



PROGRAM DIRECTOR GUIDE TO THE COMMON PROGRAM REQUIREMENTS

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Accreditation Overview

Residency programs must demonstrate substantial compliance with requirements established by the Review Committee for the specialty to be accredited. There are 27 Review Committees, each with specialty-specific program requirements, but all contain a subset of common program requirements (CPR) that all programs, regardless of specialty, must meet. The recently revised CPR reflect the transition from a process-oriented resident education to one of outcomes. While requirements for resources and process remain, their number and scope have been reduced, and specific competency-based requirements have been integrated.

As part of the accreditation process, program information is collected from a variety of sources including: program-specific information provided by the program director in the Program Information Form (PIF); resident survey question responses; and information collected by field staff (site visitors) as part of the site visit. The PIF contains questions related to the CPR and questions related to specialty-specific requirements. The Common Program Information Form (PIF) effective July 1, 2007 is closely aligned with the revised CPR so that program directors can more easily plan for documenting program compliance with the requirements.

During a site visit, ACGME Field Staff or Specialist Site Visitors interview the program director, faculty, residents/fellows, clinical department leadership, the designated institutional official (DIO) and other relevant individuals, tailoring questions to the individuals interviewed. The goal is to verify the information in the PIF and to clarify any missing or unclear information by seeking to achieve consensus across all participants and other sources of information. On occasions when a consensus cannot be achieved at the end of the site visit, the Site Visitor reports the different comments and the sources of the information. Site Visitors aggregate their findings into an objective, factual report that describes the program's compliance with the Program Requirements.

This *Program Director Guide to the Common Program Requirements* includes explanations of the intent of most common requirements (with a specific focus on those related to competency-based requirements), suggestions for implementing requirements, and bulleted guidelines for the types of expected documentation. Currently, the explanations and expected documentation in this Guide relate only to the CPR. Program directors should consult their specialty program requirements and PIF for additional information. These may be incorporated into future versions of this Guide.

To enhance usability, the Guide has been organized to follow the numbering of the CPR, with explanations and documentation information separately accessible through hyperlinks via the table of contents. Additional hyperlinks to relevant documents, such as the ACGME Policy and Procedures Manual, Institutional Requirements, ACGME Glossary of Terms and Common Acronyms, and FAQs are also included.

Selected resources available on the ACGME website that might be especially useful for new program directors have been collected together as part of the Guide and are listed below.

How does the accreditation process work?

- Overview:
http://www.acgme.org/acWebsite/newsRoom/newsRm_factSheet.asp
- Details (see ACGME Policies and Procedures, section II.B):
http://www.acgme.org/acWebsite/about/ab_ACGMEPoliciesProcedures.pdf

What types of documentation are used for accreditation decisions?

- PIF/ADS questions:
ADS Logon: <https://www.acgme.org/ads/default.asp>
- Case Log information:
<http://www.acgme.org/residentdatacollection/documentation/information.asp>
- Documents:
All programs: [Documents to make available to the site visitor](#)
Documents to attach (see Program-specific Information Form on each Review Committee website):
http://www.acgme.org/acWebsite/navPages/nav_comRRC.asp
Minimum content in current residents' files for site visitor review (see pp. 2-3, ACGM(E)-Bulletin, August 2008):
http://www.acgme.org/acWebsite/bulletin-e/ACG_10_E-Bulletin_Aug08_F.pdf
- Resident Survey questions:
About: http://www.acgme.org/acWebsite/resident_survey/res_index.asp
Survey FAQ: http://www.acgme.org/acWebsite/resident_survey/res_FAQ.asp
- Site Visitor interviews:
Role of Site Visitor in accreditation:
http://www.acgme.org/acWebsite/fieldStaff/fs_siteRole.asp
Site Visit FAQ: http://www.acgme.org/acWebsite/fieldStaff/fs_faq.asp

What is included in the Letter of Notification for Continued Accreditation?

- Key to Standard Letter of Notification for Continued Accreditation:
<http://www.acgme.org/acWebsite/utility/KeyStandard.pdf>

The Guide is intended to clarify the meaning and expectations of the CPR. Review Committee executive directors, Review Committee chairs and members, field staff, and program directors provided review and input. It will be regularly revised based on user feedback and revised as requirements change. Please email comments and suggestions to: Guide@acgme.org.

Accreditation Overview

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Links to additional useful resources:

- [ACGME Glossary of Terms and Common Acronyms in GME](#)
- [ACGME Manual of Policies and Procedures](#)
- [Institutional Requirements](#)
- [Common Program Requirements](#)

DISCLAIMER

This *Program Director Guide to the CPR* is prepared by ACGME staff. It is a **guide**. It does not supplant the Common, Program and Institutional Requirements or the Manual of Policies and Procedures, which are approved by Review Committees and the ACGME Board of Directors, and which are far more specific, complex and comprehensive than this guide.

This guide is intended to be consistent with all Common, Program and Institutional Requirements, as well as the Manual of Policies and Procedures. Insofar as there may be any actual or perceived inconsistencies, the Common, Program and Institutional requirements and the Manual of Policies and Procedures will control.

Insofar as this guide may mention a type of verification of facts on site visit (e.g., interview of residents), it is not intended to limit the mode or source of verification on site visit or otherwise.

I. Institutions

A. Sponsoring Institution

Common Program Requirement:

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

Explanation:

Since requirements in this section are for institutions, not programs, verification by members of the ACGME field staff (site visitors) takes place at the time of each program review primarily via interviews with the Designated Institutional Official (DIO). Although program directors should be knowledgeable of these requirements, they are not responsible for providing the documentation noted in this section. Requirements cover four areas: **institutional information**, **internal review**, **physical/clinical facilities**, and **accreditation for patient care**. (See [Institutional Requirements](#) [IR].)

Institutional information: An accredited residency program must operate under the authority and control of a single sponsoring institution, and that institution must document its commitment to provide the necessary educational, financial, and human resources to support GME. (See IR I.A. and IR I.B.) Master affiliation agreements are legal documents between the institution that sponsors the program(s) and Review Committee-approved participating sites to which the residents rotate for required educational experiences. They must be renewed every five years and must exist between the sponsoring institution and all major participating sites. (See IR I.C.) Master affiliation agreements are typically handled through the DIO's office and are typically prepared with legal counsel. Program directors need to know that master affiliation agreements exist with participating sites for required assignments, but they do not usually prepare these agreements themselves unless the program director is also the DIO (i.e., these are agreements between institutions, not between a program and an institution).

The review of institutions that are **single-program sponsoring institutions** (sponsors only one ACGME-accredited specialty program or one ACGME-accredited specialty program and its subspecialty program(s)) is carried out as part of the review of the specialty program by the relevant Review Committee.

Internal review: The internal review is a formal mid-cycle review conducted at the institutional level by the Graduate Medical Education Committee (GMEC) and does not substitute for the annual self evaluation that each program is required to conduct (see CPR V.C). The GMEC-sponsored internal review group must include at least one faculty member and at least one resident from within the sponsoring institution but not

I. Institutions

A. Sponsoring Institution

from within the GME program being reviewed. Additional internal or external reviewers may be included, as well as administrators from outside the program. (See IR IV.A for additional information on what is assessed and the types of data used in the review process.) The Internal review report (findings and conclusions) is not shown to the site visitor at any time during a program review. Site visitors need information about the date of the internal review, composition of the review panel, individuals interviewed, materials reviewed, and when the internal review report was reviewed by the GMEC.

Internal review reports are reviewed by site visitors only during an institutional accreditation site visit. The reports should not be included with the PIF or provided or shown to the site visitor during a program site visit. When the site visitor reviews one or more programs and their sponsoring institution during the same week, the DIO is asked to omit from the institutional review materials sent to the site visitor the internal review report(s) for any program(s) being reviewed during the same week.

Physical/clinical facilities: Institutions must provide services that help to assure that residents do not perform work extraneous to achieving educational goals and objectives. These include patient support services, such as peripheral IV access placement, phlebotomy, laboratory/pathology/radiology services, messenger and transport services, and medical records systems. Institutions must also provide resources that ensure a healthy and safe work environment for residents. These include: access to food 24 hours a day; call rooms that are safe, quiet, and private; security and safety measures including parking facilities, on-call quarters, hospital and institutional grounds, etc. (See IR II.F.) Institutions must also provide both faculty and residents ready access to adequate communication resources and technology support, ready access to specialty/subspecialty-specific and other appropriate reference material in print or electronic format, including electronic medical literature databases with search capabilities. (See IR I.B.6-7.)

Patient care: Sponsoring institutions should be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or should be recognized by another entity with reasonably equivalent standards as determined by the Institutional Review Committee. (See IR I.D.)

I. Institutions

A. Sponsoring Institution

- **Documentation for a single program sponsoring institution:** The review of institutions that sponsor only one ACGME-accredited specialty program or one ACGME-accredited specialty program and its subspecialty program(s) is carried out as part of the review of the specialty program by the relevant Residency Review Committee. At the time the program site visit within a single program sponsoring institution, copies of major affiliation agreements should be available for site visitor review. These agreements are not reviewed as part of program site visits of a multiple program sponsoring institution.

Five institutional questions in the PIF (ADS) must be answered by programs in single program sponsoring institutions. These questions will appear only for such programs and will not be visible to other programs not included in this category. The site visitor will verify matters of institutional commitment, support, and oversight and also review master affiliation agreements. Programs within a single program sponsoring institution are subject to citations related to the institution if the Review Committee finds that the program response does not demonstrate substantial compliance.

- **Documentation of the internal review:** Site visitors will look for evidence that the internal review occurred approximately at the mid-point between the last and the current review, the review group included a resident/fellow and a representative from administration, the review included interviews with program faculty and residents/fellows, and the GMEC reviewed the report and monitored appropriate follow-up. This information can be provided by the program director or DIO through a cover sheet of the actual internal review report, through copies of the GMEC meeting agendas, or through a single page summary that contains the relevant information. The report itself is not reviewed by the site visitor.
- **Documentation for physical/clinical facilities:** That physical and clinical facilities are adequate will be verified during the site visit through resident interviews. Site visitors may also tour facilities if there were prior citations relating to these areas, if concerns are raised during the site visit, or if the Review Committee has specialty-specific requirements for the program's patient care or educational facilities. There may be specialty-specific requirements for resources. (See CPR II.D.)
- **Documentation for patient care:** Site visitors may note accreditation status with JCAHO (or other recognized entity) via database information and may clarify and verify information during the DIO interview by review of accreditation letter.

I. Institutions
B. Participating Sites

Common Program Requirement:

1. *There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.
The PLA should:*
 - a) *identify the faculty who will assume both educational and supervisory responsibilities for residents;*
 - b) *specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;*
 - c) *specify the duration and content of the educational experience; and,*
 - d) *state the policies and procedures that will govern resident education during the assignment.*
2. *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 Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS)*

Explanation:

Program directors are responsible for Program Letters of Agreement (PLAs) although the DIO may oversee this process in some institutions. **Such agreements are not required for sites used only for elective assignments or for sites that are under the governance of the sponsoring institution.** Some Residency Review Committees have additional requirements related to PLAs. Check specialty requirements for more details.

The primary purposes of PLAs are to ensure an appropriate educational experience and to protect residents from undue service requirements that do not enrich their education. Unlike affiliation agreements, PLAs are intended to be short, less formal documents. The PLA can be a simple letter or memo, signed by the program director and the official at the participating site who is responsible for supervising and overseeing resident education at that location, e.g., the local site director or the medical director, which contains four items of information:

- The faculty (by name or general group) who teach and supervise residents;
- The responsibilities for teaching, supervising and formal evaluation of residents;
- The duration and content of the educational experience (this does not need to be a curriculum document; it can be a descriptive paragraph that identifies the goal(s) and learning outcomes for the assignment or a reference to a more thorough explanation in the resident handbook); and
- The policies and procedures governing the resident's education at this site. (This may be a statement that residents must abide by the policies of the site and those of the program and the GMEC.)

I. Institutions
B. Participating Sites

Additions or deletions of participating sites that provide an educational experience **required for all residents** of one month FTE (four weeks) or more must be submitted through the Accreditation Data System (ADS). Information to be entered in ADS for each participating site besides that in the PLA includes the distance (in miles) and time (in minutes) from the primary teaching site and whether the participating site is integrated (for those specialties that use that term). Changes in sites that provide **only elective experiences** are not required to be submitted through ADS but may be entered, especially if needed for the case log information system.

Additional information related to PLAs, including answers to specific questions and some sample PLAs, is available on the ACGME website:

http://www.acgme.org/acWebsite/about/ab_FAQAgreement09_26_06.pdf

- **Documentation for PLAs:** All current PLAs should be available for the site visitor; they should not be attached to the PIF; they should contain the four items listed above (B.1.a-d) as well as the required signatures and a date less than five years old. Agreements should be updated whenever there are changes in program director or site director, resident assignments, or revisions to the items specified in the CPR or the specialty requirements. **Note:** When completing the PIF section on participating sites, identify the sites that meet the criteria for not requiring a PLA by selecting the option: "PLA N/A as site is under the governance of sponsoring institution."

The ADS (PIF) table related to these requirements is shown below:

PARTICIPATING SITES

SPONSORING INSTITUTION: (The university, hospital, or foundation that has ultimate responsibility for this program.)	
Name of Sponsor:	
Address:	Single Program Sponsor? () YES () NO
City, State, Zip code:	
Type of Institution: (e.g., Teaching Hospital, General Hospital, Medical School)	
Name of Designated Institutional Official:	
Mailing Address:	Phone Number:
	Email:
Name of Chief Executive Officer:	
Does SPONSOR have an affiliation with a medical school (could be the sponsoring institution)? () YES () NO	
If yes, name the medical school below and have an affiliation agreement that describes the effect of these arrangements on this program available.	
Name of Medical School #1:	
Name of Medical School #2:	

I. Institutions
B. Participating Sites

PARTICIPATING SITE (Site #2)			
Name:			
Address:			
City, State, Zip Code:			
Integrated: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Does this site also sponsor its own program in this specialty?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does it participate in any other ACGME-accredited programs in this specialty?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Distance between #2 & #1: Miles:		Minutes:	
Type of Rotation (select one) <input type="checkbox"/> Elective <input type="checkbox"/> Required <input type="checkbox"/> Both			
Length of Resident/Fellow Rotations (in months)		Year 1:	Year 2:
		Year 3:	Year 4:
		Year 5:	Year 6:
CEO/Director/President's Name:			
Brief Educational Rationale:			

II. Program Personnel and Resources

A. Program Director

Common Program Requirement:

1. *There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.
[As further specified by the Review Committee]*
2. *The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.*
3. *Qualifications of the program director must include:*
 - a) *requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;*
 - b) *current certification in the specialty by the American Board of _____, or specialty qualifications that are judged to be acceptable by the Review Committee; and,*
 - c) *current medical licensure and appropriate medical staff appointment.
[As further specified by the Review Committee]*
4. *The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:*
 - a) *oversee and ensure the quality of didactic and clinical education in all institutions that participate in the program;*
 - b) *approve a local director at each participating institution who is accountable for resident education;*
 - c) *approve the selection of program faculty as appropriate;*
 - d) *evaluate program faculty and approve the continued participation of program faculty based on evaluation;*
 - e) *monitor resident supervision at all participating institutions;*
 - f) *prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;*
 - g) *provide each resident with documented semiannual evaluation of performance with feedback;*
 - h) *ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;*
 - i) *provide verification of residency education for all residents, including those who leave the program prior to completion;*
 - j) *implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:*
 - (1) *distribute these policies and procedures to the residents and faculty;*
 - (2) *monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements*

II. Program Personnel and Resources

A. Program Director

- (3) *adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,*
- (4) *if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.*
- k) *monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;*
- l) *comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents.*
- m) *be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;*
- n) *obtain review and approval of the sponsoring institution's GMCE/DIO before submitting to the ACGME information or requests for the following:*
 - (1) *all applications for ACGME accreditation of new programs;*
 - (2) *changes in resident complement;*
 - (3) *major changes in program structure or length of training;*
 - (4) *progress reports requested by the Review Committee;*
 - (5) *responses to all proposed adverse actions;*
 - (6) *requests for increases or any change to resident duty hours;*
 - (7) *voluntary withdrawals of ACGME-accredited programs;*
 - (8) *requests for appeal of an adverse action;*
 - (9) *appeal presentations to a Board of Appeal or the ACGME; and,*
 - (10) *proposals to ACGME for approval of innovative educational approaches.*
- o) *obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:*
 - (1) *program citations; and,*
 - (2) *request for changes in the program that would have significant impact, including financial, on the program or institution.*

[As further specified by the Review Committee]

Explanation:

The sponsoring institution's GMCE must approve a change in the program director, and then the program director must submit the change in the Accreditation Data System (ADS). Some specialties require RC approval before such changes are final. See specialty-specific program requirements.

II. Program Personnel and Resources

A. Program Director

The requirements call for continuity of program director leadership. The average length in years between program director appointment dates in the core specialties is 7.06 years (range 4.62 – 11.36).¹ Programs that have a history of frequent changes may trigger additional inquiry into the cause(s) in order to determine if the learning environment has been adversely affected. A single person (program director) must have authority for the operation of the program. **Qualifications** for program directors include: specialty expertise, educational and administrative experience, current medical licensure, appropriate medical staff appointment, and current certification in the specialty by ABMS. Some Review Committees will consider alternative specialty qualifications but approval should be obtained in advance of appointing such a program director.

The CPR contain a list of **Program Director responsibilities** (II.A.4.). This extensive list is intended not only to communicate the specific responsibilities of the position so that the individual will be effective as a program director, but also to communicate to the sponsoring institution (e.g., DIO, GMEC, department chair) the role and responsibilities of this position and why the program director needs sufficient protected time and financial support (CPR I.A) to fulfill these responsibilities. By assuring that each of the listed duties occurs on a regular basis, the program director will facilitate an enhanced learning environment. For example, the program director “must approve the selection of program faculty as appropriate.” Typically, the department chair will make such assignments, but program directors must have input into these decisions so that faculty with both clinical and teaching expertise are given responsibilities in the program.

The program director is responsible for implementing and ensuring compliance with policies and procedures for grievance and due process, duty hours, selection, evaluation and promotion of residents, disciplinary action and supervision of residents. See IR II.A-D. for minimum institutional requirements. Institutions and/or programs may have more extensive policies and procedures. These policies and procedures should be given to all residents and faculty in print format or made available on a residency program website to assure they are knowledgeable about these important issues.

A program handbook is not required but it is a convenient approach to collecting and updating all the information that must be made available to residents and faculty (policies and procedures, schedules, educational program goals, goals and objectives for each major assignment, and information on all required sites). Such a handbook could be either paper or electronic (located on a website, CD or other digital medium).

In addition, program directors should be familiar with and comply with policies and procedures as outlined in the [ACGME Manual of Policies and Procedures](#), available on the ACGME website. (See Section II, Accreditation Policies and Procedures.) When preparing for a site visit, program directors are cautioned to prepare the PIF document carefully to avoid inaccuracies, discrepancies and/or inconsistencies.

¹ Average Length in Years Between Program Director Appointment Dates (based on turnover since 2001), Department of Operations and Data Analysis, ACGME, 1/23/2007. This and a number of other reports can be accessed at the ACGME website under “[Search Programs/Sponsors](#).”

II. Program Personnel and Resources

A. Program Director

- **Documentation for program director qualifications:** This information will be documented through information provided in the PIF (entered through the Accreditation Data System – ADS). (See PIF questions below.) Verification that the program director has a current medical license and medical specialty certification occurs through the institutional credentialing process. Site visitors verify that the program director has an appropriate medical staff appointment.
- **Documentation for program director responsibilities:** Site visitors may spot check information that program directors must provide to residents and faculty and use interviews to verify that the program director organizes and oversees the educational activities in all sites and assures implementation of fair policies, grievance and due process procedures. Note the list of 10 items of information that need review and approval by the GMEC/DIO before submitting to the ACGME. (See CPR II.A.4.n.(1)-(10) above.) In addition, any document addressing program citations or program changes that would have significant impact (e.g., change in program director) must have DIO approval by signature.

The ADS (PIF) table related to these requirements is shown below.

Program Director Information

Name:							
Title:							
Address:							
City, State, Zip code:							
Telephone:		FAX:		Email:			
Date First Appointed as Program Director:							
Will Your Principal Activity Be Devoted to Resident Education?		<input type="checkbox"/> YES		<input type="checkbox"/> NO			
Term of Program Director Appointment:							
Date first appointed as faculty member in the program:							
Percentage of time the program director devotes to the program in the following activities:							
Clinical Supervision:		Administration:		Research:		Didactics/Teaching:	
Primary Specialty Board Certification:				Most Recent Year:			
Secondary Specialty Board Certification:				Most Recent Year:			
Number of years spent teaching in GME in this specialty:							

II. Program Personnel and Resources
A. Program Director

ADS (PIF) Questions:

Does the program director approve the selection of program faculty as appropriate?

Yes ____ No ____

Does the program director evaluate the faculty and approve the continued participation of program faculty based on evaluation?

Yes ____ No ____

Does the program director comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents?

Yes ____ No ____

Is the program director familiar with and does he/she comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures?

Yes ____ No ____

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Common Program Requirement:

B. Faculty

1. *At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.
The faculty must:*
 - a) *devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and*
 - b) *administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.*
2. *The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications acceptable to the Review Committee.
[As further specified by the Review Committee]*
3. *The physician faculty must possess current medical licensure and appropriate medical staff appointment.*
4. *The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.*
5. *The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.*
 - a) *The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.*
 - b) *Some members of the faculty should also demonstrate scholarship by one or more of the following:*
 - (1) *peer-reviewed funding;*
 - (2) *publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;*
 - (3) *publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
participation in national committees or educational organizations.*
 - c) *Faculty should encourage and support residents in scholarly activities.
[As further specified by the Review Committee]*

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

[As further specified by the Review Committee]

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Explanation:

Requirements for faculty include **qualifications** in the specialty, **time for and dedication to resident education** (including the competency areas), and **scholarship**.

Qualifications: Key physician faculty must have current certification in the specialty. Most Review Committees will not approve key physician faculty members who are not ABMS board certified and not eligible for certification. In the rare event that a program has such an individual, the program director should contact the Review Committee executive director for information on whether the Review Committee would consider approval and, if so, what information the Review Committee would need to determine if the individual is acceptable. In addition to information provided in the PIF, this would include a complete CV and letters of recommendation. Scholarship, training, teaching experience and national reputation are important factors for such decisions.

Dedication to resident education: Programs must demonstrate that the faculty are not only qualified in terms of credentials and experience, but are also active participants in teaching and mentoring residents. There should be sufficient depth and breadth within the faculty roster to assure that the curriculum can be implemented as planned. That is, the quality of faculty teaching and supervision and the total time per week that faculty devote to teaching and supervising is adequate both as documented in the PIF (where the role of each faculty - both physician and nonphysician - in the program must be described) and as perceived by residents. It should be evident that each participating site has a local director accountable for resident education, that residents are supervised at each site, and that there are adequate faculty resources for implementing the curriculum (teaching, evaluation, supervision, role modeling, and patient care).

Scholarship includes contributions of faculty to new knowledge, encouraging and supporting resident scholarship, and contributing to a culture of scholarly inquiry by active participation in organized clinical discussions, rounds, journal clubs and conferences. An expanded definition of scholarship recognizes not only the traditional scholarship of discovery (research as evidenced by grants and publications), but also the scholarship of integration (translational or cross-disciplinary initiatives that typically involve more risk and fewer recognized rewards), the scholarship of application (patient-oriented research that might include the systematic assessment of the effectiveness of different clinical techniques), and the scholarship of education (includes not only educational research but also creative teaching and teaching materials). Therefore, some members of the faculty should have one or more of the following:

- Peer-reviewed funding;
- Publication of original research or review articles in peer reviewed journals, or chapters in textbooks;
- Publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or
- Participation in national committees or educational organizations.

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Specialties may have additional requirements for the following items, delineated in the specialty/subspecialty-specific program requirements:

- Documentation requirements for changes in program director via ADS
 - Qualifications for program director
 - Program director responsibilities for administering and maintaining the program
 - Faculty qualifications
 - Expectations for faculty scholarship
 - Requirements for other program personnel
 - Specific resources for resident education
- **Documentation for faculty and other program personnel:** Data related to program personnel qualifications, role, etc. are entered into the Accreditation Data System (ADS). This information should be updated as needed. Information requested is shown in the tables below. Verification by site visitors may include review of PIF data, and interviews with faculty and residents as needed. Non-compliance related to faculty scholarship will be noted if the site visitor discerns a consensus view among residents that lack of scholarship is an issue and this consensus is corroborated by the lack of substantial evidence of faculty participation in rounds, conferences, journal clubs, grant-related activities, peer reviewed publications, presentations at national meetings, and little evidence of resident participation in scholarly activities.

The ADS (PIF) tables related to these requirements are shown below.

Physician Faculty Roster

[LANGUAGE APPROPRIATE TO SPECIALTY APPEARS HERE.]

Name (Position)	Degree	Based Primarily at Site #	Primary and Secondary Specialties / Field			Years as Faculty in Specialty	Average Hours Per Week Devoted to Resident Education
			Specialty / Field	Board Certification (Y/N)†	Most Recent Certification Date		
(PD)							

† Certification for the primary specialty refers to ABMS Board Certification. Certification for the secondary specialty refers to sub-Board certification. If the secondary specialty is a core ACGME specialty (e.g., Internal Medicine), certification refers to ABMS Board Certification.

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Faculty Curriculum Vitae - [LANGUAGE APPROPRIATE TO SPECIALTY APPEARS HERE.]

First Name:		MI:		Last Name:	
Present Position:					
Medical School Name:					
Degree Awarded:		Year Completed:			
Graduate Medical Education Program Name(s); include all residency and fellowships:					
Specialty/Field		Date From:		To:	

Certification and Re- Certification Information			Current Licensure Data	
Specialty	Certification Year	Re-Certification Year	State	Date of Expiration
Academic Appointments - List the past ten years, beginning with your current position.				
Start Date	End Date	Description of Position(s)		
	Present			

Concise Summary of Role in Program:
Current Professional Activities / Committees:
Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):
Selected Review Articles, Chapters and/or Textbooks (Limit of 10 in the last 5 years):
Participation in Local, Regional, and National Activities / Presentations (Limit of 10 in the last 5 years):
If not ABMS board certified, explain equivalent qualifications:

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Non Physician Faculty Roster

[LANGUAGE APPROPRIATE TO SPECIALTY APPEARS HERE.]

Name (Position)	Degree	Based Primarily at Site #	Specialty / Field	Role In Program	Years as Faculty in Specialty

II. Program Personnel and Resources

B. Faculty and

C. Other Program Personnel

Non-Physician Faculty Curriculum Vitae - [LANGUAGE APPROPRIATE TO SPECIALTY APPEARS HERE.]

First Name:		MI:		Last Name:	
Present Position:					
Degree Awarded:				Year Completed:	
Specialty/Field					

Current Licensure Data		
Type of License	State	Date of Expiration

Academic Appointments - List the past ten years, beginning with your current position.

Start Date	End Date	Description of Position(s)
	Present	

Concise Summary of Role in Program:
Current Professional Activities / Committees:
Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):
Selected Review Articles, Chapters and/or Textbooks (Limit of 10 in the last 5 years):
Participation in Local, Regional, and National Activities / Presentations (Limit of 10 in the last 5 years):

II. Program Personnel and Resources

D. Resources

E. Medical Information Access

Common Program Requirement:

D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. [As further specified by the Review Committee]

E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

Explanation:

The **resources** listed below represent general requirements contained in the [Institutional Requirements](#) (IR II.F.) that must be available for all programs.

- Laboratory facilities
- Imaging facilities/diagnostic radiology
- Chart, dictation and record keeping
- Access to computers
- IV support
- Phlebotomy support
- Patient transport
- Transport for specimens, radiographs, etc.
- Nursing support
- Clerical support for patient care

Institutions are responsible for providing ready **access to reference material** in print or electronic format (IR I.B.7.). Program sites that have online reference materials are expected to provide access to residents. Typically, this means that residents have access to computers with internet access in rooms that are conveniently located and easily accessible but secure. If online access is not possible, then access to a collection of specialty-specific print materials is required.

There may be additional specialty-specific requirements that could address resources such as space/equipment/support services for the educational activities of the program, resources for specific clinical activities, or adequate defined patient population(s) for specific clinical activities. Program directors should consult their specialty specific requirements.

II. Program Personnel and Resources

D. Resources

E. Medical Information Access

- **Documentation for resources:** When prior citations exist or concerns are raised during the visit, or where the Review Committee has requirements for physical facilities, the site visitors may use a tour to determine whether resources and facilities meet the needs of residents for providing patient care as part of their education.
- **Documentation for medical information access:** This occurs through the resident survey (see survey question below). Site visitors may use interviews and inspection of facilities for additional verification.

Resident Survey Question:

18. How often are you able to access, either in print or electronic format, the specialty specific and other reference materials that you need?

III. Resident Appointments

- A. Eligibility
- B. Number of Residents
- C. Resident Transfers
- D. Appointment of Fellows and Other Learners

Common Program Requirement:

- A. *Eligibility Criteria*
The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.
[As further specified by the Review Committee]
- B. *Number of Residents*
The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.
[As further specified by the Review Committee]
- C. *Resident Transfers*
 - 1. *Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.*
 - 2. *A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.*
- D. *Appointment of Fellows and Other Learners*
The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.
[As further specified by the Review Committee]

III. Resident Appointments

- A. Eligibility
- B. Number of Residents
- C. Resident Transfers
- D. Appointment of Fellows and Other Learners

Explanation:

Program directors should be familiar with and should comply with the sponsoring institution's written policies and procedures as well as the [ACGME Institutional Requirements](#) for **eligibility** (IR II.A.1.), selection (IR II.A.2.), and appointment (IR II.B-D.) of residents. There are also specialty-specific requirements for eligibility.

Program directors should avoid increasing the **number of residents** without obtaining prior Review Committee approval. To initiate a change (i.e., increase/decrease) in the approved resident complement, programs must login to the ADS and under "Request Changes" select "Approved Positions" from the menu. Specialties differ in the additional documents/information required to complete a complement change request. The content of this additional information is provided within ADS. All complement change requests are sent electronically to the DIO for approval except when permanent changes are requested during site visit preparation (DIO approval is provided via signature on the PIF). After the DIO has approved the complement change request, the materials submitted in ADS are forwarded to the Review Committee for review and a final decision. Consult specialty-specific requirements or contact the Review Committee executive director for more information or guidance.

Residents are considered as **transferring residents** under several conditions which include: when moving from one program to another within the same or different sponsoring institution; when entering a PGY2 program requiring a preliminary year, even if the resident was simultaneously accepted into the prelim PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). Before accepting a transferring resident, the "receiving" program director must obtain written or electronic verification of prior education from the current program director. Verification includes evaluations, rotations completed, procedural/operative experience, and a summative competency-based performance evaluation. Neither the term "transferring resident" nor the responsibilities of the two program directors noted above apply to a resident who has successfully completed a specialty residency and then is accepted into a subspecialty fellowship.

The presence of **other learners** in the program can benefit resident education by providing opportunities for interprofessional teamwork skill development and increasing appreciation and respect for other health professionals. There is also the potential that the presence of other learners can dilute the resources available for resident training, thus negatively impacting the learning environment. Program directors should follow their institutional guidelines as well as communicate with the DIO and GMEC on the number and impact of other learners.

III. Resident Appointments

A. Eligibility

B. Number of Residents

C. Resident Transfers

D. Appointment of Fellows and Other Learners

- **Documentation for eligibility:** Site visitors will review the written policies for selection and promotion of residents/fellows.
- **Documentation for number of residents:** Information is documented in the PIF and verified by the site visitor. (See PIF questions below.)
- **Documentation for resident transfers:** For residents who have transferred into the program, written verification of prior educational experience and a summative competency-based performance evaluation should be available in the resident files for site visitors to review. Examples of verification of previous educational experiences could include a list of rotations completed, evaluations of various educational experiences, procedural/operative experience. Meeting the requirement for verification before accepting a transferring resident is complicated in the case of a resident who has been simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match. In this case, the “sending” program should provide the “receiving” program a statement regarding the resident’s current standing as of one-two months prior to anticipated transfer along with a statement indicating when the summative competency-based performance evaluation will be sent to the “receiving” program. An example of an acceptable verification statement is:

“(Resident name) is currently a PGY (level) intern/resident in good standing in the (residency program) at (sponsoring institution). S/he has satisfactorily completed all rotations to date, and we anticipate s/he will satisfactorily complete her/his PGY() year on June 30, (year). A summary of her/his rotations and a summative competency-based performance evaluation will be sent to you by July 31, (year).”

Aggregate data on residents/fellows completing or leaving the program in the last three years is documented in the PIF. Site visitors verify reasons for transfers and program responses during interviews as needed.

ADS (PIF) tables related to these requirements are on the following pages:

III. Resident Appointments

- A. Eligibility**
- B. Number of Residents**
- C. Resident Transfers**
- D. Appointment of Fellows and Other Learners**

RESIDENT APPOINTMENTS

Number of Positions (for the current academic year)

Positions	Total (Positions per year also requested if Review Committee approves the number per year)
Number of Requested Positions	
Number of Filled Positions*	

If the number of filled positions exceeds the number of positions approved by the Review Committee, provide an explanation of this variance.

No increase in resident complement is requested () YES () NO

* Not applicable to new programs with no residents on duty. Count part time residents as 0.5 FTE.

Actively Enrolled Residents (if applicable)

List all residents actively enrolled in this program as of August 31 of current academic year. List names alphabetically within Year in Program. Place an (*) asterisk next to the name of each resident accepted as a transfer.

Name	Program Start Date	Expected Completion Date	Year in Program	Type of Position	Years of Prior GME	Specialty of Most Recent Prior GME	Medical School	Year of Med School Graduation

For the transfer residents noted above, did you obtain documentation of previous educational experience and competency-based performance evaluation? () YES () NO

Documentation of previous experience and competency-based performance evaluation for transfer residents should be available for review by the site visitor.

III. Resident Appointments

- A. Eligibility
- B. Number of Residents
- C. Resident Transfers
- D. Appointment of Fellows and Other Learners

Aggregate Data on Residents Completing or Leaving the Program for the Last Three (3) Years (if applicable)

Based in academic year ending:	June 30, 20__	June 30, 20__	June 30, 20__
Number of Graduates in this Program*			
Number of Residents That Completed Preliminary Year(s)			
Number of Residents Who Withdrew from the Program			
Number of Residents Who Transferred Out of the Program			
Number of Residents on Leave of Absence from the Program			
Number of Residents Dismissed from the Program			

*Excludes residents in preliminary complement year(s).

Residents Completed Program in the Last Three Years (if applicable)

List of residents who completed all training for this specialty based on the last academic year ending June 30, 20__.

Name	Start Date	Actual Date of Completion

Transferred, Withdrawn, and Dismissed Residents (if applicable)

List residents who transferred, withdrew, or were dismissed from the program for the last three years and provide the reason.

Name	Start Date	End Date	Transferred to Which Specialty/Site	Provided Resident Records to New Program Yes/No

III. Resident Appointments

- A. Eligibility
- B. Number of Residents
- C. Resident Transfers
- D. Appointment of Fellows and Other Learners

Name	Start Date	End Date	Withdrawn or Dismissed	Reason

- **Documentation of Fellows and Other Learners:** Site visitors will verify the impact of the presence of fellows or other learners on the educational opportunities available for residents through review of the resident survey (see survey question below) and interviews during the site visit as deemed necessary.

Resident Survey Question:

16. To what extent do trainees who are not part of your program (such as residents from other specialties, subspecialty fellows, PhD students and nurse practitioners) interfere, in a negative way, with your education?

IV. Educational Program

A. Curriculum components

1. Overall educational goals
2. Competency-based goals and objectives for each assignment
3. Didactic sessions
4. Delineation of resident responsibilities

Common Program Requirement:

- A. *The curriculum must contain the following educational components:*
1. *Overall educational goals for the program, which the program must distribute to residents and faculty annually;*
 2. *Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;*
 3. *Regularly scheduled didactic sessions;*
 4. *Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,*

Explanation:

Overall program educational goals describe a general overview of what the program is intended to achieve. These create a framework for expectations on the part of residents, faculty, and others in the program, and should not be a 'laundry list' of learning objectives. These must be distributed to residents and faculty annually, either electronically or on paper. While the program requirements do not specifically state that goals be reviewed with residents, programs may have a process in place that assures the residents both know and understand these overall goals.

Each assignment in which the resident is expected to participate must have a set of **competency-based goals and objectives**. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation. The goal(s) communicate the general purpose and direction of the assignment. Objectives are the intended results of the instructional process or activity. They communicate to residents, faculty, and others involved the expected results in terms of resident outcomes and typically are the basis for items within evaluation instruments.

IV. Educational Program

A. Curriculum components

1. Overall educational goals
2. Competency-based goals and objectives for each assignment
3. Didactic sessions
4. Delineation of resident responsibilities

The phrase “competency-based goals and objectives” means that the goals and objectives clearly relate to one or more of the six ACGME competency domains. Typically, short term assignments such as a journal club will have one or two goals and several objectives that are related to some, but not all six competency domains. For example, the goals and objectives for a specific simulated learning experience may relate only to Interpersonal & Communication Skills.

Sample goal for a simulated learning experience:

Improve performance in communicating effectively with patients.

Sample objectives for this simulation experience:

Provide precise information to a patient that is clearly understood.

Express openness to feedback from patients.

Pay close attention to patients and actively listen to them.

The goals and objectives for each assignment at each educational level must be distributed annually to residents and faculty. If the program has created a program handbook, all curriculum design materials (goals and objectives for each curricular element, assessment instruments used for each) could be included and the handbook distributed to residents or made available online. Residents should be reminded to review the competency-based goals and learning objectives for each learning assignment at the start of the assignment. Some specialties require that goals and objectives be reviewed with residents at the start of every assignment.

All programs must have regularly scheduled **didactic sessions**. A didactic session instructs by communicating information, such as a lecture, conference, journal club, directed case discussion, seminar, or assigned online learning module, in contrast to an independent project, practicum, mentoring session, or clinical preceptor session which are self-directed or experiential. Specific requirements for the expected kinds of didactic sessions are contained in the specialty-specific requirements. Some specialties have requirements for attendance.

An important element throughout the curriculum is clear communication of **residents’ responsibilities** for patient care, level of responsibility for patient management and how they will be supervised (and by whom). Care should be taken to assure that clinical responsibilities emphasize clinical education over service. This information could be part of the rotation orientation and be included in the written materials describing the rotation, including the “who, what, when, where, and how” of the rotation, expectations in terms of goals and objectives as well as resident and faculty responsibilities.

IV. Educational Program

A. Curriculum components

1. Overall educational goals
2. Competency-based goals and objectives for each assignment
3. Didactic sessions
4. Delineation of resident responsibilities

- **Documentation for overall educational goals:** The written educational goals should be available for site visitor review either as a separate document or as part of a Program Handbook. Verification that residents review the learning objectives will be accomplished through the resident survey (see survey question below) as well as site visitor interviews as needed.

Resident Survey Question:

9. Has your program provided you access to, either by hard copy or electronically, written goals and objectives for the program overall?

- **Documentation for competency-based goals and objectives:** Some Review Committees require that the program director attach a sample (e.g., competency-based goals and objectives for one rotation) to the PIF. During the site visit the site visitor may ask for samples of the goals and objectives for other assignments. Inclusion of these goals and objectives in a well-organized Program Handbook, while not required, will simplify this documentation requirement. Verification that residents review the learning objectives will be accomplished through the resident survey (see survey question below) as well as site visitor interviews as needed.

Resident Survey Question:

10. Has your program provided you access to, either by hard copy or electronically, written goals and objectives for each rotation and major assignment?

- **Documentation for didactic sessions:** This may include conference schedules, handouts, session evaluations, or attendance records. (Check specialty-specific program requirements.) These documents should be available for review during the site visit. Site visitors will verify the information through the resident survey (see survey questions below) as well as interviews as needed.

A confusing issue is how much attendance is 'enough.' Most Review Committees do not specify numerical requirements, although there are exceptions; check section IV.A.3 of the specialty-specific requirements. Common sense dictates that a large percentage of residents and teaching faculty should attend and that for sessions where attendance is required, the schedule be free of conflicts for the largest

IV. Educational Program

A. Curriculum components

1. Overall educational goals
2. Competency-based goals and objectives for each assignment
3. Didactic sessions
4. Delineation of resident responsibilities

percentage of people as possible. Regular evaluations (paper or verbal) of such sessions, while not required, will help the program director remain up-to-date on needs and perceptions of faculty and residents.

Resident Survey Questions:

3. *Do your faculty members regularly participate in organized clinical discussions?*
4. *Do your faculty members regularly participate in rounds?*
5. *Do your faculty members regularly participate in journal clubs?*
6. *Do your faculty members regularly participate in conferences?*

- **Documentation for resident responsibilities:** Documentation may consist of written information for each rotation or assignment and the supervision policy. Verification will occur through the resident survey (see survey questions below). Site visitors will review samples of this information.

Resident Survey Questions:

2. *Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?*

19. *Do your rotations and other major assignments emphasize clinical education over any other concerns, such as fulfilling service obligations?*

IV. Educational Program
A. Curriculum components
5. ACGME Competencies

Introduction:

The identification of the six competency domains focuses attention on other aspects of effective clinical practice and physician competence besides patient care and medical knowledge. Assigning specific outcomes to specific competency domains is not always easy or straightforward because there is significant overlap and also because there are legitimate differences in the interpretation of meaning among the specialties. What is most important is that residents have the opportunity to develop abilities for all the basic outcomes, regardless of the “bucket” in which the outcome is placed.

During the next several years, each specialty is encouraged to identify expected outcomes for each competency domain and the level of proficiency by educational level as appropriate, with agreement in the specialty on a few specific tools to be used for evaluation. This may allow the collection of outcomes nationally and the development of national standards for each outcome. Such standards could facilitate the transition from a process-oriented resident education to one of outcomes and, subsequently, to accreditation decisions that incorporate aggregated resident outcomes relative to national standards as an important program outcome.

In this section of the Guide, the basic elements of each competency domain are presented, along with suggestions for teaching and assessing outcomes, because teaching and evaluation are tightly integrated activities. The questions in the PIF for this section address learning activities related to the competency domains. A separate section of the CPR and PIF address evaluation (CPR V). In the Evaluation section of this Guide, some of the evaluation information discussed in this section is reiterated in the context of developing an evaluation system for the program.

IV. Educational Program
A. Curriculum components
5. ACGME Competencies
a. Patient Care

Common Program Requirement:

5. *ACGME Competencies*
The program must integrate the following ACGME competencies into the curriculum:
- a. *Patient Care*
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. Residents:
[As further specified by the Review Committee]

Explanation:

While each specialty has specific requirements for patient care, some principles are common. Early in their education, residents should demonstrate patient care skills relevant to that specialty for patients with common diagnoses and for uncomplicated procedures. As residents progress in educational level, they should be able to demonstrate patient care skills with non-routine, complicated patients and under increasingly difficult circumstances, while demonstrating compassionate, appropriate and effective care. Likewise, they should demonstrate proficiency in performing increasingly complex procedures and handling unexpected complications, while demonstrating compassion and sensitivity to patient needs and concerns.

The types of patient care experiences residents/fellows must have are included in the specialty-specific program requirements. Requirements may indicate numerical requirements, settings in which experiences should occur, and indications for graduated responsibility. Evaluation methods for technical proficiency in patient care are essential and may include direct observation. Methods that assess patient care skills from the patient perspective are also needed to provide information on intangible elements of care such as compassion and sensitivity (components of professionalism). Methods such as patient surveys and multi-source evaluations can provide such insight. (See CPR V. Evaluation.)

Consult the specialty-specific program requirements for more information on patient care requirements, including curricular components and evaluation methods.

- **Documentation for patient care:** Provision of learning experiences can be documented through rotation schedules, written goals and objectives, and resident files, which should be available for site visitor review. Completed procedure/case logs, if applicable, should also be available for site visitor review. There are also specialty-specific forms of required documentation indicated in many specialty PIFs. This information may be verified by the site visitor through interviews as needed.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

b. Medical Knowledge

Common Program Requirement:

5. *ACGME Competencies*

The program must integrate the following ACGME competencies into the curriculum:

b. *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. Residents:
[As further specified by the Review Committee]*

Explanation:

Medical knowledge (knowledge of biomedical, clinical, epidemiological-behavioral sciences and application of this knowledge to patient care) within each specialty is included as part of the specialty-specific program requirements. Formal teaching usually occurs within the didactic curriculum, but most learning takes place within clinical experiences. Thus, competence in medical knowledge is inextricably linked with competence in patient care.

In addition to the specialty-specific knowledge content that is assessed with local, in-training, and Board exams, it is important that each resident, regardless of specialty, demonstrates his/her ability to acquire and access new knowledge (i.e., stay up-to-date with the current literature), interpret the information they uncover, and then apply it in the clinical setting. Prior to the incorporation of the ACGME core competencies, this was called “learning around the patient” but now is often referred to as lifelong learning skills. These are learned skills and may be applied to other competency domains, especially Practice-based Learning & Improvement (PBLI) and Systems-based Practice (SBP). Structured approaches for teaching these skills may include journal club, critically appraised topic, educational prescription (a structured technique for following up on clinical questions that arise during rounds and other venues)², or other learning experience. This may be accompanied by a specific evaluation tool that identifies the criteria and standards for achievement of competence. (See CPR V.A.1. explanation section of this Guide.) Consistency among programs within each specialty may allow the development of national standards for these related medical knowledge skills, as has been done for Board exams.

- **Documentation for medical knowledge:** In addition to specialty-specific PIF questions, evidence for compliance with these requirements includes the written didactic curriculum, lecture schedule, and reading assignments. These documents should be available for site visitor review. Site visitors will verify this information through inspection and interviews as needed.

² <http://www.cebm.utoronto.ca/practise/formulate/eduprescript.htm>

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

c. Practice-based Learning and Improvement

Common Program Requirement:

5. *ACGME Competencies*

The program must integrate the following ACGME competencies into the curriculum:

c. 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 life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;*
- (2) set learning and improvement goals;*
- (3) identify and perform appropriate learning activities;*
- (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Review Committees should define expectations regarding quality improvement within specialty specific program requirements.)*
- (5) incorporate formative evaluation feedback into daily practice;*
- (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;*
- (7) use information technology to optimize learning; and,*
- (8) participate in the education of patients, families, students, residents and other health professionals.*

[As further specified by the Review Committee]

Explanation:

At the core of proficiency in Practice-based Learning & Improvement (PBLI) is lifelong learning and quality improvement. These require skills in and the practice of self evaluation and reflection (CPR IV.A.5.c.1) to engage in habitual Plan-Do-Study-Act (PDSA) cycles (CPR IV.A.5.c.2-5) for quality improvement at the individual practice level, as well as skills and practice using Evidence-based Medicine (EBM) (CPR IV.A.5.c.6-7). In addition, residents must learn and practice teaching skills to enable them to effectively educate patients, families, students, residents and other health professionals (CPR IV.A.5.c.8).

Some specialties have identified approaches to support development of **self assessment and reflection** skills and habits. For example, residents in ACGME accredited pediatrics programs must maintain an individual learning plan that must be documented annually (PR IV.A.5.c.(9)). Other tools might address attributes important to the practicing physician, such as time management, stress management, or elements of

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

c. Practice-based Learning and Improvement

the competencies. Or, a simple prompt to think about what went well, what didn't, and what the resident would like to do differently can help residents to think beyond context and to share meaning. Effective use of such tools involves assessment by the resident (self assessment) and faculty member, as well as subsequent discussion of strengths and areas for improvement that emerge. We know that 'we don't know what we don't know' so discussing differences in self-assessed abilities and faculty member-assessed abilities is a good way to gain awareness and develop better self assessment skills. Reflection is critical for gaining greater self knowledge (link to professionalism); it functions as a personal PDSA cycle (establish goals, monitor progress, question things as they happen, assess what is/is not working).

Didactic training for **EBM-related skills** will help residents develop the needed skills and habits: locating information, using information technology, appraising information, assimilating evidence (from scientific studies as well as practice data), and applying information to patient care. Resources for accomplishing this may include library professionals and a variety of articles, books, and learning modules. (For example, see the RSVP website: <http://www.acgme.org/outcome/implement/rsvp.asp>.) In addition, residents should have the opportunity to apply these skills in a structured activity such as journal club that is evaluated using a tool structured to provide meaningful feedback. Faculty oversight of this activity as teachers, mentors, and role models will aid resident development of these skills and habits.

Quality improvement (QI) skills may be obtained by active participation on a QI committee (planning; implementation; analysis of an intervention on a practice outcome; incorporation into practice if improvement has occurred; initiation of a new PDSA cycle if improvement has not occurred). Different specialties may have specific expectations regarding requirements for quality improvement related to PBLI.

A final area addressed by this competency domain is **teaching skills** used for the education of patients, families, students, residents, and other health professionals. While this overlaps the Interpersonal & Communication Skills domain, this requirement addresses the need for specific teaching skills. This is linked to practice improvement, because patients who lack a clear understanding of their condition and how they can participate in self care are likely to have worse outcomes than those who can be partners in their care because their physician has educated them effectively. Similarly, physicians who are able to effectively educate consulting physicians rather than just asking for a yes/no answer are more likely to get the information they need to provide better care.

There may be additional specialty-specific requirements for PBLI.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

c. Practice-based Learning and Improvement

- **Documentation for self assessment and reflection:** The Common PIF requests a description of one learning activity that demonstrates how the program supports development of self assessment and reflection skills and habits. (See PIF question below.) Programs may use a structured process for reflection in which a faculty advisor guides the resident in using feedback and evaluations to inform the self assessment process. Documentation of the semi-annual evaluation meetings in which this process is demonstrated would provide evidence that this requirement is being addressed. Site visitors may verify that self assessment and reflection are encouraged and that many faculty and residents engage in this activity during faculty and resident interviews.

PIF Question:

*a. Describe one learning activity in which residents engage to identify strengths, deficiencies, and limits in their knowledge and expertise (self-reflection and self-assessment); set learning and improvement goals; identify and perform appropriate learning activities to achieve self-identified goals (life-long learning).
Limit your response to 400 words.*

- **Documentation for EBM-related skills:** The Common PIF requests a description of one learning activity designed for residents to develop EBM abilities. (See PIF question below.) An appropriate learning activity could be structured EBM activities such as a journal club presentation, critical appraisal of a topic, or educational prescription with appropriate faculty oversight and formal assessment of skills. Additional documentation would be the written goals and objectives for this learning activity and how residents are assessed. Site visitors may verify through spot checks of resident files and interviews with residents and faculty as needed.

PIF Question:

*b. Describe one example of a learning activity in which residents engage to develop the skills needed to use information technology to locate, appraise, and assimilate evidence from scientific studies and apply it to their patients' health problems. The description should include:
(1) locating information
(2) using information technology
(3) appraising information
(4) assimilating evidence information (from scientific studies)
(5) applying information to patient care
Limit your response to 400 words*

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

c. Practice-based Learning and Improvement

- **Documentation for quality improvement:** The Common PIF requests a description of an example and the outcome of a QI activity in which at least one resident participated. (See PIF question below.) Documentation could be the written project description of a full PDSA cycle in which an individual resident or group of residents actively participated with appropriate faculty oversight and formal assessment of skills, or proceedings from events in which QI projects were presented orally. Site visitors may verify through resident interviews.

PIF Question:

*c. Give one example and the outcome of a planned quality improvement activity or project in which at least one resident participated in the past year that required the resident to demonstrate an ability to analyze, improve and change practice or patient care. Describe planning, implementation, evaluation and provisions of faculty support and supervision that guided this process.
Limit your response to 400 words.*

- **Documentation for teaching skills:** The common PIF requests a description of structured learning activities that demonstrates how the program supports the development of teaching skills. (See PIF question below.) Documentation would include the written goals and objectives for this learning activity and how residents are assessed. Additional documentation may include evidence for structured teaching opportunities, feedback from learners such as medical students, or patient perceptions of the clarity of residents' explanations. Site visitors may verify through resident interviews.

PIF Question:

*d. Describe how residents:
(1) develop teaching skills necessary to educate patients, families, students, and other residents;
(2) teach patients, families, and others; and
(3) receive and incorporate formative evaluation feedback into daily practice.
(If a specific tool is used to evaluate these skills have it available for review by the site visitor.)
Limit your response to 400 words.*

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

d. Interpersonal and Communication Skills

Common Program Requirement:

5. *ACGME Competencies*

The program must integrate the following ACGME competencies into the curriculum:

d) 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. Residents are expected to:

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;*
- (2) communicate effectively with physicians, other health professionals, and health related agencies;*
- (3) work effectively as a member or leader of a health care team or other professional group;*
- (4) act in a consultative role to other physicians and health professionals; and,*
- (5) maintain comprehensive, timely, and legible medical records, if applicable.*

[As further specified by the Review Committee]

Explanation:

This competency domain consists of two distinct skill sets, **communication skills** (used to perform specific tasks such as obtain a history, obtain informed consent, telephone triage, present a case, write a consultation note, inform patients of a diagnosis and therapeutic plan) and **interpersonal skills** (inherently relation and process oriented, such as relieving anxiety, establishing trusting relationships). The outcome “communicate effectively with patients, families, and the public...” requires good verbal, non-verbal and written communication skills, but also requires good relationship-building skills. A structured curriculum may include both didactics and experiential components for addressing verbal, non-verbal, and written communication skills as well as modes of interactions that contribute to relationship building across a broad range of socioeconomic and cultural backgrounds. Interactive teaching methods may include role playing, review of videotapes, and small group discussion of vignettes. **Teamwork** training is also needed. “On-the-job” training without structured teaching is not sufficient for this skill. Simulation is increasingly used as an effective method for teamwork training. (See several articles in the [ACGME Bulletin December, 2005](#).) A final but very important area in this competency domain relates to completing and maintaining comprehensive, timely and legible **medical records**. Programs must have a mechanism in place for monitoring and evaluating this skill as well as providing timely formative feedback.

There may be specialty-specific requirements for Interpersonal & Communication Skills.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

d. Interpersonal and Communication Skills

- **Documentation for communicating with patients and families:** The Common PIF requests a description of a learning activity in which residents develop competence in communicating with patients and families that includes both a didactic component and an experiential component. (See PIF question below.) Learning activities might address written communication (e.g., orders, H&P examination, progress note, transfer note, discharge summary, operative reports, diagnostic reports), oral communication (e.g., presentations, transfer of care, interactions with patients, families, colleagues, members of the health care team) and/or non verbal skills (e.g., listening, team skills). These may be structured learning activities (not just “on-the-job” training) with faculty oversight and feedback.

PIF Question:

*a. Describe one learning activity in which residents develop competence in communicating effectively with patients and families across a broad range of socioeconomic and cultural backgrounds, and with physicians, other health professionals, and health related agencies.
Limit your response to 400 words.*

- **Documentation for teamwork:** The Common PIF requests a description of a learning activity related to developing teamwork skills as either a member or leader. (See PIF question below.) Documentation may include the written goals and objectives and curriculum (didactic and experiential) for this learning activity, demonstrating that faculty actively engage the learners in developing these skills and that team member communication is bidirectional rather than unidirectional.

PIF Question:

*b. Describe one learning activity in which residents develop their skills and habits to work effectively as a member or leader of a health care team or other professional group. In the example, identify the members of the team, responsibilities of the team members, and how team members communicate to accomplish responsibilities.
Limit your response to 400 words.*

- **Documentation for medical records:** The Common PIF requests a description for how the program monitors requirements related to medical records, including a mechanism for providing feedback to residents. (See PIF question below.) Additional documentation (not required) might include a written policy for the completion of comprehensive, timely and legible medical records that includes monitoring, evaluation and feedback to residents.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

d. Interpersonal and Communication Skills

PIF Question:

*c. Explain (a) how the completion of comprehensive, timely and legible medical records is monitored and evaluated, and (b) the mechanism for providing residents feedback on their ability to competently maintain medical records.
Limit your response to 400 words.*

- **Additional documentation for Interpersonal & Communication Skills (IPCS):**
Documents that must be made available to the site visitor include written competency-based goals and objectives for each experience at each educational level. Some Review Committees ask for an example to be appended to the PIF. (See specialty PIFs for this information.) Documentation of resident evaluation at the end of each rotation or similar educational assignment must also be available to the site visitor. Site visitors may verify the information supplied in the PIF through review of these documents as well as through interviews with faculty and residents as needed. They may discuss the use of multiple evaluators, whether residents are provided with timely formative feedback, and whether assessment methods reported in the PIF are used effectively. (See CPR V.A)

IV. Educational Program
A. Curriculum components
5. ACGME Competencies
e. Professionalism

Common Program Requirement:

5. *ACGME Competencies*
The program must integrate the following ACGME competencies into the curriculum:
- e. *Professionalism*
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
- (1) compassion, integrity, and respect for others;*
 - (2) responsiveness to patient needs that supersedes self-interest;*
 - (3) respect for patient privacy and autonomy;*
 - (4) accountability to patients, society and the profession; and,*
 - (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.*
- [As further specified by the Review Committee]*

Explanation:

Proficiency in this competency domain is primarily behavioral and attitudinal and is demonstrated as part of all other competency domains. Therefore, teaching and evaluation is most effective when done in the context of patient care and related activities (e.g., conducting QI projects, leading a team, presenting M&M, reflections on practice, conversations with mentors). Evaluations are mainly perceptions, making it important that evaluators share a common belief about the components of professionalism and description of what those are. **The major components of professionalism are commitment, adherence, and sensitivity.**

- Commitment means respect, altruism, integrity, honesty, compassion, empathy, and dependability; accountability to patients and society; and professional commitment to excellence (demonstrated by engaging in activities that foster personal and professional growth as a physician).
- Adherence means accepting responsibility for continuity of care; and practicing patient-centered care that encompasses confidentiality, respect for privacy and autonomy through appropriate informed consent and shared decision-making as relevant to the specialty.
- Sensitivity means showing sensitivity to cultural, age, gender and disability issues of patients as well as of colleagues, including appropriate recognition and response to physician impairment.

Professionalism, including medical ethics, may be included as a theme throughout the program curriculum that includes both didactic and experiential components (e.g., may be integrated into already existing small group discussions of vignettes or case studies

IV. Educational Program
A. Curriculum components
5. ACGME Competencies
e. Professionalism

and role plays, computer-based modules) and may be modeled by the faculty in clinical practice and discussed with the resident as issues arise during their clinical practice.

Faculty development is critically important for **promoting professionalism behavior** because of past assumptions that since all physicians are professional, professionalism does not need to be discussed, taught or evaluated. Faculty development may include not only faculty but also residents as much as possible and include both structured workshops as well as ongoing discussion (e.g., inclusion as a discussion point in every M&M presentation). These discussions may address the impact of situational circumstances on the degree to which a professional manifests these attributes (e.g., post-call, times of personal stress, competing priorities). Such an approach will contribute to the development of a learning environment that explicitly values and encourages professionalism in all who teach, learn, and provide healthcare as part of the training program.

Remediation is important for all the competency domains, but may be especially critical in the domain of professionalism. It is challenging to teach and assess, and lapses may not be noticed until habits are formed that are then more difficult to address. There are many resources available to help. For example the LIFE Curriculum (Learning to Address Impairment and Fatigue to Enhance Patient Safety): <http://www.lifecurriculum.info/>) contains modules on disruptive behavior, substance abuse, impairment, and boundary violations. This resource is available free of charge. The April, 2006 issue of the ACGME Bulletin contains several articles about remediation: http://www.acgme.org/acWebsite/bulletin/bulletin04_06.pdf.

There may be specialty-specific requirements for professionalism.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

e. Professionalism

- **Documentation for professionalism:** The Common PIF requests a description of an experiential learning activity addressing professionalism and ethics. (See PIF question below.) This activity should be structured, should demonstrate active faculty involvement (not just passive role modeling) and timely feedback to residents, and should include a mechanism for collecting evaluations (including routine multi-source assessment). Additional documentation is provided by the written goals and objectives for this learning activity (must be available for site visitor review) and how residents are assessed.

PIF Question:

a. Describe at least one learning activity, other than lecture, by which residents develop a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Limit your response to 400 words.

- **Documentation for promoting professionalism behavior:** The Common PIF requests a description that demonstrates how the program supports development of professional behavior. (See PIF question below.) Approaches may include role modeling by program leadership, ongoing interactive conversations involving both faculty and residents about the elements of professionalism, particularly in the context of every day practice, policies regarding lapses in professionalism, and processes to address lapses when they occur. In addition, residents provide information through the resident survey on their opportunity to raise and resolve issues without fear of intimidation or retaliation. (See survey question below.) Site visitors will verify responses through interviews as needed.

PIF Question:

b. How does the program promote professional behavior by the residents and faculty?

Limit your response to 400 words.

Resident Survey Question:

17. Does your program and/or institution have a system through which you are able to raise and resolve issues without fear of intimidation or retaliation?

- **Documentation for remediation in professionalism:** The Common PIF requests a description that demonstrates how the program supports remediation in professionalism. (See PIF question below.) Approaches may include provision of immediate feedback, development of a plan specific to the behavior in question,

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

e. Professionalism

monitoring for behavior change, decisions based on specified outcomes, and consequences that are aligned with the gravity of the lapse or breach if expectations are not achieved. Site visitors may verify the response through interviews as needed.

PIF Question:

*c. How are lapses in these behaviors addressed?
Limit your response to 400 words.*

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

f. Systems-based Practice

Common Program Requirement:

5. *ACGME Competencies*

The program must integrate the following ACGME competencies into the curriculum:

f. *Systems-based Practice*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;*
- (2) coordinate patient care within the health care system relevant to their clinical specialty;*
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;*
- (4) advocate for quality patient care and optimal patient care systems;*
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,*
- (6) participate in identifying system errors and implementing potential systems solutions.*

[As further specified by the Review Committee]

IV. Educational Program
A. Curriculum components
5. ACGME Competencies
f. Systems-based Practice

Explanation:

At the heart of systems-based practice (SBP) is a focus on the broader context of patient care within the multiple layers of a **healthcare system** including purchasers (employers, government), insurers (commercial, Medicare, Medicaid), delivery systems (hospitals, physician networks, drug and technology companies, community resources), work group (local entity providing care such as a group practice, hospital service), providers (physicians, nurses, and others both as individuals and teams that provide direct care), and the users (patients and families). Awareness and effective use of these resources are advocated by entities such as the Institute for Healthcare Improvement to increase patient care quality and reduce error. These include: how national and local structures, systems, rules and regulations contribute to the experience of a specific patient and populations of patients; who pays for care and why it matters to both patient and physician; and factors within the culture, organization, management, and financing of the local care system that impact care of individuals and populations.

This competency domain is closely linked to PBLI because it is often through analysis of one's practice that system-level issues are revealed. Residents need to develop abilities in this competency domain not only to provide safe and effective care, but also to enable them to act as effective practitioners within a variety of different medical practice/delivery models.

Teamwork skills are important to demonstrating competence in SBP. Participation as members and leaders of interdisciplinary teams will allow residents opportunities to develop and demonstrate abilities in using a variety of tools and teamwork skills to identify, analyze, implement, evaluate and report improvement initiatives as well as identifying **system errors**.

There may be specialty-specific requirements for SBP.

IV. Educational Program

A. Curriculum components

5. ACGME Competencies

f. Systems-based Practice

- **Documentation for SBP:** The Common PIF requests a description of a learning activity that addresses development of abilities in the knowledge base and skills in effective coordination of patient care, applying considerations of cost containment and risk-benefit analysis, patient advocacy, and interprofessional teamwork. (See PIF question below.) Documentation may include the written goals and objectives for this learning activity, curriculum (didactic and experiential) that demonstrates the elements of SBP, and assessment of resident outcomes. Site visitors may verify responses through interviews as needed.

PIF Question:

*a. Describe the learning activity(ies) through which residents achieve competence in the elements of systems-based practice: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system; incorporate considerations of cost-containment and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; and work in interprofessional teams to enhance patient safety and care quality.
Limit your response to 400 words.*

- **Documentation for system errors:** The Common PIF requests a description of a learning activity that demonstrates how the program supports the development of resident skills for identifying system errors. (See PIF question below.) Important elements may include identified faculty to guide the activity, mechanism to ensure active engagement by each resident, and evidence of experiential learning (not just passive presence at conferences or meetings) in which residents participate in identifying a system problem or error and contribute to a potential solution. Additional documentation would be the written goals and objectives for this learning activity and how residents are assessed. Aggregated resident outcomes may be in the form of percentage of residents that completed a patient safety or other SBP project by the end of training, annual list of improvements that resulted from such projects, etc. Site visitors may verify responses through interviews as needed.

PIF Question:

*b. Describe an activity that fulfills the requirement for experiential learning in identifying system errors
Limit your response to 400 words.*

IV. Educational Program
B. Residents' Scholarly Activities

Common Program Requirement:

- B. Residents' Scholarly Activities*
- 1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.*
 - 2. Residents should participate in scholarly activity.
[As further specified by the Review Committee]*
 - 3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
[As further specified by the Review Committee]*

Explanation:

In order to pursue scholarly activities, residents not only need to work and learn in a culture that values and nurtures scholarship (i.e., faculty actively engaged in and rewarded for scholarly activities) but also need to learn specific skills, such as transforming an idea into a research question (experimental, descriptive or observational), choosing an appropriate study design, determining what instrumentation to use, preparing for data collection, management and analysis, ethical conduct of research, and the rules and regulations governing human subjects research.

- **Documentation for residents' scholarly activities:** Evidence for how the program supports the development of specific skills needed by residents for scholarly activities may be provided through written goals and objectives that must be available for site visitor review. Other forms of evidence could include availability of financial and technical support for research and other scholarly activities, the percentage of residents who have completed IRB training, attend or present at educational lectures and conferences, or lists of posters, presentations and publications to which residents have contributed (usually requested as part of the specialty-specific PIFs). Verification by site visitors that residents have opportunities for research or scholarly activities includes review of resident survey responses (see survey question below) and interviews as needed.

Resident Survey Question:

14. Does your program offer you the opportunity to participate in research or scholarly activities?

V. Evaluation
A. Resident Evaluation
1. Formative Evaluation

Common Program Requirement:

1. *Formative Evaluation*
- a. *The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.*
 - b. *The program must:*
 - (1) *provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;*
 - (2) *use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);*
 - (3) *document progressive resident performance improvement appropriate to educational level; and*
 - (4) *provide each resident with documented semiannual evaluation of performance with feedback.*
 - c. *The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.*

Explanation:

Formative evaluation or assessment³ includes both informal ‘on-the-spot’ feedback⁴ and feedback based on the planned collection of information using assessment forms. Written formative assessment provides a mechanism through which programs can document progressive resident performance improvement. Self-assessment is an important component of formative assessment, both to compare with data from other evaluators and also to develop this important lifelong learning skill.

The primary purpose of formative assessment is to help residents recognize a learning gap (e.g., knowledge, skills, behaviors). It should help residents answer their fundamental questions: Where am I now? Where am I going? How do I get where I am going? How will I know when I get there? Am I on the right track for getting there? Formative assessment is ‘successful’ if it leads the resident to proactively close the gap, thus also building lifelong learning skills. This is less likely to occur if the formative

³ The terms “evaluation” and “assessment” are often used interchangeably. “Evaluation” is more often applied to curricula and programs, while “assessment” is applied almost always only to learners. Some reserve the term “evaluation” for summative (end-of-learning period or high stakes) decisions, while using the term “assessment” only for formative purposes. For this document, the terms are assumed to be interchangeable and the reader should focus on the distinction between formative and summative.

⁴ Feedback: Communication of responses and reactions with the aim of enabling improvements to be made.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

assessment data are given to residents without discussion of what the data mean and without inviting the resident to plan strategies to improve (often called an ‘independent learning plan’).

Formative assessment is also an effective way to identify the need for formal remediation as it provides a ‘developmental history’ of the resident’s work, efforts, responses to feedback, and outcomes. Remediation then becomes a process that partners the program director or faculty advisor and resident in planning, implementing and evaluating the remediation. (See CPR IV.A.5.e.) Thus, ongoing discussions between residents and teaching faculty about the meaning of formative assessments may be part of the assessment system.

Programs need to demonstrate planning for and use of an **assessment system** that includes both formative and summative evaluations and identifies the methods used to assess each competency domain and who the evaluators are for each. Effective assessment systems are based on a few core principles: assessment based on identified learning objectives/outcomes related to the six competency domains; use of multiple tools by multiple evaluators on multiple occasions; tools with descriptive criterion-based anchors for the rating scale to aid in fairer and more consistent evaluations. The assessment system must be monitored to assure **timely completion of evaluations** and to assure that the required **semiannual reviews with feedback** take place and are documented.

Data derived from formative assessments should not be used to make high stakes decisions (promotion, graduation). Such data should be discussed with the resident, who can provide more meaning to the context of the situation, and used to guide planning for further learning and to identify the need for remediation. Because so many data points are being collected with formative evaluation, patterns begin to emerge that allow a more accurate ‘diagnosis’ of the resident’s gaps and capabilities – regardless of any ‘spin’ the resident might put on the results.

The assessment system may include **faculty development** activities such as scheduled faculty meetings. Time could be set aside during faculty meetings to discuss topics such as the assessment tools and methods for using them effectively; and how best to distribute and collect completed evaluations in a timely manner. In addition, the assessment system may also include scheduled meetings with residents so that they know and understand the **performance criteria** on which they will be assessed and the performance standards (i.e., ‘how much is enough’ for a given level of training or learning experience). The goal is that both faculty and residents will share a common understanding of what is expected and how it will be evaluated and that they perceive assessments as a fair and close approximation of actual ability.

CPR V.A.1.c states that evaluations of resident performance must be **accessible for review by the resident**, in accordance with institutional policy.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

- **Documentation for assessment system:** The Common PIF requests information on the frequency of assessment as well as the assessment methods and types of evaluators the program uses to evaluate each of the six competency domains. In general, there should be evidence of multiple methods and multiple evaluators as well as alignment between the methods of assessment and the skill being assessed. Site visitors may verify the information provided through spot checks of resident files and interviews as needed. Programs using an electronic evaluation system may obtain more information from the ACGME website section on the Site Visit [Electronic Evaluation Systems](#).

The information requested in the ADS (PIF) is shown below.

Are residents evaluated on their performance following each learning experience?

YES NO

Are these evaluations documented (in written or electronic format)?

YES NO

Using the table below (add rows as needed):

- provide the methods of evaluation used for assessing resident competence in each of the six required ACGME competencies and,*
- identify the evaluators for each method (e.g., If performance in patient care is evaluated at the end of a rotation using a global form completed by faculty and senior residents and also using a checklist to evaluate observed histories and physicals by the ward attending and continuity clinic preceptor, then under patient care select global assessment for a method and faculty member and senior resident for evaluators; also under patient care select direct observation for a method and attending and preceptor as the evaluators for each of that method.)*

Examples of assessment methods:

direct observation, videotaped/recorded assessment, global assessment, simulations/models, record/chart review, standardized patient examination, multisource assessment, project assessment, patient survey, in-house written examination, in-training examination, oral exam, objective structured clinical examination, structured case discussions, anatomic or animal models, role-play or simulations, formal oral exam, practice/billing audit, review of case or procedure log, review of patient outcomes, review of drug prescribing, resident experience narrative and any other applicable assessment method.

Examples of types of evaluators:

self, program director, nurse, faculty supervisor, medical student, faculty member, attending, preceptor, allied health professional, chief resident, junior resident, resident supervisor, patient, family, peers, technicians, clerical staff, evaluation committee, consultants.

V. Evaluation
 A. Resident Evaluation
 1. Formative Evaluation

Competency	Assessment Method(s)	Evaluator(s)
Patient Care		
Medical Knowledge		
Practice-based learning & improvement		
Interpersonal & Communication Skills		
Professionalism		
Systems-based Practice		

- **Documentation for faculty development on assessment:** The Common PIF requests information on how the program supports faculty development related to assessment. (See PIF question below.) Documentation may include a structured and interactive learning activity that enables the evaluators to develop skills in both teaching and evaluation of the competencies.

PIF Question:

*Describe how evaluators are educated to use the assessment methods listed above so that residents are evaluated fairly and consistently.
 Limit your response to 400 words.*

- **Documentation for performance criteria:** The Common PIF requests a description of how the program assures that residents know and understand the performance criteria on which they will be assessed. (See PIF question below.) Documentation may include a process for communicating the criteria used for each evaluation and the standards set by the program, as well as a mechanism to ensure that every resident is made aware of this information.

V. Evaluation
A. Resident Evaluation
1. Formative Evaluation

PIF Question:

*Describe how residents are informed of the performance criteria on which they will be evaluated.
Limit your response to 400 words.*

- **Documentation for timely completion:** The Common PIF requests a description of how the program assures the timely completion of evaluations. (See PIF question below.) This description may include a structured mechanism with ongoing monitoring by a designated individual. In addition, residents provide information through the resident survey on the frequency of feedback they receive. (See survey question below.) Site visitors may use interviews for added verification.

PIF Question:

*Describe the system which ensures that faculty completes written evaluations of residents in a timely manner following each rotation or educational experience.
Limit your response to 400 words.*

Resident Survey Question:

11. Do you receive written or electronic feedback on your performance for each rotation and major assignment?

- **Documentation for semiannual reviews:** The Common PIF requests a description of the process used by the program for the semiannual evaluation of all residents. (See PIF question below.) The process involves the program director or a designee who meets with the resident semi-annually to provide some continuity in guiding the resident through the assessment process. Written documentation of each evaluation will enable the resident to more clearly see developmental progress over time. Designating an individual to monitor semiannual reviews will help assure that they take place as scheduled. Site visitors may spot check resident files and use interviews for added verification.

PIF Question:

*Describe the process used to complete and document written semiannual resident evaluations, including the mechanism for reviewing results (e.g., who meets with the residents and how the results are documented in resident files).
Limit your response to 400 words.*

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

- **Documentation for accessibility of evaluations:** Documentation for this requirement is obtained through the resident survey (see survey question below) and verified by site visitors through resident interviews.

Resident Survey Question:

12. Are you able to review your current and previous performance evaluations upon request?

V. Evaluation
A. Resident Evaluation
2. Summative Evaluation

Common Program Requirement:

2. *Summative Evaluation*
The program director must provide a summative evaluation for each resident upon completion of the program. This 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 evaluation must:
- a) document the resident's performance during the final period of education, and*
 - b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.*

Explanation:

Summative evaluations are needed when critical “high stakes” decisions must be made. Currently in GME, these decisions are related to promotion and graduation, and so they are typically made at the end of each residency year (for progression or promotion to the next year) and at the completion of the program. In addition to the principles for formative assessment (assessment based on identified learning objectives/outcomes related to the six competency domains; use of multiple tools by multiple evaluators on multiple occasions; and tools with descriptive criterion-based anchors for the rating scale to aid in ‘fairer’ evaluations), the psychometric characteristics of summative evaluation tools are important. That is, both the evaluator and resident should believe that an assessment tool used for summative evaluations provides evidence that can be used to make valid and reliable decisions.

The program director must provide a summative evaluation for each resident at the completion of the program. Characteristics of good summative assessments include:

- decisions are based on pre-established criteria and thresholds, not as measured against performance of past or current residents;
- decisions are based on current performance, not based on formative assessments, which capture the process of developing abilities;
- residents are informed when an assessment is for summative purposes rather than formative purposes; and
- written summative evaluation is discussed with the resident and is available for his/her review.

The end-of-program verification statement that the ACGME requires all program directors to record has changed in the new CPR. Rather than verifying that the resident has “demonstrated sufficient professional ability to practice competently and independently,” program directors must now verify that the resident has “demonstrated sufficient competence to enter practice without direct supervision.” The new statement clearly applies only to the resident’s abilities at the time of graduation. It summarizes in very succinct language the goal of all GME programs. If the program director does not

V. Evaluation

A. Resident Evaluation

2. Summative Evaluation

feel comfortable signing such a statement for a resident, that resident should not be allowed to graduate, even if the specified time for residency education has expired. Such a situation is less likely if ACGME requirements for evaluation have been systematically implemented. Problems will have been identified much earlier, opportunities for remediation provided, and dismissal decisions considered well before the end of residency/fellowship education.

Both the end-of-program summative evaluation and the end-of-program verification statement for all graduates should be retained in perpetuity in a site that conforms to reasonable document security standards (protected from fire, flood, and theft). To ensure that the institution can demonstrate appropriate due process for dismissed residents, program directors should seek the advice of the DIO on the documents to keep for dismissed residents.

- **Documentation for summative evaluation**: Among the documents that must be available for the site visitor are copies of the summative evaluations for the most recent year's graduates. Site visitors will review these evaluations to determine if the program is in compliance with the requirements. In addition, site visitors will interview residents to verify resident survey responses concerning availability of current and previous evaluations. (See survey question below.)

Resident Survey Question:

12. Are you able to review your current and previous performance evaluations upon request?

V. Evaluation
B. Faculty Evaluation

Common Program Requirement:

- B. Faculty Evaluation*
- 1. At least annually, the program must evaluate faculty performance, as it relates to the educational program.*
 - 2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.*
 - 3. This evaluation must include at least annual written confidential evaluations by the residents.*

Explanation:

Regular evaluation of faculty is critical to maintaining and improving the quality and effectiveness of a residency program. The CPR require that faculty be evaluated on their clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. Residents should be asked to evaluate only those areas on which they have direct knowledge and information on which to judge quality. For example, residents can accurately report their perceptions of faculty clinical teaching abilities, commitment to the educational program, clinical knowledge and professionalism. They would have direct knowledge of the quality of a faculty's scholarly activities related to research only if they were working with that faculty on a research project. Otherwise, their evaluation of scholarly activity would be based on indirect knowledge.

Programs or the clinical department may have a written plan for how teaching faculty are evaluated annually. The faculty evaluation plan may include: who evaluates faculty; when evaluations take place; evaluation form(s) used (paper or electronic); methods for distributing forms and collecting and analyzing completed forms; methods to assure a high rate of return for completed evaluations; timing and format for providing feedback to faculty based on evaluation data; and methods to review and improve the evaluation plan. As with any evaluation system, evaluators, including residents, need to be educated about the performance criteria and expected standards of performance.

Faculty evaluations completed by residents must be confidential. This means, at a minimum, that faculty have no way of identifying how any individual resident evaluated them. In practice, faculty can view only aggregated numerical ratings (mean and range) and narrative comments from which all identifying information has been removed, including who made the comment as well as any comments that pertain to other individuals. Institutions may have additional requirements for confidentiality. Confidential should not be confused with anonymous. It is expected that someone, perhaps the program coordinator, would collect/collate the faculty evaluations in order to manage residents' compliance. Some programs may have developed a set of principles that guide evaluation of faculty; if present, this may be included in the written faculty evaluation plan.

V. Evaluation

B. Faculty Evaluation

- **Documentation for faculty evaluation:** The Common PIF includes two questions that describe features of the faculty evaluation system. (See PIF questions below.) The system may include a structured mechanism for the annual distribution and collection of evaluations along with identified personnel to ensure that the system is working, confidential resident input, and provision of feedback to faculty at least annually. Documentation includes a description of the system (may be contained in a program handbook if a handbook is used by the program) and samples of forms used for faculty evaluation that should be available for review by the site visitor. Site visitors may verify compliance by reviewing responses to the resident survey (see survey question below) and through interviews as needed.

ADS (PIF) Question:

Describe the system used by the residents to provide annual confidential written evaluations of the teaching faculty. (Have samples of forms available for review by the site visitor.)

Limit your response to 400 words.

ADS (PIF) Question:

Describe the program's (or department's, if applicable) system for evaluating and providing feedback to the teaching faculty.

Limit your response to 400 words.

Resident Survey Question:

7. Do you have the opportunity to confidentially evaluate your FACULTY, in writing or electronically, at least once a year?

V. Evaluation
C. Program Evaluation and Improvement

Common Program Requirement:

- C. Program Evaluation and Improvement*
- 1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:*
 - a) resident performance;*
 - b) faculty development;*
 - c) graduate performance, including performance of program graduates on the certification examination; and,*
 - d) program quality. Specifically:*
 - (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and*
 - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.*
 - 2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.*

Explanation:

Program directors are expected to lead an ongoing effort to monitor and improve the quality and effectiveness of the program. This annual evaluation is unrelated to the GMCC internal review that must take place midway during the accreditation cycle, although results of that review may become part of this annual program evaluation. At a minimum, methods must be developed and implemented for systematically collecting and analyzing data in the following areas: resident performance, faculty development, graduate performance, and program quality. A written plan for program evaluation and improvement will help to assure that a systematic evaluation takes place annually, that results are used to identify what is working well and what needs to be improved, and that needed improvements are implemented.

Resident performance:

Results of in-training exams or other resident assessments and presentations/publications are examples of resident performance data that could be used as part of the program evaluation. As the [ACGME Learning Portfolio](#) becomes widely used and more data are collected by specialties using the same set of tools, it may be possible to establish national standards for competency-based resident outcomes by specialty/subspecialty. Such standards could be used to evaluate program performance in much the same way that certification exam scores or pass rates are currently used to provide insight into how well a program is supporting resident learning of medical knowledge.

V. Evaluation

C. Program Evaluation and Improvement

Faculty development:

Faculty participation in faculty development activities should be monitored and recorded. Data may be collected by annual review of updated CVs or by a separate annual survey. Activities should – over time – include not only CME-type activities directed toward acquisition of clinical knowledge and skills, but also activities directed toward developing teaching abilities, professionalism, and abilities for incorporating PBLI, SBP, and IPCS into practice and teaching. The types of activities could include both didactic (conferences, grand rounds, journal clubs, lecture-based CME events) and experiential (workshops, directed QI projects, practice-improvement self study).

Graduate performance:

Results of performance on board certification examinations is one measure of graduate performance. Data can also be collected by annual surveys of graduates. Typically, such surveys target physicians one year and five years after graduation. Forms used may be provided by the institution, developed locally or adapted from the published literature (or unpublished but available online). Survey questions may inquire about such items as current professional activities of graduates and perceptions on how well prepared they are as a result of the program.

Program quality: Annually, current residents and faculty must have the opportunity to evaluate the program. Such evaluation could include planning/organization, support/delivery, and quality. To assure confidentiality responses should be de-identified. Clerical staff should collect completed written information, remove any identifiers and collate responses. The program director and faculty may then analyze and review the collated information.

Programs may have residents complete a confidential written evaluation of rotations or specific assignments or learning experiences as part of a targeted improvement plan. The residents' confidential evaluation of the teaching faculty may also be used as part of this evaluation. To assure confidentiality of such evaluations in small programs, the responses should be collected over a sufficient period of time so that the collated information contains responses from several residents (or students) and cannot be linked to specific respondents. Some programs periodically evaluate other areas that impact program quality, including resident selection process, graduates' practice choices, the curriculum, assessment system (including self assessment), remediation, and linking patient outcomes to resident performance. A recent issue of the ACGME Bulletin included several articles describing such efforts.⁵

The deidentified data collected in these areas may be analyzed by the program director and selected faculty and residents (if it is a large program) or by all if it is a small program. A program evaluation committee may be formed to identify outstanding features of the program and areas that could be improved. If the program personnel

⁵ April, 2006 ACGME Bulletin http://www.acgme.org/acWebsite/bulletin/bulletin04_06.pdf

V. Evaluation

C. Program Evaluation and Improvement

determine areas for improvement, they should develop a written plan of action for review/approval by the teaching faculty.

- **Documentation for program evaluation and improvement:** The Common PIF asks several questions about program evaluation and improvement that will help to demonstrate if the program is in compliance with these requirements. (See PIF questions below.) Important components include an annual comprehensive review of the program in which representative faculty and residents engage in an interactive discussion of collected data, with documentation by meeting minutes. Additional documentation includes the written improvement action plan prepared after a review of the aggregated results of residents' performance and/or other program evaluation results. This written action plan may be based on one or more outcome measure(s) and reflect a program PDSA cycle, and must be available for the site visitor. Site visitors may verify responses and documentation through resident survey responses (see survey questions below) and review of the action plan. Site visitors may use interviews for added verification.

ADS (PIF) Question:

*Describe the approach used for program evaluation.
Limit your response to 400 words.*

ADS (PIF) Question:

*Describe one example of how the program used the aggregated results of residents' performance and/or other program evaluation results to improve the program. (Have the written plan of action available for review by the site visitor.)
Limit your response to 400 words.*

ADS (PIF) Question:

*Describe the improvement efforts (not explained above) currently undertaken in the program based on feedback from the ACGME resident survey. What improvements, if any, has the program undertaken to address potential issues identified by the most recent ACGME resident survey summary report? Please review your survey summary.
Limit your response to 400 words.*

V. Evaluation
C. Program Evaluation and Improvement

ADS (PIF) Question:

Board Pass Rates for Residents graduating during the last three (3) years academic (rolling average)

Academic Year ending	Number of residents completing the program	Number of residents taking first stage of Board exam for the first time	Number of first time takers who passed the first stage of the Board exam	Number of residents taking second stage of Board exam for the first time	Number of first time takers who passed second stage of Board exam
June 30, 20__					
June 30, 20__					
June 30, 20__					

Resident Survey Questions:

8. Do you have the opportunity to confidentially evaluate your overall PROGRAM in writing or electronically at least once a year?

15. Have residents/fellows had the opportunity to assess the program for purposes of program improvement?

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

Common Program Requirement:

- A. *Principles*
1. *The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.*
 2. *The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.*
 3. *Didactic and clinical education must have priority in the allotment of residents' time and energy.*
 4. *Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.*

Explanation:

The primary goal of residency education is resident learning through patient care experiences. Residents are first and foremost students. The program must assure that there are adequate opportunities for the patient care activities relevant to the specialty, while assuring safe, high quality care for patients and a learning environment that supports development of abilities in a resident-centered way (enough responsibility and independence when the resident is ready but not overwhelming the residents too soon and jeopardizing patient care).

The sponsoring institution is required to develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common and specialty/subspecialty-specific Program Requirements and to provide a copy of the institution's duty hour policies and procedures as part of the ACGME institutional accreditation review process. These policies and procedures must include resident supervision, fatigue, duty hours, on-call activities, moonlighting, and duty hour exceptions. For all requirements related to duty hours and moonlighting, institutions or programs may set standards that are more restrictive than the ACGME common requirements or specialty-specific program requirements. Programs should have program-level policies on supervision and duty hours. Programs are responsible for assuring that all residents and faculty are familiar with the policies and procedures and for designing the resident learning environment to enable these policies and procedures to be properly implemented. Residents are responsible for adhering to the policies and procedures. Clear and frequent communication among institutional officials, program directors, faculty and residents is essential for achieving these goals.

VI. Resident Duty Hours in the Learning and Working Environment

B. Supervision of Residents

C. Fatigue

Common Program Requirement:

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

Explanation:

Principles underlying a sound **supervision** policy include: maximizing the resident educational experience while maintaining a focus on patient safety and quality patient care; clear communication of which medical staff physician has supervisory responsibility, the nature of that responsibility, and contact information for anticipated circumstances; and criteria for determining needed level of supervision for a given resident under a given set of circumstances. Clear definitions are preferred over general statements and may address levels of supervision and responsibility, determination and description of graduated levels of responsibility, expectations for how supervision will be documented in the medical record, progress notes, etc. as well as procedures for monitoring resident supervision.

The intent of the requirement on **fatigue** is not only to raise faculty and residents' awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care, but also to provide them with tools for recognizing when they are at risk and strategies to minimize the effects of fatigue (in addition to getting more sleep). Programs must educate faculty and residents on the signs of fatigue and sleep deprivation and implement policies to prevent and counteract potential effects on patient care and learning. This may be done by the program or by the sponsoring institution for all its programs. Note the inclusion of faculty in this requirement.

The most effective curriculum will include both didactic and experiential components, such as a combination of readings, presentations, case-based discussions, and role plays. Resources include a bibliography of articles on the effect of sleep loss on performance is available on the ACGME website: http://www.acgme.org/acWebsite/dutyHours/dh_sleepdepbib2.pdf as well as the LIFE Curriculum (Learning to Address Impairment and Fatigue to Enhance Patient Safety): <http://www.life3curriculum.info/>, available free-of-charge. It includes video segments, expert commentaries, discussion questions, suggested role play exercises and resources that may be used for self-study, embedded in classroom sessions or as one or more workshops.

VI. Resident Duty Hours in the Learning and Working Environment

B. Supervision of Residents

C. Fatigue

- **Documentation for supervision:** The Common PIF asks for a description of how residents are supervised. (See PIF question below.) Additional documentation includes the written resident supervision policy. Site visitors will verify through review of supervision policies and resident survey responses (see survey question below), and may use interviews for additional verification as needed.

ADS (PIF) Question:

Briefly describe how the faculty provides appropriate supervision of residents in patient care activities.

Resident Survey Question:

2. Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?

- **Documentation for fatigue requirements:** Resident perceptions about sufficient education on fatigue and sleep deprivation are reported as part of the Resident Survey. (See survey question below.) Compliance will be determined through site visitor review of relevant policies and procedures, survey responses, and interviews. Interviews will focus on knowledge of policies and procedures, monitoring practices for signs of fatigue and sleep deprivation, and evidence that schedules are adjusted appropriately when necessary.

Resident Survey Question:

13. Have you had sufficient education (from your program, your hospital(s), your institution, or your faculty) to recognize and counteract the signs of fatigue and sleep deprivation?

VI. Resident Duty Hours in the Learning and Working Environment

D. Duty Hours

Common Program Requirement:

- D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)*
Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- 1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.*
 - 2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.*
 - 3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.*

Explanation:

Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, short call, home call, night float and day float, transfer of patient care, and administrative activities related to patient care. Most if not all questions related to interpretation of the duty hour standards are addressed in a frequently updated FAQ located on the ACGME duty hour website: http://www.acgme.org/acWebsite/dutyHours/dh_faqs.pdf (April, 2007 update).

Both the program and its sponsoring institution are required to monitor resident duty hours. There is no requirement for how monitoring and tracking should be handled. Programs and institutions report using a variety of approaches to reduce resident hours, including scheduling changes (e.g., short call, night float, redesigning patient care and education systems) and using nurse practitioners, physician assistants or hospitalists to assume some patient care responsibilities formerly held by residents. Some examples are described on the ACGME Duty Hour website: http://www.acgme.org/acWebsite/dutyHours/dh_innovative.asp.

The sponsoring institution must have written formal policies and procedures governing resident duty hours that provide guidance for programs to meet the duty hour requirements.

VI. Resident Duty Hours in the Learning and Working Environment

D. Duty Hours

- **Documentation for duty hour requirements:** The Common PIF contains 6 duty hour questions. (See PIF questions below.) For programs having four or more residents, residents report their perceptions on compliance with the common duty hour requirements by responding to several survey questions. (See survey questions below.) The aggregated results of the Resident Survey are available to program directors and DIOs through ADS if 70% of the residents/fellows complete the survey. Programs can use this information to determine if compliance problems suggested by the data are confirmed by the residents, and can also use the data to pinpoint compliance problems and to address them before their next ACGME site visit.

ADS (PIF) Questions:

RESIDENT DUTY HOURS

For the previous four week period:	Response:
Excluding call from home, what was the average number of hours on duty per week per resident for the last four week rotation(s)?	
On average, how many days per week of in-house call (excluding home call and night float) were residents assigned for their last four week rotation(s)?	
Excluding call from home, what was the longest shift (in hours) worked by any resident during the last four week rotation(s)? (This is not the maximum hours per week)	
On average, do residents have 1 full day out of 7 free from educational and clinical responsibilities (If no, explain below)?	
Do residents have a 10 hour period between daily duty periods and after in-house call (If no, explain below)?	
Do residents have appropriate duty hours when rotating on other clinical services, in accordance with the ACGME-approved program requirements (If no, explain below)?	

Resident Survey Questions:

20. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Have you met this requirement?

21. Residents/fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. Have you met this requirement?

22. There should be a 10-hour time period provided between all daily duty periods and after in-house call. Have you met this requirement?

VI. Resident Duty Hours in the Learning and Working Environment

D. Duty Hours

29. *If you noted any issues with duty hours in the section above, would you say that those issues occurred mostly on rotations to other services outside your specialty?*

30. *Averaged over your last 4-week rotation, excluding call from home, how many hours per week were you on duty?*

32. *How many times in the previous 3 months did you get fewer than 10 hours off duty between duty shifts?*

- **Note on determining compliance:** In the accreditation process, the ACGME uses a substantial compliance model that emphasizes continuous improvement by institutions and programs for compliance with all ACGME standards, and promotion of good learning, resident well-being and safe patient care. Programs and sponsoring institutions should examine any data suggesting non-compliance in order to determine underlying causes. Site visitors will interview residents in order to verify and clarify all questions where the responses suggested non-compliance as well as any negative comments in the comment section of the survey. The ACGME does not specify what, if any, systems programs or institutions might use for monitoring.

VI. Resident Duty Hours in the Learning and Working Environment

E. On-call Activities

Common Program Requirement:

E. On-call Activities

- 1. In-house call must occur no more frequently than every third night, averaged over a four-week period.*
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.*
- 3. No new patients may be accepted after 24 hours of continuous duty.*
- 4. At-home call (or pager call)*
 - a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.*
 - b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.*
 - c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.*

Explanation:

On-call duty is defined as a continuous duty period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home. At-home call (pager call) may be overnight or may be for a longer period, such as a weekend. Assignment of at-home call must be appropriate to the service intensity and frequency of being called, and it should not be used for high intensity settings. At-home call also needs to be compliant with the requirement that one day out of seven must be free from all program assignments and duties. Regular duty shifts, such as those worked in the ICU, on Emergency Medicine rotations and during “night float,” used instead of in-house call to reduce the continuous duty period are exempt from the requirement that call be scheduled no more frequently than every third night.

The activity that drives the 24-hour limit is “continuous duty.” If a resident spends 12 hours in the hospital caring for patients, performing surgery, or attending conferences, followed by 12 hours on-call, he/she has spent 24 hours of “continuous duty” time. The resident now has up to 6 additional hours during which their activities are limited to participation in didactic activities, transferring care of patients, conducting continuity outpatient clinics, and maintaining continuity of medical and surgical care as defined by their specialty’s Program Requirements.

VI. Resident Duty Hours in the Learning and Working Environment
E. On-call Activities

The goal of the added hours at the end of the on-call period is to promote didactic learning and continuity of care, including ambulatory and surgical continuity. The Review Committees have developed clarifying language for activities that are permitted during the six hours after the end of the 24-hour continuous duty period. (See summary document: http://www.acgme.org/acWebsite/dutyHours/dh_specificDutyHours.pdf.) Additional questions related to on-call activities are addressed in the Duty Hour FAQ: http://www.acgme.org/acWebsite/dutyHours/dh_faqs.pdf.

- **Documentation for on-call activities:** The Common PIF contains six duty hour questions, some of which specifically address requirements related to on-call activities. (See PIF questions below.) For programs having four or more residents, residents report their perceptions of how well they believe they have met these requirements by responding to several survey questions. (See survey questions below.) Additional documentation includes work and call schedules and written policies and procedures for resident duty hours, night float (if present), and the working environment. The aggregated results of the Resident Survey are available to program directors and DIOs through ADS if 70% of the residents/fellows complete the survey. Programs can use this information to determine if compliance problems suggested by the data are confirmed by the residents, and can also use the data to pinpoint compliance problems and to address them before their next ACGME site visit.

ADS (PIF) Questions:

RESIDENT DUTY HOURS

For the previous four week period:	Response:
Excluding call from home, what was the average number of hours on duty per week per resident for the last four week rotation(s)?	
On average, how many days per week of in-house call (excluding home call and night float) were residents assigned for their last four week rotation(s)?	
Excluding call from home, what was the longest shift (in hours) worked by any resident during the last four week rotation(s)? (This is not the maximum hours per week)	
On average, do residents have 1 full day out of 7 free from educational and clinical responsibilities (If no, explain below)?	
Do residents have a 10 hour period between daily duty periods and after in-house call (If no, explain below)?	
Do residents have appropriate duty hours when rotating on other clinical services, in accordance with the ACGME-approved program requirements (If no, explain below)?	

VI. Resident Duty Hours in the Learning and Working Environment

E. On-call Activities

Resident Survey Questions:

23. *In-house call must occur no more frequently than every third night, averaged over a four-week period. Have you met this requirement?*

24. *Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents/fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care. Have you met this requirement?*

25. *No new patients may be accepted after 24 hours of continuous duty. Have you met this requirement?*

26. *At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident and fellow. Have you met this requirement?*

27. *Residents/fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. Have you met this requirement?*

31. *How many times in the previous 3 months did you work more than 30 continuous hours?*

- **Verification of compliance:** Site visitors will review resident survey results, spot check documents, and interview faculty and residents. They will look for evidence that resident activities are monitored and that there are systems to provide back-up support when patient care responsibilities are prolonged or unexpected circumstances create resident fatigue.

VI. Resident Duty Hours in the Learning and Working Environment

F. Moonlighting

G. Duty Hours Exceptions

Common Program Requirement:

F. Moonlighting

- 1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.*
- 2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.*

G. Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

- 1. In preparing a request for an exception the Program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.*
- 2. Prior to submitting the request to the Review Committee, the Program director must obtain approval of the institution's GMEC and DIO.*

VI. Resident Duty Hours in the Learning and Working Environment

F. Moonlighting

G. Duty Hours Exceptions

Explanation:

Moonlighting: Consistent with ACGME [Institutional Requirements](#) (II.D.4.j), the written policy on moonlighting⁶ must include the following: residents must not be required to engage in moonlighting; a prospective, written statement of permission from the program director is required and must be maintained in the resident's file; residents' performance must be monitored for the effect of moonlighting activities and adverse effects may lead to withdrawal of permission. Program directors have primary responsibility for monitoring these effects. Internal (in-house) moonlighting must be considered part of the 80-hour weekly limit on duty hours. None of the other numeric standards (e.g., 10 hours rest period, one in seven free of all program responsibilities) apply. However the expectation is that the residents' total hours spent in-house will not exceed what is advisable for patient safety and resident learning and well-being. The intent is to apply the same standard to all hours residents spend in teaching institutions, whether those hours are part of the required educational program or are spent moonlighting in-house. In addition, it prevents institutions from inappropriately using in-house moonlighting to replace clinical service activities that residents may have covered previously as part of the educational program. Individual programs and institutions may prohibit or limit resident moonlighting and may wish to notify residents and applicants of any such restrictions. Additional questions related to this requirement are addressed in the duty hour FAQ: http://www.acgme.org/acWebsite/dutyHours/dh_faqs.pdf.

Duty Hours Exceptions: An increase in duty hours above 80 hours per week can be granted only when there is a legitimate educational justification for the added hours. The expectation is that all hours in the extended week contribute to resident education. An example is that a surgical program needs to demonstrate that residents do not attain the required case experiences in some categories unless resident hours are extended beyond the weekly limit, and that all reasonable efforts to limit activities that do not contribute to enhancing their surgical skills have already been made. Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and for a subgroup of the residents/fellows in the program (e.g., the chief resident year) or for individual rotations or experiences. Any duty hour exception requests must be endorsed by the sponsoring institution's GMEC and DIO and approved by the Review Committee. The maximum duration of the approval may not exceed the length of time until the program's next site visit and review. At the time of each site visit, the program must provide information about the exception. The Review Committee will re-evaluate both patient safety and the educational rationale for the exception, and may continue, deny, or modify the exception. Consult [ACGME Policies and Procedures](#) (II.D.) for additional information regarding duty hour exceptions. Nine Review Committees categorically do not permit programs to use the duty hour exception: anesthesiology, emergency medicine, family medicine, internal medicine, neurology, nuclear medicine, pediatrics, diagnostic radiology, and transitional year.

⁶ Patient care activities external to the educational program in which residents engage at sites used by the educational program ("in-house" moonlighting) and other clinical sites.

VI. Resident Duty Hours in the Learning and Working Environment

F. Moonlighting

G. Duty Hours Exceptions

- **Documentation for moonlighting:** Site visitors will verify compliance with moonlighting requirements by review of the written policy on moonlighting and interviews with the program director and the residents. Interviews will focus on familiarity with policies and procedures, compliance, and monitoring of residents for undue fatigue and ability to provide safe and effective patient care as well as to fully participate in all educational activities.
- **Documentation for duty hours exceptions:** The Common PIF contains several questions related to duty hour exception requirements. (See PIF questions below.) Site visitor verification for programs with duty hour exceptions will pay particular attention to monitoring of the educational justifications.

ADS (PIF) Questions:

Does the program have approval from the Review Committee for an exception to the 80-hour per week duty hour limit?

Yes _____ No _____

If yes, provide the date of the Review Committee approval. _____

If yes, provide a description of the exception (e.g., specific rotations, program-wide).

If yes, and the program is requesting continued approval of the exception, complete the following:

Patient Safety: Describe how the program and institution have monitored, evaluated, and ensured patient safety with extended resident work hours.

Educational Rationale: Describe the educational rationale for the exception in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of education.

Moonlighting Policy: Describe the program's moonlighting policies for residents who have the duty hour exception.

Call Schedules: Describe the resident call schedules during the times specified for the exception.

Faculty Monitoring: Describe the faculty development activities about the effects of resident fatigue and sleep deprivation.

VII. Experimentation and Innovation

Common Program Requirement:

Requests for experimentation or innovative projects that may deviate from the institutional, common and specialty specific program requirements must be approved in advance by the RC. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Procedures located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

Explanation:

Innovations are initiated at the program level and may involve an individual program, a group of residents (e.g., PGY1 residents) or an individual resident (e.g., chief resident). Such projects differ from ACGME-approved pilot projects, which are initiated by the Review Committee and affect several programs. Programs may also be involved in non-ACGME-approved pilots or innovative projects (e.g., initiated and supported by the institution or grant agency) but these are not subject to documentation, monitoring or review by the Review Committee as long as deviations from requirements do not occur as part of the project.

Procedures for approving proposals, including eligibility criteria, proposal content, and monitoring, are available from the ACGME website: [Proposal for Program Experimentation and Innovation](#). The program director should complete the [Program Experimentation and Innovative Projects Proposal Form](#) and supply all of the requested information. The DIO must sign the proposal indicating review and approval of the sponsoring institution's GMEC. Proposals should not exceed five pages in length. Additional documents should be attached as numbered appendices. One copy of the proposal should be sent via standard mail to the executive director to the appropriate ACGME Review Committee.

Proposals which include requests for a waiver/suspension of Common Program or Institutional Requirements require ACGME approval; the proposal will be reviewed by ACGME prior to consideration by the Review Committee. This process may delay the response time from the Review Committee. Program directors should estimate six-nine months for a decision from the Review Committee. The Review Committee executive director will provide official notification to the program director and DIO of the Review Committee's decision, which will include the duration of the approval (will not exceed the next accreditation review) and the method of monitoring (e.g., progress reports, updates) by the Review Committee. Reviews and decisions will be made following policy approval. (See [ACGME Policies and Procedures](#): II.D. Procedures for Approving Proposals for Experimentation and Innovative Projects.)