ACGME International

PROGRAM DIRECTORS' GUIDE TO THE INTERNATIONAL FOUNDATIONAL PROGRAM REQUIREMENTS for Residency Programs

EDITION 5. 01 April 2022

Accreditation Overview

To be accredited, residency programs must demonstrate substantial compliance with requirements established by ACGME International (ACGME-I). Before obtaining Advanced Specialty Accreditation, each program must demonstrate substantial compliance with the International Foundational Program Requirements.

As part of the accreditation process, program information is collected from a variety of sources, including: program-specific information provided by the program director and entered into the ACGME-I's Accreditation Data System (ADS); the Advanced Specialty Application; ACGME-I Resident and Faculty Survey responses; case and procedural logs; and information collected by Accreditation Field Representatives through the site visit. ADS addresses questions related to the International Foundational Program Requirements, and the program's application addresses questions related to Advanced Specialty Requirements.

During an accreditation site visit, the ACGME-I Accreditation Field Representative interviews the program director, core faculty members, residents/fellows, clinical department leadership, the designated institutional official (DIO), and other relevant personnel, tailoring questions to the individuals interviewed. The goal is to verify the information in ADS, the program application, and the required attachments, and to clarify any missing or unclear information by seeking to achieve consensus across all participants and other sources of information. On occasions when a consensus cannot be achieved at the end of the site visit, the Accreditation Field Representative reports the sources of the information and aggregates the findings into an objective, factual report that describes the program's compliance with the International Foundational and Advanced Specialty Requirements.

All ACGME-I-accredited residencies with a status other than Initial Accreditation are reviewed annually. Annual compliance is judged using information entered into ADS as part of the program's Annual Update, results of the ACGME-I Resident/Fellow and Faculty Surveys, the program's responses to citations and, where required, graduates' Case Logs.

This *Program Directors' Guide to the International Foundational Requirements* includes explanations of the intent of most foundational requirements, suggestions for implementing requirements, and bulleted guidelines for the types of expected documentation. The explanations and expected documentation in this Guide relate only to the International Foundational Program Requirements. Program directors should consult their Advanced Specialty Requirements and program application for additional information. Advanced Specialty Requirements and applications are available on the specialty's web page on the ACGME-I website, www.acgme-i.org.

To enhance usability, the Guide has been organized to follow the numbering of the International Foundational Program Requirements. The Guide is intended to clarify the meaning and expectations of the International Foundational Program Requirements. It will be regularly revised based on user feedback, and as requirements change. Email comments and suggestions to acgme-i@acgme-i.org.

Guide Format:

a. The requirements themselves are listed first on the pages
b. Data entry points for ADS are noted with an arrow. ➢

Foundational Requirements Content Outline

click on each heading to go directly to that section of the document

---

CONTENTS **PAGE**

Links to additional useful resources:
- ACGME-I Glossary of Terms
- Institutional Requirements
- Foundational Requirements

ACKNOWLEDGEMENTS

The *Program Directors' Guide to the International Foundational Program Requirements*is prepared by ACGME-I staff members. It is a guide and does not supplant the Foundational, Advanced Specialty, or Institutional Requirements, which provide all applicable requirements and are used by the International Review Committee to make accreditation decisions for Sponsoring Institutions and programs.

When applicable to ACGME-I, the *Program Directors' Guide to the International Foundational Program Requirements* includes Background and Intent Statements from the ACGME Common Program Requirements, which are accessible at https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements, and information and guidance contained in the *ACGME Program Directors' Guide to the Common Program Requirements,* accessible at *https://www.acgme.org/Program-Directors-and-Coordinators/Welcome/Program-Directors-Guide-to-the-Common-Program-Requirements.*

I. Institutions

A. Sponsoring Institution

Foundational Requirement:

1. One Sponsoring Institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions. [Requirement I.A.1.]
2. The Sponsoring Institution and the program must ensure that the program director has sufficient protected time and financial support for the educational and administrative responsibilities to theprogram. [Requirement I.A.2.]

Definition of Terms:

Protected time – Protected time is an accommodation that allows program directors to devote a portion of their total effort to the educational program. Protected time occurs during regular business hours and is professional time that is dedicated to teaching, mentoring, and evaluating residents, and to administrative duties associated with the residency program, such as evaluating faculty members, monitoring resident work hours and clinical Case Logs, and preparing and submitting information to ACGME-I. Protected time for educational and administrative activities does not include providing direct clinical care, engaging in research that does not include residents, and fulfilling departmental or institutional administrative responsibilities.

Sponsoring Institution – The organization (or entity) that assumes the ultimate financial and academic responsibility for the residency program. The Sponsoring Institution has the primary purpose of providing educational programs and/or health care services. A university, medical school, hospital, school of public health, health department or public health agency, an organized health delivery system, or ambulatory clinic are all examples of entities that can be Sponsoring Institutions.

Explanation:

Since requirements in this section are for institutions, not programs, verification of institutional support takes place at the time of a site visit primarily through the Accreditation Field Representative's interview with the designated institutional official (DIO) and Department Chair.

A. Sponsoring Institution's Responsibility
   Sponsoring Institution requirements support these International Foundational Program Requirements by requiring that an accredited residency program must operate under the authority and control of a single Sponsoring Institution, and that institution must document its commitment to provide the necessary educational, financial, and human resources to support graduate medical education.

One way the Sponsoring Institution carries out the responsibility for oversight of its programs is by reviewing all program Letters of Notification and monitoring action plans for correction of citations and areas of non-compliance with ACGME-I requirements. The GMEC is also responsible for establishing criteria for adequate program performance and providing oversight of underperforming programs through a Special Review Process. These GMEC responsibilities do not substitute for the annual self-evaluation that each program is required to conduct (Foundational Requirement V.D.).

- Documentation of Sponsoring Institution Responsibilities: Through interviews with the DIO, the Accreditation Field Representative will look for evidence that the GMEC is conducting a regular review of program Letters of Notification and monitoring action plans for correction of areas of non-compliance.

B. Resources Required of the Sponsoring Institution

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

Sponsoring Institutions should be accredited by the Joint Commission International (JC-I) or be recognized by another entity with reasonably equivalent standards as determined by ACGME-I.

Documentation for Physical/Clinical Facilities: The adequacy of physical and clinical facilities will be verified during the site visit through resident/fellow interviews. The Accreditation Field Representative may also tour facilities if there were prior citations relating to these areas, if concerns are raised during the site visit, or if ACGME-I has Advanced Specialty Requirements for a program’s patient care or educational facilities. There may be Advanced Specialty Requirements for resources.

- Documentation for Patient Care: The Accreditation Field Representative may verify patient care accreditation status with JC-I (or another recognized entity)through database information and may clarify and verify information by reviewing the accreditation letter during the DIO interview.

C. Sufficient Protected Time and Financial Support for the Program Director
Foundational Requirement II.A.2.d) indicates that the program director must have no less than 50 percent or 20 hours a week of protected time for the administrative and educational activities of the program. This requirement represents a minimum time allotment and would likely be insufficient for a residency program with a large number of residents or many participating sites. The Review Committee-International judges the adequacy of program director support by verifying if the program director has adequate time to meet all the responsibilities outlined in International Foundational Program Requirement II.A.2. This is assessed during the site visit to the program, through the program's Annual Update, from ACGME-I Resident/Fellow and Faculty Survey results, and, when applicable, the Case Logs of program graduates.

I. Institutions

B. Participating Sites

Foundational Requirements:

1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must approved by the designated institutional official (DIO) and be renewed at least every five years.

   The PLA should:

   a) identify the faculty member(s) who will assume both educational and supervisory responsibilities for residents;
   b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
   c) specify the duration and content of the educational experience; and,
   d) state the policies and procedures that will govern resident education during the assignment.[Requirement I.B.1]

2. The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents through the ACGME-I Accreditation Data System (ADS). [Requirement I.B.2.]
3. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. [Requirement I.B.3.]

Definition of Terms:

Didactic – A planned, systematic, instructed learning experience, such as a conference, journal club, or grand rounds.

Participating site – An organization providing educational experiences or educational assignments/rotations that are not under the jurisdiction of the Sponsoring Institution. Required rotations that are not in a resident's specialty department but are within the Sponsoring Institution are not participating sites. For example, an intensive care unit within the Sponsoring Institution that provides required rotations for emergency medicine residents is not a participating site. A pediatric hospital that is not part of the Sponsoring Institution and is used for required rotations for anesthesiology residents is a participating site. A participating site can be within the Sponsoring Institution's country or jurisdiction or can be an out-of-country posting.

Site director – The faculty member at a participating site who is responsible for the administration of the educational program at that site, including assessment of residents and oversight of the policies and procedures that govern a resident's education while at that site.

Explanation:
Program directors are responsible for program letters of agreement (PLAs), although the designated institutional official (DIO) oversees this process. Agreements must be in place for all sites with required rotations and for sites regularly used for elective assignments. If a participating site is infrequently used for elective rotations, a PLA is not required; however, the program should have in place written confirmation of the required elements of a PLA noted below.

The primary purposes of PLAs are to ensure an appropriate educational experience and to protect residents from undue service requirements that do not enrich their education. PLAs are intended to be short, less formal documents. A PLA can be a simple letter or memo, signed by the program director and the site director, or the medical director. A PLA must include four items of information:

1. The site director(s) (by name or general group) who teach(es) and supervise(s) residents at the participating site.
2. The responsibilities for teaching, supervising, and formal evaluation of residents at the participating site.
3. The duration of experience at the site in each year of the program, the specific educational purpose of the experience, and the content (both clinical experiences and formal didactics) of the educational experience. The explanation does not need to be a curriculum document; it can be a descriptive paragraph that identifies the goal(s) and learning outcomes for the assignment or a reference to a more thorough explanation in the resident handbook.
4. The policies and procedures governing resident education at this site. This maybe a statement that residents must abide by the policies of the site and those of the program and the Graduate Medical Education Committee (GMEC).

Additions or deletions of a participating site that provides an educational experience must be submitted in ADS. Information to be entered in ADS for each participating site includes the distance (in miles) and time (in minutes) from the primary clinical site; the name of the site director, whether the experience is required; the date the PLA is effective; the number of months residents will spend at the site during each year of the program; and a brief description of the content of the educational experience at the site, including faculty coverage, volume and variety of clinical experience, site support,and the impact of the site on the overall education of residents. Finally, ADS will ask about resources available at the site, such as sleeping rooms, showers, secure areas, cafeteria, etc.

- Documentation for PLAs: On program initial applications, all current PLAs are uploaded into ADS. For programs seeking Continued Accreditation, the current PLAs should be available for the Accreditation Field Representative to review. All PLAs should contain the four items listed above, as well as the required signatures and a date more recent than five years old. Agreements should be updated whenever there are changes in program director or site director or resident assignments, or whenever there are revisions to the items specified in the International Foundational Program Requirements or the Advanced SpecialtyRequirements.

A. Resident Participation in Required Didactics
ACGME-I requires that all residents have the same educational experiences, and this includes residents not rotating at the Sponsoring Institution. Programs can repeat required didactics on a regular schedule that will allow all residents to have all educational experiences prior to graduation. Programs can also provide didactic sessions in multiple locations or use distance technology to provide didactics to those not at the Sponsoring Institution.

II. Program Personnel and Resources

A. Program Director

Foundational Requirements:

1. There must be a single program director with authority and accountability for the operation of the program. The Sponsoring Institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME-I via the ADS. [Requirement II.A.1.]
2. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME-I Competency areas. The program director must: [Requirement II.A.2.]
   a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
   b) monitor the clinical and working environment at all participating sites;
   c) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate without fear of intimidation or retaliation
   d) dedicate no less than 50 percent (a minimum of 20 hours per week) of his/her professional effort to the administrative and educational activities of the educational program;
   e) approve a local director at each participating site who is accountable for resident education;
   f) approve the selection of program faculty as appropriate;
   g) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
   h) monitor resident supervision at all participating institutions;
   i) in specialties where ACGME-I Case Logs are required, monitor resident Case Logs at least semi-annually and counsel residents or revise clinical experiences as needed.
   j) prepare and submit all information required and requested by the ACGME-I, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
   k) meet with and review with each resident the documented semiannual evaluation of performance including progress on the specialty-specific milestones;
   l) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
   m) provide verification of residency education for all residents, including those who leave the program prior to completion;
   n) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment and must:
      (1) distribute these policies and procedures to the residents and faculty members; and,
      (2) monitor resident duty hours, according to institutional and program.
   o) monitor the need for and ensue the provision of back-up support systems when patient care responsibilities are unusually difficult or prolonged;
   p) comply with the Sponsoring Institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
   q) obtain review and approval of the Sponsoring Institution's GMEC/DIO before submitting to the ACGME-I information or requests for the following:
      (1) all applications for ACGME-I accreditation of new programs;
      (2) changes in resident complement;
      (3) major changes in program structure or length of training;
      (4) progress reports requested by the ACGME-I Review Committee;
      (5) responses to all proposed adverse actions;
      (6) voluntary withdrawals of ACGME-I accredited programs;

(7) requests for appeal of an adverse action; and,
(8) appeal presentations to ACGME-I Review Committee.

r) obtain DIO review and co-sign off on all program information forms, as well as any correspondence or document submitted to the ACGME-I that addresses:
(1) program citations; and/or,
(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

3. The program director should continue in his/her position for a length of time adequate to maintain continuity of leadership and program stability. [Requirement II.A.3.]

4. Qualifications of the program director should include: [Requirement II.A.4.]
a) a minimum of three years documented experience as a clinician, administrator, and educator in the program specialty;
b) current American Board of Medical Specialty (ABMS) certification in the program specialty or specialty qualifications that are deemed equivalent or acceptable to the ACGME-I Review Committee; and,
c) current medical licensure to practice in the Sponsoring Institution's host country and appropriate medical staff appointment.

Definition of Terms:

Learning and working environment – The environment and context for conduct of residency education that must emphasize excellence in safety and quality of care rendered to patients by residents; excellence in professionalism through faculty members providing a humanistic learning environment that includes problem solving, intellectual rigor and discovery; and the commitment to the well-being of residents, faculty members, and all members of the health care team.

Milestones – Performance levels residents are expected to demonstrate for skills, knowledge, and behaviors in the six ACGME-I Core Competency domains. The Milestones lay out a framework of observable behaviors and other attributes associated with a resident's development and as such, describe a learning trajectory that takes the resident from a beginner in the specialty to a highly proficient resident or early practitioner. The Milestones are not a complete description of a clinical discipline; they are not a curriculum or a performance evaluation tool by themselves. The Milestones are intended for formative purposes to help learners and programs improve. The Milestones are developed for each specialty and are available on the specialty web page at on the ACGME-I website, www.acgme-i.org. Programs must report assessments of each resident on the Milestones semi-annually in the Accreditation Data System (ADS).

Program director – the individual designated with authority and accountability for the operation of a residency or fellowship program.

Explanation:

Programs that have a history of frequent changes may trigger additional inquiry into the cause(s) to determine if the learning environment has been adversely affected. A single person (program director) must have authority for the operation of the program.

The selection of a program director should be informed by the mission of the program and the needs of the community. Qualifications for program directors include specialty expertise, educational and administrative experience, current medical licensure, and appropriate medical staff appointment.

The period of three years from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established.

A. Program Director Responsibilities

The International Foundational Program Requirements contain a list of program director responsibilities (Requirement II.A.2.). This extensive list is intended not only to communicate the specific responsibilities of the position so that the individual will be effective as a program director, but also to communicate to the Sponsoring Institution, the designated institutional official (DIO), Graduate MedicalEducation Committee (GMEC), and department chair the role and responsibilities of this position and why the program director needs sufficient protected time and financial support to fulfill these responsibilities.

Program Directors must devote at least 50 percent or a minimum of 20 hours per week to the educational and administrative activities of the program. Educational and administrative activities include teaching, mentoring, and evaluating residents; evaluating faculty members; completing tasks associated with Clinical Competency Committee and Program Evaluation Committee meetings; monitoring resident work hours and clinical Case Logs; and preparing and submitting information to ACGME-I. Protected time for educational and administrative activities does not include providing direct clinical care, however, when the program director is teaching and supervising residents while providing clinical care, this time can count as educational activity. Engaging in research that does not include residents or fulfilling departmental or institutional administrative responsibilities does not count as educational or administrative activity associated with the educational program.

By ensuring that each of the listed duties occurs on a regular basis, the program director will facilitate an enhanced learning environment. For example, the program director “must approve the selection of program faculty as appropriate.” Typically, the department chair will make such assignments, but the program director must have input into these decisions so that faculty members with both clinical and teaching expertise are given responsibilities in the program.

The program director is responsible for implementing and ensuring compliance with policies and procedures for grievance and due process; clinical work and education (duty) hours; selection, evaluation, and promotion of residents; disciplinary action; and supervision of residents. Institutions and/or programs may have more extensive policies and procedures. These policies and procedures should be given to all residents and faculty members in print format or be made available on a residency program website to ensure all residents and faculty members are knowledgeable about these important issues.

A program handbook is not required but is a convenient approach to collecting and updating all information that must be made available to residents and faculty members. Information on policies and procedures, schedules, educational program goals, goals and objectives for each major assignment, and information on all required sites can be placed in a resident handbook. Such a handbook could be either paper or electronic and can be maintained on a website or other digital medium.

- Documentation for program director qualifications: Program director qualifications will be documented through information entered in ADS. Verification that the program director has a current medical license and medical specialty certification occurs through the institutional credentialing process. Accreditation Field Representatives verify that the program director has an appropriate medical staff appointment.

- Documentation for program director responsibilities: The Accreditation Field Representative may spot check information that the program director must provide to residents and faculty members, and use interviews to verify that the program director organizes and oversees the educational activities at all sites, and ensures implementation of fair policies, grievance, and due process procedures. Other information, such as board scores, mid-level examination passrates, ACGME-I Resident/Fellow and Faculty Survey responses, Case Logs, clinical work and education (duty) hour compliance data, and resident remediation plans may be examined and confirmed during a site visit.

  Resident/Fellow and Faculty Survey results are reviewed during the annual review of all programs with a status other than Initial Accreditation.

ADS will request the following information on the program director:

- Medical school and date of degree
- Names and dates of graduate medical education programs
- Licensures with expiration dates
- Academic appointments for the last 10 years, with dates
- Concise summary of roles and responsibilities in the program
- A listing of up to 10 professional activities and committees within the last five years
- A listing of the most representative peer-reviewed publications from the last five years (limit 10)
- A listing of selected review articles, chapters, and/or textbooks within the last five years (limit 10)
- Participation in local, regional, and national activities/presentations within the last five years (limit 10)

I. Program Personnel and Resources

B. Faculty

Foundational Requirement:

1. There must be a sufficient number of (physician and non-physician) faculty members with documented qualifications to instruct and supervise all residents for the program. [RequirementII.B.1.]
2. A portion of the faculty must be core physician faculty members who:
   a) are expect evaluators of the competency domains;
   b) work closely with and support the program director;
   c) assist in developing and implementing evaluation systems;
   d) teach and advise residents; and,
   e) devote a minimum of 15 hours per week to resident education and administration. [Requirement II.B.2.]
3. All faculty members must: [Requirement II.B.3.]
   a) be role models of professionalism
   b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;
   c) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and to demonstrate a strong interest in the education of residents;
   d) administer and maintain an educational environment conducive to educating residents in each of the ACGME-I competency areas;
   e) participate in faculty development programs designated to enhance the effectiveness of their teaching and to promote scholarly activity;
   f) establish and maintain an environment of inquiry and scholarship with an active research component.
      (1) Faculty members must regularly participate in organized clinical discussions, rounds,journal clubs, and conferences.
      (2) Faculty members should encourage and support residents in pursuing scholarly activities [Requirement II.B.3.f).(2)]
4. All physician faculty members must:
   a) have current ABMS certification in the program specialty and
   b) possess qualifications that meet all criteria for appointment as a faculty member at the program's Sponsoring Institution [Requirement II.B.4.a)]
5. Physician Faculty to Resident Ratio [Requirement II.B.5.]
   a) In addition to the program director, the core physician faculty to resident ratio must be no less than one to six.
   b) The ratio of all physician faculty to residents, which includes all core faculty and the program director, should be one to one.
6. Non-physician faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.

Definition of Terms:

Core faculty members – 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 completing the annual ACGME-I Faculty Survey. The program director identifies certain faculty members as core faculty members in the Accreditation Data System (ADS). The list of core faculty members should be reviewed annually.

Explanation:
Requirements for faculty members include responsibilities and qualifications.

A. Core Faculty Members
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 completing the annual ACGME-I Faculty Survey.

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

C. Faculty Development
Faculty development is intended to describe structured programming developed for the purpose of enhancing skills in teaching, mentoring and evaluating residents. Faculty development may occur in a variety of configurations, such as lectures, workshops, or guided discussions, and can use internal or external resources. Programming should always be based on the needs of faculty members and can be specific to the institution or the program. ACGME-I has developed a library of resources, available in its distance education platform, Explore. The site provides resources in multiple areas, such as teaching, evaluation, and well-being, and allows program directors to view the development activities completed by faculty members. Faculty development programming is reported to ACGME-I for the program faculty in aggregate.

D. Faculty Member Qualifications
Qualifications of physician faculty members are evaluated during review of the Sponsoring Institution and the processes used to appoint faculty members. The ACGME-I Institutional Requirements outline the general areas that must be considered when appointing physicians as faculty members. Programs attest that faculty members have met the criteria for appointment as a faculty member as part of the program's Annual Update.

- Documentation for Faculty: Data related to program personnel qualifications, roles, etc. are entered in ADS. This information should be updated regularly as needed.

ADS will request the following information on faculty members:

- Medical school and date of degree
- Names and dates of graduate medical education programs
- Board identification number for faculty members who are certified by a US board
- Academic appointments for the last 10 years, with dates
- Concise summary of roles and responsibilities in the program

For initial applications, the following information will also be required for the program director and core faculty members:

- A listing of up to 10 professional activities and committees within the last five years
- A listing of the most representative peer-reviewed publications from the last five years (limit 10)
- A listing of selected review articles, chapters, and/or textbooks within the last five years (limit 10)
- Participation in local, regional, and national activities/presentations within the last five years (limit 10)
- Number of hours per week the faculty member devotes to the program in each of the following areas: clinical supervision of residents; administration of the program; research/scholarly activity with residents; and didactic teaching with residents, as well as the total hours the faculty member devotes each week to the program.

ADS will ask for the areas in which program faculty members participated in faculty development during the prior academic year. Additionally, questions on the area of Educational Content from the ACGME-I Resident/Fellow Survey will be used to verify whether the program provides opportunities to participate in research or scholarly activity, and questions in the area of Faculty will be used to verify faculty member interest in teaching and resident education. The ACGME-I Faculty Survey also asks core faculty members questions related to sufficient time for resident supervision and about their involvement with residents on a scholarly project.

Information on faculty members entered in ADS, including scholarly activity information, and results of the Resident/Fellow and Faculty Surveys are reviewed annually for all programs with a status other than Initial Accreditation.

During a site visit, verification by the Accreditation Field Representative includes interviews with faculty members and residents.

II. Program Personnel and Resources

C. Other Program Personnel
D. Resources

Foundational Requirements

Other Program Personnel

1. The institution and the program must jointly ensure the availability of all necessary professional,
   technical, and clerical personnel for the effective administration of the program. [Requirement II.C.1.]
2. There must be a program coordinator who must be supported for at least 20 hours a week for administrative time. [Requirement II.C.2.]

Resources

1. The program, in partnership with its Sponsoring Institution, must ensure health and safe learning and working environments that promote resident well-being and provide for [Requirement II.D.1.]
   a) access to food while on duty;
   b) safe, quiet, and provide sleep/rest facilities available and accessible for residents with proximity appropriate for safe patients care; and,
   c) clean and private facilities for lactation that have refrigeration capabilities with proximity appropriate for safe patient care.
2. The institution and the program must jointly ensure the availability of adequate resources for resident education. [Requirement II.D.2.]
3. There must be a sufficient population of patients of different ages and genders with a variety of ethnic, racial, sociocultural, and economic backgrounds, having a range of clinical problems to meet the program's educational goals and provide a breadth and depth of experience in the specialty. [Requirement II.D.3.]
4. Residents must have software resources and ready access to specialty-specific and other appropriate reference material in print or electronic format. [Requirement II.D.4. and II.D.5.]
   a) Electronic medical literature data bases with search capabilities must be available.

Definition of Terms:

Program coordinator – A lead administrative person whose job responsibilities include managing the day-to-day operations of the program and serving as an important liaison with learners, faculty members, other staff members, and ACGME-I. The program coordinator is critical to the success of the program and must therefore possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME-I accreditation policies and procedures, the applicable requirements, and documentation required in the Accreditation Data System (ADS) and the program application. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Explanation
Specific requirements for other personnel and physical resources vary with the specialty and are listed in the Advanced Specialty Requirements. The specialty application will require information on required personnel, equipment, specialized services, and care units. Initial applications for procedural specialties will require information on procedures performed within the most recent 12-month period. This information is used to judge the adequacy of the patient population in relation to the program's requested resident complement and program length.

The resources listed below represent general requirements contained in the International Institutional Requirements that must be available for all programs:

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

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

- Documentation for Resources: For program initial applications, ADS will ask for a description of the educational and clinical resources available for resident education. When answering this question, it is important to address whether the resources specified in the International Institutional Requirements will be available to the program's residents, and to address resident access to any additional resources included in the Advanced Specialty Requirements. Additionally, it will be important to describe the range of clinical problems available to meet the program's educational goals.

When prior citations exist or concerns are raised during the site visit, or where the ACGME-I has requirements for physical facilities, the Accreditation Field Representative may request a tour to determine whether resources and facilities meet the needs of residents for providing patient care as part of their education.

Documentation of medical information access is provided through the ACGME-I Resident/Fellow Survey, through questions in the area of Resources. Information on resources entered in ADS and results of the Resident/Fellow and Faculty Surveys are reviewed annually for all programs with a status other than Initial Accreditation. During a site visit, the Accreditation Field Representative may use interviews and inspection of facilities for additional verification.

A. Other Program Personnel
In addition to faculty members, the program must have adequate support from clerical, research, and technical staff members, and from other health care providers in the delivery of care. These additional personnel may include staff members with clerical skills, project managers, education experts, and staff members who maintain electronic communication and resources. These individuals may support more than one program in more than one specialty.

- Documentation for Other Program Personnel: For both program initial applications and programs seeking Continued Accreditation, ADS will request a listing of all non-physician faculty members who have documented qualifications to instruct and supervise all residents in the program. Information must be entered on each non-physician faculty member's degree, specialty or field, and number of years teaching in the specialty. ACGME-I Resident/Fellow Survey responses in the area of Faculty will provide the Accreditation Field Representative with information on residents' satisfaction with education and supervision from staff and non-physician faculty members. The Accreditation Field Representative may have follow-up questions.

➢ ADS will request information on the amount of salary support per week that is allocated to the program coordinator.

B. Resources to Promote Resident Well-Being
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 that must be met while residents are working. Residents should have access to refrigeration where food can 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 fatigued residents.

III. Resident Appointments

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

Foundational Requirement:

Eligibility Criteria

1. The program director must comply with the criteria for resident eligibility as specified in the ACGME-I Institutional Requirements. [Requirement III.A.1.]

Number of Residents

1. The program director may not appoint more residents than approved by the ACGME-I Review Committee. [Requirement III.B.1.]
2. The program's educational resources must be adequate to support the number of residents appointed to the program. [Requirement III.B.2.]
3. There should be at least three residents in each year of the program unless otherwise specified by specialty or approved by the Review Committee-International [Requirement III.B.3.]

Resident Transfers

1. Before accepting a resident, who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences, including the summative competency-based performance evaluation. [Requirement III.C.1.]
2. The program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion. [RequirementIII.C.2.]

Appointment of Fellows and Other Learners

1. The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with Sponsoring Institution guidelines. [Requirement III.D.1.]

Definition of Terms:

Transfer resident – Residents are considered to be transfer residents under several conditions. A resident moving from one program to another within the same or a different Sponsoring Institution is a transfer resident. A resident entering a residency that requires a preliminary broad-based clinical year, such as anesthesiology or ophthalmology, is a transfer resident if the requirements for a broad-based clinical year were completed as part of another ACGME-I-accredited residency or as a preliminary resident in an ACGME-I-accredited internal medicine or general surgery program. A physician who has successfully completed a residency program and is accepted into a subsequent residency or fellowship program is not considered a transfer resident.

Explanation:

A. Resident Eligibility

Program directors should be familiar and should comply with the Sponsoring Institution's written policies and procedures as well as the Institutional Requirements regarding eligibility, selection, and appointment of residents. There are also specialty-specific requirements for eligibility.

- Documentation for Eligibility: During a site visit, the Accreditation Field Representative will review the written policies for selection and promotion of residents/fellows. For example, selection may be based on medical students who have passed the USMLE Step 1 and 2 Clinical Knowledge examination, or secure examinations of equivalent reliability that measure similar basic science and clinical competencies and have similar standards.

B. Number of Residents

When a program receives ACGME-I accreditation, the Review Committee-International will also determine the appropriate number of residents, or resident complement, for the program. Programs are expected to request and maintain an equal number of residents for each year of the program.

- Documentation for Residents: Information is documented in the Accreditation Data System (ADS) on the number of ACGME-I-approved positions for each year of the program, and the number of filled positions, as well as information on current residents, including their program start dates, expected completion dates, years of prior ACGME-I-accredited or internationally-approved graduate medical education (GME) (and specialty if applicable), medical school, home country, and date of medical school graduation. This information is verified by the Accreditation Field Representative at the time of the site visit.

  Aggregate data on residents/fellows completing or leaving the program in the last three years is documented in ADS. All residents are listed according to their year in the program, as is their status (active full-time, off-cycle, left program, completed training, or inactive). Resident attrition is reviewed annually for all programs with a status other than Initial Accreditation. During a site visit, Accreditation Field Representatives verify reasons for transfers and program responses during interviews.

C. Requesting a Change in Resident Complement

Prior ACGME-I approval is needed to increase the resident complement of a program (the number of residents in the program). A request can be made for either a permanent or a temporary increase in resident complement. Temporary increases are granted for a finite period and usually cover additional residents when there is an overlap due to residents who do not complete their program on time or were admitted off-schedule. Programs with Initial Accreditation can only request temporary complement increases, and programs with probationary status cannot request any increase, permanent or temporary, in resident complement.

To initiate a change (either an increase or decrease) in the approved resident complement, log into ADS and click on “Complement Change” on the right-hand side of the program’s Overview page. All complement change requests are sent electronically to the DIO for approval. Block diagrams and an educational rationale for the change are required. Programs should update responses to any existing citations and revise the Faculty Roster as needed to ensure that the required core faculty to resident ratios are maintained with the requested increase. The educational rationale should outline how resident education and patient care will improve with the addition of residents. Simply needing more specialists in a country or jurisdiction is not a sufficient educational rationale for a complement increase.

D. Transfer Residents

Before accepting a transferring resident, the “receiving” program director must obtain written or electronic verification of prior education from the current program director. Verification must include evaluations, rotations completed, procedural/operative experience, and, if the resident is transferring from an ACGME-I-accredited program, a summative competency-based performance evaluation. Neither the term “transferring resident” nor the responsibilities of the two program directors noted here apply to a resident who has successfully completed a specialty residency program and is then accepted into a subspecialty fellowship program.

- Documentation for Resident Transfers: Programs are required to have files of current residents who have transferred into the program from either a non-ACGME-I-accredited program and from a program accredited by ACGME-I. These files should contain written verification of prior educational experience and, if the resident transferred from an ACGME-I-accredited program, a summative competency-based performance evaluation. If applicable, files of residents who transferred into or out of the program should be available to the Accreditation Field Representative during the site visit.

  Examples of verification of previous educational experiences include a list of rotations completed, evaluations of various educational experiences, and procedural/operative experience. Meeting the requirement for verification before accepting a resident is complicated in the case of a resident who has been accepted into the program but needs to complete an ACGME-I-accredited transitional year residency. In such a case, the transitional year program must provide the “receiving” program with a statement regarding the resident’s current standing as of one-to-two months prior to anticipated completion, along with a statement indicating when the summative competency-based performance evaluation will be sent. An example of an acceptable verification statement is:

  “(Resident name) is currently a transitional year resident in good standing at (Sponsoring Institution). (Resident name) has satisfactorily completed all rotations to-date, and we anticipate s/he will satisfactorily complete this education on (dd/mm/yy). A summary of (resident name)’s rotations and a summative competency-based performance evaluation will be sent to you by (dd/mm/yy).”

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

- Documentation for Fellows and Other Learners: ADS requests a list of other learners who will share program resources with residents. For initial applications, programs will also be required to provide a description of the impact those learners will have on the educational program. During a site visit, the Accreditation Field Representative will verify the impact of the presence of fellows or other learners on the educational opportunities available to residents through review of ACGME-I Resident/Fellow Survey results and interviews during the site visit.

  For programs with a status other than Initial Accreditation, Resident/ Fellow Survey results are reviewed annually to determine the impact of other learners on the residents' education.

IV. Educational Program

A ACGME-I Competencies

Foundational Requirement:

A. The program must integrate the following ACGME-I Competencies into the curriculum, and structure the curriculum to support resident attainment of each. [Requirement IV.A.]

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

Definition of Terms:

Competencies – Specific knowledge, skills, behaviors, and attitudes and the appropriate educational experiences required of residents to complete graduate medical education programs. The ACGME-I Competencies are:

- Professionalism – the commitment to carrying out professional responsibilities and an adherence to ethical principles
- Patient Care and Procedural Skills – provision of care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- Medical Knowledge – knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care
- Practice-based Learning and Improvement – the ability to investigate and evaluate the physician's care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning
- Interpersonal and Communication Skills –skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals
- Systems-based Practice – awareness of and responsiveness to the larger context and system of health care, including the social determinates of health, as well as the ability to call effectively on other resources in the system to provide optimal patient care

---

Explanation:

The Competencies provide the conceptual framework describing the required domains for a trusted physician to enter autonomous practice. The International Foundational Program Requirements contain the ACGME-I Core Competencies, and specialty- specific competencies and subcompetencies are in the Advanced Specialty Program Requirements. Developmental trajectories in each of the Competencies are outlined in the Milestones for each specialty.

IV. Educational Program

B. Regularly Scheduled Educational Activities

Foundational Requirements:

1. Residents must be provided with protected time to participate in regularly scheduled educational activities. [Requirement IV.B.1.]
2. The core curriculum must include a didactic program based upon the core knowledge content and the areas defined as resident outcomes in the specialty. [Requirement IV.B.2.]
3. Regularly scheduled didactic sessions should include: [Requirement IV.B.3.]
   a) multidisciplinary conferences;
   b) morbidity and mortality conferences;
   c) journal clubs or evidence-based reviews;
   d) case-based planned didactic experiences;
   e) seminars and workshops to meet specific competencies, including Professionalism;
   f) computer-aided instruction;
   g) simulation; and,
   h) grand rounds.

Definition of Terms:
Didactic – a planned, systematic instructed learning experience, such as a conference, journal club, or grand rounds

Protected time – time away from clinical responsibilities to allow for participation in education activities

---

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

The International Foundational Program Requirements state that all residents must participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible; however, clinical times and resident responsibilities must not make it impossible for residents to regularly attend. Programs should define core didactic activities for which time is protected and the circumstances under which residents may be excused from educational activities.

Residents rotating at a site away from the primary clinical site pose a particular challenge to providing access to planned educational or didactic activities. The program needs to take didactic activities into account when assigning residents to distant rotations, and alternatives must be provided to allow residents to participate. Some examples of alternatives include using distance technology or regularly cycling educational activities so that all residents will have access at some time during the educational program.

- Documentation for Didactic Sessions: A list of scheduled didactic sessions is a required attachment for all program applications. Conference schedules, hand-outs, session evaluations, or attendance records may also be requested for review during the site visit. During a site visit, verification of the information will be accomplished through the Resident/Fellow Survey questions in the area of Faculty, from responses of core faculty members on the Faculty Survey, and during site visit interviews.

  Resident/Fellow and Faculty Survey results are reviewed annually for all programs with a status other than Initial Accreditation.

IV. Educational Program

C. Clinical Experiences

Foundational Requirements:

1. The curriculum must contain the following educational components [Requirement IV.C.1.]
   a) A set of program aims, consistent with the Sponsoring Institution's mission, the needs of the country or jurisdiction that the program serves, and the desired distinctive capabilities of its graduates;
   b) Overall educational goals for the program must be distributed to residents and faculty members annually in either written or electronic form;
   c) Competency-based goals and objectives for each assignment at each educational level must be distributed to residents and faculty members annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation.
2. Educational experiences must be structured to ensure the program provides each resident increased responsibility in patient care and management, leadership, supervision, teaching, and administration. [Requirement IV.C.2.]

Definition of Terms:

Competency-based goals and objectives – a defined set of learning objectives for each assignment in the educational program. An assignment can be a rotation; a scheduled recurring session, such as journal club or grand rounds; a simulated learning experience; or a required resident project, such as a quality improvement project that is not explicitly part of a recurring session or rotation. The goals communicate the general purpose and direction of the assignment; the objectives are the intended results of the instructional process or activity that communicate to residents, faculty members, and others involved the expected results in terms of resident outcomes, and that typically form the basis for items within evaluation instruments.

Overall program educational goals – descriptions that provide a general overview of what the program is intended to achieve. These create a framework for expectations on the part of residents, faculty members, and others in the program, and should not be considered a 'laundry list' of learning objectives. The overall educational goals must be distributed to residents and faculty members annually, either electronically or on paper.While the International Foundational Program Requirements do not specifically state that goals must be reviewed with residents, programs should have a process in place that ensures the residents both know and understand these overall goals.

Program aims – a set of key expectations for the program. While programs must demonstrate substantial compliance with the ACGME-I requirements, it is recognized that within this framework programs may place different emphasis on research, leadership, public health, etc. based on the mission of the Sponsoring Institution and the community served.

Explanation

A. Program Aims

The program's aims are statements of the outcomes that the program expects to produce and are used to evaluate the program's effectiveness in producing those outcomes. Aims can outline the type of graduate the program intends to produce or the type of medical care graduates will deliver. Program aims specify the factors that set a program apart from other programs in neighboring countries, and how the educational program contributes to the overall mission of the department and Sponsoring Institution.

Sample Program Aims:

- Educate residents to be excellent practitioners of medically directed anesthesiology within an anesthesia care team model.
- Educate residents to enter primary care practice.
- Produce excellent, independent practitioners who will be leaders in academic medicine.

Program aims are developed using input from a wide range of sources and should be reviewed and approved by leadership in education and patient care.

- Documentation for Program Aims: Program mission and aims are entered in ADS and will be included in the program's overview page. The Review Committee-International will not judge the adequacy of a program's aims or mission statement in making its accreditation decision; however, for programs on annual review, the program aims will form the basis of the required Self-Study and will be reviewed by the Accreditation Field Representative during the program's accreditation site visit.

B. Overall Educational Goals

Program aims will differ from overall educational goals in that the educational goalsoutline what the residents, upon graduation, should know; how the resident is expected to perform, and how the resident is expected to interact with others to deliver quality patient care.

Sample Overall Educational Goals:

At the end of the educational program residents can:

- gather clinical data from a patient interview, physical examination, and diagnostic modalities, such as laboratory results and radiology studies;
- use obtained clinical data to diagnose the clinical problem at hand or generate a differential diagnosis; and,
- formulate diagnostic and therapeutic plans that consider risks, benefits, costs, patient preferences, and ethical and psychological issues.

- Documentation for Overall Educational Goals: The program's overall educational goals are a required attachment to be uploaded with the program application. Verification that residents review the learning objectives will be accomplished through the Resident/Fellow Survey questions in the area of Educational Content, as well as through interviews during the accreditation site visit.

C. Competency-Based Goals and Objectives
"Competency-based" means that the goals and objectives must clearly relate to one or more of the six ACGME-I Core Competency domains. Typically, short-term assignments, such as a journal club, will have one or two goals and several objectives that are related to some, but not all six Core Competencies. For example,the goals and objectives for a specific simulated learning experience may relate only to Interpersonal and Communication Skills.

Sample Goal for a Simulated Learning Experience:
- Improve performance in communicating effectively with patients.

Sample Objectives for this Simulation Experience:
- Provide precise information to a patient that is clearly understood.
- Express openness to feedback from patients.
- Pay close attention to patients and actively listen to them.

The goals and objectives for each assignment at each educational level must be distributed annually to residents and faculty members. If the program has created a program handbook, all curriculum design materials (i.e., goals and objectives for each curricular element, assessment instruments used for each) could be included, and the handbook should be distributed to residents or made available online. Goals and objectives should be reviewed with residents at the start of every assignment.

- Documentation for Competency-Based Goals and Objectives: Documentation of a sample of competency-based goals and objectives for one assignment at each educational level must be submitted (uploaded) with the program application. During the accreditation site visit, overall educational goals of the program, as well as the competency-based goals and objectives for each assignment at eacheducational level, should be available for the Accreditation Field Representative to review. Inclusion of these in a well-organized program handbook is not required; however, having the competency-based goals and objectives in one place will simplify the documentation requirement. Verification that residents review the learning objectives will be accomplished through ACGME-I Resident/Fellow Survey questions in the area of Educational Content. Responses to the Resident/Fellow survey are reviewed annually for all programs with a status other than Initial Accreditation. During a site visit, interviews with residents and faculty members will verify survey responses.

D. Resident Responsibilities

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

As a resident progresses through the educational program, the level of supervision needed should also change. Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty members.

- Documentation for Resident Responsibilities: Documentation may consist of written information for each rotation or assignment. A program's supervision policy addressing progressive responsibilities for patient care and faculty member responsibility for supervision is required as an attachment to initial program applications and should also be available for the Accreditation Field Representative to review for programs seeking Continued Accreditation. Resident supervision policies must be specific to the specialty. Institution-wide supervision policies, except for single program institutions, are not acceptable. Responses to ACGME-I Resident/Fellow Survey questions in the area of Faculty and responses of core faculty members on the ACGME-I Faculty Survey are reviewed annually for all programs with a status other than Initial Accreditation. During site visit, interviews with residents and faculty members will verify survey responses.

IV. Educational Program

D. Scholarly Activity

Foundational Requirements

1. Residents' Scholarly Activities
   a) 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. [Requirement IV.D.1.a)]
   b) Residents should participate in scholarly activity. [Requirement IV.D.1.b)]
   c) The Sponsoring Institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. [Requirement IV.D.2.c)]

2. Faculty Scholarly Activity
   a) Among their scholarly activity, programs must demonstrate faculty members' accomplishments in at least three of the following domains: [IV.D.2.a)]
      (1) Research in basic science, education, translational science, patient care, or population health;
      (2) Peer reviewed grants;
      (3) Quality improvement and/or patient safety initiatives;
      (4) Systematic reviews, meta-analyses, review articled, chapters in medical textbooks, or case reports;
      (5) Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials; and,
      (6) Active membership in national or international committees or leadership in educational organizations and innovations in education.
   b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: [IV.D.2.b)]
      (1) Faculty member 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; and peer-reviewed publication.

Explanation:

The requirement for scholarly activity for residents and faculty members is not to promote scholarship for its own sake, but as a proxy for the creation of a clinical learning environment that encourages inquiry and an evidence-based, scholarly approach to patient care. ACGME-I recognizes the diversity of residencies. It is expected that the program's scholarship will reflect its mission and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, or teaching, while other programs might choose to emphasize more classical forms of biomedical research as the focus for scholarship.

One important factor in providing resources for scholarly activity is time. Faculty members and residents may need protected time away from clinical activities to spend on scholarly activity.

A. Resident Scholarly Activity

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

Didactic instruction on conducting research is also important, and general information may be provided at the institutional level for all residency programs.

- Documentation for Resident Scholarly Activity: Evidence for how the program supports the development of specific skills needed by residents for scholarly activity may be provided through written goals and objectives that should be available for review by the Accreditation Field Representative during the accreditation site visit. Other such evidence could include availability of financial and technical support for research and other scholarly activity. Scholarly activityof residents is documented in ADS on the Resident Scholarship table for programs seeking Continued Accreditation. During a site visit, the Accreditation Field Representative will verify through interviews that residents have opportunities for research or scholarly activity.

  For all programs with a status other than Initial Accreditation, review of resident scholarly activity is accomplished annually through review of ACGME-I Resident/Fellow Survey responses in the area of Faculty and Educational Content and through review of resident scholarly activity entered in ADS during the program’s Annual Update.

B. Faculty Scholarly Activity

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

Faculty scholarly activity must be disseminated to count; however, a wide range of disseminations are acceptable. It is important to note that conference attendance alone does not count toward meeting scholarly activity requirements. Faculty members must present a lecture, workshop, or poster, or be actively involved in planning and organizing the conference for this activity to count.

- Documentation for Faculty Scholarly Activity: Faculty scholarly activity is updated annually in ADS for faculty scholarship that was disseminated during the prior academic year. The Review Committee-International uses this information to judge the scholarly activity of the faculty as a whole by considering how all faculty members are involved in scholarly activities. A program with one or two researchers who produce all the scholarly activity for the faculty is not sufficient. To promote an educational environment of inquiry within the program, faculty scholarly activity should be evident for the majority of faculty members.

  Faculty scholarly activity entered in ADS during the program's Annual Update is reviewed annually for all programs with a status other than Initial Accreditation.

V. Evaluation

A. Resident Evaluation

Foundational Requirement:

1. Formative Evaluation
   a) The members of the faculty must directly observe, evaluate, and provide feedback on resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. [Requirement V.A.1.a)]
   b) The program must: [Requirement V.A.1.b)]
      (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
      (2) use multiple evaluators, including faculty members, peers, patients, self, and other professional staff members;
      (3) document progressive resident performance improvement appropriate to educational level in each of the milestones; and,
      (4) provide each resident with a documented semi-annual evaluation of performance with feedback aimed to assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.
   c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy. [Requirement V.A.1.c)]
   d) Assessment must include a review of case volume, and breadth and complexity of both inpatient and outpatient cases. [Requirement V.A.1.d)]
   e) Assessment should specifically monitor resident knowledge by use of formal in-service cognitive exams. [Requirement V.A.1.e)]

2. Summative Evaluation
   a) The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution and must be accessible for review by the resident in accordance with institutional policy. [Requirement V.A.2.a)]
   b) The evaluation must: [Requirement V.A.2.b)]
      (1) document the resident's performance during the final period of education; and,
      (2) verify the resident has demonstrated sufficient competence to enter practice without direct supervision.

Definition of Terms:

Feedback – Communicating an evaluation of resident performance with the aim of enabling improvement. Feedback should always include dialogue between the evaluator and the resident that empowers 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 does not always need to be formally documented.

Formative evaluation – Assessment of a resident with the primary purpose of providing feedback for improvement, as well as to reinforce skills and behaviors that meet established criteria and performance standards. More specifically, formative evaluations help residents identify their strengths and weaknesses, and target areas that need work. Formative evaluations also allow program directors and faculty members to recognize where residents are struggling and address problems immediately.

Summative evaluation – Assessment with the primary purpose of establishing if performance measured at a single defined point in time meets established performance standards. Summative evaluation is used to make decisions about promotion to the next level of the educational program, or program completion.

Explanation:
Direct observation is key to the evaluation of resident performance and progress. Continuity of observation is important, even in short rotations, to allow faculty members to know the resident and for the resident to know faculty members. Timely completion of resident evaluation following completion of an assignment is crucial to a resident's development. Evaluations must address strengths and areas for improvement.

A. Formative Evaluation
   This type of assessment includes both informal, 'on-the-spot' feedback and feedback based on the planned collection of information using assessment forms.

   Written formative assessment provides a mechanism through which programs can document progressive resident performance improvement. Self-assessment is an important component of formative assessment, both to compare with data from other evaluators and to develop this important lifelong learning skill.

   The primary purpose of formative assessment is to help residents recognize a learning gap. Routine constructive feedback is the key for reaching proficiency. It should help residents answer the fundamental questions: Where am I now? Where am I going? How do I get to where I am going? How will I know when I get there? Am I on the right track for getting there? Formative assessment is successful if it leads the resident to proactively close the gap, thus also building lifelong learning skills. This is less likely to occur if the formative assessment is given to residents without discussion of what the information means and without inviting the residents to plan strategies to improve.

Formative assessment is also an effective way to identify the need for formal remediation as it provides a 'developmental history' of the resident's work, efforts, responses to feedback, and outcomes. Remediation then becomes a process that partners the program director or faculty advisor and resident in planning, implementing, and evaluating the remediation.

Programs need to demonstrate planning for and use of an assessment system that includes both formative and summative evaluations, identifies the methods used to assess each of the six Core Competency domains, and states who the evaluators are for each. Not all of the six ACGME-I Core Competencies need to be evaluated during each clinical or didactic assignment. Instead, the evaluation system should be planned so that assessments occur when the experience will provide the most valid information during each level of the program.

Effective assessment systems include these core principles:

- assessment based on identified learning objectives/outcomes related to the six Core Competency domains;
- use of multiple tools by multiple evaluators on multiple occasions; and,
- tools with descriptive criterion-based anchors for the rating scale to aid in fairer and more consistent evaluations.

The assessment system must be monitored to ensure timely completion of evaluations and that the required semiannual reviews with feedback take place and are documented.

Formative assessment data is not intended for use in major decisions about a resident's promotion, dismissal, or graduation.

Examples of Assessment Methods:

- Anatomic or animal models
- Direct observation (Mini-CEX)
- Formal oral examination
- Global assessment
- In-house written examination
- In-training examinations
- Multisource assessment
- Objective structured clinical exam (OSCE)
- Oral exam
- Patient survey
- Practice/billing audit
- Project assessment
- Record/chart review
- Resident experience narrative
- Review of case or procedure log
- Review of drug prescribing
- Review of patient outcomes
- Role-play
- Simulations/models
- Standardized patient examination
- Structured case discussion
- Videotaped/recorded assessment

Examples of Types of Evaluators:

- Allied Health Professional
- Attending
- Chief Resident
- Clerical staff member
- Consultant
- Evaluation Committee
- Faculty Member
- Faculty member during consultations
- Faculty Supervisor
- Family
- Junior Resident
- Medical Student
- Nurse
- Patient
- Peer
- Preceptor
- Program Coordinator
- Program Director
- Resident Supervisor
- Self
- Technician

- Documentation for Assessment System: The Accreditation Data System (ADS) will request the following information on resident evaluation both for new applications and for programs seeking Continued Accreditation:
  - The assessment method from a drop-down menu for each of the ACGME-I's six Core Competency areas
  - Identification of the evaluators for each method (see list of potential evaluators below)
  - List of other key assessment methods used but not included in the drop-down menu
  - Description of how evaluators are educated to use the assessment methods
  - Description of how residents are informed of the performance criteria on which they will be evaluated
  - Description of how the program ensures that faculty members complete written evaluations in a timely manner following each rotation or educational experience

  There should be evidence of multiple methods and multiple evaluators, as well as alignment between the methods of assessment and the skill being assessed. Programs being reviewed for Continued Accreditation must have current resident files available for the Accreditation Field Representative to review containing completed assessments and completed evaluations showing use of multiple evaluators. Responses to questions on the ACGME-I Resident/Fellow Survey in the area of Evaluation and on the ACGME-I Faculty Survey will also provide information on assessment. Planned assessment forms are required to be included as attachments with program initial applications. During a site visit, the Accreditation Field Representative will spot-check resident files and verify information through interviews.

  Resident/Fellow and Faculty Survey responses in the area of Evaluation are reviewed annually for all programs with a status other than Initial Accreditation.

- Documentation for Performance Criteria: ADS requests a description of how the program ensures that residents know and understand the performance criteria on which they will be assessed. Documentation may include a process for communicating the criteria used for each evaluation and the standards set by the program, as well as a mechanism to ensure that every resident is made aware of this information.

- Documentation for Timely Completion: ADS requests a description of how the program ensures the timely completion of evaluations. This description may include a structured mechanism with ongoing monitoring by a designated individual. Responses to questions on the ACGME-I Resident/Fellow Survey in the area of Evaluation and on the ACGME-I Faculty Survey pertaining to estimating the time faculty members take to provide end-of-rotation assessments are reviewed annually for all programs with a status other than Initial Accreditation. During a site visit, the Accreditation Field Representative may use interviews for added verification.

- Documentation for Semiannual Reviews: The process involves the program director or a designee who meets with the resident semi-annually to guide the resident through the assessment process. Written documentation of each evaluation will enable the resident to more clearly see developmental progress over time. Designating an individual to monitor semi-annual reviews will help ensure they take place as scheduled. The Accreditation Field Representative may spot-check resident files and use interviews for added verification.

- Documentation for Accessibility of Evaluations: Documentation for this requirement is obtained through responses to questions on the ACGME-I Resident/Fellow Survey in the area of Evaluations and is verified by the Accreditation Field Representative through resident interviews.

Resident/Fellow and Faculty Survey responses in the area of Evaluation are reviewed annually for all programs with a status other than Initial Accreditation.

B. Summative Evaluation

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

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

If the country's physician certification regulations allow a resident to become a specialist following completion of the ACGME-I-accredited program, the summative evaluation must include the statement that the program director verifies the resident is "competent to enter practice without supervision." If the country requires additional education or experience beyond completion of the ACGME-I-accredited program, then the summative evaluation must indicate the additional activities required for independent practice, such as an examination and/or additional year(s) of indirect supervision prior to receiving a license for independent practice.

If the program director does not feel comfortable signing such a statement for a resident, that resident should not be allowed to graduate, even if the specified time for residency education has expired. Such a situation is less likely if ACGME-I requirements for evaluation have been systematically and fully implemented, as problems will have been identified much earlier, opportunities for remediation provided, and dismissal decisions considered well before the end of residency/fellowship education. Both the end-of-program summative evaluation and the end-of-program verification statement for all graduates should be retained in perpetuity in a site that conforms to reasonable document security standards. To ensure that the institution can demonstrate appropriate due process for dismissed residents, the program director should seek the direction of the designated institutional official (DIO) on which documents to keep for dismissed residents.

- Documentation for Summative Evaluation: For programs seeking Continued Accreditation, copies of the summative evaluations for the most recent year's graduates must be available to the Accreditation Field Representative, who will review these evaluations to determine if the program is in compliance with the requirements. In addition, the Accreditation Field Representative will interview residents to verify ACGME-I Resident/Fellow Survey responses concerning availability of current and previous evaluations.

  For program initial applications, a blank copy of the summative evaluation of residents, documenting performance during the final period of education and, if applicable, verifying that a resident has demonstrated sufficient competence to enter practice without direct supervision, must be uploaded into ADS.

V. Evaluation

B. Clinical Competency Committee

Foundational Requirements

1. Programs must provide residents with objective performance evaluations based on the ACGME-I Competencies and regular evaluation of the Milestones. [Requirement V.B.1.]
2. The program director must appoint a Clinical Competency Committee (CCC) to review performance evaluations for each resident. [Requirement V.B.2.].
3. The CCC must [Requirement V.B.3.]:
   a) be composed of at least three program faculty members, at least one of whom is a core faculty member;
   b) have a written description of its responsibilities, including its responsibility to the Sponsoring Institutions and to the program director; and,
   c) participate actively in:
      (1) reviewing all resident evaluations by all evaluators, Case Logs, the Milestones, incident reports, and other data semi-annually; and,
      (2) making recommendations to the program director for resident progress, including promotion, remediation, corrective actions or dismissal.
4. The findings of the CCC and program director must be shared with each resident on at least a semi-annual basis. [Requirement V.B.3.d)]

Definition of Terms:
Clinical Competency Committee (CCC) – a required body comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of residents in a program.

Milestones – a set of developmental performance expectations in each of the six ACGME-I Core Competencies that provide a framework for a required periodic assessment of a resident. The Milestones guide the judgement of the program director and faculty members evaluating the residents. They are not the totality of a specialty, a complete assessment of all knowledge, skills, and attitudes, or a complete overall determination of a resident's abilities. Rather, the Milestones are a tool to provide an interim identification of progress in competency areas toward that necessary for unsupervised practice.

Explanation:
The primary purposes of the CCC, which is composed of members of the program's core teaching faculty and other key personnel, are to review all of the various evaluations of the residents, to judge each resident's current development in the six ACGME-I Core Competency domains, and to make recommendations to the program director based on the residents' progress, including regarding promotion, remediation, and dismissal. The CCC's responsibilities and evaluation criteria must be documented and consistent.

The program director must appoint the CCC; however, the program director may or may not be a member of the CCC. The intent of the requirements is to permit flexibility so each program can determine the best structure for its own circumstances. 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 CCC 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.

The CCC may include more than physician faculty members; other physicians and non-physicians who teach and evaluate the program's residents may be included. There may be additional members of the CCC. Chief residents who have completed a residency program in their primary specialty may also serve on the CCC.

- Documentation for CCC: For initial program applications, the following information will be requested in the Accreditation Data System (ADS):
  - List of CCC members
  - The process used by the CCC to complete semiannual and summative evaluations

  Programs seeking Continued Accreditation will be asked to list the members if the CCC and should also have samples of program evaluations and written resident improvement or remediation plans available for review at the time of the accreditation site visit. The ACGME-I Resident/Fellow Survey asks questions about feedback and the Accreditation Field Representative will validate responses during on-site interviews with residents.

  Resident/Fellow and Faculty Survey responses in the area of Evaluation are reviewed annually for all programs with a status other than Initial Accreditation.

V. Evaluation

C. Faculty Evaluation

Foundational Requirement:

1. The program must evaluate faculty member performance as it related to the educational program at least once a year. [Requirement V.C.1.]
2. These evaluations should include a review of each faculty member's clinical teaching abilities,commitment to the educational program, participation in faculty development related to the individual's skills as an educator, clinical knowledge, professionalism, and scholarly activities.[Requirement V.C.2.]
3. The evaluation of faculty members must include the confidential evaluations written by the residents each year. [Requirement V.C.3.]

Explanation:

Faculty members should be evaluated based on their role in resident education, including clinical care, teaching and research in aspects such as clinical productivity, review of patient outcomes, or peer review of scholarly activity. Sometimes the program director may need to work with others to determine the effectiveness of faculty members' performance with regard to their role in the educational program. The process should reflect the local environment and identify the necessary information.

Residents should be asked to evaluate only those areas about which they have direct knowledge and information. For example, residents can accurately report their perceptions of a faculty member's clinical teaching abilities, commitment to the educational program, clinical knowledge, and professionalism. They would have direct knowledge of the quality of a faculty member's scholarly activity related to research only if they were working with that faculty member on a research project. Otherwise, their evaluation of scholarly activity would be based on indirect knowledge.

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

Assessment of faculty members is an important part of improving the teaching program.Feedback to the faculty members is important to help individual faculty members measure and increase their contribution to the mission of the program and improve their individual effectiveness as teachers. It is suggested that assessment include research and scholarly activity, their clinical work, and their educational activities. This specific requirement for written and confidential evaluations of faculty members is intended to collect the most honest feedback from the residents, which requires minimizing any possibility for fear of retaliation or intimidation of the residents as a result of comments made.

- Documentation for Faculty Evaluation: Programs seeking Continued Accreditation are asked to have written confidential evaluations of faculty members by the residents available for review during the accreditation site visit. The Accreditation Field Representative may verify compliance by reviewing responses to ACGME-I Resident/Fellow Survey questions in the area of Evaluation, and through interviews. The Accreditation Field Representative will also verify that the Program Evaluation Committee is using faculty member evaluations in its annual review of the program. Examples of forms to be used for confidential faculty member evaluations must be available for the Accreditation Field Representative to review for new program applications.

A. Faculty Development

Faculty development related to faculty members' role as teacher and mentor can be accomplished in a number of ways. Time could be set aside during faculty meetings to discuss topics like assessment tools and methods for using them effectively, and how best to distribute and collect completed evaluations in a timely manner. Faculty members could review online resources available through ACGME-I's online learning platform, Explore. Discussion of videos could be done online or during a faculty meeting. Development can also be accomplished at the institutional level, particularly for universal topics, such as dealing with difficult residents or encouraging and mentoring residents' scholarly projects.

- Documentation for Faculty Development: All programs are asked to list the areas in which program faculty participated in faculty development activities. For programs seeking Continued Accreditation, the Accreditation Field Representative will request to see a listing of faculty development activities and those faculty members who attended them.

B. Confidentiality of Evaluations

The International Foundational Program Requirements specify that there must be a confidential evaluation of faculty member performance. It is important to note that confidential evaluations do not necessarily have to be anonymous. For an evaluation to be anonymous, the evaluator is not known by anyone, offering a higher level of security.

Although not required, the advantage of an anonymous evaluation is that it is the most reassuring to the resident. Anonymous evaluations may be accomplished by collecting them via a system that does not identify an individual resident. Because it might be possible for faculty members to guess the identity by timing when the evaluation appears, the individual comments might be collected throughout the year and batched feedback might be best given at the end of the year. For very small programs, the feedback may need to be collected over two years to accumulate a larger group of evaluations.

For a confidential evaluation, the reviewer is not known by the individual being evaluated, but the identity of the evaluator might be known by someone such as the program director or department chair. Confidential faculty evaluations are a critical piece of information to help improve the program but can be a challenge in small programs.

Confidential evaluations only work if the residents trust that their identity will be kept secret. This requires they have a high degree of trust in the individual who does know their identity. The trusted individual may be the program coordinator collecting the evaluations. The coordinator often has an informal relationship with the residents, which is seen as friendlier or less threatening than the program director. However, the program coordinator must never be allowed to be intimidated by the program director or a faculty member to reveal an evaluating resident's identity. The trusted individual may also be the program director or department chair, who oversees the faculty member. However, these individuals may be viewed as more intimidating to a resident because of their supervisory relationship. In this instance, the trusted individual must be someone else, particularly when the resident is evaluating the program director or the department chair. Another scenario has the trusted individual being someone outside of the program, such as the DIO or an individual who reports to a different department.

Confidentiality is at risk when the written evaluation contains details that might identify a specific patient or case or resident interaction that the faculty member can recall and attribute to the specific individual resident. Residents should be instructed to be general enough to preclude that level of detail and still maintain the effectiveness of the evaluation as a quality improvement tool.

V. Evaluation

D. Program Evaluation and Improvement
E. Program Evaluation Committee

Foundational Requirement:

Program Evaluation and Improvement

1. The program must document formal, systematic evaluation of the curriculum at least once per year that is based on the program's stated mission and aims and that monitors and tracks each of the following areas: [Requirement V.D.1.]
   a) resident performance, including Milestones evaluations;
   b) faculty development;
   c) graduate performance, including performance of program graduates taking the certification examination; and,
   d) program quality;
   e) Residents and faculty members must have the opportunity to evaluate the program confidentially and in writing at a minimum of once per year.
   f) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
   g) measures of resident and faculty member well-being;
   h) engagement in quality improvement and patient safety efforts; and,
   i) scholarly activity of residents and faculty members.
2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. [Requirement V.D.2.]
3. Programs that are reviewed annually as part of the Next Accreditation System-International (NAS-I), must complete a Self-Study prior to the program's accreditation site visit. [RequirementV.D.3.]
   a) The Self-Study must include a longitudinal evaluation of the program and its learning environment using data from the following:
      (1) the annual reviews of the program; and,
      (2) an analysis of the program's strengths and self-identified areas for improvement.
   b) A summary of the Self-Study must be submitted to the DIO.

Program Evaluation Committee

1. The program director must appoint a Program Evaluation Committee (PEC) to evaluate the program. [Requirement V.E.1.]
2. The PEC must: [Requirement V.E.2.]
   a) be composed of at least two program faculty members, at least one of whom is a core faculty member, and must include resident representatives from different years of the educational program;
   b) have a written description of its responsibilities, including its responsibility to the Sponsoring Institution and to the program director; and,
   c) participate actively in:
      (1) planning, developing, implementing, and evaluating all significant activities of the residency program;
      (2) developing competency-based curriculum goals and objectives;
      (3) annually reviewing the program using evaluations from faculty members, residents, and others;
      (4) creating the Annual Program Evaluation document;
      (5) reviewing the GMEC internal review of the residency program with recommended action plans; and,
      (6) ensuring that areas of non-compliance with ACGME-I standards are corrected.

Definition of Terms:
Next Accreditation System-International (NAS-I) – All ACGME-I-accredited programs with a status other than Initial Accreditation are reviewed annually. This review of programs uses an annual assessment of processes and outcomes of education, and determination of substantial compliance with applicable requirements by reviewing information collected each year. Each program receives an annual accreditation decision, and citations are resolved or extended or new citations are given. Following the review, programs receive an annual Letter of Notification that outlines the program's accreditation status, approved resident complement, citations, and areas for improvement.

Self-Study – An objective, comprehensive evaluation of a residency program with the aim of improving it, conducted ahead of the scheduled accreditation visit. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment that occurs through sequential annual program evaluations with an emphasis on program strengths and self-identified areas for improvement.

Well-being – psychological, emotional, and physical health that allows physicians to retain the joy in medicine while managing their own real-life stresses.

Explanation:
To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement as part of an Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality. The program should set additional metrics that reflect the program's stated mission and aims.

The program director is expected to lead an ongoing effort to monitor and improve the quality and effectiveness of the program. A written plan for program evaluation and improvement will help to ensure that a systematic evaluation takes place annually, that aggregated results are used to identify what is working well and what needs to be improved, and that needed improvements are implemented. As part of a quality improvement cycle, it is also important for the program to annually evaluate the effectiveness of past initiatives and make adjustments as needed.

The following are examples of aggregated data to evaluate:
1. Resident performance
   - Milestones assessments
   - Results of in-training exams
   - Case and procedure logs
   - Resident presentations/publications

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

3. Graduate performance
   - Results of performance on board certification, intermediate, or advanced specialty examinations
   - Annual surveys of graduates. Typically, such surveys target physicians one year and five years after graduation. Forms may be provided by the institution, developed locally, or adapted from other sources or published literature. Survey questions may inquire about such items as current professional activities of graduates, the patient characteristics of the graduates' practice, and perceptions on how well-prepared graduates feel as a result of the program.
   - Surveys of employers and/or practice sites (hospitals, clinics) of the graduates

4. Additional metrics
   - ACGME-I well-being survey for residents and faculty members. This validated survey is conducted annually at the time of the ACGME-I Resident/Fellow and Faculty Surveys. Aggregated data from the survey is available to program directors and DIOs only. Results are not available to the Review Committee-International and are not used for accreditation decisions.
   - Faculty member scholarly activity

A. Assessment of Program Quality
   Current residents and faculty members must have the opportunity to evaluate the program annually. To ensure confidentiality, responses should be de-identified. An appropriate staff member (program coordinator, institutional quality improvement staff member, Graduate Medical Education (GME) Office staff member, etc.) should collect completed written information, remove any identifiers, and collate responses.The program director and faculty members may then analyze and review the collated information.

Programs may have residents complete confidential, written evaluations of rotations, specific assignments, or learning experiences as part of a targeted improvement plan. The residents' confidential evaluations of the teaching faculty members may also be used as part of this evaluation. To ensure confidentiality of such evaluations in programs with a small number of residents, the responses should be collected over a sufficient period of time to ensure that the collated information contains responses from several residents and cannot be linked to specific respondents.

Some programs periodically evaluate other areas that impact program quality, including the resident selection process, graduates' practice choices, the curriculum, assessment system (including self-assessment), remediation, and linking patient outcomes to resident performance.

The de-identified data collected in these areas may be analyzed by the program director and selected faculty members and residents if it is a large program, or by all if it is a small program. The PEC will then identify outstanding features of the program and areas that could be improved. A written plan of action for review/approval by the members of the teaching faculty should be developed for identified areas for improvement.

- Documentation for Program Evaluation and Improvement: For initial applications,ADS asks several questions about program evaluation and improvement that will help to demonstrate if the program is in compliance with these requirements, including the names of the members of the PEC and a description of its processes for conducting the annual review. During a site visit, the Accreditation Field Representative will review on-site samples of documents planned or already in use as part of the program evaluation.

  For programs seeking Continued Accreditation, documentation of PEC meeting minutes and the written improvement action plan prepared after a review of the aggregated results of program evaluation information should be available for the Accreditation Field Representative to review during the accreditation site visit. This written action plan may be based on one or more outcome measure(s) and reflective of a Plan, Do, Study, Act (PDSA) cycle. The Accreditation Field Representative may use interviews for added verification.

  Resident/Fellow and Faculty Survey responses in the area of Evaluation are reviewed annually for all programs with a status other than Initial Accreditation.

B. The Self-Study

The goal of the Self-Study is for programs to conduct an objective and comprehensive evaluation. Annual Program Evaluations are the key elements of this process. To provide context for the Self-Study, the following concepts must be considered:

1. That the program determines its aims.
2. That the program provides an assessment of the institutional, local, regional, and national environments relevant to the program that leads to opportunities and threats.

It is expected that development of the Self-Study includes program leadership, residents, graduates, and others who interact closely with residents. Citations, areas for improvement, and other information from ACGME-I, the Annual Program Evaluation, and other program or institutional data sources should be used.

Additional information, including the steps to completing a Self-Study, and forms to use for data collection and reporting to ACGME-I are available on www.acgme-i.org.

C. The PEC

The primary purposes of the PEC are to annually review the program and to produce the Annual Program Evaluation. Data used will depend on the program's aims and evaluation plan. Institutional requirements for conducting the Annual Program Evaluation may be in place and programs are encouraged to contact their GME Office for guidance.

V. The Learning and Working Environment

A. Principles

Foundational Requirement:

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

Definition of Terms:

Service obligations – those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff members. Examplesof 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.

Explanation:

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty member modeling of:
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

The primary goal of residency education is resident learning through patient care experiences. Residents are first and foremost learners. The program must ensure that there are adequate opportunities for the patient care activities relevant to the specialty, while ensuring safe, high-quality care for patients. The learning environment must support development of abilities in a resident-centered way with incremental responsibility and independence.

The Sponsoring Institution is required to develop and implement written policies and procedures regarding resident work hours to ensure compliance with the International Institutional, International Foundational, and Advanced Specialty Requirements. The institution must provide a copy of its work hour policies and procedures as part of the ACGME-I institutional accreditation review process. These policies and procedures must cover resident supervision, fatigue, workhours, and on-call activities. For all requirements related to workhours, institutions or programs may set standards that are more restrictive than the ACGME-I International Foundational Requirements or Advanced Specialty Requirements.

Programs must have program-level policies on supervision and work hours. Programs are responsible for ensuring that all residents and faculty members are familiar with the policies and procedures and for designing the resident learning environment to enable these policies and procedures to be properly implemented. Residents are responsible for adhering to the policies and procedures. Clear and frequent communication among institutional officials, program directors, faculty members, and residents is essential for achieving these goals.

- Documentation for Learning Environment: Programs applying for ACGME-I accreditation will be asked in ADS to describe how they handle (or plan to handle) resident complaints and concerns in a confidential or protected manner, and how they do (or plan to) minimize residents' fear of intimidation or retaliation. ADS will also ask for a description of how the programs plan to ensure that resident education is not adversely affected by heavy service obligations. The Accreditation Field Representative will review responses to ACGME-I Resident/Fellow Survey questions in the areas of Faculty and Resources, and responses to ACGME-I Faculty Survey questions related to appropriate resident workload and program provisions for patient safety. This information will be verified during on-site interviews with residents and faculty members.

  Resident/Fellow and Faculty Survey responses are reviewed annually for all programs with a status other than Initial Accreditation.

VI. The Learning and Working Environment

B. Patient Safety

C. Quality Improvement

Foundational Requirement:

Patient Safety

1. The program and its faculty members, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. [Requirement VI.B.1.]
2. The program must have a structure that promotes safe, interprofessional, team-based care. [Requirement VI.B.2.]
3. Education on patient safety [Requirement VI.B.3.]
    a) Programs must provide formal educational activities that promote patient-safety-related goals, tools, and techniques.
    b) Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events at the clinical site, and how to report patient safety events, including near misses, at the clinical site.

Quality Improvement

1. Residents must receive training and experience and participate in quality improvement processes, including an understanding of health care disparities. [Requirement VI.C.1.]
2. Residents must have the opportunity to participate in interprofessional quality improvement activities. [Requirement VI.C.2.]

Definition of Terms:

Interprofessional team – The physicians and other health care professionals, including case workers, dietitians, nurses, pharmacists, physical therapists, etc., as appropriate, assigned to the delivery of care for an individual patient.

Near miss – An event or situation that did not produce patient injury, but only because of chance.

Patient safety event – An adverse event, near miss, or other event resulting from unsafe conditions in the clinical care setting.

Explanation:

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.

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

Most resident-led quality improvement (QI) projects, while expedient for meeting minimum educational standards, are limited in scope and can only expose the learners to some of the most basic elements of QI. Interprofessional, team-based QI efforts provide residents with experiential learning that goes beyond basic QI methods to include developing skills and behaviors in shared leadership, communications, systems-based thinking, change management, and professionalism.

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.

To optimize residents' exposure to QI, at least some portion of their QI experience should address the populations for which they provide direct patient care. This requires timely, easy access to performance data at the level of their own patients so there is personal connection to the care processes and outcomes they are targeting for improvement. Residents also need access to support for data analysis.

A. Recommendations for Educational Strategies in Patient Safety and Quality Improvement

Culture

- Non-punitive approaches
- Identification of systems-based underlying causes
- Solutions aimed at correcting the underlying causes rather than pointing fingers at individuals

Didactics

- Providing an overview of the risks and hazards of health care
- Common patient safety events in particular environments, for example, medication errors in high-risk areas such as the Emergency Department or ICUs, or in the operating room
- Prevention strategies
- How to report near misses/close calls and adverse events, including how to inform patients and families about an adverse event
- Where to find help when a patient safety event occurs

Experiential Learning

- Morbidity and mortality conferences
- Simulation activities

- Documentation for Patient Safety and Quality Improvement Activities: The ACGME-I Resident/Fellow and Faculty Surveys include questions on interprofessional teamwork and participation in quality improvement and patient safety activities. At the time of the accreditation site visit, responses are verified through on-site interviews.

VI. The Learning and Working Environment

D. Supervision and Accountability

Foundational Requirement

Supervision of Residents

1. The program must ensure that qualified faculty members provide appropriate supervision of residents in patient care activities. [Requirement VI.D.1.]
2. All residents must have supervision commensurate to their level of education. Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty members. [Requirement VI.D.2.]
3. To promote oversight of resident supervision while providing residents with graded authority and responsibility, the program must have a supervision policy that includes the following classifications of supervision: [Requirement VI.D.3.]
   a) Direct Supervision: The supervising physician is physically present with the resident and patient.
   b) Indirect Supervision with Direct Supervision Immediately Available: The supervising physicianis physically within the site of patient care and available to provide direct supervision.
   c) Indirect Supervision with Direct Supervision Available: The supervising physician is available by phone or other means, and able to provide supervision, but is not physically present within the site of care.
   d) Oversight: The supervising physician is available to provide review and feedback of procedures or patient care encounters after care is delivered.

Explanation:

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

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

- Documentation for Supervision: For initial applications, the resident supervision policy is uploaded into ADS. This policy should address resident responsibility for patient care, progressive responsibility for patient management, and faculty member responsibility for supervision. For all programs, ADS asks for a description of how the members of the faculty provide appropriate supervision of residents during patient care. The Accreditation Field Representative will seek verification through review of supervision policies, and ACGME-I Resident/Fellow Survey responses to questions in the area of Faculty, and ACGME-I Faculty Survey responses to questions on resident supervision. Interviews during the accreditation site visit will be used for additional verification.

  ACGME-I Resident/Fellow Survey responses to questions in the area of Faculty and ACGME-I Faculty Survey responses to questions on resident supervision are reviewed annually for all programs with a status other than Initial Accreditation.

VI. The Learning and Working Environment

E. Professionalism

Foundational Requirement

1. The program, in partnership with its Sponsoring Institution, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. [Requirement VI.E.1.]
2. Residents and faculty members must demonstrate an understanding of their personal role in the:[Requirement VI.E.2.]
   a) provision of patient- and family-centered care; and,
   b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events.
3. The program must provide a culture of professionalism that supports patient safety and personal responsibility. [Requirement VI.E.3.]
4. The program must provide a professional, civil, and respectful environment that is free from mistreatment, abuse, or coercion of students, residents, and faculty members. [Requirement VI.E.4.]
5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest, including 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. [Requirement VI.E.5.]
6. The program, in partnership with its Sponsoring Institution, should have a process for education of residents and faculty members regarding unprofessional behavior, as well as a confidential process for reporting, investigating, and addressing such concerns. [Requirement VI.E.6.]

Definition of Terms:
Adverse event – An injury that was caused by medical management, rather than the underlying disease, and that prolonged hospitalization, produced a disability at the time of discharge, or both.

Fitness for work – The condition of being mentally and physically able to effectively perform required clinical responsibilities and promote patient safety.

Explanation:
Educating residents in their professional responsibilities includes an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic education.
Patient care responsibilities provide residents with experiential learning opportunities that cannot be replicated in other settings.

Professionalism includes an understanding of one's personal role in the management of patient care as it relates to the safety and welfare of patients entrusted to the physician's care. This encompasses the ability to report unsafe conditions and adverse events. Physicians must also take responsibility to ensure that they are fit for work.

Professionalism requirements emphasize 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 a resident's or faculty member's fitness for work, depending on the situation, and in accordance with institutional policies. This includes:

- Management of time before, during, and after clinical assignments
- Recognition of impairment (illness, fatigue, substance use) in themselves, their peers, and other members of the health care team
- Commitment to lifelong learning
- Monitoring patient care performance
- Accurate reporting of clinical and educational work hours (formerly referred to as duty hours), patient outcomes, and clinical experience data

The requirement of responsiveness to patient needs that supersedes self-interest may be misinterpreted as referring to continuing to provide patient care in the face of illness and fatigue, with the sense that one "just has to keep going." This is not, however, in the best interest of the patient. Fatigue and illness can contribute to medical and procedural errors. Therefore, residents should be aware that when they are ill or fatigued, it would be best to transition patient care responsibilities to another qualified and rested provider.

- Documentation of Professionalism: For initial program applications, ADS will ask for an example of a learning activity designed to advance residents' knowledge of ethical principles foundational to the medical professions. Firing a site visit, the Accreditation Field Representative will verify this information during on-site interviews.

  ACGME-I Resident/Fellow and Faculty surveys contain questions on service obligations, the ability to raise concerns without fear, and satisfaction with the process to deal with problems and concerns. Responses to these questions are reviewed annually for all programs with a status other than Initial Accreditation.

VI. The Learning and Working Environment

F. Well-Being

Foundational Requirements

1. The program, in partnership with its Sponsoring Institution, must demonstrate a responsibility to address well-being of residents and faculty members, which includes policies and programs that encourage optimal well-being, access to health and personal care, and recognition of burnout, depression, and substance abuse. [Requirement VI.F.1.]
2. The responsibility of the program, in partnership with its Sponsoring Institution, to address well-being must include: [Requirement VI.F. 2.]
   a) attention to scheduling, work intensity, and work compression minimizing non-physician obligations and providing administrative support to impact resident well-being;
   b) evaluating workplace safety;
   c) providing the opportunity to attend medical, mental health, and dental care appointments; and,
   d) attention to resident and faculty member burnout, depression, and substance abuse.
3. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. [Requirement VI.F.3.]
   a) The program, in partnership with its Sponsoring Institution, must encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
4. When residents are unable to attend work due to circumstances such as fatigue, illness, family emergencies, or parental responsibilities, the program must allow an appropriate length of absence from patient care responsibilities. [Requirement VI.F.4.]
   a) Residents must be permitted to take leave from patient care responsibilities without fear of negative consequences. [Requirement VI.F.4.]

Definition of Terms:
Work Compression – An increase in the amount of work to be completed without a corresponding increase in the amount of time provided to complete that work.

Explanation:
Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician, and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of the residency experience.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for each other's well-being. For example, a culture that encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behavior and prepares residents with the skills and attitudes needed to thrive throughout their careers.

A. Partnership between the Sponsoring Institution and the Program
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 requirements emphasize 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:
- monitoring workplace injuries
- physical or emotional violence
- vehicle collisions
- emotional well-being after adverse events

Residents must have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents should be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

B. Education to Identify the Symptoms of Burnout, Depression, and Substance Abuse Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and concern that seeking help may have a negative impact on theircareer. 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, can 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.

- Documentation for Well-Being: ADS includes questions regarding opportunities for residents to attend medical, mental health, and dental care appointments, and if the program educates faculty members and residents on symptoms of burnout, depression, and substance abuse. This information is reviewed annually for all programs with a status other than Initial Accreditation.

  A validated well-being survey is given to residents and faculty members at the time of the ACGME-I Resident/Fellow and Faculty Surveys annually. The data from these surveys is aggregated and only available to the programs and their Sponsoring Institutions. The Review Committee-International does not have access to these results and they are not used in making accreditation decisions.

VI. The Learning and Working Environment

G. Fatigue
H. Transitions of Care

Foundational Requirements

Fatigue

1. Faculty members and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning. [Requirement VI.G.1.]
2. The program, in partnership with its Sponsoring Institution, must ensure adequate sleeping facilities and safe transportation options for residents who may be too fatigued to safely return home. [Requirement VI.G.2.]

Transitions of Care

1. The program must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. [Requirement VI.H.1.]
2. The program, in partnership with its Sponsoring Institution, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. [Requirement VI.H.2.]
3. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. [Requirement VI.H.3.]

Definition of Terms:

Hand-off – Also called a 'hand-over,' this is an activity for the transfer of patient information and knowledge along with authority and responsibility for care from one clinician or team of clinicians to another clinician or team of clinicians during transitions of care across the continuum. The process is achieved through effective communication that ensures continuity and safety of patient care.

Transitions of care – The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.

Explanation:

A. Fatigue

Experiencing fatigue in a supervised environment during residency prepares residents for managing fatigue in practice. It is expected that programs will adopt fatigue mitigation processes, educate residents on these processes, and ensure there are no negative consequences and/or stigma for using fatigue mitigation strategies.

Although these requirements emphasize the importance of adequate rest before and after clinical responsibilities**,** fatigue mitigation strategies must be taught. This may be done by the program or by the Sponsoring Institution for all its programs. The most effective curriculum will include both didactic and experiential components, such as a combination of readings, presentations, case-based discussions, and role plays.

Specific topics may include:

- strategic napping
- judicious use of caffeine
- availability of other caregivers
- time management to maximize sleep while 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
- ensuring sufficient sleep recovery periods

- Documentation for Fatigue Requirements: ADS asks for a listing of the ways that the program educates residents to recognize the signs of fatigue and sleep deprivation, and what the institution provides to residents who may be too fatigued to safely return home. In addition, the ACGME-I Resident/Fellow Survey asks if residents are educated on signs of fatigue. During the site visit, on-site interviews will verify survey responses and focus on knowledge of policies and procedures, monitoring practices for signs of fatigue and sleep deprivation, and evidence that schedules are adjusted appropriately when necessary.

  Resident/Fellow Survey results are reviewed annually for all programs with a status other than Initial Accreditation.

B. Transitions of Care

Inadequate transitions of care can result in patient harm, from minor to severe. The Joint Commission for Hospital Accreditation lists the following critical elements of a patient hand-off:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness of admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs

VI. The Learning and Working Environment

I. Clinical Experience and Education
J. On-Call Activities

Foundational Requirements

Clinical Experience and Education

1. Residents must accurately report their clinical and educational work hours, patient outcomes, Case Logs, and other clinical experience data. [Requirement VI.I.1.]
2. Clinical and education work hours must be limited to 80 hours per week, averaged over a four- week period, inclusive of all in-house clinical and educational activities and clinical work done at home. [Requirement VI.I.2.]
3. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of in-house call. [Requirement VI.I.3.]
4. Adequate time for rest and personal activities must be provided. This should consist of an eight-hour time period provided between all daily duty periods and 14-hour period after 24 hours of in-house call. [Requirement VI.I.4.]

On-Call Activities

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

Definition of Terms:

Clinical and educational work hours – (Previously referred to as ‘duty hours’) All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases.

In-house call – Clinical and educational work hours, beyond the scheduled workday, when residents are required to be immediately available within an assigned site, as needed, for clinical responsibilities. In-house call does not include night float, being oncall from home, or regularly scheduled overnight duties.

One day off – One continuous 24-hour period free from all administrative, clinical, and educational activities.

Explanation:
Clinical and education work hours include those hours spent on clinical care, in-house call, short call, home call, night float and day float, care transitions, and administrative activities related to patient care.

Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit to residents' work and educational hours is not exceeded. 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 demonstrate non-compliance with the requirement. These programs should adjust schedules so that residents work fewer than 80 hours per week, which would allow them to remain beyond their scheduled work period when needed without violating the 80-hour limit. Programs may wish to consider using night float and/or adjusting the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

A. Working from 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. 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.

   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 to ensure 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.

B. Monitoring Resident Work Hours

   Both the program and its Sponsoring Institution are required to monitor resident workhours. There is no requirement for how monitoring and tracking is accomplished.

Programs and institutions report using a variety of approaches to reduce resident hours, including scheduling changes, such as short call, night float, redesigning patient care and education systems, and using nurse practitioners, physician assistants, or hospitalists to assume some patient care responsibilities formerly done by residents.

The Sponsoring Institution must have written formal policies and procedures governing resident work hours that provide guidance for programs to meet the clinical work and education hour requirements.

- Documentation for Work Hour Requirements: For program initial applications, ADS contains several work hour-related questions, including requesting the projected average number of work hours per week per resident and the projected average number of days per week of in-house call, and a description of how the program will ensure that residents' schedules comply with ACGME-I work hour standards. Programs seeking Continued Accreditation will be asked to provide information on average work hours per week, days per week of in-house call, number of hours for the longest shift (excluding call from home), and if work hours are appropriate when residents rotate on other clinical services. Residents report their perceptions on compliance with the work hour requirements on the ACGME-I Resident/Fellow Survey. The aggregated results of the survey are available to program directors and DIOs through ADS, and programs can use this information to determine if compliance problems are suggested by the data.

  Programs and Sponsoring Institutions should regularly examine any data suggesting non-compliance with work hour requirements to determine underlying causes. During a site visit, the Accreditation Field Representative will interview residents in order to verify and clarify all questions where the responses suggested non-compliance related to work hours. ACGME-I does not specify any systems programs or institutions might use for monitoring compliance with work hour requirements.

  Resident/Fellow Survey results in the area of Duty Hours are reviewed annually for all programs with a status other than Initial Accreditation.

C. On-Call Activities

On-call activities are defined as a continuous work period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home. At-home call (pager call) may be overnight or may be for a longer period, such as a weekend.

Assignment of at-home call must be appropriate to the service intensity and frequency of being called, and it should not be used for high-intensity settings. At- home call also needs to be compliant with the requirement that one day out of seven be free from all program assignments and duties. Regular shifts, such as those worked in the Intensive Care Unit (ICU), on emergency medicine rotations, and during “night float,” used instead of in-house call to reduce the continuous work period are exempt from the requirement that call be scheduled no more frequently than every third night.

The activity that drives the 24-hour limit is continuous work hours. If a resident spends 12 hours in the hospital caring for patients, performing surgery, or attending conferences, followed by 12 hours on call, the resident has had 24 hours of continuous work time. The resident now has up to six additional hours during which activities are limited to participation in didactics, transferring care of patients, conducting continuity outpatient clinics (but not seeing new patients), and maintaining continuity of medical and surgical care as defined by the specialty’s Advanced Specialty Program Requirements.

The goal of the added hours at the end of the on-call period is to promote didactic learning and continuity of care of return patients, including ambulatory and surgical continuity.

- Documentation for On-Call Activities: ADS contains a work hour question that specifically address requirements related to on-call activities. Residents report their perceptions of how well they believe the program has met these requirements by responding to several questions on the ACGME-I Resident/Fellow Survey. Additional documentation includes work and call schedules and written policies and procedures for resident work hours, night float, and the working environment.

  During a site visit, the Accreditation Field Representative will review ACGME-I Resident/Fellow Survey results, spot-check documents, and verify information during faculty member and resident interviews, and will look for evidence that resident activities are monitored, and that there are systems to provide back-up support when patient care responsibilities are prolonged or unexpected circumstances create resident fatigue.

  Resident/Fellow Survey results in the area of Duty Hours are reviewed annually for all programs with a status other than Initial Accreditation.

Appendix 1. Table of Required Approvals

Requirement number	Requirement	Must be submitted to designated institutional official (DIO) prior to submission to ACGME-I	Must be approved by the Graduate Medical Education Committee (GMEC) prior to submission to ACGME-I
I.B.1.	There must be a Program Letter of Agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. The PLA must be approved by the DIO.	X	X
I.B.2.	The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents, through the ACGME's Accreditation Data System (ADS).		X
II.A.2 j)	The program director must prepare and submit all information required and requested by the ACGME-I, including program application forms and annual resident updates to ADS and ensure the information submitted is accurate and complete.	X	X
III.A.2 q)	The program director must obtain review and approval from the Sponsoring Institution's GMEC/DIO before submitting to the ACGME-I information or request for the following: • All initial applications for ACGME-I accreditation of new programs • Changes in resident complement • Major changes in program structure or length of the educational program • Progress reports requested by the Review Committee-International • Voluntary withdrawals of ACGME-I accredited programs • Requests for appeal of an adverse action; and • Appeal presentations to the Review Committee-International	X	X

Requirement number	Requirement	Must be submitted to designated institutional official (DIO) prior to submission to ACGME-I	Must be approved by the Graduate Medical Education Committee (GMEC) prior to submission to ACGME-I
II.A.2.r)	The program director must obtain DIO review and co-sign-off on all program application forms, as well as on any correspondence or document submitted to the ACGME-I that addresses: • Program citations • Requests for changes in the program that would have significant impact, including financial on the program or institution		X
III.D.1.	The program must report the presence of other learners to the DIO and GMEC in accordance with Sponsoring Institution guidelines.	X (NOT submitted to the ACGME-I)	X (NOT submitted to the ACGME-I)
V.D.3.b)	A summary of the Self-Study must be submitted to the DIO		X

Appendix 2. References

Leadership and Mentorship

Nasca, Thomas J. 2015. "Professionalism and Its Implications for Governance and Accountability of Graduate Medical Education in the United States." *JAMA* 313, no. 18 (December): 1801.

Sambunjak, Dario, and Ana Marušić. 2009. "Mentoring." *JAMA* 302, no. 23: 2591. Accessible at: https://doi.org/10.1001/jama.2009.1858.

Tjan, Anthony K. 2017. "What the Best Mentors Do." *Harvard Business Review*, December 5, 2017. Accessible at: https://hbr.org/2017/02/what-the-best-mentors-do).

Development of Resident Individualized Learning Plans

Li, Su-Ting T., and Ann E. Burke. 2010. "Individualized Learning Plans: Basics and Beyond." *Academic Pediatrics* 10, no. 5: 289–92. Accessible at: https://doi.org/10.1016/j.acap.2010.08.002.

Li, Su-Ting T., Debora A. Paterniti, John Patrick T. Co, and Daniel C. West. 2010. "Successful Self-Directed Lifelong Learning in Medicine: A Conceptual Model Derived From Qualitative Analysis of a National Survey of Pediatric Residents." *Academic Medicine* 85, no. 7: 1229–36. Accessible at: https://doi.org/10.1097/acm.0b013e3181e1931c.

Residents Failing to Progress

Dupras, Denise M., Randall S. Edson, Andrew J. Halvorsen, Robert H. Hopkins, and Furman S. McDonald. 2012. "'Problem Residents': Prevalence, Problems and Remediation in the Era of Core Competencies." *The American Journal of Medicine* 125, no. 4: 421–25. Accessible at: https://doi.org/10.1016/j.amjmed.2011.12.008.

Yao, David C. Scott M. Wright. 2000. "National Survey of Internal Medicine Residency Program Directors Regarding Problem Residents." *JAMA* 284, no. 9 (June): 1099. Accessible at: https://doi.org/10.1001/jama.284.9.1099.

Disclosing Medical Errors

Chan, David K., Thomas H. Gallagher, Richard Reznick, and Wendy Levinson. 2005. "How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients." *Surgery* 138, no. 5: 851–58. Accessible at: https://doi.org/10.1016/j.surg.2005.04.015.

Gallagher, Thomas H. 2003. "Patients and Physicians Attitudes Regarding the Disclosure of Medical Errors." *JAMA* 289, no. 8: 1001. Accessible at: https://doi.org/10.1001/jama.289.8.1001.

Gallagher, Thomas H., Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. 2006. "Choosing Your Words Carefully." *Archives of Internal Medicine* 166, no. 15: 1585. Accessible at: https://doi.org/10.1001/archinte.166.15.1585.

Leape, Lucian L. 2002. “Reporting of Adverse Events.” *New England Journal of Medicine* 347, no. 20: 1633–38. Accessible at: https://doi.org/10.1056/nejmnejmhpr011493.

White, Andrew A., Thomas H. Gallagher, Melissa J. Krauss, Jane Garbutt, Amy D. Waterman, W Claiborne Dunagan, Victoria J. Fraser, Wendy Levinson, and Eric B. Larson. 2008. “The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients.” *Academic Medicine* 83, no. 3: 250–56. Accessible at: https://doi.org/10.1097/acm.0b013e3181636e96.

Standardizing Patient Hand-Offs

Abraham, Joanna, Thomas G. Kannampallil, and Vimla L. Patel. 2008. “Bridging Gaps in Handoffs: A Continuity of Care Based Approach. *Journal of Surgical Education* 65, no. 6: 476–485.

Cohen, Michael D, Brian Hilligoss, and André Kajdacsy-Balla Amaral. 2011. “A Handoff Is Not a Telegram: an Understanding of the Patient Is Co-Constructed.” *Critical Care* 16, no. 1: 303. Accessible at: https://doi.org/10.1186/cc10536.

Solet, Darrell J., J. Michael Norvell, Gale H. Rutan, and Richard M. Frankel. 2005. “Lost in Translation: Challenges and Opportunities in Physician-to-Physician Communication During Patient Handoffs.” *Academic Medicine* 80, no. 12: 1094–99. Accessible at: https://doi.org/10.1097/00001888-200512000-00005.

