ACGME Program Requirements for Graduate Medical Education in Physical Medicine and Rehabilitation

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ACGME Program Requirements for Graduate Medical Education
in Physical Medicine and Rehabilitation

Common Program Requirements (Residency) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

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

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

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

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

Int.B. **Definition of Specialty**

Physical medicine and rehabilitation is the medical specialty ~~which~~ that focuses on the diagnoses, evaluation, and management of persons of all ages with physical and/or cognitive impairments, disabilities, and functional limitations.

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52 **Int.C. Length of Educational Program**
53
54 The educational programs in physical medicine and rehabilitation are configured
55 in 36-month and 48-month formats, and must include a minimum of 36 months of
56 clinical education. (Core)*
57
58 **I. Oversight**
59
60 **I.A. Sponsoring Institution**
61
62 ***The Sponsoring Institution is the organization or entity that assumes the***
63 ***ultimate financial and academic responsibility for a program of graduate***
64 ***medical education, consistent with the ACGME Institutional Requirements.***
65
66 ***When the Sponsoring Institution is not a rotation site for the program, the***
67 ***most commonly utilized site of clinical activity for the program is the***
68 ***primary clinical site.***
69

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

70
71 **I.A.1. The program must be sponsored by one ACGME-accredited**
72 **Sponsoring Institution. (Core)**
73
74 **I.B. Participating Sites**
75
76 ***A participating site is an organization providing educational experiences or***
77 ***educational assignments/rotations for residents.***
78
79 **I.B.1. The program, with approval of its Sponsoring Institution, must**
80 **designate a primary clinical site. (Core)**
81
82 I.B.1.a) Physical medicine and rehabilitation must be organized as an
83 identifiable specialty within the sponsoring institution. (Detail)†
84
85 **I.B.2. There must be a program letter of agreement (PLA) between the**
86 **program and each participating site that governs the relationship**
87 **between the program and the participating site providing a required**
88 **assignment. (Core)**
89
90 **I.B.2.a) The PLA must:**
91
92 **I.B.2.a).(1) be renewed at least every 10 years; and, (Core)**
93

94 **I.B.2.a).(2)** **be approved by the designated institutional official**
95 **(DIO).** (Core)
96
97 **I.B.3.** **The program must monitor the clinical learning and working**
98 **environment at all participating sites.** (Core)
99
100 **I.B.3.a)** **At each participating site there must be one faculty member,**
101 **designated by the program director as the site director, who**
102 **is accountable for resident education at that site, in**
103 **collaboration with the program director.** (Core)
104

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

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:
- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

105
106 **I.B.4.** **The program director must submit any additions or deletions of**
107 **participating sites routinely providing an educational experience,**
108 **required for all residents, of one month full time equivalent (FTE) or**
109 **more through the ACGME's Accreditation Data System (ADS).** (Core)
110
111 I.B.5. The program should avoid affiliations with sites at such distances from the
112 primary clinical site as to make resident attendance at rounds and
113 conferences impractical, unless there is no comparable educational
114 experience at the primary clinical site. (Detail)
115
116 **I.C.** **The program, in partnership with its Sponsoring Institution, must engage in**
117 **practices that focus on mission-driven, ongoing, systematic recruitment**
118 **and retention of a diverse and inclusive workforce of residents, fellows (if**
119 **present), faculty members, senior administrative staff members, and other**
120 **relevant members of its academic community.** (Core)
121

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must

include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

122
123 **I.D. Resources**
124
125 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
126 **ensure the availability of adequate resources for resident education.**
127 **(Core)**
128
129 I.D.1.a) Beds assigned to the physical medicine and rehabilitation service
130 must be grouped in geographic area(s) within each site. (Detail)
131
132 I.D.1.b) There must be educational conference rooms and office space
133 with computer and Internet access available to residents and
134 faculty at each site. (Detail)
135
136 I.D.1.c) There must be an accessible anatomy laboratory for dissection or
137 an equivalently structured program in anatomy. (Core)
138
139 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
140 **ensure healthy and safe learning and working environments that**
141 **promote resident well-being and provide for: (Core)**
142
143 **I.D.2.a) access to food while on duty; (Core)**
144
145 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
146 **and accessible for residents with proximity appropriate for**
147 **safe patient care; (Core)**
148

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

149
150 **I.D.2.c) clean and private facilities for lactation that have refrigeration**
151 **capabilities, with proximity appropriate for safe patient care;**
152 **(Core)**
153

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

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154
155 **I.D.2.d)** **security and safety measures appropriate to the participating**
156 **site; and,** (Core)
157
158 **I.D.2.e)** **accommodations for residents with disabilities consistent**
159 **with the Sponsoring Institution's policy.** (Core)
160
161 **I.D.3.** **Residents must have ready access to specialty-specific and other**
162 **appropriate reference material in print or electronic format. This**
163 **must include access to electronic medical literature databases with**
164 **full text capabilities.** (Core)
165
166 **I.D.4.** **The program's educational and clinical resources must be adequate**
167 **to support the number of residents appointed to the program.** (Core)
168
169 **I.E.** **The presence of other learners and other care providers, including, but not**
170 **limited to, residents from other programs, subspecialty fellows, and**
171 **advanced practice providers, must enrich the appointed residents'**
172 **education.** (Core)
173
174 **I.E.1.** **The program must report circumstances when the presence of other**
175 **learners has interfered with the residents' education to the DIO and**
176 **Graduate Medical Education Committee (GMEC).** (Core)
177

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

178
179 **II. Personnel**
180
181 **II.A. Program Director**
182
183 **II.A.1.** **There must be one faculty member appointed as program director**
184 **with authority and accountability for the overall program, including**
185 **compliance with all applicable program requirements.** (Core)
186
187 **II.A.1.a)** **The Sponsoring Institution's GMEC must approve a change in**
188 **program director.** (Core)
189
190 **II.A.1.b)** **Final approval of the program director resides with the**
191 **Review Committee.** (Core)
192

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

GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

193
194 **II.A.1.c)** **The program must demonstrate retention of the program**
195 **director for a length of time adequate to maintain continuity**
196 **of leadership and program stability.** (Core)
197

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

198
199 **II.A.2.** **At a minimum, the program director must be provided with the**
200 **salary support required to devote 20 percent FTE of non-clinical**
201 **time to the administration of the program.** (Core)
202
203 II.A.2.a) Additional support for the program director and the associate
204 program director(s) must be provided based on program size as
205 follows: (Core)
206

Number of Approved Resident Positions	Minimum Aggregate Program Director/Associate Program Director FTE
6-10	.30
11-15	.35
16-20	.40
21-25	.45
26-30	.50
31-35	.55
≥ 36	.60

207

Background and Intent: Twenty percent FTE is defined as one day per week.

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

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

208
209 **II.A.3.** **Qualifications of the program director:**
210
211 **II.A.3.a)** **must include specialty expertise and at least three years of**
212 **documented educational and/or administrative experience, or**
213 **qualifications acceptable to the Review Committee;** (Core)
214

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the

individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

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

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

215

216 **II.A.3.b)** **must include current certification in the specialty for which**
217 **they are the program director by the American Board of**
218 Physical Medicine and Rehabilitation **or by the American**
219 **Osteopathic Board of** Physical Medicine and Rehabilitation**, or**
220 **specialty qualifications that are acceptable to the Review**
221 **Committee;** **(Core)**
222
223 II.A.3.b).(1) The Review Committee will not accept alternate
224 qualifications to ABPMR or AOBPMR certification. (Core)
225
226 **II.A.3.c)** **must include current medical licensure and appropriate**
227 **medical staff appointment; and,** **(Core)**
228
229 **II.A.3.d)** **must include ongoing clinical activity.** **(Core)**
230

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

231
232 **II.A.4.** **Program Director Responsibilities**
233
234 **The program director must have responsibility, authority, and**
235 **accountability for: administration and operations; teaching and**
236 **scholarly activity; resident recruitment and selection, evaluation,**
237 **and promotion of residents, and disciplinary action; supervision of**
238 **residents; and resident education in the context of patient care.** **(Core)**
239
240 **II.A.4.a)** **The program director must:**
241
242 **II.A.4.a).(1)** **be a role model of professionalism;** **(Core)**
243

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

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approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

244
245 **II.A.4.a).(2)** **design and conduct the program in a fashion**
246 **consistent with the needs of the community, the**
247 **mission(s) of the Sponsoring Institution, and the**
248 **mission(s) of the program; (Core)**
249

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

250
251 **II.A.4.a).(3)** **administer and maintain a learning environment**
252 **conducive to educating the residents in each of the**
253 **ACGME Competency domains; (Core)**
254

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

255
256 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
257 **prior to approval as program faculty members for**
258 **participation in the residency program education and**
259 **at least annually thereafter, as outlined in V.B.; (Core)**
260
261 **II.A.4.a).(5)** **have the authority to approve program faculty**
262 **members for participation in the residency program**
263 **education at all sites; (Core)**
264
265 **II.A.4.a).(6)** **have the authority to remove program faculty**
266 **members from participation in the residency program**
267 **education at all sites; (Core)**
268
269 **II.A.4.a).(7)** **have the authority to remove residents from**
270 **supervising interactions and/or learning environments**
271 **that do not meet the standards of the program; (Core)**
272

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

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

273
274 **II.A.4.a).(8)** **submit accurate and complete information required**
275 **and requested by the DIO, GMEC, and ACGME;** (Core)
276
277 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
278 **information related to the applicant's eligibility for the**
279 **relevant specialty board examination(s);** (Core)
280
281 **II.A.4.a).(10)** **provide a learning and working environment in which**
282 **residents have the opportunity to raise concerns and**
283 **provide feedback in a confidential manner as**
284 **appropriate, without fear of intimidation or retaliation;**
285 (Core)
286
287 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
288 **Institution's policies and procedures related to**
289 **grievances and due process;** (Core)
290
291 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
292 **Institution's policies and procedures for due process**
293 **when action is taken to suspend or dismiss, not to**
294 **promote, or not to renew the appointment of a**
295 **resident;** (Core)
296

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

297
298 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
299 **Institution's policies and procedures on employment**
300 **and non-discrimination;** (Core)
301
302 **II.A.4.a).(13).(a)** **Residents must not be required to sign a non-**
303 **competition guarantee or restrictive covenant.**
304 (Core)
305
306 **II.A.4.a).(14)** **document verification of program completion for all**
307 **graduating residents within 30 days;** (Core)
308
309 **II.A.4.a).(15)** **provide verification of an individual resident's**
310 **completion upon the resident's request, within 30**
311 **days; and,** (Core)
312

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who

have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

313
314 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
315 **Institution's DIO before submitting information or**
316 **requests to the ACGME, as required in the Institutional**
317 **Requirements and outlined in the ACGME Program**
318 **Director's Guide to the Common Program**
319 **Requirements.** **(Core)**
320
321 **II.B.** **Faculty**
322
323 ***Faculty members are a foundational element of graduate medical education***
324 ***– faculty members teach residents how to care for patients. Faculty***
325 ***members provide an important bridge allowing residents to grow and***
326 ***become practice-ready, ensuring that patients receive the highest quality of***
327 ***care. They are role models for future generations of physicians by***
328 ***demonstrating compassion, commitment to excellence in teaching and***
329 ***patient care, professionalism, and a dedication to lifelong learning. Faculty***
330 ***members experience the pride and joy of fostering the growth and***
331 ***development of future colleagues. The care they provide is enhanced by***
332 ***the opportunity to teach. By employing a scholarly approach to patient***
333 ***care, faculty members, through the graduate medical education system,***
334 ***improve the health of the individual and the population.***
335
336 ***Faculty members ensure that patients receive the level of care expected***
337 ***from a specialist in the field. They recognize and respond to the needs of***
338 ***the patients, residents, community, and institution. Faculty members***
339 ***provide appropriate levels of supervision to promote patient safety. Faculty***
340 ***members create an effective learning environment by acting in a***
341 ***professional manner and attending to the well-being of the residents and***
342 ***themselves.***
343

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

344
345 **II.B.1.** **At each participating site, there must be a sufficient number of**
346 **faculty members with competence to instruct and supervise all**
347 **residents at that location.** **(Core)**
348
349 **II.B.2.** **Faculty members must:**
350
351 **II.B.2.a)** **be role models of professionalism;** **(Core)**
352
353 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality,**
354 **cost-effective, patient-centered care;** **(Core)**
355

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed

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during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

356
357 **II.B.2.c)** **demonstrate a strong interest in the education of residents;**
358 **(Core)**
359
360 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
361 **their supervisory and teaching responsibilities; (Core)**
362
363 **II.B.2.e)** **administer and maintain an educational environment**
364 **conducive to educating residents; (Core)**
365
366 **II.B.2.f)** **regularly participate in organized clinical discussions,**
367 **rounds, journal clubs, and conferences; and, (Core)**
368
369 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
370 **at least annually: (Core)**
371

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

372
373 **II.B.2.g).(1)** **as educators; (Core)**
374
375 **II.B.2.g).(2)** **in quality improvement and patient safety; (Core)**
376
377 **II.B.2.g).(3)** **in fostering their own and their residents' well-being;**
378 **and, (Core)**
379
380 **II.B.2.g).(4)** **in patient care based on their practice-based learning**
381 **and improvement efforts. (Core)**
382

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

383
384 **II.B.3.** **Faculty Qualifications**
385
386 **II.B.3.a)** **Faculty members must have appropriate qualifications in**
387 **their field and hold appropriate institutional appointments.**
388 **(Core)**
389

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390 **II.B.3.b)** **Physician faculty members must:**
391
392 **II.B.3.b).(1)** **have current certification in the specialty by the**
393 **American Board of** Physical Medicine and Rehabilitation
394 **or the American Osteopathic Board of** Physical
395 Medicine and Rehabilitation**, or possess qualifications**
396 **judged acceptable to the Review Committee.** (Core)
397

Specialty-Specific Background and Intent: Years of practice are not an equivalent for board certification. The onus of documenting evidence for consideration of alternate qualifications is on the program director; however, the determination of whether qualifications are an acceptable alternative to certification by the ABPMR or AOBPMR is a judgment call on the part of the Review Committee. The Review Committee will take into consideration a significant record of publication in peer-reviewed journals as evidence of adequate specialty qualifications.

398
399 **II.B.3.c)** **Any non-physician faculty members who participate in**
400 **residency program education must be approved by the**
401 **program director.** (Core)
402

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

403
404 **II.B.4.** **Core Faculty**
405
406 **Core faculty members must have a significant role in the education**
407 **and supervision of residents and must devote a significant portion**
408 **of their entire effort to resident education and/or administration, and**
409 **must, as a component of their activities, teach, evaluate, and**
410 **provide formative feedback to residents.** (Core)
411

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

412
413 **II.B.4.a)** **Core faculty members must be designated by the program**
414 **director.** (Core)
415
416 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
417 **Faculty Survey.** (Core)
418

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419 II.B.4.c) There must be one core faculty member for every three residents
420 in the program. (Core)
421
422 **II.C. Program Coordinator**
423
424 **II.C.1. There must be a program coordinator. (Core)**
425
426 **II.C.2. At a minimum, the program coordinator must be supported at 50**
427 **percent FTE for the administration of the program. (Core)**
428

Background and Intent: Fifty percent FTE is defined as two-and-a-half (2.5) days per week.

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

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

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

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

429
430 **II.D. Other Program Personnel**
431
432 **The program, in partnership with its Sponsoring Institution, must jointly**
433 **ensure the availability of necessary personnel for the effective**
434 **administration of the program. (Core)**
435

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

436
437 **III. Resident Appointments**
438
439 **III.A. Eligibility Requirements**
440

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441 **III.A.1.** **An applicant must meet one of the following qualifications to be**
442 **eligible for appointment to an ACGME-accredited program:** (Core)
443
444 **III.A.1.a)** **graduation from a medical school in the United States or**
445 **Canada, accredited by the Liaison Committee on Medical**
446 **Education (LCME) or graduation from a college of**
447 **osteopathic medicine in the United States, accredited by the**
448 **American Osteopathic Association Commission on**
449 **Osteopathic College Accreditation (AOACOCA); or,** (Core)
450
451 **III.A.1.b)** **graduation from a medical school outside of the United**
452 **States or Canada, and meeting one of the following additional**
453 **qualifications:** (Core)
454
455 **III.A.1.b).(1)** **holding a currently valid certificate from the**
456 **Educational Commission for Foreign Medical**
457 **Graduates (ECFMG) prior to appointment; or,** (Core)
458
459 **III.A.1.b).(2)** **holding a full and unrestricted license to practice**
460 **medicine in the United States licensing jurisdiction in**
461 **which the ACGME-accredited program is located.** (Core)
462
463 **III.A.2.** **All prerequisite post-graduate clinical education required for initial**
464 **entry or transfer into ACGME-accredited residency programs must**
465 **be completed in ACGME-accredited residency programs, AOA-**
466 **approved residency programs, Royal College of Physicians and**
467 **Surgeons of Canada (RCPSC)-accredited or College of Family**
468 **Physicians of Canada (CFPC)-accredited residency programs**
469 **located in Canada, or in residency programs with ACGME**
470 **International (ACGME-I) Advanced Specialty Accreditation.** (Core)
471
472 **III.A.2.a)** **Residency programs must receive verification of each**
473 **resident's level of competency in the required clinical field**
474 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**
475 **from the prior training program upon matriculation.** (Core)
476
477 III.A.2.a).(1) Prior to commencing the 36 months of physical medicine
478 and rehabilitation education, a resident must have
479 successfully completed 12 months of education in
480 fundamental clinical skills in a residency program that
481 satisfies the requirements in III.A.2. (Core)
482

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

483
484 **III.A.3.** **A physician who has completed a residency program that was not**
485 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**

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Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

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

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

III.B.2. Programs should have at least two residents enrolled per level of education. (Detail)

III.C. Resident Transfers

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

IV. Educational Program

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

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

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

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

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

537 **IV.A.1.a) The program's aims must be made available to program**
538 **applicants, residents, and faculty members.** (Core)
539
540 **IV.A.2. competency-based goals and objectives for each educational**
541 **experience designed to promote progress on a trajectory to**
542 **autonomous practice. These must be distributed, reviewed, and**
543 **available to residents and faculty members;** (Core)
544

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

545
546 **IV.A.3. delineation of resident responsibilities for patient care, progressive**
547 **responsibility for patient management, and graded supervision;** (Core)
548

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

549
550 **IV.A.4. a broad range of structured didactic activities;** (Core)
551
552 **IV.A.4.a) Residents must be provided with protected time to participate**
553 **in core didactic activities.** (Core)
554

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

555
556 **IV.A.5. advancement of residents' knowledge of ethical principles**
557 **foundational to medical professionalism; and,** (Core)
558
559 **IV.A.6. advancement in the residents' knowledge of the basic principles of**
560 **scientific inquiry, including how research is designed, conducted,**
561 **evaluated, explained to patients, and applied to patient care.** (Core)
562
563 **IV.B. ACGME Competencies**
564

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

565
566 **IV.B.1.** **The program must integrate the following ACGME Competencies**
567 **into the curriculum:** **(Core)**
568
569 **IV.B.1.a)** **Professionalism**
570
571 **Residents must demonstrate a commitment to**
572 **professionalism and an adherence to ethical principles.** **(Core)**
573
574 **IV.B.1.a).(1)** **Residents must demonstrate competence in:**
575
576 **IV.B.1.a).(1).(a)** **compassion, integrity, and respect for others;**
577 **(Core)**
578
579 **IV.B.1.a).(1).(b)** **responsiveness to patient needs that**
580 **supersedes self-interest;** **(Core)**
581

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

582
583 **IV.B.1.a).(1).(c)** **respect for patient privacy and autonomy;** **(Core)**
584
585 **IV.B.1.a).(1).(d)** **accountability to patients, society, and the**
586 **profession;** **(Core)**
587
588 **IV.B.1.a).(1).(e)** **respect and responsiveness to diverse patient**
589 **populations, including but not limited to**
590 **diversity in gender, age, culture, race, religion,**
591 **disabilities, national origin, socioeconomic**
592 **status, and sexual orientation;** **(Core)**
593
594 **IV.B.1.a).(1).(f)** **ability to recognize and develop a plan for one's**
595 **own personal and professional well-being; and,**
596 **(Core)**
597
598 **IV.B.1.a).(1).(g)** **appropriately disclosing and addressing**
599 **conflict or duality of interest.** **(Core)**
600
601 **IV.B.1.b)** **Patient Care and Procedural Skills**
602

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per

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

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

603
604 **IV.B.1.b).(1)** **Residents must be able to provide patient care that is**
605 **compassionate, appropriate, and effective for the**
606 **treatment of health problems and the promotion of**
607 **health.** (Core)
608
609 IV.B.1.b).(1).(a) Residents must demonstrate competence in the
610 evaluation and management of patients with
611 physical and/or cognitive impairments, disabilities,
612 and functional limitations, including: (Core)
613
614 IV.B.1.b).(1).(a).(i) history and physical examination pertinent
615 to physical medicine and rehabilitation; (Core)
616
617 IV.B.1.b).(1).(a).(ii) assessment of impairment, activity
618 limitation, and participation restrictions; (Core)
619
620 IV.B.1.b).(1).(a).(iii) review and interpretation of pertinent
621 laboratory and imaging materials for the
622 patient; (Core)
623
624 IV.B.1.b).(1).(a).(iv) providing prescriptions for orthotics,
625 prosthetics, wheelchairs, assistive devices
626 for ambulation, and other durable medical
627 equipment or assistive devices; (Core)
628
629 IV.B.1.b).(1).(a).(v) pediatric rehabilitation; (Core)
630
631 IV.B.1.b).(1).(a).(vi) geriatric rehabilitation; (Core)
632
633 IV.B.1.b).(1).(a).(vii) application of bioethics principles to
634 decision making in the diagnosis and
635 management of their patients; and, (Core)
636
637 IV.B.1.b).(1).(a).(viii) providing prescription of evaluation and
638 treatment by physical therapists,
639 occupational therapists, speech/language
640 pathologists, therapeutic recreational
641 specialists, psychologists, and vocational
642 counselors. (Core)

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

IV.B.1.b).(2).(a) Residents must be involved in a minimum of 200 electrodiagnostic evaluations, of which residents must demonstrate competence in the performance, documentation, and interpretation of a minimum of 150 complete electrodiagnostic studies from separate patient encounters. demonstrate competence in the: (Core)

IV.B.1.b).(2).(a).(i) performance, documentation, and interpretation of 200 complete electrodiagnostic evaluations from separate patient encounters; and, (Core)

Specialty-Specific Background and Intent: Each patient encounter may only be counted as one consultation, even if multiple EMGs or nerve conduction studies are performed during an examination and may only be counted as "performed" by one resident. More than one resident may count an "observed" study on a patient. Somatosensory evoked potentials may be counted toward the electrodiagnostic consultation requirement but are not required.

IV.B.1.b).(2).(b) Residents must demonstrate competence in the performance of therapeutic and diagnostic injections. (Outcome Core)

Specialty-Specific Background and Intent: Therapeutic and diagnostic injections include those for spasticity management, as well as joint, soft tissue, and axial injections.

IV.B.1.c) **Medical Knowledge**

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

IV.B.1.c).(1) Residents must demonstrate competence in their knowledge of the diagnosis, pathogenesis, treatment, prevention, and rehabilitation of those neuromusculoskeletal, neurobehavioral, and other system disorders common to this specialty in patients of each gender and all ages. (Core)

IV.B.1.c).(2) Residents must demonstrate fundamental knowledge of orthotics and prosthetics, including fitting and manufacturing. (Core)

IV.B.1.c).(3) Residents must demonstrate knowledge of the principles of pharmacology as they relate to the indications for and

687 complications of drugs utilized in physical medicine and
688 rehabilitation. (Core)
689
690 **IV.B.1.d) Practice-based Learning and Improvement**
691
692 **Residents must demonstrate the ability to investigate and**
693 **evaluate their care of patients, to appraise and assimilate**
694 **scientific evidence, and to continuously improve patient care**
695 **based on constant self-evaluation and lifelong learning. (Core)**
696

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

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

697
698 **IV.B.1.d).(1) Residents must demonstrate competence in:**
699
700 **IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in**
701 **one's knowledge and expertise; (Core)**
702
703 **IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)**
704
705 **IV.B.1.d).(1).(c) identifying and performing appropriate learning**
706 **activities; (Core)**
707
708 **IV.B.1.d).(1).(d) systematically analyzing practice using quality**
709 **improvement methods, and implementing**
710 **changes with the goal of practice improvement;**
711 **(Core)**
712
713 **IV.B.1.d).(1).(e) incorporating feedback and formative**
714 **evaluation into daily practice; (Core)**
715
716 **IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence**
717 **from scientific studies related to their patients'**
718 **health problems; and, (Core)**
719
720 **IV.B.1.d).(1).(g) using information technology to optimize**
721 **learning. (Core)**
722
723 **IV.B.1.e) Interpersonal and Communication Skills**
724
725 **Residents must demonstrate interpersonal and**
726 **communication skills that result in the effective exchange of**
727 **information and collaboration with patients, their families,**
728 **and health professionals. (Core)**

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729
730 **IV.B.1.e).(1)** **Residents must demonstrate competence in:**
731
732 **IV.B.1.e).(1).(a)** **communicating effectively with patients,**
733 **families, and the public, as appropriate, across**
734 **a broad range of socioeconomic and cultural**
735 **backgrounds;** (Core)
736
737 **IV.B.1.e).(1).(b)** **communicating effectively with physicians,**
738 **other health professionals, and health-related**
739 **agencies;** (Core)
740
741 **IV.B.1.e).(1).(c)** **working effectively as a member or leader of a**
742 **health care team or other professional group;**
743 (Core)
744
745 **IV.B.1.e).(1).(d)** **educating patients, families, students,**
746 **residents, and other health professionals;** (Core)
747
748 **IV.B.1.e).(1).(e)** **acting in a consultative role to other physicians**
749 **and health professionals; and,** (Core)
750
751 **IV.B.1.e).(1).(f)** **maintaining comprehensive, timely, and legible**
752 **medical records, if applicable.** (Core)
753
754 **IV.B.1.e).(2)** **Residents must learn to communicate with patients**
755 **and families to partner with them to assess their care**
756 **goals, including, when appropriate, end-of-life goals.**
757 (Core)
758

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

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

759
760 **IV.B.1.f)** **Systems-based Practice**
761
762 **Residents must demonstrate an awareness of and**
763 **responsiveness to the larger context and system of health**
764 **care, including the social determinants of health, as well as**
765 **the ability to call effectively on other resources to provide**
766 **optimal health care.** (Core)
767
768 **IV.B.1.f).(1)** **Residents must demonstrate competence in:**
769

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770 **IV.B.1.f).(1).(a)** **working effectively in various health care**
771 **delivery settings and systems relevant to their**
772 **clinical specialty;** (Core)
773

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

774
775 **IV.B.1.f).(1).(b)** **coordinating patient care across the health care**
776 **continuum and beyond as relevant to their**
777 **clinical specialty;** (Core)
778

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

779
780 **IV.B.1.f).(1).(c)** **advocating for quality patient care and optimal**
781 **patient care systems;** (Core)
782
783 **IV.B.1.f).(1).(d)** **working in interprofessional teams to enhance**
784 **patient safety and improve patient care quality;**
785 (Core)
786
787 **IV.B.1.f).(1).(e)** **participating in identifying system errors and**
788 **implementing potential systems solutions;** (Core)
789
790 **IV.B.1.f).(1).(f)** **incorporating considerations of value, cost**
791 **awareness, delivery and payment, and risk-**
792 **benefit analysis in patient and/or population-**
793 **based care as appropriate;** (Core)
794
795 **IV.B.1.f).(1).(g)** **understanding health care finances and its**
796 **impact on individual patients' health decisions;**
797 **and,** (Core)
798
799 **IV.B.1.f).(1).(h)** demonstrating knowledge of the types of patients
800 served, referral patterns, and services available in
801 the continuum of rehabilitation care in community
802 rehabilitation facilities. (Core)
803
804 **IV.B.1.f).(2)** **Residents must learn to advocate for patients within**
805 **the health care system to achieve the patient's and**
806 **family's care goals, including, when appropriate, end-**
807 **of-life goals.** (Core)
808
809 **IV.C. Curriculum Organization and Resident Experiences**
810

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811 **IV.C.1.** **The curriculum must be structured to optimize resident educational**
812 **experiences, the length of these experiences, and supervisory**
813 **continuity.** (Core)
814
815 IV.C.1.a) Assignment of rotations must be structured to minimize the
816 frequency of rotational transitions, and rotations must be of
817 sufficient length to provide a quality educational experience,
818 defined by continuity of patient care, ongoing supervision,
819 longitudinal relationships with faculty members, and meaningful
820 assessment and feedback. (Core)
821
822 IV.C.1.b) Clinical experiences should be structured to facilitate learning in a
823 manner that allows residents to function as part of an effective
824 interprofessional team that works together longitudinally with
825 shared goals of patient safety and quality improvement. (Core)
826

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

827
828 **IV.C.2.** **The program must provide instruction and experience in pain**
829 **management if applicable for the specialty, including recognition of**
830 **the signs of addiction.** (Core)
831
832 IV.C.3. Curriculum Organization
833
834 IV.C.3.a) Programs must provide either 36 or 48 months of education. (Core)
835
836 IV.C.3.b) A program of 36 months' duration must provide all 36 months in
837 physical medicine and rehabilitation education, and must ensure
838 that residents appointed at the PG-2 level have received
839 satisfactory education in fundamental clinical skills prior to entry.
840 (Core)
841
842 IV.C.3.b).(1) No more than six months can be elective. (Detail)
843
844 IV.C.3.b).(1).(a) No more than one month of this elective time may
845 be taken in a residency program that does not
846 satisfy the requirements in III.A.2., unless prior
847 approval is given by the Review Committee. (Detail)
848
849 IV.C.3.c) A program of 48 months' duration must be responsible for the
850 quality of the integrated educational experience for the entire
851 program. (Core)
852
853 IV.C.3.d) The first 12 months of the 48 months must be devoted to the
854 development of fundamental clinical skills and must be completed
855 prior to beginning PGY-2 physical medicine and rehabilitation

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rotations. (Core)

IV.C.3.d).(1) These 12 months of education in fundamental clinical skills must be completed in either:

IV.C.3.d).(1).(a) a transitional year program that satisfies the requirements in III.A.2., or; (Core)

IV.C.3.d).(1).(b) a residency program that satisfies the requirements in III.A.2. (Core)

IV.C.3.d).(1).(b).(i) at least six months must include emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, surgery, or any combination of these patient care experiences. (Core)

IV.C.3.d).(1).(b).(ii) The remaining months of these 12 months of education may include any combination of accredited specialty or subspecialty education. (Detail)

IV.C.3.d).(1).(b).(iii) Rotations in any of the specialties or subspecialties selected must be for a period of at least four weeks. (Detail)

IV.C.3.d).(1).(b).(iv) No more than eight weeks may be in non-direct patient care experiences, such as pathology, radiology and research and no more than four weeks may be in physical medicine and rehabilitation. (Detail)

IV.C.4. Resident Experiences

IV.C.4.a) Each resident must have an assigned faculty advisor/mentor. (Core)

IV.C.4.a).(1) The faculty advisor/mentor must regularly meet with the resident for activities such as monitoring, feedback, facilitation of scholarly activity, or career counseling. (Detail)

IV.C.4.b) Residents must have outpatient experience that includes significant experience in the care of patients with musculoskeletal disorders. (Core)

IV.C.4.b).(1) The outpatient experience should be at least 12 months in duration, excluding time spent in ~~EMG~~ electrodiagnostic studies training. (Core ~~Detail~~)

IV.C.4.c) Residents must have direct and complete responsibility for the rehabilitative management of patients on the inpatient physical medicine and rehabilitation service. (Core)

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IV.C.4.c).(1) The inpatient experience should be at least 12 months in duration. (Core ~~Detail~~)

IV.C.4.c).(2) Each resident assigned to an acute inpatient rehabilitation service should be responsible for a minimum of six physical medicine and rehabilitation inpatients. (Detail)

IV.C.4.c).(3) Each resident assigned to an acute inpatient rehabilitation service should not be responsible for more than 14 physical medicine and rehabilitation inpatients. (Core ~~Detail~~)

Specialty-Specific Background and Intent: The cap of 14 inpatients applies to the typical workday and does not apply to weekends, holidays, or on-call coverage as there is minimal coverage and residents don’t have their typical responsibilities during these times. The cap applies when an inpatient service resident is on vacation. If a situation arises and the cap is temporarily exceeded, it is expected that patient safety will be ensured by providing additional medical support as needed.

IV.C.4.c).(4) Residents should care for a minimum ~~an~~ average daily patient load of eight patients over the 12-month inpatient experience. (Detail)

Specialty-Specific Background and Intent: It is the program director’s responsibility to ensure that the number of inpatients available for each resident is adequate. Insufficient experience will not meet educational needs and an excessive patient load implies an inappropriate reliance on residents for service. Because patient acuity may vary significantly by hospital, the expectation for a minimum average daily census of eight patients (range six to 14) may be averaged over the experiences for the whole 12 months. In settings with a census greater than 14, programs should provide additional medical support to the resident to ensure safe patient care.

IV.C.4.c).(5) Residents should have inpatient rounds to evaluate patients with faculty members at least five times per week. (Detail)

Specialty-Specific Background and Intent: A subacute rotation may only be counted toward the inpatient requirement if the resident has the same direct and primary responsibility for an assigned group of patients as on an acute inpatient rehabilitation service with an attending physician rounding daily (a minimum of five times/week) to supervise and teach the resident on a subacute rotation.

IV.C.4.d) Residents must have two months of clinical experience that must include outpatient management of the common disabling disorders of childhood, including cerebral palsy and muscular dystrophy, and may include inpatient pediatric rehabilitation and pediatric rehabilitation consults. (Core)

Specialty-Specific Background and Intent: Outpatient experiences may be under the supervision of attending physicians in pediatric rehabilitation and related specialties, such as

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pediatric neurology, pediatric neurological surgery, neuro-developmental pediatrics, or pediatric orthopaedic surgery.

936
937 IV.C.4.e) Residents must directly observe and participate in the various
938 therapies in the treatment areas, including the proper use and
939 function of equipment. (Detail)
940
941 IV.C.4.f) Residents must have experience in providing consultation to other
942 inpatient services. (Core)
943
944 IV.C.4.f).(1) Residents must have increasing responsibility in patient
945 care, leadership, teaching, and administration. (Core)
946
947 IV.C.4.f).(1).(a) Clinical experiences should allow for progressive
948 responsibility with lesser degrees of supervision as
949 a resident advances and demonstrates additional
950 competencies. (Detail)
951
952 IV.C.4.g) Residents must have progressive responsibility in diagnosing,
953 assessing, and managing the conditions commonly encountered
954 in the rehabilitative management of patients of all ages in the
955 following areas: (Core)
956
957 IV.C.4.g).(1) acute and chronic musculoskeletal syndromes, including
958 sports-related injuries, occupational injuries, rheumatologic
959 disorders, and use of musculoskeletal ultrasound; (Detail)
960
961 IV.C.4.g).(2) acute and chronic pain conditions, including use of
962 medications, therapeutic and diagnostic injections, and
963 psychological and vocational counseling; (Detail)
964
965 IV.C.4.g).(3) congenital or acquired myopathies, peripheral
966 neuropathies, motor neuron and motor system diseases,
967 and other neuromuscular diseases; (Detail)
968
969 IV.C.4.g).(4) congenital or acquired amputations; (Detail)
970
971 IV.C.4.g).(5) congenital or acquired brain injury; (Detail)
972
973 IV.C.4.g).(6) congenital or acquired spinal cord disorders; (Detail)
974
975 IV.C.4.g).(7) medical conditioning, reconditioning, and fitness; (Detail)
976
977 IV.C.4.g).(8) orthopaedic disorders, including post-fracture care and
978 post-operative joint arthroplasty; (Detail)
979
980 IV.C.4.g).(9) pulmonary, cardiac, oncologic, infectious,
981 immunosuppressive, and other common medical
982 conditions seen in patients with physical disabilities; (Detail)
983
984 IV.C.4.g).(10) stroke; and, (Detail)

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IV.C.4.g).(11)		tissue disorders such as ulcers and wound care. (Detail)
IV.C.4.h)		Residents should participate in community service, professional organizations, or institutional committee activities. (Detail)
IV.C.4.i)		There must be didactic instruction that is well organized, thoughtfully integrated, based on sound educational principles, and carried out and attended on a regularly scheduled basis. (Detail)
IV.C.4.j)		Didactic instruction must expose residents to topics appropriate to their level of education. (Detail)
IV.C.4.k)		Didactic instruction must include lectures by faculty members, seminars, and journal clubs. (Detail)
IV.C.4.l)		The didactics must include:
IV.C.4.l).(1)		instruction in basic sciences relevant to physical medicine and rehabilitation, such as anatomy, pathology, pathophysiology, and physiology of the neuromusculoskeletal systems; biomechanics; electrodiagnostic medicine; functional anatomy; and kinesiology; (Detail)
IV.C.4.l).(2)		effective teaching methods; (Detail)
IV.C.4.l).(3)		medical administration, including risk management and cost-effectiveness; and, (Detail)
IV.C.4.l).(4)		use and interpretation of psychometric and vocational evaluations and test instruments in the common practice of rehabilitation medicine. (Detail)

IV.D. Scholarship

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

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

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1035 ***programs might choose to utilize more classic forms of biomedical***
1036 ***research as the focus for scholarship.***
1037
1038 **IV.D.1. Program Responsibilities**
1039
1040 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1041 **activities consistent with its mission(s) and aims.** (Core)
1042
1043 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1044 **must allocate adequate resources to facilitate resident and**
1045 **faculty involvement in scholarly activities.** (Core)
1046
1047 **IV.D.1.c) The program must advance residents' knowledge and**
1048 **practice of the scholarly approach to evidence-based patient**
1049 **care.** (Core)
1050

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care. Elements of a scholarly approach to patient care include: • Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan • Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature • When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation) • Improving resident learning by encouraging them to teach using a scholarly approach The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

1051
1052 **IV.D.2. Faculty Scholarly Activity**
1053
1054 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
1055 **accomplishments in at least three of the following domains:**
1056 (Core)
1057
1058 - **Research in basic science, education, translational**
1059 **science, patient care, or population health**
1060 - **Peer-reviewed grants**
1061 - **Quality improvement and/or patient safety initiatives**

- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)‡

IV.D.2.b).(2) peer-reviewed publication. (Outcome)

IV.D.3. Resident Scholarly Activity

IV.D.3.a) Residents must participate in scholarship. (Core)

IV.D.3.a).(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. (Core)

IV.D.3.a).(2) Residents should have assigned time to conduct research or other scholarly activities. (Detail)

IV.D.3.a).(3) Each resident should demonstrate scholarship through at least one scientific presentation, abstract, or publication. (Outcome)

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1103 **V. Evaluation**
1104
1105 **V.A. Resident Evaluation**
1106
1107 **V.A.1. Feedback and Evaluation**
1108

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **residents identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where residents are struggling and address problems immediately**

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

1109
1110 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1111 **frequently provide feedback on resident performance during**
1112 **each rotation or similar educational assignment.** (Core)
1113

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

1114
1115 **V.A.1.b) Evaluation must be documented at the completion of the**
1116 **assignment.** (Core)
1117

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1118 **V.A.1.b).(1)** **For block rotations of greater than three months in**
1119 **duration, evaluation must be documented at least**
1120 **every three months.** (Core)
1121
1122 **V.A.1.b).(2)** **Longitudinal experiences, such as continuity clinic in**
1123 **the context of other clinical responsibilities, must be**
1124 **evaluated at least every three months and at**
1125 **completion.** (Core)
1126
1127 **V.A.1.c)** **The program must provide an objective performance**
1128 **evaluation based on the Competencies and the specialty-**
1129 **specific Milestones, and must:** (Core)
1130
1131 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
1132 **patients, self, and other professional staff members);**
1133 **and,** (Core)
1134
1135 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
1136 **Committee for its synthesis of progressive resident**
1137 **performance and improvement toward unsupervised**
1138 **practice.** (Core)
1139
1140 **V.A.1.d)** **The program director or their designee, with input from the**
1141 **Clinical Competency Committee, must:**
1142
1143 **V.A.1.d).(1)** **meet with and review with each resident their**
1144 **documented semi-annual evaluation of performance,**
1145 **including progress along the specialty-specific**
1146 **Milestones;** (Core)
1147
1148 **V.A.1.d).(2)** **assist residents in developing individualized learning**
1149 **plans to capitalize on their strengths and identify areas**
1150 **for growth; and,** (Core)
1151
1152 **V.A.1.d).(3)** **develop plans for residents failing to progress,**
1153 **following institutional policies and procedures.** (Core)
1154

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there

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are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

1155
1156 **V.A.1.e)** **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** (Core)
1157
1158
1159
1160 **V.A.1.f)** **The evaluations of a resident's performance must be accessible for review by the resident.** (Core)
1161
1162
1163 **V.A.2.** **Final Evaluation**
1164
1165 **V.A.2.a)** **The program director must provide a final evaluation for each resident upon completion of the program.** (Core)
1166
1167
1168 **V.A.2.a).(1)** **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** (Core)
1169
1170
1171
1172
1173
1174 **V.A.2.a).(2)** **The final evaluation must:**
1175
1176 **V.A.2.a).(2).(a)** **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** (Core)
1177
1178
1179
1180
1181 **V.A.2.a).(2).(b)** **verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;** (Core)
1182
1183
1184
1185 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical Competency Committee; and,** (Core)
1186
1187
1188 **V.A.2.a).(2).(d)** **be shared with the resident upon completion of the program.** (Core)
1189
1190
1191 **V.A.3.** **A Clinical Competency Committee must be appointed by the program director.** (Core)
1192
1193
1194 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** (Core)
1195
1196
1197
1198 **V.A.3.a).(1)** **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** (Core)
1199
1200
1201
1202

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Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

1203
1204 **V.A.3.b)** **The Clinical Competency Committee must:**
1205
1206 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
1207 **(Core)**
1208
1209 **V.A.3.b).(2)** **determine each resident's progress on achievement of**
1210 **the specialty-specific Milestones; and, (Core)**
1211
1212 **V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations**
1213 **and advise the program director regarding each**
1214 **resident's progress. (Core)**
1215
1216 **V.B.** **Faculty Evaluation**
1217
1218 **V.B.1.** **The program must have a process to evaluate each faculty**
1219 **member's performance as it relates to the educational program at**
1220 **least annually. (Core)**
1221

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information.

The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.** (Core)

V.B.1.b) **This evaluation must include written, anonymous, and confidential evaluations by the residents.** (Core)

V.B.2. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

V.B.3. **Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.** (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

V.C. **Program Evaluation and Improvement**

V.C.1. **The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.** (Core)

V.C.1.a) **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.** (Core)

V.C.1.b) **Program Evaluation Committee responsibilities must include:**

V.C.1.b).(1) **acting as an advisor to the program director, through program oversight;** (Core)

V.C.1.b).(2) **review of the program's self-determined goals and progress toward meeting them;** (Core)

V.C.1.b).(3) **guiding ongoing program improvement, including development of new goals, based upon outcomes; and,** (Core)

V.C.1.b).(4) **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

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1265

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

1266
1267 **V.C.1.c)** **The Program Evaluation Committee should consider the**
1268 **following elements in its assessment of the program:**
1269
1270 **V.C.1.c).(1)** **curriculum;** (Core)
1271
1272 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
1273 (Core)
1274
1275 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
1276 **Areas for Improvement, and comments;** (Core)
1277
1278 **V.C.1.c).(4)** **quality and safety of patient care;** (Core)
1279
1280 **V.C.1.c).(5)** **aggregate resident and faculty:**
1281
1282 **V.C.1.c).(5).(a)** **well-being;** (Core)
1283
1284 **V.C.1.c).(5).(b)** **recruitment and retention;** (Core)
1285
1286 **V.C.1.c).(5).(c)** **workforce diversity;** (Core)
1287
1288 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient**
1289 **safety;** (Core)
1290
1291 **V.C.1.c).(5).(e)** **scholarly activity;** (Core)
1292
1293 **V.C.1.c).(5).(f)** **ACGME Resident and Faculty Surveys; and,**
1294 (Core)
1295
1296 **V.C.1.c).(5).(g)** **written evaluations of the program.** (Core)
1297
1298 **V.C.1.c).(6)** **aggregate resident:**
1299
1300 **V.C.1.c).(6).(a)** **achievement of the Milestones;** (Core)
1301
1302 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1303 (Core)
1304
1305 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** (Core)
1306
1307 **V.C.1.c).(6).(d)** **graduate performance.** (Core)
1308
1309 **V.C.1.c).(7)** **aggregate faculty:**

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1310
1311 **V.C.1.c).(7).(a)** **evaluation; and,** **(Core)**
1312
1313 **V.C.1.c).(7).(b)** **professional development.** **(Core)**
1314
1315 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1316 **program's mission and aims, strengths, areas for**
1317 **improvement, and threats.** **(Core)**
1318
1319 **V.C.1.e)** **The annual review, including the action plan, must:**
1320
1321 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1322 **the teaching faculty and the residents; and,** **(Core)**
1323
1324 **V.C.1.e).(2)** **be submitted to the DIO.** **(Core)**
1325
1326 **V.C.2.** **The program must complete a Self-Study prior to its 10-Year**
1327 **Accreditation Site Visit.** **(Core)**
1328
1329 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1330 **(Core)**
1331

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

1332
1333 ***V.C.3.*** ***One goal of ACGME-accredited education is to educate physicians***
1334 ***who seek and achieve board certification. One measure of the***
1335 ***effectiveness of the educational program is the ultimate pass rate.***
1336
1337 ***The program director should encourage all eligible program***
1338 ***graduates to take the certifying examination offered by the***
1339 ***applicable American Board of Medical Specialties (ABMS) member***
1340 ***board or American Osteopathic Association (AOA) certifying board.***
1341
1342 **V.C.3.a)** **For specialties in which the ABMS member board and/or AOA**
1343 **certifying board offer(s) an annual written exam, in the**
1344 **preceding three years, the program's aggregate pass rate of**
1345 **those taking the examination for the first time must be higher**
1346 **than the bottom fifth percentile of programs in that specialty.**
1347 **(Outcome)**
1348

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1349 **V.C.3.b)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

1356 **V.C.3.c)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

1363 **V.C.3.d)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

1369 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** (Outcome)

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1376 **V.C.3.f)** **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

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The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1380
1381 **VI. The Learning and Working Environment**
1382
1383 ***Residency education must occur in the context of a learning and working***
1384 ***environment that emphasizes the following principles:***
1385
1386 - ***Excellence in the safety and quality of care rendered to patients by residents***
1387 ***today***
1388
1389 - ***Excellence in the safety and quality of care rendered to patients by today's***
1390 ***residents in their future practice***
1391
1392 - ***Excellence in professionalism through faculty modeling of:***
1393
1394 - ***the effacement of self-interest in a humanistic environment that supports***
1395 ***the professional development of physicians***
1396
1397 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1398
1399 - ***Commitment to the well-being of the students, residents, faculty members, and***
1400 ***all members of the health care team***
1401

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is

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too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** (Core)

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** (Core)

VI.A.1.a).(2) Education on Patient Safety

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1449 1450 1451 **Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.** **(Core)**

1452

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

1453

1454 **VI.A.1.a).(3)** **Patient Safety Events**

1455

1456–1464 ***Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***

1465

1466 1467 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other clinical staff members must:**

1468

1469 1470 1471 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**

1472

1473 1474 1475 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**

1476

1477 1478 1479 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information of their institution's patient safety reports.** **(Core)**

1480

1481–1486 **VI.A.1.a).(3).(b)** **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**

1487

1488 1489 **VI.A.1.a).(4)** **Resident Education and Experience in Disclosure of Adverse Events**

1490

1491–1495 ***Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.***

1496

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1497 **VI.A.1.a).(4).(a)** **All residents must receive training in how to disclose adverse events to patients and families.** (Core)

1501 **VI.A.1.a).(4).(b)** **Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** (Detail)

1505 **VI.A.1.b)** **Quality Improvement**

1507 **VI.A.1.b).(1)** **Education in Quality Improvement**

1509 ***A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.***

1514 **VI.A.1.b).(1).(a)** **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

1518 **VI.A.1.b).(2)** **Quality Metrics**

1520 ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***

1524 **VI.A.1.b).(2).(a)** **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

1528 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**

1530 ***Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.***

1534 **VI.A.1.b).(3).(a)** **Residents must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

1538 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at reducing health care disparities.** (Detail)

1541 **VI.A.2.** **Supervision and Accountability**

1543 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate,***

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1548 ***and monitor a structured chain of responsibility and***
1549 ***accountability as it relates to the supervision of all patient***
1550 ***care.***
1551
1552 ***Supervision in the setting of graduate medical education***
1553 ***provides safe and effective care to patients; ensures each***
1554 ***resident's development of the skills, knowledge, and attitudes***
1555 ***required to enter the unsupervised practice of medicine; and***
1556 ***establishes a foundation for continued professional growth.***
1557
1558 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1559 **appropriately-credentialed and privileged attending**
1560 **physician (or licensed independent practitioner as**
1561 **specified by the applicable Review Committee) who is**
1562 **responsible and accountable for the patient's care.**
1563 **(Core)**
1564

Specialty-Specific Background and Intent: Advanced nurse practitioners and psychologists may supervise residents, as appropriate.

1565
1566 **VI.A.2.a).(1).(a)** **This information must be available to residents,**
1567 **faculty members, other members of the health**
1568 **care team, and patients. (Core)**
1569
1570 **VI.A.2.a).(1).(b)** **Residents and faculty members must inform**
1571 **each patient of their respective roles in that**
1572 **patient's care when providing direct patient**
1573 **care. (Core)**
1574
1575 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
1576 ***For many aspects of patient care, the supervising physician***
1577 ***may be a more advanced resident or fellow. Other portions of***
1578 ***care provided by the resident can be adequately supervised***
1579 ***by the appropriate availability of the supervising faculty***
1580 ***member, fellow, or senior resident physician, either on site or***
1581 ***by means of telecommunication technology. Some activities***
1582 ***require the physical presence of the supervising faculty***
1583 ***member. In some circumstances, supervision may include***
1584 ***post-hoc review of resident-delivered care with feedback.***
1585

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

1586

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1587 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** (Core)

1594 **VI.A.2.b).(2)** **The program must define when physical presence of a supervising physician is required.** (Core)

1597 **VI.A.2.c)** **Levels of Supervision**

1599 **To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** (Core)

1603 **VI.A.2.c).(1)** **Direct Supervision:**

1605 **VI.A.2.c).(1).(a)** **the supervising physician is physically present with the resident during the key portions of the patient interaction; or,** (Core)

1609 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).** (Core)

1613 **VI.A.2.c).(1).(b)** **the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.** (Core)

1619 VI.A.2.c).(1).(b).(i) Prior to allowing supervision of procedures through telecommunication, residents must have demonstrated the ability to perform the procedure while the supervising physician was physically present. (Core)

1625 VI.A.2.c).(1).(b).(i).(a) If the supervising physician is monitoring the procedure through telecommunication technology, but is not physically present on-site, a back-up supervising physician must be physically present to immediately assume care, if needed. (Core)

1632

Specialty-specific Background and Intent: The types of procedures that are appropriate to perform utilizing telesupervision depend on several factors including patient complexity and risk, in addition to the resident's level of training and previous experience performing the procedure. Routine peripheral joint and soft tissue injections are examples of procedures that could readily be considered for telesupervision if the resident has had sufficient experience

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and demonstrated the ability to competently perform the procedure. Procedures such as axial spine injections are riskier procedures that are more appropriately performed under direct supervision.

1633
1634 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.** (Core)
1635
1636
1637
1638
1639
1640 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)
1641
1642
1643
1644 **VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)
1645
1646
1647
1648
1649 **VI.A.2.d).(1)** **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)
1650
1651
1652
1653 **VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** (Core)
1654
1655
1656
1657
1658 **VI.A.2.d).(3)** **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)
1659
1660
1661
1662
1663
1664 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)
1665
1666
1667
1668 **VI.A.2.e).(1)** **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)
1669
1670
1671
1672

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

1673
1674 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident**
1675

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1676 **and to delegate to the resident the appropriate level of patient**
1677 **care authority and responsibility.** (Core)
1678
1679 **VI.B. Professionalism**
1680
1681 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
1682 **educate residents and faculty members concerning the professional**
1683 **responsibilities of physicians, including their obligation to be**
1684 **appropriately rested and fit to provide the care required by their**
1685 **patients.** (Core)
1686
1687 **VI.B.2.** **The learning objectives of the program must:**
1688
1689 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1690 **patient care responsibilities, clinical teaching, and didactic**
1691 **educational events;** (Core)
1692
1693 **VI.B.2.b)** **be accomplished without excessive reliance on residents to**
1694 **fulfill non-physician obligations; and,** (Core)
1695

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

1696
1697 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
1698

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

1699
1700 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1701 **must provide a culture of professionalism that supports patient**
1702 **safety and personal responsibility.** (Core)
1703
1704 **VI.B.4.** **Residents and faculty members must demonstrate an understanding**
1705 **of their personal role in the:**
1706
1707 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1708

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1709 **VI.B.4.b)** **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

VI.B.4.c) **assurance of their fitness for work, including:** (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) **management of their time before, during, and after clinical assignments; and,** (Outcome)

VI.B.4.c).(2) **recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.** (Outcome)

VI.B.4.d) **commitment to lifelong learning;** (Outcome)

VI.B.4.e) **monitoring of their patient care performance improvement indicators; and,** (Outcome)

VI.B.4.f) **accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.** (Outcome)

VI.B.5. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** (Outcome)

VI.B.6. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.** (Core)

VI.B.7. **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** (Core)

VI.C. **Well-Being**

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1750
1751 ***Psychological, emotional, and physical well-being are critical in the***
1752 ***development of the competent, caring, and resilient physician and require***
1753 ***proactive attention to life inside and outside of medicine. Well-being***
1754 ***requires that physicians retain the joy in medicine while managing their***
1755 ***own real-life stresses. Self-care and responsibility to support other***
1756 ***members of the health care team are important components of***
1757 ***professionalism; they are also skills that must be modeled, learned, and***
1758 ***nurtured in the context of other aspects of residency training.***
1759
1760 ***Residents and faculty members are at risk for burnout and depression.***
1761 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1762 ***responsibility to address well-being as other aspects of resident***
1763 ***competence. Physicians and all members of the health care team share***
1764 ***responsibility for the well-being of each other. For example, a culture which***
1765 ***encourages covering for colleagues after an illness without the expectation***
1766 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1767 ***clinical learning environment models constructive behaviors, and prepares***
1768 ***residents with the skills and attitudes needed to thrive throughout their***
1769 ***careers.***
1770

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

1771
1772 **VI.C.1.** **The responsibility of the program, in partnership with the**
1773 **Sponsoring Institution, to address well-being must include:**
1774
1775 **VI.C.1.a)** **efforts to enhance the meaning that each resident finds in the**
1776 **experience of being a physician, including protecting time**
1777 **with patients, minimizing non-physician obligations,**
1778 **providing administrative support, promoting progressive**
1779 **autonomy and flexibility, and enhancing professional**
1780 **relationships;** (Core)
1781
1782 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1783 **compression that impacts resident well-being;** (Core)
1784
1785 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1786 **residents and faculty members;** (Core)

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1787

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

1788
1789 **VI.C.1.d)** **policies and programs that encourage optimal resident and**
1790 **faculty member well-being; and, (Core)**
1791

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

1792
1793 **VI.C.1.d).(1)** **Residents must be given the opportunity to attend**
1794 **medical, mental health, and dental care appointments,**
1795 **including those scheduled during their working hours.**
1796 **(Core)**
1797

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

1798
1799 **VI.C.1.e)** **attention to resident and faculty member burnout,**
1800 **depression, and substance use disorders. The program, in**
1801 **partnership with its Sponsoring Institution, must educate**
1802 **faculty members and residents in identification of the**
1803 **symptoms of burnout, depression, and substance use**
1804 **disorders, including means to assist those who experience**
1805 **these conditions. Residents and faculty members must also**
1806 **be educated to recognize those symptoms in themselves and**
1807 **how to seek appropriate care. The program, in partnership**
1808 **with its Sponsoring Institution, must: (Core)**
1809

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

1810
1811 **VI.C.1.e).(1)** **encourage residents and faculty members to alert the**
1812 **program director or other designated personnel or**
1813 **programs when they are concerned that another**
1814 **resident, fellow, or faculty member may be displaying**
1815 **signs of burnout, depression, a substance use**
1816 **disorder, suicidal ideation, or potential for violence;**
1817 **(Core)**

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1818

Background and Intent: Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

1819
1820 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1821 **and,** (Core)
1822
1823 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1824 **health assessment, counseling, and treatment,**
1825 **including access to urgent and emergent care 24**
1826 **hours a day, seven days a week.** (Core)
1827

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

1828
1829 **VI.C.2.** **There are circumstances in which residents may be unable to attend**
1830 **work, including but not limited to fatigue, illness, family**
1831 **emergencies, and parental leave. Each program must allow an**
1832 **appropriate length of absence for residents unable to perform their**
1833 **patient care responsibilities.** (Core)
1834
1835 **VI.C.2.a)** **The program must have policies and procedures in place to**
1836 **ensure coverage of patient care.** (Core)
1837
1838 **VI.C.2.b)** **These policies must be implemented without fear of negative**
1839 **consequences for the resident who is or was unable to**
1840 **provide the clinical work.** (Core)
1841

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Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

1842
1843 **VI.D. Fatigue Mitigation**
1844
1845 **VI.D.1. Programs must:**
1846
1847 **VI.D.1.a) educate all faculty members and residents to recognize the**
1848 **signs of fatigue and sleep deprivation;** (Core)
1849
1850 **VI.D.1.b) educate all faculty members and residents in alertness**
1851 **management and fatigue mitigation processes; and,** (Core)
1852
1853 **VI.D.1.c) encourage residents to use fatigue mitigation processes to**
1854 **manage the potential negative effects of fatigue on patient**
1855 **care and learning.** (Detail)
1856

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

1857
1858 **VI.D.2. Each program must ensure continuity of patient care, consistent**
1859 **with the program's policies and procedures referenced in VI.C.2–**
1860 **VI.C.2.b), in the event that a resident may be unable to perform their**
1861 **patient care responsibilities due to excessive fatigue.** (Core)
1862
1863 **VI.D.3. The program, in partnership with its Sponsoring Institution, must**
1864 **ensure adequate sleep facilities and safe transportation options for**
1865 **residents who may be too fatigued to safely return home.** (Core)
1866
1867 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
1868
1869 **VI.E.1. Clinical Responsibilities**
1870

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1871 1872 1873 **The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.** (Core)

1874

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

1875

1876 **VI.E.2. Teamwork**

1877

1878 1879 1880 1881 **Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.** (Core)

1882

Specialty-Specific Background and Intent: Appropriately credentialed professional staff members in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, social service, speech-language pathology, therapeutic recreation, and vocational counseling should be integrated into residents' didactic and clinical experience whenever relevant.

1883

1884 **VI.E.3. Transitions of Care**

1885

1886 1887 1888 **VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** (Core)

1889

1890 1891 1892 1893 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)

1894

1895 1896 1897 **VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process.** (Outcome)

1898

1899 1900 1901 **VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.** (Core)

1902

1903 1904 1905 1906 1907 **VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** (Core)

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1908
1909 **VI.F.** **Clinical Experience and Education**
1910
1911 ***Programs, in partnership with their Sponsoring Institutions, must design***
1912 ***an effective program structure that is configured to provide residents with***
1913 ***educational and clinical experience opportunities, as well as reasonable***
1914 ***opportunities for rest and personal activities.***
1915

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.

1916
1917 **VI.F.1.** **Maximum Hours of Clinical and Educational Work per Week**
1918
1919 **Clinical and educational work hours must be limited to no more than**
1920 **80 hours per week, averaged over a four-week period, inclusive of all**
1921 **in-house clinical and educational activities, clinical work done from**
1922 **home, and all moonlighting.** (Core)
1923

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents
PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

1924
1925 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
1926
1927 **VI.F.2.a) The program must design an effective program structure that**
1928 **is configured to provide residents with educational**
1929 **opportunities, as well as reasonable opportunities for rest**
1930 **and personal well-being.** (Core)
1931

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1932 **VI.F.2.b)** **Residents should have eight hours off between scheduled**
1933 **clinical work and education periods.** **(Detail)**
1934
1935 **VI.F.2.b).(1)** **There may be circumstances when residents choose**
1936 **to stay to care for their patients or return to the**
1937 **hospital with fewer than eight hours free of clinical**
1938 **experience and education. This must occur within the**
1939 **context of the 80-hour and the one-day-off-in-seven**
1940 **requirements.** **(Detail)**
1941

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

1942
1943 **VI.F.2.c)** **Residents must have at least 14 hours free of clinical work**
1944 **and education after 24 hours of in-house call.** **(Core)**
1945

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

1946
1947 **VI.F.2.d)** **Residents must be scheduled for a minimum of one day in**
1948 **seven free of clinical work and required education (when**
1949 **averaged over four weeks). At-home call cannot be assigned**
1950 **on these free days.** **(Core)**
1951

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

1952
1953 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
1954

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1955 **VI.F.3.a)** **Clinical and educational work periods for residents must not**
1956 **exceed 24 hours of continuous scheduled clinical**
1957 **assignments.** **(Core)**
1958

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

1959
1960 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
1961 **activities related to patient safety, such as providing**
1962 **effective transitions of care, and/or resident education.**
1963 **(Core)**
1964
1965 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
1966 **be assigned to a resident during this time.** **(Core)**
1967

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as

a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

1968
1969 **VI.F.4. Clinical and Educational Work Hour Exceptions**
1970
1971 **VI.F.4.a) In rare circumstances, after handing off all other**
1972 **responsibilities, a resident, on their own initiative, may elect**
1973 **to remain or return to the clinical site in the following**
1974 **circumstances:**
1975
1976 **VI.F.4.a).(1) to continue to provide care to a single severely ill or**
1977 **unstable patient; (Detail)**
1978
1979 **VI.F.4.a).(2) humanistic attention to the needs of a patient or**
1980 **family; or, (Detail)**
1981
1982 **VI.F.4.a).(3) to attend unique educational events. (Detail)**
1983
1984 **VI.F.4.b) These additional hours of care or education will be counted**
1985 **toward the 80-hour weekly limit. (Detail)**
1986

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

1987
1988 **VI.F.4.c) A Review Committee may grant rotation-specific exceptions**
1989 **for up to 10 percent or a maximum of 88 clinical and**
1990 **educational work hours to individual programs based on a**
1991 **sound educational rationale.**
1992
1993 The Review Committee for Physical Medicine and Rehabilitation
1994 will not consider requests for exceptions to the 80-hour limit to the
1995 residents' work week.
1996
1997 **VI.F.5. Moonlighting**
1998
1999 **VI.F.5.a) Moonlighting must not interfere with the ability of the resident**
2000 **to achieve the goals and objectives of the educational**
2001 **program, and must not interfere with the resident's fitness for**
2002 **work nor compromise patient safety. (Core)**
2003

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2004 **VI.F.5.b)** **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)
2005
2006
2007
2008 **VI.F.5.c)** **PGY-1 residents are not permitted to moonlight.** (Core)
2009

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

2010
2011 **VI.F.6.** **In-House Night Float**
2012
2013 **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** (Core)
2014
2015
2016 VI.F.6.a) Night float cannot exceed more than 18 nights total per year. (Detail)
2017

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

2018
2019 **VI.F.7.** **Maximum In-House On-Call Frequency**
2020
2021 **Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** (Core)
2022
2023 **VI.F.8.** **At-Home Call**
2024
2025 **VI.F.8.a)** **Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.** (Core)
2026
2027
2028
2029
2030
2031
2032 **VI.F.8.a).(1)** **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.** (Core)
2033
2034
2035
2036 **VI.F.8.b)** **Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** (Detail)
2037
2038
2039
2040

Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in

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an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

2041
2042 ***
2043
2044 *__Core Requirements__: Statements that define structure, resource, or process elements
2045 essential to every graduate medical educational program.
2046
2047 †**Detail Requirements**: Statements that describe a specific structure, resource, or process, for
2048 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2049 substantial compliance with the Outcome Requirements may utilize alternative or innovative
2050 approaches to meet Core Requirements.
2051
2052 ‡**Outcome Requirements**: Statements that specify expected measurable or observable
2053 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2054 graduate medical education.
2055
2056 **Osteopathic Recognition**
2057 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
2058 Requirements also apply (www.acgme.org/OsteopathicRecognition).

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