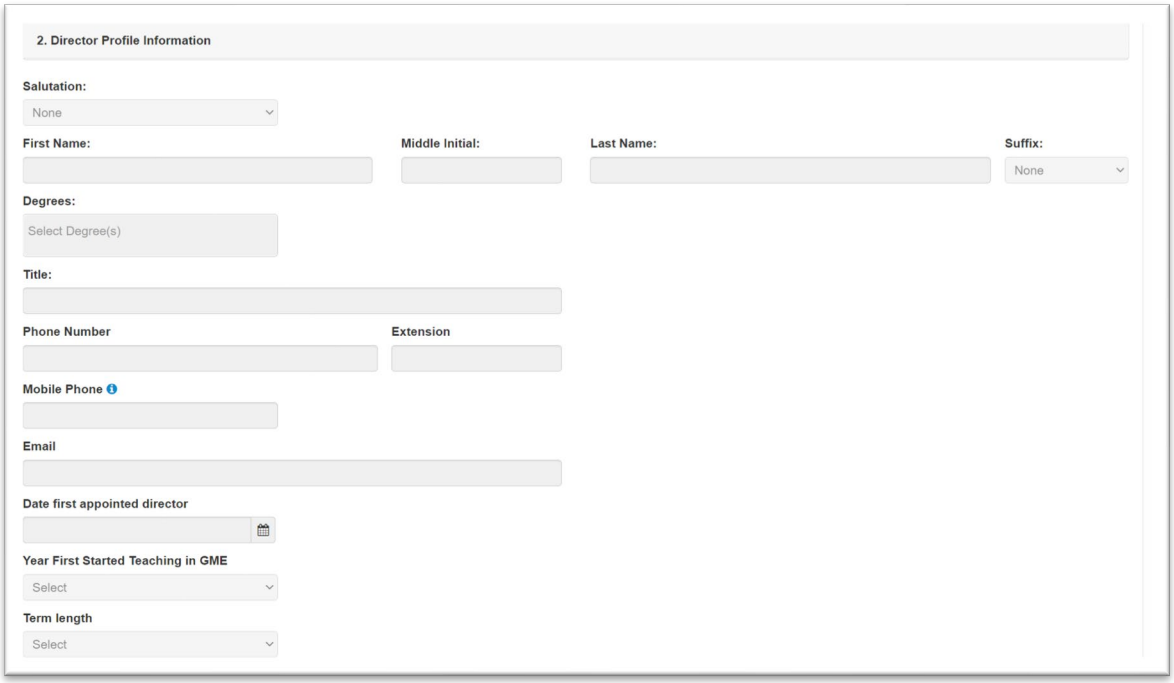
ADS Steps and Screenshots for Initiating a New Program Director Request:

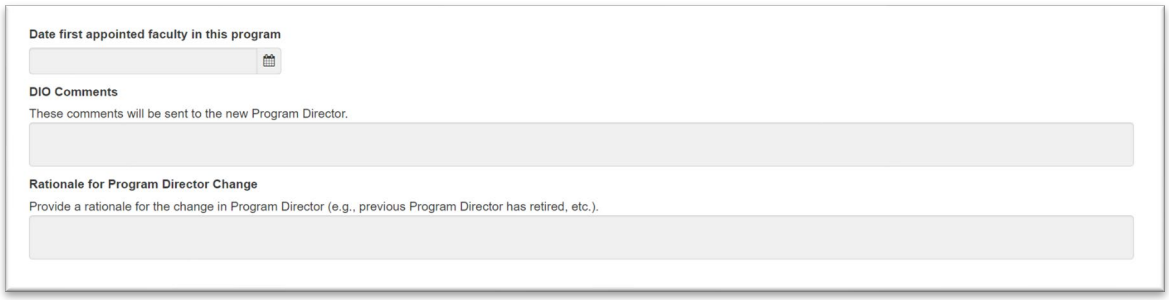
1. Log into the Sponsoring Institution's ADS account with the DIO's login information.
2. Go to the **Sponsored Programs** tab and locate the program for which the program director will change.
3. On the **Program** tab, click **New Program Director**.
4. Read the instructions carefully and select one of two options: **"Choose Program Faculty"** or **"Search/Add New Person."**



5. The **DIO completes** two key sections: **DIO questions** and **Director Profile Information**, including the rationale for the change.

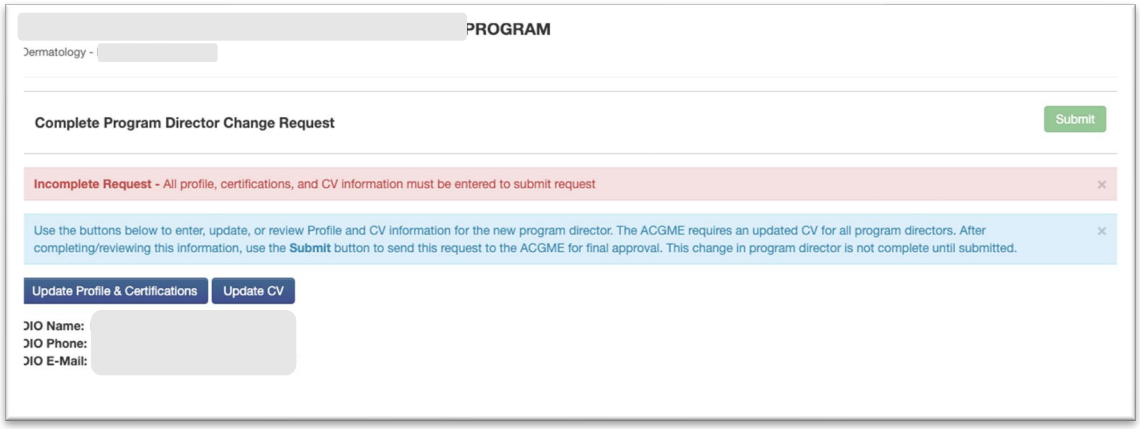






6. When the **DIO submits the change**, the **old program director's ADS access will be immediately disabled** and **the new program director will receive an email notification with the username and password (if new to ADS) and a notification to review the change**. The new contact information is immediately reflected in ADS and on the public ACGME website.
7. Once the **new program director** logs into ADS, **the change request will be available on the Overview tab** toward the bottom of the page for review, completion of any missing information, and submission. The program director change is not complete until submitted by the new program director.

   NOTE: It is critical that the new program director or a designee complete all required fields on both the "Profile and Certifications" and "CV" tabs associated with the request. Fields that require information or updates will be marked in red. This will reduce the need for ACGME staff members to seek updated information from programs and it will ensure timely review and approval by Review Committees.



8. Once the new program director submits the completed request, an email notification will be generated in ADS to the ACGME, the DIO, and the DIO's staff members.

9. Review Committee staff members will reach out to programs with questions or requests for additional information as needed if the new program director change request is incomplete. Programs will be notified through ADS if a request is denied.

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

[The Review Committee may further specify]

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

GUIDANCE

The program director has many important responsibilities in a residency program. It can take years for individuals to understand and reach a level of expertise in the role and develop effective working relationships with all the individuals with whom they must interact, including the designated institutional official, program faculty members, faculty members and leaders in related educational programs, administrators at the clinical sites to which residents rotate, community leaders, and others. For these reasons, continuity in the program director role is often associated with success of the program.

[The Review Committee may further specify]

This common program requirement allows specialties to further specify. Currently, only a few specialties have added a requirement that further specifies the minimum amount of time a program director should serve in their role. To review the specialty-specific Program Requirements, go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

The Background and Intent associated with this requirement encourages programs “to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.” While having a formal succession planning process at the program or Sponsoring Institution level would be ideal, there are many ways programs can think about succession planning. In larger programs, having one or more assistant/associate program directors may be a good option for ensuring continuity of leadership in the program in case of a program director change. In other cases, having a faculty mentoring process to identify faculty members with an interest in a graduate medical education leadership career path and supporting them in achieving various leadership competencies would also be a way to develop talent for a program director or assistant/associate program director role.

COMMON PROGRAM REQUIREMENTS

II.A. Program Director

II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

[The Review Committee must further specify minimum dedicated time for program administration and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s).]

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in resident education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team who are new to the role, may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

GUIDANCE

II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration.

The Background and Intent associated with this requirement further explains the rationale, provides various examples of what may constitute program director support, and identifies instances in which minimum support may need to be increased.

It is important to note that Review Committees consider approved resident complement rather than filled resident complement when assessing program director or program leadership support for administration of the program.

This requirement is closely linked to Institutional Requirements II.B.-II.B.4. A Sponsoring Institution is not necessarily the entity that provides compensation directly to a program director, and, in many cases, a program director's employer is not the Sponsoring Institution. However, each accredited Sponsoring Institution is accountable to the ACGME's Institutional Review Committee for ensuring that program directors receive support and dedicated time in substantial compliance with this requirement.

[Each specialty Review Committee must further specify minimum dedicated time for program administration and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s).]

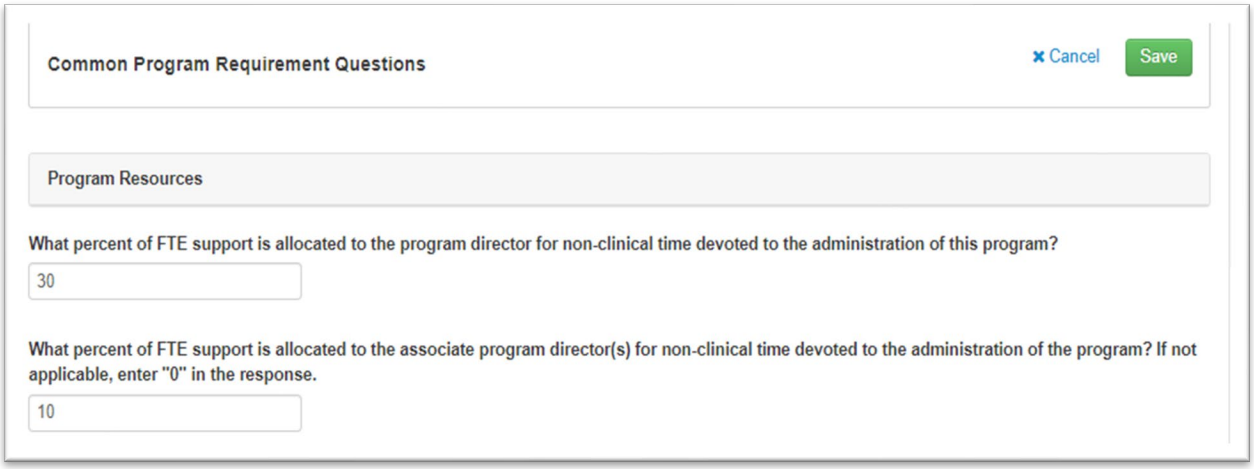
Since Review Committees must specify minimum dedicated time for the program director or program leadership, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

This Program Leadership Dedicated Time summary document also provides a snapshot of program director dedicated time and support across all ACGME-accredited specialties.

Accreditation Data System (ADS) Screenshot: Program Director Support

Annually, the program director is asked to answer or update the following questions as part of the ADS Annual Update regarding support adequate for the administration of the program based on its size and configuration.


Common Program Requirement Questions
Cancel
Save
Program Resources
What percent of FTE support is allocated to the program director for non-clinical time devoted to the administration of this program?
30
What percent of FTE support is allocated to the associate program director(s) for non-clinical time devoted to the administration of the program? If not applicable, enter "0" in the response.
10

COMMON PROGRAM REQUIREMENTS

II.A.3. Qualifications of the program director:

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee; (Core)

[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; and, (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

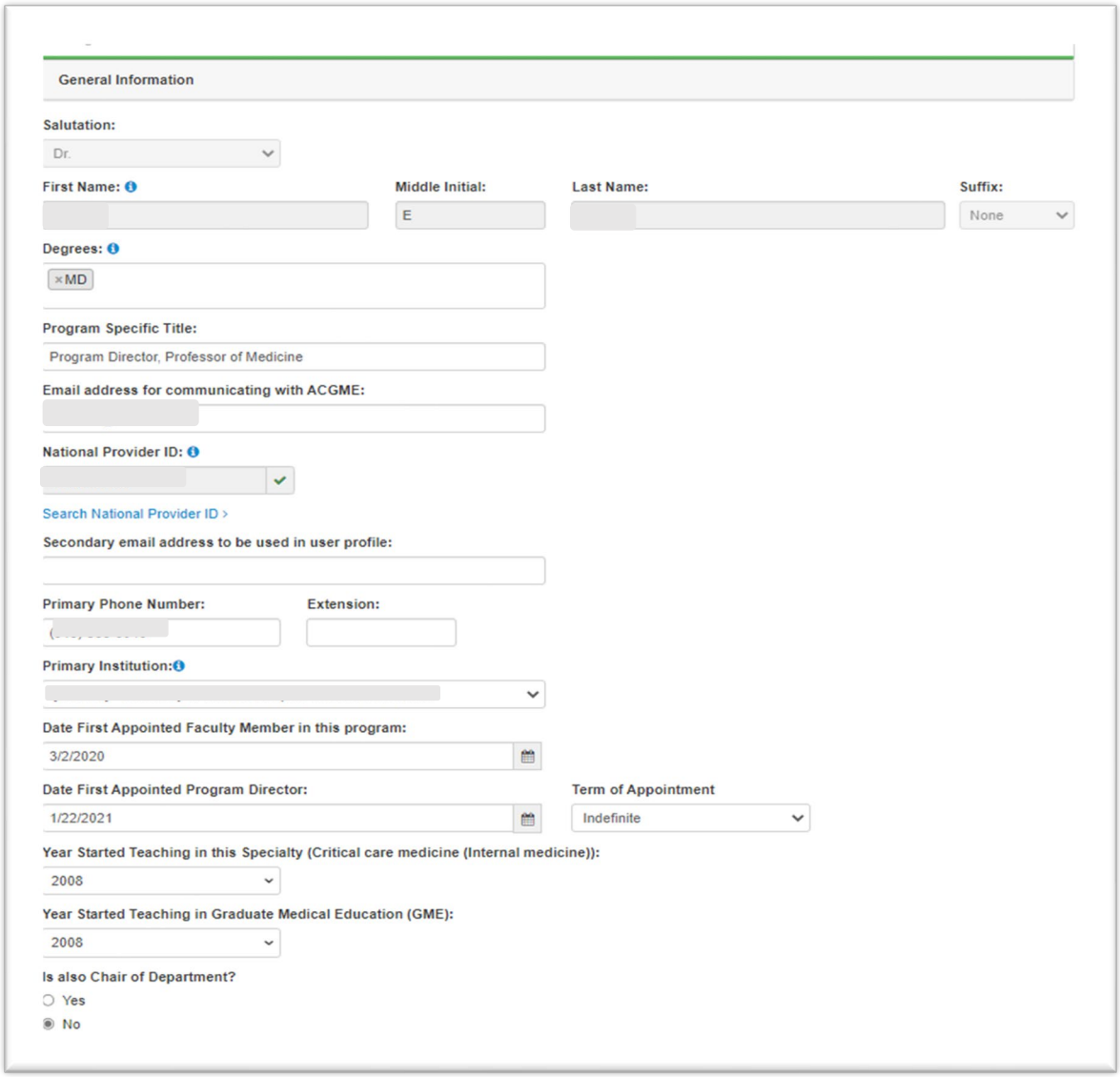
[The Review Committee may further specify additional program director qualifications]

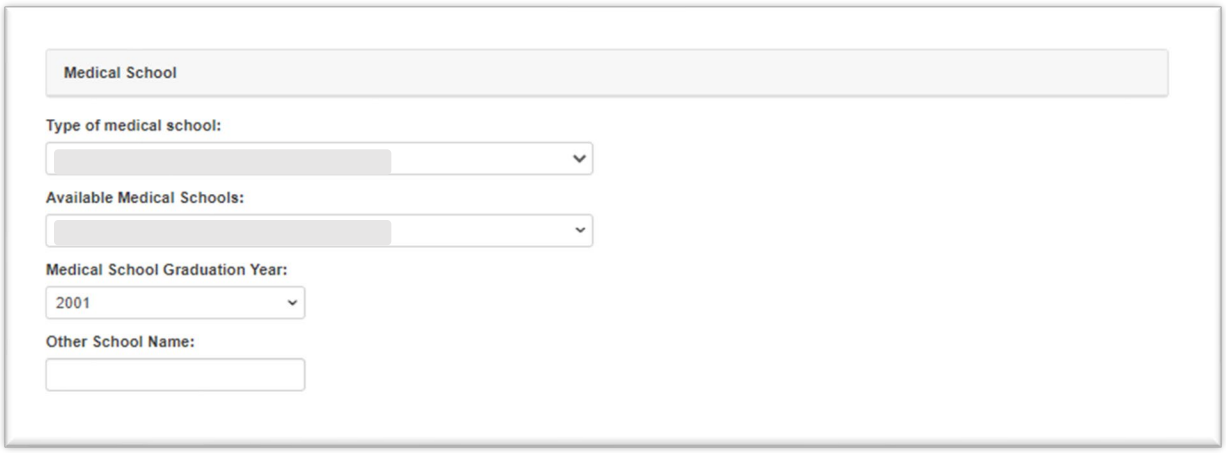
GUIDANCE

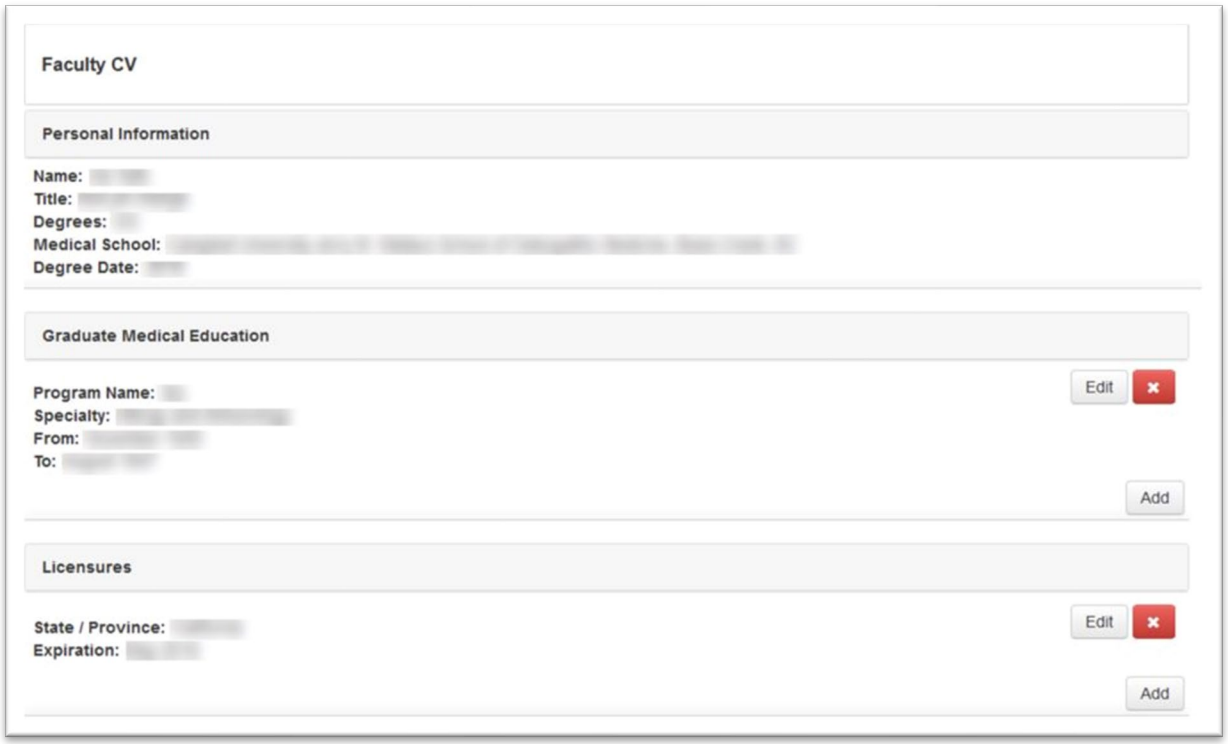
II.A.3.a) Specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee.

Program director education and training, clinical and administrative experience and expertise, and other demographic information are captured on the program director profile and curriculum vitae (CV) in the Accreditation Data System (ADS). Programs should complete all required information when adding a new program director into ADS as part of an application or when submitting a program director change for an existing program. It is also important to carefully review and update all the program director information if a profile for that individual already exists in ADS.

ADS Screenshots: Program Director Profile and CV




Medical School
Type of medical school:
Available Medical Schools:
Medical School Graduation Year:
2001
Other School Name:


Faculty CV
Personal Information
Name:
Title:
Degrees:
Medical School:
Degree Date:
Graduate Medical Education
Program Name:
Specialty:
From:
To:
Edit
Add
Licensures
State / Province:
Expiration:
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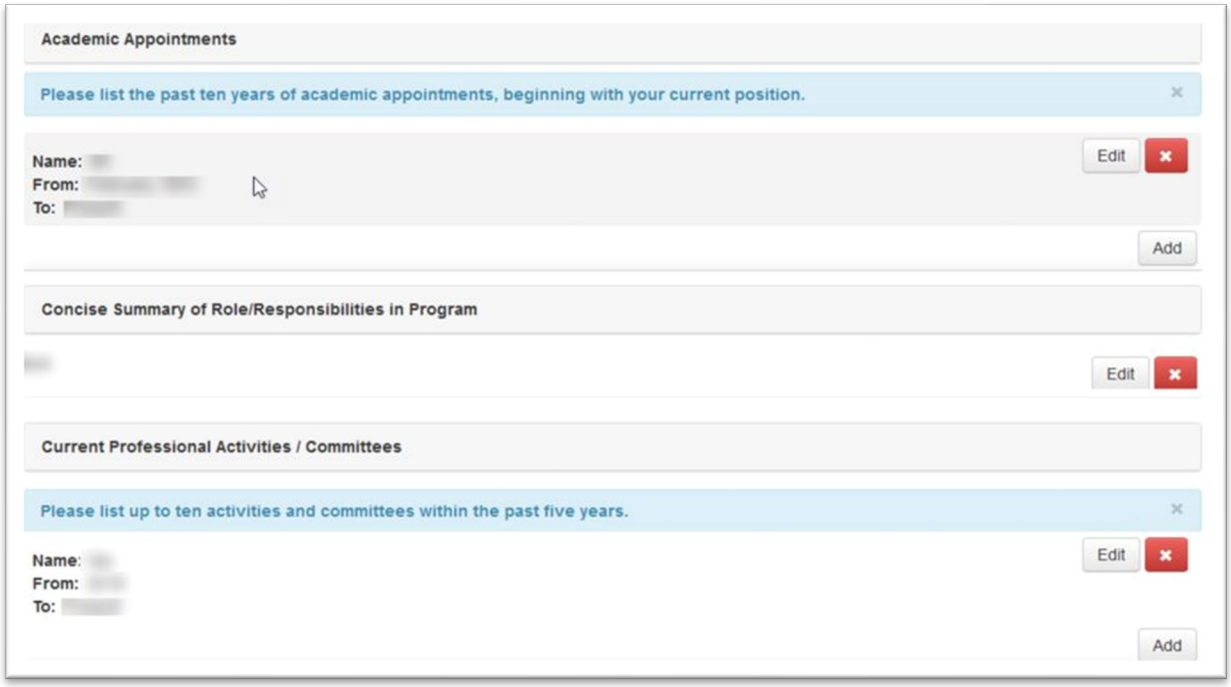


II.A.3.b) Current certification in the specialty for which they are the program director or specialty qualifications that are acceptable to the Review Committee.

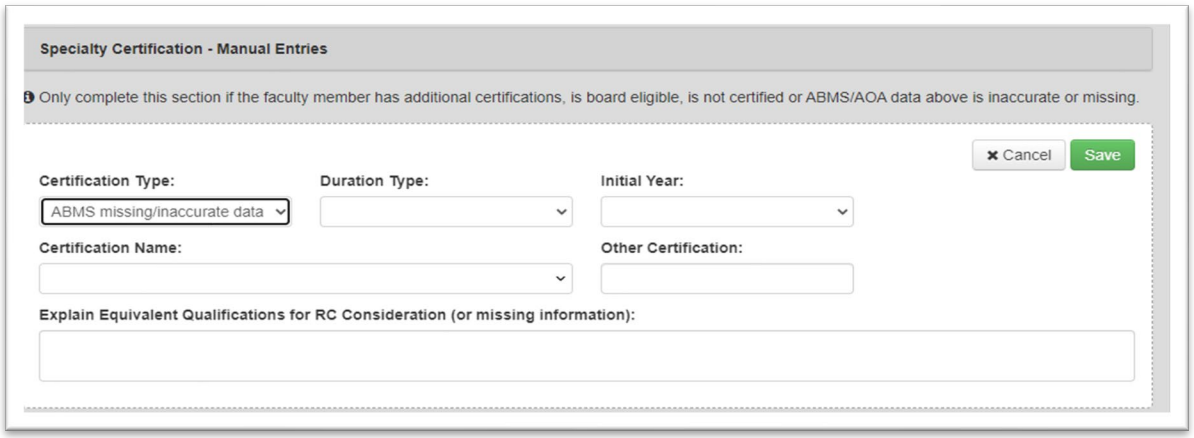
[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]

Some Review Committees will accept *only* certification in the appropriate specialty by an American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board for the program director. Other Review Committees will accept other qualifications for the program director. Programs are encouraged to refer to the specialty-specific Program Requirements for more information on this requirement.

The ACGME automatically populates data received from the ABMS and the AOA for the program director on their individual ADS profile page, where data are available. Program director board certification data will be matched to the ABMS and AOA datasets based on National Provider Identifier (NPI) number, as well as name, date of birth, and medical school graduation year. Program directors who are newly entered into ADS will have their certification information matched and populated within 24 hours.

Programs are only required to manually enter the program director's ABMS/AOA board certification data in ADS if no data is displayed or it is incorrect. In this case, a manual entry for "ABMS missing/inaccurate data" or "AOA missing/inaccurate data" should be added on the program director's profile with a duration type, initial certification year, certification name, and an explanation for Review Committee consideration.

ADS Screenshot: ABMS/AOA Missing/Inaccurate Data

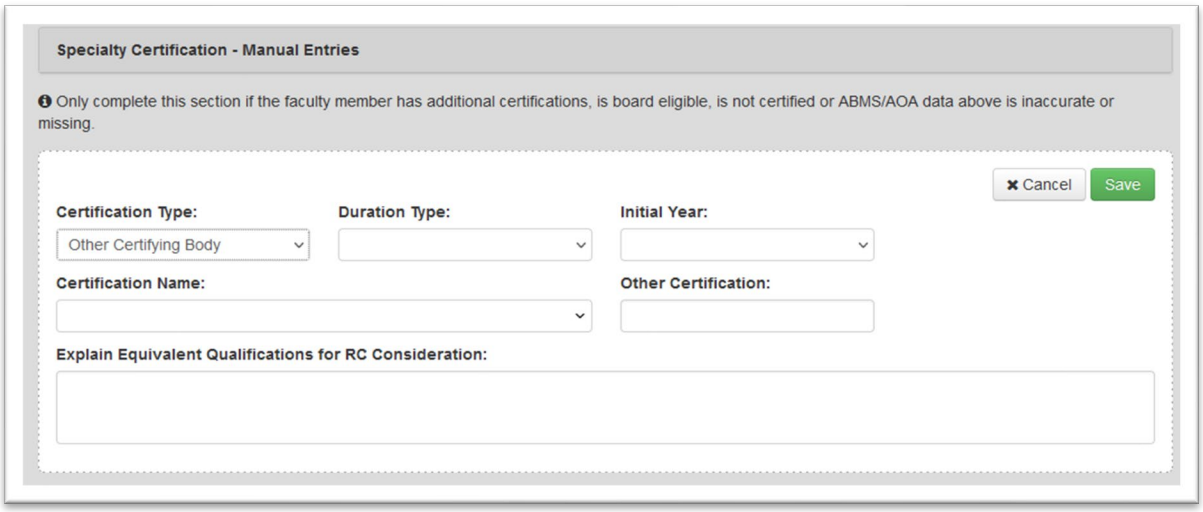


Common issues related to the ABMS and AOA data not auto-populating on the program director's profile and in the faculty roster include:

- The NPI number in ADS is incorrect or does not match the NPI number in the ABMS/AOA dataset.
- A lag in when updated board certification data are received by the ACGME from the ABMS and AOA.

For Review Committees that allow other acceptable specialty qualifications for the program director, programs can provide a manual entry on the program director's profile page in the "Specialty Certification – Manual Entries" section of ADS.

ADS Screenshot: Specialty Certification – Manual Entries for Program Directors Who are Board Eligible, Not Certified, or Certified by Another Certifying Body



II.A.3.c) and II.A.3.d) Medical Licensure, Medical Staff Appointment, and Ongoing Clinical Activity

These two requirements go hand in hand and are self explanatory.

Common Citations Regarding Program Director Qualifications Include:

- No or not enough previous experience in the specialty
- No or not enough previous educational/administrative experience
- Board certifications that are lapsed
- No board certification information entered at all

[The Review Committee may further specify additional program director qualifications]

The ACGME Review Committees want to help programs succeed. One essential element of program success is having a qualified individual as program director. Based on years of cumulative experience with both programs that are successful and those that are not so successful, many Review Committees have developed minimal qualifications for program directors in each specialty. Review Committees may specify other requirements related to additional qualifications and clarifications for appointment, so programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to program director qualifications should be directed to specialty Review Committee staff.

COMMON PROGRAM REQUIREMENTS

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

II.A.4.a).(3) administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)

Background and Intent: The program director may establish a leadership team to Assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in V.B.; (Core)

II.A.4.a).(5)	have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)
II.A.4.a).(6)	have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)
II.A.4.a).(7)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

GUIDANCE

Simply put, the program director is *the* person who is ultimately responsible for the program.

II.A.4.a).(1) and II.A.4.a).(3) [The program director must:] be a role model of professionalism; and administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains.

NOTE: While the guidance below is related to Requirements II.A.4.a).(1) and II.A.4.a).(3), it does not constitute actual requirements. The intent of this section is to emphasize the importance of the program director and faculty leadership as noted in the Background and Intent, including role modeling of professionalism, high-quality patient care, educational excellence, and scholarly approach to work.

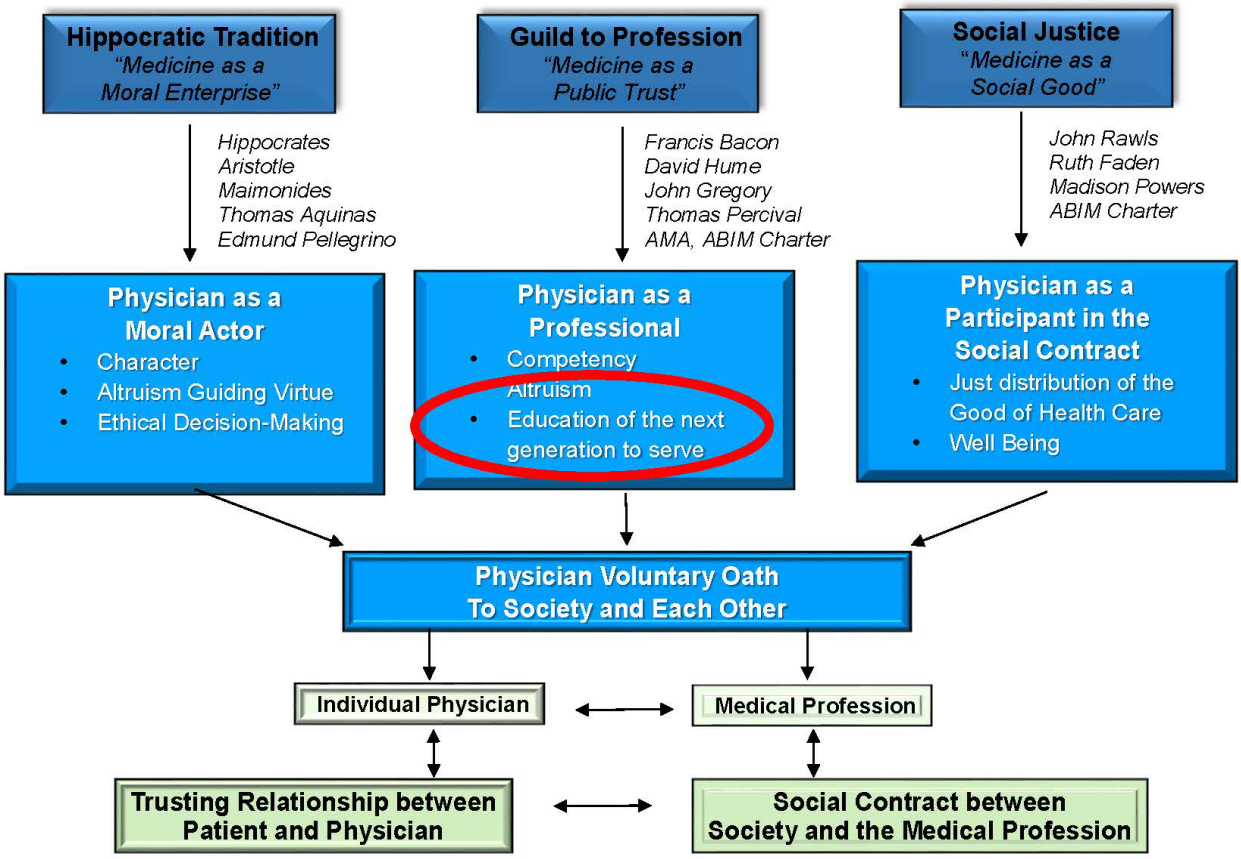
While this section is not tied to a specific requirement, program directors are urged to consult some or all the references for inspiration related to mentorship, humanism, and leadership.

Leadership

The concept of program director and faculty leadership takes many forms and is important regardless of program size. The designation of faculty leadership can be a formal or informal process, but what is most important is the composition of such a group. The group can be composed of physicians and non-physicians who know the residents well, have frequent interactions with them, and most importantly, can serve as role models in clinical care, professionalism, and scholarship. In addition, they can serve as a sounding board for the program director and help in shaping the program.

As ACGME President and Chief Executive Officer Dr. Thomas J. Nasca stated in the article "Professionalism and its Implications for Governance and Accountability of Graduate Medical Education in the United States" [Nasca, Thomas J. 2015. "Professionalism and Its Implications for Governance and Accountability of Graduate Medical Education in the United States." *JAMA* 313, no. 18: 1801. Graphic available at https://doi.org/10.1001/jama.2015.3738)]:

> The philosophical roots of professionalism include the Hippocratic tradition of medicine as a moral enterprise; the transition of medicine from guild to profession with a commitment to competence, altruism, and public trust; and *the responsibility of the profession to prepare the next generation of physicians to serve the public*. (Emphasis added)



Mentorship

While there are many articles that define and describe mentoring and mentorship, there are several characteristics that constitute this relationship. Mentorship is a long-term relationship between a more senior person (mentor) and a less experienced person (mentee). While both benefit from the relationship, it is generally established for the betterment of the mentee. According to Sambunjak and Marušić (Sambunjak, Dario, and Ana Marušić. 2009. "Mentoring." *JAMA* 302, no. 23: 2591. https://doi.org/10.1001/jama.2009.1858), mentorship includes three components: helping mentees acquire and integrate new learning; managing a personal aspect of transitional states; and maximizing the mentee's potential to become a fulfilled and achieving practitioner. Mentorship therefore helps physicians uphold the responsibility to educate the next generation of physicians to serve patients.

Tjan (Tjan, Anthony K. 2017. "What the Best Mentors Do." *Harvard Business Review*, December 5, 2017. https://hbr.org/2017/02/what-the-best-mentors-do) interviewed scores of leaders and concluded that successful mentors have four characteristics: 1) they put the relationship before the mentorship; 2) they focus on character rather than competence and on shaping character, values, self-awareness, empathy, and capacity for respect; 3) they shout loudly with optimism and keep quiet with cynicism; and 4) they are more loyal to their mentees than to their companies.

Additional References:

1. Sambunjak, Dario, Sharon E. Straus, and Ana Marušić. 2006. “Mentoring in Academic Medicine.” *JAMA* 296, no. 9: 1103. https://doi.org/10.1001/jama.296.9.1103.

2. Lacombe, Michael A. 1990. “Recent Advances.” *The American Journal of Medicine* 88, no. 4: 407–8. https://doi.org/10.1016/0002-9343(90)90497-2.

Humanism

1. Chou, Carol M., Katherine Kellom, and Judy A. Shea. 2014. “Attitudes and Habits of Highly Humanistic Physicians.” *Academic Medicine* 89, no. 9: 1252–58. https://doi.org/10.1097/acm.0000000000000405.
2. Montgomery, Lynda L., Sana Loue, and Kurt C. Stange. 2017. “Linking the Heart and the Head: Humanism and Professionalism in Medical Education and Practice.” *Family Medicine* 49, no. 5: 378–83. https://www.ncbi.nlm.nih.gov/pubmed/28535319.

Humanism in health care is characterized by a respectful and compassionate relationship between physicians and their patients. It reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others. The humanistic health care professional has two key attributes: altruism and empathy. Chou et al. (2014) stated that “Humanism in medicine combines scientific knowledge and skills with respectful, compassionate care that is sensitive to the values, autonomy and cultural backgrounds of patients and their families.”

Evidence demonstrates that compassion and empathy are critical components of good medicine. When provided with humanistic care, patients are more likely to adhere to their treatment regimens, and this adherence makes it more likely that they adhere to preventive practices and may heal more quickly. Studies indicate that the characteristics of humanism can be taught. While Chou et al. acknowledged this, they sought to determine how humanism can be maintained in a world of increasing demands and technologies. They interviewed faculty members in internal medicine who had been identified by the residents to be excellent role models for humanism. They found three themes: *attitudes* needed to sustain humanism included humility, curiosity, standard of behavior (“I treat patients the way I would want to be treated”), importance for the patient, importance for the physician (joy in caring for patients), and more than just the disease (“my role is being there with and for the patient”); *habits* included self-reflection, seeking a connection with the patients, teaching/role modeling (“knowing that I’m responsible not just for the patients in front of me, but modeling how my students and residents are going to treat their patients”), balance, and mindfulness and spiritual practices; and humanism and maintenance of humanism in medical practice takes *effort*. Many of the physicians interviewed noted that humanism takes deliberate, intentional work, and identified the need for environmental support. While one may conclude that the work that goes into deliberative practice of humanism imposes additional workload on physicians that leads to burnout, the physicians in the study believed that humanism, as represented by the joy in caring for patients and educating residents, actually was a deterrent to burnout.

II.A.4.a).(2) [The program director must:] design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program.

This requirement is intended to bring intentionality to the development, design, and implementation of each residency program in consideration of the needs and desires of its stakeholders. Programs are encouraged to develop and clearly articulate their mission with the

input of the communities they serve, their residents, their Sponsoring Institution, and others. Although the process may prove to be time consuming, developing this foundation will likely prove rewarding for all involved. Once developed, the mission of the program should periodically be re-evaluated for potential improvement, again incorporating input from stakeholders.

II.A.4.a).(5) [The program director must:] have the authority to evaluate and approve program faculty members for participation in the residency program education at all sites.

This requirement applies to faculty members at the primary clinical site and at any participating sites used by the program. It is important that the faculty members who participate in the education of residents are interested in and dedicated to the educational program.

II.A.4.a).(6) [The program director must:] have the authority to remove program faculty members from participation in the residency program education at all sites.

This requirement is often misunderstood. It does not mean the program director can terminate the employment of a faculty member, but rather that the program director has the authority to remove a faculty member from the teaching service. For example, if a faculty member is consistently reported as being unable or refusing to teach, berating the residents, and generally being unavailable for educational activities, the program director may decide to remove the faculty member from the teaching service. However, the faculty member may still continue with other clinical and administrative responsibilities within the department.

II.A.4.a).(7) [The program director must:] have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program.

For example, residents might be assigned to a participating site for a one-month rotation and residents report that their role is only to provide service. Faculty members at the site do not provide supervision, evaluation, or education and are not available to the residents. The program director may choose to discontinue the rotation and have the residents rotate to another participating site that can provide the appropriate an educational experience.

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.4. Program Director Responsibilities

II.A.4.a) The program director must:

II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)

GUIDANCE

II.A.4.a).(8). It is the responsibility of the program director to submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.

The submission of incomplete and/or inaccurate information by a program is one of the most common citations given by the Review Committees. Programs are required to submit specific information as part of an application, annually during the Accreditation Data System (ADS) Annual Update process, as part of preparing for a program site visit, or for other types of requests submitted to the ACGME. The program director is responsible for the accuracy and completeness of information submitted to the ACGME.

This requirement captures a broad array of information and Review Committees will issue citations related to this requirement if there are consistent gaps in data submitted to the ACGME. Some examples include:

1. An application or updated application has significant gaps in data required by the ACGME, the data was submitted in a format that is hard to understand for the Review Committee, or there are a lot of discrepancies between various parts of the application or updated application
2. The program's Annual Update is not completed, not approved by the designated institutional official (DIO), or has significant gaps in data required by the ACGME
3. For an application or updated application, required attachment documents were not provided, are missing key information, or do not meet common and specialty-specific requirements. For example:
    a. Program letter(s) of agreement (PLA): not submitted, outdated, lacking the appropriate components, or lacking requisite signatures (see I.B.2.a) and I.B.3.)
    b. Block diagram: not submitted, does not capture all required clinical experiences, or includes participating sites that do not align with the participating sites listed in ADS
    c. Goals and objectives were not provided, they are not competency based, or they are not level- or rotation-specific
    d. The supervision policy does not reflect appropriate levels of supervision (see VI.A.2.c) through VI.A.2.c).(3))
4. Responses to previous citations were not provided or were inadequate, if applicable
5. Program director and faculty qualifications: missing or outdated residency/fellowship training, academic appointments, licensure, board certification information
6. Program director and faculty curriculum vitae (CV): incomplete or outdated scholarly activity
7. Faculty and resident scholarly activity information not submitted as part of the Annual Update
8. Clinical experience: ACGME Case Log or patient numerics data not submitted or incomplete
9. Accreditation Field Representative needed to spend a significant amount of time during the site visit to make clarifications, corrections, and look for missing information

The ACGME created three brief videos available here to help with avoiding common errors in the data submitted to the ACGME:

1) creating a block diagram (NOTE: some specialties require a specialty-specific block diagram, so programs must check ADS for instructions on whether the common block diagram instructions or specialty-specific instructions apply)
2) responding to citations
3) providing information on scholarly activity

ADS Annual Update

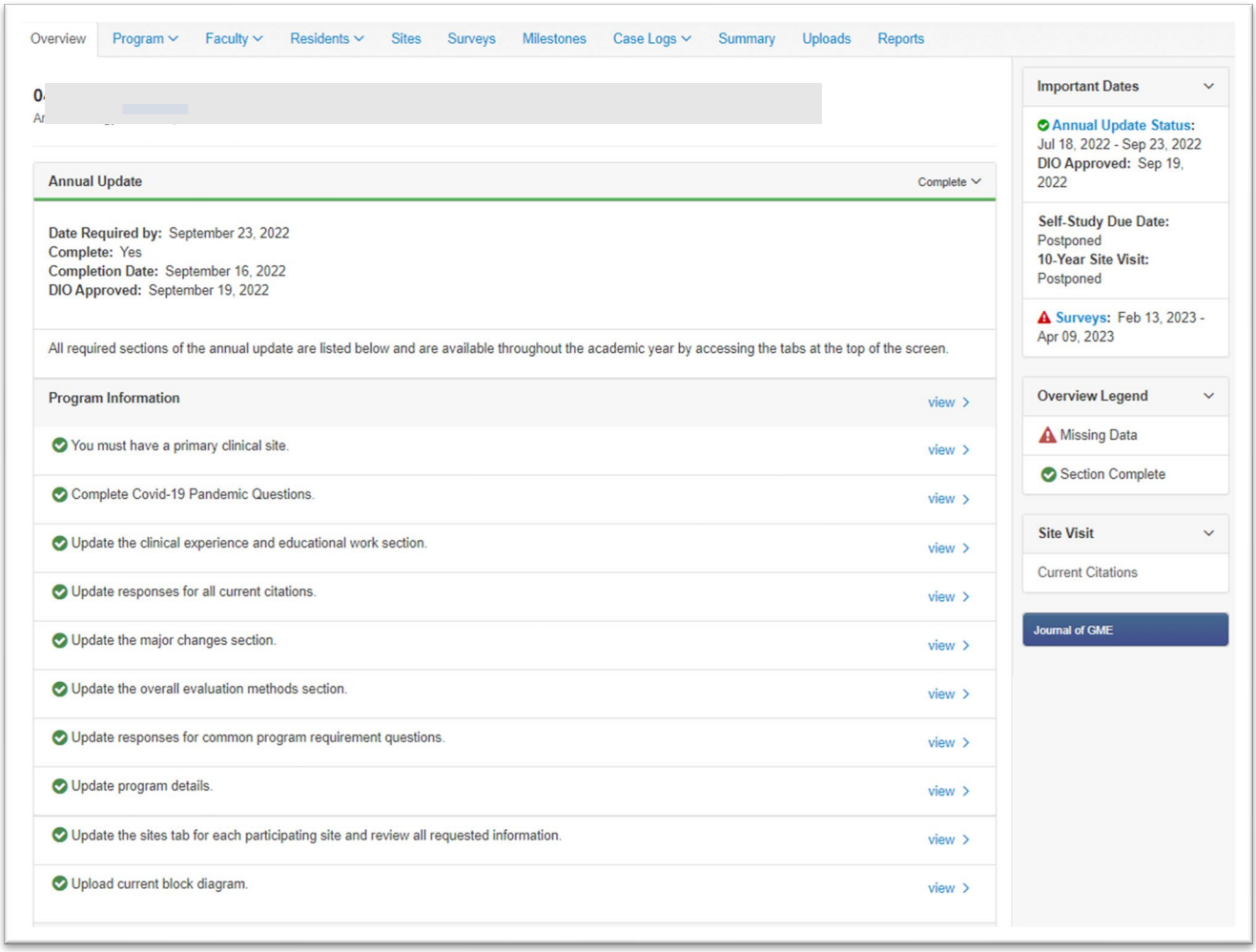
For programs that achieve a status of Initial or Continued Accreditation, the ACGME will review them annually and provide an accreditation decision. As part of this annual review process, programs must complete the ADS Annual Update process each academic year between July and September. The exact date varies by specialty/subspecialty; The program director and program coordinator will receive a notification in ADS with a reminder to perform the required program ADS Annual Update and a deadline. Program directors are responsible for ensuring that all program information is updated in ADS, that the Annual Update is submitted by the program's due date, and that it is approved by the DIO.

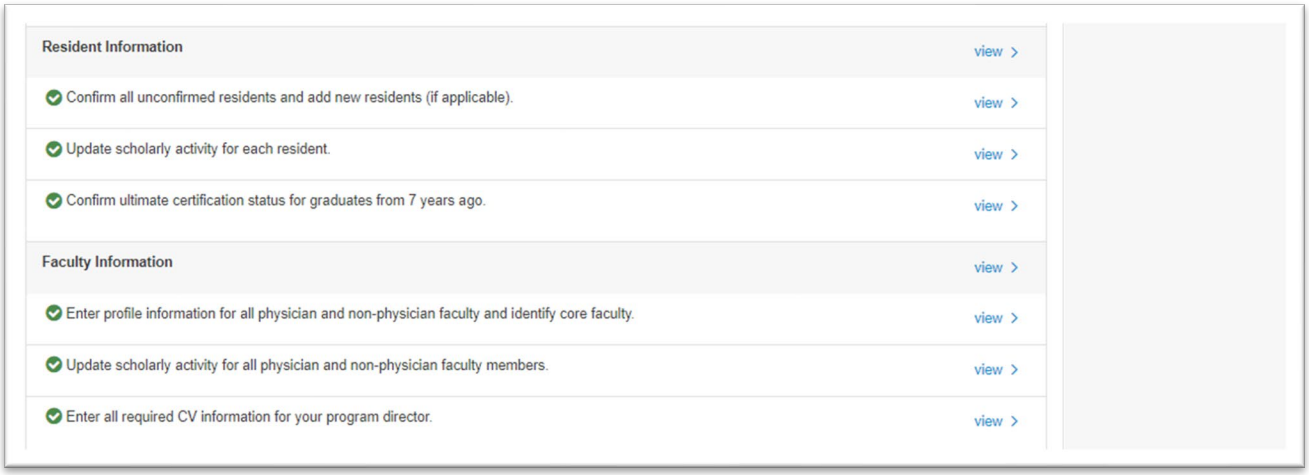
Key data to be reviewed and updated during the Annual Update:

1. **Program information**
    a. Update program details.
    b. Complete Common Program Requirements questions, clinical and educational work section, overall evaluations methods section, etc.
    c. Provide or update responses to current citations, if applicable.
    d. Update the major changes and other program updates section.
    e. Update the sites tab and add, delete, or update information for each participating site.
    f. Upload current block diagram, if applicable.
2. **Faculty information**
    a. Update the program director's profile and CV, if applicable.
    b. Enter or update all physician and non-physician faculty members' profiles and CVs (if applicable).
        i. Complete all information and ensure dates are accurate.
        ii. Note number limitations for current professional activities, selected bibliography, review articles, chapters, and/or textbooks.
        iii. Remove program director and faculty scholarly activities which occurred more than five years ago.
        iv. For the physician and non-physician faculty rosters, provide accurate information, including board certification, identification of an individual as a core faculty member, and time spent in the program.
    c. Enter faculty scholarly activity for the previous academic year.
3. **Resident information**
    a. Update resident profiles and identify new residents to the program, confirm or update PGY level, and identify graduating residents.
    b. Confirm resident ultimate certification status for graduates from seven years prior.
    c. Enter resident scholarly activity for the previous academic year.

ADS Screenshot: Program Annual Update Checklist

When logging into ADS, on the Program Overview tab, the program director and/or program coordinator can see a checklist of all information that should be reviewed and updated during the Annual Update.

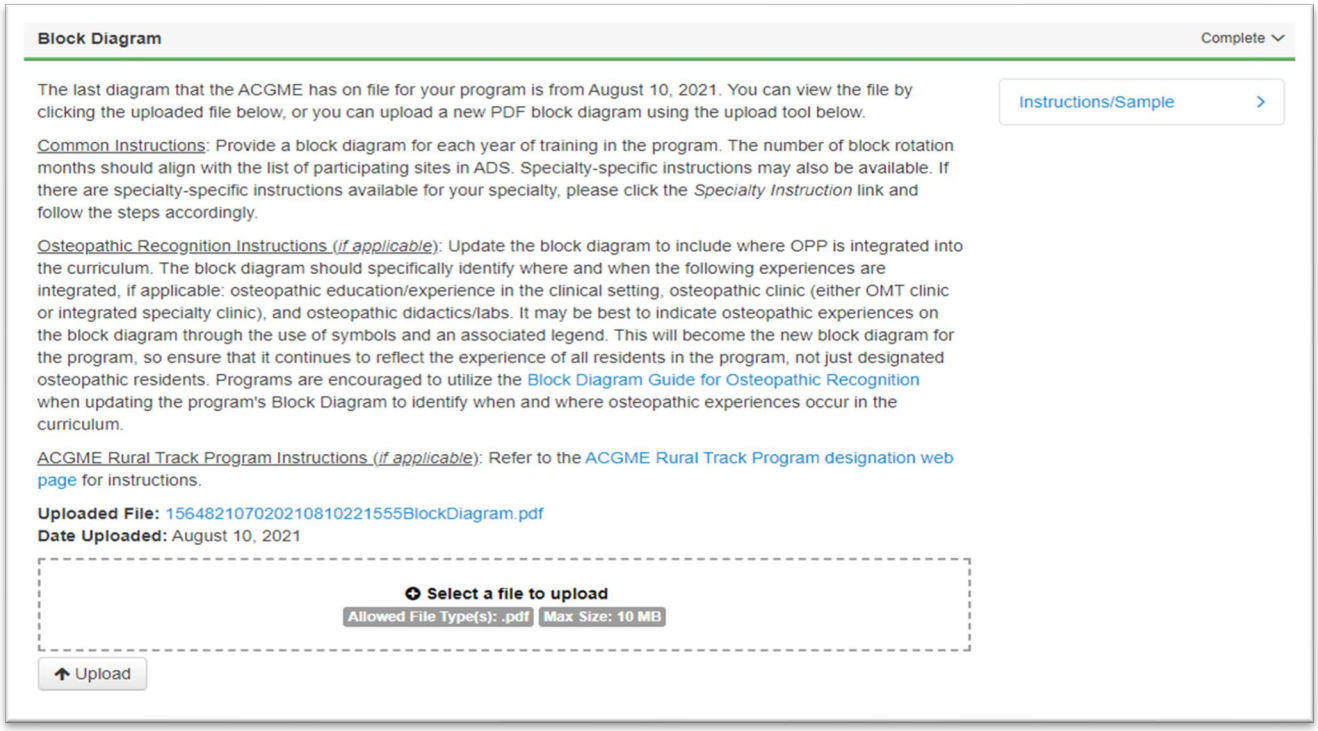




Block Diagrams

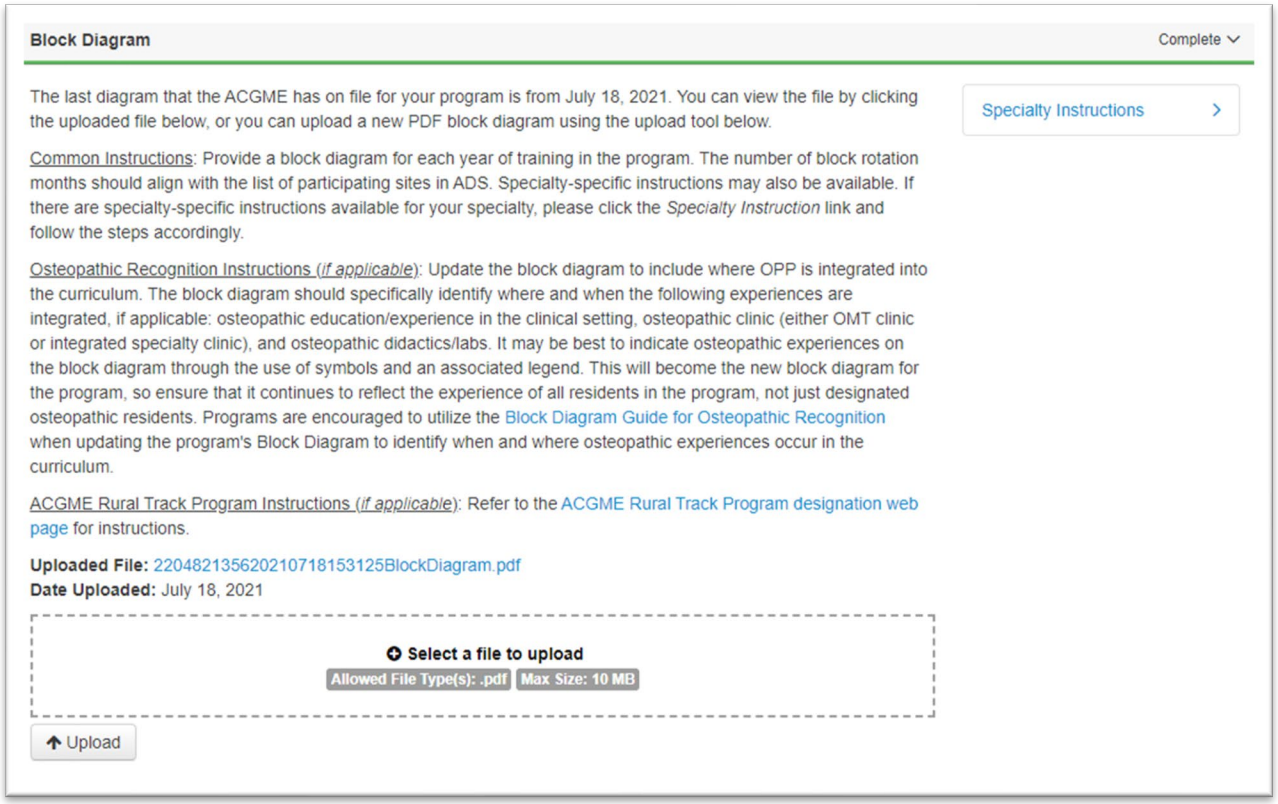
When completing an application for accreditation of a new program in ADS, instructions are provided for completing a block diagram. Subsequently, the block diagram may need to be updated during the ADS Annual Update to reflect changes in the program.

ADS Screenshot: Common Block Diagram Instructions



ADS Screenshot: Specialty-Specific Block Diagram Instructions

Some Review Committees have created specialty-specific block diagrams and do not accept the common block diagram. For these specialties, the program will not see the sample block diagram in ADS, but rather a link to the specialty instructions on the ACGME specialty-specific web page.



Review Committees use block diagrams:

1. To review rotation length(s)
2. To get a summary of time spent at each participating site
3. To get a summary of time spent on each rotation type

The block diagram must clearly illustrate the length of rotations in a program. Rotation length has educational implications since longer rotations provide more opportunities for the educators on that rotation to observe and assess the residents, providing more accurate evaluations and increased opportunities to provide feedback. Rotation length also has clinical implications in that short rotations increase the number of team turnovers. The block diagram also provides a summary of the types of clinical experiences and the time spent at each participating site. An accurate block diagram therefore illustrates how much *cumulative* time a resident spends in a particular clinical experience or subspecialty area at all of the participating sites used by the program.

Programs may use the block diagram:

1. To ensure that Program Requirements are met (by documenting the participating site and the program year during which required experiences take place, the block diagram helps programs ensure that the Program Requirements are being met)
2. To ensure that certifying board requirements are met (many certifying boards require that candidates fulfill certain chronological educational requirements)
3. In recruitment of residents (an accurate and complete block diagram may provide potential applicants a quick yet detailed snapshot of what they can expect each year in the program)

4. When a program is contemplating or requesting a permanent increase of its resident complement (block diagrams for each of the years anticipated for the transition to the new full complement are extremely useful to—and required by—the Review Committee. This will allow the program to ensure that each rotation and participating site will have an appropriate number of residents at any time during the transition)

NOTE: Rotation schedules for individual residents are important for use by the residents, faculty members, and other personnel involved in a program, but rotation schedules are NOT block diagrams, and are not required by the ACGME. A block diagram is not a depiction of the rotation schedule of an individual resident.

A block diagram:

1. Depicts the rotations assigned in each program year (a block diagram shows each of the rotations a resident will typically be assigned in each year of the program, the amount of time that a resident spends on each of these rotations, and the participating sites the rotations occur at).
2. Is flexible in defining rotation lengths (a block diagram can show rotations as short as one week or as long as several months).
3. Provides other important information, such as:
    a. inpatient time on a rotation;
    b. outpatient time on a rotation;
    c. research time on a rotation;
    d. rotation(s) offering particular required experience(s).

Tips for completing the block diagram:

- Show program name and number
- Clearly identify each clinical site
- Use participating site numbers from ADS
- Clearly explain any abbreviations
- Clearly explain any local jargon
- Differentiate rotations with the same name
- Identify rotations for key clinical experience

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.4 Program Director Responsibilities

II.A.4.a) The program director must:

II.A.4.a).(9) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

GUIDANCE

While the transition to a single graduate medical education (GME) accreditation system that was outlined in the Memorandum of Understanding among the ACGME, American Osteopathic Association (AOA), and Association of American Colleges of Osteopathic Medicine (AACOM) ended June 30, 2020, *individuals* who entered AOA-approved programs may be affected by the transition for several years *after* 2020. Furthermore, the number of individuals completing ACGME-accredited programs who will be eligible to be certified by AOA boards has increased considerably. Finally, the Common Program Requirements that became effective July 1, 2019 expand eligibility for ACGME-accredited fellowship programs to an unprecedented level. There are now many more permutations and combinations of educational pathways and board-determined eligibility standards that may be confusing to sort out. The following is an attempt to delineate some of those educational pathways and their effects on board eligibility.

Note that eligibility to enter an ACGME-accredited program is under ACGME purview and is clearly delineated in the ACGME Program Requirements. Eligibility for certification in a specialty or subspecialty is individually determined by more than 40 different American Board of Medical Specialties (ABMS) and AOA boards, and can be changed at any time by any of those boards. Accordingly, the ACGME cannot provide accurate, up-to-date criteria for certification. It is the responsibility of the program director to ascertain and convey to each applicant the pertinent eligibility criteria in any given specialty or subspecialty. The following general guidance applies:

1. For a resident who enters residency directly from medical school, assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
    - Allopathic and osteopathic physicians would be eligible for certification by an ABMS member board.
    - Osteopathic physicians would be eligible for certification by an AOA board. Allopathic physicians in an ACGME-accredited program with Osteopathic Recognition in a designated osteopathic position would be eligible for certification by an AOA board. Allopathic physicians in an ACGME-accredited osteopathic neuromusculoskeletal medicine program are also eligible for AOA board certification in neuromusculoskeletal medicine.

2. For a resident who transfers from one program that has been accredited by the ACGME throughout the resident's tenure to another ACGME-accredited program, assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
    - Allopathic and osteopathic physicians would be eligible for certification by an ABMS member board.
    - Osteopathic physicians would be eligible for certification by an AOA board. Allopathic physicians in an ACGME-accredited program with Osteopathic Recognition in a designated osteopathic position would be eligible for certification by an AOA board. Allopathic physicians in an ACGME-accredited osteopathic neuromusculoskeletal medicine program are also eligible for AOA board certification in neuromusculoskeletal medicine.

3. For a resident who transfers from an AOA-approved program to an ACGME-accredited program, assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
    - The individual may be eligible for certification by an ABMS member board. The program director should check with the applicable ABMS member board to determine eligibility.
    - The individual may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

4. For a resident who transfers from a program that is currently accredited by the ACGME but that was AOA-approved when the resident entered the program, assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
    - The individual may be eligible for certification by an ABMS member board. The program director should check with the applicable ABMS member board to determine eligibility.
    - The individual may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A Program Director

II.A.4. Program Director Responsibilities

II.A.4.a) The program director must:

II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a).(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

II.A.4.a).(13) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(13).(a) Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

GUIDANCE

II.A.4.a).(10) Raising Concerns, Providing Feedback, and Submitting Grievances

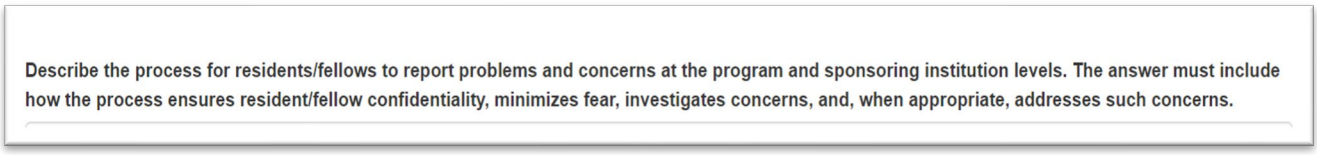
There must be both institutional and programmatic processes that support residents in raising concerns and providing feedback confidentially. Residents should first attempt to address concerns within their programs. In some programs, chief residents, junior faculty members, or administrators facilitate communication between residents and program leaders by conveying residents' concerns and feedback in a confidential manner. Programs may solicit residents' concerns and feedback confidentially using program evaluations, rotation evaluations, class or program meetings, and other means.

If attempts to address concerns within the program are ineffective, residents must be able to raise concerns or provide feedback confidentially through institutional mechanisms (see Institutional Requirement III.A.), which may include specific, confidential reporting processes related to patient safety events, supervision concerns, or professionalism issues. Avenues to raise concerns and provide feedback outside of the program may involve the designated institutional official (DIO), other institutional officers, and/or groups, such as resident/fellow forums or the Graduate Medical Education Committee (GMEC).

"Each Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest." (Institutional Requirement IV.E.) This requirement ensures there are formal processes through which residents can address concerns about their education or the clinical learning environment. Sponsoring Institutions and programs must manage conflicts of interest of individuals or groups who make decisions in grievance processes. Program directors should contact the DIO if they have questions about the Sponsoring Institution's or program's grievance procedures or policies.

For programs applying or re-applying for accreditation and accredited programs with a status of Initial Accreditation and Initial Accreditation with Warning, the ACGME includes a question in the ADS Annual Update that programs must answer or update annually until they move to a Continued Accreditation status.

ADS Screenshot: Common Program Requirements Question Regarding the Process of Reporting Problems and Concerns



The ACGME's Institutional Review Committee and/or the specialty Review Committees may investigate potential non-compliance with these requirements indicated by the results of the annual ACGME Resident/Fellow and/or Faculty Surveys or by complaints or concerns submitted to the ACGME.

II.A.4.a).(12) Actions against Residents and Due Process

(See related requirement V.A.1. on feedback and evaluation)

Each program must determine criteria for promotion and/or renewal of a resident's appointment. Sponsoring Institutions "must ensure that each [program] provides a resident/fellow with a written notice of intent when that resident's/fellow's agreement [of appointment] will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed." (Institutional Requirement IV.D.1.a))

There must be an institutional policy that provides due process to any resident who is suspended or dismissed from a program, who is not promoted to the next program year, or whose residency appointment will not be renewed. Questions about institutional policy should be directed to the Sponsoring Institution's DIO. Sponsoring Institutions and programs are not required to provide due process in the remediation of residents through probation, warning, or other locally defined disciplinary or academic actions that are not identified in the requirement.

It is common for program directors, coordinators, residents, fellows, faculty members, and DIOs to collaborate with their local human resources or legal departments, and/or with institutional officers/committees to ensure compliance with institutional policy related to actions against residents and the provision of due process.

II.A.4.a).(13) Employment and Discrimination

Laws and regulations concerning employment and discrimination include, but are not limited to, those for which enforcement is overseen by the US Equal Employment Opportunity Commission. Other federal, state, and local laws and regulations may also apply. It is common for program directors, coordinators, residents, fellows, faculty members, and DIOs to collaborate with their local human resources or legal departments and/or with institutional officers/committees to ensure compliance with institutional policy related to employment and discrimination. Sponsoring Institutions must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations (Institutional Requirement IV.I.5).

II.A.4.a).(13).(a) Non-Competition Guarantees and Restrictive Covenants

Sponsoring Institutions and programs must not require residents to enter into restrictive covenants or non-competition guarantees. (See Institutional Requirement IV.M.) The participation of residents in graduate medical education must not be contingent upon such contractual provisions, which may limit residents' professional options after completing their programs.

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.4. Program Director Responsibilities

II.A.4.a) The program director must:

II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; (Core)

II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; and (Core)

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

GUIDANCE

It is important to the resident who has completed a program, to the program itself, and to the Sponsoring Institution that program completion be verified in a timely manner. The ACGME does not specify exactly what must be included in such verification, nor does it require that any particular format be used for such verification.

The Verification of Graduate Medical Education Training (VGMET) Form

Several organizations have collaborated to develop a Verification of Graduate Medical Education Training (VGMET) Form that programs can use or adapt to their needs. The VGMET Form was jointly developed by the American Hospital Association (AHA), the National Association Medical Staff Services (NAMSS), the Organization of Program Director Associations (OPDA), and the ACGME. It is designed to satisfy national credentialing standards, and to be completed once (and only once) by the program director, and then copied and reused in perpetuity.

Clarification

The VGMET Form was not designed or intended for applications for licensure or certification. For licensure purposes, use this Federation Credentials Verification Service (FCVS) Form . The FCVS Form can be used if the physician is using FCVS or is seeking licensure independently.

There is no time limit on a program's obligation to continue providing verifications of residents' graduate medical education appointments. Programs are accountable for ensuring timely verifications for graduate medical education regardless of the location and control of the relevant program records. When making major program changes or transferring program sponsorship, program directors should work with the designated institutional official (DIO) and others to ensure that they are able to continue fulfilling their responsibility for timely verifications.

When a program closes and will no longer be accredited by the ACGME, program directors may transfer responsibility for verifications to another party, such as the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB).

The verification of training should not be confused with the final evaluation described in section V.A.2. of the Common Program Requirements, which must include the specific elements outlined in those requirements. Programs may use one form to meet both the requirement for verification of training and final evaluation, but they must ensure that the final evaluation includes the specific elements the ACGME requires.

Milestones Information

The verification of training and education requirements *do not indicate* that programs should share residents' Milestones information with certifying bodies.

Milestones *can* and *should* be utilized in the determination by a program director that an individual resident has satisfactorily completed the program and is able to engage in autonomous practice of the specialty. (See requirement V.A.2.a).(1).) However, a resident's attainment of a specific level on the Milestones *should not* be specified in the program director's verification of program completion. The Milestones were not designed or intended for use in such high-stakes applications for credentialing, certification, and licensure. The Milestones are designed as a formative judgment of progress at least twice a year. Therefore, the ACGME actively discourages specification of Milestones achievement in verification of program completion.

Milestones Resources

Programs are encouraged to visit the Milestones section of the ACGME website to review additional resources and tools:

- The ACGME Milestones Guidebook
- Milestones FAQs
- Use of Individual Milestones Data by External Entities for High Stakes Decisions

COMMON PROGRAM REQUIREMENTS

II. Personnel

II.A. Program Director

II.A.4. Program Director Responsibilities

II.A.4.a) The program director must:

II.A.4.a).(16) obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. (Core)

GUIDANCE

The table below shows a list of items that need approval from the Sponsoring Institution's designated institutional official (DIO) and/or Graduate Medical Education Committee (GMEC), both within and external to the ACGME Accreditation Data System (ADS).

		Must be approved by **DIO** outside ADS	Must be approved by **DIO** in ADS	Must be approved by **GMEC** prior to being submitted to the ACGME
	Institutional Requirements			
I.B.4.b).(4)	Applications for ACGME accreditation of new programs		X	X
I.B.4.b).(5)	Requests for permanent changes in resident/fellow complement		X	X
I.B.4.b).(6)	Major changes in each of its ACGME-accredited programs' structure or duration of education (change in length of training)		X	X
I.B.4.b).(7)	Additions and deletions of each of its ACGME-accredited programs' participating sites		X	X
I.B.4.b).(8)	Appointment of new program directors		X	X
I.B.4.b).(9)	Progress reports requested by a Review Committee		X	X
I.B.4.b).(11)	Requests for exceptions to clinical and educational work hour requirements			X
I.B.4.b).(12)	Voluntary withdrawal of ACGME program accreditation		X	X
I.B.4.b).(13)	Requests for appeal of an adverse action by a Review Committee	X		X
I.B.4.b).(14)	Appeal presentations to an ACGME Appeals Panel	X		X
I.B.4.b).(15)	Exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements			X
	Common Program Requirements			
I.B.2.a).(2)	There must be a Program Letter of Agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. The PLA must be approved by the DIO.	X		

I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full-time equivalent (FTE) or more through the ACGME's Accreditation Data System. *NOTE: See Institutional Requirement I.B.4.b).(7) above.*		X	X
I.E.1.	The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and GMEC.	X (NOT submitted to the ACGME)		X (NOT submitted to the ACGME)
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director.		X	X
II.A.4.a).(8)	The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. *Examples: Application, ADS Annual Update, progress report, complement change, program director change*		X	X
II.A.4.a).(16)	The program director must obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. *Examples: Application, ADS Annual Update, progress report, complement change, program director change*		X	
III.A.3.	A physician who has completed a residency program that was not accredited by the ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations conducted by the ACGME-accredited program. *This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.*		X	X

III.A.4.a).(2)	An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but who does meet all of the following additional qualifications and conditions: review and approval of the applicant's exceptional qualifications by the GMEC.			X
V.C.1.e.(2)	The annual review, including the action plan, must be submitted to the DIO.	X		
V.C.2.a)	The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. A summary of the Self-Study must be submitted to the DIO.	X		
VI.F.4.c).(2)	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.	X		X

Resources for Sponsoring Institutions

- Roles and Responsibilities of a Sponsoring Institution

  Note: The above link will take you to a course in Learn at ACGME, the ACGME's online learning portal. Graduate medical education (GME) community members who have not yet created a free account in Learn at ACGME will need to create one to access the course.

COMMON PROGRAM REQUIREMENTS

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to residents to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment.

II.B.1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. (Core)

[The Review Committee may further specify]

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

II.B.2.g).(1) as educators; (Core)

II.B.2.g).(2) in quality improvement and patient safety; (Core)

II.B.2.g).(3) in fostering their own and their residents' well-being; and, (Core)

II.B.2.g).(4) in patient care based on their practice-based learning and improvement efforts. (Core)

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

[The Review Committee may further specify additional faculty responsibilities]

GUIDANCE

II.B. Faculty

As a foundational element of graduate medical education, faculty members have numerous responsibilities in the education of residents. Selection of faculty members should be carefully considered to ensure they fulfill the stated requirements that follow. In addition to providing consistently high-quality patient care, faculty members must teach and supervise residents in the provision of equivalent high-quality care and allow graded supervision that enables residents to achieve readiness for autonomous practice at the end of their training and education. Non-clinical faculty members should be similarly capable in their areas of expertise. Faculty members should be effective in the provision of both formal and informal, written and oral feedback and participate in faculty development activities to enhance their teaching and evaluative skills. They should demonstrate a commitment to the education of residents and to the privilege of training the next generation of physicians.

The Background and Intent for this requirement clarifies that the term “Faculty” refers to the entire teaching force responsible for educating residents. The term “faculty,” including “core faculty,” does not imply or require an academic appointment.

II.B.1. Need for a Sufficient Number of Faculty Members

The requirement is intended to ensure that there are enough competent faculty members to teach and supervise residents at all participating sites. Participating sites cannot be selected solely based on the availability of a specific procedure or a unique patient care experience in the absence of faculty members with the interest, ability, and commitment to resident education.

[The Review Committee may further specify]

Programs should reference the specialty-specific Program Requirements to ensure they are compliant with the minimum number of faculty members and/ or faculty-to-resident ratio requirements of their particular specialty. Programs may also reference the Number of Faculty document available on the Institutional Application and Requirements page of the Institutional Review Committee section of the ACGME website.

II.B.2.a)-c) Faculty Members as Role Models of Professionalism, Commitment to delivery of Safe, Quality, Cost-Effective, Patient-Centered Care

In addition to being role models, faculty members must also demonstrate a strong interest in the education of residents. As a reference, A. Keith W. Brownell and Luc Côté determined that residents learned the most about professionalism from observing faculty member role models. (Brownell, A. Keith W., and Luc Côté. 2001. “Senior Residents’ Views on the Meaning of Professionalism and How They Learn about It.” *Academic Medicine* 76, no. 7: 734–37. https://doi.org/10.1097/00001888-200107000-00019.)

II.B.2.d) Faculty Members Must Devote Sufficient Time to the Educational Program

In addition to demonstrating a commitment to the educational program, faculty members must also have sufficient time to fulfill their responsibilities. Some faculty members may need defined protected time to fulfill their responsibilities, while other faculty members can supervise and teach within their defined assignments. Sufficient time for resident education is a shared

responsibility of individual faculty members and the department or institution. Pressure for clinical productivity must not preclude sufficient time to teach and supervise residents in the program.

II.B.2.e) Faculty Members as Part of Administration and Maintenance of an Educational Environment Conducive to Educating Residents

An educational environment includes more elements than the provision of patient care. An environment geared toward resident education allows time for questions and discussions which support evidence-based medical decision making. There should be appropriate discussions about the evidence-based references, pathophysiology, and rationale of clinical decisions to a sufficient degree to maintain an environment of continuous learning.

II.B.2.f) Faculty Member Participation in Organized Clinical Discussion, Rounds, Journal Clubs, and Conferences

Formal didactic educational activities should include experienced faculty members who can provide commentary and clinical insights to augment the information being presented. *All* faculty members do not need to participate in *all* didactic activities. However, it is inappropriate for residents to consistently lead organized didactic experiences without a faculty presence.

II.B.2.g).(1)-(4) Faculty Members Pursuit of Faculty Development Designed to Enhance Skills as an Educator, Quality Improvement and Patient Safety, Well-Being, and Patient Care

Programs should ensure that there are opportunities for their faculty members to participate in professional development activities designed to optimize their skills. Faculty members should participate annually in faculty development activities in one of these four areas: as an educator, quality improvement and patient safety, fostering their own and their residents' well-being, and patient care based on their practice-based learning and improvement efforts. This does not preclude faculty development in other important areas such as clinical knowledge, leadership, team building, communications, and patient relationships.

The Background and Intent states that faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner and it may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

[The Review Committee may further specify additional faculty responsibilities]

Review Committees may specify other requirements related to additional faculty responsibilities, so programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to program director qualifications should be directed to specialty Review Committee staff.

COMMON PROGRAM REQUIREMENTS

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

[The Review Committee may further specify]

II.B.3.b) Physician faculty members must:

II.B.3.b).(1) have current certification in the specialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[The Review Committee may further specify additional qualifications]

II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director. (Core)

[The Review Committee may further specify]

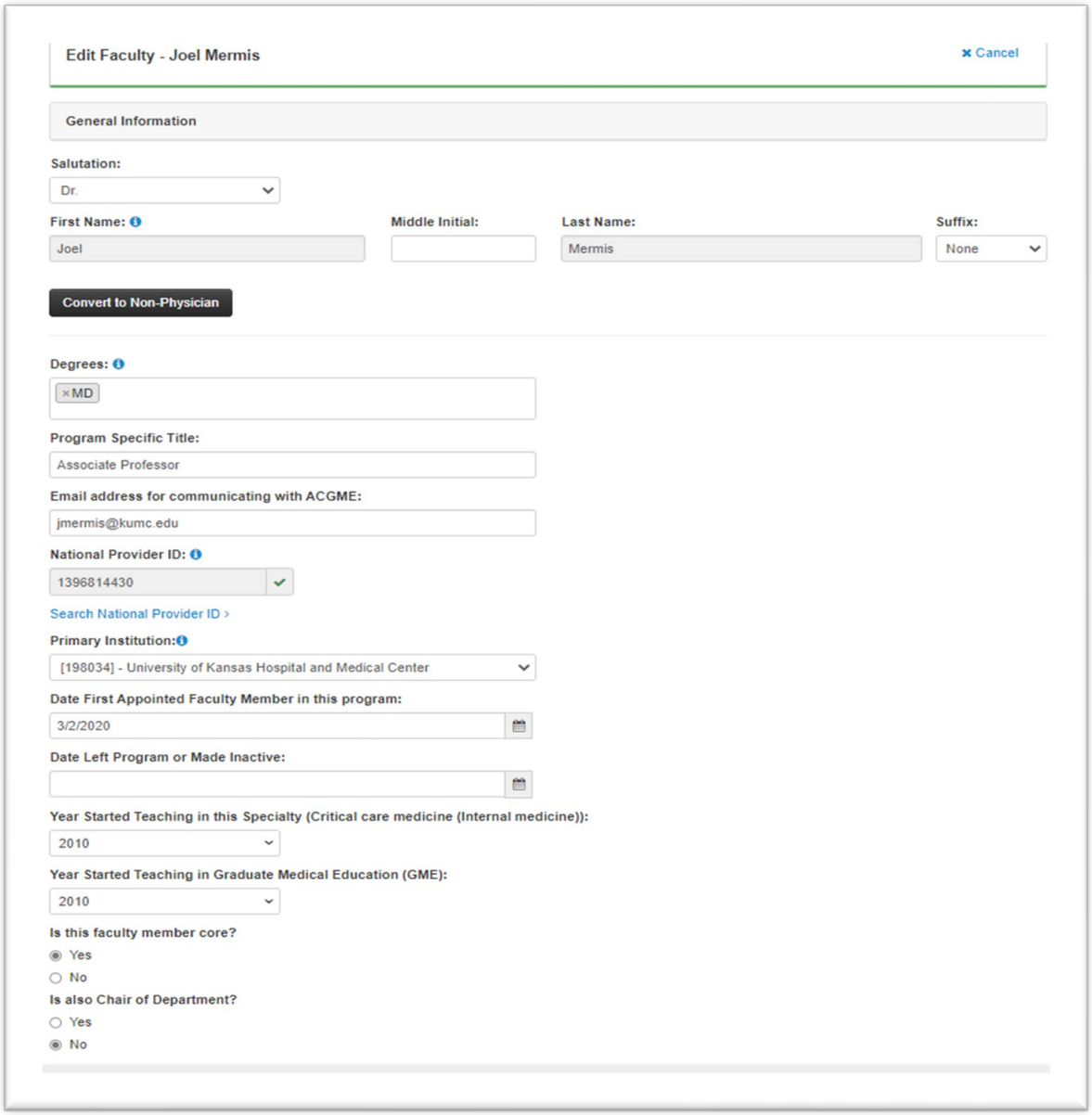
Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

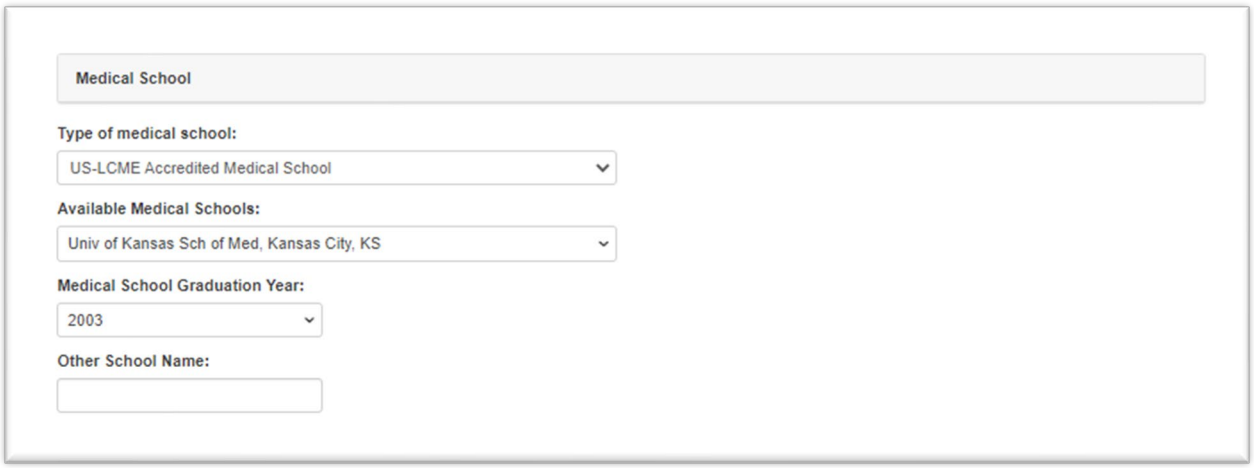
GUIDANCE

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.

Minimum faculty member qualifications include having specialty or subspecialty board certification, a license to practice, and appropriate institutional appointment. Additional qualifications include expertise in the field and skills as an educator. Faculty information is captured in the faculty profile and curriculum vitae (CV) in the Accreditation Data System (ADS). Programs should complete all required information when adding a new faculty member into ADS. It is also important to carefully review and update all the faculty information if a profile for that individual already exists in ADS and you are importing the profile into your program.

ADS Screenshots: Faculty Profile and CV




Medical School
Type of medical school:
US-LCME Accredited Medical School
Available Medical Schools:
Univ of Kansas Sch of Med, Kansas City, KS
Medical School Graduation Year:
2003
Other School Name:


Faculty CV
Personal Information
Name:
Title:
Degrees:
Medical School:
Degree Date:
Graduate Medical Education
Program Name:
Specialty:
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To:
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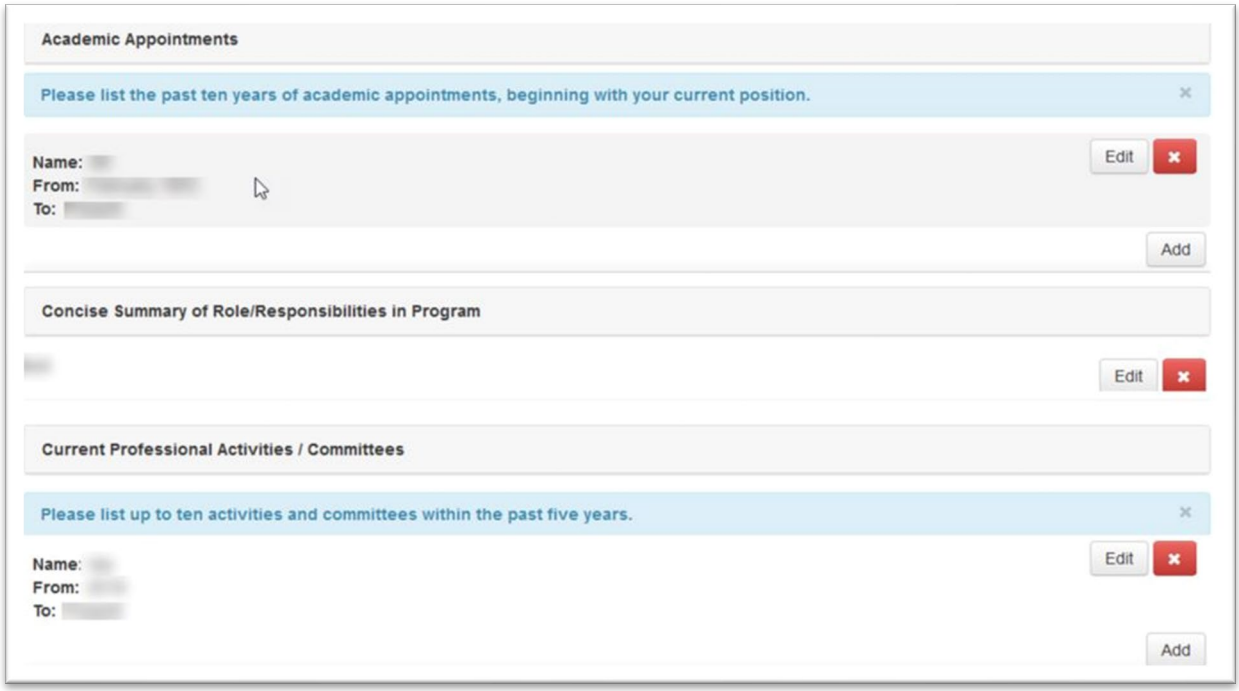
Add
Licensures
State / Province:
Expiration:
Edit
Add


Academic Appointments
Please list the past ten years of academic appointments, beginning with your current position.
Name:
From:
To:
Edit
Add
Concise Summary of Role/Responsibilities in Program
Edit
Current Professional Activities / Committees
Please list up to ten activities and committees within the past five years.
Name:
From:
To:
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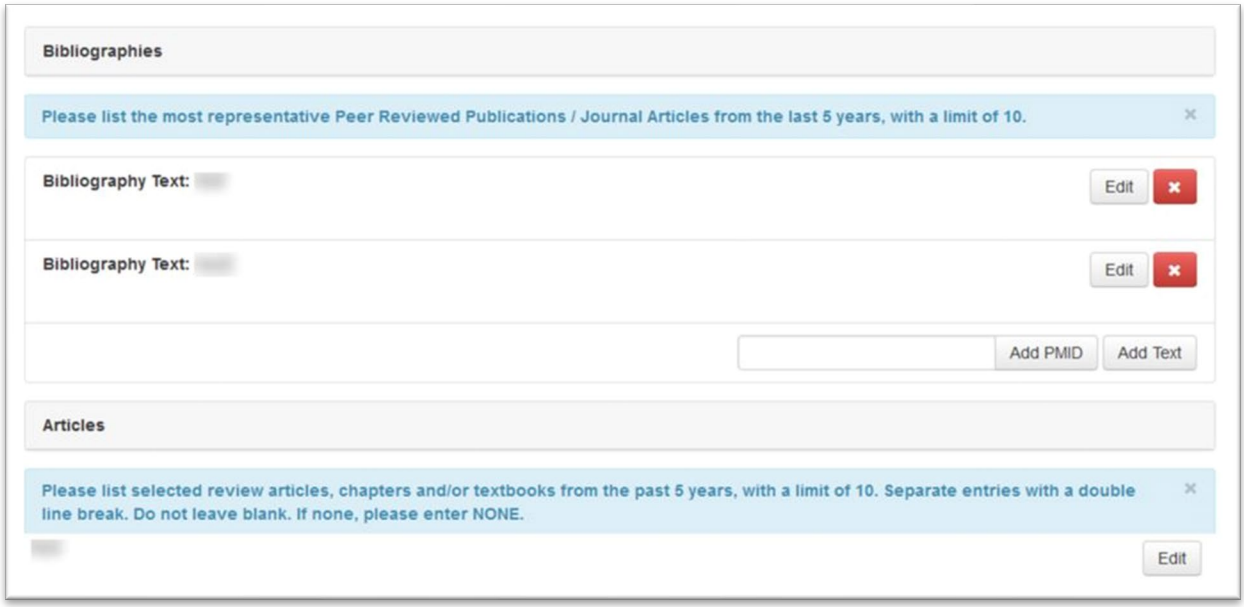
Add


Bibliographies
Please list the most representative Peer Reviewed Publications / Journal Articles from the last 5 years, with a limit of 10.
Bibliography Text:
Edit
Bibliography Text:
Edit
Add PMID
Add Text
Articles
Please list selected review articles, chapters and/or textbooks from the past 5 years, with a limit of 10. Separate entries with a double line break. Do not leave blank. If none, please enter NONE.
Edit


Participation in Local, Regional and National Activities / Presentations / Abstracts / Grants
Please list participation in local, regional and national activities/presentations from the past 5 years, with a limit of 10. Separate entries with a double line break. Do not leave blank. If none, please enter NONE.
Edit

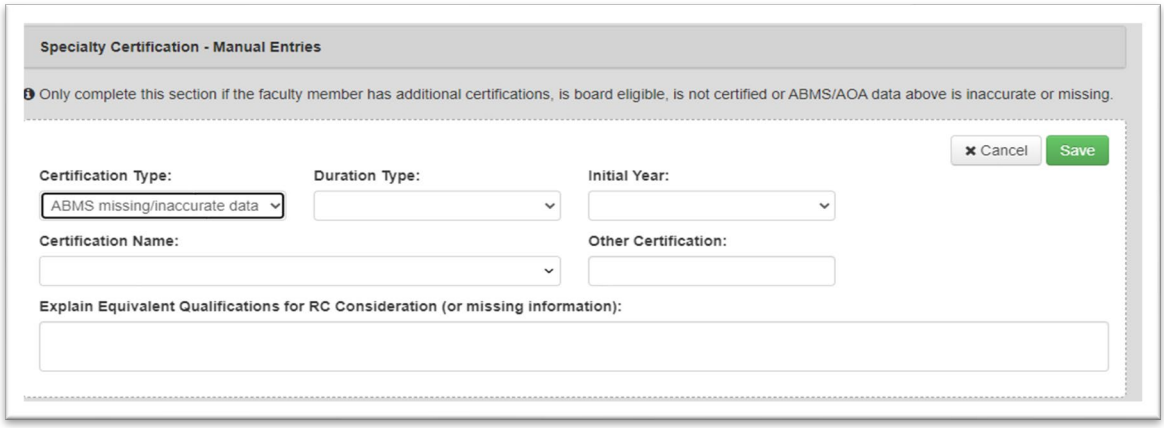
II.B.3.b) Physician faculty members must have current certification in the specialty by the ABMS or AOA, or possess qualifications judged acceptable to the Review Committee.

Some Review Committees will accept *only* certification in the appropriate specialty by an American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board for the program director. Other Review Committees will accept other qualifications for the program director. Programs are encouraged to refer to the specialty-specific Program Requirements for more information on this requirement.

The ACGME automatically populates data received from the ABMS and the AOA for all faculty members on their individual ADS faculty profile page where data are available. Physician faculty members' board certification data will be obtained from board datasets based on National Provider Identifier (NPI) number, as well as name, date of birth, and medical school graduation year. Faculty members who are newly entered into ADS will have their certification information matched and populated within 24 hours.

Programs are only required to manually enter faculty members' ABMS/AOA board certification data in ADS if no data is displayed or it is incorrect.. In this case, a manual entry for "ABMS missing/inaccurate data" or "AOA missing/inaccurate data" should be added on the faculty profile with a duration type, initial certification year, certification name, and an explanation for Review Committee consideration.

ADS Screenshot: ABMS/AOA Missing/Inaccurate Data



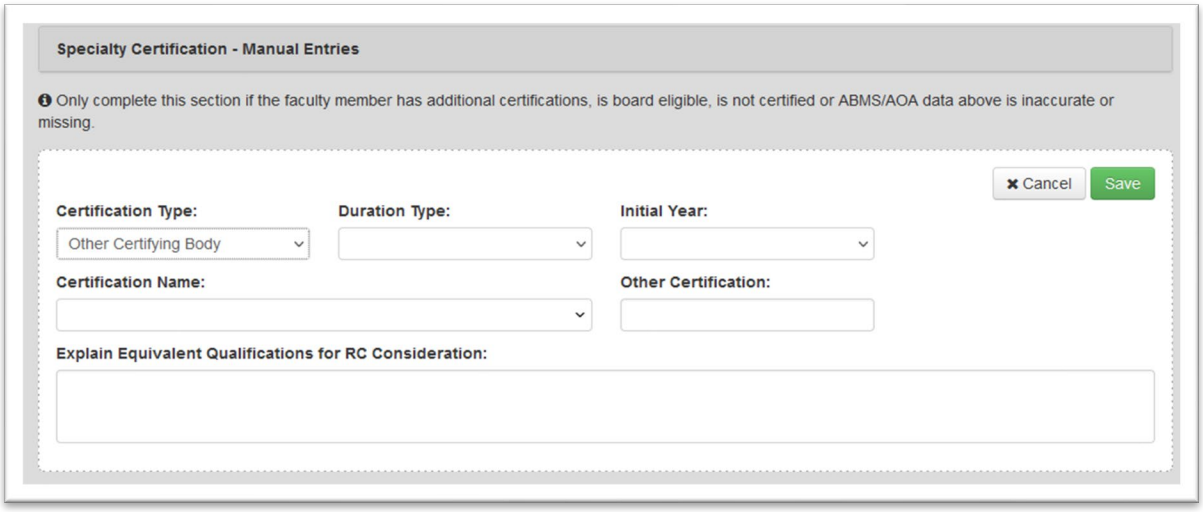
Common issues related to the ABMS and AOA data not auto-populating on the faculty profile and in the faculty roster include:

- The NPI number in ADS is incorrect or does not match the NPI number in the ABMS/AOA dataset.
- A lag in when updated board certification data are received by the ACGME from the ABMS and AOA.

For faculty members that are board eligible, are not certified, or are certified by another certifying body, programs must continue to manually provide that information for Review Committees through a manual entry on the faculty profile page in the "Specialty Certification – Manual Entries" section of ADS. Some faculty members who are not certified by the relevant ABMS member board or the AOA may possess other qualifications that the individual Review

Committee would determine to be acceptable. For example, a physician with expertise in a specific field may have certification in another country, scholarly achievements, and other attributes which the program has determined qualify the physician to serve as a faculty member. Alternatively, a physician faculty member who does not hold ABMS or AOA certification, but does hold certification from the American Board of Genetic Counselors, is an acceptable qualification of the Review Committee for Medical Genetics and Genomics. In such cases, the Review Committee will make the final determination as to whether the physician meets the requirements to be a faculty member.

ADS Screenshot: Specialty Certification – Manual Entries for Faculty Who Are Board Eligible, Not Certified, or Certified by Another Certifying Body

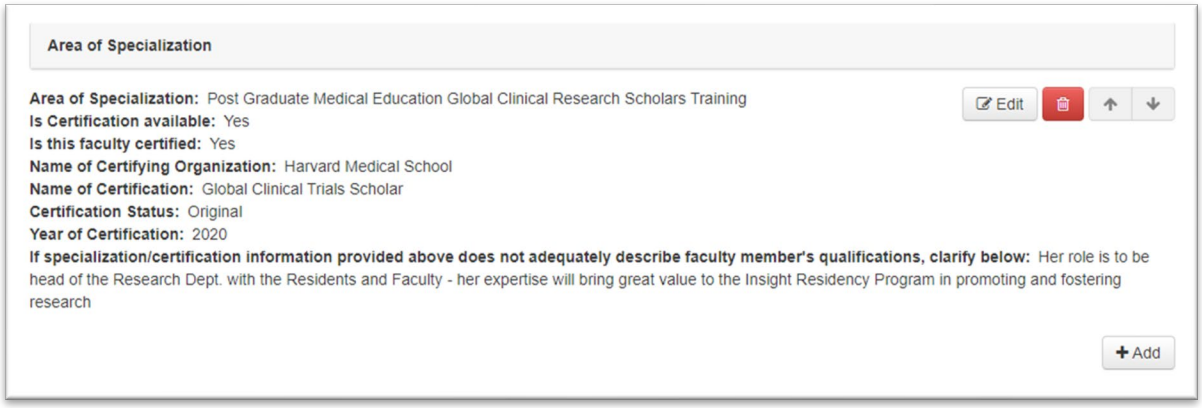


II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director.

Non-physicians are often important contributors to programs and warrant appointment to the faculty. These individuals may bring specialized expertise in public health, patient safety, laboratory science, pharmacology, basic science, research, a specific procedural skill, or other important aspects of medicine.

As stated in the Background and Intent, the provision of optimal and safe patient care requires a team approach. Non-physician educators may provide valuable contributions to the residents' knowledge and skills. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a faculty member or a core faculty member.

ADS Screenshot: Non-Physician Faculty Qualifications



[The Review Committee may further specify]

Review Committees may specify other requirements related to faculty qualifications, specialty certification and non-physician faculty, so programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to program director qualifications should be directed to specialty Review Committee staff.

COMMON PROGRAM REQUIREMENTS

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the independent practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee may further specify requirements regarding dedicated time for core faculty members]

[The Review Committee may specify requirements specific to associate program director(s)]

GUIDANCE

II.B.4. Core Faculty

Core faculty members have responsibilities specific to the educational program. These individuals may be associate/assistant program directors, participating site directors, conference organizers, or subspecialty experts responsible for a segment of the curriculum. They may be members of the Program Evaluation Committee and/or Clinical Competency Committee, have expertise in medical education, or be health care professionals dedicated to the program who are developing into future educational leaders.

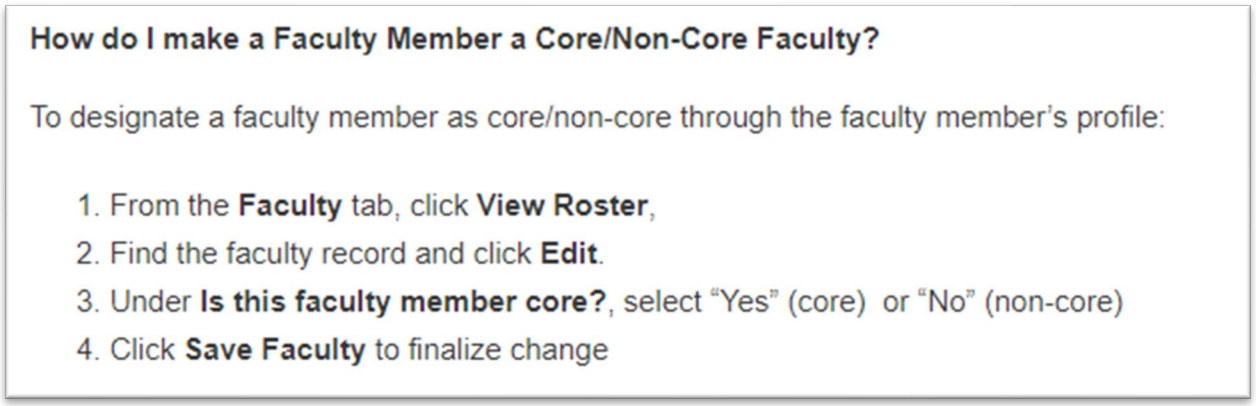
As the Background and Intent for this requirement states, “Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents’ progress toward achievement of competence in and the independent practice of the specialty.”

II.B.4.a) Designating Faculty Members as Core Faculty

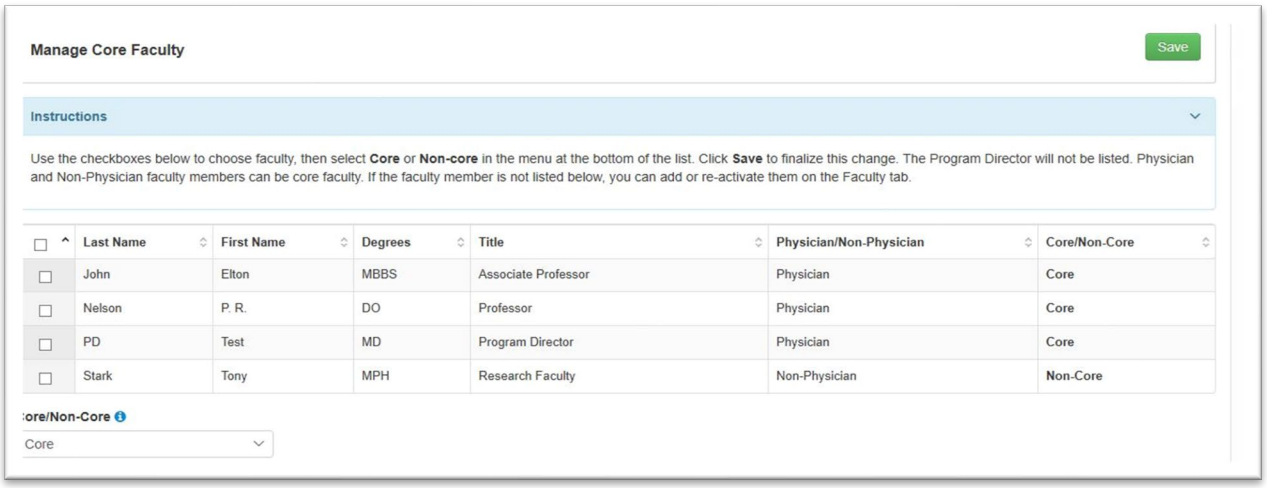
It is the responsibility of the program director to determine which members of the faculty best meet the needs of the program and to designate those individuals as core faculty members in the Accreditation Data System (ADS). As stated in the Background and Intent for this requirement, “Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program’s Clinical Competency Committee, Program Evaluation Committee, and other GME committees.”

ADS Screenshots: Designating Core Faculty in ADS

1. Programs can designate individual faculty members as core/non-core



2. **Programs can designate multiple faculty members as core/non-core at the same time**



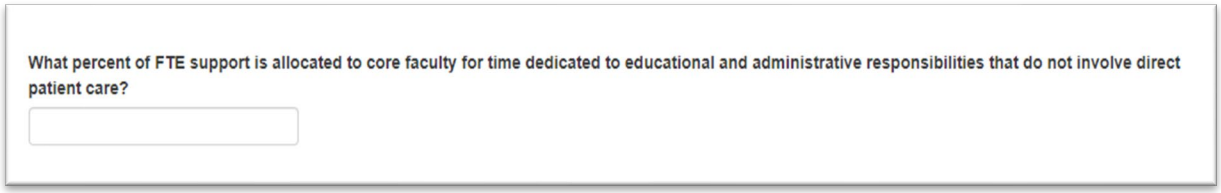
II.B.4.b) Core faculty members must complete the ACGME Faculty Survey.
Core faculty members are expected to complete the annual ACGME Faculty Survey, which is one of the instruments used by the specialty Review Committee to assess the program. Therefore, core faculty members should be selected for their broad knowledge of and involvement in the program, which provides them with the insight necessary to effectively evaluate the program.

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]
Since Review Committees must specify minimum dedicated time for the program coordinator, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

[The Review Committee may further specify requirements regarding dedicated time for core faculty members]
This Core Faculty Dedicated Time summary document provides a snapshot of the core faculty dedicated time and support across all ACGME-accredited specialties.

ADS Screenshot: Program Resources: Percent of FTE Support – Core Faculty (*If Applicable*). As part of a new program application as well as the Accreditation Data System (ADS) Annual Update process, programs must provide the percent of FTE support allocated to core faculty, if applicable for their specialty.



[The Review Committee may specify requirements specific to associate program director(s)]
Programs should consult the specialty-specific Program Requirements for further specification.

ADS Screenshot: Program Resources: Percent of FTE Support – Associate Program Director(s) (*If Applicable*). As part of a new program application as well as the Accreditation Data System (ADS) Annual Update process, programs must provide the percent of FTE support allocated to associate program director(s), if applicable for their specialty.

COMMON PROGRAM REQUIREMENTS

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)

[The Review Committee must further specify minimum dedicated time for the program coordinator.]

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as

not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

[The Review Committee may further specify]

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

GUIDANCE

II.C. Program Coordinator

Requirement II.C.1. specifies that each program must have a program coordinator. Requirement II.C.2. further specifies that the program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration.

[The Review Committee must further specify minimum dedicated time for the program coordinator.]

Since Review Committees must specify minimum dedicated time for the program coordinator, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

This Coordinator Dedicated Time summary document also provides a snapshot of the program coordinator dedicated time and support across all ACGME-accredited specialties.

The Background and Intent for requirement II.C. explains that "each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME."

The ACGME acknowledges that "the program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents."

Other important considerations described in the Background and Intent for this requirement include the following:

- The source of funding for the specified salary support is not addressed.
- Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators.
- Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program so long as the individual's total dedicated time across programs does not exceed 100 percent FTE.

- The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program.
- Assignment of other responsibilities, beyond those directly related to program administration, will necessitate consideration of allocation of additional support.
- The dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted.

The ACGME monitors compliance with requirements in section II.C. in various ways including
- questions program leadership must answer as part of an application or during the ADS Annual Update
- questions Accreditation Field Representatives ask during site visits of the program at various stages of accreditation.

ADS Screenshot: Program Resources: Percent of FTE Support – Program Coordinators. As part of a new program application as well as the Accreditation Data System (ADS) Annual Update process, programs must provide the percent of FTE support allocated to the program coordinator(s).

II.D. Other Program Personnel
[The Review Committee may further specify]

Programs should review the specialty-specific Program Requirements for further specification, if applicable.

The Background and Intent for this requirement explains that in addition to program coordinators, there may be others needed to help in the administration of a program. These individuals may include project managers, experts in education and/or communication, and those with clerical skills. These individuals may provide support for more than one program in more than one specialty.

COMMON PROGRAM REQUIREMENTS

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

III.A.1.b).(2) holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)

[The Review Committee may further specify prerequisite postgraduate clinical education]

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited 521 program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.4. Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

III.A.4.a) An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.- III.A.3., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.4.a).(1) evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and, (Core)

III.A.4.a).(2) review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.4.a).(3) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.4.b) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

GUIDANCE

In addition to the Common Program Requirements related to resident eligibility requirements, program directors must comply with the policies and procedures of the Sponsoring Institution and the ACGME Institutional Requirements for resident appointment. See Institutional Requirements IV.B., IV.B.1., and IV.B.2. for additional information.

III.A.1. Eligibility Requirements

The following links provide helpful information about residency eligibility requirements:

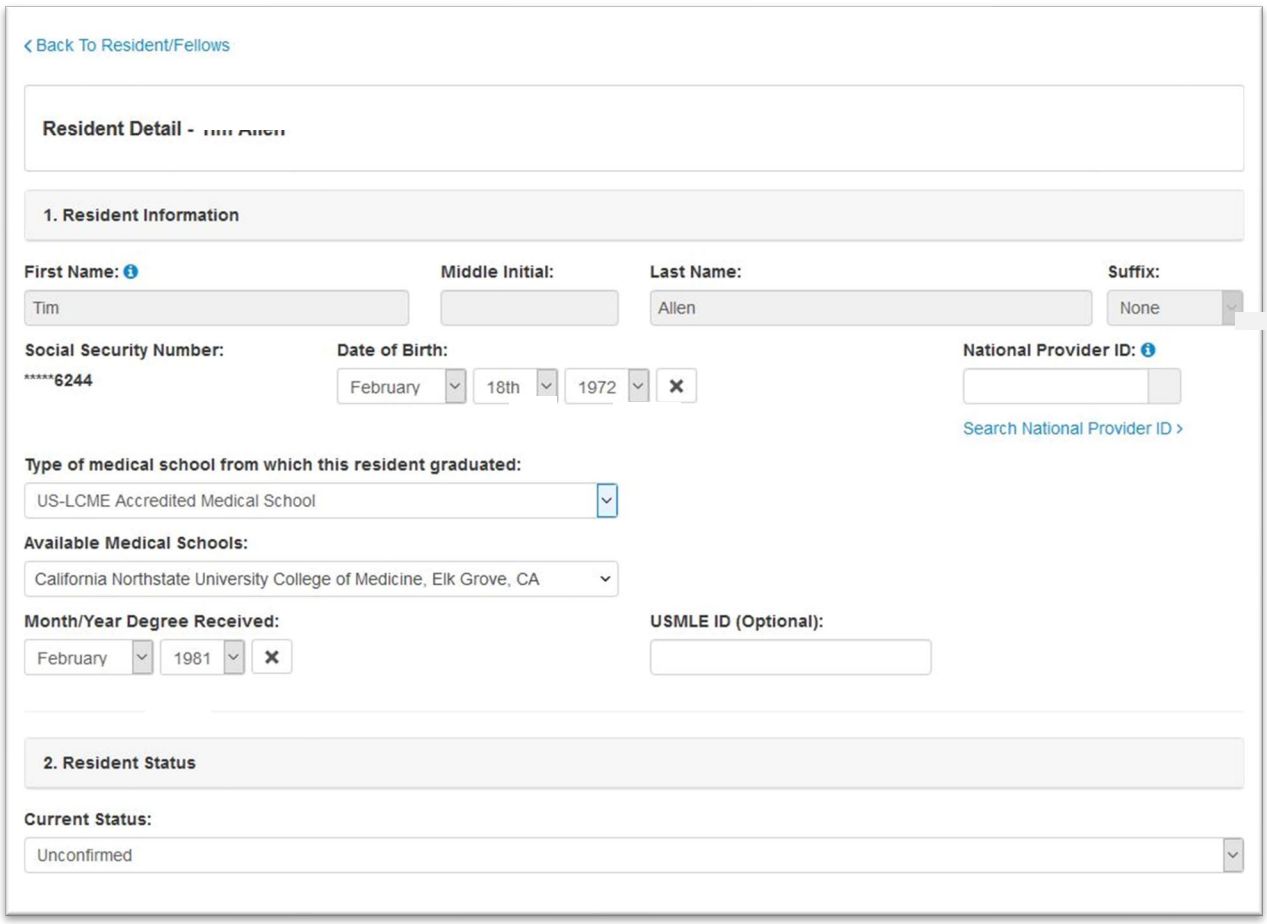
> United States: Liaison Committee on Medical Education (LCME) Doctor of Medicine (MD) graduates
> http://lcme.org/about/
>
> United States: American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (AOA-COCA) Doctor of Osteopathic Medicine (DO) graduates
> https://osteopathic.org/accreditation/
>
> Canada: Committee on Accreditation of Canadian Medical Schools (CACMS) jointly with LCME Doctor of Medicine (MD) graduates
> https://cacms-cafmc.ca/about-cacms/

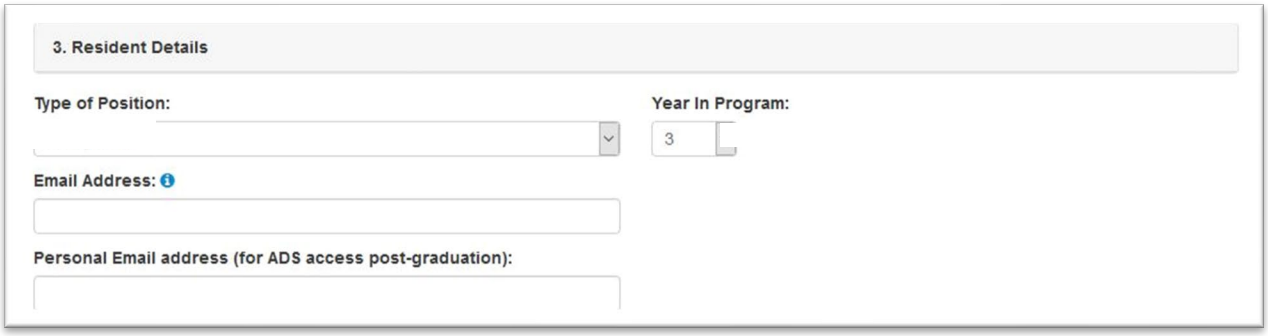
Residents who completed an AOA-approved program that became ACGME accredited during the transition to a single graduate medical education (GME) accreditation system may be eligible for American Board of Medical Specialties (ABMS) and/or AOA board certification.

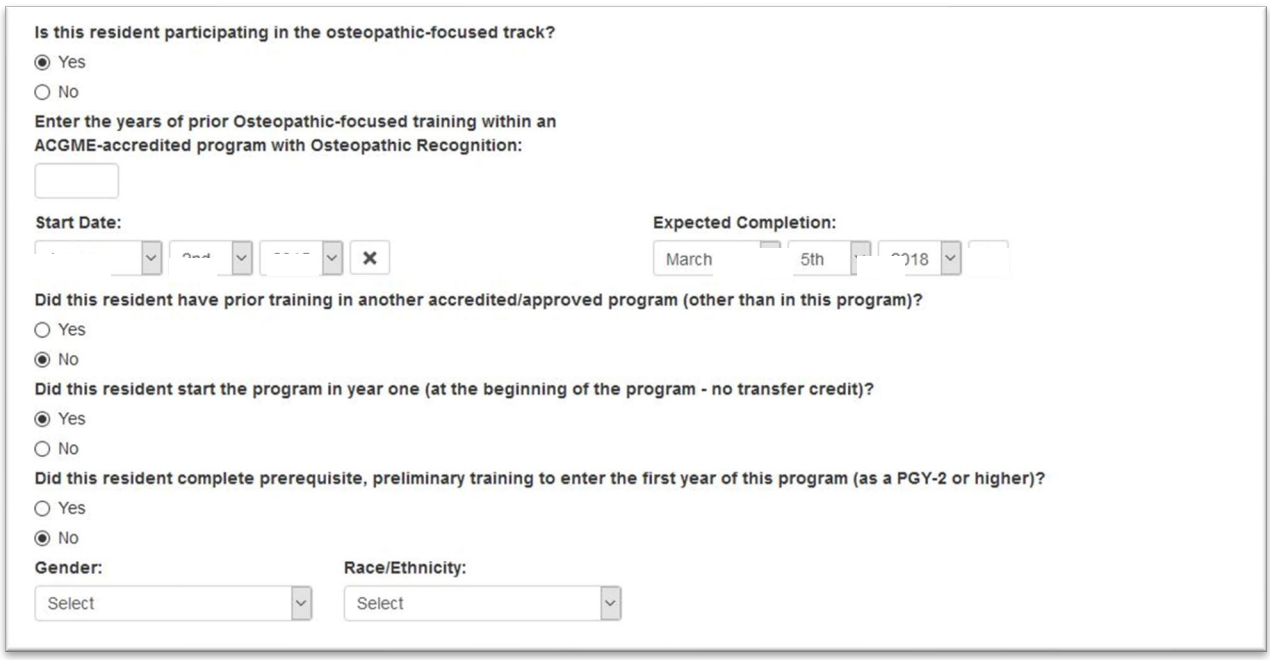
While program accreditation is under the purview of the ACGME, individual board certification is under the jurisdiction of the individual certifying boards. For individual specialty board qualifying information, program directors and residents must communicate with the applicable certifying board.

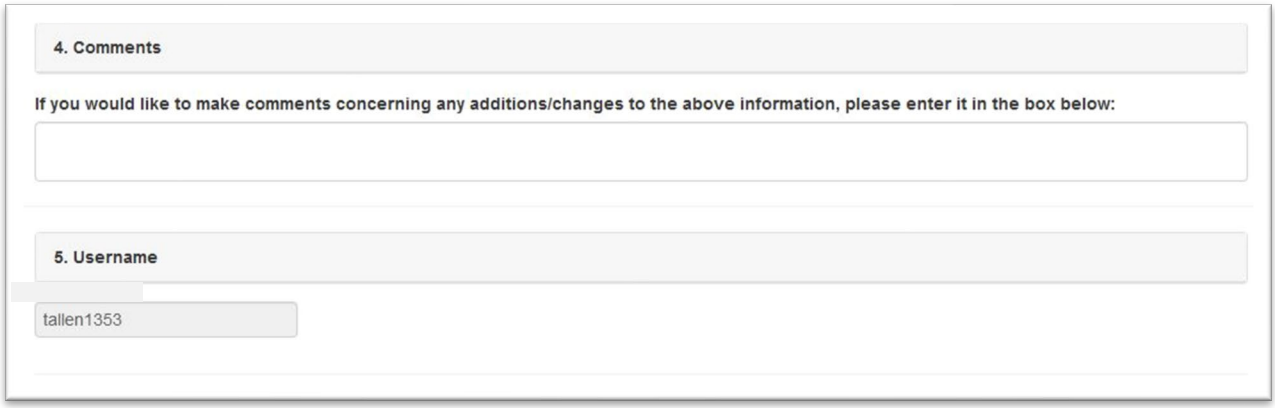
ADS Screenshots: Resident eligibility requirements

The ACGME collects information on each resident during the Accreditation Data System (ADS) Annual Update process when programs input new residents into ADS and update their resident roster. Information collected includes the type of medical school the resident graduated from, the graduation date, and the Educational Commission for Foreign Medical Graduates (ECFMG) certificate where applicable.

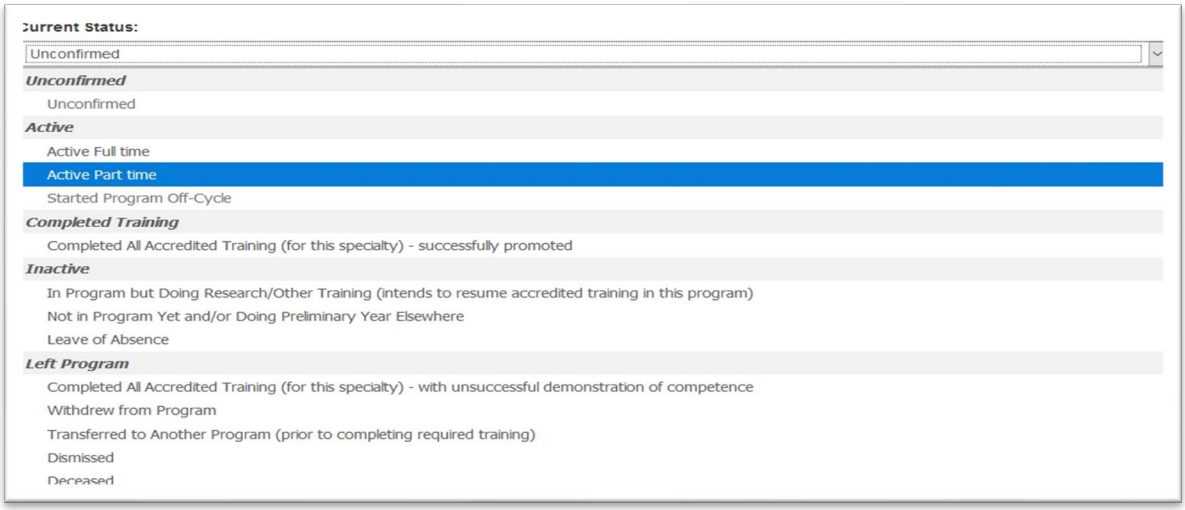

Back To Resident/Fellows
Resident Detail -
1. Resident Information
First Name:
Tim
Middle Initial:
Last Name:
Allen
Suffix:
None
Social Security Number:
*****6244
Date of Birth:
February
18th
1972
National Provider ID:
Search National Provider ID ›
Type of medical school from which this resident graduated:
US-LCME Accredited Medical School
Available Medical Schools:
California Northstate University College of Medicine, Elk Grove, CA
Month/Year Degree Received:
February
1981
USMLE ID (Optional):
2. Resident Status
Current Status:
Unconfirmed


3. Resident Details
Type of Position:
Year In Program:
3
Email Address:
Personal Email address (for ADS access post-graduation):





The table below provides definitions of the different resident statuses:



III.A.2. Prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs

Prerequisite post-graduate clinical education must be obtained in the following types of programs:

- ACGME-accredited residency programs
- AOA-approved residency programs
- Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada
- Residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation

III.A.2.a) Verification of competency in the required clinical field

To verify the competence of each matriculating resident, all prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be verified by the program director. Any one of the following three evaluation tools may be used:

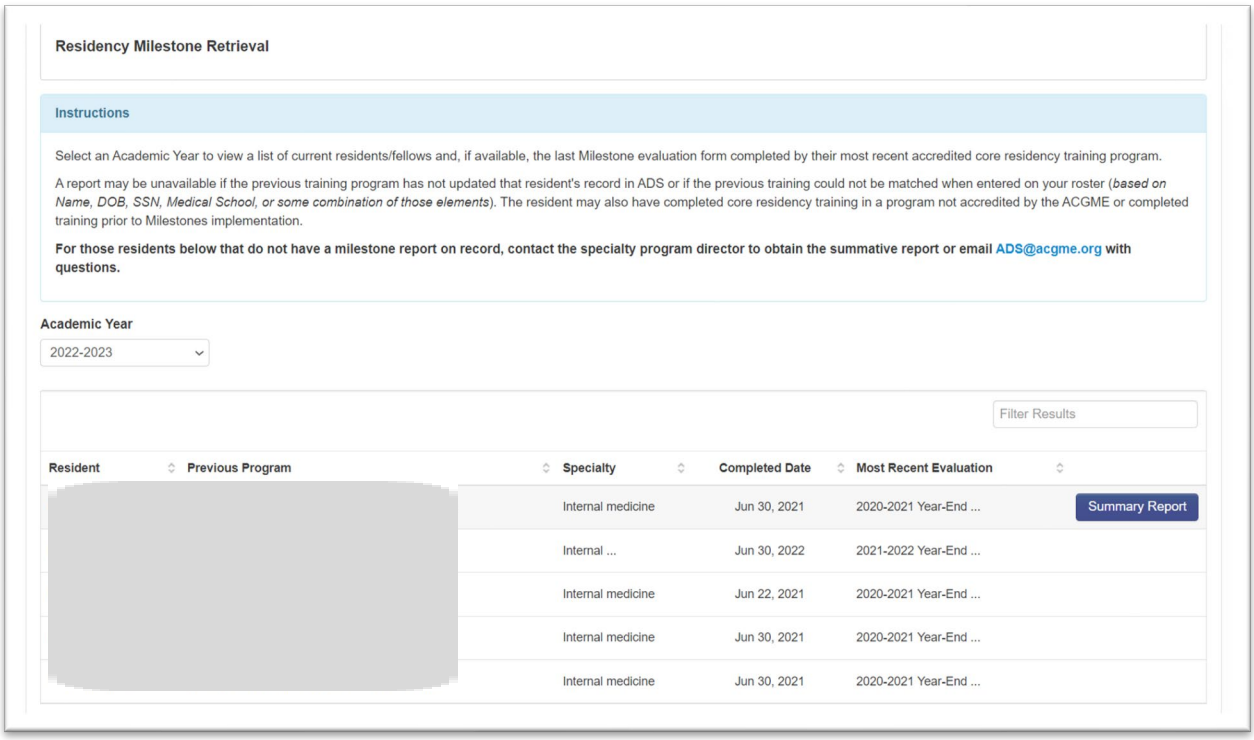
- ACGME Milestones evaluations
- ACGME-I Milestones evaluations
- CanMEDS Milestones evaluations

ADS Screenshot: Retrieving Milestones reports from a previous residency program

Once a transfer resident is entered in ADS and starts in a new residency program, program leadership can retrieve the Milestones report for that resident from the previous program by following these steps:

- Log into ADS
- Go to the Reports tab
- Select “Residency Milestones Retrieval” in the Reports section
- Select the academic year to view a list of current residents and, if available, the last Milestone evaluation form completed by their most recent accredited core residency program
- Click on the “Summary Report” button for that particular resident

NOTE: A report may be unavailable if the previous program has not updated that resident's record in ADS or if the previous training and education could not be matched when entered on your roster (based on name, date of birth, social security number, medical school, or some combination of those elements). The resident may also have completed core residency training and education in a program not accredited by the ACGME or completed training and education prior to Milestones implementation. For residents that do not have a milestone report on record, contact the previous specialty program director to obtain the summative report or email ADS@acgme.org with questions.



[The Review Committee may further specify prerequisite postgraduate clinical education]

Since Review Committees may specify other requirements related to prerequisite postgraduate clinical education, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- Select the specialty
- Click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- Select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to participating sites should be directed to specialty Review Committee staff.

III.A.3. Unaccredited Prior Training

A physician who has completed a residency program that was not accredited by the ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the Graduate Medical Education Committee (GMEC), may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

This requirement describes exceptions to the general requirement in III.A.2. It only applies to an individual who has graduated from a residency in the same specialty. Residents should expect to enter at the PGY-1 level, but if they are performing at a higher level that can be demonstrated through the Milestone evaluation, they can be advanced to the PGY-2 level.

It is important to note that exceptions to the normal pathway of education may affect eligibility for certification; therefore, the resident and program director should confirm individual board eligibility with the applicable certifying board(s).

For additional information regarding ACGME-I Advanced Specialty Accreditation, see the ACGME-I Accreditation Process page.

III.A.4. Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

Some specialties will allow exceptions to resident eligibility requirements. Review the information in the document ACGME Review Committee Eligibility Decisions or refer to the specialty-specific Program Requirements. Review Committees that allow exceptions require completion of a prerequisite residency program prior to admission.

Programs can also access the Common Program Requirements FAQs for additional information on resident eligibility.

See the table below for information on eligibility for specialty certification by ABMS Member Boards and AOA member boards during the transition period to a single GME accreditation system based on training and program accreditation status. This information is accurate as of June 2022 and is subject to change in the future. Refer to the ABMS and AOA websites for most current information

The AOA provides a pathway for osteopathic physicians (whether they were educated in AOA-approved or ACGME-accredited programs) to sit for AOA board examinations in the areas the AOA certifies. Allopathic physicians who complete an ACGME-accredited program with Osteopathic Recognition in a designated osteopathic position are also eligible for AOA board certification. Allopathic physicians who complete an ACGME-accredited osteopathic neuromusculoskeletal medicine program are eligible for AOA board certification in neuromusculoskeletal medicine. For AOA programs that achieved ACGME accreditation during the transition, all osteopathic residents in the program at the time it achieved ACGME accreditation will receive AOA approval following completion of the program, which will satisfy the AOA board eligibility requirements.

During the transition, the ABMS boards will offer certification to osteopathic physicians under specific circumstances (see table below). Please see individual ABMS Member Board or AOA Specialty Certifying Board websites for a comprehensive summary of all requirements for board eligibility. Note that the rules for entering advanced ACGME training and education are established by the ACGME. Those rules may allow a resident to enter advanced ACGME training and education, but do not guarantee that the resident will be eligible to sit for the ABMS board examination.

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
Allergy and Immunology	**American Board of Allergy and Immunology (ABAI)** Two full years in an ACGME-accredited allergy and immunology program AND must be eligible to take the certifying examination for either the American Board of Internal Medicine or the American Board of Pediatrics. In 2016, the ACGME approved allergy and immunology programs accredited by the American Osteopathic Association to be approved for dual accreditation. Graduates of a dually accredited program are now eligible to apply for admission to the ABAI Certification Examination in Allergy and Immunology. Therefore, candidates with one year of training in an AOA-accredited program and one year of training in an ACGME-accredited program may be considered for admission to the allergy and immunology examination. Candidates who submit appropriate documentation will be reviewed by the ABAI Ethics and Professionalism Committee to ensure their training meets the requirements for admission to the examination.	**Allergy and Immunology - Joint Examination** Completed an AOA-approved or ACGME-accredited program
Anesthesiology	**American Board of Anesthesiology (ABA)** All three years of clinical anesthesia (CA 1-3) training must occur in programs that are accredited by the ACGME for the entire period of training. All physicians who graduate from an AOA-approved anesthesiology residency program on or after the date the program receives full ACGME accreditation will receive ABA credit for the CA 1-3 years of satisfactory training in the newly accredited program.	**American Osteopathic Board of Anesthesiology** Completed an AOA-approved or ACGME-accredited program

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
Colon and Rectal Surgery	**American Board of Colon and Rectal Surgery** Not applicable. There are no AOA-approved programs.	N/A
Dermatology	**American Board of Dermatology** Program must achieve ACGME accreditation prior to completion.	**American Osteopathic Board of Dermatology** Completed an AOA-approved or ACGME-accredited program
Emergency Medicine	**American Board of Emergency Medicine** Program must achieve ACGME accreditation prior to completion.	**American Osteopathic Board of Emergency Medicine** Completed an AOA-approved or ACGME-accredited program
Family Medicine	**American Board of Family Medicine (ABFM)** A time-limited exemption during the transition period will be offered to allow osteopathic family physicians who have completed three years of an AOA-approved family medicine residency program to be eligible for ABFM specialty certification.	**American Osteopathic Board of Family Physicians** Completed an AOA-approved or ACGME-accredited program
Internal Medicine	**American Board of Internal Medicine (ABIM)** Program must achieve ACGME accreditation prior to resident's completion of the program. In addition, the program director must be certified by ABIM, or other ABMS member board if applicable, by the completion of the transition period (2016-2023) to a single GME accreditation system in order to attest to ABIM initial eligibility criteria. Beginning in 2024, only graduates of programs with program directors certified by ABIM, or other ABMS board if applicable, will be eligible for certification by ABIM.	**American Osteopathic Board of Internal Medicine** Completed an AOA-approved or ACGME-accredited program
Medical Genetics and Genomics	**American Board of Medical Genetics and Genomics**	N/A

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
	There are no AOA-approved residency programs in medical genetics and genomics. A minimum of one year of GME training in either an ACGME-accredited program or a program in the ACGME pre-accreditation phase with 12 months of direct patient care is required prior to beginning the medical genetics and genomics residency.	
Neuromusculoskeletal Medicine	N/A	**American Osteopathic Board of Neuromusculoskeletal Medicine** Completed an AOA-approved or ACGME-accredited program
Neurological Surgery	**American Board of Neurological Surgery (ABNS)** Neurological surgery training is 84 months in total. There are 54 months of “core" neurological surgery training which must be completed in an ACGME-accredited program. For the 30 months of research or elective time, there is flexibility depending upon the quality of the clinical or research experience. It is not necessary for this experience to be in an ACGME-accredited program. However, written approval from the ABNS is required for any off-site elective experiences. The ABNS works collaboratively with the ACGME when questions arise to ensure high-quality training and education.	**American Osteopathic Board of Surgery: Neurological Surgery** Completed an AOA-approved or ACGME-accredited program
Nuclear Medicine	**American Board of Nuclear Medicine** Not applicable. There are no AOA-approved nuclear medicine programs.	**American Osteopathic Board of Nuclear Medicine** Completed an AOA-approved or ACGME-accredited program

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
Obstetrics and Gynecology	**American Board of Obstetrics and Gynecology** Program must have achieved ACGME accreditation prior to completion.	**American Osteopathic Board of Obstetrics and Gynecology** Completed an AOA-approved or ACGME-accredited program
Ophthalmology	**American Board of Ophthalmology** All training must be in an ACGME-accredited program.	**American Osteopathic Board of Ophthalmology and Otolaryngology** Completed an AOA-approved or ACGME-accredited program
Orthopaedic Surgery	**American Board of Orthopaedic Surgery** All training must be in an ACGME-accredited program.	**American Osteopathic Board of Orthopedic Surgery** Completed an AOA-approved or ACGME-accredited program
Otolaryngology – Head and Neck Surgery	**American Board of Otolaryngology – Head and Neck Surgery (ABOHNS)** All training must be in an ACGME-accredited program. Based on the timing of AOA-approved residencies transitioning to ACGME accreditation, ABOHNS started seeing some applicants from the traditional AOA-approved residencies in 2021. This transition will be completed with all residents in newly ACGME-accredited residency programs by 2025.	**American Osteopathic Board of Ophthalmology and Otolaryngology** Completed an AOA-approved or ACGME-accredited program
Pathology	**American Board of Pathology** Not applicable. There are no AOA-approved programs in pathology.	**American Osteopathic Board of Pathology** Completed an AOA-approved or ACGME-accredited program
Pediatrics	**American Board of Pediatrics** All residency training must be completed in an ACGME- or RCPSC-accredited program.	**American Osteopathic Board of Pediatrics** Completed an AOA-approved or ACGME-accredited program

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
Physical Medicine and Rehabilitation	**American Board of Physical Medicine and Rehabilitation (ABPMR)** Through June 30, 2020, the ABPMR will recognize AOA-approved training as acceptable toward PGY-1-level physical medicine and rehabilitation residency training. Due to the impact of the transition to a single GME accreditation system, the ABPMR will recognize physicians who completed at least 36 months of AOA-approved physical medicine and rehabilitation training as eligible for certification in circumstances where ACGME accreditation was granted by the time of program completion. Program completion must have occurred July 1, 2015, and forward to coincide with the transition to a single GME accreditation system.	**American Osteopathic Board of Physical Medicine and Rehabilitation** Completed an AOA-approved or ACGME-accredited program
Plastic Surgery	**American Board of Plastic Surgery** All training must be in an ACGME-accredited program.	**American Osteopathic Board of Surgery: Plastic and Reconstructive Surgery** Completed an AOA-approved or ACGME-accredited program
Preventive Medicine	**American Board of Preventive Medicine** PGY-1 year can take place in an AOA-approved program. Years 2 and 3 must be in an ACGME-accredited program.	**American Osteopathic Board of Preventive Medicine** Completed an AOA-approved or ACGME-accredited program
Psychiatry and Neurology	**American Board of Psychiatry and Neurology** Program must achieve ACGME accreditation prior to completion.	**American Osteopathic Board of Neurology and Psychiatry** Completed an AOA-approved or ACGME-accredited program
Radiology	**American Board of Radiology**	**American Osteopathic Board of Radiology**

	ABMS Board Certification Requirements	AOA Board Certification Requirements
Specialty	**ABMS Member Board and Training and Program Accreditation Status**	**AOA Member Board and Training Eligibility Criteria for Specialty Certification**
	All residency training must be completed in an ACGME- or RCPSC-accredited program.	Completed an AOA-approved or ACGME-accredited program
Surgery	**American Board of Surgery** The final three years of the basic five-year surgery residency must be in an ACGME-accredited program.	**American Osteopathic Board of Surgery** Completed an AOA-approved or ACGME-accredited program
Thoracic Surgery	**American Board of Thoracic Surgery** The last three years of a surgical residency (PGY 3-5) must be completed in an ACGME-accredited program followed by completion of an ACGME-accredited thoracic surgical residency.	**American Osteopathic Board of Surgery: Thoracic and Cardiovascular Surgery** Completed an AOA-approved or ACGME-accredited program
Urology	**American Board of Urology** All training must be in an ACGME- or RCPSC-accredited program.	**American Osteopathic Board of Surgery: Urological Surgery** Completed an AOA-approved or ACGME-accredited program

IMPORTANT NOTE:

The ACGME provides accreditation to programs, NOT certification to individuals. Applicants may mistakenly assume that acceptance to an ACGME-accredited program ensures eligibility for ABMS or AOA board certification. Program directors MUST make this clear to all applicants, as required in Common Program Requirement II.A.4.a).(9): “The program director must provide applicants who are offered an interview with information related to the applicant’s eligibility for the relevant specialty board examination(s).”

To ensure that the program director and applicants have a common understanding of this information, programs may wish to use a letter signed by both parties. Sample letters to convey this critical information are provided below.

DRAFT SAMPLE LETTER: Letter from Program Director to the Applicant

Eligibility for Board Certification for Applicants to the Program

Date:

To: Residency Applicants
Re: Eligibility for Board Certification

Dear:

As part of your application and interview for a potential residency position in our program, this letter is to notify you that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and that you meet the ACGME requirements for matriculation in our program.

Upon graduating from our program, most of our residency graduates seek board certification from the American Board of _____ or the American Osteopathic Board of _____. Board certification is a separate process from residency training and education and has additional requirements. Some board organizations require that you complete *all* of your education in an ACGME-accredited residency. If *part* of your residency education occurred in a non-ACGME-accredited program, even if it was approved by the American Osteopathic Association or accredited by the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or ACGME International (ACGME-I) with Advanced Specialty Accreditation, there is a possibility that you may not be eligible for board certification upon completion of your education.

It is important that you contact the appropriate certifying board to understand your eligibility for board certification before you accept a position for residency (if offered) at our institution.

Please contact the American Board of _____ at (website URL) or American Osteopathic Board of _____ at (website).

I have read this letter and understand the requirements for board certification.

_____ _____
Applicant Name Applicant Signature/Date

_____ _____
Program Director Name Program Director Signature/Date

DRAFT SAMPLE LETTER: Letter from the Program Director to the Applicant: Residency

[Date]

Dear [Ms./Mr./Dr.] [Last Name]:

I am writing this letter to you in compliance with ACGME Program Requirement II.A.4.a).(9): *The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s)*.

[ ] The relevant American Board of Medical Specialties (ABMS) member board is the American Board of [Specialty]. Taking into account the path of your medical education, to date, and assuming your acceptance to, satisfactory performance in, and completion of this program, you [ ] would [ ] would not be eligible for certification by the American Board of [Specialty].

[ ] The relevant American Osteopathic Association board is the American Osteopathic Board of [Specialty]. Taking into account the path of your medical education, to date, and assuming your acceptance to, satisfactory performance in, and completion of this program, you [ ] would [ ] would not be eligible for certification by the American Osteopathic Board of [Specialty].

[ ] There is no relevant ABMS member board in [Specialty].

[ ] The is no relevant AOA board in [Specialty].

Sincerely,

[Program Director Name]
Program Director in [Specialty]
[Institution Name]

COMMON PROGRAM REQUIREMENTS

III. Resident Appointments

III.B. The program director must not appoint more residents than approved by the Review Committee. (Core)

III.B.1. All complement increases must be approved by the Review Committee. (Core)

[The Review Committee may further specify minimum complement numbers]

GUIDANCE

III.B. Resident Complement
Review Committees approve resident complement for a program at the time of an application and the program director must not appoint more residents than approved by the Review Committee. Some Review Committees approve complement by total while others approve complement by both total and program year.

Complement increases can be permanent or temporary.

Permanent complement change requests: A program may request a permanent complement increase to expand its size. Programs can also request a decrease in permanent complement if they need to decrease the size of the program below the approved complement. All permanent complement increase requests must be submitted through the Accreditation Data System (ADS) and require approval by the Review Committee. Review Committees assess all requests for permanent complement increases thoroughly, considering the clinical, educational, and other resources available to the program. Additional information or a site visit may be requested for a permanent complement change request, depending on the details of the request. Review Committees review permanent increase requests at their scheduled meetings and therefore programs should check posted meeting agenda closing dates on the applicable specialty page of the ACGME website and plan accordingly before submitting a request.

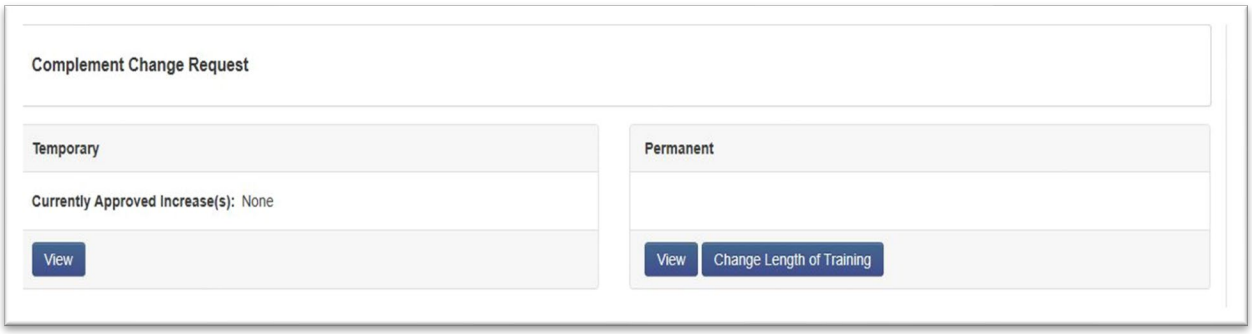
Temporary complement change requests: A program may request a temporary complement increase for many reasons, including remediation, resident well-being needs, medical, parental, or caregiver leave, and a resident beginning the program off-cycle. Temporary complement increase requests must be submitted through ADS and require approval by the Review Committee, although the submission and approval process differs by Review Committee and programs must consult specialty-specific guidance referenced below in this document.

Program directors are strongly encouraged to contact their graduate medical education office and the applicable specialty certifying board for guidance on extending a resident's education and training, as the impact and requirements vary from one certifying board to another.

To initiate a request to change the program's approved complement:

- The program director must:
  - Log into ADS;
  - Under the "Program" tab, select "Complement Change" from the right panel under "Requests;"
  - Select either "Temporary" or "Permanent" request;
  - Complete all required information and submit.
- Once submitted, the request will be forwarded to the designated institutional official (DIO) for approval.
- Once approved by the DIO, the request will be forwarded to the specialty Review Committee.
- ACGME staff will notify the program of the Review Committee's decision. The notification time may vary based on the type of request and whether it needs to be reviewed during a Review Committee meeting.

ADS screenshot: Complement Change Requests



[The Review Committee may further specify minimum complement numbers]

For more information on resident complement and whether your specialty Review Committee specifies minimum complement numbers, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- Select the specialty
- Click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- Select the currently in effect specialty program requirements.

Each Review Committee also provides additional information on the specialty-specific process to request a complement change in the Documents and Resources section of their specialty-specific web page. Questions about specialty-specific Program Requirements related to resident complement should be directed to specialty Review Committee staff.

COMMON PROGRAM REQUIREMENTS

III. Resident Appointments

III.C. Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)

[The Review Committee may further specify]

GUIDANCE

III.C. Resident Transfers

Residents are considered transfer residents under several conditions, including:

- when moving from one program to another within the same or different Sponsoring Institution;
- when moving from one program to another within the same or different specialty;
- when entering as a PGY-2 in a program requiring a preliminary year, regardless of whether the resident was accepted to the preliminary year and the specialty program as part of the match (i.e., accepted to both the preliminary program and the specialty program upon graduation from medical school).

The term does not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Before accepting a transferring resident, the “receiving” program director must obtain written or electronic verification of prior educational experiences and performance from the program the resident is transferring from.

Documentation includes evaluations, rotations completed, procedural/operative experience/Case Logs if applicable, and a summative competency-based performance evaluation.

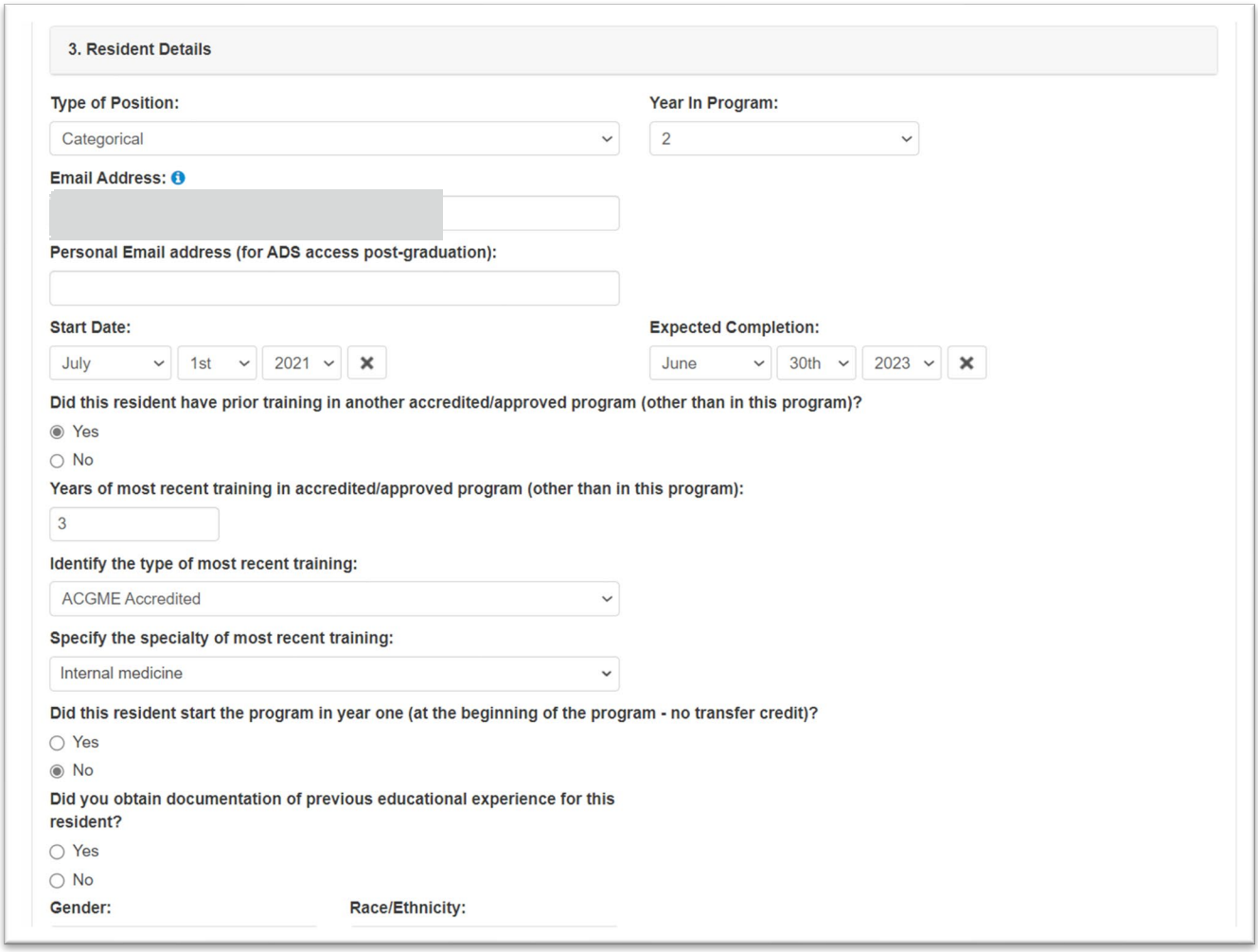
While a Milestones evaluation cannot be used in the decision to accept a transferring resident, a Milestones evaluation must be obtained upon matriculation.

The ACGME monitors compliance with this requirement in various ways, including:

- resident-level questions that program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update when entering/updating their resident roster;
- questions asked and documentation reviewed by Accreditation Field Representatives during site visits of the program at various stages of accreditation.

ADS Screenshot: Identifying transfer residents

During the ADS Annual Update, programs update their resident roster and information on each resident. On the resident profile page, under the Resident Details section, programs are asked to answer several questions regarding a transferring resident and confirm that documentation of prior training and education has been obtained for a transfer resident.

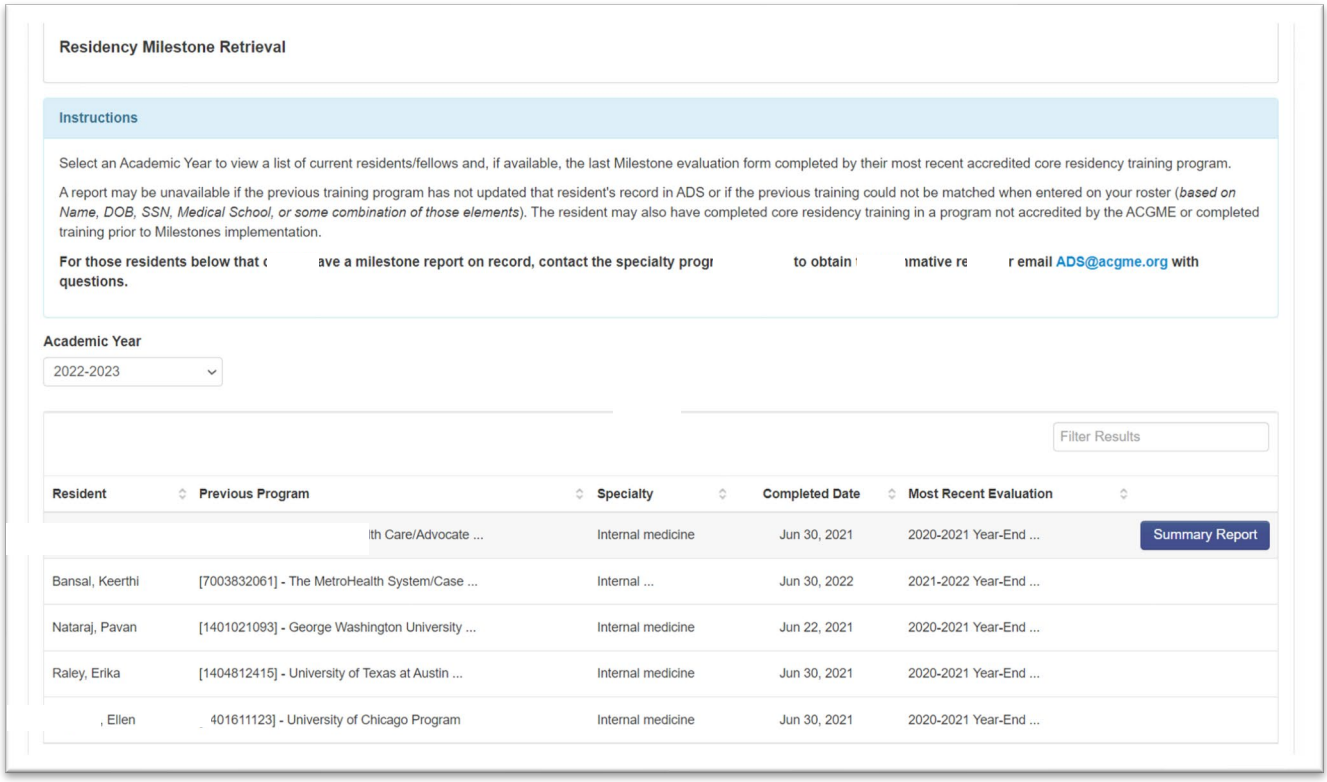


ADS Screenshot: Retrieving Milestones reports from previous residency program

Once a transfer resident starts in a new residency program, program leadership can retrieve the Milestones report for that resident from the previous program by following these steps:

- Log into ADS
- Go to the Reports tab
- Select “Residency Milestones Retrieval” in the Reports section
- Select the academic year to view a list of current residents and, if available, the last Milestone evaluation form completed by their most recent accredited core residency program
- Click on the “Summary Report” button for that particular resident

NOTE: A report may be unavailable if the previous program has not updated that resident's record in ADS or if the previous training and education could not be matched when entered on your roster (based on name, date of birth, social security number, medical school, or some combination of those elements). The resident may also have completed core residency training and education in a program not accredited by the ACGME or completed training and education prior to Milestones implementation. For residents that do not have a milestone report on record, contact the previous specialty program director to obtain the summative report or email ADS@acgme.org with questions.



[The Review Committee may further specify]

Since Review Committees may specify other requirements related to resident transfers, programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- Select the specialty
- Click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- Select the currently in effect specialty program requirements.

Questions about specialty-specific Program Requirements related to resident transfers should be directed to specialty Review Committee staff.

Programs can also access the Common Program Requirements FAQs for additional information on resident transfers and Milestones retrieval.

COMMON PROGRAM REQUIREMENTS

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. The curriculum must contain the following educational components: (Core)

IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.1.a) The program's aims must be made available to program applicants, residents, and faculty members. (Core)

IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

IV.A.3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced

learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. a broad range of structured didactic activities; (Core)

IV.A.4.a) Residents must be provided with protected time to participate in core didactic activities. (Core)

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.5. advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, (Core)

IV.A.6. advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care. (Core)

GUIDANCE

The Common Program Requirements do not list detailed curricular elements for each specialty. The overarching intent of the Common Program Requirements related to the educational program is to ensure that programs provide a framework for:

1. a comprehensive education for residents pertinent to the specific mission and aims of the Sponsoring Institution, the program, and the community served; and,
2. the development of knowledgeable, skilled, and compassionate physicians capable of autonomous practice.

IV.A.1. Program Aims

Programs must develop aims to add context to the program's expectations and focus on aspects such as:

1. What types of residents is the program educating?
2. What are their future roles in the community?

Having aims allows the program to construct curricular elements that address career options (e.g., clinical practice, research, primary care, or health policy and advocacy). For example, a program in a rural community might focus its resident education on issues relevant to that community, while a program in an institution with a goal to produce physician-scientists might want to provide more education in research. The Program Evaluation Committee (PEC) should play a central role in the development of program aims and should ensure that the program is working toward these aims.

For information about how to set and validate program aims, review this brief slide presentation.

Program aims should be vetted with program and institutional leaders, and in some institutions, setting aims will be an institution-level initiative. In setting aims, programs should generally take a longer-term strategic view. However, aims may change over time. Factors such as a shift in program focus initiated by institutional or department leadership, changes in local or national demand for a resident workforce with certain capabilities, or new opportunities to train and educate residents in a different setting may prompt revision of program aims.

It bears re-emphasizing that while Common Program Requirement IV.A.1. requires that the program develop a set of program aims consistent with its mission and the community it serves, the Review Committees will *not* evaluate the specifics of the program aims for accreditation purposes. What Review Committees will evaluate is that a program has defined its program aims and that it has a process to share them with applicants to the program, residents, and faculty members.

New programs submitting an application for accreditation and programs with a status of Initial Accreditation or Initial Accreditation with Warning must provide or update their program aims in the Accreditation Data System (ADS) as part of an application or the ADS Annual Update.

Accreditation Field Representatives also verify that a program has identified program aims and that it has a process in place to share those with program applicants, residents, and faculty members.

IV.A.2. Goals and Objectives

The program must design competency-based, level-specific goals and objectives for each educational experience/rotation to ensure that faculty members and residents are aware of the purpose of a particular rotation in meeting their educational needs.

What are goals and objectives?

- A goal is an overarching principle that guides decision making.
- Objectives are specific, measurable steps that can be taken to meet the goal.

Benjamin Bloom created a taxonomy of measurable verbs that help describe observable knowledge, skills, attitudes, behaviors, and abilities. The theory of "Bloom's Taxonomy of Measurable Verbs" is based on the premise that there are observable action levels that can help explicitly define what a student must do to demonstrate learning. (See table of Bloom's Taxonomy Action Verbs.)

The information in the table indicates what one would expect for a particular item. For example, under Knowledge, an individual remembers previously learned information. For Application, an individual can use this knowledge to solve a problem. The words in the list are concise, explicit, and measurable.

Common mistakes in creating goals and objectives:

1. Using vague verbs and phrases that cannot be measured.

   Words to avoid include:

   - believe
   - comprehend
   - know
   - perceive
   - recognize
   - understand

   Phrases to avoid include:

   - appreciation for
   - capable of
   - familiar with
   - knowledge of

2. Creating goals and objectives that are not level-specific and/or competency-based.

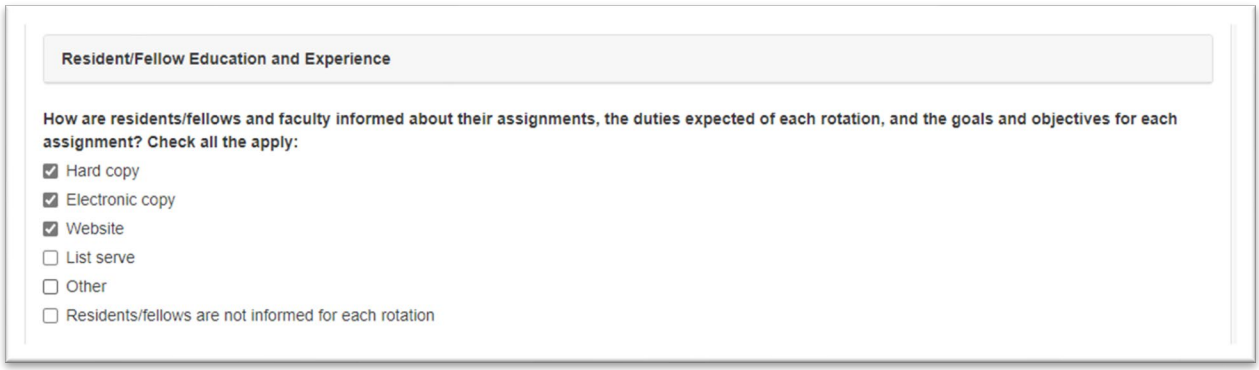
SMART is a useful mnemonic for writing goals and objectives, developed from George T. Doran's 1981 paper "There's a S.M.A.R.T. Way to Write Management's Goals and Objectives." (Doran, George T. 1981. "There's a S.M.A.R.T. Way to Write Management's Goals and Objectives," Management Review, Vol. 70, Issue 11, pp. 35-36.):

S - Specific
M - Measurable
A - Attainable
R - Relevant
T - Time-Bound

Goals and objectives must be competency-based and level-specific. For example, a PGY-1 resident must demonstrate the ability to independently perform a complete history and physical examination as part of the Patient Care Competency. As part of the same Competency, a PGY-3 resident in a three-year program must demonstrate the ability to guide and supervise a PGY-1 resident in obtaining a complete history and physical examination and take an active role in the formulation of diagnostic and treatment plans.

Goals and objectives must be distributed, reviewed, and available to residents and faculty members to ensure an understanding of learning expectations. New programs submitting an application for accreditation and programs with a status of Initial Accreditation or Initial Accreditation with Warning must answer the question shown in the screenshot below in ADS as part of the application or during the ADS Annual Update process. Finally, Accreditation Field Representatives also verify during a site visit that the program has a process in place for informing residents of goals and objectives for all educational assignments.

ADS Screenshot: Goals and Objectives

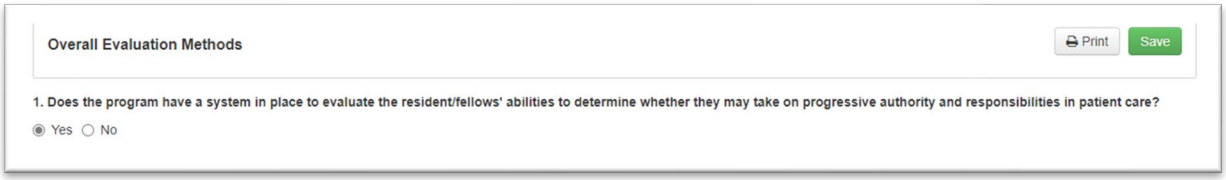


IV.A.3. Resident Responsibilities and Graded Supervision

Requirement IV.A.3. is closely related to requirements in section VI.A.2. related to supervision and accountability and programs are encouraged to review those requirements and associated guidance as well. The responsibilities and supervision of residents must be clearly delineated. The ACGME assesses compliance with this requirement in multiple ways, including through review of the supervision policy as well as answers to the question shown below for programs

submitting an application or during the Initial Accreditation stage. Accreditation Field Representatives also verify information related to this requirement during accreditation site visits.

ADS Screenshot: Resident Progressive Authority and Responsibilities in Patient Care



IV.A.4. Structured Didactic Activities

There are many forms of didactic activities, including lectures, workshops, courses, simulation with feedback, case discussions, grand rounds, board review, and journal club. Faculty members' presence, participation, and leadership is key. In addition, residents must have the opportunity to participate in didactic activities. While residents may occasionally miss didactic activities because of priorities related to patient care, it is important that the program provide protected time to allow their attendance. Residents on rotations at a distant site should be given the opportunity to participate in didactic activities online, via recorded conferences, and through other means as applicable.

Program leaders should conduct periodic reviews of the program's curriculum to determine if adjustments need to be made (e.g., new treatment protocols or concepts may need to be incorporated). If Milestones evaluation and in-training examination results consistently indicate a significant portion of residents are not performing well in a particular area, program leaders should address that knowledge deficiency in the didactic curriculum.

IV.A.5. Ethical Principles Foundational to Medical Professionalism

"The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

Dr. Francis M. Peabody
Boston, 1927

"It is essential, therefore, that physicians understand clearly that to serve the goals of medicine, they have a responsibility to continue to care for their patients when they can no longer prescribe a particular form of treatment or offer the likelihood of a cure."

Dr. Michael E. Whitcomb
What Does It Mean to Be a Physician?
Academic Medicine Vol 82, October 2007

The American Medical Association (AMA) has codified medical ethics and ethical principles for physicians:

- AMA Ethical principles
- The AMA Code of Medical Ethics

IV.A.6. Basic Principles of Scientific Inquiry, including How Research is Designed, Conducted, Evaluated, Explained to Patients, and Applied to Patient Care

The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan;
- challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature;
- when appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation); and,
- improving residents' learning by encouraging them to teach using a scholarly approach.

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

This requirement states that the curriculum must include education in basic principles of scholarship. Examples of components of this education include:

- Animal Investigation Committee procedures
- Basic research design
- Basic statistics
- Data collection and spreadsheet entry
- Evidence-based literature review
- Institutional Review Board procedures
- Medical writing
- Obtaining informed consent from patients/families
- Presentation skills

There are many ways to provide these curricular elements. Programs may wish to cover the topics at monthly sessions over a one-year period. These sessions do not need to be taught by the program director; this is an opportunity for collaboration, where experts in the topic can be

invited to speak. There are many web-based curricula for teaching these topics, and there may be courses provided by the medical school or the Institutional Review Board. The National Institutes of Health may also be a good resource. In addition, web-based resources and textbooks about the conduct of evidence-based literature review and for quality improvement and patient safety studies are widely available.

Key to this process is faculty mentorship. While there may be some residents who begin the program with specific research plans, many do not. They need guidance from faculty mentors who can help them design and conduct a study, gather and analyze data, and write up results for presentation or publication. Faculty members also need to be involved in, or even lead, journal club and other scholarly activities.

An environment of scholarship is essential to ensuring residents continue applying the methods of the scholarly approach in their own practice after completion of the program.

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

GUIDANCE

The ACGME and the American Board of Medical Specialties developed the six Core Competencies necessary for a practicing physician:

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

The Core Competencies provide a systematic framework to think about both curriculum and assessment in medical education. Each specialty was tasked with crafting specific milestones within each Competency.

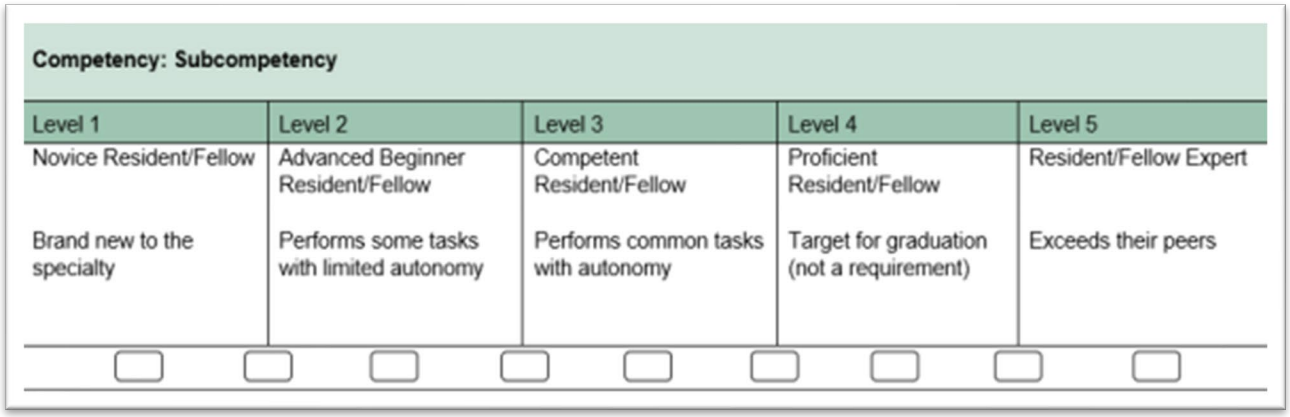
The Milestones in graduate medical education (GME) provide narrative descriptions of the Competencies and subcompetencies along a developmental continuum with varying degrees of granularity. Simply stated, the Milestones describe performance levels residents are expected to demonstrate for skills, knowledge, and behaviors in the six Core Competency domains. The Milestones lay out a framework of observable behaviors and other attributes associated with a resident's development as a physician.

It is essential to recognize that milestones, based on the concept of stages of professional development, are designed to be criterion-based and agnostic to the actual PGY level of the resident. Programs should judge each resident based on the actual level of performance as described in the Milestones, not in relation to peers or others.

The Milestones describe the learning trajectory within a subcompetency that takes the resident from a beginner in the specialty to a highly proficient resident or resident expert. The Milestones are different from many other assessments because there is an opportunity for the learner to demonstrate the attainment of aspirational levels of the subcompetency. The Level 4 milestones are designed as the graduation target but do not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. (See the Milestones FAQs for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach all of the milestones?") The Milestones allow for a shared understanding of the expectations for the learner.

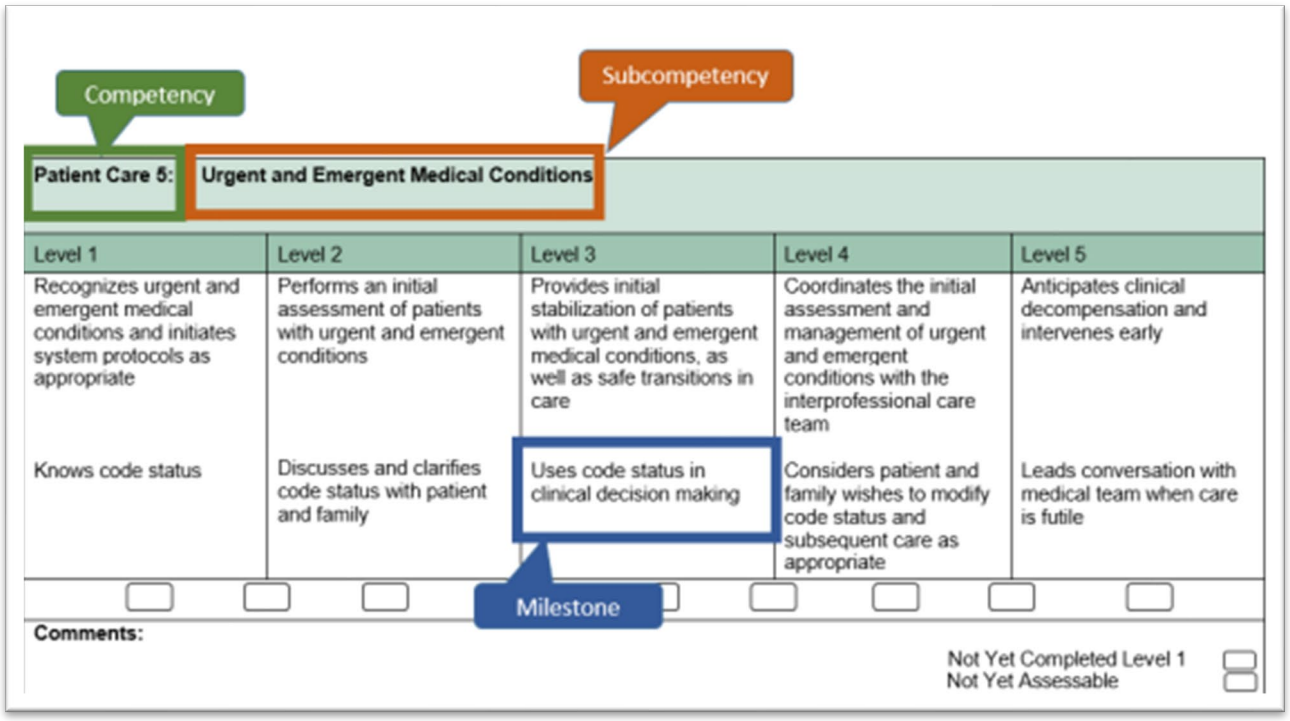
It is also important to recognize what the Milestones *are not*. First and foremost, they do not describe or represent a complete description of a clinical discipline. They represent the core of a discipline, but programs will need to use good judgment to fill in the gaps in curriculum and assessment. It is essential that the Milestones do not serve as curricula in and of themselves, but rather guide a thoughtful analysis of curricula to identify strengths and gaps. Second, they are not tools designed to affect program accreditation, and therefore Review Committees do not see or review any individual resident Milestones ratings or aggregated Milestones data for a particular program. The Milestones are intended for formative purposes to help learners, faculty members, and programs.

General Description of Milestone Levels Related to Stage of Education



Competency: Subcompetency				
Level 1	Level 2	Level 3	Level 4	Level 5
Novice Resident/Fellow	Advanced Beginner Resident/Fellow	Competent Resident/Fellow	Proficient Resident/Fellow	Resident/Fellow Expert
Brand new to the specialty	Performs some tasks with limited autonomy	Performs common tasks with autonomy	Target for graduation (not a requirement)	Exceeds their peers

Example of the Basic Anatomy of a Milestone



Several key aspects about the use of the Milestones deserve special attention. First, the Milestones reported to the ACGME were not designed to be used as evaluation forms for specific rotations or experiences. The Milestones are designed as a formative judgment of progress at least twice a year. The language from the Milestones may be helpful as part of a mapping exercise to determine which subcompetencies are best covered in specific rotations and curricular experiences. The Milestones can also be used for guided self-assessment and reflection by the resident in preparation for feedback sessions and in creating individual learning plans. Residents should use the Milestones for self-assessment with input and feedback from a faculty advisor, mentor, or program director. Residents should not judge themselves on the Milestones in isolation. Milestones feedback is most effective when performed in dialogue

between a learner and a faculty advisor. The Milestones can be useful in faculty development by helping faculty members recognize performance expectations of learners, more explicitly assess the trajectory of skill progression in their specialty, and discern how to ideally assess a learner's performance. Finally, it is imperative that programs remember that the Milestones are not inclusive of the broader curriculum and that limiting assessments to the Milestones could leave many topics without proper and essential assessment and evaluation.

The Supplemental Guides are a tool to aid in the development of a shared mental model of the Milestones for each specialty. The Milestones Supplemental Guide for each specialty includes the overall intent of each subcompetency, examples for each individual milestone, ideas for assessment methods, and other resources. An editable version of each Supplemental Guide is available so that each program can identify what it expects to see at each level. It can also be used to aid in mapping to curricula, rotations, and assessments. Many of the Supplemental Guides include a map from Milestones 1.0 to 2.0 to show topics that were carried over and those that were deleted or added. It is recommended that the Supplemental Guide be shared with all learners and faculty. Milestones Supplemental Guides can be found on the Milestones section of each Specialty page of the ACGME website.

Other Milestones Resources

The ACGME provides many resources for residents, faculty members, and program administration and leadership, and new resources are developed regularly. Visit the Milestones section of the ACGME website to review available resources and tools: https://www.acgme.org/what-we-do/accreditation/milestones/resources/

- Milestones by specialty
- The ACGME Milestones Guidebook
- Milestones FAQs
- Clinician Educator Milestones that can be used for residents or faculty members to develop a personal professional development plan
- Learn at ACGME offers an extensive array of online education and resources on a variety of topics, including assessment
- Milestones 2.0: A Step Forward (Supplement in JGME)

The ACGME also offers courses designed to help faculty members and leaders achieve the goals of competency-based assessment in graduate medical education. Visit the Developing Faculty Competencies in Assessment course page for information on dates, fees, and registration availability.

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1) Residents must demonstrate competence in:

IV.B.1.a).(1).(a) compassion, integrity, and respect for others; (Core)

IV.B.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest; (Core)

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another provider. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.a).(1).(c) respect for patient privacy and autonomy; (Core)

IV.B.1.a).(1).(d) accountability to patients, society, and the profession; (Core)

IV.B.1.a).(1).(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

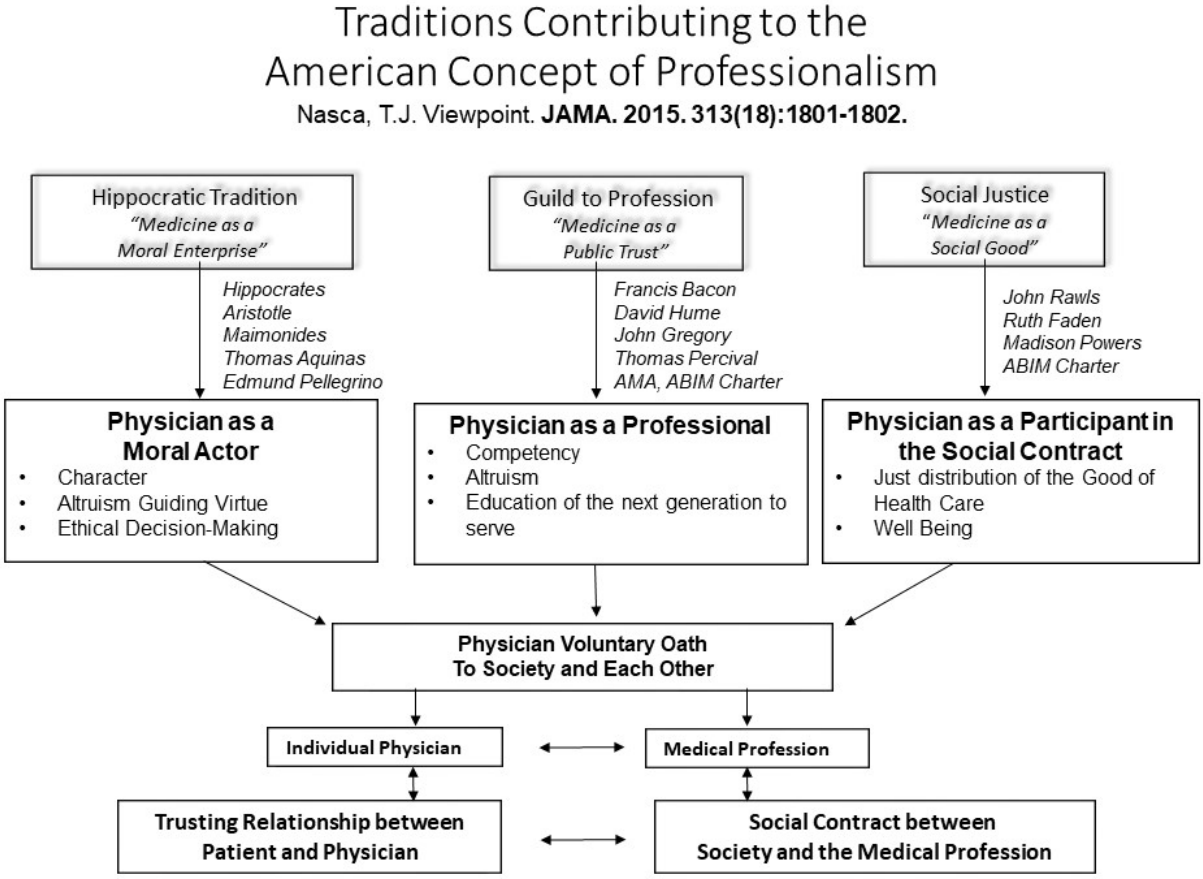
IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)

IV.B.1.a).(1).(g) appropriately disclosing and addressing conflict or duality of interest. (Core)

GUIDANCE

Professionalism is at the core of being a physician, yet, teaching it can be difficult, and evaluation of professionalism presents significant challenges. There are many factors that influence the erosion of professionalism, including state control, corporate demands, and overemphasis on income and power. Some argue that the loss of ethics and morals underlies this erosion, and therefore propose that medical professionalism cannot be taught separately from ethical principles, morality, and emotional intelligence.

The components of professionalism of physicians are best summarized by the relationship chart created by ACGME President and Chief Executive Officer Thomas J. Nasca, MD. (Nasca, Thomas J. 2015. "Professionalism and its Implications for Governance and Accountability of Graduate Medical Education in the United States." *JAMA* 313(18): 1801-1802. doi:10.1001/jama.2015.3738.)



Dr. Nasca states: "The philosophical roots of professionalism include the Hippocratic tradition of medicine as a moral enterprise; the transition of medicine from guild to profession with a commitment to competence, altruism, and public trust; and the responsibility of the profession to prepare the next generation of physicians to serve the public" (Nasca, 2015).

Often neglected in this equation is physician well-being. A physician who is unwell may not be able to provide good care to patients.

Elements of professionalism must be addressed in the program curriculum. Programs have reported more success with simulation, workshops, and case discussions. Some programs have incorporated education on professionalism into morbidity and mortality conferences and other case review conferences. More importantly, repeated sessions throughout the educational program provide reminders of the elements of professionalism and keep residents on track to develop a lifelong commitment to this critical aspect of being a physician.

Researchers A. Keith W. Brownell and Luc Côté surveyed senior residents on their views about the meaning of professionalism and how they learned about it, and determined that the majority learned the most from observing role models. (Brownell, A. Keith W. and Luc Cote. 2001. "Senior Residents' Views on the Meaning of Professionalism and How They Learn about It." *Academic Medicine* 76. 734-7. doi:10.1097/00001888-200107000-00019).

Since role modeling of professionalism by faculty members is key to the professional behavior of residents, it is important to incorporate professionalism into faculty development sessions. While good role models and mentors are essential for the education of residents and fellows, there is no way to guarantee their presence. In addition, role modeling as a method of teaching professionalism has been criticized as imprecise and lacking structure.

Resources:

- The American Medical Association (AMA) and the American Osteopathic Association (AOA) have defined rules and guidelines for physician professional responsibility and conduct; those resources are provided below:
    - AMA Declaration of Professional Responsibility
    - AOA Rules and Guidelines on Physicians' Professional Conduct
- The May 12, 2015 issue of JAMA (https://jamanetwork.com/journals/jama/issue/313/18) is a great resource for programs and takes a deep dive into professionalism, including Viewpoints from scholars and academic leaders about the responsibility and accountability of medicine to self-govern, self-regulate, and ensure the highest degree of professionalism.

Related Requirements: II.A.4.a) and II.A.4.a).(1): The program director must be a role model of professionalism.

Examples of linking professionalism values to specific behaviors:

Values	Behaviors
Responsibility	• Follows through on tasks • Arrives on time
Maturity	• Accepts blame for failure • Does not make inappropriate demands • Is not abusive and critical in times of stress
Communication Skills	• Listens well • Is not hostile, derogatory, sarcastic • Is not loud or disruptive
Respect	• Maintains patient confidentiality

	• Is patient • Is sensitive to physical/emotional needs • Is not biased/discriminatory

From Jim Wagner, MD, The University of Texas Southwestern Medical School as referenced in Kirk, Lynne M. 2007. "Professionalism in Medicine: Definitions and Considerations for Teaching." *Proceedings (Baylor University. Medical Center)* 20(1):13-16. doi:10.1080/08998280.2007.11928225

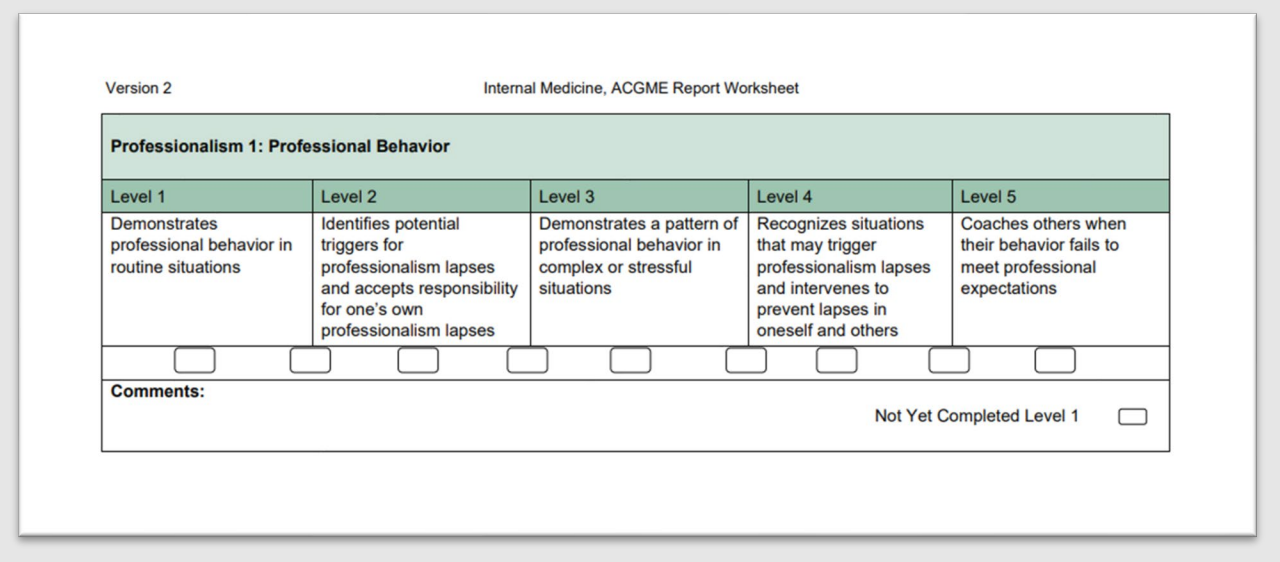
To review specialty-specific requirements for professionalism, go to https://www.acgme.org/specialties/:

- Select the specialty
- Click on "Program Requirements and FAQs and Applications" in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty's or subspecialty's Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on "Milestones" in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of an Internal Medicine Milestones evaluation of professionalism:



Version 2 Internal Medicine, ACGME Report Worksheet

Professionalism 1: Professional Behavior				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates professional behavior in routine situations	Identifies potential triggers for professionalism lapses and accepts responsibility for one's own professionalism lapses	Demonstrates a pattern of professional behavior in complex or stressful situations	Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in oneself and others	Coaches others when their behavior fails to meet professional expectations
☐	☐	☐	☐	☐
Comments:				
				Not Yet Completed Level 1 ☐

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.b) Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

IV.B.1.b).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

[The Review Committee must further specify]

IV.B.1.b).(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

[The Review Committee may further specify]

GUIDANCE

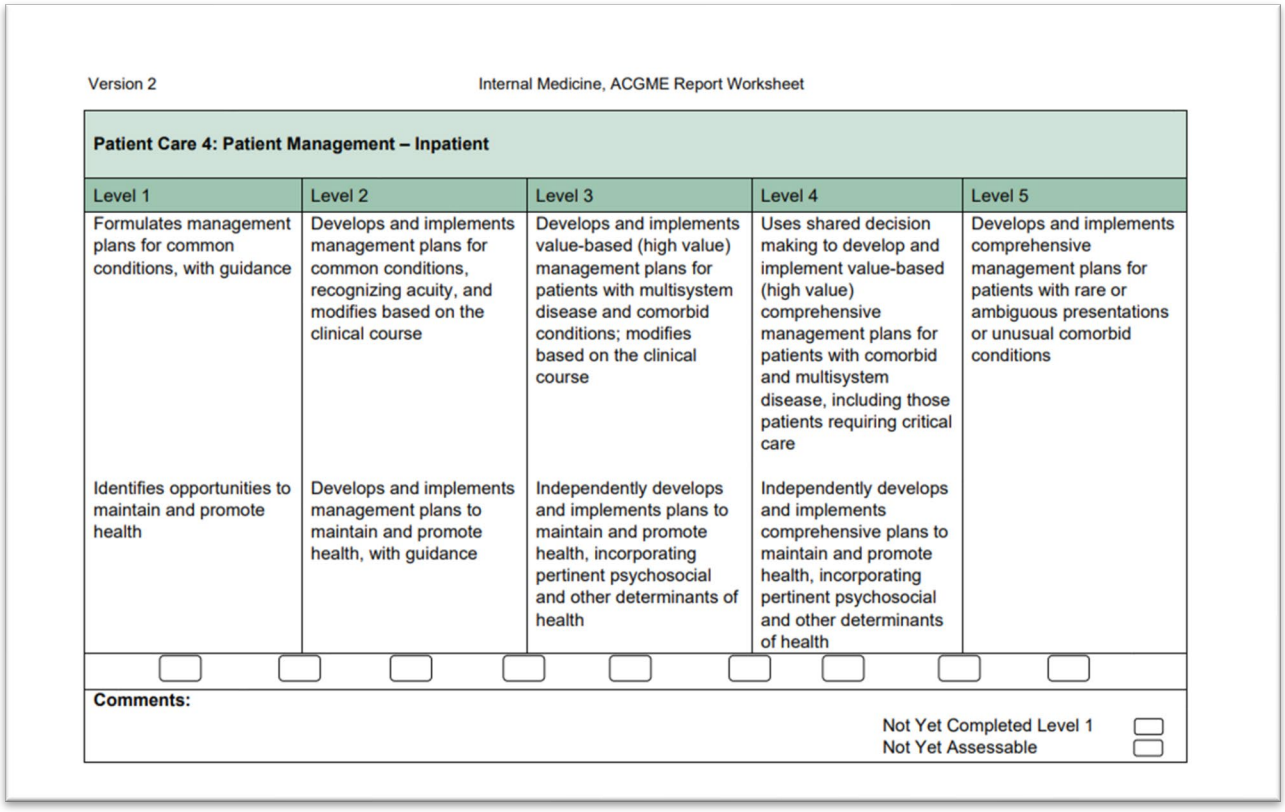
To review the specialty-specific Program Requirements for the patient care and procedural skills Competency, go to https://www.acgme.org/specialties/:

- Select the specialty
- Click on “Program Requirements and FAQs and Applications” in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty’s or subspecialty’s Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on “Milestones” in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of an Internal Medicine Milestones evaluation of patient care skills:



Version 2 Internal Medicine, ACGME Report Worksheet

Patient Care 4: Patient Management – Inpatient				
Level 1	Level 2	Level 3	Level 4	Level 5
Formulates management plans for common conditions, with guidance	Develops and implements management plans for common conditions, recognizing acuity, and modifies based on the clinical course	Develops and implements value-based (high value) management plans for patients with multisystem disease and comorbid conditions; modifies based on the clinical course	Uses shared decision making to develop and implement value-based (high value) comprehensive management plans for patients with comorbid and multisystem disease, including those patients requiring critical care	Develops and implements comprehensive management plans for patients with rare or ambiguous presentations or unusual comorbid conditions
Identifies opportunities to maintain and promote health	Develops and implements management plans to maintain and promote health, with guidance	Independently develops and implements plans to maintain and promote health, incorporating pertinent psychosocial and other determinants of health	Independently develops and implements comprehensive plans to maintain and promote health, incorporating pertinent psychosocial and other determinants of health	

Comments:

Not Yet Completed Level 1
Not Yet Assessable

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

[The Review Committee must further specify]

GUIDANCE

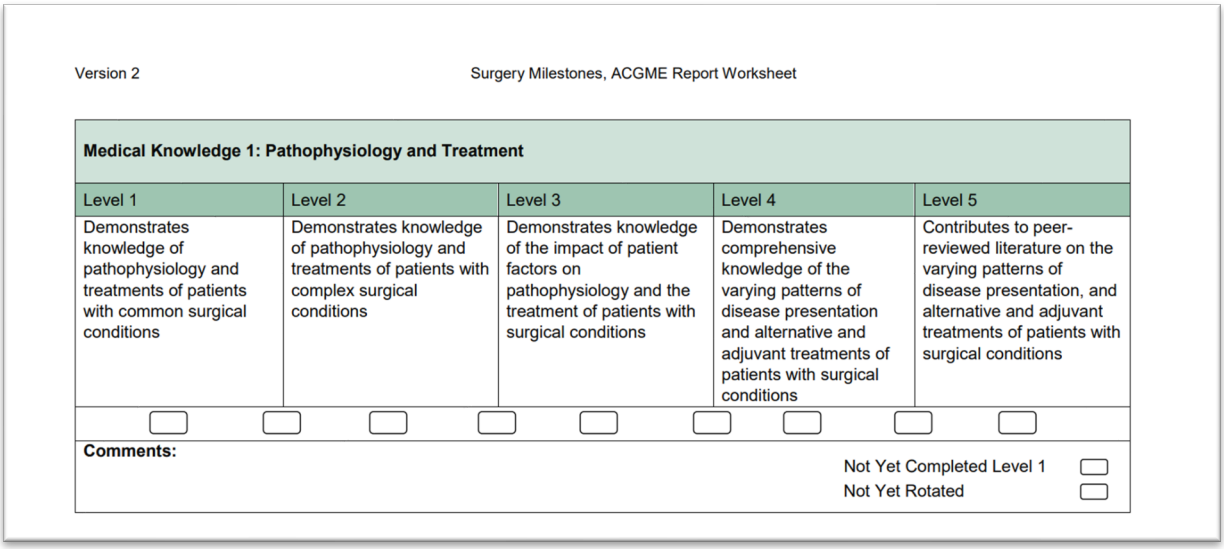
To review the specialty-specific Program Requirements for the medical knowledge Competency, go to https://www.acgme.org/specialties/:

- Select the specialty
- Click on “Program Requirements and FAQs and Applications” in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty’s or subspecialty’s Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on “Milestones” in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of a Surgery Milestones evaluation of medical knowledge skills:



Version 2 Surgery Milestones, ACGME Report Worksheet

Medical Knowledge 1: Pathophysiology and Treatment				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of pathophysiology and treatments of patients with common surgical conditions	Demonstrates knowledge of pathophysiology and treatments of patients with complex surgical conditions	Demonstrates knowledge of the impact of patient factors on pathophysiology and the treatment of patients with surgical conditions	Demonstrates comprehensive knowledge of the varying patterns of disease presentation and alternative and adjuvant treatments of patients with surgical conditions	Contributes to peer-reviewed literature on the varying patterns of disease presentation, and alternative and adjuvant treatments of patients with surgical conditions

Comments:

Not Yet Completed Level 1 ☐
Not Yet Rotated ☐

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

IV.B.1.d).(1) Residents must demonstrate competence in:

IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)

IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)

IV.B.1.d).(1).(c) identifying and performing appropriate learning activities; (Core)

IV.B.1.d).(1).(d) systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; (Core)

IV.B.1.d).(1).(e) incorporating feedback and formative evaluation into daily practice; (Core)

IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and, (Core)

IV.B.1.d).(1).(g) using information technology to optimize learning. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies]

GUIDANCE

The Competency of practice-based learning and improvement is best developed in an environment that provides residents with enough information to investigate and evaluate the care of their patients. The environment needs to support open and honest attempts to improve, and not punish errors or mistakes as personal weakness.

To identify strengths, deficiencies, and limitations, residents should learn to self-reflect to answer the question: How can I improve care for my patients? This may include single patients, such as at a case conference during which residents present individual patients they have cared for and reflect on how they may improve on that care for a similar patient in the future. A more systematic approach provides residents with information about the outcomes of their care for a larger sample of their patients. This information may demonstrate a resident's compliance with a specific protocol or clinical guideline for a defined group of patients. Examples include the number of patients who receive key elements of care in a sepsis bundle or the complication rate for a certain procedure. It is not required that each resident have a personal project. Some outcome measures will require institutional assistance to link the activity to a broader departmental goal.

Learning and improvement goals can be formulated after a resident determines what to improve and may follow a deliberate process such as a "Plan-Do-Study-Act" cycle under the guidance of a faculty member to systematically analyze the resident's practice. This may be performed in conjunction with the ongoing quality improvement efforts of the Sponsoring Institution.

Residents constantly receive feedback and suggestions. They may wish to target a certain behavior for improvement, or try out suggestions for improvement, and consider how to analyze and incorporate these improvements into practice.

Locating and assimilating evidence may occur while a resident is preparing for upcoming case presentations or during the actual care of a patient using a Cochrane Review or a PubMed search or other clinical references. A resident may need to learn how an individual patient's circumstances fit into the larger knowledge base, and how to use published literature to fit the scenario. This may incorporate activities such as literature review for case conferences or journal club where a critical review of the literature is demonstrated and learned.

To review the specialty-specific Program Requirements for the practice-based learning and improvement Competency, go to https://www.acgme.org/specialties:

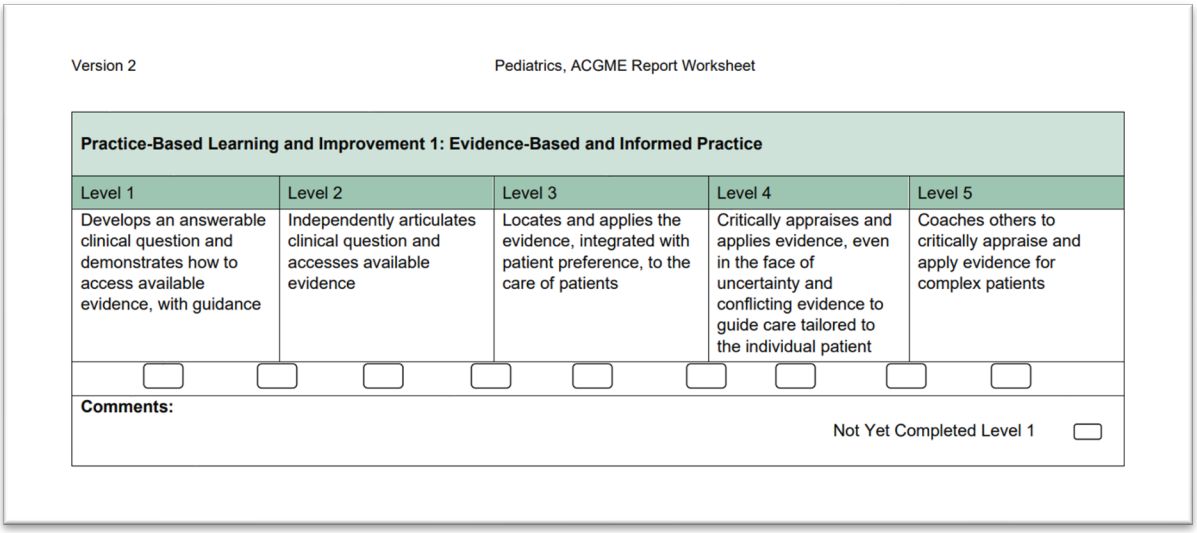
- Select the specialty
- Click on "Program Requirements and FAQs and Applications" in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty's or subspecialty's Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on "Milestones" in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of a Pediatrics Milestones evaluation of practice-based learning and

improvement skills:



Version 2 Pediatrics, ACGME Report Worksheet

Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice

Level 1	Level 2	Level 3	Level 4	Level 5
Develops an answerable clinical question and demonstrates how to access available evidence, with guidance	Independently articulates clinical question and accesses available evidence	Locates and applies the evidence, integrated with patient preference, to the care of patients	Critically appraises and applies evidence, even in the face of uncertainty and conflicting evidence to guide care tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients

Comments:

Not Yet Completed Level 1

Resources

1. "Practice-Based Learning and Improvement: ACGME Core Competencies." 2016. NEJM Knowledge+. November 18, 2016. https://knowledgeplus.nejm.org/blog/practice-based-learning-and-improvement/.

   A description of why practice-based learning is important and how it fits into lifelong learning.

2. "Practice-Based Learning - ACGME Competencies." n.d. University of Maryland Medical Center. https://www.umms.org/ummc/pros/gme/acgme-competencies/practice-based-learning.

   An example of the resources compiled at one institution to address practice-based learning and the key components of:
   - Life-long learning and practice improvement (self-reflection)
   - Appraisal and assimilation of scientific literature (EBM)
   - Able to implement quality improvement
   - Actively participate in the education of others

3. Bernabeo, Elizabeth, Sarah Hood, William Iobst, Eric Holmboe, and Kelly Caverzagie. 2013. "Optimizing the Implementation of Practice Improvement Modules in Training: Lessons from Educators." *Journal of Graduate Medical Education* 5 (1): 74–80. https://doi.org/10.4300/jgme-d-11-00281.1.

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e).(1) Residents must demonstrate competence in:

IV.B.1.e).(1).(a) communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)

IV.B.1.e).(1).(b) communicating effectively with physicians, other health professionals, and health-related agencies; (Core)

IV.B.1.e).(1).(c) working effectively as a member or leader of a health care team or other professional group; (Core)

IV.B.1.e).(1).(d) educating patients, families, students, residents, and other health professionals; (Core)

IV.B.1.e).(1).(e) acting in a consultative role to other physicians and health professionals; and, (Core)

IV.B.1.e).(1).(f) maintaining comprehensive, timely, and legible medical records, if applicable. (Core)

IV.B.1.e).(2) Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies]

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate

effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

GUIDANCE

The ability to communicate is one of the basic tenets of the physician-patient relationship, and an important component of professionalism. Yet education related to communication skills is frequently neglected. Apart from medical knowledge and the ability to provide good patient care, physicians need communication skills in many aspects of their practice. Examples include:

1. The physician and the patient:
    a. History taking and physical examination — ability to elicit pertinent information, and the capacity to listen attentively to what a patient/family member has to say
    b. Explaining medical information, such as diagnosis, complications, and treatment (surgical and medical)
    c. Shared decision making regarding diagnostic and therapeutic interventions
    d. Instructions related to prescriptions — patients often take medications incorrectly because of inadequate instructions
    e. Delivering bad news
    f. Discharge instructions
    g. Sensitivity to different cultural and socioeconomic backgrounds
    h. Respect for privacy and confidentiality
    i. Obtaining informed consent for procedures or study participation
    j. End-of-life decisions
2. Physician to physician or other health care providers:
    a. Consultations
    b. Sign-outs
    c. Patient transfers
    d. Leading and participating in team-based medical care
3. Written and other communication
    a. Medical records
    b. Procedure notes
    c. Consults
    d. Transfers
    e. Lectures and presentations

It is well known that good communication skills improve patient satisfaction and treatment adherence and reduce medication errors. Modalities of communication skills include:

- skills-based: word usage; approach to patients and families
- content-based: patient interviewing; obtaining informed consent
- advanced encounters: delivering bad news; disclosing errors; shared decision making
- interaction-focused: physician-patient and/or physician-family; interprofessional

Techniques used to teach interpersonal and communication skills include:

- Role play
- Standardized patients

- Simulation
- Real-life experiences, such as during morbidity and mortality conference

References

1. Peterson, Eleanor B., Kimberly A. Boland, Kristina A. Bryant, Tara F. McKinley, Melissa B. Porter, Katherine E. Potter, and Aaron W. Calhoun. 2016. "Development of a Comprehensive Communication Skills Curriculum for Pediatrics Residents." *Journal of Graduate Medical Education* 8 (5): 739–46. https://doi.org/10.4300/jgme-d-15-00485.1.
2. Sullivan, Amy M., Laura K. Rock, Nina M. Gadmer, Diana E. Norwich, and Richard M. Schwartzstein. 2016. "The Impact of Resident Training on Communication with Families in the ICU: Resident and Family Outcomes." *Annals of the American Thoracic Society*. https://doi.org/10.1513/annalsats.201508-495oc.
3. Wild, Dorothea, Haq Nawaz, Saif Ullah, Christina Via, William Vance, and Paul Petraro. 2018. "Teaching Residents to Put Patients First: Creation and Evaluation of a Comprehensive Curriculum in Patient-Centered Communication." *BMC Medical Education* 18 (1). https://doi.org/10.1186/s12909-018-1371-3.
4. Bragard, Isabelle, Isabelle Merckaert, Yves Libert, Nicole Delvaux, Anne-Marie Etienne, Serge Marchal, Christine Reynaert, Darius Razavi. 2012. "Communication Skills Training for Residents: Which Variables Predict Learning of Skills?" *Open J Med Psychol* 1:68-75.

While many of the efforts in teaching communication skills are successful, there is evidence that success also depends on human variables. The ability to develop effective communication skills is dependent on a number of human factors, including:

- individual characteristics, such as sociodemographics, professional and personal experiences, health, burnout, depersonalization, ability to cope, psychological characteristics, and technological demands;
- contextual characteristics, such as professional and personal environments;
- pre-training communication skills.

Some examples of patient comments regarding negative communication experiences include:

- "I wish he would face me instead of the computer."
- "She seemed in a hurry and did not have time to listen to my fears about the surgery."
- "He seemed to be hiding something when he told me about the medication mistake."
- "I felt like I did not matter, my concerns were ignored."
- "He seemed in a hurry to pull the plug on my dad, so he could get on to the next task."

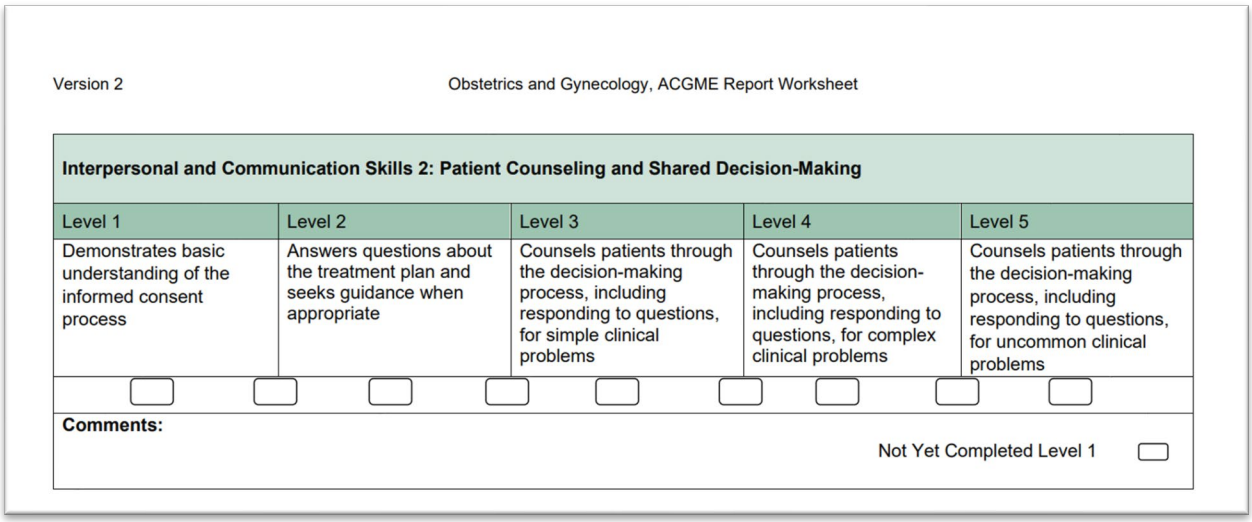
To review the specialty-specific Program Requirements for the interpersonal and communication skills Competency, go to https://www.acgme.org/specialties:

- Select the specialty
- Click on "Program Requirements and FAQs and Applications" in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty's or subspecialty's Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on "Milestones" in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of an Obstetrics and Gynecology Milestones evaluation of interpersonal and communication skills:



Version 2 Obstetrics and Gynecology, ACGME Report Worksheet

Interpersonal and Communication Skills 2: Patient Counseling and Shared Decision-Making				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates basic understanding of the informed consent process	Answers questions about the treatment plan and seeks guidance when appropriate	Counsels patients through the decision-making process, including responding to questions, for simple clinical problems	Counsels patients through the decision-making process, including responding to questions, for complex clinical problems	Counsels patients through the decision-making process, including responding to questions, for uncommon clinical problems
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not Yet Completed Level 1 ☐

COMMON PROGRAM REQUIREMENTS

IV.B. ACGME Competencies

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f).(1) Residents must demonstrate competence in:

IV.B.1.f).(1).(a) working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1).(b) coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(c) advocating for quality patient care and optimal patient care systems; (Core)

IV.B.1.f).(1).(d) working in interprofessional teams to enhance patient safety and improve patient care quality; (Core)

IV.B.1.f).(1).(e) participating in identifying system errors and implementing potential systems solutions; (Core)

IV.B.1.f).(1).(f) incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and, (Core)

IV.B.1.f).(1).(g) understanding health care finances and its impact on individual patients' health decisions. (Core)

IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies]

GUIDANCE

Physicians are increasingly dependent on the health care system to support their patients and need to optimize this system for the benefit of their patients. At the same time, physicians can significantly influence the health care system to ensure appropriate support for patients and their families. Most residents work passively in these settings, but the curriculum must provide education on how residents can actively and positively impact the system in future practice. Residents should be prepared to answer the question: How can I help to improve the system of care?

There are many ways residents can participate in specialty-specific didactics or discussions regarding their practice environment or institution-wide, multi-specialty, or multi-disciplinary discussions. Residents may participate in one or more institutional or program committees seeking to address health care system issues. The learning activities can be longitudinal or part of regularly scheduled workshops.

Resources

1. "Systems-Based Practice: ACGME Core Competencies (Part 4 of 7)." 2016. *NEJM Knowledge*. November 18, 2016. https://knowledgeplus.nejm.org/blog/acgme-core-competencies-systems-based-practice/.

2. Nabors, Christopher, Stephen J. Peterson, Roger Weems, Leanne Forman, Arif Mumtaz, Randy Goldberg, Kausik Kar, Joseph A. Borges, Ida Doctor, Orpha Lubben, Nisha Pherwani, and William H. Frishman. 2011. "A Multidisciplinary Approach for Teaching Systems-Based Practice to Internal Medicine Residents." *Journal of Graduate Medical Education* Vol. 3, No. 1, pp. 75-80. https://doi.org/10.4300/JGME-D-10-00037.1

3. Johnson, Julie K., Stephen H. Miller, and Sheldon D. Horowitz. 2008. "Systems-Based Practice: Improving the Safety and Quality of Patient Care by Recognizing and Improving the Systems in Which We Work." In *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Vol. 2. Rockville, MD: Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK43731/#_ncbi_dlg_citbx_NBK43731

4. Wachtel, Ruth E. and Franklin Dexter. "Curriculum Providing Cognitive Knowledge and Problem-Solving Skills for Anesthesia Systems-Based Practice." *Journal of Graduate Medical Education* 2, no. 4, (2010) 624-632. https://doi.org/10.4300/JGME-D-10-00064.1

To review the specialty-specific Program Requirements for the systems-based practice Competency, go to https://www.acgme.org/specialties:

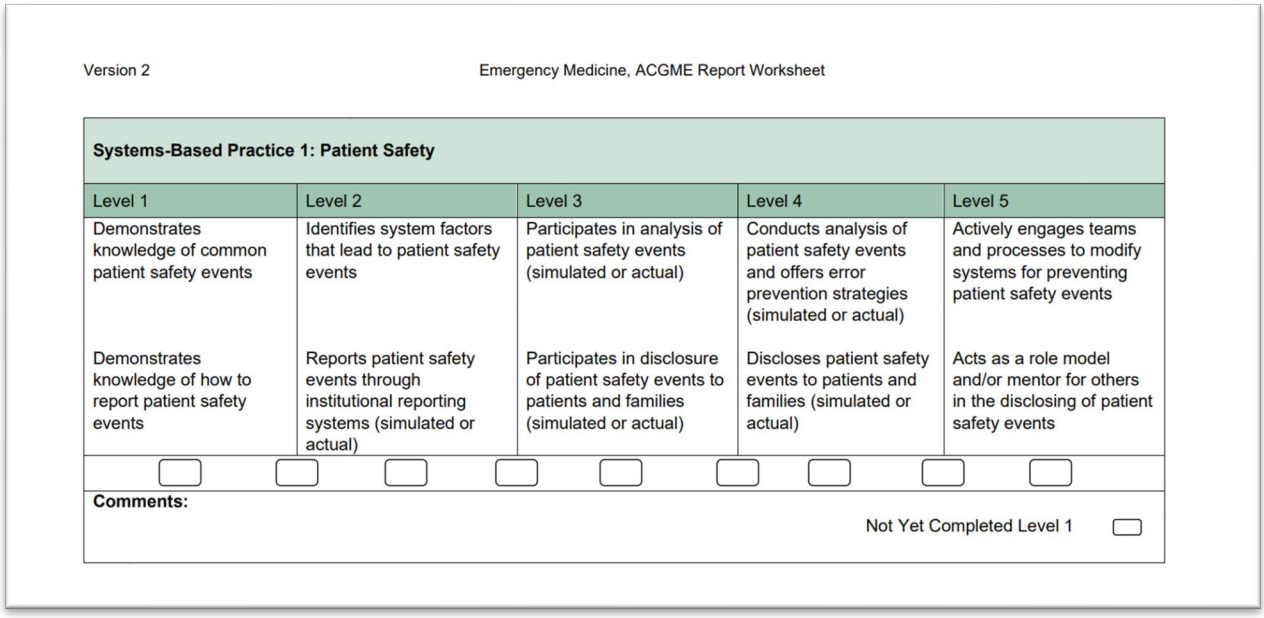
- Select the specialty

- Click on “Program Requirements and FAQs and Applications” in the right-hand menu on the page
- Select the currently in effect specialty Program Requirements

In addition, the Milestones are used to assess the progression of a resident in specific competencies and subcompetencies. To access a specialty’s or subspecialty’s Milestones, go to https://www.acgme.org/Specialties:

- Select the specialty
- Click on “Milestones” in the right-hand menu on the page
- Select from the list of applicable Milestones

Below is an example of an Emergency Medicine Milestones evaluation of systems-based practice skills:



Version 2 Emergency Medicine, ACGME Report Worksheet

Systems-Based Practice 1: Patient Safety				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems for preventing patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Acts as a role model and/or mentor for others in the disclosing of patient safety events
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not Yet Completed Level 1 ☐

COMMON PROGRAM REQUIREMENTS

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

[The Review Committee must further specify]

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

[The Review Committee may specify required didactic and clinical experiences]

GUIDANCE

[The Review Committee must further specify]

IV.C.1. requires programs to optimize all educational experiences, the length of the experiences, and supervision continuity. Review Committees must further specify additional requirements, therefore programs must review the specialty-specific Program Requirements and go to: https://www.acgme.org/specialties/

- select the specialty
- click on Program Requirements and FAQs and Applications in the right-hand menu on the page
- select the currently in effect specialty program requirements.

Questions about specialty requirements should be directed to specialty Review Committee staff members.

For example, to locate the Program Requirements for Orthopaedic Surgery, click on Orthopaedic Surgery and then Program Requirements and FAQs and Applications on the right-hand menu. A PDF version of the current Program Requirements for Orthopaedic Surgery is available in the "Currently in Effect" section. As Program Requirements are revised and approved by the ACGME Board of Directors, Program Requirements that are approved but not yet effective can be found in the "Future Effective Date" section of the same page.

[The Review Committee may specify required didactic and clinical experiences]

Requirement IV.C. allows Review Committees to specify required didactic and clinical experiences, so programs should consult the specialty-specific Program Requirements for additional information.

COMMON PROGRAM REQUIREMENTS

IV. Educational Program

IV.C. Curriculum Organization and Resident Experiences

IV.C.2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)

[The Review Committee may further specify]

[The Review Committee may specify required didactic and clinical experiences]

GUIDANCE

This requirement directs programs to develop evidence-based educational interventions to effectively teach residents how to:

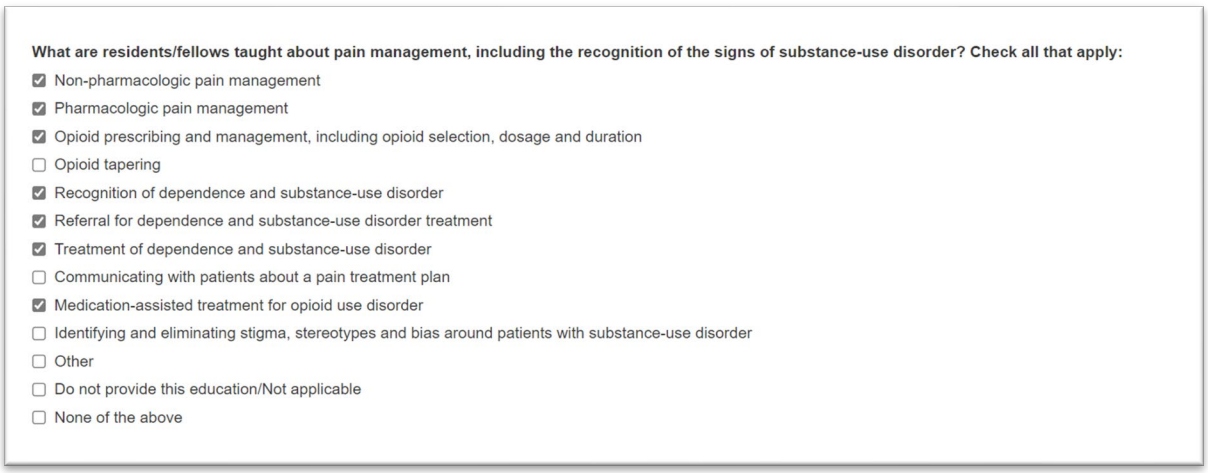
- Prevent substance use disorder wherever possible while effectively treating pain;
- Recognize substance use disorder in its earliest stages;
- Function effectively in systems of care for effective pain relief and substance use disorder;
- Use non-pharmacologic means wherever possible; and,
- Participate in clinical trials of new non-opioid pain relief customized to the needs of the clinical disorders of the populations they serve.

The ACGME expects that the education of residents and faculty members regarding opioid prescribing be woven into the fabric of graduate medical education and training and includes, but is not limited to, didactic lectures, specific learning modules that residents have to complete, chart reviews, and small-group discussions about difficult patients.

The ACGME monitors compliance with requirements in section IV.C.2. in various ways, including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual ACGME Resident/Fellow and Faculty Surveys;
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

ADS Screenshot: ADS Annual Update Common Program Requirements question for applications and programs with a status of Initial and Continued Accreditation



The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section IV.C.2. These two crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and their crosswalk to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

GME Stakeholder Congress on Preparing Residents and Fellows to Manage Pain and Substance Use Disorder

On March 30-31, 2021, the ACGME hosted a virtual graduate medical education (GME) Stakeholder Congress on Preparing Residents and Fellows to Manage Pain and Substance Use Disorder. The Congress brought together experts from across the medical education spectrum with the goal of supporting programs in implementing Common Program Requirement IV.C.2. by developing considerations for general and specialty-specific elements of a foundational curriculum for the recognition and treatment of pain and substance use disorder.

- 2021 Opioid Congress Proceedings Paper
- 2021 Opioid Congress Summary of Recommendations
- 2021 Opioid Congress Resources for Preparing Residents/Fellows to Manage Pain and Substance Use Disorder

National Academy of Medicine (NAM) Action Collaborative on Countering the US Opioid Epidemic

The ACGME participates in and supports the NAM Action Collaborative on Countering the US Opioid Epidemic.

Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse or overdose from these drugs.

The CDC developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

The CDC has also provided a number of Opioid Prescribing Guideline Resources that complement and supplement the guideline, including clinical tools, practitioner FAQs, web-based training for practitioner, and public educational videos.

Additional Resources for Pain Management and Substance Use Disorder

The following resources can be used to help programs and institutions identify solutions to meet local needs. The ACGME does not endorse the use of any specific tool or resource.

- The ACGME-accredited multidisciplinary subspecialty of addiction medicine: The ACGME Program Requirements for Addiction Medicine (subspecialty) provide detailed curricular elements related to medical knowledge and patient care that might be useful in defining curricular and didactic substance use disorder experiences for residents and fellows.
- New England Journal of Medicine Knowledge + Pain Management and Opioids learning module: The New England Journal of Medicine, in partnership with Boston University School of Medicine's SCOPE of Pain and Area9 Lyceum, has instated a learning module to assist in furthering education regarding pain management, opioid prescribing, and Opioid Use Disorder (OUD).

- Medication assisted treatment waiver training: Medication assisted treatment (MAT) of substance use disorders involves a combination of medications that target the brain, and psychosocial interventions (e.g., counseling, skills development) aimed at improving treatment outcomes. Research shows that medications and therapy together may be more successful than either treatment method alone.
- ACP Pain Management Learning Series: The American College of Physicians provides interactive modules, case studies, and videos supporting patient-centered pain management, OUD identification, and OUD treatment. Content stresses communication techniques and interdisciplinary team care. Modules can be viewed in a linear fashion or independently. An X-Express buprenorphine waiver video supports implementation for limited waiver applicants.
- FDA caution to avoid abrupt decrease or discontinuation of prescribed opioids: The US Food and Drug Administration (FDA) identifies harm reported from sudden discontinuation of opioid pain medicines, and requires label changes to guide prescribers on gradual, individualized tapering. April 9, 2019.
- Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) 63. SAMHSA: This guide provides a comprehensive overview and guidance on issues related to Opioid Use Disorder: signs and symptoms; diagnostic criteria; co-occurrence with other substance use disorders; and prevention and treatment, including opioid withdrawal techniques, pharmacotherapies, tapering opioids, and non-pharmacologic interventions.

- MAT Waivered Prescriber Support Initiative Presents: Medications for Opioid Use Disorder
- Articles of Interest:
  - Lembke, Anna, Keith Humphreys, and Jordan Newmark. “Weighing the Risks and Benefits of Chronic Opioid Therapy.” *American Family Physician* 93, no. 12 (June 16, 2016): 982-90. https://www.ncbi.nlm.nih.gov/pubmed/27304767.
  - Salsitz, Edwin A. “Chronic Pain, Chronic Opioid Addiction: a Complex Nexus.” *Journal of Medical Toxicology* 12, no. 1 (2015): 54-57. https://doi.org/10.1007/s13181-015-0521-9.

What does this mean for GME?

- Current residents and fellows will prescribe opioids for the next 40 years.
- Everyone involved in GME must be part of the solution.
- Clinical learning environments must use protocols and procedures that are:
  - evidence-based
  - customized to the needs of the clinical disorders of the populations served
  - effective in teaching residents how to:
    - treat pain while preventing substance use disorder
    - recognize substance use disorder in its earliest stages
    - function effectively in systems of care for effective pain relief and substance use disorder treatment
    - use non-pharmacologic means wherever possible
    - participate in clinical trials of new non-opioid pain relief

COMMON PROGRAM REQUIREMENTS

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

[The Review Committee may further specify]

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan
- Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature
- When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)

- Improving resident learning by encouraging them to teach using a scholarly approach

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

GUIDANCE

IV.D.1. Program responsibilities related to scholarship

This section focuses on requirements for program responsibilities related to scholarship and it is closely linked to both IV.D.2. — faculty scholarly activity — and IV.D.3. — resident scholarly activity.

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims.

Scholarly activity is not limited to basic science research. The program must determine its mission and aims and match scholarly activities accordingly. For example, a program located in a rural environment may want to focus on meeting the needs of the community, and advance scholarly efforts on quality improvement measures or projects that would benefit the people it serves, while a large cancer center in an urban institution may want to recruit faculty members and residents whose primary research focus is in basic science.

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.

The work taking place in a basic science laboratory or the conduct of large clinical trials may require significant personnel, laboratory, and other resources. There are many other scholarly activities that may not require such resources. A key universal resource requirement for scholarly activities is time. Faculty members and residents may need protected time away from clinical activities to successfully engage in and perform scholarly activity.

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.

This requirement is explained by the Background and Intent: *The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.*

The intent is to create an environment of scholarship to encourage critical thinking in providing patient care, e.g., discussing the rationale for a new and expensive therapeutic option; discontinuing a "popular" treatment option based on evidence that it provides no benefits; adapting an approach to early discontinuation of central venous catheters or bladder catheters when these devices are no longer essential for the care of the patient; or the judicious use of antibiotics. These scholarly approaches are all designed to instill curiosity and critical thinking in patient care. There is evidence that fostering this mindset in residents during residency implants lifelong habits that continue decades after graduation.

"Education must prepare students to be independent, self-reliant human beings. But education, at its best, also must help students go beyond their private interests, gain a more integrative view of knowledge, and relate their learning to the realities of life."

-Ernest Boyer

An environment of scholarship:

- Leads to the creation of new knowledge
- Encourages lifelong learning
- Creates a mindset of inquiry
    - Might reduce “jumping on any bandwagon that comes along”
    - Mindful practice: for example, antibiotic stewardship, infection control, and careful consideration of new (and expensive) drugs before use

Boyer’s Models of Scholarship:

- The scholarship of *DISCOVERY*
    - Traditional definition: research
    - Search for new knowledge
    - Discovery of new information and new models
    - Sharing discoveries through scholarly publication

- The scholarship of *INTEGRATION*
    - Integration of knowledge from different sources
    - Presents overview of findings in a resource topic
    - Bringing findings together from different disciplines to discover convergence
    - Identify trends and see knowledge in new ways
    - Examples: professional development workshops, literature reviews, meta-analysis, quality improvement projects

- The scholarship of *APPLICATION*
    - Discovering ways that new knowledge can be used to solve real-world problems
    - New intellectual problems can arise out of the very act of application
    - Examples: translational research, development of community activities that link with academic work, development of centers for study or service, quality improvement projects

- The scholarship of *TEACHING*
    - Search for innovative approaches and best practices to develop skills and disseminate knowledge
    - Examples: courses; innovative teaching materials; educational research; instructional activities; publication of books or other teaching materials; quality improvement projects; digital scholarship, including open education resources (Massive Open Online Courses (MOOCs), Khan Academy, digital publishing, and providing courses in Blackboard®, Bridge®, and Moodle®)

COMMON PROGRAM REQUIREMENTS

IV. Educational Program

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of

inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1)	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)

GUIDANCE

The requirements for faculty scholarship in IV.D.2. are closely linked to the program responsibility of ensuring that residents and faculty members are provided with a scholarly environment as specified in IV.D.1. and resident scholarly activity as specified in IV.D.3.

Faculty scholarly activity demonstrates to the Review Committees that:

- Faculty members have the skills to analyze and utilize new knowledge
- The program has the ability to teach those skills to residents and fellows
- An environment of scholarship exists in the program

While there is undeniable value of scholarly activity, such as the publication of peer-reviewed journal articles and presentation of basic science research at national conferences, other activities are equally valuable. Scholarship is not done only for its own sake, but also serves as a proxy for the creation of a clinical learning environment that encourages an environment of inquiry and an evidence-based, scholarly approach to patient care.

As stated in the philosophical statement above, the following bears repeating:

> *Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice life-long learning. The program and its faculty must create an* ***environment*** *that fosters the acquisition of such skills through resident participation in scholarly activities.*
>
> And
>
> *It is expected that* ***a program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves****. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while others might use more classic forms of biomedical research as the focus for scholarship.*

There is wide variability in programs and the communities they serve. For example, a program in a remote, rural community might focus on primary care education and training, and may not want or have the resources to put together a million-dollar laboratory to study some characteristics of a murine model of disease. Instead, it may emphasize improving vaccination rates, increasing compliance with diabetes care, or determining how to deal with an opioid epidemic in the community.

IV.D.2.a) Among their [faculty] scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports

- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

The program will be reviewed in aggregate. This requirement does not mean that each faculty member must have activity in three domains.

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

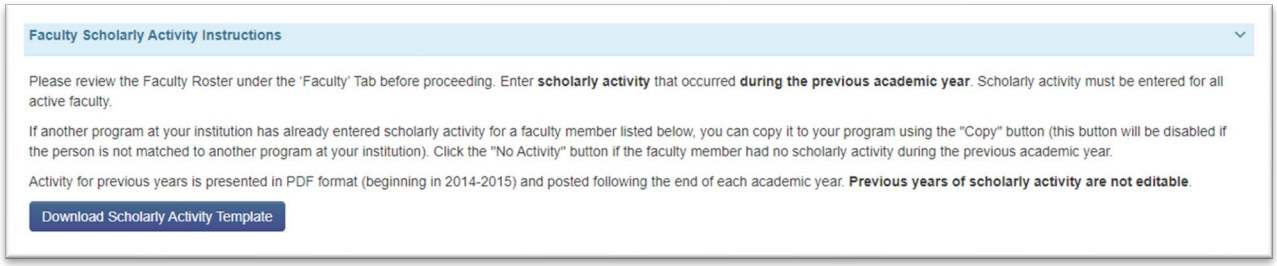
IV.D.2.b).(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;

IV.D.2.b).(2) peer-reviewed publication.

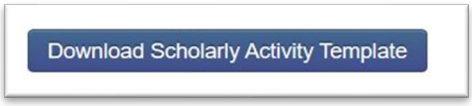
The Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2), so programs are encouraged to reference the specialty-specific Program Requirements. This ACGME Review Committee Faculty Scholarly Activity Decisions document provides a synopsis of the faculty scholarly activity requirement across all specialties and subspecialties. Some Review Committees also provide further information on their interpretation of these requirements in associated specialty-specific FAQs. These documents, for specialties that provide them, can be found on the Program Requirements and FAQs and Applications section of the specialty-specific web pages.

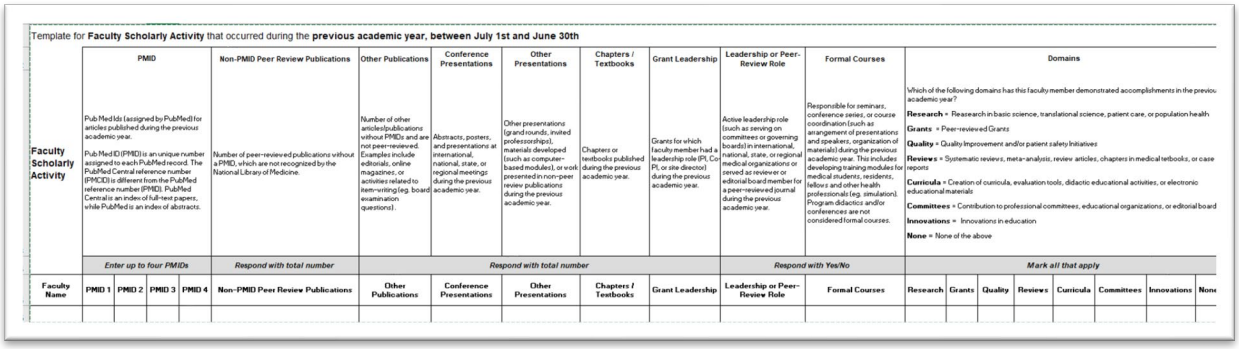
Accreditation Data System (ADS) Screenshots: Below are screenshots of the faculty scholarly activity instructions and data entry screens.

1. **Faculty scholarly activity instructions**



2. **The "Download Scholarly Activity Template" button in the screenshot above will pull up an Excel spreadsheet to enter information.** The purpose of the spreadsheet is for programs to disseminate it to program faculty members to aid in the collection of accurate scholarly activity data. The spreadsheet includes definitions of the different types of scholarly activities.

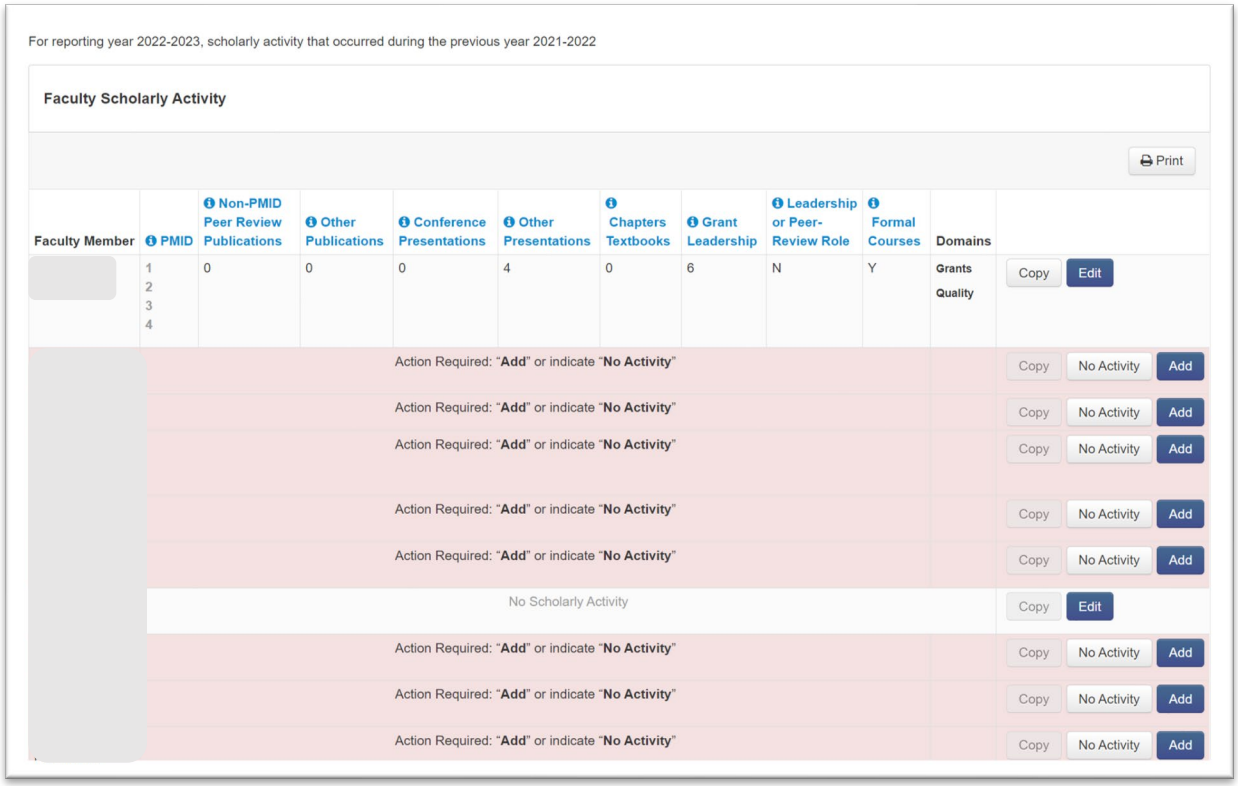




Template for **Faculty Scholarly Activity** that occurred during the **previous academic year, between July 1st and June 30th**

	PMID				Non-PMID Peer Review Publications	Other Publications	Conference Presentations	Other Presentations	Chapters / Textbooks	Grant Leadership	Leadership or Peer-Review Role	Formal Courses	Domains							
Faculty Scholarly Activity	PubMed Ids (assigned by PubMed) for articles published during the previous academic year. PubMed ID (PMID) is an unique number assigned to each PubMed record. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts.				Number of peer-reviewed publications without a PMID, which are not recognized by the National Library of Medicine.	Number of other articles/publications without PMIDs and are not peer-reviewed. Examples include editorials, online magazines, or activities related to item-writing (eg. board examination questions).	Abstracts, posters, and presentations at international, national, state, or regional meetings during the previous academic year.	Other presentations (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications during the previous academic year.	Chapters or textbooks published during the previous academic year.	Grants for which faculty member had a leadership role (PI, Co-PI, or site director) during the previous academic year.	Active leadership role (such as serving on committees or governing boards) in international, national, state, or regional medical organizations or served as reviewer or editorial board member for a peer-reviewed journal during the previous academic year.	Responsible for seminars, conference series, or course coordination (such as arrangement of presentations and speakers), organization of material(s) during the previous academic year. This includes developing training modules for medical students, residents, fellows and other health professionals (eg. simulation). Program didactics and/or conferences are not considered formal courses.	Which of the following domains has this faculty member demonstrated accomplishments in the previous academic year? **Research** = Research in basic science, translational science, patient care, or population health **Grants** = Peer-reviewed Grants **Quality** = Quality Improvement and/or patient safety Initiatives **Reviews** = Systematic reviews, meta-analysis, review articles, chapters in medical textbooks, or case reports **Curricula** = Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials **Committees** = Contribution to professional committees, educational organizations, or editorial board **Innovations** = Innovations in education **None** = None of the above							
	Enter up to four PMIDs				*Respond with total number*	*Respond with total number*					*Respond with Yes/No*		*Mark all that apply*							
Faculty Name	**PMID 1**	**PMID 2**	**PMID 3**	**PMID 4**	**Non-PMID Peer Review Publications**	**Other Publications**	**Conference Presentations**	**Other Presentations**	**Chapters / Textbooks**	**Grant Leadership**	**Leadership or Peer-Review Role**	**Formal Courses**	**Research**	**Grants**	**Quality**	**Reviews**	**Curricula**	**Committees**	**Innovations**	**None**

3. **The faculty scholarly activity summary provides a list of all faculty members in the program and allows programs to update scholarly activity information for each individual faculty member by adding it, copying information another program has entered, or reporting "no activity."**



For reporting year 2022-2023, scholarly activity that occurred during the previous year 2021-2022

Faculty Scholarly Activity

Print

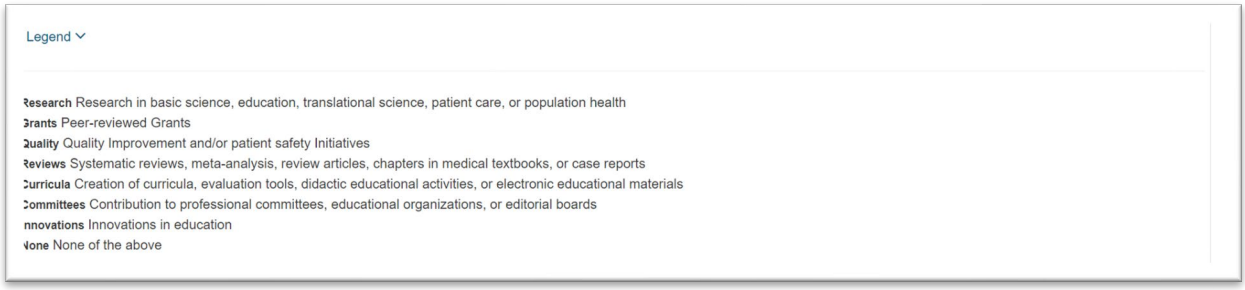
Faculty Member	PMID	Non-PMID Peer Review Publications	Other Publications	Conference Presentations	Other Presentations	Chapters Textbooks	Grant Leadership	Leadership or Peer-Review Role	Formal Courses	Domains	
	1 2 3 4	0	0	0	4	0	6	N	Y	Grants Quality	Copy Edit
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				No Scholarly Activity							Copy Edit
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add
				Action Required: "**Add**" or indicate "**No Activity**"							Copy No Activity Add

4. **The columns on the faculty scholarly activity data entry screen have an "information" button that expands to provide a more specific definition of each type of scholarly activity. Those definitions are also provided in the downloadable Excel template, and are included below.**
    - **PubMed IDs (PMIDs):**
      PMID Lookup

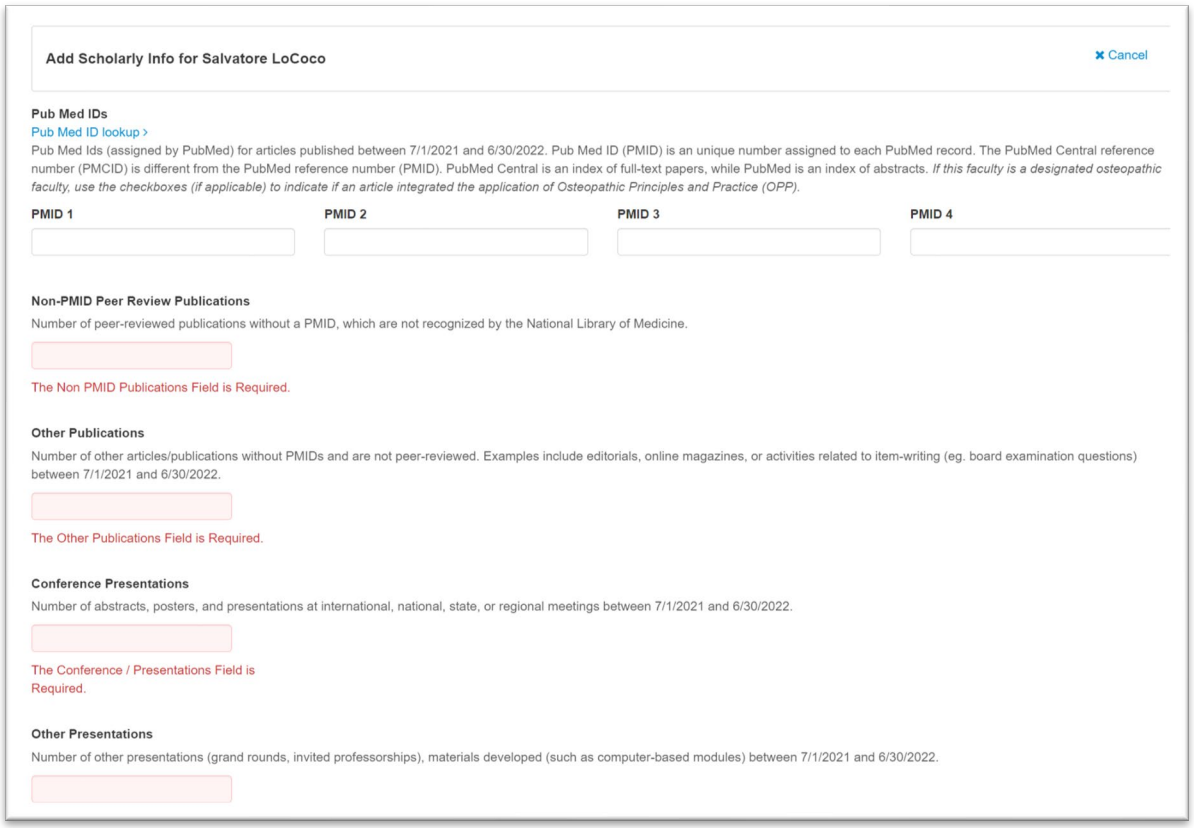
Enter up to four PMIDs (assigned by PubMed) for articles published during the previous academic year. The PMID is a unique number assigned to each PubMed record. This is generally an eight-digit number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts. If this faculty is a designated osteopathic faculty, use the checkboxes (if applicable) to indicate if an article integrated the application of Osteopathic Principles and Practice (OPP).

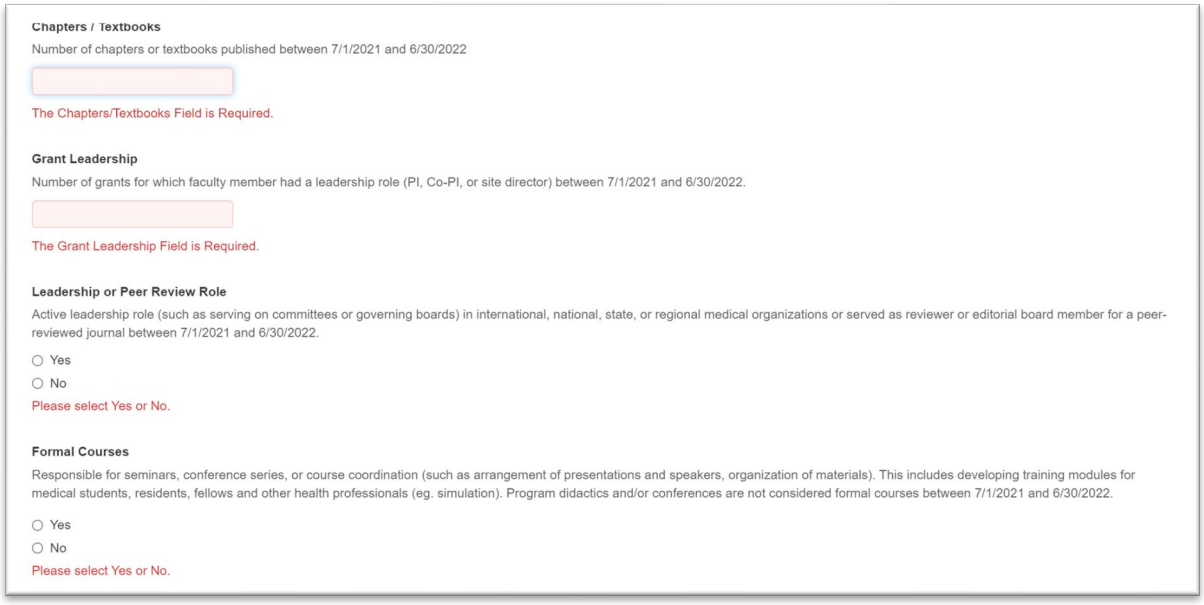
- **Non-PMID Peer Review Publications:** Number of peer-reviewed publications without a PMID, which are not recognized by the National Library of Medicine during the previous academic year.
- **Other Publications:** Number of other articles/publications without PMIDs and not peer-reviewed. Examples include editorials, online magazines, or other activities related to item-writing (e.g. board examination questions) during the previous academic year.
- **Conference Presentations:** Number of abstracts, posters, and presentations at international, national, state, or regional meetings during the previous academic year.
- **Other Presentations:** Number of other presentations (e.g., grand rounds, invited professorships), materials developed (such as computer-based modules) during the previous academic year.
- **Chapters/Textbooks:** Number of chapters or textbooks published during the previous academic year.
- **Grant Leadership:** Number of grants for which faculty member had a leadership role (e.g., principal investigator (PI), co-PI, or site director) during the previous academic year.
- **Leadership or Peer-Review Role:** Active leadership role (such as serving on committees or governing boards) in international, national, state, or regional medical organizations or served as reviewer or editorial board member for a peer-reviewed journal during the previous academic year.
- **Formal Courses:** Responsible for seminars, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials). This includes developing training modules for medical students, residents, fellows, and other health professionals (e.g., simulation). Program didactics and/or conferences are not considered formal courses.

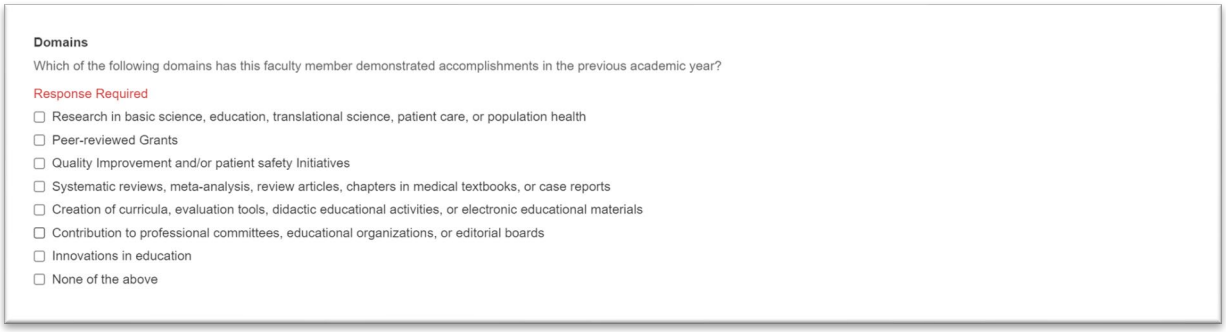
5. **The legend at the bottom of the faculty scholarly activity data entry screen provides the key domains available as choices for the scholarly activity. These domains are also available in the Excel template and on the individual faculty scholarly activity entry screen.**



6. The screenshots below depict the individual faculty scholarly activity data entry.







Resources:

The following presentation is available on the ACGME website and provides helpful tips for entering scholarly activity in ADS as part of the ADS Annual Update and avoiding common citations.

- Avoiding Common Errors in the ADS Annual Update-Entering Scholarly Activity into ADS Video

COMMON PROGRAM REQUIREMENTS

IV. Educational Program

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.3. Resident Scholarly Activity

IV.D.3.a) Residents must participate in scholarship (Core)

[The Review Committee may further specify]

GUIDANCE

The requirement for resident participation in scholarship in IV.D.3.a) is closely linked to the program responsibility of ensuring that the faculty members and residents are provided with a scholarly environment as specified in IV.D.1. and faculty scholarly activity as specified in IV.D.2.

Resident/fellow scholarly activity demonstrates to the Review Committees that the program can teach scholarship skills to residents/fellows and that an environment of scholarship exists in the program.

While there is undeniable value of scholarly activity, such as the publication of peer-reviewed journal articles and presentation of basic science research at national conferences, other activities are equally valuable. Scholarship is not done only for its own sake, but also serves as a proxy for the creation of a clinical learning environment that encourages an environment of inquiry and an evidence-based, scholarly approach to patient care.

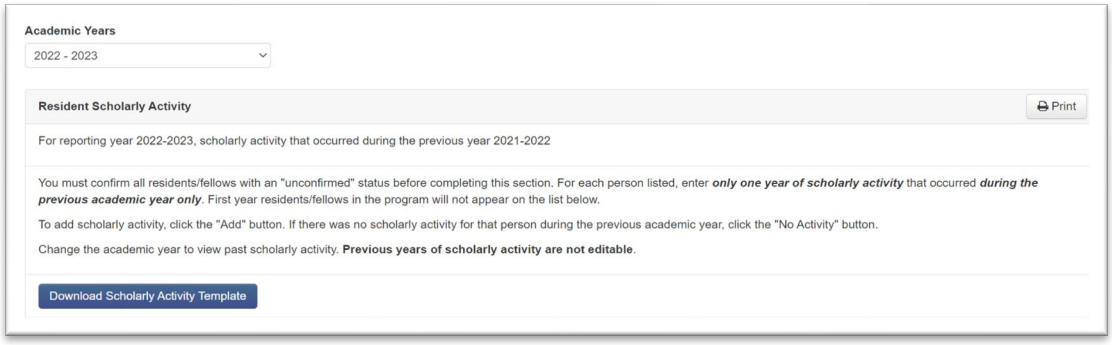
As stated in the philosophical statement above, the following bears repeating:

> *Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice life-long learning. The program and its faculty must create an* ***environment*** *that fosters the acquisition of such skills through resident/fellow participation in scholarly activities.*
>
> And
>
> *It is expected that* ***a program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves****. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while others might use more classic forms of biomedical research as the focus for scholarship.*

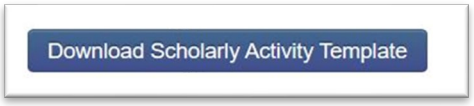
There is wide variability in programs and the communities they serve, and the Review Committees consider this difference when evaluating programs. For example, a program in a remote, rural community might focus on primary care education and training and may not want or have the resources to put together a million-dollar laboratory to study some characteristics of a murine model of disease. Instead, it may emphasize improving vaccination rates, increasing compliance with diabetes care, or determining how to deal with an opioid epidemic in the community.

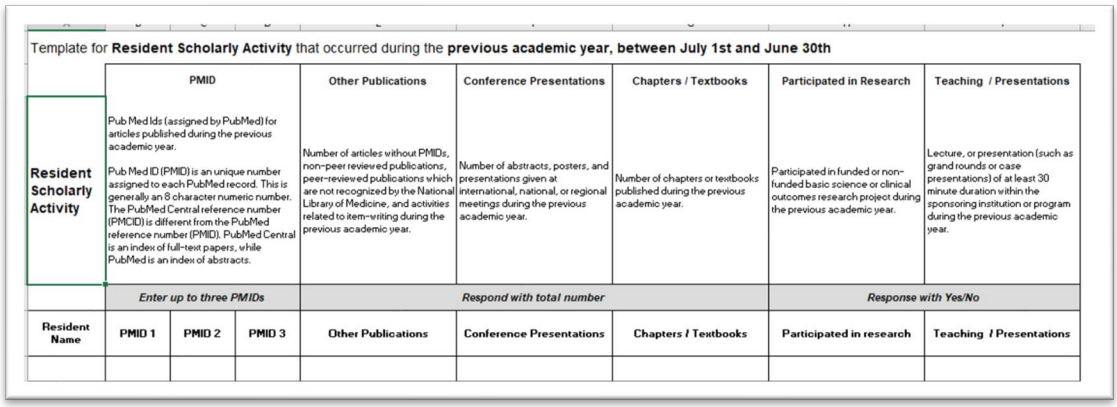
Accreditation Data System (ADS) Screenshots: Below are screenshots of the resident scholarly activity instructions and data entry screens.

1. **Resident scholarly activity instructions**



2. **The "Download Scholarly Activity Template" button in the screenshot above will pull up an Excel spreadsheet to enter information.** The purpose of the spreadsheet is for programs to disseminate it to program residents to aid in the collection of accurate scholarly activity data. The spreadsheet includes definitions of the different types of scholarly activities.

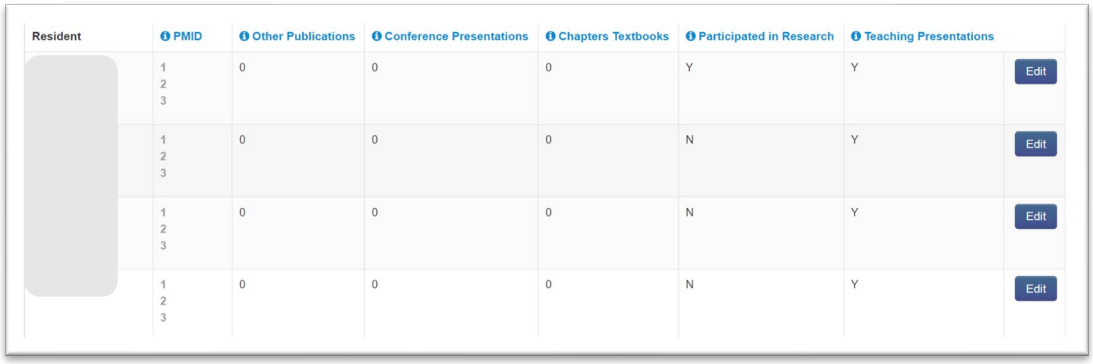




Template for **Resident Scholarly Activity** that occurred during the **previous academic year, between July 1st and June 30th**

	PMID			Other Publications	Conference Presentations	Chapters / Textbooks	Participated in Research	Teaching / Presentations
Resident Scholarly Activity	Pub Med Ids (assigned by PubMed) for articles published during the previous academic year. Pub Med ID (PMID) is an unique number assigned to each PubMed record. This is generally an 8 character numeric number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts.			Number of articles without PMIDs, non-peer reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing during the previous academic year.	Number of abstracts, posters, and presentations given at international, national, or regional meetings during the previous academic year.	Number of chapters or textbooks published during the previous academic year.	Participated in funded or non-funded basic science or clinical outcomes research project during the previous academic year.	Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program during the previous academic year.
	Enter up to three PMIDs			*Respond with total number*			*Response with Yes/No*	
Resident Name	**PMID 1**	**PMID 2**	**PMID 3**	**Other Publications**	**Conference Presentations**	**Chapters / Textbooks**	**Participated in research**	**Teaching / Presentations**

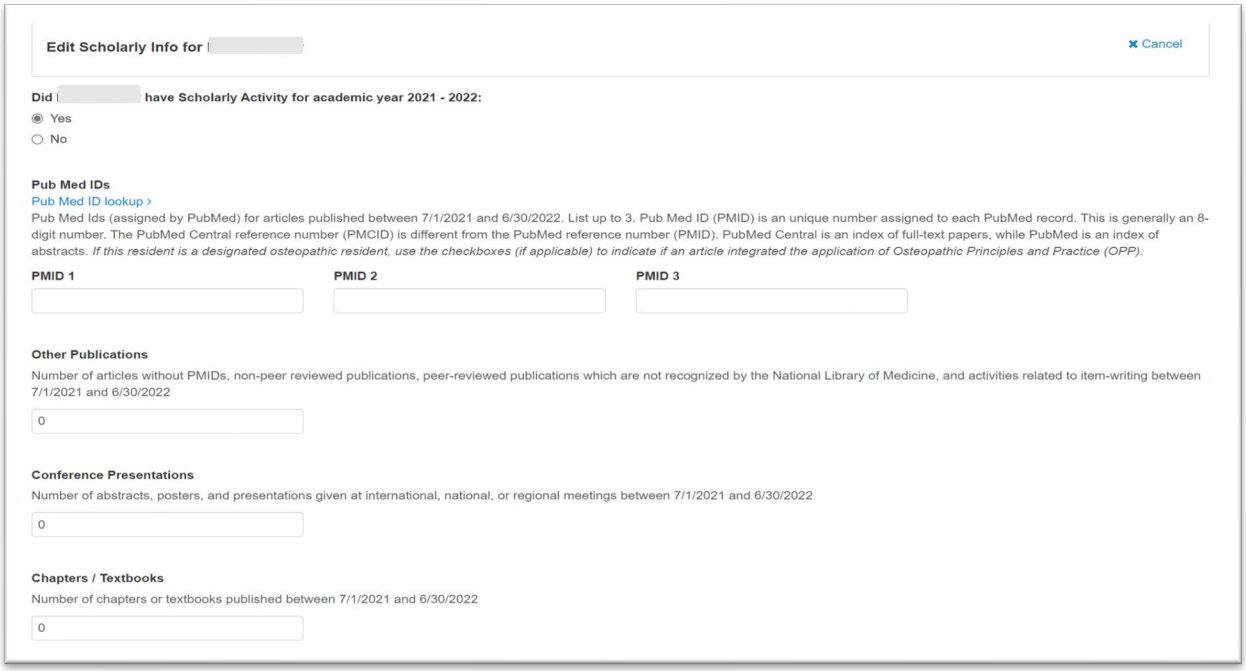
3. **The resident scholarly activity summary provides a list of all residents in the program and allows programs to update scholarly activity information for each individual resident.** NOTE: the information requested is for the previous academic year only. First-year residents in the program will not appear on the list.



Resident	PMID	Other Publications	Conference Presentations	Chapters Textbooks	Participated in Research	Teaching Presentations	
	1 2 3	0	0	0	Y	Y	Edit
	1 2 3	0	0	0	N	Y	Edit
	1 2 3	0	0	0	N	Y	Edit
	1 2 3	0	0	0	N	Y	Edit

4. **The columns on the resident scholarly activity data entry screen have an "information" button that expands to provide a more specific definition of each type of scholarly activity. Those definitions are also provided in the downloadable Excel template and are included below.**
   - **PubMed IDs (PMIDs):**
     PMID Lookup
     Enter up to four PMIDs (assigned by PubMed) for articles published during the previous academic year. The PMID is a unique number assigned to each PubMed record. This is generally an eight-digit number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts. If this resident is a designated osteopathic resident, use the checkboxes (if applicable) to indicate if an article integrated the application of Osteopathic Principles and Practice (OPP).
   - **Other Publications:** Number of articles without PMIDs, non-peer-reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing (e.g., board examination questions) during the previous academic year.
   - **Conference Presentations:** Number of abstracts, posters, and presentations given at international, national, or regional meetings during the previous academic year.
   - **Chapters/Textbooks:** Number of chapters or textbooks published during the previous academic year.
   - **Participated in Research:** Participated in funded or non-funded basic science or clinical outcomes research project during the previous academic year.
   - **Teaching Presentations:** Lecture or presentation (such as grand rounds or case presentations) of at least 30-minute duration within the Sponsoring Institution or program during the previous academic year.

5. **The screenshots below depict the individual resident scholarly activity data entry.**



If a program sends its residents to a one-month rotation at a participating site where faculty members produce a large amount of scholarly activity, it would be improper for the program to “claim” and list all the scholarly activities at that participating site. Doing so does not meet substantial compliance with the requirement to create an environment of scholarship. The idea behind this requirement is that residents be “immersed” in an environment of scholarship and inquiry throughout their educational programs. Therefore, scholarly activity listed should be from the primary clinical site.

Resources:

The following presentation is available on the ACGME website and provides helpful tips for entering scholarly activity in ADS as part of the ADS Annual Update and avoiding common citations.

- Avoiding Common Errors in the ADS Annual Update-Entering Scholarly Activity into ADS Video

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented. Formative and summative evaluation have distinct definitions. Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion. End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program. Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth;

GUIDANCE

This requirement was written with the intention of ensuring that the program director and faculty members help residents and fellows in developing individualized learning plans (ILPs) to capitalize on their strengths and identify any areas that need additional support or effort.

Generally, ILPs include self-assessment and reflection, career goals, development of plans to achieve the goal(s), assessment of progress toward the goal(s), and revising/generating new goals. An ILP is a living document that must be reviewed to ensure progress and refocus as needed. Goals can be short term and/or long term. ILPs help residents learn the concepts of lifelong learning and practice-based learning and improvement.

Barriers to successful implementation of an ILP (identified by residents):

1. Difficulty in self-reflection
2. Environmental strain: fatigue, time constraints
3. Competing demands: personal and work
4. Difficulty with goal generation

Difficulties in developing a plan and plan implementation:

1. Not seeing the patient population needed for clinical goals
2. Not having the time to consistently review the plan with a mentor
3. Created goals that cannot be tracked (lack of objective measures)

The ACGME has developed several resources for programs that include more information on ILPs, including components of an ILP and what ILPs are and are not. This Clinical Competency Committee Guidebook provides more insight on this requirement and ILPs.

Components of an ILP (Li & Burke, 2010):

1. Reflection on goals and self-assessment of strengths and weaknesses
2. Generation of specific learning goals and/or objectives
3. Specific plans or strategies to achieve each goal focused on what the
1. learner will do to improve
4. Mutual agreement on how the assessment of progress on each goal will be
2. determined
5. Eventual revision of goals or creation of new goals based on performance
6. Expected timeline

ILPs ARE:

- Formulated by the individual (resident/fellow) – made by the learner, for the learner
- Guided by a facilitator (faculty member, advisor, coach, or program director)
- An exercise in self-assessment and self-reflection
- Iterative
- An ACGME core requirement

- An indicator of insight and ability to become an independent lifelong learner

ILPs are NOT:

- Set in stone – they can and should be revisited by both the learner and the facilitator
- A portfolio
- Evaluations
- The sole or major responsibility of the program director (or faculty) or the program

Additional References:

1. Li, Su-Ting T., and Ann E. Burke. 2010. “Individualized Learning Plans: Basics and Beyond.” *Academic Pediatrics* 10(5): 289–92. https://doi.org/10.1016/j.acap.2010.08.002.
2. Li, Su-Ting T., Debora A. Paterniti, John Patrick T. Co, and Daniel C. West. 2010. “Successful Self-Directed Lifelong Learning in Medicine: A Conceptual Model Derived From Qualitative Analysis of a National Survey of Pediatric Residents.” *Academic Medicine* 85(7): 1229–36. https://doi.org/10.1097/acm.0b013e3181e1931c.
3. Li, Su-Ting T., Debora A. Paterniti, Daniel J. Tancredi, John Patrick T. Co, and Daniel C. West. 2011. “Is Residents' Progress on Individualized Learning Plans Related to the Type of Learning Goal Set?” *Academic Medicine* 86(10): 1293-1299. doi:10.1097/ACM.0b013e31822be22b.
4. University of Washington Graduate Medical Education. “Resident and Fellow Education: Individualized Learning Plan (ILP).” https://sites.uw.edu/uwgme/resident-evaluation/#ilp. Accessed 2023.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.
Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures. (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed

tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

GUIDANCE

V.A.1.d). and V.A.1.d).(3). The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures.

The Background and Intent box reinforces the importance of institutional policies and procedures in this process: “To ensure due process, it is essential that the program director follow institutional policies and procedures.” It is therefore strongly encouraged that program directors work closely with the designated institutional official (DIO) to ensure all applicable policies and procedures are followed and the appropriate institutional departments are engaged in the process of addressing residents failing to progress at the appropriate time.

The goal of these processes is to help residents in difficulty to succeed while also ensuring appropriate documentation of resident performance and due process.

Milestones assessments and evaluations by the Clinical Competency Committee (CCC) are essential to the early identification of residents in difficulty.

Below are references to a few studies that address the issue of residents failing to progress.

1. **Smith, Jessica, Monica Lypson, Mark Silverberg, Moshe Weizberg, Tiffany Murano, Michael Lukela, and Sally Santen. 2017 “Defining Uniform Processes for Remediation, Probation and Termination in Residency Training.” *Western Journal of Emergency Medicine* 18, no. 1: 110–13. https://doi.org/10.5811/westjem.2016.10.31483.**

The authors state that: “It is important that residency programs identify trainees who progress appropriately, as well as identify residents who fail to achieve educational milestones as expected so they may be remediated. The process of remediation varies greatly across training programs, due in part to the lack of standardized definitions for good standing, remediation, probation and termination.”

The authors provided standardized definitions for terms used in remediation, probation, and termination related to residency education as listed below:

Informal Remediation: The first step in the process when warning signs of problems exist but are not so significant that formal remediation is warranted. This is a critical time to start documentation of the process to determine if there is an eventual need to escalate to a formal remediation process. Many programs have developed documentation templates or standard language, and completed forms or email notifications to the resident are placed in the resident’s file. Some create confidential notes placed in “shadow files,” which are destroyed once the remediation process is completed successfully.

It is important to engage the program director, CCC, and resident at this stage.

Formal Remediation: The next step in the management of residents in difficulty. This step is implemented when the resident fails to correct identified deficiencies during informal

remediation or when the deficiencies are so significant that the step of informal remediation is skipped.

Components of formal remediation:

1. Document the need for formal remediation and inform the resident in writing. It is important that the resident read and sign a formal document. The document must also be signed by the program director.
2. Provide the resident with program and institutional grievance and due process policies.
3. Determine the length of time of formal remediation, decided by the program director and the CCC. Do not leave the date open-ended — there must be a target date.
4. Create a correction plan with expected outcomes — there must be specific targets based on the deficiencies.
5. Include a time frame for reassessment and the consequences of not meeting the expected outcome within the time frame.
6. Place all documentation in the resident's file.
7. Notify the graduate medical education (GME) office, including the DIO.

Probation: Probation is initiated when a resident fails to correct deficiencies identified during formal remediation. The program director and the CCC may place a resident on immediate probation if major problems occur.

Some programs set a limit of six months to the period of formal remediation. If there is no or not enough improvement after six months of formal remediation, the resident is then placed on probation.

Notes related to probation:

1. The period of probation must be definite, not open-ended.
2. The program must follow due process, especially if non-renewal or termination is being considered.
3. The same points listed in formal remediation need to be followed: dates, target outcome, consequences of not meeting the requirements, and documentation.
4. The GME office *must* be involved. Other participants in the probation process include the program director, the CCC, the department chair, and faculty members assigned to remediate the resident.
5. The legal department must be involved.
6. Probation must be disclosed in the final Verification of Graduate Medical Education Training (VGMET) Form, employment letters, and letters of references.
7. If the resident does not meet the requirements outlined in the letter of probation, the program may choose non-renewal of contract, or termination.

Termination: A resident may be terminated if that resident fails to meet the terms of probation. In some instances, a resident may be terminated immediately if the problem is severe enough.

Those involved in the process of probation must be involved in the termination process. In addition, if there is a house officer/resident union, a representative of the union needs to be involved.

Termination must be disclosed in the final VGMET Form, employment letters, and letters of references.

2. **Dupras, Denise M., Randall S. Edson, Andrew J. Halvorsen, Robert H. Hopkins, and Furman S. McDonald. 2012. "'Problem Residents': Prevalence, Problems and Remediation in the Era of Core Competencies."** ***The American Journal of Medicine*** **125, no. 4: 421–25. https://doi.org/10.1016/j.amjmed.2011.12.008.**

The authors studied the prevalence of residents in difficulty, and the problems associated with placing a resident in remediation. They suggested a change of terms from "problem residents" to "residents in difficulty" (RID).

The authors conducted a survey of members of the Association of Program Directors in Internal Medicine.

- 372 program directors were surveyed (97.1% of 383 US categorical internal medicine programs).
- 268 program directors (72%) completed the survey.
- 197 program directors reported RID.
- 3.5% of residents were identified as RID (532 of 15,031 total residents with a mean of 2.9 RIDs per program).

They noted that factors that correlated with subsequent need for probation/remediation included low scores on the Internal Medicine In-Training Examination and the US Medical Licensing Examination Step 3.

Residents in difficulty were most frequently identified by faculty member (#1). They were also identified by supervising/chief residents, program directors, fellows, and nurses.

The most common deficiencies of residents in difficulty identified in this study included:

- Patient care (53%)
- Medical knowledge (48%)
- Organization/prioritization, communication (40%)
- Professionalism (41%)
- The majority (77%) had MULTIPLE deficiencies

The most common contributing factors to residents having difficulty in the study were:

- Depression
- Anxiety
- Personality disorders

Less common contributing factors to residents having difficulty included:

- Learning disability
- Illness
- Substance use disorder
- Divorce

In this study, the authors noted that actions taken by program directors to address residents in difficulty included:

- Remediation (including repeating a rotation or an entire year)
- Disciplinary action
- Probation

- Dismissal

In this study, only 34.5% of program directors retrospectively identified warning signs.

Conclusions:

- The majority of residents in difficulty have deficiencies in multiple competencies.
- Medical knowledge and patient care deficiencies are much easier to remediate.
- Deficiencies in professionalism are common (41%).
- Residents respond poorly to remediation.
- There is a concern that unprofessional behavior in residents is predictive of future disciplinary action by specialty boards.

3. **Cosco, Dominique, Denise Dupras, Maggie So, Eugene Lee, Jason Schneider, and Randall Edson. 2014. "Look on the Bright Side: Case Studies in Successful Remediation of Problem Learners. Tools for Faculty and Staff/Remediation."** ***Academic Medicine Insight*** **12 no. 3: 8-11.**

Cosco et al. studied cases in which remediation of problem learners was successful and identified some key steps:

1. Identification of the issue (competency-based)
2. Multiple sources of learner assessment
3. Early feedback and intervention
4. Resident reflection with buy-in
5. Specific remediation goals with outlined consequences for failure to meet goals
6. Frequent follow-up
7. Group effort
8. Thorough documentation

4. **Papadakis, Maxine A., Gerald K. Arnold, Linda L. Blank, Eric S. Holmboe, and Rebecca S. Lipner. 2008. "Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards."** ***Annals of Internal Medicine*** **148, no. 11: 869. https://doi.org/10.7326/0003-4819-148-11-200806030-00009.**

Papadakis et al. evaluated the incidence of subsequent disciplinary action by state licensing boards according to performance during residency and concluded that poor performance on behavioral and cognitive measures during residency is associated with greater risk for state licensing board actions against practicing physicians at every point on a performance continuum. These findings support the ACGME standards for professionalism and cognitive performance and the development of best practices to remediate these deficiencies.

5. **Lefebvre, Cedric, Kelly Williamson, Peter Moffett, Angela Cummings, Beth Gianopulos, Elizabeth Winters, and Mitchell Sokolosky. 2018. "Legal Considerations in the Remediation and Dismissal of Graduate Medical Trainees."** ***Journal of Graduate Medical Education*** **10, no. 3: 253–57. https://doi.org/10.4300/jgme-d-17-00813.1.**

Lefebvre et al. reviewed the legal considerations in placing residents in remediation or dismissing them from the program, and have the following summary points:

1. Sponsoring Institutions and their programs must provide residents with due process in cases of contract non-renewal, non-promotion, suspension, or dismissal.
2. Adherence to remediation policy, use of consistent remediation language, and documentation of all phases of remediation are important to optimize outcomes and limit legal liability when dismissal occurs.
3. Programs are generally on solid legal ground when they exercise due process for the remediated resident, when they take actions based on educational standards and patient safety, and when they only disclose educational records to inquiring parties in good faith.
4. Courts have consistently declined to consider the tort of educational malpractice.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.A. Resident Evaluation

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.2.a).(1) The specialty-specific Milestones, and when applicable, the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)

GUIDANCE

As requirement V.A.2.a).(1) specifies, the program director must use the specialty-specific Milestones, and when applicable, the specialty-specific Case Logs as tools to ensure residents are able to engage in autonomous practice upon completion of the program. However, the program director should consider a number of other items to make the determination about a resident's ability to engage in autonomous practice (e.g., semi-annual and summative evaluations and recommendations from the Clinical Competency Committee).

Milestones

Milestones evaluation is an educational and formative assessment methodology designed to help promote improvement in every specialty and subspecialty graduate medical education (GME) program in the United States. The Milestones were not designed or intended for use by external entities, such as state medical licensing boards or credentialing entities, to inform or to make high-stakes decisions. The ACGME is concerned that GME programs may artificially inflate individual Milestones assessment data if the Milestones are used for high-stakes decisions. Their value would risk being lost as an honest and valuable assessment tool for continuous improvement and professional development.

The Milestones are designed only for use in evaluation of residents in the context of their participation in ACGME-accredited programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competence in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six Core Competency domains, nor are they designed to be relevant in any other context.

The Level 4 milestones are designed as the graduation target but do not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. (See the Milestones FAQs for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?").

NOTE: Program directors are urged to read the following article regarding appropriate use of the Milestones:

- Use of Individual Milestones Data by External Entities for High Stakes Decisions - A Function for Which they Are not Designed or Intended

Milestones Resources

The ACGME provides many resources for residents, faculty members, and program administration and leadership, and new resources are developed regularly. Visit the Milestones section of the ACGME website to review available resources and tools:

- The ACGME Milestones Guidebook
- Milestones 2.0: A Step Forward (Supplement in JGME)
- Milestones FAQs
- Clinician Educator Milestones that can be used for residents or faculty members to develop a personal professional development plan.
- The ACGME also offers courses designed to help faculty members and leaders achieve the goals of competency-based assessment in GME. Visit the Developing Faculty

Competencies in Assessment course page for information on dates, fees, and registration availability.
- Learn at ACGME offers an extensive array of online education and resources on a variety of topics, including assessment.

Case Logs

When applicable, Case Logs must also be used by the program director to determine if residents are able to engage in independent practice upon completion of the educational program. The program director should monitor residents' Case Logs throughout their training to ensure they are able to meet Case Log minima for their specialty, if applicable, and to achieve competence in key procedures.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.A. Resident Evaluation

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.2.a).(2) The final evaluation must:

V.A.2.a).(2).(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.2.a).(2).(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; (Core)

V.A.2.a).(2).(c) consider recommendations from the Clinical Competency Committee; and, (Core)

V.A.2.a).(2).(d) be shared with the resident upon completion of the program. (Core)

GUIDANCE

It is important to note that the final evaluation requirement specified in V.A.2.a).(2) is different from the verification of training and education specified in II.A.4.a).(14). Programs may use one form to meet both the requirement for final evaluation and verification of training and education, but they must ensure that the final evaluation includes the specific elements identified below as well as in V.A.2.a).(1). Some of the most common elements that are missed by programs and are cited by Review Committees when programs use the same form for verification of training and final evaluation relate to:

- the specific language around readiness for autonomous practice; and,
- review of milestones and, as applicable, Case Log data.

The **Verification of Graduate Medical Education Training (VGMET)** Form, which programs can use or adapt to their needs, was jointly developed by several organizations: the American Hospital Association (AHA), the National Association Medical Staff Services (NAMSS), the Organization of Program Director Associations (OPDA), and the ACGME. It is designed to satisfy national credentialing standards, and to be completed once (and only once) by the program director, and then copied and re-used in perpetuity.

V.A.2.a).(2).(a) [The final evaluation must:] become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy.

This requirement is self-explanatory.

V.A.2.a).(2).(b) [The final evaluation must:] verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

It is important for the program director to affirmatively state in the final evaluation, "Dr. [resident name] has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice." It is also desirable to add the specialty or subspecialty, i.e., "…to enter autonomous practice of [specialty or subspecialty]." This is a frequently missed and cited requirement and therefore program directors are strongly encouraged to ensure that this language is included in the final evaluation.

While Milestones assessments and case logs must be used in the determination of an individual resident's ability to practice autonomously, the achievement of specific milestones by an individual resident or the number of procedures performed do not need to be documented in the final evaluation. See requirement V.A.2.a).(1) for additional information.

V.A.2.a).(2).(c) [The final evaluation must:] consider recommendations from the Clinical Competency Committee.

Refer to requirement V.A.3.b) Clinical Competency Committee for more information.

V.A.2.a).(2).(d) [The final evaluation must:] be shared with the resident upon completion of the program.

This requirement is self-explanatory.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.A. Resident Evaluation

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to have flexibility for each program to decide the best structure for its own circumstances, but a program should consider: Its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a).(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions. Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b).(1) review all resident evaluations at least semi-annually; (Core)

V.A.3.b).(2) determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)

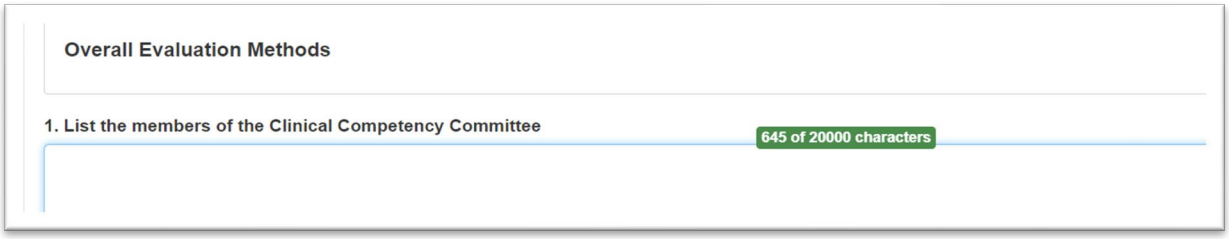
V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

GUIDANCE

The membership of the Clinical Competency Committee (CCC) and the roles of the program director, physician and non-physician faculty members, and chief residents are outlined in the Background and Intent section preceding these requirements. The requirements are purposefully stated in general terms to allow programs flexibility to include individuals who are most appropriate locally, and to structure their meetings according to their specific needs. Of note, the role of the chief resident on the CCC is clarified. Chief residents who have completed specialty or core residency programs can be members of the CCC. For example, someone who has completed an internal medicine or pediatrics residency program and is then appointed as chief resident would qualify for membership. However, chief residents in surgery are in their fifth year of the educational program and are residents, and therefore cannot be members of the CCC.

Program coordinators are essential in the CCC process through their involvement with many, if not all, aspects of the program, and their knowledge of the residents/fellows. Program coordinators may attend CCC meetings in an administrative role at the discretion of the program director. However, the program coordinator cannot be a CCC member, or make judgments in or after the meeting regarding resident performance. Program coordinators should provide assessment and feedback through the program's assessment system, such as by participating in multisource assessment instruments.

Accreditation Data System (ADS) Screenshot: All programs are expected to provide the membership of the CCC as part of a new application or during the ADS Annual Update. This question is located on the Program Tab > Overall Evaluation Methods – CCC Membership.



V.A.3.b).(1): If there is a disagreement in assessment between the program director and the CCC, note **V.A.2. and V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program.** (Core)

Requirements V.A.3.b).(1)- (3) articulate three critical responsibilities of the CCC. The CCC must review all resident evaluations at least semi-annually. Based on the size and structure of the program, this may be insufficient to assess all residents and some programs may have CCCs that meet quarterly or monthly. The CCC is also responsible for reviewing each resident's progress on the Milestones semiannually.

RESOURCES

The ACGME has provided the following online resources:

1. Clinical Competency Committees: A Guidebook for Programs

2. The Milestones Guidebook
   This guidebook provides suggestions for effective use of Milestones assessments. In addition, the specialty and subspecialty Milestones Work Groups have begun creating Supplemental Guides (for Milestones 2.0 versions) with specific guidance in ratings of residents' performance.

3. Introduction to Milestones Interactive Course
   Note: The above link will take you to the Introduction to Milestones course housed in Learn at ACGME, the ACGME's online learning portal. New graduate medical education (GME) community members will need to create a free account before they are able to access the course.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore,

the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

GUIDANCE

The section of the Common Program Requirements addressing faculty evaluation has several components:

1. Who to evaluate
2. What to evaluate: teaching abilities; engagement with the program; professionalism; and scholarly activities
3. Giving faculty members feedback on their evaluations at least annually
4. Incorporation of the educational evaluations into faculty development plans and should be part of the Annual Program Evaluation.

Who to Evaluate
As stated in the Background and Intent, all faculty members who have significant interactions with the residents must receive feedback.

What to Evaluate
Faculty members should be evaluated based on their role in resident education, including clinical care, teaching, and research in aspects such as clinical productivity, review of patient outcomes, or peer review of scholarly activity. Sometimes, the program director may need to work with others to determine the effectiveness of faculty members' performance with regard to their role in the educational program. The process should reflect the local environment and identify the necessary information.

As noted in the Background and Intent, assessment of the members of the faculty is an important part of improving the teaching program. Feedback is important to help individual faculty members measure and increase their contribution to the mission of the program and improve their individual effectiveness as teachers. It is suggested that assessment include research and scholarly activity, clinical work, and educational activities. The specific requirement for written and confidential evaluations of faculty members is intended to collect the most honest feedback from the residents, which requires minimizing any possibility for fear of retaliation or intimidation of the residents as a result of comments made.

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents.

Programs with a smaller number of residents often struggle with maintaining confidentiality of a resident's evaluation. For a confidential evaluation, the reviewer is not known by the individual being evaluated, but the identity of the evaluator might be known by someone such as the program director or departmental chair. For an anonymous evaluation, the evaluator is not known by anyone, offering a higher level of security. Frequently, feedback from multiple anonymous evaluations is aggregated so that it is impossible to guess the individual source.

The advantage of a confidential evaluation is that someone can respond if needed to an egregious situation if it is reported or that a residency program director or departmental chair can place the information in better context. Confidential evaluations only work if the residents trust their identity will be kept secret, which requires they must have a high degree of trust in the individual who knows their identity. The trusted individual may be the program coordinator who is collecting the evaluations or the program director or department chair who oversees the

faculty member. However, these individuals may be intimidating to a resident because of their supervisory relationship. In this instance, the trusted individual must be someone else, particularly when the resident is evaluating the program director and the department chair. Another scenario has the trusted individual being someone outside of the program, such as the designated institutional official (DIO) or an individual who reports to a different department.

The advantage of an anonymous evaluation is that it is the most reassuring to the resident. Anonymous evaluations may be accomplished by collecting them via a system that does not identify an individual resident. Because it might be possible for faculty members to guess the identity by timing when the evaluation appears, the individual comments might be collected throughout the year and batched feedback might be best given at the end of the year or even over two years for very small programs. Another option is to batch resident feedback across multiple programs the faculty member is associated with.

Confidentiality is at risk when the written evaluation contains details that might identify a specific patient, case, or resident interaction that the faculty member can recall and attribute to the specific individual resident.

Confidential faculty evaluations are a critical piece of information to help improve the program, but they are a special challenge in small programs. Some of the strategies above may help to collect that information while preserving confidentiality.

The ACGME monitors compliance with requirements V.B.1.- 3. in various ways, including:

- Questions program leadership must answer as part of an application or during the ADS Annual Update;
- Documents programs submit as part of an application or site visit (e.g., sample evaluation forms);
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys;
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section V.B.1.-3. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

Many institutions have “home-grown” versions of faculty evaluation forms. In addition, departments may have annual evaluation forms that address clinical performance, role in education, and scholarship. Below are some examples.

1. **Williams, Brent C., Debra K. Litzelman, Stewart F. Babbott, Robert M. Lubitz, and Tim P. Hofer. 2002. “Validation of a Global Measure of Faculty’s Clinical Teaching**

Performance.” *Academic Medicine* 77(2): 177–80. https://doi.org/10.1097/00001888-200202000-00020.

Created a Global Rating Scale (GRS) – a single-item, five-point global measure of faculty members’ clinical teaching performance previously known to be reliable.
Evaluation completed by 98 senior medical residents from four academic institutions; also completed the 26-item Stanford Faculty Development questionnaire for 10 faculty members with whom they had teaching contact during residency.

The GRS correlated highly with measures of seven specific aspects of teaching effectiveness. The scale is reportedly simple to use, readily administered as part of an incentive or reward program, or for review in promotion decisions.

2. **Mintz, Marcy, Danielle A. Southern, William A. Ghali, and Irene W. Y. Ma. 2015. “Validation of the 25-Item Stanford Faculty Development Program Tool on Clinical Teaching Effectiveness.” *Teaching and Learning in Medicine* 27(2): 174–81. https://doi.org/10.1080/10401334.2015.1011645.**

   Domains:
   - Learning climate
   - Control of session
   - Communication of goals
   - Promotes understanding and retention
   - Evaluation
   - Feedback
   - Promotes self-directed learning

3. **Kassis, Karyn, Rebecca Wallihan, Larry Hurtubise, Sara Goode, Margaret Chase, and John Mahan. 2017. “Milestone-Based Tool for Learner Evaluation of Faculty Clinical Teaching.” *MedEdPORTAL Publications* 13. https://doi.org/10.15766/mep_2374-8265.10626.**

   Created a 10-question evaluation tool to assess clinical teaching skills with descriptive Milestones behavior anchors using a combination of the Stanford Faculty Development Clinical Teaching Model and annual ACGME Resident/Fellow Survey questions.

   Conclusion: The tool provided faculty members with more meaningful teaching evaluations and feedback.

   Domains:
   - Milestone 1: Establishes positive learning domain
   - Milestone 2: Maintains control of educational session
   - Milestone 3: Establishes learning goals
   - Milestone 4: Promotes understanding and retention of knowledge and skills
   - Milestone 5: Provides formative feedback
   - Milestone 6: Promotes clinical reasoning
   - Milestone 7: Promotes evidence-based medicine
   - Milestone 8: Promotes self-directed learning in learners
   - Milestone 9: Balances supervision and autonomy

- Milestone 10: Displays professionalism

Faculty members must receive structured feedback on their evaluations at least once a year. The feedback should include strengths and opportunities for improvement, and be considered in planning for faculty development sessions and tracked as part of the Annual Program Evaluation. For example, if residents' evaluations of faculty members consistently show that faculty evaluations of residents are not constructive and do not provide information to help the residents improve, there might be a need to provide a faculty development session on evaluating residents.

4. **Myerholtz, Linda, Alfred Reid, Hannah M. Baker, Lisa Rollins, Cristen P. Page. 2019. "Residency Faculty Teaching Evaluation: What Do Faculty, Residents, and Program Directors Want?"** ***Family Medicine*** **51(6): 509-515. https://doi.org/10.22454/FamMed.2019.168353.**

   This study explores existing and ideal characteristics of faculty teaching evaluation systems from the perspectives of key stakeholders: faculty members, residents, and residency program directors.

   Conclusion: Program directors, faculty members, and residents share a desire to provide faculty members with meaningful, specific, and real-time feedback. Programs should strive to provide a culture in which feedback is an integral part of the learning process for both residents and faculty members.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b).(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; (Core)

V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

V.C.1.b).(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c).(1) curriculum; (Core)

V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)

V.C.1.c).(4) quality and safety of patient care; (Core)

V.C.1.c).(5) aggregate resident and faculty:

V.C.1.c).(5).(a) well-being; (Core)

V.C.1.c.(5).(b) recruitment and retention; (Core)

V.C.1.c.(5).(c) workforce diversity; (Core)

V.C.1.c.(5).(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c.(5).(e) scholarly activity; (Core)

V.C.1.c.(5).(f) ACGME Resident and Faulty Surveys; and, (Core)

V.C.1.c.(5).(g) written evaluations of the program. (Core)

V.C.1.(6) aggregate resident:

V.C.1.c.(6).(a) achievement of the Milestones; (Core)

V.C.1.c.(6).(b) in-training examinations (where applicable); (Core)

V.C.1.c.(6).(c) board pass and certification rate, and, (Core)

V.C.1.c(6).(d) graduate performance. (Core)

V.C.1.(7) aggregate faculty:

V.C.1.(7).(a) evaluation; and, (Core)

V.C.1.c.(7).(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The annual review, including the action plan, must:

V. C.1.e).(1)	be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)
V.C.1.e).(2)	be submitted to the DIO. (Core)

GUIDANCE

Per requirement V.C.1.a), the Program Evaluation Committee (PEC) must include at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. Members of the PEC should know the program well and be invested in program improvement and success. Resident members are important because they "live and work" within the context of the program.

Accreditation Data System (ADS) Screenshot: Programs must provide the membership of the PEC in ADS when submitting a new application or as part of the ADS Annual Update.

What Does the PEC Do?

- The PEC should participate actively in:
    - Planning, developing, implementing, and evaluating educational activities of the program;
    - Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
    - Addressing areas of non-compliance with ACGME requirements;
    - Annually reviewing the program using evaluations of faculty members, residents, and others; and,
    - Monitoring well-being
- Some PECs include review of resident Milestone assessments to determine weak points in curricular elements of the program in order to make necessary changes.
- End product: **Annual Program Evaluation**

Requirements V.C.1.e).(1)-(2) emphasize the need to review and discuss the Annual Program Evaluation with faculty members and residents and also share it with the designated institutional official (DIO).

The Sponsoring Institution's DIO and Graduate Medical Education Committee (GMEC) are responsible for overseeing Annual Program Evaluations. The DIO and GMEC may expect programs to submit Annual Program Evaluation information in a specific format. The DIO should be contacted with any questions about how to submit an annual review and action plan.

Suggested template for internal program use in the Annual Program Evaluation. Note that this is a sample template and the ACGME does not require its use.

SAMPLE Template – Annual Program Evaluation
(For Internal PROGRAM Use Only)

Program:
Date:
Academic Year:

Program Evaluation Committee Membership:
Faculty Members:
1. _____
2. _____
3. _____

Residents/Fellows:
1. _____
2. _____

Resident/Fellow Complement

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Positions Approved							
Current Complement							

Accreditation Status of the Program

□ Continued Accreditation
□ Continued Accreditation with Warning
□ Probationary Accreditation
□ Initial Accreditation
□ Initial Accreditation with Warning
□ Continued Accreditation without Outcomes

Current Program Citations

Insert Text from ACGME Letter of Notification (LON)	*Current* Program Response to Citation
1.	
2.	
3.	

Current Areas for Improvement (AFIs)

Insert Text from ACGME LON	Program Actions to Address Areas for Improvement (AFIs)
1.	
2.	
3.	

Program Aims

Aim(s)	Met (M)/Unmet (U)

Plans for Unmet Goals

1. _____
2. _____
3. _____

Strengths of the Program

1. _____
2. _____
3. _____

Challenges/Threats to the Program

1. _____
2. _____
3. _____

Opportunities for the Program

1. _____
2. _____
3. _____

Program Curriculum

Curricular Element	Action: Modify (M), Add (A) or Delete (D)	Steps Taken	Timeline for Completion

Quality Improvement (QI) and Patient Safety (PS)

QI/PS Activity	Active Role Faculty (F) Resident or Fellow (R)	Has QI/PS Improved in the Past Year? (Yes/No)	Describe Improvement, Including Efforts to Include Faculty Member(s) and Residents/Fellows	Describe QI/PS Activities that Can be Added or Improved

Well-Being and Diversity

Activity	Successes	Needs Improvement
Well-being		

Diversity		
Recruitment		
Retention		

Scholarship

Resident/Fellow/Faculty Scholarly Activities (append lists here)	If applicable, list efforts to increase scholarship

ACGME Annual Resident/Fellow Survey

Areas with Improvement	Areas with Deterioration	Plans to Address Areas of Deterioration if Applicable

ACGME Annual Faculty Survey

Areas with Improvement	Areas with Deterioration	Plans to Address Areas of Deterioration if applicable

Written Evaluations of the Program

Who provides written evaluations of the program?

- □ Residents/fellows in this program
- □ Other hospital/clinic/facility personnel
- □ Residents/fellows in other programs
- □ Faculty members in other programs
- □ Faculty members in this program

Areas Identified for Program Improvement	Plans for Program Improvement/Target Date

Aggregate Resident/Fellow Achievement of Milestones

Exceeded National Means	Below National Means	Plans to Improve Milestones Achievement

Aggregate Resident/Fellow Performance on In-Training Examinations (if Applicable)

Performance of Cohort this Year Compared to Prior Year	Subject Areas where Cohort Fell Short of Program Expectations	Plans to Improve Performance in the In-Training Examination

Aggregate Performance of Residents/Fellows and Graduates on Board Certification Examinations in the Specialty/Subspecialty Program

Number Eligible to Take	Number Eligible Who Took the Written Examination	How Many of Those Who Took the Exam Passed?

If applicable, how does the program plan to improve resident/fellow/graduate performance on the examinations in the board certification process over the next year?

Performance of Program Graduates

In what ways does the program monitor the performance of program graduates?

- Surveys of the graduates
- Surveys of the partners of the graduates
- Surveys of the employers of the graduates
- Surveys of the practice sites (hospitals, clinics, etc.) of the graduates
- Monitoring of the continuing board certification of the graduates
- Monitoring of state licensing board actions against graduates
- Monitoring of medicolegal actions against graduates
- Program does not monitor program graduates' performance

Areas for Improvement for Performance of Graduates	Plans to Address Areas Identified as Needing Improvement

Faculty Evaluation

By whom are the faculty members in this program evaluated (for their contributions to the educational program)?

- Medical students
- Residents/fellows in this program
- Residents/fellows in other programs
- Peer faculty members in this program
- Peer faculty members in other programs

Areas for Improvement Identified for Faculty Member Contributions to the Program	Plans to Address Areas Identified as Needing Improvement

Faculty Development Activities

List Faculty Development Activities Available in the Past Year	Percent Faculty Participation	If Applicable, How Does the Program Plan to Increase Participation in Faculty Development Activities?

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.C. Program Evaluation and Improvement

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c).(6) aggregate resident:

V.C.1.c).(6).(d) graduate performance. (Core)

GUIDANCE

Aggregate Performance of Program Graduates in the Annual Program Evaluation

When conducting and documenting an Annual Program Evaluation, a Program Evaluation Committee (PEC) should consider aggregated information about the performance of the program's graduates. This requirement permits flexibility to identify indicators of graduate performance that are feasible to measure and relevant to an individual program's aims.

While it may be possible to analyze a wide variety of performance information, the PEC should determine objective criteria for graduate performance that have specific meanings in the context of the Annual Program Evaluation. Some criteria may be unique to the specialty or subspecialty (e.g., self-reported performance in a defined area of patient care); others may be broadly defined (e.g., proportion of graduates working in a targeted practice setting).

Some Sponsoring Institutions have standardized elements of Annual Program Evaluations that may include relevant performance indicators for graduates. Some Sponsoring Institutions also collect data that pertain to this requirement, such as what might be obtained by surveying program graduates. PECs may benefit from consulting the designated institutional official or other individuals if there is uncertainty about the Sponsoring Institution's policies and practices related to graduate performance data.

Graduate follow-up surveys are important for many reasons:

1. They provide information about the adequacy of the educational program.
2. They can help determine if program innovations and curricular changes had any impact.
3. Information regarding geographic location, practice type, employment setting, scholarly activities, and patient characteristics in the graduate's practice are critical in determining whether the program is achieving its mission. The information can be used to make changes in the curriculum and to refocus if needed.

COMMON PROGRAM REQUIREMENTS

V.C.2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)

V.C.2.a) A summary of the Self-Study must be submitted to the DIO. (Core)

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this 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. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

GUIDANCE

Note: The ACGME is not currently scheduling any programs to begin a Self-Study. Sponsoring Institution Self-Studies and 10-year Accreditation Site Visits are proceeding according to the Institutional Review Committee's announced plan. Click here for additional FAQs regarding the Program Self-Study.

While the Common Program Requirements specific to the Self-Study are listed in V.C.2. and V.C.2.a), it is important to note there are components related to the program aims and the Self-Study in multiple sections of the Common Program Requirements.

Self-Study Description

The ACGME Program Self-Study was established as a key component of the ACGME's current accreditation model. With the goal of conducting an objective and comprehensive review of the program, the Self-Study is a tool for program self-reflection and strategic planning that uses the Annual Program Evaluation as a foundation on which to build the in-depth, multi-year program evaluation.

Two concepts are fundamental in the development of the Self-Study:

1) Determination of the program's aims and mission; and,
2) Critical assessment of the institutional, local, regional, and even national environment (context) in which the program operates.

These lead to a thoughtful analysis of program strengths, weaknesses, opportunities, and threats that will allow a program to distinguish itself from other programs in the specialty (such as highlighting differences between community and urban programs). Ultimately, the goal of the Self-Study is to provide a platform for a forward-thinking and systematic approach to making program improvements.

Programs are encouraged to include a broad array of participants in the Self-Study process, including program leaders, residents, faculty members, and other stakeholders, such as program graduates, institutional and quality improvement personnel, leaders from related programs, or nursing and other health care personnel who interact closely with the residents in the program.

Program Aims

Each program is expected to develop a curriculum with specific aims that are "consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates." While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that a program's aims will reflect the nuanced, program-specific goals for that program and its graduates.

Sections of the Common Program Requirements that relate to program aims, the Self-Study, and the Program Evaluation Committee include:

IV. Educational Program

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. The curriculum must contain the following educational components: (Core)

IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.1.a) The program's aims must be made overall educational goals for the program, which the program must make available to program applicants, residents, and faculty members. (Core)

IV.D. Scholarship

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

V. Evaluation

V.C. Program Evaluation and Improvement

V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; (Core)

V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

V.C.1.b).(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use

metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

The Program Evaluation Committee

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)

V.C.2.a) A summary of the Self-Study must be submitted to the DIO.(Core)

Self-Study and Program Aims Resources

ACGME. 2021. "Steps for Conducting the ACGME Program Self-Study." https://www.acgme.org/What-We-Do/Accreditation/Self-Study.

ACGME. 2021. "Self-Study Summary." Document updated July 2021. https://www.acgme.org/Portals/0/PDFs/SelfStudy/SSSummary.docx.

ACGME. 2021. "Self-Study Summary of Achievements." Document updated July 2021. https://www.acgme.org/Portals/0/PDFs/SelfStudy/SummaryAchievements.docx.

Philibert, Ingrid. 2017. "The Annual Program Evaluation, Self-Study, and 10-Year Accreditation Site Visit: Connected Steps in Facilitating Program Improvement." *Journal of Graduate Medical Education* 9(1): 147-149. https://doi.org/10.4300/JGME-D-17-00047.1.

Philibert, Ingrid, John H. Beernink, Barbara H. Bush, Donna A. Caniano, Andrea Chow, John J. Coyle, Joseph Gilhooly, et al. 2017. "Improvement in Context: Exploring Aims, Improvement Priorities, and Environmental Considerations in a National Sample of Programs Using 'Small Data.'" *Journal of Graduate Medical Education* 9(6): 791-797. https://doi.org/10.4300/JGME-D-17-00952.1.

COMMON PROGRAM REQUIREMENTS

V. Evaluation

V.C. Program Evaluation and Improvement

V.C.3. *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

V.C.3.a) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.b) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.c) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.d) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.e) For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations.

By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

V.C.3.f) Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

GUIDANCE

Board pass rate is one outcome that can demonstrate a program is preparing its graduates for independent practice. Replacing the previous requirement of a five-year rolling average with a three-year rolling average makes the data more relevant to the most recent graduates and a more current time frame in the program. The variability in the board pass rates in programs from year to year, (especially with small programs) is considered by the Review Committees. While in a small program one resident failing the board exam(s) may have a relatively larger negative impact on the pass rate, the opposite is also true that one resident passing the board exam(s) will also have a larger positive impact and it will be easier for the program to improve.

Only programs meeting both of the following conditions will receive a citation for this requirement:

1) The program must be in the lowest five percent of all programs in the specialty for board pass rate; and,

2) The program must have a board pass rate below 80 percent.

That means that if there are 100 programs in a specialty, approximately five programs could receive that citation, but only if their individual board pass rate for graduates is below 80 percent.

The board pass rate for first-time takers will count those who pass in the numerator and those who are taking the exam for the first time in the denominator. Residency graduates who do not take the exam, or those who are taking it for the second time or more, do not count in the denominator. A resident who delays taking the examination will be counted in the year that the resident takes the exam.

The board pass rate for each program is reported to the ACGME directly from the American Board of Medical Specialties member board and the American Osteopathic Association board in the specialty. No names or other individual identifiers are reported to the ACGME.

If board pass rates are an area of concern for a program, programs are strongly encouraged to provide the Review Committee an update on their efforts to improve this metric in the Major Changes section of the Accreditation Data System (ADS) during the ADS Annual update. Below are some strategies programs can use to investigate and address concerns related to board pass rates:

1) The program may evaluate its didactic curriculum to identify weaknesses and make efforts to improve.

2) The annual in-training examination results can be helpful in identifying content area(s) where residents did not perform well. In addition, the in-training examination helps identify those residents who are underperforming in comparison to their peers.

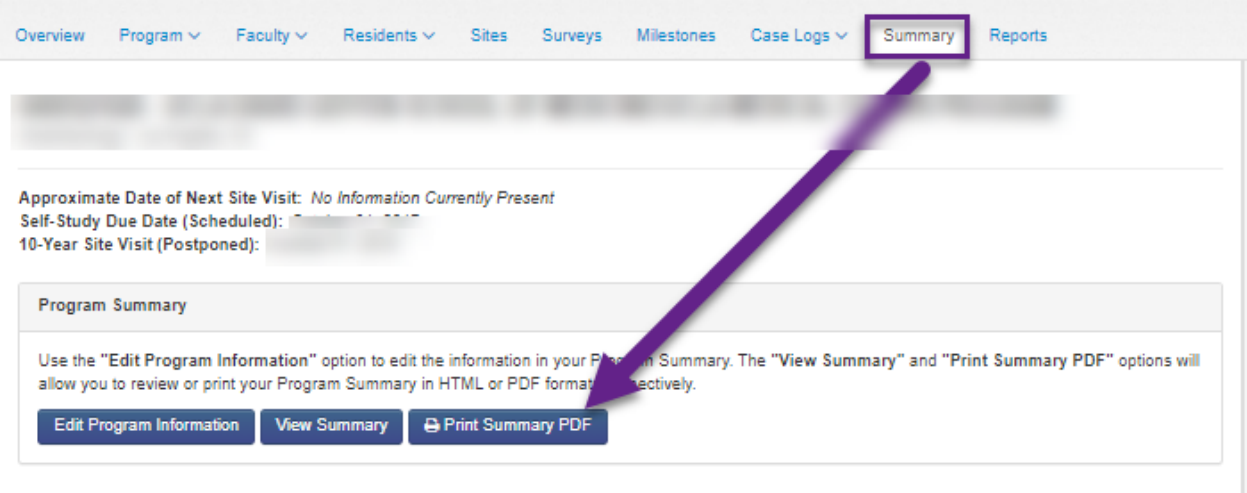
3) A structured certifying board examination review can be implemented, addressing content specifications of the specialty board.

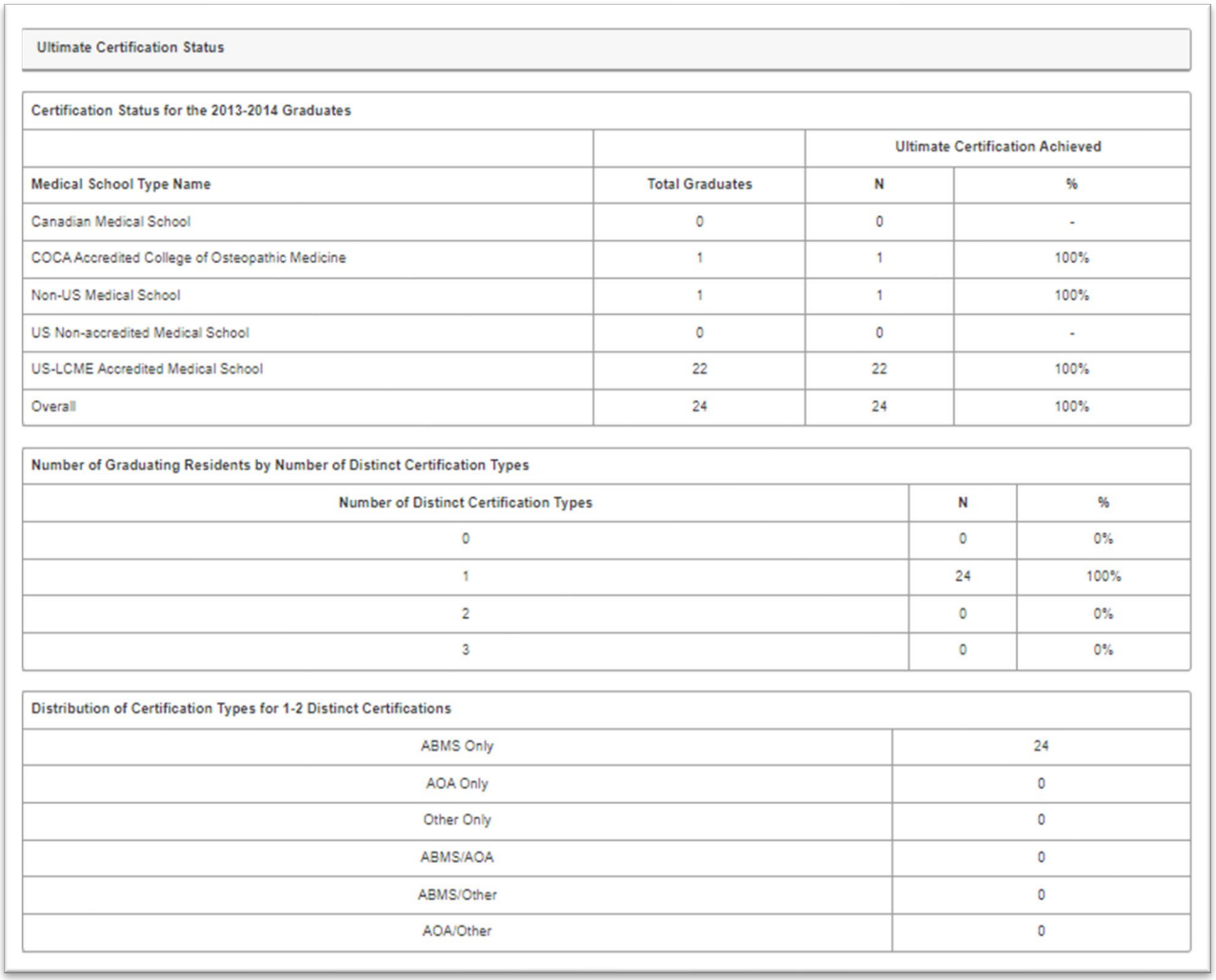
4) Some residents may benefit from a more structured plan outlined in an individualized learning plan (see Requirement V.A.1.d).(2)).

5) It is important for the Program Evaluation Committee to review board certification data annually and in-training examination performance as part of the Annual Program Review, to determine whether program changes are needed. These might include changes in the didactic curriculum and the establishment of conferences to address curricular weaknesses.

Per Requirement V.C.3.f), the ultimate board pass rate of a program's graduates is an important program outcome in addition to the rolling average first-time pass rate noted in V.C.3.a)-e). Neither should be considered in isolation. Note that most American Board of Medical Specialties boards allow up to seven years for a candidate to achieve board certification.

While the most recent three-year rolling average board pass rate may best reflect the preparation of the most recent graduates, the ultimate certification rates likely reflect the ultimate goal of the program to produce graduates who can practice independently and achieve board certification. This requirement is intended to allow the ACGME to gather data on this outcome and determine its best use. The Program Evaluation Committee may also find this information valuable in assessing the program aims and goals. Below is a screenshot of the summary of resident board certification.





Ultimate Certification Status

Certification Status for the 2013-2014 Graduates

		Ultimate Certification Achieved	
Medical School Type Name	Total Graduates	N	%
Canadian Medical School	0	0	-
COCA Accredited College of Osteopathic Medicine	1	1	100%
Non-US Medical School	1	1	100%
US Non-accredited Medical School	0	0	-
US-LCME Accredited Medical School	22	22	100%
Overall	24	24	100%

Number of Graduating Residents by Number of Distinct Certification Types

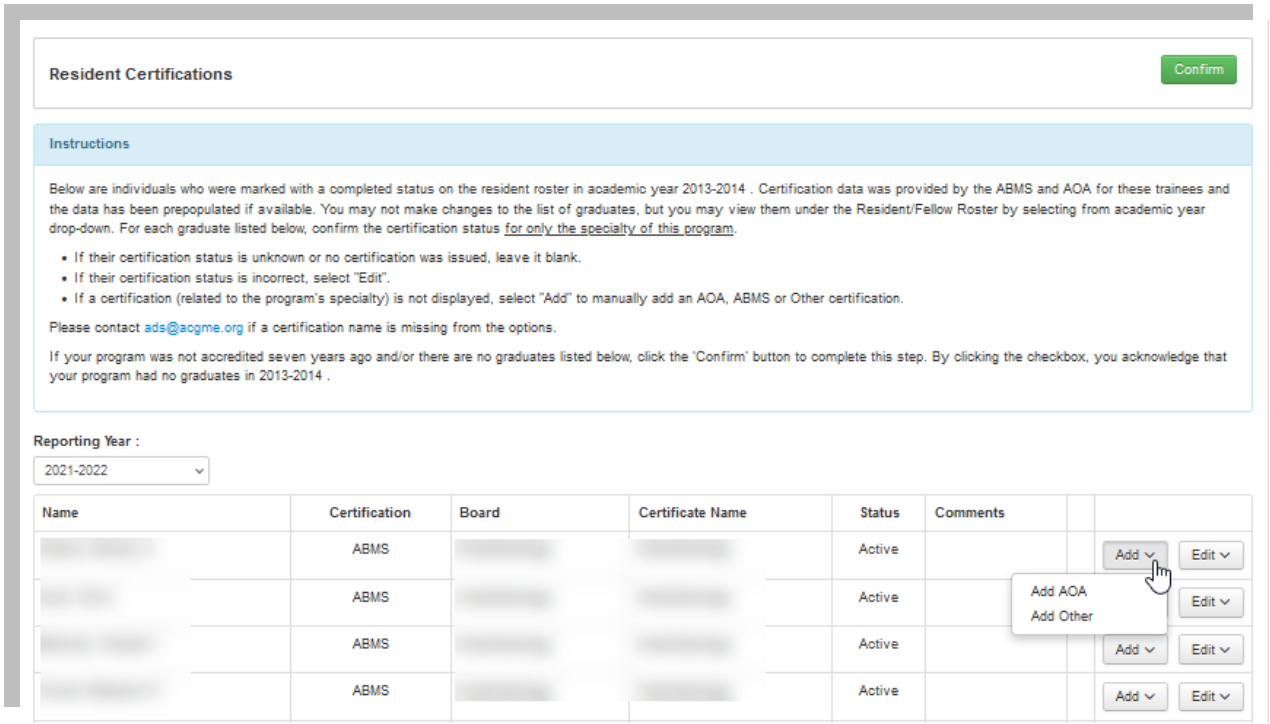
Number of Distinct Certification Types	N	%
0	0	0%
1	24	100%
2	0	0%
3	0	0%

Distribution of Certification Types for 1-2 Distinct Certifications

ABMS Only	24
AOA Only	0
Other Only	0
ABMS/AOA	0
ABMS/Other	0
AOA/Other	0

The requirement does not specify a minimum for the ultimate certification rate, and programs will not currently be cited based on the requirement unless they fail to confirm the data provided by the ABMS and AOA and populated in ADS for their residents/fellows on a yearly basis. Programs cannot edit the graduate list, but they can edit the certification if incorrect, add a certification if it is not displayed, or confirm that the program was not accredited or there were no graduates for the specific reporting year. Data for the current reporting year can be edited as part of the Annual ADS Update or through the end of the academic year. Once the rollover to a new academic year occurs, the graduate data will be “View Only” and no edits can be made.

Accreditation Data System (ADS) Screenshot: Below is a screenshot of the resident board certification data that is imported from the ABMS and AOA and which programs must verify during the ADS Annual Update.


Resident Certifications
Confirm
Instructions
Below are individuals who were marked with a completed status on the resident roster in academic year 2013-2014 . Certification data was provided by the ABMS and AOA for these trainees and the data has been prepopulated if available. You may not make changes to the list of graduates, but you may view them under the Resident/Fellow Roster by selecting from academic year drop-down. For each graduate listed below, confirm the certification status for only the specialty of this program.
If their certification status is unknown or no certification was issued, leave it blank.
If their certification status is incorrect, select "Edit".
If a certification (related to the program's specialty) is not displayed, select "Add" to manually add an AOA, ABMS or Other certification.
Please contact ads@acgme.org if a certification name is missing from the options.
If your program was not accredited seven years ago and/or there are no graduates listed below, click the 'Confirm' button to complete this step. By clicking the checkbox, you acknowledge that your program had no graduates in 2013-2014 .
Reporting Year :
2021-2022
Name
Certification
Board
Certificate Name
Status
Comments
ABMS
Active
Add
Edit
Add AOA
Add Other

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by residents Today*
- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*
- *Excellence in professionalism through faculty modeling of:*
  - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
  - *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

*VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

*VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

[The Review Committee may further specify]

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

*VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

*VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

*VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

*VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

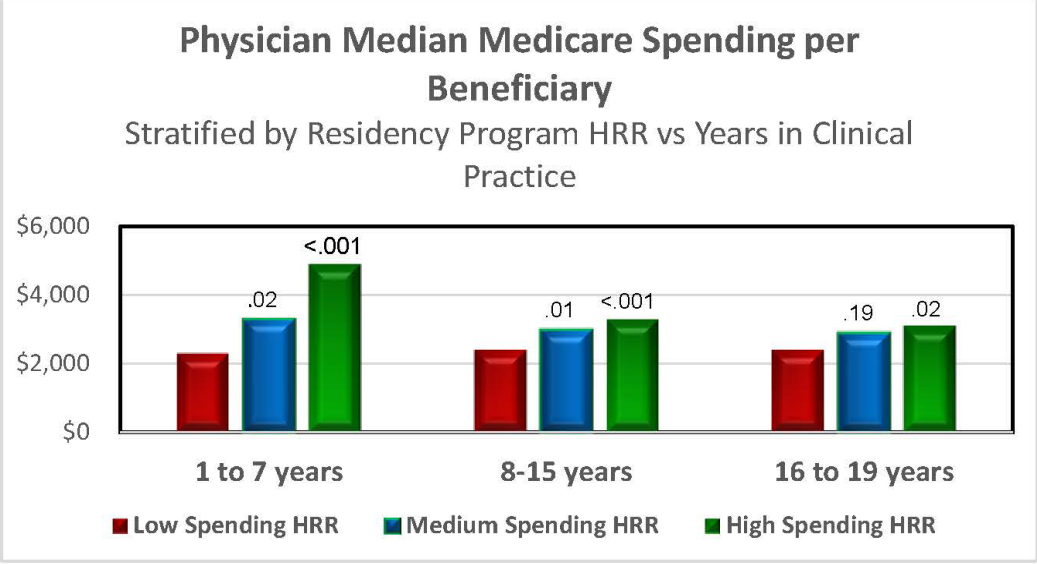
*VI.A.1.a).(4).(b)	Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

GUIDANCE

Why is it so important to teach residents and fellows safe patient care and quality improvement? There are a number of studies (see below for examples) that show that what residents and fellows learn during their education and training stays with them and affects their practice for many years to come. Consider that the 32-year-old resident today has the potential to be practicing beyond 2054.

1. **Asch, David A. 2009. "Evaluating Obstetrical Residency Programs Using Patient Outcomes."** ***JAMA*** **302(12): 1277. https://doi.org/10.1001/jama.2009.1356.**
   Asch et al studied 4,906,169 deliveries by 4,124 physicians from 107 US obstetrics and gynecology residency programs. The programs were ranked based on FLEX, NBME Parts I, II, III, and USMLE Steps 1, 2, 3 scores. The study found that women treated by obstetricians in the bottom quintile of programs had one-third higher complication rates than those from the top quintile, and that the effect was durable through 15-17 years after residency.

2. **Chen, Candice, Stephen Petterson, Robert Phillips, Andrew Bazemore, and Fitzhugh Mullan. 2014. "Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries."** ***JAMA*** **312(22): 2385. https://doi.org/10.1001/jama.2014.15973.**
   Chen et al. evaluated spending patterns in regions of residency education and training and graduates' subsequent expenditures in practice based on multilevel, multivariable analysis of 2011 Medicare claims data from family medicine and internal medicine residents completing residency between 1992 and 2010. The Hospital Referral Regions (HRR) were classified based on expenditures as low-, average-, and high-spending. The study determined that the spending levels during residency were associated with the same pattern of expenditures for subsequent care graduates provided.



3. **Sirovich, Brenda E., Rebecca S. Lipner, Mary Johnston, and Eric S. Holmboe. 2014. "The Association between Residency Training and Internists' Ability to Practice**

Conservatively." *JAMA Internal Medicine* 174(10): 1640. https://doi.org/10.1001/jamainternmed.2014.3337.
Sirovich et al. evaluated the association between residency education and training and internists' ability to practice conservatively following graduation, assessing the responses of 6,639 first-time takers of the American Board of Internal Medicine certifying exam (357 programs). They divided the management options according to Appropriately Conservative Management (ACM) and Appropriately Aggressive Management (AAM) subscales. They defined the correct response as the least or most aggressive management strategy, and found that regardless of overall medical knowledge, internists trained in HRRs (Hospital Referral Regions) with lower-intensity medical practice were more likely to recognize when conservative management was appropriate and, more importantly, were capable of choosing an aggressive approach when indicated.

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1. Chan, David K., Thomas H. Gallagher, Richard Reznick, and Wendy Levinson. 2005. "How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients." Surgery 138(5): 851–58. https://doi.org/10.1016/j.surg.2005.04.015.

2. Gallagher, Thomas H. 2003. "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors." JAMA 289(8): 1001. https://doi.org/10.1001/jama.289.8.1001.

3. Gallagher, Thomas H., Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. 2006. "Choosing Your Words Carefully." Archives of Internal Medicine 166(15): 1585. https://doi.org/10.1001/archinte.166.15.1585.

4. Kessler, David A. 1993. "Introducing MEDWatch. A New Approach to Reporting Medication and Device Adverse Effects and Product Problems." JAMA 269(21): 2765–68. https://doi.org/10.1001/jama.1993.03500210065033.

5. Leape, Lucian L. 2002. "Reporting of Adverse Events." *New England Journal of Medicine* 347(20): 1633–38. https://doi.org/10.1056/nejmnejmhpr011493.

6. Nebeker, Jonathan R., Paul Barach, and Matthew H. Samore. 2004. "Clarifying Adverse Drug Events: A Clinician's Guide to Terminology, Documentation, and Reporting." *Annals of Internal Medicine* 140(10): 795. https://doi.org/10.7326/0003-4819-140-10-200405180-00009.

7. White, Andrew A., Thomas H. Gallagher, Melissa J. Krauss, Jane Garbutt, Amy D. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, Wendy Levinson, and Eric B. Larson. 2008. "The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients." *Academic Medicine* 83(3): 250–56. https://doi.org/10.1097/acm.0b013e3181636e96.

CLER Findings for Graduate Medical Education in Patient Safety

The ACGME established the Clinical Learning Environment Review (CLER) Program to provide formative assessment and feedback to participating sites of ACGME-accredited Sponsoring

Institutions. CLER findings and other information contained in CLER national reports are not linked to ACGME program requirements but may provide useful insights for programs. Actions taken in response to CLER findings should not be interpreted as fulfilling requirements.

Findings of CLER site visits for creating an environment for safe patient care and quality improvement are summarized in Issue Brief No. 2 (2016), which can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

Findings described in CLER Issue Brief No. 2:

> The ultimate goal of GME [graduate medical education] is to provide residents and fellows with the experiences that they need to deliver the safest and highest quality patient care and the opportunities to become well-versed enough in the science and practice of patient safety to lead improvements in patient care throughout their professional career.
>
> In order to achieve this, they need to be able to identify risks to their patients, understand how to prioritize and mitigate those risks in a sustainable way, and know how to lead and role model these skills when they transition to independent practice. Medicine and health care delivery is continually evolving. It is therefore imperative to provide residents and fellows with lifelong skills to recognize system vulnerabilities, and to develop and implement strategies to mitigate these vulnerabilities, so that they are well prepared to meet the challenges of a continually changing health care environment throughout their careers.
>
> The CLER Program findings demonstrate that education about patient safety has been introduced into GME. To date, much of the education has focused on didactic activities with much emphasis on online learning. There are many opportunities for Clinical Learning Environments (CLEs) to provide resident and fellow physicians with experiential learning, such as how to conduct patient safety event inquiries and translate the findings into systems-based improvements that result in better patient care.
>
> The findings also suggest that resident and fellow physicians are beginning to engage in their CLEs' processes for reporting patient safety events. CLEs have an opportunity to build upon this engagement by increasing resident and fellow involvement in the processes of investigating events and providing feedback that results in creating and implementing plans to improve care. Lastly, it is important to note that resident and fellow physicians look to their mentors and other members of the health care team to model systems-based patient safety behaviors and lead the way in ongoing efforts to improve patient safety.

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

*VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

*VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

*VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

*VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

[The Review Committee may further specify under any requirement in VI.A.1.b)-VI.A.1.b).(3).(a).(i)]

GUIDANCE

Why is it so important to teach residents and fellows safe patient care and quality improvement? There are a number of studies (see below for examples) that show that what residents and fellows learn during their education and training stays with them and affects their practice for many years to come. Consider that the 32-year-old resident today has the potential to be practicing beyond 2054.

1. **Asch, David A. 2009. "Evaluating Obstetrical Residency Programs Using Patient Outcomes."** ***JAMA*** **302(12)2009: 1277.** https://doi.org/10.1001/jama.2009.1356.
   Asch et al studied 4,906,169 deliveries by 4,124 physicians from 107 US obstetrics and gynecology residency programs. The programs were ranked based on FLEX, NBME Parts I, II, III, and USMLE Steps 1, 2, 3 scores. The study found that women treated by obstetricians in the bottom quintile of programs had one third higher complication rates than those from the top quintile, and that the effect was durable through 15-17 years after residency.

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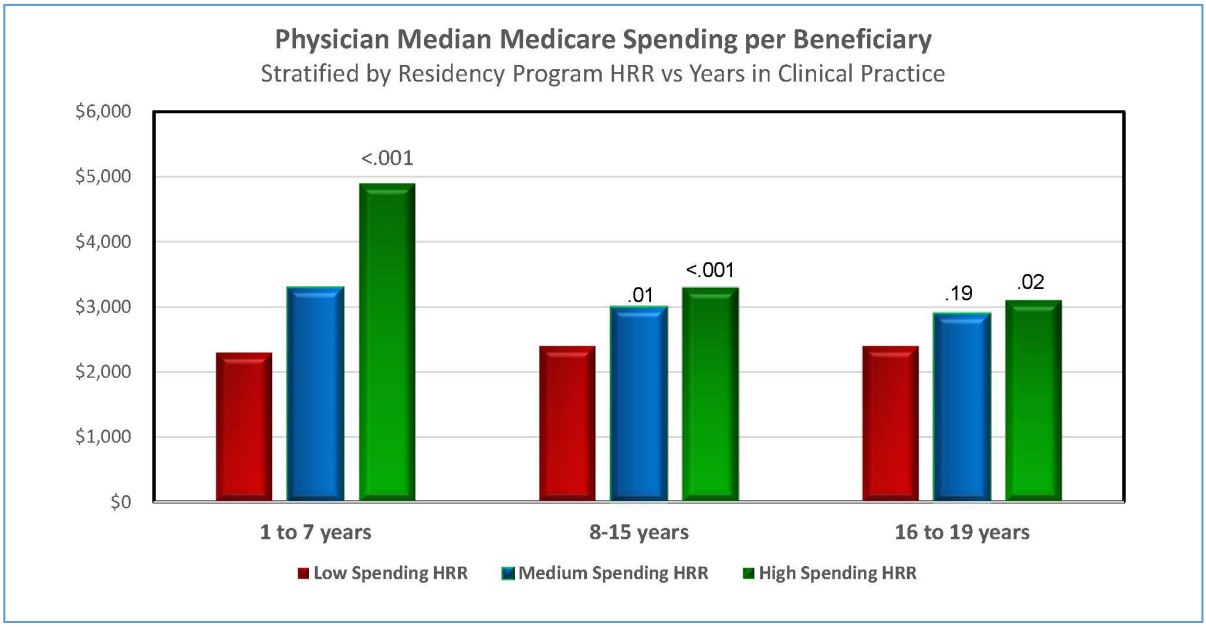


CLER Findings for Graduate Medical Education in Health Care Quality

The ACGME established the Clinical Learning Environment Review (CLER) Program to provide formative assessment and feedback to participating sites of ACGME-accredited Sponsoring Institutions. CLER findings and other information contained in CLER national reports are not linked to ACGME program requirements but may provide useful insights for programs. Actions taken in response to CLER findings should not be interpreted as fulfilling requirements.

Findings of CLER site visits for creating an environment for safe patient care and quality improvement are summarized in CLER Issue Brief No. 3 (2016), which can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents.

Findings described in CLER Issue Brief No. 3:

> If residents and fellows are to learn to improve the health of the populations they serve, they need to be aware of quality goals, such as those set by regulators, payers, and others outside the [clinical learning environment] CLE (e.g., use of universal protocol, reducing central line associated blood stream infections, catheter-associated urinary tract infections, or potentially avoidable 30-day readmissions). They should also learn to critically evaluate their CLE's own processes of patient care and how those affect patient outcomes.
>
> Didactic approaches are helpful but insufficient, and data from the CLER site visits suggest that residents' and fellows' exposure to QI [quality improvement] is often fragmented. Learners rarely have the opportunity to work through the full scope of an improvement effort. Instead, they may plan an intervention they never get to test, or implement a change with limited knowledge of the background evidence and no

opportunity for follow-up evaluation. Experiential training in all phases of QI is necessary to develop the skills essential to improving health care quality.

QI is both a *systems-based and team-oriented activity*. Well-trained residents and fellows need to learn how to work with an interprofessional team to achieve sustained improvements in health care quality. Most resident-led projects, while expedient for meeting minimum educational standards, are limited in scope and can only expose the learners to some of the most basic elements of QI. Interprofessional, team-based quality improvement efforts, especially those that align with CLE priorities, provide residents and fellows with experiential learning that goes beyond basic QI methods to include developing skills and behaviors in shared leadership, communications, systems-based thinking, change management, and professionalism.

In order to optimize residents' and fellows' exposure to QI, at least some portion of their QI experience should address the populations for which they provide direct patient care. This requires timely, easy access to performance data at the level of their own patients so there is personal connection to the care processes and outcomes they are targeting for improvement. Residents and fellows also need access to support for data analysis. When this support is provided in a coordinated manner, the resulting information benefits both the resident, patients, and the CLE.

Optimal QI strategies should include formal, reliable, and regular structural links between the efforts generated by residents, fellows, and faculty members and the CLE's staff-led efforts to improve care. Coordinating resident and fellow QI efforts with those of the organization would benefit patients, tap into a rich resource of innovation, and provide the foundation for life-long QI success.

When CLEs *set expectations and actively work with faculty members* so that they become knowledgeable, skilled, and enthusiastically engaged in the CLE's QI efforts, it reinforces for residents and fellows the importance of QI to both their training and their future careers in patient care. While the CLER site visits focused principally on the residents and fellows, they need to learn from exemplary behaviors modeled by the faculty members who serve as their mentors."

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.A.2. Supervision and Accountability

VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

Background and Intent: *A*ppropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.b).(2) The program must define when physical presence of a supervising physician is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) Direct Supervision:

the supervising physician is physically present with the resident during the key portions of the patient interaction; or, (Core)

[The Review Committee may further specify]

VI.A.2.c).(1).(a).(i) PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). (Core)

[The Review Committee may describe the condition under which PGY-1 residents progress to be supervised indirectly]

VI.A.2.c).(1).(b) the supervising physician and/or patient is not physically present with the resident and the supervising physician is

concurrently monitoring the patient care through appropriate telecommunication technology. (Core)

[The Review Committee may further specify]

[The Review Committee may choose not to permit VI.A.2.c).(1).(b)]

VI.A.2.c).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

GUIDANCE

The requirements in VI.A.2. are closely linked with Requirement IV.A.3., which addresses resident responsibilities and graded supervision.

The responsibilities and supervision of the residents must be clearly delineated. As stated in VI.A.2.a).(1).(a)-(b), each resident must have an identifiable and appropriately credentialed and privileged attending physician who is responsible and accountable for a patient's care. This and the contact information for the attending physician must be made available to residents, faculty members, and other members of the health care team.

As stated in VI.A.2.b).(1), the program must demonstrate that the level of supervision in place for each resident is based on the individual resident's level of education and ability, as well as patient complexity and acuity. Progressive authority and conditional independence are a privilege and must be assigned by the program director and faculty members. The Clinical Competency Committee (CCC) is key in helping the program director assign progressive authority based on criteria established by the program and through Milestones assessments. In addition, during each rotation, supervising faculty members can help assess the skills of each resident.

The Common Program Requirements underscore the philosophy behind the different levels of supervision:

> *VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

Distinct levels of supervision include Direct, Indirect, and Oversight (see VI.A.2.c)). While supervision is critical to a resident's professional development, there is also such a thing as "over-supervision," which occurs when more advanced residents, though deemed capable, are not allowed to make independent decisions and provide autonomous care. This is detrimental to the development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine.

An additional dimension to supervision is continuity in faculty assignments. Because of multiple constraints, faculty members are increasingly adopting shorter assignments. One-week faculty rotations are common, with some even taking assignments that last only two or three days. Such brief supervision assignments provide insufficient time for faculty members to get to know

residents to determine their knowledge and skills, and therefore should be avoided, if possible. There is evidence that short faculty supervision assignments are detrimental to patient care:

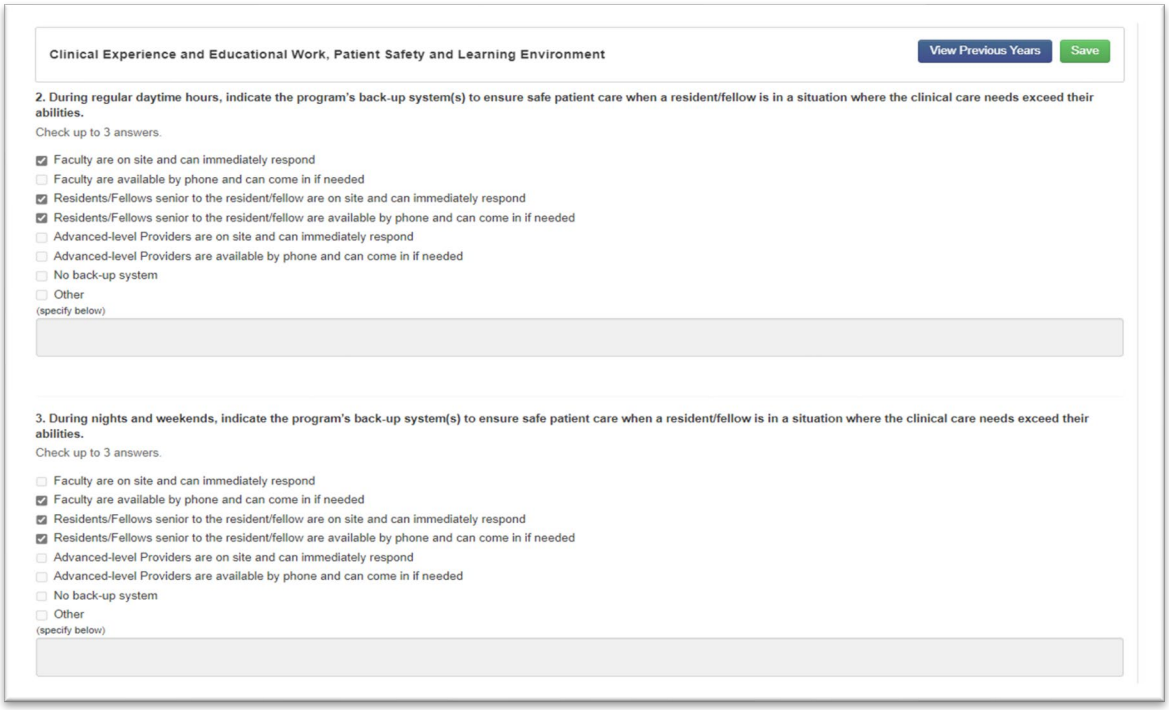
> **Bernabeo, Elizabeth C., Matthew C. Holtman, Shiphra Ginsburg, Julie R. Rosenbaum, and Eric S. Holmboe. 2011. "Lost in Transition: The Experience and Impact of Frequent Changes in the Inpatient Learning Environment."** ***Academic Medicine*** **86(5): 591–98. https://doi.org/10.1097/acm.0b013e318212c2c9.**

There is an added complexity to the requirements for supervision — the increasing use of telemedicine. There are many models of telemedicine, including tele-stroke, tele-psychiatry, tele-dermatology, and tele-ophthalmology. Telemedicine has also been used for decades in specialties like radiology and emergency medicine. The use of telemedicine is increasingly adopted by institutions because of added patient satisfaction, ability to provide care and follow-up in remote areas, significant cost reduction, and in response to pandemic conditions, as was seen during the COVID-19 pandemic.

The ACGME monitors compliance with the requirements in section VI.A.2. in various ways, including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys; and,
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

ADS Screenshots: ADS questions regarding back-up systems for applications and programs at all accreditation statuses



The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section VI.A.2. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

CLER Findings for Graduate Medical Education in Supervision

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Findings of the ACGME's Clinical Learning Environment Review (CLER) Program regarding supervision are reported in CLER Issue Brief No. 6 (2016), which can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

[The Review Committee may further specify]

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

GUIDANCE

Other Professionalism Resources:

1. II.A.4.a).(1) The program director must be a role model of professionalism
2. IV.A.5. Educational Program – Professionalism
3. IV.B. and IV.B.1. Competencies – Professionalism
4. Milestones section of the ACGME website: Milestones (acgme.org)
   There are many aspects of professionalism. The assessment of professionalism is included in every set of specialty or subspecialty Milestones.
5. Refining the Milestones for Assessment of Professionalism Skills

Professionalism is at the core of being a physician, yet teaching it is difficult. In addition to elements described in Section IV of the Common Program Requirements regarding the educational program and the Competencies, professionalism as detailed in Section VI addresses other components.

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

These "professional responsibilities" include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. Patient care responsibilities provide residents and fellows experiential learning opportunities that cannot be replicated in other settings.

The perennial argument questions at what point patient care responsibilities interfere with learning because residents are required to fulfill non-physician obligations. As described in the Background and Intent section for this requirement, "routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff members. Examples of such obligations include transport of stable patients from the wards or units for routine procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education."

VI.B.2.c) [The learning objectives of the program must:] ensure manageable patient care responsibilities.

"Manageable patient care responsibilities" are not defined in the Common Program Requirements. This varies by specialty, and more importantly, by PGY level. For specific requirements pertaining to patient number caps and other patient care responsibilities, refer to the specialty-specific Program Requirements, which can be accessed from the applicable specialty section of the ACGME website: https://www.acgme.org/specialties.

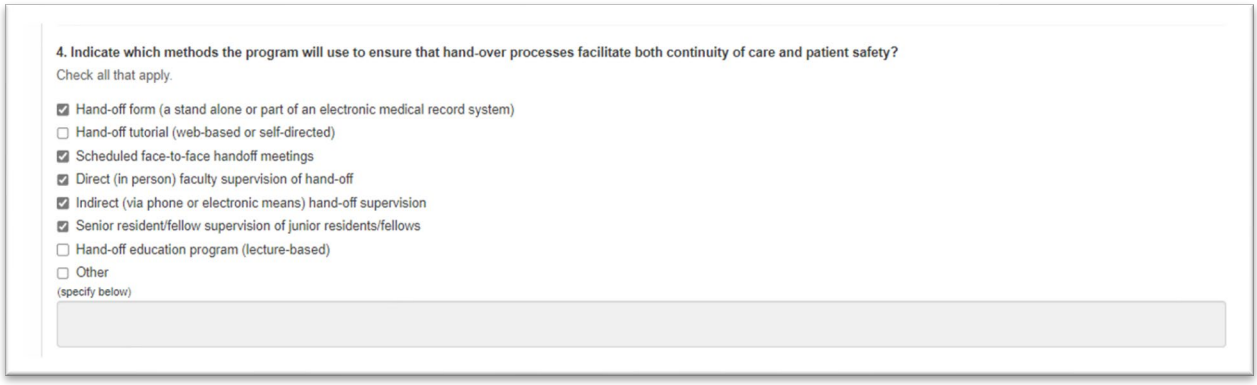
VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.

This requirement is closely linked to IV.B. and IV.B.1.(a).(1).(a)-(g) Competencies Professionalism

Professionalism includes an understanding of one's *personal* role in the management of patients as relates to the safety and welfare of patients entrusted to the physician's care. This encompasses the ability to report unsafe conditions and adverse events. Physicians must also take responsibility to ensure they are fit for work. This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about other residents' or faculty members' fitness for work, depending on the situation, and in accordance with institutional policies. This includes:

- Management of time before, during, and after clinical assignments
- Recognition of impairment (illness, fatigue, substance use) in themselves, their peers, and other members of the health care team
- Commitment to lifelong learning
- Monitoring patient care performance
- Accurate reporting of clinical and educational work hours (formerly referred to as duty hours), patient outcomes, and clinical experience data

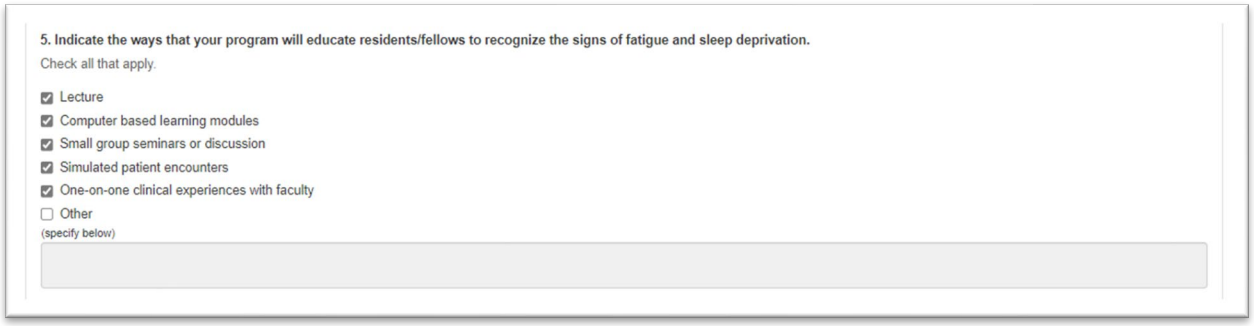
Accreditation Data System (ADS) Screenshots: ADS Common Program Requirements Questions. Some of the questions only apply to applications while others apply to programs at all accreditation statuses:

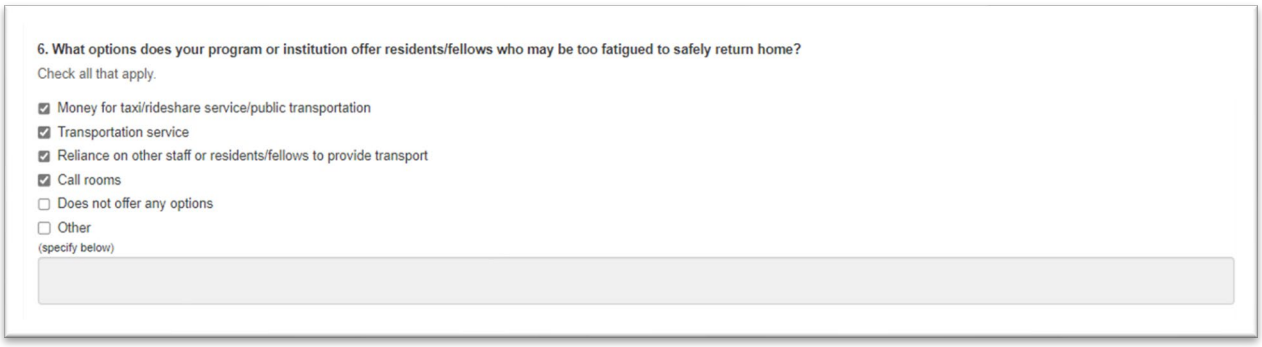

4. Indicate which methods the program will use to ensure that hand-over processes facilitate both continuity of care and patient safety?

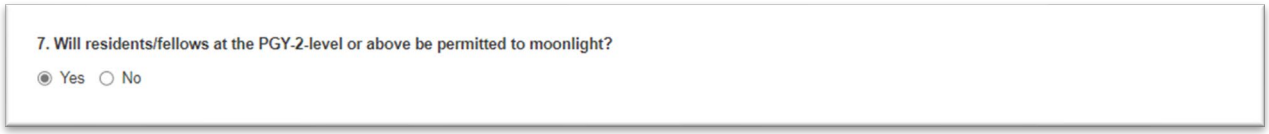
Check all that apply.

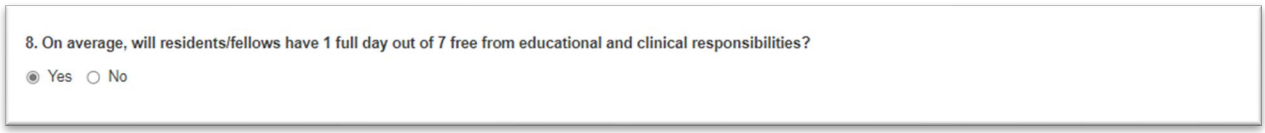
- [x] Hand-off form (a stand alone or part of an electronic medical record system)
- [ ] Hand-off tutorial (web-based or self-directed)
- [x] Scheduled face-to-face handoff meetings
- [x] Direct (in person) faculty supervision of hand-off
- [x] Indirect (via phone or electronic means) hand-off supervision
- [x] Senior resident/fellow supervision of junior residents/fellows
- [ ] Hand-off education program (lecture-based)
- [ ] Other

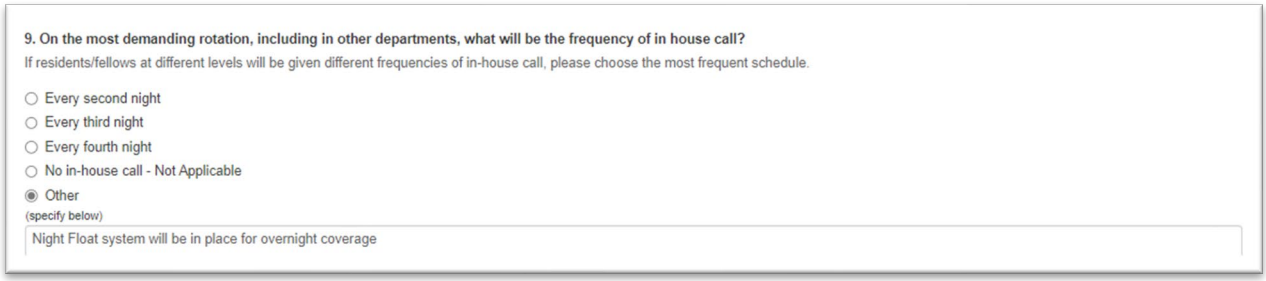
(specify below)

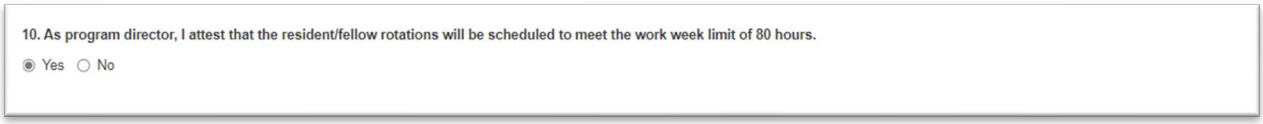












VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

The requirement for “responsiveness to patient needs that supersedes self-interest” may be misinterpreted as referring to continuing to provide patient care in the face of illness and fatigue, with the sense that one “just has to keep going.” This is not, however, in the best interest of the patient. Fatigue and illness can contribute to medical and procedural errors. Residents should be aware that when they are ill or fatigued, it would be best to transition patient care responsibilities to another qualified and rested provider.

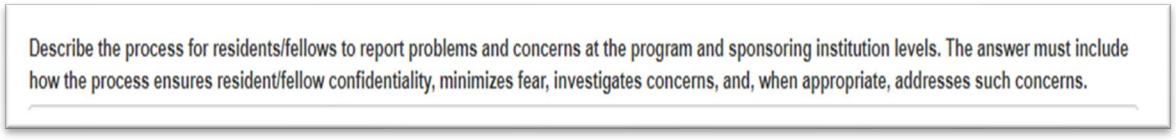
VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty members, and staff members.

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

A professional, equitable, respectful, and civil environment that's free from discrimination, sexual and other forms of abuse, racism, mistreatment, or coercion of students, residents, faculty members, and staff members is a comprehensive way of expressing the idea that inclusiveness and belonging are essential to fostering an effective learning environment for all. Professionalism refers to the way in which individuals are handled in a professional manner within and outside the learning environment. This implies that the standards, practices, and motivations of the profession are used to fulfill the social contract between medicine and society. It further implies that elements of evaluation are evidence-based and fairly administered and includes the ability to recognize and not penalize differences as lack of professionalism while taking into consideration that professionalism should not be centered on identities of privilege and power. Professionalism demands that honesty, integrity, and accountability of the individuals and the organization are foundational to the process. An equitable environment refers to ensuring that resources are provided according to need in the learning environment and that all individuals are treated in a fair manner. Respectful means that individuals in the learning environment are all encouraged to treat one another with dignity and humility such that the supposition of dominant cultural norms is exchanged for sensitivity, listening, acceptance, welcoming, and fostering a sense of belonging. Civility refers to a wide range of behaviors, from emotional to physical, and should employ courtesy and politeness between individuals who share the learning environment.

The ACGME recently clarified that the naming of offenses including mistreatment, abuse, harassment including sexual harassment, and coercion is based on the principle that even a single resident who is the victim of these behaviors has standing to complain about violations of this requirement and can lead to an investigation.

ADS Screenshot: ADS Common Program Requirement question for applications and the ADS Annual Update for programs at initial accreditation:



CLER Findings for Graduate Medical Education in Professionalism

The ACGME established the Clinical Learning Environment Review (CLER) Program to provide formative assessment and feedback to participating sites of ACGME-accredited Sponsoring Institutions. CLER findings and other information contained in CLER national reports are not linked to ACGME program requirements but may provide useful insights for programs. Actions taken in response to CLER findings should not be interpreted as fulfilling requirements.

Findings of CLER site visits on professionalism are reported in Issue Brief No. 8 (2016), which can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance use disorders. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available on the Physician Well-being section of the ACGME website http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being.

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be

displaying signs of burnout, depression, substance use disorder, suicidal ideation, or potential for violence; (Core)

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.
The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

GUIDANCE

Tools and resources for institutions and programs to support physician well-being are located at: https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/Resources/

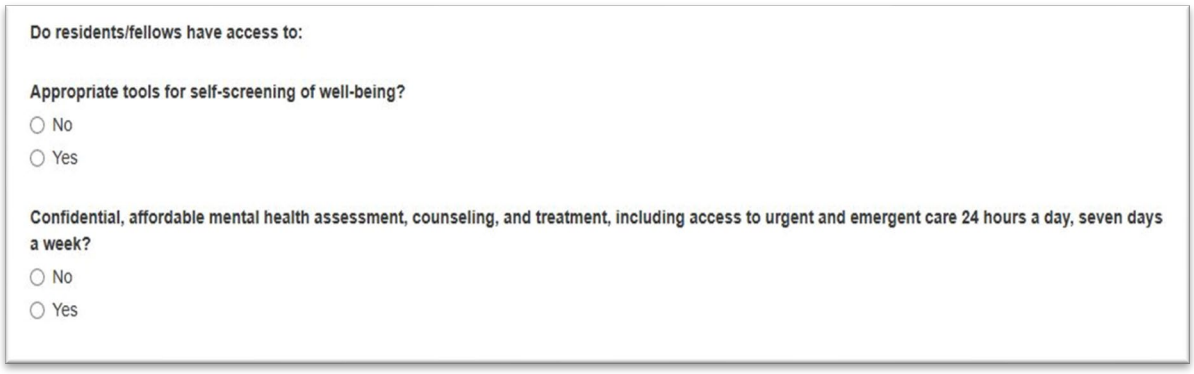
Topics include:

- Tools and resources
- Identifying and addressing burnout
- Promoting well-being
- Assessing and addressing emotional and psychological distress/ depression/suicide
- Improving the learning and working environment
- Coping with tragedy
- Other institutional/partner sites and resources

The ACGME monitors compliance with the requirements in section VI.C. in various ways, including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys;
- Questions Field Representatives ask during site visits of the program at various stages of accreditation; and,
- Documentation provided as part of an application or during Initial Accreditation.

ADS Screenshots: ADS Annual Update Common Program Requirements Questions



The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section VI.C. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, (Core)

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

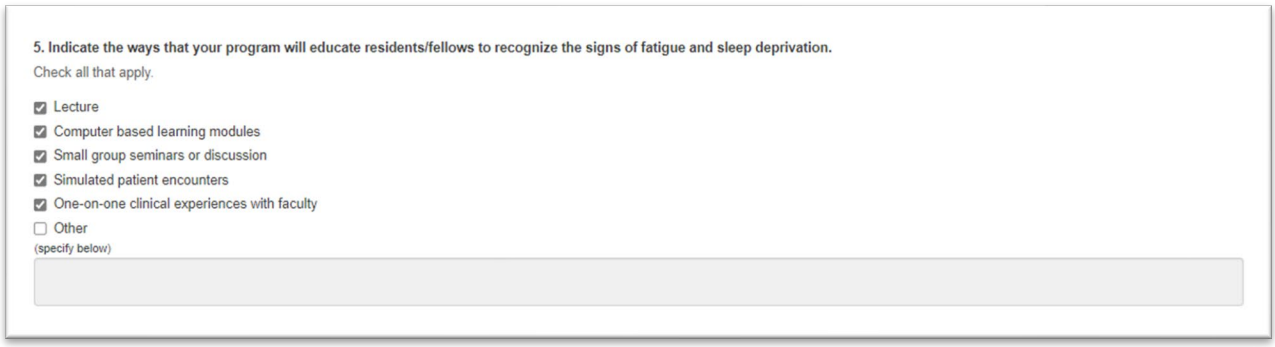
VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

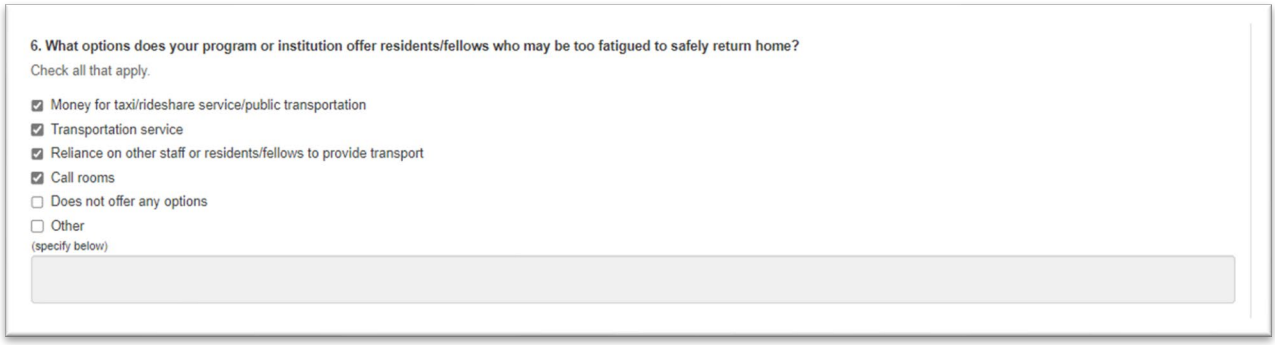
GUIDANCE

The ACGME monitors compliance with the requirements in section VI.D. in various ways, including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys; and,
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

ADS Screenshots: ADS questions related to fatigue mitigation





The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section VI.D. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

CLER Findings for Graduate Medical Education in Fatigue Management, Mitigation and Duty Hours

The ACGME established the Clinical Learning Environment Review (CLER) Program to provide formative assessment and feedback to participating sites of ACGME-accredited Sponsoring Institutions. CLER findings and other information contained in CLER national reports are not

linked to ACGME program requirements but may provide useful insights for programs. Actions taken in response to CLER findings should not be interpreted as fulfilling requirements.

Findings of CLER site visits relating to fatigue management, mitigation, and clinical work and education hours are summarized in CLER Issue Brief No. 7 (2017), which can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

Findings described in CLER Issue Brief No. 7:

> Most clinical learning environments have met their responsibilities to follow work hour requirements and implemented the basic strategies required for ACGME accreditation. Nevertheless, residents, fellows, faculty members, and nurses still report instances of resident and fellow fatigue. Fatigued providers can place patients at risk for medical errors, and also jeopardize their own health (e.g., car accidents, burnout). Fatigue management is about both patient safety and practitioner well-being. Moreover, "fatigue" can also be a precursor to burnout or a marker for depression. Clinical learning environments should be encouraged to train residents, fellows, faculty members, and other clinical staff members to consider such factors—and not only work hours—in determining a provider's "fitness for duty".
>
> For meaningful change to occur and be sustained, clinical learning environments must promote a culture that focuses on prevention, early detection, and meaningful mitigation of fatigue. A healthy culture promotes a positive response when a person acknowledges being fatigued—encouraging the person to engage back-up systems. Similarly, a supportive culture celebrates asking for help when fatigued as a sign of good clinical judgment and strength rather than of weakness. A well-functioning system would include a low threshold for residents and fellows to report fatigue and easy mechanisms to invoke a back-up system to support or relieve them of their clinical activities until rested. To overcome widespread resident and fellow reluctance to using these solutions, they must be viewed as both accessible and non-punitive—protecting both the fatigued individual and other team members who may need to assume additional clinical responsibilities until the fatigued individual is rested.
>
> These findings demonstrate there are substantive opportunities to improve patient safety if clinical learning environments engage their frontline clinical providers, including the GME [graduate medical education] community, in re-envisioning how to more effectively prevent and manage fatigue and its impact on patient safety in their health care environments.

Resources:

1. Fatigue mitigation: https://sites.duke.edu/thelifecurriculum/2014/05/08/the-life-curriculum/
2. Well-being: https://gmewellness.upmc.com/?_ga=2.214765521.794333632.1657210383-1973063117.1654787161

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

[Optimal clinical workload may be further specified by each Review Committee]

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

[The Review Committee may further specify]

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the

event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

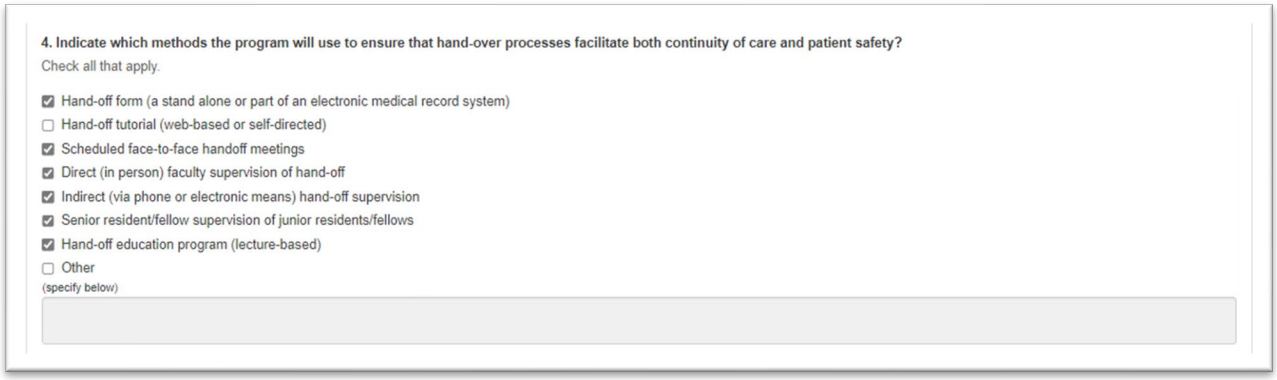
GUIDANCE

The emphasis in Section VI.E. of the Common Program Requirements, Clinical Responsibilities, Teamwork, and Transitions of Care, is on team-based care and transitions of care.

The ACGME monitors compliance with the requirements in section VI.E. in various ways, including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys; and,
- Questions Accreditation Field Representatives ask during site visits of the program at various stages of accreditation.

ADS Screenshot: ADS Annual Update question regarding hand-off for applications and programs with Initial Accreditation.



The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section VI.E. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

CLER Findings for Graduate Medical Education in Care Transitions

The ACGME established the Clinical Learning Environment Review (CLER) Program to provide formative assessment and feedback to participating sites of ACGME-accredited Sponsoring Institutions. CLER findings and other information contained in CLER national reports are not linked to ACGME program requirements but may provide useful insights for programs. Actions taken in response to CLER findings should not be interpreted as fulfilling requirements.

CLER Issue Brief No. 5 (2016) addresses care transitions, and can be found on the Resources and Documents page of the CLER section of the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

As with all of the CLER Issue Briefs, this section is preceded by a narrative. In this instance, a chief resident expresses frustration over a nursing home transfer of a critically ill patient with an acute abdomen about whose very complicated prior medical and surgical history she had absolutely no information. This lack of knowledge by the receiving physician posed significant risks to the care of the patient. This narrative highlights the risks of communication failure when patients are transferred from one service to another, or from one institution to another.

Findings described in CLER Issue Brief No. 5:

> From the findings, it appears that residents and fellows are very often key implementers of policies and procedures that relate to improving the discharge process. However, the findings also suggest that residents and fellows are not frequently asked to be involved in the strategic planning, development, and design of these policies and procedures. CLEs [clinical learning environments] would benefit from including residents and fellows in strategic planning around transitions of care. When the resident and fellow role in such strategies is limited to implementing changes designed by others, they lose the opportunity to gain experience in developing systems-based approaches to quality improvement.
>
> Resident and fellow hand-offs of patient care responsibilities is an essential skill—similar to the skills needed to perform a critical clinical procedure. As such, residents and fellows should be formally educated in the skills of care transitions and routinely evaluated for the purpose of continual improvement.
>
> Simulation can be an important tool for improving care transitions and can likely be achieved using low cost programs that can be conducted in the service units, rather than requiring the resources of a high-fidelity laboratory facility. Many CLEs indicated that they have implemented formal programs to improve communication in one or more of their service areas as a way to improve communication among various members of the health care team and enhance the quality of care transitions.
>
> To increase the validity and reliability of care transitions, faculty members also need clear guidance as to what is expected during a transfer. As with residents and fellows, lack of standardization will impair faculty member ability to model the correct approach to such transitions or evaluate and mentor residents' performance in this area. Often faculty members quickly transfer responsibility for teaching and monitoring care transitions to senior residents, while not realizing that senior residents can vary widely in how and what they teach according to what has been modeled to them by their attending physicians.

Moreover, patient hand-offs are an important communication skill that transcends any individual training program. With increasing reliance on electronic communication, CLEs would benefit from greater diligence in assuring that residents and fellows develop the verbal and electronic communication skills that ensure effective hand-offs. Resident and fellow hand-offs should be supervised and evaluated by faculty members in a fashion similar to evaluation of other clinical care and communication competencies. By calling attention to the importance of effective hand-offs, such supervision could promote better care transitions throughout the CLE.

The following is a list of elements that should be common to all hand-offs, as noted in CLER Issue Brief No. 5:

1. The creation of “to-do” lists
2. The use of “if-then” statements
3. The ability and expectation for the receiver of information to ask questions
4. “Read-back” at the end of a patient hand-off
5. Setting of expectations for when it is essential to move the hand-off to the patient’s bedside

Joint Commission Guidance

In a Sentinel Event Alert regarding inadequate hand-off communication, The Joint Commission lists the following critical elements of a hand-off:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness of admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs

Additional Resources

Inadequate hand-offs can result in a real potential for patient harm, from minor to severe.

There are numerous efforts across specialties, institutions, and regulatory organizations to improve hand-offs. The following links provide examples and information related to hand-offs:

1. The American College of Obstetricians and Gynecologists provided a committee opinion on communication strategies for patient hand-offs:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/communication-strategies-for-patient-handoffs

2. Agency for Healthcare Research and Quality: https://psnet.ahrq.gov/primers/primer/9/Handoffs-and-Signouts

3. Standardization of Inpatient Handoff Communication – from the American Academy of Pediatrics Committee on Hospital Care https://pediatrics.aappublications.org/content/138/5/e20162681

There are also many studies related to hand-offs. Below are a few references:

Abraham, Joanna, Thomas G. Kannampallil, and Vimla L. Patel. 2008. "Bridging Gaps in Handoffs: A Continuity of Care Based Approach." *Journal of Surgical Education* 65(6): 476-485. https://pubmed.ncbi.nlm.nih.gov/22094355/.

Cohen, Michael D., Brian Hilligoss, and André Kajdacsy-Balla Amaral. 2011. "A Handoff Is Not a Telegram: an Understanding of the Patient Is Co-Constructed." *Critical Care* 16(1): 303. https://doi.org/10.1186/cc10536.

Solet, Darrell J., J. Michael Norvell, Gale H. Rutan, and Richard M. Frankel. 2005. "Lost in Translation: Challenges and Opportunities in Physician-to-Physician Communication During Patient Handoffs." *Academic Medicine* 80(12): 1094–99. https://doi.org/10.1097/00001888-200512000-00005.

Wohlauer, Max V., Vineet M. Arora, Leora I. Horwitz, Ellen J. Bass, Sean E. Mahar, and Ingrid Philibert. 2012. "The Patient Handoff." *Academic Medicine* 87(4): 411–18. https://doi.org/10.1097/acm.0b013e318248e766.

COMMON PROGRAM REQUIREMENTS

VI. The Learning and Working Environment

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work

periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process.

Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents
PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.
The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of

the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-

hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

[The Review Committee may further specify under any requirement in VI.F. – VI.F.8.b)]

Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

GUIDANCE

Section VI.F. of the Common Program Requirements addresses clinical experience and education. As the Background and Intent box clarifies, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty” in response to concerns that use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

In a letter (Nasca, Thomas J, Philibert, Ingrid. 2008. “Resident Duty-Hour Limits.” *Health Affairs*. 27(5):1484. https://www.healthaffairs.org/doi/10.1377/hlthaff.27.5.1484) regarding resident duty hour limits, ACGME President and Chief Executive Officer Dr. Thomas J. Nasca stated that “the goal is not creating a better way to ‘watch the clock,’ but rather, ensuring that conditions conducive to resident learning, socialization to the medical profession, and safe and effective patient care consistently occur. This is what ACGME aims to achieve in its efforts to refine the standards and accreditation approach related to duty hours in the coming months.”

The ACGME monitors compliance with the requirements in section VI.F. in various ways including:

- Questions program leadership must answer as part of an application or during the Accreditation Data System (ADS) Annual Update;
- Questions residents and faculty members answer as part of the annual Resident/Fellow and Faculty Surveys; and,
- Questions Field Representatives ask during site visits of the program at various stages of accreditation.

The Resident/Fellow and Faculty Surveys include several questions that address the requirements in section VI.F. The following crosswalk documents provide additional information for programs on the key areas addressed by the survey questions and how they map to the ACGME Common Program Requirements:

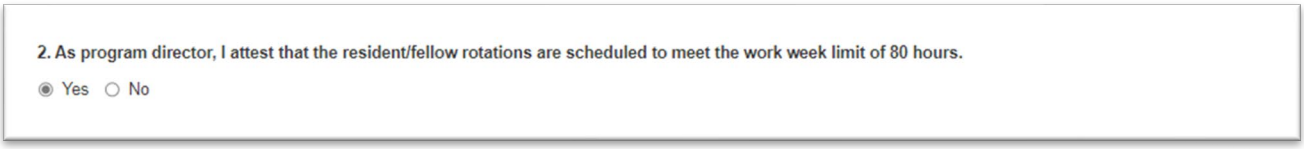
- Resident/Fellow Survey-Common Program Requirements Crosswalk
- Faculty Survey-Common Program Requirements Crosswalk

In addition to the guidance included here, the Common Program Requirements FAQs address multiple questions from the graduate medical education community related to section VI.F.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

The language in the requirements bears repeating: *Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period*, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

ADS Screenshot: As part of the ADS Annual Update, the program director must attest that resident rotation schedules meet the 80-hour work week requirement.



Programs that regularly schedule residents to work 80 hours per week and still permit them to remain beyond their scheduled work period will undoubtedly exceed the 80-hour maximum, which would mean they are not in substantial compliance with the requirement.

The ACGME Review Committees strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs are subject to citation and are at risk for an adverse accreditation action.

In a letter to the community on January 9, 2019, Dr. Nasca emphasized the need to meet this requirement:

"As we start off the New Year, this letter is a reminder of the importance of creating a clinical learning environment that focuses on a culture of patient safety in residency and fellowship programs year round. An important component of creating that environment is compliance with the Maximum Hours of Clinical and Educational Work per Week requirement (Common Program Requirement VI.F.1.) that went into effect in July 2017. This ACGME Common Program Requirement states that 'Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)'"

Some studies indicate that working more than 80 hours per week has adverse effects:

1. **Ouyang, David, Jonathan H. Chen, Gomathi Krishnan, Jason Hom, Ronald Witteles, and Jeffrey Chi. 2016. "Patient Outcomes When Housestaff Exceed 80 Hours per Week."** ***The American Journal of Medicine*** **129(9). https://doi.org/10.1016/j.amjmed.2016.03.023.**
   David Ouyang and his colleagues conducted a retrospective cohort study to determine whether residents/fellows working more than 80 hours per week had an impact on patient care in an inpatient general medicine service. Of the 4,767 hospitalizations reviewed, 41 percent were cared for by residents/fellows who worked more than 80 hours per week. These patients had a significantly higher length of stay, and a higher rate of intensive care unit transfer. There was no association between hours worked with in-hospital mortality or 30-day readmission rates.

2. **Desai, Sanjay V., David A. Asch, Lisa M. Bellini, Krisda H. Chaiyachati, Manqing Liu, Alice L. Sternberg, James Tonascia, et al. 2018. "Education Outcomes in a Duty-Hour Flexibility Trial in Internal Medicine."** ***New England Journal of Medicine*** **378(16): 1494–1508. https://doi.org/10.1056/nejmoa1800965.)**
   Desai and colleagues conducted a study of 63 internal medicine programs to determine if there were differences between residents who adhered to the 2011 ACGME duty hour policies compared to those who worked under more flexible policies that had no limits on shift length or mandatory time off between shifts. It is interesting to note that the PGY-1 residents in the flexible hours programs were less satisfied with their educational experience

(includes educational quality and overall well-being), but their program directors were more satisfied with overall educational quality, including having time for bedside teaching.

VI.F.2. Mandatory Time Free of Clinical Work and Education
While it is expected that resident schedules will be structured to ensure residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time or return to the clinical site during this time-off period to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and educational work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

The requirements in this category are self-explanatory.

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods.

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.F. 3. Maximum Clinical Work and Education Period Length
VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

VI.F.4. Clinical and Educational Work Hour Exceptions
These exceptions are intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described in VI.F.4.a).(1)-(3). It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient;

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or,

VI.F.4.a).(3) to attend unique educational events.

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit.

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.

The provision for exceptions for up to 88 hours per week specifies that exceptions may be granted for particular rotations if the program can justify the increase based on criteria specified by the Review Committee. Currently, the only Review Committee that allows exceptions to the 80-hour weekly limit is the Review Committee for Neurological Surgery. The underlying philosophy for this requirement is that while it is expected that all residents should be able to learn and train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. Designated institutional official/Graduate Medical Education Committee approval is required before the request will be considered by the Review Committee.

VI.F.8. At-Home Call

There are a number of requirements related to at-home call:

- Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum.
- It is not subject to the every-third-night limitation, but must meet the requirement for one day in seven off.
- It must not be so frequent that it precludes rest or reasonable personal time.
- Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

One of the most common misconceptions regarding this requirement is that residents are required to record every single minute they spend on at-home call answering phone calls and providing documentation. This is not the expectation. However, program directors must ensure that at-home call time is reasonable.