

Family Medicine

Most Common Citations in Core Family Medicine Programs

1. **The Education Program:** Educational Program - Patient Care Experience: FMC patient pop/visits; **n=60**
2. **The Education Program:** Educational Program - Patient Care Experience: Maternity Care; **n=45**
3. **Institutional Support:** Institutional Support-Sponsoring Institution; **n=35**
4. **Prog Pers & Resources:** Responsibilities of Program Director; **n=25**
5. **The Education Program:** Curricular Development Management of Health Systems; **n=18**
6. **The Education Program:** Service to Education Imbalance; **n=18**

Potential Challenges for Prospective THC's Applying for Accreditation

Institutional Support:

- Internal Review/Process/Midpoint Institutional Requirement IV.A.2: Internal reviews must be in process and documented in the GMEC minutes by approximately the midpoint of the accreditation cycle. The accreditation cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site visit.
 - Must a single residency institution conduct an internal review as specified in the institutional requirements?
 - A single residency institution is expected to be in compliance with the Institutional Requirements but may have a modified version of a GMEC. The Committee must conduct an internal review mid-way through the interval between site visits and should include representatives from other specialty areas and from administration. It should not include the program director and faculty of the program being reviewed, but they should be interviewed during the process. Since there are no other residencies in a single residency institution, resident membership on this committee is not required. Formal minutes should be kept of the meeting at which the GMEC reviews the information and makes its conclusions. These must be discussed with the program director. If it is found that the program is not in compliance with the program requirements, it is the responsibility of the sponsoring institution to ensure that the program has the required resources to achieve compliance.
 - The DIO must make sure that internal reviews are scheduled and take place as required. Documentation in the GMEC meeting minutes of date, attendees, etc. is important and will be verified by the site visitor.
- Sponsoring Institution/Educational and work Environment Institutional Program Requirement II.F.1 The Sponsoring Institution and its programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation.
 - NOTE: The suggested approach is to have a third-party resolution process.

Participating Sites:

- I.B.3. Participating hospitals may not be at such a distance from the primary teaching sites that they require excessive travel time or otherwise fragment the educational experience.
 - NOTE: Undue travel may have a negative impact on the resident's education and safety, and patient care and safety, continuity of care, conference attendance and resident well-being. Sites should be as close as possible to the primary hospital and FMC as possible.

Resident Support Group:

- II.A.4.k).(1) Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.
 - NOTE: New programs should be aware of this program requirement.

Faculty:

- II.B.2. The physician faculty must have current certification in the specialty by the American Board of Family Medicine, or possess qualifications acceptable to the Review Committee.
 - NOTE: This is a very important to the FM RRC and very few exceptions are considered.
- II.B.3.a) Family physician faculty must have admitting privileges in the hospital(s) where the FMC patients are hospitalized. Programs should assess the skills and credentials of individual faculty to perform procedures and care for the types of problems they will be teaching the residents. The professional skills of the teacher should always be documented as up to date and meeting the criteria for credentials and privileges of the primary hospital.
 - NOTE: Faculty members are expected to role-model patient care in all settings including inpatient settings.

Faculty Scholarly Activity:

- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:
 - II.B.5.b).(1) peer-reviewed funding;
 - II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks;
 - II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
 - II.B.5.b).(4) participation in national committees or educational organizations.
- II.B.5.c) Faculty should encourage and support residents in scholarly activities.

- NOTE: Examples of scholarly activity include those mentioned above plus professional presentations beyond the local level and quality improvement or practice improvement projects. Scholarly activity cannot only be quality improvement projects. Faculty should aim for one type of scholarly activity each year. Make sure that faculty scholarly activity information in the PIF is consistent with information provided in faculty CVs.

Number of Faculty:

- II.B.7. Faculty/Resident Ratio
 - There must be a sufficient number of hours contributed by a critical mass of family physician faculty to prevent fragmentation of the learning experience. In addition to the program director, there must be at least one full-time equivalent (FTE) family physician faculty for each six residents in the program. Any program in operation must have at least two family physician faculty members, including the director, regardless of resident complement. By the time a program offers all three years of training with the required minimum number of resident positions (i.e., 4-4-4) at least one of the additional family physician faculty must be full time. A full-time commitment is at least 1400 hours per year devoted to the residency spent in resident administration, resident teaching, resident precepting and attending duties, exclusive of time spent in direct patient care without the presence of residents. As the resident complement increases beyond the minimally acceptable size, additional full-time family physician faculty will be needed to provide a core group of family physician faculty. Where part-time faculty members are utilized, there must be evidence of sufficient continuity of teaching and supervision.
- IV.A.5.a).(2).(c).(ii) Faculty Supervision
 - Whenever residents are performing clinical duties in the FMC, there must be an appropriate number of family physician faculty who, without other obligations, are engaged in active teaching and supervision of the residents. The appropriate number of faculty must be determined in relation to the level of training of the residents, the number of patients being seen in a clinic session, and the competency of the residents. In general, there should be at least one supervising family physician faculty member who is freed of all other activities for every four residents working in the clinic at any given time. If only one resident is seeing patients in the FMC, a single faculty member may be engaged in other activities to a maximum of 50%, but the teaching and supervision of the resident must take priority. Faculty time involved with medical students and other learners under the faculty's clinical supervision should not dilute the supervision of residents.
- NOTE: It is very important that these faculty to resident ratios be met.

FMC/FQHC/THC Criteria:

- II.D.2.a).(4) Programs that involve training in Community, Migrant Health Centers (C/MHCs) or Federally Qualified Health Centers (FQHC) must provide assurance that these facilities meet the

criteria for an FMC, as outlined below, unless an exception is approved by the Review Committee.

- II.D.2.b) Administration and Staffing
 - II.D.2.b).(1) The program director must have control of the educational activities that occur in the FMC, and of the activities of the support personnel. The program director must participate in and provide leadership for decisions affecting the FMC.
- II.D.2.c).(2) When an FMC is at such a distance from the primary hospital that the patients are hospitalized elsewhere, the program director must demonstrate how the residents will efficiently maintain continuity for their patients at one hospital while having their required rotations at another; the extent to which residents are able to participate in the program's educational activities, such as required conferences must also be demonstrated.
- II.D.2.d).(2) A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Center.
- II.D.2.d).(3) Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.
- II.D.2.d).(5) The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.
- II.D.2.g).(4) Programs not currently using an electronic medical record system should document their plans for conversion to one in the near future.
- II.D.2.h) Source of Income
 - The fiscal operation of the FMC must reflect an appropriate balance between education and service. Service demands must not adversely affect educational objectives. A plan should be in place to ensure fiscal stability of the program.
- IV.A.5.a).(2).(c).(iii).(c) The three-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year. The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these patients are seen in continuity by the residents.
- IV.A.5.a).(2).(c).(iii).(d) Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the residents' panels who are seen at home, at long-term care sites, and patients seen in an OB continuity care setting.
- IV.A.5.a).(2).(c).(iv) FMC Continuity and Accessibility
- IV.A.5.a).(2).(c).(iv).(a) The learning of continuity of care requires stable, protected physician-patient relationships that are structured to enhance both resident learning and patient care.

Therefore, assignment of patients to a personal physician in the FMC is required. Whenever possible, residents should see their own patients to develop the doctor-patient relationship. In addition, there should be a team structure to ensure appropriate back-up for the patients to experience continuity of care.

- NOTE: The primary setting for training in the knowledge, skills, and attitudes of family medicine is the model office or Family Medicine Center where each resident must provide continuing, comprehensive care to a panel of patient families. This should operate as a model for which residents to base their future practices upon.
- FMCs must have:
 - a reception and appointment desk area for FMC use only,
 - a waiting room,
 - a business office,
 - a separate private area for resident precepting
 - Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care.
 - The FMC must have procedure room(s) that are separate from exam rooms
 - Additional space for individual and small group counseling must be included.
 - Faculty offices, if not in the FMC, must be immediately adjacent to the Center.
 - Basic diagnostic and therapeutic space should be in the FMC, including laboratory tests commonly included as waived or point-of-service (e.g., urine analysis and wet mounts) which may require efficiency of physician interpretation should be available within the FMC. Diagnostic laboratory and imaging services should either be in the FMC or nearby to provide prompt and convenient access by patients and residents
- What are the expectations regarding FM physicians having offices in the residency program's FMC? (*Program Requirements II.D.2*)
 - The requirements state that non-residency activities may not take place in the Family Medicine Center. Family physicians may have their offices in the FMC only if they are identified as teaching faculty who contribute at least 400 hours per year to the residency.
- What are the expectations regarding other non-FM physicians having offices in the FMC? (*Program Requirements II.D.2*)
 - Physicians from other specialties may have offices in the FMC, in which they see private patients, if they contribute at least 1400 hours per year to the family medicine residency and no more than 600 hours is devoted to seeing their own private practices in the FMC without FM residents.
 - Other clinics, such as occupational medicine, may take place in the FMC if these activities are directed by the family medicine faculty and exist for the purpose of teaching the family medicine residents.

- Accredited programs in Family Medicine Sports Medicine and in Family Medicine-Geriatric Medicine may take place in the FMC.
- If a private practice is used as the FMC for the rural component of a 1-2 program, all of the physicians in the practice must be actively involved in the education of the Family Medicine residents. Their involvement in the teaching program must be documented by the Program Director at the time of each review. Because of the small number of residents at the rural site, the faculty need not contribute the hours listed above to the program.
- What are the expectations related to the FMC?
(*Program Requirements II.D.2*)
 - This is the model unit that must be contained within walls and is clearly identified as the Family Medicine Center on the door of entry to this unit. When one enters the door of the FMC, one finds all of the components that are listed as required, and nothing else. That is, there are no non-residency related activities taking place within the walls of the FMC. While this unit may be on the same floor as other specialty clinics or private practices, it must be a discrete unit that is separated from those activities by walls.

Minimum Number of Residents:

- III.B.2.a) To provide adequate peer interaction, a program should offer at least four positions at each level and should retain, on average, a minimum complement of 12 residents.
- III.B.3. Special Tracks
 - III.B.3.a) In certain cases, such as programs that operate in the 1-2 format, the Review Committee may approve a smaller resident complement, but this should include at least one resident at each of the second and third levels or two residents at one of these levels to ensure peer interaction.
 - III.B.3.b) Such programs are encouraged to arrange opportunities for the residents to interact with other residents (e.g., through didactic sessions at the parent program).
- NOTE: A critical mass of residents is required, unless it is a special track program such as a 1-2 program. In this instance, it is very important that the residents in the rural program interact with other residents from the parent program.

Inpatient Criteria and Experiences:

- II.D.3. Inpatient Facilities
 - II.D.3.a) The inpatient facilities must be of sufficient size and have an adequate number of occupied teaching beds to ensure an appropriate patient load and variety of problems for the education of the number of residents and other learners on the services. Inpatient facilities must also provide sufficient physical, human, and educational resources for training in family medicine. In determining the adequacy of the number of occupied beds in the primary and hospitals, the patient census, the types of patients and their availability for residency education, and the range of support services will be considered.

- NOTE: The minimum number of beds should be at least 135.
- IV.A.5.a).(2).(e) Inpatient Experiences
 - IV.A.5.a).(2).(e).(i) The resident must develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. In-patient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service, and must involve teaching and role-modeling by family physician faculty. Daily faculty rounds must occur to ensure appropriate supervision and teaching. Each resident must also receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. Additional experience will occur on other inpatient services.
 - IV.A.5.a).(2).(e).(ii) The length, breadth, and intensity of the experience must ensure that every resident becomes competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician. Residents must demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures of medicine, appropriate consultation and discharge planning and continuing care. Residents must demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient's condition.
 - IV.A.5.a).(2).(e).(iii) Residents are expected to maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. The residency must foster a team system that ensures continuity of care from the patient's perspective when the primary resident is unable to be present in both inpatient and outpatient settings. The continuity resident is expected to communicate daily with the hospital resident, and to provide long-term continuity care after discharge.
 - IV.A.5.a).(2).(e).(iv) The residency must define and monitor the most common medical problems cared for by family physicians in the hospital where inpatient experience takes place. Residents must receive ample clinical experience in caring for these problems. There must also be a didactic curriculum that covers these common medical problems. This list of common diagnoses should be generally consistent with national data that are published about family medicine. The program must document how the residents' skills are progressing from care that is dependent on supervision by faculty toward unsupervised, independent care at the time of graduation. The program must also document the residents' competency in providing supervision to others in a learning environment.
 - IV.A.5.a).(2).(e).(v) Upon completion of training, residents must be competent to provide hospital care. Assessment of resident hospital practice must be included in the required semiannual resident evaluation.

- IV.A.5.a).(2).(e).(vi) By the conclusion of the residency, residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision, and to utilize appropriate consultation by other specialists. Procedural skill documentation should indicate when the resident is capable of independent performance of the procedure.
- NOTE: Inpatient experiences are an essential component of family medicine programs and faculty members are expected to provide meaningful direct patient care and teaching as well. Using internal medicine physicians or pediatricians only does not meet program requirements.

Program Evaluation:

- Evaluation/Program/Annual Formal and Systematic Evaluation of Curriculum Common Program Requirement: V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. Evaluation/Program/Written Plan of Action Common Program Requirement: V.C.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.
 - NOTE: Single program sponsored programs are not exempt from this requirement. The annual program evaluation is distinct from the mid-cycle internal review conducted by the GMEC. Programs need to document that the annual internal review takes place, opportunities for improvement are identified and subsequent action is taken to improve (normally documented in meeting minutes).

Internal Medicine

Most Common Citations in Core Internal Medicine Programs

123 Core Programs Reviewed; Total of 478 Citations = 3.9 citations/program

Name and Description of Citations; times cited; % of total

- 1. Patient Care Experience** - inadequate continuity clinic volume; inadequate patient population; inadequate qualifications for CCU director; residents do not write orders for their patients; insufficient ambulatory time; consultations from other specialties not provided in a timely manner for ambulatory patients; **n = 71; 14.9% of total**
- 2. Didactic Components** - core conferences do not include all required elements; core conferences are not repeated with sufficient frequency; teaching rounds are not regularly scheduled; **n = 42; 8.8% of total**
- 3. Evaluation of Program** - no action plan to address deficiencies; residents not included in annual review of the program; curriculum not reviewed at least annually; residents do not formally evaluate the program in writing; **n = 37; 7.7% of total**
- 4. Responsibilities of Program Director** - inadequate oversight of IM subs; no mechanism to monitor duty hours; inadequate/inaccurate PIF; no approval for increases in complement; **n = 35; 7.3% of total**
- 5. Institutional Support** - internal review did not occur mid-cycle; no formal written protocol for internal review; inadequate oversight of program; environment of fear/intimidation; IM program not in a department of medicine; approval not obtained for major change in structure; **n = 32; 6.7% of total**
- 6. Evaluation of Residents** - semiannual evaluation not documented; faculty do not routinely provide verbal feedback at the end of a rotation; inadequate multi-source evaluation; **n = 32; 6.7% of total**
- 7. Qualifications of Faculty** - lack of ABIM/ABMS certification; **n = 25; 5.2% of total**
- 8. Responsibilities of Faculty** - insufficient time devoted to educational program; faculty do not encourage residents in scholarly activities; written goals and objectives not reviewed with residents at start of each assignment; **n = 25; 5.2% of total**
- 9. Service to Education Imbalance** - excessive reliance placed on residents to meet service needs; more than eight learners on rounds with the residents **n = 25; 5.2% of total**
- 10. Procedural Experience** - procedural logbooks/tracking system not maintained; insufficient instruction and clinical experience with procedures; **n = 21; 4.4% of total**

Potential Challenges for Prospective THC's Applying for Accreditation

Will the prospective THC be able to ensure that the program director has the requisite experience, qualifications and time to the program?

Relevant Program Requirements:

- Qualifications of the program director must include:
 - II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee,

- II.A.3.a).(1) which includes at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency program, and
- II.A.3.a).(2) at least three years of graduate medical education administrative experience prior to appointment.
- II.A.3.b) current certification in the specialty by the American Board of Internal Medicine, or specialty qualifications that are acceptable to the Review Committee; and,
- II.A.3.b).(1) The Review Committee only accepts current Board certification in internal medicine.
- II.A.4.q) dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the administrative and educational activities of the internal medicine educational program and receive institutional support for this time;

Will the prospective THC be able to demonstrate that it has the requisite faculty with the necessary qualifications who will be able to devote sufficient time to the program?

Relevant Program Requirements:

- II.C.3. Core Faculty: The residency program must include institutionally based core faculty in addition to the program director and associate program directors. The core faculty are the expert competency evaluators who work closely with the program director and associate program directors, who assist in developing and implementing the evaluation system, and who teach and advise residents. The core faculty must:
 - II.C.3.a) be ABIM-certified internists who are clinically active, either in direct patient care or in the supervision of patient care;
 - II.C.3.b) dedicate an average of at least 15 hours per individual per week throughout the year to residency training;
 - II.C.3.c) be specifically trained in the evaluation and assessment of the ACGME competencies;
 - II.C.3.d) spend significant time in the evaluation of residents including the direct observation of residents with patients; and,
 - II.C.3.e) advise residents with respect to their career and educational goals.
- I.A.2.g) provide support for core faculty based on program size, according to the following faculty to resident ratio:

Residents	Core Faculty
<60	4
76-90	6
91-105	7
106-120	8
121-135	9
136-150	10
151-165	11
166-180	12
>180	13

Will the prospective THC be able to ensure compliance to the requirements for subspecialty faculty with requisite subspecialty expertise?

Relevant Program Requirements:

- II.C.2. Subspecialty Education Coordinators
In conjunction with division chiefs, the program director must identify a qualified individual, the Subspecialty Education Coordinator, in each of the following subspecialties of internal medicine: cardiology, critical care, endocrinology, hematology, gastroenterology, geriatric medicine, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology.
- II.C.2.a) The Subspecialty Education Coordinator must be:
- II.C.2.a).(1) currently certified in the subspecialty by the ABIM, and
- II.C.2.a).(2) accountable to the program director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty. (N.B.: Core Faculty may also serve as Subspecialty Education Coordinators.)

Will the prospective THC ensure that the sponsoring institution has all the support services noted in the requirements?

Relevant Program Requirements:

- II.D.1. The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. Residents must have clinical experiences in efficient, effective ambulatory and inpatient care settings.
- II.D.2. Additional services must include those for: cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, noninvasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging.

How will the prospective THC meet the inpatient medicine experience requirements? How will they meet the requirement for Emergency Medicine experience?

Relevant Program Requirements:

- IV.A.1.b) Residency training is primarily an educational experience in patient-centered care. The educational efforts of faculty and residents should enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training must occur in the ambulatory setting and at least 1/3 must occur in the inpatient setting. Emergency medicine may count for no more than two weeks toward the required 1/3 ambulatory time.
- IV.A.2.c).(1).(h) Internal medicine residents must be assigned to emergency medicine for at least four weeks of direct experience in blocks of not less than two weeks.
- IV.A.2.c).(1).(h).(i) Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of selected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable.

Will the prospective THC be able to ensure that residents have required experiences in critical care medicine requirements?

Relevant Program Requirements:

- IV.A.2.c).(1).(a) These experiences must include: required critical care rotations (e.g., medical or respiratory intensive care units, cardiac care units) which cannot be fewer than three months and more than six months over the 36 months of training.

Will the prospective THC be able to ensure that residents will be exposed to each of the IM subspecialties and neurology?

Relevant Program Requirements:

- IV.A.2.b) The curriculum must ensure that each resident has sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.
- IV.A.2.c).(1) Faculty with credentials appropriate to the care setting must supervise all clinical experiences. These experiences must include:
- IV.A.2.c).(1).(b) exposure to each of the internal medicine subspecialties and neurology.

Obstetrics and Gynecology

Most Common Citations in Obstetrics and Gynecology Programs

This is a specialty that provides health care services to women through direct patient care as well as surgical procedures. Consequently, the residencies are rigorous and successful programs adhere closely to the requirements. The requirements that are included in this listing are oriented toward the organization of the program, program director and faculty member responsibilities, program resources, patient care especially gynecological procedures, resident scholarship, and supervision. These categories of requirements appear to be the most pertinent for the HRSA applicants.

Potential Challenges for Prospective THC's Applying for Accreditation

Program Structure and Organization:

- I.A.2. The program must exist in an educational environment that should include at least two other relevant graduate medical education programs such as internal medicine, pediatrics, surgery, or family medicine. The program director must obtain teaching commitments from the other departments involved in the education of obstetrics-gynecology residents.
- I.A.3. Participation by any site providing six months or more of training in a program of three or more years must be approved by the Review Committee.
- I.B.3. The Review Committee for Obstetrics-Gynecology uses the following categories for the purpose of monitoring the structure of residencies:
 - I.B.3.a) Independent--An independent program is conducted within a single educational site under a single program director. Extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see I.B.3.d).
 - I.B.3.b) Integrated--An integrated program is conducted within multiple educational sites but under a single program director. Each educational site involved in an integrated program must provide the same quality of education and level of supervision required authority of the program director and the role that the site will play in the overall program. Residents may rotate at any level, including the final year of the program. The program director must have authority over the educational program in each hospital, including the teaching appointments and assignments of all faculty and all residents, and must ensure the adequacy of the educational experience for each resident. Additional extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see I.B.3.d). If a program includes rotations for a total of more than six months for any resident at sites other than those included in the integrated program, that program becomes a non-integrated program.
 - I.B.3.c) Non-integrated--A non-integrated program is one in which any resident spends a total of more than six months in extramural rotations outside the sponsoring institution (or sites, in the case of integrated programs).
 - I.B.3.d) Extramural Rotations--Extramural rotations may be arranged by the program director of either an independent or an integrated program to enhance the educational experience of the residents.

- The following requirements for the duration of extramural rotations must be observed:
 - I.B.3.d).(1) If the total time of extramural rotation from the parent program by any resident during the entire residency exceeds six months, the program is considered to be a non-integrated program, and the entire program must receive prior approval by the Review Committee. Residents may not spend more than 18 months away from the sponsoring institution(s) without prior approval of the Review Committee.
 - I.B.3.d).(2) Rotations for a total of less than six months will not require that the program be designated as a non-integrated program, and these rotations may be arranged by the program director without prior Review Committee approval.

Program Director Responsibilities:

- II.A.4.n) The program director must obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests.
- II.A.4.r) The program director must ensure that formal teaching activities in obstetrics-gynecology be structured and regularly scheduled. They generally should consist of patient rounds, case conferences, journal clubs, and protected time for didactic conferences covering all aspects of the specialty, including basic sciences pertinent to the specialty. In cross-disciplinary conferences such as perinatology, physicians from appropriate specialties should be invited to participate; and,
- II.A.4.s) annually collect, compile, and retain the numbers and types of operative procedures performed by residents in the program, together with information describing the total resident experience in each institution and facility utilized in the clinical education of residents. This information must be provided in the format and form specified by the Review Committee.
 - NOTE: This requirement constitutes a major citation area for this specialty which is very procedurally-oriented.

Faculty Members:

- II.B.1.c) On an obstetrics and gynecology service, adequate supervision requires the 24-hour presence of faculty in the hospital except when residents are not assigned in-house call responsibilities. Faculty must be immediately available to the resident if clinical activity is taking place in the operating rooms and/or labor and delivery areas. Faculty must be within easy walking distance of patient care units. Clinical services provided in ambulatory (office) locations require on-site supervision. Open and generously used lines of two-way communication are important and should be encouraged.
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

Program Resources:

- II.C.1. At a minimum, a full-time program coordinator is required for all programs, and must receive full financial support from the institution.

- II.D.1. Outpatient Facilities: The program must provide appropriate facilities and equipment, including patient medical and laboratory data retrieval capabilities to manage patients in a timely fashion, so that efficient and effective education ambulatory care can be accomplished.
- II.D.2. Inpatient Facilities: The program must provide appropriate facilities and equipment, including patient medical and laboratory data retrieval capabilities, to manage critically ill patients and those undergoing obstetric or gynecologic operative procedures.
- III.B.2. The maximum number of residents in a program is linked to the number that can be accommodated within the framework of these requirements. One of the most important considerations is the clinical experience available to give each resident adequate primary responsibility. Because this usually centers on the senior resident year, the maximum number of residents in a program depends on how many senior residents the program can educate. Usually the maximum number of residents in a program is the number of senior residents the program can accommodate multiplied by four.

Patient Care:

- IV.A.2.c) Growth in knowledge and experience in the primary and preventive care role is best provided to residents by maximizing their participation in an ambulatory environment designed to enable continuity of care over an extended period of time. Specific educational experiences for the primary and preventive care role should take place throughout the four years of residency and may be addressed in one or more of the following settings:
 - IV.A.2.c).(1) Continuity clinics
 - IV.A.2.c).(2) Obstetrical high-risk clinic
 - IV.A.2.c).(3) Family Medicine rotation.
 - IV.A.2.c).(4) Internal Medicine outpatient rotation
 - IV.A.2.c).(5) Emergency care rotation.
- IV.A.5.a).(2).(a).(xi) Obstetric pathology.
- IV.A.5.a).(2).(b) Gynecology
 - IV.A.5.a).(2).(b).(i) The full range of medical and surgical gynecology for all age groups, including experience in the management of critically ill patients;**
 - IV.A.5.a).(2).(b).(ii) Diagnosis and management of pelvic floor dysfunction, including experience with various operations for its correction;**
 - IV.A.5.a).(2).(b).(iii) Diagnosis and medical and surgical management of urinary incontinence; **
 - IV.A.5.a).(2).(b).(iv) Oncology, including prevention, diagnosis, and treatment; **
 - IV.A.5.a).(2).(b).(v) Diagnosis and nonsurgical management of breast disease;
 - IV.A.5.a).(2).(b).(vi) Reproductive endocrinology and infertility;**
 - IV.A.5.a).(2).(b).(vii) Clinical skills in family planning;
 - IV.A.5.a).(2).(b).(viii) Psychosomatic and psychosexual counseling;
 - IV.A.5.a).(2).(b).(ix) The full range of commonly employed gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques;**

- IV.A.5.a).(2).(b).(x) Counseling and educating patients about the normal physiology of the reproductive tract and about high-risk behaviors that may compromise reproductive function; and,
 - IV.A.5.a).(2).(b).(xi) Gynecologic pathology.
- **source of many citations*
- IV.A.5.a).(6) Residents will have increasing responsibility that must progress in an orderly fashion, culminating in a chief resident year. The chief resident year consists of 12 months of clinical experience 10 months of which must be spent in the parent and/or integrated site(s) that occur within the last 24 months of the resident's program. The chief resident must have sufficient independent operating experience to become technically competent and have enough total responsibility for management of patients to ensure proficiency in the diagnostic and treatment skills that are required of a specialist in obstetrics-gynecology in office and hospital practice.

Case Logs:

- NOTE: Ob/Gyn pays special attention to Case Logs at the time a program is reviewed. This emphasis may gain greater importance when the next accreditation system is implemented, especially if Case Logs are identified as an annual informational data source. Non-compliance with required procedures accounts for the greatest number of citations for this specialty.

Scholarly Activities:

- IV.B. Residents' Scholarly Activities
 - IV.B.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.
 - IV.B.2. Residents should participate in scholarly activity.
 - IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

Supervision of Residents:

- NOTE: Supervision is a serious consideration for this specialty.
- VI.B.2. Supervision of residents in obstetrics and gynecology is required to ensure proper (1) quality of care, (2) education, (3) patient safety, and (4) fulfillment of responsibility of the attending physicians to their patients. These considerations must be integrated with the goal of independent competence in the full range of obstetrics and gynecology at the completion of residency. This implies a graduated and increasing level of independent resident action. Each program director must balance quality assurance for patient care, resident education, and independent resident action. The level of resident supervision should be commensurate with the amount of independent function that is designated at each resident level. Residents, as well as faculty, may provide supervision.

Pediatrics

Most Common Citations in Core Pediatrics Programs

1. **Supervision** – inadequate supervision of adolescent medicine and DBP
2. **Qualifications of Faculty** – lack ABP cert
3. **PD Responsibilities** – provision of complete and/or accurate information
4. **Service to Education Imbalance** – excessive patient volume
5. **Evaluation of the Program** – not confidential; lack of improvement plan
6. **Performance on Board Exam** – 60% pass rate not met
7. **Scholarly Activities** – lack of scholarly activity by faculty
8. **PICU** – insufficient volume; complexity and acuity
9. **Resident Appointment Issues** – attrition, presence of other learners
10. **Inpatient** – inadequate experience with full range of subspecialties

Program Requirement Areas of Concern for Prospective THC's Applying for Accreditation

Participating Sites:

- PR: I.B.4: Although no limit is placed on the duration of rotations to sites that are integrated with the primary hospital's pediatric program (although the duration must have Review Committee approval), rotations to participating sites that are not integrated with the primary hospital may not exceed a total of nine months during the three years of training. No more than three months of these outside rotations may be in sites that do not have their own pediatric residency.

Educational Program:

- PR: IV.A.5.b)(1)(a)(i): Resident experience on the inpatient service must be for a minimum of five months.
- PR: IV.A.5.b)(1)(b)(i): Residents must have a minimum of four months experience in emergency and acute illness. Two of these months should be in emergency medicine, of which the equivalent of one month may be completed longitudinally. At least one of these months must be a block rotation in an emergency department that serves as the receiving point for EMS transport and ambulance traffic and which is the access point for seriously-injured and acutely-ill pediatric patients. This may be either a pediatric emergency department or a combined pediatric/adult emergency department. Assignment to an acute care center or walk-in clinic to which patients are triaged from the emergency department will not fulfill this requirement.
- PR: IV.A.5.b)(1)(f)(vi)(a): The intensive care experiences must provide the opportunity for residents to deal with the special needs of critically-ill patients and their families. The intensive care experience must be for a minimum of five and a maximum of six months.
- PR: IV.A.5.b)(1)(f)(ix)(a): Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), residents must commit to at least seven months in subspecialty rotations, four of which must be taken at the primary teaching site and/or integrated hospitals.

- PR: IV.A.5.b)(1)(f)(ix)(b-c): Within these seven months, each resident must complete a minimum of four different one-month block rotations taken from the following list of pediatric subspecialties or closely allied specialties:
 - Allergy/Immunology
 - Cardiology
 - Endocrinology
 - Genetics
 - Gastroenterology
 - Hematology/Oncology
 - Infectious Diseases
 - Nephrology
 - Neurology
 - Pulmonary
 - Rheumatology
 - For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.

Psychiatry

Psychiatry Program Requirements: Common Citation Areas and Areas of Concern

Faculty Qualifications:

- Faculty/Qualifications/Specialty Certification Common Program Requirement: II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.
 - NOTE: RRC rarely grants exceptions to this requirement for physician faculty that provide required education. While there is no specific number, in general the RRC is looking for more than half of all physician faculty to be certified.
- Faculty/Qualifications/Department Chair/Current Board Certification Program Requirement: II.C.3.c) The chair of psychiatry must be certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the Review Committee.
 - NOTE: No exceptions – the Department chair must have current ABPN certification in psychiatry
- Program Resources/Faculty/Sufficient Qualified Faculty at Participating Sites Common Program Requirement II.B.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.
 - NOTE: Programs need to closely monitor workload and add additional faculty (not assign additional residents) to rotations or services with excessive workload.
- Faculty Qualifications/associate Program Director Program Requirement II.C.1. An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program. The sponsoring institution must provide additional dedicated time either for the program director or for the associate program directors based on program size and complexity of training sites. At a minimum, a total of 30 hours per week, program director or combined program director and associate program director time, is required for an approved complement of 24 to 40 residents....
 - NOTE: New programs need to be aware of this requirement. The minimum number of residents per program is 12 (3 per year times four years). Such programs are not required to have an associate program director.

Scholarly Activity:

- Program Director/Responsibilities/Ensure Participation of Residents and Faculty in Research-related Didactics Program Requirement: IV.A.5.b).(3).(j).(iv) The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.
 - NOTE: Program needs to demonstrate that residents have protected time for this. Documentation of faculty participation is also important. The journal club articles need

to be examples of rigorous studies that are used to teach research methods and data evaluation skills.

- Faculty/Responsibilities/Scholarship/Active Research Common Program Requirement: II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.
- Faculty/Responsibilities/Scholarship Common Program Requirement: II.B.5.b) Some members of the faculty should also demonstrate scholarship by 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.
 - NOTE: Documentation of research activity (peer-reviewed publications, invited presentations at meetings, etc.) need to be accurately documented in the faculty CVs; listing of resident publications, presentations also need to reflect on-going and meaningful participation. While it is understandable that small programs would have a more limited list of projects/publications, it would not be acceptable to have none since the last site visit.

Curriculum Development:

- Educational Program/Curriculum/Electives/Written Goals and Objectives Program Requirement: Introduction.B.2.e) Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans. Electives must have written goals and objectives, and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.
 - NOTE: RRC pays close attention to electives as indicated in this PR.
- Educational Program/Curriculum/Education Policy Committee Program Requirement II.C.4. The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in: planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee); determining curriculum goals and objectives; and evaluating both the teaching staff and the residents.
 - NOTE: This requirement might be difficult for single-program sponsor programs to comply with. In those cases, the subspecialty faculty may be those at participating sites that provide required educational experiences in the subspecialties. It is important to document these meetings with minutes that include dates, attendees and the business

discussed. An often cited area is lack of involvement of the EPC in resident selection when there is no separate resident selection committee.

Program Director Responsibilities:

- Program Director/Responsibilities/ACGME Required Information/Accurate and Complete Common Program Requirement: II.A.4.f) The program director must 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.
 - NOTE: Usually this is referring to poorly prepared PIFs, but also includes instances where the program did not provide required information in ADS.
- Program Director/Responsibilities/Resident Stress Program Requirement: II.A.4.s) The program director must monitor residents' stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.
 - NOTE: Policies and procedures must be in place – with full institutional support; evidence that the policies and procedures are consistently followed needs to be provided.

Institutional Support:

- Internal Review/Process/Midpoint Institutional Requirement IV.A.2 Internal reviews must be in process and documented in the GMEC minutes by approximately the midpoint of the accreditation cycle. The accreditation cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site visit.
 - NOTE: DIO must make sure that internal reviews are scheduled and take place as required. Documentation in the GMEC meeting minutes of date, attendees, etc. is important and will be verified by the site visitor.
- Sponsoring Institution/Educational and work Environment Institutional Program Requirement II.F.1 The Sponsoring Institution and its programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation.
 - NOTE: Suggested approach is to have a third-party resolution process.

Resident Appointments:

- Resident Appointment/Number/Minimum Three Residents Per Year (Previous Citation) Program Requirement: III.B.1. In order to promote an educationally-sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must have at least three residents at each level of education.

- NOTE: New programs need to be aware of this requirement, since not all specialties require a minimum number of residents per year.

Other Program Personnel:

- Program Resources/Other Program Personnel/Residency Coordinator Program Requirement: II.C.2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.
 - NOTE: This specialty requires all programs to have a program coordinator. For small programs, this person need not be full time. However, programs with part time coordinators who receive frequent citations will be cited for the coordinator not having adequate time.

Program Evaluation:

- Evaluation/Program/Annual Formal and Systematic Evaluation of Curriculum Common Program Requirement: V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. Evaluation/Program/Written Plan of Action Common Program Requirement: V.C.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.
 - NOTE: Single program sponsored programs are not exempt from this requirement. The annual program evaluation is distinct from the mid-cycle internal review conducted by the GMEC. Programs need to document that the annual internal review takes place, opportunities for improvement are identified and subsequent action is taken to improve.