

## **ACGME Program Requirements for Graduate Medical Education in Family Medicine Geriatric Medicine and Family Medicine Sports Medicine**

### **I. Introduction**

The following generic requirements pertain to programs in Family Medicine Geriatric Medicine, and Family Medicine Sports Medicine. Each program must comply with the requirements listed below, as well as with the specialty content found in the Program Requirements for each respective area.

These programs must exist in conjunction with and be an integrated part of a family medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Their existence should not compromise the integrity of the core program.

### **II. Institutions**

#### **II.A. Sponsoring Institution**

**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.**

#### **II.B. Participating Institutions**

**II.B.1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**

**II.B.2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**

**II.B.2.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**

**II.B.2.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

**II.B.2.c) specify the duration and content of the educational experience; and**

**II.B.2.d) state the policies and procedures that will govern resident education during the assignment.**

- II.B.3. Participation by any institution providing more than 3 months of training in a program must be approved by the Residency Review Committee (RRC).
- II.B.4. A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the Program Director.

### III. Program Personnel and Resources

#### III.A. Program Director

- III.A.1. **There must be a single Program Director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either Program Director or department chair, the Program Director should promptly notify the Executive Director of the RRC through the Web Accreditation Data System of the ACGME.** The Director must be fully committed to the program in order to devote sufficient time to the achievement of the educational goals and objectives. She or he must have sufficient authority to manage, control, and direct the program.
- III.A.2. **The Program Director, together with the faculty, is responsible for the general administration of the program,** including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation, **and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the Program Director and faculty are essential to maintaining such an appropriate continuity of leadership.**
- III.A.3. **Qualifications of the Program Director are as follows:**
- III.A.3.a) **The Program Director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
- III.A.3.b) **The Program Director must be certified in the specialty by the American Board of Family Medicine, or possess qualifications judged to be acceptable by the RRC.** Directors of programs in geriatric medicine may be certified by either the American Board of Family Medicine or the American Board of Internal Medicine, and must possess a Certificate of Added Qualification (CAQ) in Geriatric Medicine from the same Board. Directors of programs in sports medicine may be certified by any of the following Boards: American Board of Emergency Medicine, American Board of Family Medicine, American Board of Internal Medicine, or American Board of Pediatrics; Directors must possess a CAQ in

Sports Medicine from that same Board. The RRC will determine the adequacy of alternate qualifications.

**III.A.3.c) The Program Director must be appointed in good standing and based at the primary teaching site.**

**III.A.4. Responsibilities of the Program Director are as follows:**

**III.A.4.a) The Program Director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**

**III.A.4.b) The Program Director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**

**III.A.4.c) The Program Director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

**III.A.4.d) The Program Director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**

**III.A.4.d).(1) the addition or deletion of a participating institution;**

**III.A.4.d).(2) a change in the format of the educational program;**

**III.A.4.d).(3) a change in the approved resident complement for those specialties that approve resident complement.**

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

**III.A.4.e) The Program Director is responsible for the preparation of a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment. This statement must be distributed to residents and members of the teaching staff, and be readily available for review.**

- III.A.4.f) The Program Director is responsible for the selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.
- III.A.4.g) The Program Director is responsible for the supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
- III.B. Faculty**
- III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**
- III.B.2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, a commitment to their own continuing medical education, and participation in scholarly activities; and must support the goals and objectives of the educational program of which they are a member.**
- III.B.3. 3. Qualifications of the physician faculty are as follows:**
- III.B.3.a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
- III.B.3.b) The physician faculty must be certified in the specialty by the American Board of Family Medicine, and hold a CAQ in geriatric medicine or sports medicine, as appropriate, or possess qualifications judged to be acceptable by the RRC.**
- III.B.3.c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- III.B.4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Although not all members of the teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity. *Scholarship* is defined as the following:**
- III.B.4.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**

- III.B.4.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
- III.B.4.c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.
- III.B.4.d) Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

**III.B.5. Qualifications of the nonphysician faculty are as follows:**

- III.B.5.a) Nonphysician faculty must be appropriately qualified in their field.
- III.B.5.b) Nonphysician faculty must possess appropriate institutional appointments.

**III.C. Other Program Personnel**

**Additional necessary professional, technical, and clerical personnel must be provided to support the administration and educational conduct of the program.**

**III.D. Resources**

**The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**

- III.D.1. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions.
- III.D.2. The library services should include the electronic retrieval of information from medical databases. There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

**IV. Resident Appointments**

#### **IV.A. Eligibility Criteria**

**The Program Director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**

IV.A.1. Residents who are appointed to programs in geriatric medicine should have satisfactorily completed an ACGME-accredited residency in family medicine or internal medicine, or a family medicine residency that has been accredited by the College of Family Physicians of Canada or by the American Osteopathic Association. Residents appointed to the sports medicine programs should have completed an ACGME-accredited residency in emergency medicine, family medicine, internal medicine, or pediatrics.

(N.B.: Candidates who have not completed an ACGME-accredited residency in the specialties listed above may not be eligible to sit for the certification examination for a CAQ in these specialties. If accepted into the program, they must be so advised in writing by the Program Director, with the inclusion of a statement encouraging them to contact their primary specialty board for verification. They may, however, participate in the training program.)

#### **IV.B. Number of Residents**

**The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.**

#### **IV.C. Resident Transfers**

**To determine the appropriate level of education for residents who are transferring from another residency program, the Program Director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A Program Director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

#### **IV.D. Appointment of Fellows and Other Students**

**The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.**

### **V. Program Curriculum**

#### **V.A. Program Design**

**V.A.1.**

**Format**

**The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.**

The Director and teaching staff of a program must prepare and comply with written educational goals for the program. All educational components of the residency program must be related to these goals, and should be structured educational experiences for which a specific methodology and method of evaluation exist.

**V.A.2.**

**Goals and Objectives**

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.**

**V.B.**

**Specialty Curriculum**

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

**V.C.**

**Residents Scholarly Activities**

**Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

The program must provide support for resident participation in scholarly activities, and offer guidance and technical support (e.g., research design, statistical analysis) for residents involved in research. Residents must participate in journal clubs and research conferences.

**V.D.**

**ACGME Competencies**

(Applicable to programs in Family Medicine Geriatric Medicine and Family Medicine Sports Medicine as of July 1, 2006.)

**The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

**V.D.1.**

***Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**

- V.D.2. ***Medical Knowledge*** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
- V.D.3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
- V.D.4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
- V.D.5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
- V.D.6. ***Systems-based practice***, as manifested by actions that 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.

## **VI. Resident Duty Hours and the Working Environment**

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

### **VI.A. Supervision of Residents**

- VI.A.1. All patient care must be supervised by qualified faculty. The Program Director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- VI.A.2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- VI.A.3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

### **VI.B. Duty Hours**

- VI.B.1. Duty hours are defined as all clinical and academic activities related to the residency 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.

- VI.B.2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- VI.B.3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
- VI.B.4. 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.
  - VI.B.4.a) The RRC will not consider requests for a rest period of fewer than 10 hours.

#### VI.C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

- VI.C.1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
  - VI.C.1.a) The schedule for the residents should allow them to make full use of their educational experiences without counterproductive stress, fatigue, or depression. There should be adequate staff to prevent excessive patient loads and excessive length and frequency of call.
  - VI.C.1.b) Formal written policies on these matters must be established and available for review.
- VI.C.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents 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.
- VI.C.3. No new patients may be accepted after 24 hours of continuous duty.
- VI.C.4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.

- VI.C.4.a)** The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents 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.
- VI.C.4.b)** When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- VI.C.4.c)** The Program Director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

**VI.D. Moonlighting**

- VI.D.1.** Because residency education is a full-time endeavor, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.D.2.** The Program Director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
- VI.D.3.** Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

**VI.E. Oversight**

- VI.E.1.** Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.
- VI.E.2.** Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

**VI.F. Duty Hours Exceptions**

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VI.F.1. The RRC for Family Medicine will not consider requests for an exception to the limit to 80 hours per week, averaged monthly.

## **VII. Evaluation**

### **VII.A. Resident**

#### **VII.A.1. Formative Evaluation**

**VII.A.1.a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**

**VII.A.1.b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**

**VII.A.1.c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**

#### **VII.A.2. Final Evaluation**

**The Program Director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.**

### **VII.B. Faculty**

**The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.**

### **VII.C. Program**

**The educational effectiveness of a program must be evaluated at least annually in a systematic manner.**

- VII.C.1. Representative program personnel (i.e., at least the Program Director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
- VII.C.2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**
- VII.C.3. There should also be periodic evaluation of the use of resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.**

### **VIII. Experimentation and Innovation**

**Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

### **IX. Certification**

**Residents who plan to seek certification by the American Board of Family Medicine should communicate with the office of the board regarding the full requirements for certification.**

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