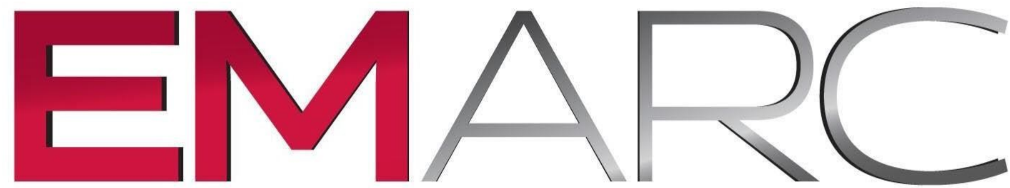


# Welcome to EMARC

This manual is designed to help new program coordinators acclimate to life managing an Emergency Medicine residency program. There is a timeline of general events to help you organize and prioritize your daily, weekly, and monthly projects. Feel free to use any of the tools contained in this document and edit so that they work and best meet your needs. This manual is a continual work in progress!

Please email your comments, questions, concerns, or any important information you feel should be included to our EMARC Leadership:

EMARC Chair: Erin Cruz erin.cruz@ecuhealth.org

EMARC Vice Chair: Jeannine Bottis jeannine.bottis@umassmed.edu

Thanks & Enjoy!

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CORD EM
COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

## Welcome to the Emergency Medicine Association of Residency Coordinators (EMARC)!

EMARC is an organization structured within the Council of Emergency Medicine Residency Directors (CORD), established to provide educational opportunities and professional development for residency coordinators.

We have a wonderful support group! Reach out any time you have questions.

**Sign up for the EMARC Community**

The EMARC Community is located on the CORD Community site. https://community.cordem.org/home.
If you don't know your login or aren't yet signed up; send an email to cord@cordem.org and CORD staff will get you set up. From the main page communities tab, click all communities, then you can choose to join the communities you are interested in (All Members, Clerkship Coordinators, EMARC). Once you have joined, these are now listed under my communities.

Be sure to edit your profile and set preferences for notifications (real time or a daily digest). You can post a message by clicking on the “Create” button, then Discussion Thread and follow the instructions asked (i.e. Post to Community, subject, and message).

**New Program Coordinator Resources**
In the EMARC Community, click on Library. Here you will find useful resources as well as this program coordinator manual.

**EMARC Social Media**
Join our Facebook page: Emergency Medicine Association of Residency Coordinators (EMARC)
Join our Instagram: @cord_emarc

CORD EM
COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

# EMARC Mission

The Emergency Medicine Association of Residency Coordinators (EMARC), a Community of Practice of the Council of Residency Directors in Emergency Medicine (CORD), is a national community for professionals who support emergency medicine education at every level.

We welcome residency, fellowship, and clerkship coordinators and administrators who are dedicated to shaping high-quality training experiences. EMARC focuses on advancing skills, sharing knowledge, and strengthening connections through collaborative education, mentorship, and resource sharing.

Together, we work to promote best practices, elevate the role of program and clerkship leadership, and support an inclusive, engaged network of professionals committed to the success of emergency medicine learners and programs.

**EMARC History**

In the mid-1990s, a private company presented an educational workshop for EM Residency Coordinators. Two years later, EM Residency Coordinators (Shari Augustine, Donna Morgan, Marie Wegeman, and Jackie Strange) that attended these workshops worked together to provide an educational format that was organized and operated by the EM Residency Coordinators. These annual workshops were held in conjunction with the SAEM Annual Meeting to obtain the best exposure for attendance.

In 2001, it became evident to the participating EM Residency Coordinators that our informal group needed to become more structured. We needed a formal organization that would be governed and operated by the EM Residency Coordinators.

A volunteer committee of 6 residency coordinators was charged with investigating options for our group's structure and affiliation. The results of their efforts were shared with the residency coordinators at the 2002 annual workshop. Emergency Medicine Association of Residency Coordinators (EMARC) was born. The residency coordinators that attended this forum approved the mission statement and goals of EMARC and voted on the organizational structure and affiliation with the Council of Residency Directors in Emergency Medicine (CORD). An Interim Executive Committee was formed to create EMARC's by-laws and to set terms for affiliation with CORD.

In 2003, the members of EMARC approved the By-laws and affiliation agreement with CORD and elected their first Executive Committee.

Founding Executive Committee members were:
**Chairman:** Anne Hoffmann- New York-Presbyterian
**Vice-Chairman:** Marie Wegeman- Louisiana State University
**Secretary:** Christine Rupkey- University of Michigan
**Treasurer:** Stephanie Morville – Johns Hopkins University

# EMARC Program Coordinator Mentor Program and Policy

The EMARC Mentor Program connects new and experienced Emergency Medicine (EM) coordinators to foster professional growth, networking, and peer-to-peer support. Matches are made based on program size, role type, and/or geographic region.

This program offers new coordinators a dedicated contact for guidance, resources, and encouragement. Instead of “reinventing the wheel,” participants can share proven strategies, avoid common pitfalls and build confidence in their role.

Mentorship connections extend beyond virtual meetings — they also create friendly faces at our annual conference. Mentor/mentee pairs are encouraged to connect in person for coffee, snacks, or a meal during the event.

To request a mentor, please email the Growth and Guidance Committee at erin.cruz@ecuhealth.org

**Mentor Eligibility Requirements**

To serve as a mentor, a Program Coordinator must:

Have at least one year of experience in the role.
Commit to a 12-month mentorship relationship upon being paired.
Dedicate 4–7 hours over the course of the year.
Demonstrate enthusiasm for Graduate Medical Education (GME) and the Program Coordinator role.
Consistently meet GME and ACGME deadlines.
Possess strong knowledge of available resources and best practices.

**Mentor Expectations and Time Commitment**

| **Expectations** | **Time investment/*timeline*** |
|---|---|
| Complete program intake form and review initial meeting topic list | 30 minutes<br><br>*Upon signing up to participate as a mentor* |
| Schedule and conduct initial virtual meeting (FaceTime, Skype, Zoom, etc.), using program intake forms and topic list as guides | 30-60 minutes<br><br>*Within 1 month of being paired with a mentee* |
| Introduce mentee in the EMARC Facebook group or EMARC Community (include background + 3 fun facts)<br><br>. | 10 minutes prep, 2 minute presentation<br><br>*Within 2 weeks of initial meeting* |
| Conduct monthly check-ins (phone call, email, or chat) and remain available for questions/advice | 5-20 minutes per month<br><br>*Monthly* |
| Meet in person at CORD Academic Assembly if attending (coffee, meal, or break) | 15 minutes – 1 hour or longer<br><br>1x a year |

**Total Annual Commitment**: Approximately 4-7 hours over 12 months

**First Meeting Suggested Agenda**
The following outline provides a framework for your initial conversation. Adapt as needed based on your match's needs and preferences.

**Recommended Items to Bring:**
- Mentor: CV/resume, notes on recent ACGME changes, photos (optional)
- Mentee: CV/resume, position description, photos (optional)

(Photos can be personal — trips, pets, hobbies — to help build rapport.)

**1. Introductions**
- Name, professional background, and current role
- Personal details you are comfortable sharing (hobbies, family, hometown, etc.)

**2. Role Overview**
- Describe your responsibilities (students, residents, fellows, other tasks)
- Discuss similarities and differences between roles

**3. Expectations**
- Why you joined the program and what you hope to gain
- Preferred methods and frequency of communication

**4. Mentee Questions**
- Current challenges, confusing acronyms, or specific scenarios needing guidance

**5. Mentor Insights**
- Lessons learned during your first year
- What you wish you had known at the start
- Helpful resources and tips

**6. Seasonal Check-In**
- Discuss current GME cycle activities (e.g., recruitment, WebADS, program review, graduation prep)
- Reference recent PC or GMEC meeting minutes if helpful

**7. Next Steps**
- Schedule your next meeting or follow-up check-in

## Acronyms & Important Websites

| | |
|---|---|
| AAEM | American Academy of Emergency Medicine – WWW.AAEM.ORG |
| AAMC | American Association of Medical Colleges – WWW.AAMC.ORG |
| ABEM | American Board of Emergency Medicine – WWW.ABEM.ORG |
| ACEP | American College of Emergency Physicians – WWW.ACEP.ORG |
| ACGME | American Council of Graduate Medical Education – WWW.ACGME.ORG |
| ACLS | Advanced Cardiac Life Support |
| AHME | Association for Hospital Medical Education - WWW.AHME.ORG |
| AMA | American Medical Association – WWW.AMA.ORG |
| APD | Associate/ Assistant Program Director |
| APP | Advanced Practice Provider |
| ATLS | Advances Trauma Life Support |
| AWLS | Advanced Wilderness Life Support |
| AY | Academic Year |
| BLS | Basic Life Support |
| CCC | Clinical Competency Committee |
| CLER | Clinical Learning Environment Review |
| CME | Continuing Medical Education |
| CORD | Council of Emergency Medicine Residency Directors – WWW.CORDEM.ORG |
| CPC | Clinical Pathologic Case |
| CV | Curriculum Vitae |
| ECFMG | Education Commission for Foreign Medical Graduates – WWW.ECFMG.ORG |
| EMARC | Emergency Medicine Association of Residency Coordinators |
| EMS | Emergency Medicine Services |
| EMRA | Emergency Medicine Residency Association – WWW.EMRA.ORG |
| EPA | Entrustable Professional Activity |
| FCVS | Federation Credentials Verification Service (Federation of State Medical Boards) WWW.FSMB.ORG |
| FILP | Focused Individualized Learning Plan |
| FMG | Foreign Medical Graduate |
| FREIDA | Fellowship and Residency Electronic Interactive Database Access System WWW.FREIDA.AMA.ASSN.ORG |
| GME | Graduate Medical Education |
| ILP | Individualized Learning Plan |
| IMG | International Medical Graduate |
| NBME | National Board of Medical Examiners – WWWNBME.ORG |
| NP | Nurse Practitioner |
| NRMP | National Resident Matching Program – WWW.NRMP.ORG |
| PA | Physician Assistant |
| PALS | Pediatric Advances Life Support |
| PDSA | Plan Do Study Act |

| | |
|---|---|
| PEC | Program Evaluation Committee |
| PGY | Post Graduate Year |
| PLA | Program Letter of Agreement |
| PMP | Prescription Monitoring Program |
| RAMS | Residents and Medical Students (through SAEM) |
| ResidencyCAS | Residency Centralized Application Service (recruitment season interview platform) – WWW.RESIDENCYCAS.COM |
| RRC | Residency Review Committee (ACGME) |
| SAEM | Society for Academic Emergency Medicine – WWW.SAEM.ORG |
| SDOT | Standardized Direct Observational Assessment Tool |
| SLOE | Standardized Letter of Evaluation |
| TAGME | Training Administrators of Graduate Medical Education – WWW.TAGME.ORG |
| USMLE | United States Medical Licensing Examination – WWW.USMLE.ORG |

*For a full list of acronyms, please refer to the coordinator resource page on our CORD website https://www.cordem.org/involved/communities-of-practice/emarc/emarc-resources/acronyms-list

# Timeline

Below is an example of an Emergency Medicine Residency Program Timeline. Some of the items may not pertain to your program. This is to give you an idea of the items that come up throughout the year. Feel free to copy the timeline and tailor it to fit the needs of your program and how you best work.

Weekly

- Credentialing of former residents (as emails come in)
- Payroll
- Conference attendance & schedule

Monthly

- Didactic Schedule emailed out
- Check compliance of resident work hours (duty hours)
- Check resident procedure logs
- ROSH Review or monthly exams
- Patient Care Follow-ups
- Review learner upcoming schedules (Electives, Teaching, Administrative, Off-Service rotators)
- Send out evaluations (faculty reviewing residents, residents reviewing faculty, residents reviewing rotation)
- Calculate average # of patients per ED shift per resident (if you track this)
- Journal Club articles
- End of month didactic feedback
- SDOT assignment reminders
- Moonlighting compliance- logging hours

<u>July</u>

- Update ABEM with new and current resident information
- Select EMRA rep(s)
- ACEP- prepare for residency recruitment fair in the Fall.
    - Check into reserving a table through EMRA/ACEP
    - Book group discount for residents and faculty attending
- ACGME Web ADS annual update comes out
- Compile and input information into AMA FREIDA, GME Track, ABEM annual survey, ACGME Web ADS, EMRA, department website, and SAEM

August

- Update program website and recruitment material
- ResidencyCAS opens mid-Sept.
- Schedule interview dates, start recruiting faculty to interview
- Set up PEC meeting for the year

September

- Fall Resident Retreat (chiefs organize)
- Annual residency photo
- Residency CAS/ERAS open
    - Create filters w/ PD
    - Set Timelines (when to send out invites, waitlist, rejections, etc.)
    - Review applicant evaluations forms and/or scorecards
- Register with NRMP- email will be sent to you
    - Get match history on all applicants that are not current medical students
    - Will receive an email re: quota (# of spots available, make sure yours is correct)
    - Note Important dates to be aware of
        - Deadline for Rank list
        - Match week
        - Match Day
- Recruitment Prep
    - If in-person interviews
        - Set up reservations for dinners
        - Plan lunch on interview days
        - Name tags for applicants
    - Check materials if handing anything out to applicants as well as emails
        - Invitations
        - Waitlist
        - Rejections
        - Interview day reminders
        - Faculty score sheets
- CCC meetings & prep (if you plan to review each class at different times, start scheduling those meetings)
    - Resident Peer evals get sent out prior to meetings
    - Self-evals and goals sent out prior to meetings
    - Schedule semi-annual meetings with PD for dates after the CCC meets
- PEC meeting

October

- ACEP
- Interview Season

November
- CCC meetings & prep
- Interview Season

December
- CCC meetings & prep
- Interview Season
  - Send out rejection emails
- ABEM emails out a registration link for programs to register for the in-service exam.
- Annual Program Evaluations (when is this due to your GME?)
- ACGME Milestones Due in WebADS

January
- Selection for next chiefs (send job descriptions out to PGY-2's)
- Finish interviews
- Create a Power Point for Match Meeting
- Final Rank meeting/ finalize NRMP match list w/ PD
- Submit Match List/ PD to Certify in NRMP
- SAEM Conference prepare for residency recruitment fair in the Spring.
  - Check into reserving a table through EMRA or SAEM Conference directly
- Prepare for CORD!

February
- Chief selection voting (nursing leadership, residents, faculty, PD, APD, coordinator)
- Solicit resident feedback for annual curriculum review (March)
- ACGME Surveys come out for both faculty & residents
- Annual Program evaluations
  - Faculty evaluate the program
  - Residents evaluation the program
- In-Service Exam (last week of February)
  - Residents are not allowed to work the night of the exam (need to leave the hospital by 10 pm) and the morning of the in-service exam.
  - Department coverage if needed (we have PA coverage for this day)
- Prepare for regional SAEM
- Prepare for Resident Appreciation Day

March

- CCC meetings & prep (AGAIN- need to happen twice each academic year)
- CORD
- Match Day!
  - Celebrate!
  - Begin the process of onboarding new residents
  - Send out photos w/ contact info and bio introducing matched applicants to the department
  - Update website
- Program Directors start working on block schedule for the next academic year
- APD starts working on the didactic schedule for the next academic year
- Curriculum Review meeting (annually)
- Update your program policy handbook/manual
- Start a checklist for incoming and outgoing residents
- Plan interview dates for the next academic year
- Revise recruitment material
- Order graduation gifts
- Spring voting for graduation awards

April

- CCC meeting & prep
- In-service results come back (PD's receive this)
- Graduation planning and finishing touches
- ABEM certificate cycle comes out for graduates (April 15th)
- Orientation schedule- start planning
- Budget review

May

- CCC meeting & prep
- SAEM- resident Table gather swag, tablecloth, whatever else if needed
- PEC meeting
- Start collating EM Important dates for the new academic year, sent to off-services, chiefs, PD, coordinators where your residents rotate
  - Retreat
  - Graduation
  - Class Conferences: SAEM, ACEP, Stowe
  - In-Service
  - Orientation booster

June

- ACGME Milestones Due in WebADS
- *check to see when State/Region ACEP summer gathering/meeting is. Try to have interns join as well
- Need copy of medical school diplomas
- Welcome Picnic for incoming interns
- Exit Paperwork for graduates
- Assist with training verification forms (current/past)
- Email moonlighting policy and approval forms to residents
- New intern bios, pictures go out to department
- Graduation checklist
  - Attendees
  - Invitations
  - venue/location
  - Decor
  - Catering
  - New interns invited?
  - Graduation programs
  - Graduation information for PD (spouse, children, where they are going)
  - Table tents for grads families to reserve tables
  - Awards table
  - Power-points

## Roles/Responsibilities of the Program Coordinator

Responsible for administration of the residency program as outlined in the ACGME requirement and institutional graduate medical education guidelines.

Accreditation

- Important to know when deadlines are
- Process ACGME paperwork
- Update WebADS with resident information
- Coordinate preparations for self-study
- Coordinate preparations for site visit

Alumni

- Provide assistance with any additional information they need
- Keep an accurate list of contacts/ where they are practicing if possible

Residency Budget

- Prepares and maintains the residency budget
- Processes payment for all residency GME expenses
- Prepare check requests, travel authorizations, reimbursements, and expenses
- Process annual payroll ISRs for residents

Communication

- Maintains communication with residents to ensure compliance with policies and procedures
- Distributes resident rotation schedules to faculty, residents, off-service departments
- Responds to inquiries regarding residency program
- Transcribes letters, reports and other written communication on behalf of PD
- Schedule meetings
- Handle confidential communication
- Distribute/assign information on candidates to faculty reviews/interviewers
- Distribute applicable information to all candidates
- Communicates with all applicants via interview platform/email throughout interview season

Conferences

- Assist the Associate PD with the monthly didactic schedule
- Keep attendance for both faculty & residents in software program
- Gather and track conference evaluations
- Journal club- prepare and distribute articles
- Send out conference evaluations to the presenters at the end of each month

Courses
- Arrange for certifications and in-service exams
  - PALS
  - BLS
  - ACLS
  - Proctor in-service exam

Credentialing
- Assist the resident with all required paperwork through this process
- Ensure graduates have met all resident requirements prior to the end of June
- Prepare and distribute all postgraduate emergency medicine verifications

Graduation
- Organize the ceremony
- Order/distribute/email Invitations
- Order awards and/or diploma accessories

Management
- Manages and coordinates the daily operations and logistics for the EM residency program
- Acts for and regularly makes decisions on behalf of PD, within prescribed limits of authority
- Assists in the implementation and running of the CCC & PEC meetings
- Manages all software used for maintaining accurate resident and program records

Meetings
- Schedule meetings for PD
- Prepare agendas
- Prepare and maintain meeting minutes
- Prepare and maintain APE reports

Mentoring
- Mentor and support ED residents

Moonlighting
- Manage and maintain resident moonlighting paperwork
- Reviews moonlighting hours for work hour compliance

Resident Management Services
- Responsible for managing whole program (Become a SUPERSTAR and proficient)
- Evaluations- by residents and faculty
- Schedules
- Procedure logs
- Duty hours
- Patient care follow-ups
- Didactic calendar
- Block schedule
- Archived information on graduates

Recruitment
- Verify statistics used for reporting to FRIEDA
- Manages extensive initial contacts via email, telephone, and/or written correspondence
- Manage software to produce residency applications (ResidencyCAS/ERAS) and rank lists (NRMP)
- Invite and schedule applicants
- Communicate with letters of regret to applicants not selected to interview
- Serve as an information source for the program
- Develop and maintain any and all materials used by faculty during interview of candidates
- Manage review of residency applications
- Coordinates applicant interview day
- Track and maintain evaluation scores of interviewed applicants and prepare data for initial match rank list
- Assist chief resident in management of
    - Plans and arrange interview socials
- Prepare and submit final ranking list to NRMP

Residency Coordinator Group
- Participate and play an active role in EMARC and your GME office
- Serve as a liaison with other departments and affiliated institutions
- Serve as liaison with departmental faculty on any resident issue
- Engage with GME at home institution to advocate for your residency program
- Join an EMARC committee of interest

Resident Evaluations
- Distribute, collect, and tabulate all evaluations regarding residents, rotations, and faculty- twice per year
- Prepare information for PD so they are ready to conduct evaluations of each residents
- Prepare and coordinate annual program evaluation

Resident folders
- Maintain personnel documentation (either paper or electronic) for all residents

Resident Orientation
- Coordinate the appointment process of all residents, consisting of initiation of appointment, reappointments, and terminations
- Assist new residents with settling in to ensure smooth transition
- Coordinate IT assignments such as pagers and computer access
- Attend GME orientation

Resident Rotations
- Coordinator rotations, including electives
- Prepare and distribute evaluations of each rotation

Resident Surveys
- Coordinate all annual surveys & graduate surveys

Vacation/ Sick Time
- Manage and maintain accurate resident sick time, vacation time, FMLA leave, etc.
- Make sure policies are being followed according to Institution, Program, ACGME, and ABEM.

Website
- Revise and maintain residency information for residency recruitment
- Provide update to GME office for any online changes
- Maintain accurate information on all websites (ACGME WebADS, FREIDA, SAEM, etc.)

## CCC (Clinical Competency Committee)

The CCC is a required body comprising three or more members of the program faculty. The program director may appoint additional members as deemed necessary. The additional members must be physician faculty members within your program, another institutional program, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. A written description of the responsibilities of the CCC must be on file.

The CCC must review all resident evaluations semi-annually. The CCC must determine each resident's progress on achievement of the specialty-specific Milestones.

The CCC must meet prior to the residents' semi-annual evaluations and advise the program directly regarding each resident's progress.

Examples of items to provide the CCC:

- Daily shift cards
- Procedural and Clinical Competency Evaluations
- Procedures logs
- Off-service evaluations
- Simulation/ OSCE/ Mock Oral Board evaluations
- Conference attendance
- In-training exam scores
- Reading group quizzes
- Duty hour logging noncompliance issues
- Professionalism issues
- Chart deficiencies
- PBLI log audits
- Lecture evaluations
- Nursing evaluations
- Patient evaluations
- Peer evaluations
- Self-evaluations

## PEC (Program Evaluation Committee)

The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

The PEC must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. PEC responsibilities must include review of the program's self-determined goals and progress toward meeting them. The responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. The responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. The PEC should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. They must evaluate the program's mission and aims, strengths, areas for improvement, and threats. The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO.

# (ACGME) the American College of Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) is an independent, 501(c)(3), not-for-profit organization that sets and monitors voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the US.

*The Mission of the ACGME is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education.*

What is ACGME Accreditation? (overview/ accreditation)

Common Program Requirements
EM Specific Program Requirements
EM Program FAQ's

EM min. Procedure Requirements

**WebADS**
The ACGME Data Collection Systems comprise the Accreditation Data System (ADS), which includes the Case Log System, and the Resident/Fellow and Faculty Surveys.

ADS is a web-based software system that contains critical accreditation data for all Sponsoring Institutions and programs. It is a tool to collect and organize information for accreditation purposes and serves as a means of communication between the ACGME and Sponsoring Institutions and programs. It is also used internally by the Department of Field Activities and the staff of the Review Committees in conducting accreditation activities. ADS incorporates several applications and functions, including the Annual Update, Milestones, Case Logs, and the application for accreditation.

The Department of Field Activities uses ADS for site visit scheduling and housing site visit reports for submission to the Review Committees, and programs use ADS to evaluate site visitors. The Clinical Learning Environment Review (CLER) Program uses ADS to schedule CLER visits and manage additional details of the CLER process.

The Resident/Fellow and Faculty Surveys are managed in a separate system in order to protect and preserve anonymity and confidentiality. Conducted annually, the surveys poll program residents/fellows and faculty members to collect critical evaluations of components of their programs to assist in their review for the purposes

of accreditation. The Surveys are only accessible by those participating during specific windows during the academic year. These participation windows are communicated directly to institutions and programs via email. All accredited programs are required to meet a minimum level of participation compliance with the ACGME Surveys.

**ACGME Contacts & Support**


*Executive Director*
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*Associate Executive Director*
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Data Systems Technical Support
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312.755.7474

# (ABEM) American Board of Emergency Medicine

The American Board of Emergency Medicine (ABEM) certifies emergency physicians who meet its educational, professional standing, and examination standards. ABEM certification is sought and earned by emergency physicians on a voluntary basis. ABEM is accredited by the NCCA and is a member board of the American Board of Medical Specialties.

**Mission**
To ensure the highest standards in the especially of Emergency Medicine

**Purpose**

- To improve the quality of emergency medical care
- To establish and maintain high standards of excellence in Emergency Medicine and subspecialties
- To enhance Emergency Medicine education and related subspecialties
- To evaluate physicians and promote professional development through initial and continuous certification in Emergency Medicine and its subspecialties
- To certify physicians who have demonstrated special knowledge and skills in Emergency Medicine and its subspecialties
- To enhance the value of certification for ABEM diplomates
- To serve the public and medical profession by reporting the certification status of ABEM diplomates

*ABEM holds the interests of patients and their families in the highest standing, particularly with regard to the provision of the safest and highest-quality emergency care. ABEM addresses its commitment to patients by supporting the physicians who provide care to the acutely ill and injured, and by working to transform the specialty of Emergency Medicine.*

**In-Training Exam (ITE)**
ABEM develops and administers an In-Training Examination (ITE) annually to Emergency Medicine residency programs. Programs are not required to participate in this exam.

The primary purpose of the ABEM In-Training Examination is to provide an estimate of the likelihood that a resident will be able to pass the Qualifying Examination. The ITE targets the expected knowledge and experience of an EM3 resident. The exam is not designed for program evaluations, and the results should not be used to compare programs or residents across programs.

### Becoming Board Eligible

Your Program Director will inform ABEM when you meet the training criteria necessary to be board eligible for certification. Board eligibility begins after your graduation date once your Program Director verifies your completed training. It expires five years later, on December 31 of the final year.

Criteria to meet board eligibility status:

- Have graduated from an ACGME-, RCPSC-, or ACEM-accredited Emergency Medicine program or an ABEM-approved combined training program.
- Fulfill the ABEM Policy on Medical Licensure.

## ResidencyCAS

Recruitment Management software. We will be using ResidencyCAS for the first time as a whole specialty this recruitment cycle 2026-2027. All medical students will be applying here, applications will be reviewed, interviews, etc. will all be managed under this platform. https://residencycas.com/

# NRMP

www.nrmp.org

**The Main Residency Match**

**Purpose**
The purpose of the *Main Residency Match* is to provide a uniform time for both applicants and programs to make their training selections without pressure. Through the *Main Residency Match*, applicants may be "matched" to programs using the certified rank order lists (ROL) of the applicants and program directors, or they may obtain one of the available unfilled positions during the Match Week Supplemental Offer and Acceptance Program®. *The Main Residency Match* is managed through the NRMP's Registration, Ranking, and Results® (R3®) system.

**Programs that participate in the Main Residency Match**

- Categorical Position ("C"): Post graduate year one (PGY-1) position that provides the full training required for board certification in a specialty.
- Primary Position ("M"): PGY-1 position in Medicine or Pediatrics that provides a training emphasis on primary care.
- Preliminary Position ("P"): One-year position in a Transitional Year or specialty program.
- Advanced Position ("A"): Position in a specialty program that begins the year after the Match and after one or more years of required preliminary training
- Reserved Positions ("R"): PGY-2 positions in specialty programs that begin in the year of the Match and are reserved for physicians with prior graduate medical education. These positions are also known as "Physician Positions".

Some specialties may offer both categorical and advanced type positions. Examples are Dermatology, Anesthesiology, Neurology, Physical Medicine and Rehabilitation, and Diagnostic Radiology.

Primary components of the Match include registration, creating and certifying a rank order list, and accessing Match results and reports. Because each task is completed using the NRMP's secure and confidential Registration, Ranking, and Results® (R3®) system, the toolkit is built around the three "Rs" to ensure institutional officials and program directors have the information and materials needed to successfully complete each task.

**The NRMP Policy**
NRMP requires each program to act in good faith to provide complete, timely, and accurate information to interviewees, including:

- A copy of the contract the applicant will be expected to sign if matched to the program
- Our Program's recruitment policy
- The Institution's policy on visa status and eligibility for appointment
- The Institution's onboarding for employment
- The Institution's drug testing

The NRMP recommends programs obtain signed acknowledgement from each interviewee that confirms these policies regarding eligibility for appointment have been shared.

**Institution Activation, Match Registration, and Program Updates**
NRMP registration for the Main Residency Match traditionally opens on September 15. **Institutional officials MUST activate the institution and participating programs before program directors and coordinators can update any information.** When a Match opens, institution and program users can register their individual user account, sign the Match Participation Agreement, and review program details in the R3 system. Under the All In Policy, programs that elect to participate in the Match must register and attempt to fill all positions through the Main Residency Match or another national matching plan.

Please note that institutional officials, program directors, and program coordinators must use their own accounts to access the R3 system. Sharing login information and using someone else's account to access the R3 system is a breach of the Match Participation Agreement and could result in penalties.

**Interviews**
Interviews typically begin in October and continue through January. NRMP policy requires applicants and programs to provide complete, timely, and accurate information during the application, interview, and matching processes. **Institutional officials and program directors are responsible for ensuring all staff involved in the interview and matching processes understand and adhere to the terms of the Match Participation Agreement.**

Match Code of Conduct: Applicants
Match Code of Conduct: Programs
Match Code of Conduct: Medical Schools
Professional Behavior
Information Programs Must Share With Interviewees

**Ranking**
Quota Changes, SOAP Participation, and Program Withdrawal

On February 1st, programs can begin entering their rank order lists and setting their Match Week Supplemental Offer and Acceptance Program® (SOAP®) participation status in the R3 system. Program quotas (the number of positions offered in the Match), SOAP participation status, and program withdrawals must be finalized by 11:59 p.m. ET on January 31. All changes must be approved by the institutional official by that time. Please note that programs cannot certify their rank order lists until changes have been approved.

Programs that choose not to participate in SOAP will not be able to fill any positions until after SOAP concludes on the Thursday of Match Week.

Quotas will be changed after the January 31st deadline *only in cases of extreme emergency*, such as loss of funding or loss of accreditation, or if the ACGME approved an increase in resident complement. Requests for those exceptions must be made in writing by the institutional official and sent to the attention of the NRMP President and CEO by email at support@nrmp.org.

**Rank Order Lists**
Ranking traditionally opens in the R3 system on February 1st and closes on March 1st, the Rank Order List Deadline. By 9:00 p.m. ET on March 1st, a program's certified rank order list MUST be in the R3 system for it to be used when the matching algorithm is processed.

March 1st is also the deadline for creating reversions and for institutional officials to approve them. A program director cannot certify the rank order list if the program has change approvals pending; accordingly, institutional officials are encouraged not to wait until the last minute to complete these steps.

**Match Week Preparation**
Between the Rank Order List Deadline and Match Week, the NRMP takes a number of steps to ensure the accuracy of Match results. Ahead of Match Week, program directors should update the program contact information in the R3 system and review the Match Week schedule and Supplemental Offer and Acceptance Program® (SOAP®) resources in case their programs do not fill. Institutional officials should update their institution's billing contact information to ensure the institution receives the Match invoice and does not incur late fees.

**Match Week**
**Dates listed below can change yearly so be sure to check Match Calendars for current dates*

For 2026, Match Week begins on Monday, March 16th, when programs learn if they filled. For unfilled programs, SOAP also begins if they are participating. Programs receive their

Confidential Roster of Matched Applicants on Thursday, March 19th, and other Match reports are posted in the R3 system on Match Day, Friday, March 20th.

**Waiver Requests**
If for any reason an applicant or program cannot or will not honor a binding match commitment, a waiver must be obtained from the NRMP. Applicants and program directors are not authorized to release each other from a binding commitment. Neither can programs discuss, interview for, or offer a position to an applicant until the NRMP has granted a waiver.

**Published Data**
Data and survey reports released by the NRMP for the current Match season can be found under links specific to the Match. Reports from prior Match years can be found in archives.

While a Match is “open” in the NRMP’s Registration, Ranking, and Results® (R3®) system, participants registered for that Match can view and download reports including:

- Match Results by Ranked Applicants and Characteristics of Matched Applicants for program staff and designated institutional officials
- Match Results for Seniors and Characteristics of Matched Seniors for medical school officials
- Rank order lists for applicants

The NRMP recommends reports be downloaded and/or printed on Match Day or soon thereafter because **requests for Match reports submitted after a Match closes in the R3 system will incur a $200 fee per report**. Requests for reports should be submitted to datarequest@nrmp.org and will be processed after payment has been received.

**Print Copies of Results and Data Reports**
Print copies of current year Results and Data: Main Residency Match and Results and Data: Specialties Matching Service are available for $50 each plus shipping. To order, please send an email to datarequest@nrmp.org.

# ACGME Common Program Requirements (Residency)

**Revision Information**

ACGME-approved interim revision September 3, 2025; effective September 3, 2025

**Definitions**

For more information, see the ACGME Glossary of Terms.

Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

**Osteopathic Recognition**

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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**ACGME Common Program Requirements (Residency)**

**Common Program Requirements (Residency) are in BOLD**

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

**Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."**

## Introduction

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

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

***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, accessible, affordable, high-quality care for all, to improve the health of the populations they serve.***

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

**Definition of Specialty**
***[The Review Committee must further specify]***


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# Section 1: Oversight

**Sponsoring Institution**
***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.***

***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***

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

**1.1.** **The program must be sponsored by one ACGME-accredited Sponsoring Institution.** (Core)

**Participating Sites**
***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***

**1.2.** **The program, with approval of its Sponsoring Institution, must designate a primary clinical site.** (Core)

**[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]**

**1.3.** **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.** (Core)

**1.3.a.** **The PLA must be renewed at least every 10 years.** (Core)

**1.3.b.** **The PLA must be approved by the designated institutional official (DIO).** (Core)

**1.4.** **The program must monitor the clinical learning and working environment at all participating sites.** (Core)


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**1.5.** **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** **(Core)**

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

**Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:**

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

**1.6.** **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).** **(Core)**

**[The Review Committee may further specify]**

**1.7.** **Resources**
**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.** **(Core)**

**[The Review Committee must further specify]**

**1.8.** **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**

**1.8.a.** **access to food while on duty;** **(Core)**

**1.8.b.** **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care;** **(Core)**


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

**1.8.c.** **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**

**Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in 6.13.c.1.**

**1.8.d.** **security and safety measures appropriate to the participating site; and, (Core)**

**1.8.e.** **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

**1.9.** **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

**1.10.** **Other Learners and Health Care Personnel**

**The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)**

**[The Review Committee may further specify]**

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


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## Section 2: Personnel

**2.1. Program Director**
**There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements.** (Core)

**2.2. The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment.** (Core)

**2.2.a. Final approval of the program director resides with the Review Committee.** (Core)

**[For specialties that require Review Committee approval of the program director, the Review Committee may further specify. This requirement will be deleted for those specialties that do not require Review Committee approval of the program director.]**

**Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.**

**2.3. The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

**[The Review Committee may further specify]**

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

**2.4. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration.** (Core)

**[The Review Committee must further specify minimum dedicated time for program administration, and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s).]**


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**Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.**

**The ultimate outcome of graduate medical education is excellence in resident education and patient care.**

**The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in 2.6. – 2.6.l. Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.**

**Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.**

**2.5. Qualifications of the Program Director**

**The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee.** (Core)

**Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.**


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

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

**2.5.a.** **The program director must possess current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee.** (Core)

**[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]**

**2.5.b.** **The program director must demonstrate ongoing clinical activity.** (Core)

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

**[The Review Committee may further specify additional program director qualifications]**

**2.6.** **Program Director Responsibilities**
**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.** (Core)

**2.6.a.** **The program director must be a role model of professionalism.** (Core)

**Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.**

**2.6.b.** **The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program.** **(Core)**

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

**2.6.c.** **The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains.** **(Core)**

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

**2.6.d.** **The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval.** **(Core)**

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

**2.6.e.** **The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program.** **(Core)**

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


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

**2.6.f.** **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.** (Core)

**Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.**

**2.6.g.** **The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation.** (Core)

**2.6.h.** **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident.** (Core)

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

**2.6.i.** **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination.** (Core)

**2.6.j.** **The program director must document verification of education for all residents within 30 days of completion of or departure from the program.** (Core)

**2.6.k.** **The program director must provide verification of an individual resident's education upon the resident's request, within 30 days.** (Core)

**Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.**

**2.6.l.** **The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s).** (Core)

**[This requirement may be omitted at the discretion of the Review Committee]**


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**Faculty**

***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***

***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***

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

**2.7. There must be a sufficient number of faculty members with competence to instruct and supervise all residents.** (Core)

**[The Review Committee may further specify]**

**2.8. Faculty Responsibilities**
**Faculty members must be role models of professionalism.** (Core)

**2.8.a. Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care.** (Core)

| Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve. |
|---|

**2.8.b. Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities.** (Core)

**2.8.c. Faculty members must administer and maintain an educational environment conducive to educating residents.** (Core)


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**2.8.d.** **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** (Core)

**2.8.e.** **Faculty members must pursue faculty development designed to enhance their skills at least annually:** (Core)

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

**2.8.e.1.** **as educators and evaluators;** (Detail)

**2.8.e.2.** **in quality improvement, eliminating health care disparities, and patient safety;** (Detail)

**2.8.e.3.** **in fostering their own and their residents' well-being; and,** (Detail)

**2.8.e.4.** **in patient care based on their practice-based learning and improvement efforts.** (Detail)

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

**[The Review Committee may further specify additional faculty responsibilities]**

**2.9.** **Faculty Qualifications**
**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

**[The Review Committee may further specify]**

**2.10.** **Physician Faculty Members**
**Physician faculty members must have current certification in the specialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee.** (Core)

**[The Review Committee may further specify additional qualifications and/or requirements regarding non-physician faculty members]**


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**2.11. Core Faculty**

**Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents.** (Core)

> **Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of 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. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.**

**2.11.a. Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

**[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]**

**[The Review Committee may further specify either:**

1. **requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program, or**
2. **requirements regarding the role and responsibilities of core faculty members, including both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.]**

> **Background and Intent: If the Review Committee adds requirements as described in number (1) above, the Review Committee may choose to include background and intent as follows:**
>
> **Background and Intent: Provision of support for the time required for the core faculty members' responsibilities related to resident education and/or administration of the program, as well as flexibility regarding how this support is provided, are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to,**

**salary support, supplemental compensation, educational value units, or relief of time from other professional duties.**

**It is important to remember that the dedicated time and support requirement is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the core faculty members, is also addressed in Institutional Requirement 2.2.b. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/ subspecialty-specific Program Requirements.**

**If the Review Committee adds requirements as described in number (2) above, the following Background and Intent must be included:**

**Background and Intent: The core faculty time requirements address the role and responsibilities of core faculty members, including both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.**

**[The Review Committee may specify requirements specific to associate program director(s)]**

**2.12. Program Coordinator**
**There must be a program coordinator. (Core)**

**2.12.a. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**

**[The Review Committee must further specify minimum dedicated time for the program coordinator]**

**Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.**

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

**The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in**


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**leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.**

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

**The minimum required dedicated time and support specified in 2.12.b. includes activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement 2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.**

**2.13. Other Program Personnel**

**The program, in partnership with its Sponsoring Institution , must jointly ensure the availability of necessary personnel for the effective administration of the program.** (Core)

**[The Review Committee may further specify]**

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


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## Section 3: Resident Appointments

**3.1. Residents must not be required to sign a non-competition guarantee or restrictive covenant.** **(Core)**

**3.2. Eligibility Requirements**
**An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:** **(Core)**

**3.2.a. graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,** **(Core)**

**3.2.b. graduation from a medical school outside of the United States, and meeting one of the following additional qualifications:** **(Core)**

- **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,** **(Core)**
- **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.** **(Core)**

**3.3. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.** **(Core)**

**3.3.a. Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.** **(Core)**

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

**[The Review Committee may further specify prerequisite postgraduate clinical education]**


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**3.3.b. Resident Eligibility Exception**
**The Review Committee for ______ will allow the following exception to the resident eligibility requirements:** **(Core)**

**[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]**

**3.3.b.1. An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2. – 3.3., but who does meet all of the following additional qualifications and conditions:** **(Core)**

**3.3.b.1.a. evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and,** **(Core)**

**3.3.b.1.b. review and approval of the applicant's exceptional qualifications by the GMEC; and,** **(Core)**

**3.3.b.1.c. verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.** **(Core)**

**3.3.b.2. Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.** **(Core)**

**3.4. Resident Complement**
**The program director must not appoint more residents than approved by the Review Committee.** **(Core)**

**[The Review Committee may further specify minimum complement numbers]**

| **Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.** |
|---|

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


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**[The Review Committee may further specify]**

## Section 4: Educational Program

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

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

***It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***

**4.1. Length of Program**
**[The Review Committee must further specify]**

**4.2. Educational Components**
**The curriculum must contain the following educational components:**

**4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members;** (Core)

**4.2.b. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members;** (Core)

> **Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.**

**4.2.c. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;** (Core)

> **Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education.**


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**An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.**

**4.2.d.** **a broad range of structured didactic activities; and,** (Core)

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

**4.2.e.** **formal educational activities that promote patient safety-related goals, tools, and techniques.** (Core)

**ACGME Competencies**

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

**The program must integrate all ACGME Competencies into the curriculum.**

**4.3.** **ACGME Competencies – Professionalism**
**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.** (Core)

**Residents must demonstrate competence in:**

**4.3.a.** **compassion, integrity, and respect for others;** (Core)

**4.3.b.** **responsiveness to patient needs that supersedes self-interest;** (Core)

**4.3.c.** **cultural awareness;** (Core)

**4.3.d.** **respect for patient privacy and autonomy;** (Core)

**4.3.e.** **accountability to patients, society, and the profession;** (Core)

**4.3.f.** **respect and responsiveness to heterogeneous patient populations, including but not limited to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;** (Core)

**4.3.g.** **ability to recognize and develop a plan for one's own personal and professional well-being; and,** (Core)

**4.3.h.** **appropriately disclosing and addressing conflict or duality of interest.** **(Core)**

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

**4.4.** **ACGME Competencies – Patient Care and Procedural Skills (Part A)**
**Residents must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.** **(Core)**

**[The Review Committee must further specify]**

**Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.**

**4.5.** **ACGME Competencies – Patient Care and Procedural Skills (Part B)**
**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.** **(Core)**

**[The Review Committee may further specify]**

**4.6.** **ACGME Competencies – Medical Knowledge**
**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.** **(Core)**

**[The Review Committee must further specify]**

**4.7.** **ACGME Competencies – Practice-Based Learning and Improvement**
**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.** **(Core)**

**4.7.a.** **Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise.** **(Core)**

**4.7.b.** **Residents must demonstrate competence in setting learning and improvement goals.** **(Core)**


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**4.7.c.** **Residents must demonstrate competence in identifying and performing appropriate learning activities.** (Core)

**4.7.d.** **Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement.** (Core)

**4.7.e.** **Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice.** (Core)

**4.7.f.** **Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.** (Core)

**[The Review Committee may further specify by adding to the list of sub-competencies]**

**4.8.** **ACGME Competencies – Interpersonal and Communication Skills**
**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.** (Core)

**4.8.a.** **Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient.** (Core)

**4.8.b.** **Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies.** (Core)

**4.8.c.** **Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group.** (Core)

**4.8.d.** **Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals.** (Core)

**4.8.e.** **Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals.** (Core)

**4.8.f.** **Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable.** (Core)

**4.8.g.** **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** (Core)


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**[The Review Committee may further specify by adding to the list of sub-competencies]**

**4.9. ACGME Competencies – Systems-Based Practice**

**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.** **(Core)**

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

**4.9.a. Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty.** **(Core)**

**4.9.b. Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty.** **(Core)**

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

**4.9.c. Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems.** **(Core)**

**4.9.d. Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions.** **(Core)**

**4.9.e. Residents must demonstrate competence in incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate.** **(Core)**

**4.9.f. Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions.** **(Core)**

**4.9.g. Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated).** **(Detail)**

**4.9.h. Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals.** **(Core)**


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**[The Review Committee may further specify by adding to the list of sub-competencies]**

**Curriculum Organization and Resident Experiences**

**4.10. Curriculum Structure**
**The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events.** (Core)

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

**[The Review Committee must further specify]**

**4.11. Didactic and Clinical Experiences**
**Residents must be provided with protected time to participate in core didactic activities.** (Core)

**[The Review Committee may specify required didactic and clinical experiences]**

**4.12. Pain Management**
**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder.** (Core)

**[The Review Committee may further specify]**

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

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


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**4.13. Program Responsibilities**

**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims.** **(Core)**

**4.13.a. The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.** **(Core)**

**[The Review Committee may further specify]**

**4.13.b. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.** **(Core)**

**4.14. Faculty Scholarly Activity**

**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:** **(Core)**

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

**4.14.a. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

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

**[Review Committee will choose to require either the first bullet or both bullets under 4.14.a.]**


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

**4.15. Resident Scholarly Activity**
**Residents must participate in scholarship.** (Core)

**[The Review Committee may further specify]**

## Section 5: Evaluation

**5.1. Resident Evaluation: Feedback and Evaluation**
**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.** (Core)

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

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

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

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

**End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when**


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**residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.**

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

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

**5.1.a.** **Evaluation must be documented at the completion of the assignment. (Core)**

**5.1.a.1.** **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**

**5.1.a.2.** **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**

**5.1.b.** **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)**

**5.1.b.1.** **The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**

**5.1.b.2.** **The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**

**5.1.c.** **The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)**

**5.1.d.** **The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)**

**5.1.e.** **The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)**

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

**Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.**

**5.1.f.** **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** (Core)

**5.1.g.** **The evaluations of a resident's performance must be accessible for review by the resident.** (Core)

**[The Review Committee may further specify under any requirement in 5.1.a. - g.]**

**5.2.** **Resident Evaluation: Final Evaluation**
**The program director must provide a final evaluation for each resident upon completion of the program.** (Core)

**5.2.a.** **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** (Core)

**5.2.b.** **The final 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.** (Core)

**5.2.c.** **The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.** (Core)

**5.2.d.** **The final evaluation must be shared with the resident upon completion of the program.** (Core)


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**5.3. Clinical Competency Committee**
**A Clinical Competency Committee must be appointed by the program director.** **(Core)**

**5.3.a. At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** **(Core)**

**5.3.b. Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** **(Core)**

> **Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.**
>
> **Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.**

**5.3.c. The Clinical Competency Committee must review all resident evaluations at least semi-annually.** **(Core)**

**5.3.d. The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones.** **(Core)**

**5.3.e. The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** **(Core)**

**5.4. Faculty Evaluation**
**The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually.** **(Core)**

> **Background and Intent: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty**


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**improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the varied operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.**

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

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

**5.4.c.** **Faculty members must receive feedback on their evaluations at least annually.** (Core)

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

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

**5.5.** **Program Evaluation and Improvement**

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

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


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**5.5.b.** **Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.** (Core)

**5.5.c.** **Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** (Core)

**5.5.d.** **Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

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

**5.5.e.** **The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program .** (Core)

**Background and Intent: Other data to be considered for assessment include:**

- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

**5.5.f.** **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.** (Core)

**5.5.g.** **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO.** **(Core)**

**5.5.h.** **The program must complete a Self-Study and submit it to the DIO.** **(Core)**

**Board Certification**

***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***

**[If certification in the specialty is not offered by the ABMS and/or the AOA, 5.6. – 5.6.e. will be omitted.]**

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

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

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

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

**5.6.d.** **For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

**Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five**


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**percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.**

**There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and 5.6.d. is designed to address this.**

**5.6.e.** **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

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

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

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

## Section 6: The Learning and Working Environment

**The Learning and Working Environment**
***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***
- ***Appreciation for the privilege of caring for patients***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

**Culture of Safety**
***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess***


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***the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***

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

**Patient Safety Events**

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

**6.2.** **Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events.** **(Core)**

**6.2.a.** **Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports.** **(Core)**

**6.3.** **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**

**Quality Metrics**

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

**6.4.** **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** **(Core)**

**Supervision and Accountability**

***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

***Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.***

**6.5.** **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be**

**available to residents, faculty members, other members of the health care team, and patients.** **(Core)**

> **Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.**

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

**[The Review Committee may specify which activities require different levels of supervision.]**

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

**Levels of Supervision**

***To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***

**6.7. Direct Supervision**

***The supervising physician is physically present with the resident during the key portions of the patient interaction.***

**[The Review Committee may further specify]**

***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***

**[The RC may choose to eliminate this piece of the definition]**

**6.7.a. PGY-1 residents must initially be supervised directly, only as described in the above definition.** **(Core)**

**[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]**


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**6.7.b. [The Review Committee may further specify]**

**Indirect Supervision**
***The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.***

**Oversight**
***The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.***

**6.8. The program must define when physical presence of a supervising physician is required. (Core)**

**6.9. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**

**6.9.a. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**

**6.9.b. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**

**6.9.c. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**

**6.10. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)**

**6.10.a. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)**

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

**6.11. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)**

**6.12. Professionalism**
**Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)**


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**Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.**

**6.12.a. The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations.** (Core)

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

**6.12.b. The learning objectives of the program must ensure manageable patient care responsibilities.** (Core)

**[The Review Committee may further specify]**

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

**6.12.c. The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.** (Core)


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**6.12.d.** **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** **(Core)**

> **Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.**

**6.12.e.** **Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.** **(Core)**

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

> **Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.**
>
> **The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.**

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

**Well-Being**

***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 residency training.***

***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***


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***health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.***

**6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:**

**6.13.a. attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)**

**6.13.b. evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)**

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

**6.13.c. policies and programs that encourage optimal resident and faculty member well-being; and, (Core)**

| **Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.** |
|---|

**6.13.c.1. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**

**6.13.d. education of residents and faculty members in:**

**6.13.d.1. identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**

**6.13.d.2. recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**

**6.13.d.3. access to appropriate tools for self-screening. (Core)**


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**Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).**

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

**6.13.e.** **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.** (Core)

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

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

**6.14.** **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** (Core)

**6.14.a.** **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.** (Core)

**6.14.b.** **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.** (Core)


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

**6.15. Fatigue Mitigation**

**Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.** **(Detail)**

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

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

**6.16. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** **(Core)**

**6.17. Clinical Responsibilities**

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

**[Optimal clinical workload may be further specified by each Review Committee]**

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

**6.18. Teamwork**


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**Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system.** **(Core)**

**[The Review Committee may further specify]**

**Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.**

**6.19. Transitions of Care**
**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** **(Core)**

**6.19.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.** **(Core)**

**6.19.b. Programs must ensure that residents are competent in communicating with team members in the hand-off process.** **(Outcome)**

**Clinical Experience and Education**
***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***

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

**6.20. Maximum Hours of Clinical and Educational Work per Week**
**Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, including all in-house clinical and educational activities, clinical work done from home, and all moonlighting.** **(Core)**

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

***Work from Home***


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

**Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.**

**6.21. Mandatory Time Free of Clinical Work and Education**
**Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)

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


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**6.21.a.** **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.** (Core)

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

**6.21.b.** **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.** (Core)

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

**6.22.** **Maximum Clinical Work and Education Period Length**
**Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

**6.22.a.** **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

**Background and Intent: The additional time referenced in 6.22.a. should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.**

**6.23.** **Clinical and Educational Work Hour Exceptions**
**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or**


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**unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events.** (Detail)

**6.23.a. These additional hours of care or education must be counted toward the 80-hour weekly limit.** (Detail)

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

**6.24. A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

**6.24.a. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** (Detail)

**Background and Intent: Exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.**

**6.25. Moonlighting**

**Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.** (Core)

**6.25.a. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)

**6.25.b. PGY-1 residents are not permitted to moonlight.** (Core)

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


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**6.26. In-House Night Float**
**Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** **(Core)**

**[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]**

**6.27. Maximum In-House On-Call Frequency**
**Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** **(Core)**

**6.28. At-Home Call**
**Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.** **(Core)**

**6.28.a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.** **(Core)**

**[The Review Committee may further specify under any requirement in 6.20. – 6.28.]**

| Background and Intent: As noted in 6.20., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.<br><br>In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time. |
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# ACGME Program Requirements for Graduate Medical Education in Emergency Medicine

**Revision Information**

ACGME-approved interim revision September 3, 2025; effective September 3, 2025

**Definitions**

For more information, see the ACGME Glossary of Terms.

Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

**Osteopathic Recognition**

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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**ACGME Program Requirements for Graduate Medical Education**

**in Emergency Medicine**

**Common Program Requirements (Residency) are in BOLD**

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

## Introduction

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

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

***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, accessible, affordable, high-quality care for all, to improve the health of the populations they serve.***

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

**Definition of Specialty**
*Residencies in emergency medicine prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, under the guidance and supervision of a qualified*


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*faculty member, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well-being.*

## Section 1: Oversight

**Sponsoring Institution**
***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.***

***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***

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

**1.1.** **The program must be sponsored by one ACGME-accredited Sponsoring Institution.** **(Core)**

**Participating Sites**
***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***

**1.2.** **The program, with approval of its Sponsoring Institution, must designate a primary clinical site.** **(Core)**

**1.3.** **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.** **(Core)**

**1.3.a.** **The PLA must be renewed at least every 10 years.** **(Core)**

**1.3.b.** **The PLA must be approved by the designated institutional official (DIO).** **(Core)**

**1.4.** **The program must monitor the clinical learning and working environment at all participating sites.** **(Core)**


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**1.5. At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** **(Core)**

> **Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.**
>
> **Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:**
>
> - **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
> - **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
> - **Specifying the duration and content of the educational experience**
> - **Stating the policies and procedures that will govern resident education during the assignment**

**1.6. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).** **(Core)**

1.6.a. The program should be based at the primary clinical site. (Core)

1.6.b. Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)

1.6.c. Each participating site must offer significant educational opportunities to the overall program. (Core)

1.6.d. Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)

1.6.e. The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)

> Specialty-Specific Background and Intent: The Review Committee for Emergency Medicine considers a participating site to be geographically distant if it requires extended travel


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(consistently more than half an hour each way) or if the distance between the site and the Sponsoring Institution exceeds 60 miles.

**1.7. Resources**

**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.** **(Core)**

1.7.a. The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)

1.7.b. At every site in which the emergency department provides resident education, the following must be provided: (Core)

1.7.b.1. adequate space for patient care; (Core)

1.7.b.2. space for clinical support services; (Core)

1.7.b.3. diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)

1.7.b.4. laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)

1.7.b.5. office space for core physician faculty members, and residents; (Core)

1.7.b.6. instructional space; (Core)

1.7.b.7. information systems; and, (Core)

1.7.b.8. appropriate security services and systems to ensure a safe working environment. (Core)

1.7.c. Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)

1.7.d. Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)

1.7.e. Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)

1.7.e.1. If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)


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1.7.e.2. Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)

1.7.f. The patient population must include patients broadly representative of society and with a wide variety of clinical problems. (Core)

1.7.g. The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)

1.7.g.1. The primary clinical site should have a significant number of critically-ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)

1.7.g.2. All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)

1.7.h. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)

**1.8. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**

**1.8.a. access to food while on duty; (Core)**

**1.8.b. safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**

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

| **Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for** |
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**lactation is also critical for the well-being of the resident and the resident's family, as outlined in 6.13.c.1.**

**1.8.d. security and safety measures appropriate to the participating site; and, (Core)**

**1.8.e. accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

**1.9. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

**1.10. Other Learners and Health Care Personnel**
**The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)**

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

## Section 2: Personnel

**2.1. Program Director**
**There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**

**2.2. The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)**

**2.2.a. Final approval of the program director resides with the Review Committee. (Core)**

**Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.**


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**2.3. The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

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

**2.4. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration.** (Core)

2.4.a. The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core)

| Number of Approved Resident Positions | Minimum Support Required (FTE) | Minimum Number of Assistant or Associate Program Directors |
|---|---|---|
| 18-20 | 0.6 | 1 |
| 21-25 | 0.7 | 1 |
| 26-30 | 0.8 | 1 |
| 31-35 | 0.85 | 1 |
| 36-40 | 1.0 | 2 |
| 41-45 | 1.10 | 2 |
| 46-50 | 1.20 | 2 |
| 51-53 | 1.20 | 2 |
| 54-55 | 1.30 | 3 |
| 56-60 | 1.40 | 3 |
| 61-65 | 1.50 | 3 |
| 66-70 | 1.55 | 3 |
| 71-75 | 1.55 | 3 |
| 76-80 | 1.55 | 3 |
| 81-85 | 1.55 | 3 |
| 86-90 | 1.55 | 3 |
| 91-95 | 1.55 | 3 |
| 96-100 | 1.55 | 3 |

2.4.b. From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)

**Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.**

**The ultimate outcome of graduate medical education is excellence in resident education and patient care.**

**The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in 2.6.a. – 2.6.l. Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.**

**Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.**

**2.5. Qualifications of the Program Director**

**The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**


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**Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.**

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

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

Specialty-Specific Background and Intent: To ensure programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents with an optimal learning experience, it is essential that program director candidates have previous experience as a core faculty member in an ACGME-accredited or AOA-approved emergency medicine program. It is desirable that the core faculty experience occurred in the program the program director will lead.

**2.5.a.** **The program director must possess current certification in the specialty for which they are the program director by the American Board of** Emergency Medicine (ABEM) **or by the American Osteopathic Board of** Emergency Medicine (AOBEM)**, or specialty qualifications that are acceptable to the Review Committee.**

2.5.a.1. The Review Committee for Emergency Medicine will only consider ABMS and AOA board certification as acceptable program director certification qualifications. (Core)

**2.5.b.** **The program director must demonstrate ongoing clinical activity. (Core)**

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

2.5.c. The program director must be a core physician faculty member. (Core)

2.5.d. The program director must have demonstrated experience in a leadership role. (Core)


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Specialty-Specific Background and Intent: Leadership experiences acceptable to the Review Committee when considering a new program director candidate include:

- experience as an assistant/associate program director or site director
- administrative program experience, such as serving on the program's Clinical Competency Committee (CCC), Program Evaluation Committee, or GMEC, or serving as a fellowship program director
- leadership role in the program, such as chair of the department, chair of the CCC, research director, etc.

2.5.e. The program director must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)

**2.6. Program Director Responsibilities**

**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)**

**2.6.a. The program director must be a role model of professionalism. (Core)**

**Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.**

**2.6.b. The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)**

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


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**2.6.c.** **The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains.** (Core)

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

**2.6.d.** **The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval.** (Core)

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

**2.6.e.** **The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program.** (Core)

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

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

**2.6.f.** **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.** (Core)

**Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.**

**2.6.g.** **The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment,**


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**and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation.** **(Core)**

**2.6.h. The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident.** **(Core)**

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

**2.6.i. The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination.** **(Core)**

**2.6.j. The program director must document verification of education for all residents within 30 days of completion of or departure from the program.** **(Core)**

**2.6.k. The program director must provide verification of an individual resident's education upon the resident's request, within 30 days.** **(Core)**

**Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.**

**2.6.l. The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s).** **(Core)**

**Faculty**

***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***

***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***

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

**2.7.** **There must be a sufficient number of faculty members with competence to instruct and supervise all residents.** **(Core)**

**2.8.** **Faculty Responsibilities**
**Faculty members must be role models of professionalism.** **(Core)**

**2.8.a.** **Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care.** **(Core)**

**Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.**

**2.8.b.** **Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities.** **(Core)**

**2.8.c.** **Faculty members must administer and maintain an educational environment conducive to educating residents.** **(Core)**

**2.8.d.** **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** **(Core)**

**2.8.e.** **Faculty members must pursue faculty development designed to enhance their skills at least annually:** **(Core)**

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


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**2.8.e.1.** **as educators and evaluators;** **(Detail)**

**2.8.e.2.** **in quality improvement, eliminating health care disparities, and patient safety;** **(Detail)**

**2.8.e.3.** **in fostering their own and their residents' well-being; and,** **(Detail)**

**2.8.e.4.** **in patient care based on their practice-based learning and improvement efforts.** **(Detail)**

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

2.8.f. Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine. (Core)

**2.9. Faculty Qualifications**
**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.** **(Core)**

2.9.a. Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be certified in pediatrics, emergency medicine, or pediatric emergency medicine by the ABEM, American Board of Pediatrics, AOBEM, or American Osteopathic Board of Pediatrics. (Core)

2.9.a.1. Faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the emergency department in all other settings. (Core)

Specialty-Specific Background and Intent: The requirements above allow the pediatric emergency medicine fellowship requirements concerning faculty certification and supervision to also apply to emergency medicine residents when rotating on pediatric emergency medicine rotations/services where pediatric emergency medicine fellows are also present. According to the Program Requirements for Pediatric Emergency Medicine, it is acceptable for a faculty member certified solely in pediatrics to supervise pediatric emergency medicine fellows. The requirements above permit this supervision for emergency medicine residents on these rotations/services as the only exception.

**2.10. Physician Faculty Members**
**Physician faculty members must have current certification in the specialty by the American Board of** Emergency Medicine **or the American Osteopathic Board of**

Emergency Medicine**, or possess qualifications judged acceptable to the Review Committee.** **(Core)**

2.10.a. In lieu of the qualifications in 2.10., physician faculty members must have certification by a subspecialty board sponsored or co-sponsored by either the ABEM or the AOBEM. (Core)

**2.11. Core Faculty**

**Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents.** **(Core)**

**Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of 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. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.**

**2.11.a. Core faculty members must complete the annual ACGME Faculty Survey.** **(Core)**

2.11.b. There must be a minimum of one core physician faculty member for every three residents in the program. (Core)

2.11.c. At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)

2.11.d. Assistant or associate program directors must be clinically active in emergency medicine. (Core)

2.11.e. Assistant or associate program directors must be core faculty members. (Core)

**2.12. Program Coordinator**

**There must be a program coordinator.** **(Core)**


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**2.12.a.** **The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration.** **(Core)**

2.12.b. At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)

| Number of Approved Resident Positions | Minimum Support Required (FTE) |
|---|---|
| 18-20 | 0.9 |
| 21-25 | 1.0 |
| 26-30 | 1.10 |
| 31-35 | 1.20 |
| 36-40 | 1.30 |
| 41-45 | 1.40 |
| 46-50 | 1.50 |
| 51-55 | 1.60 |
| 56-60 | 1.70 |
| 61-65 | 1.80 |
| 66-70 | 1.90 |
| 71-75 | 2.0 |
| 76-80 | 2.10 |
| 81-85 | 2.20 |
| 86-90 | 2.30 |
| 91-95 | 2.40 |
| 96-100 | 2.50 |

**Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.**

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

**The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and**


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**Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.**

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

**The minimum required dedicated time and support specified in 2.12.b. includes activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.**

**In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement 2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.**

**2.13. Other Program Personnel**

**The program, in partnership with its Sponsoring Institution , must jointly ensure the availability of necessary personnel for the effective administration of the program.** (Core)

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

## Section 3: Resident Appointments

**3.1.** **Residents must not be required to sign a non-competition guarantee or restrictive covenant.** **(Core)**

**3.2.** **Eligibility Requirements**
**An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:** **(Core)**

**3.2.a.** **graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,** **(Core)**

**3.2.b.** **graduation from a medical school outside of the United States, and meeting one of the following additional qualifications:** **(Core)**

- **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,** **(Core)**
- **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.** **(Core)**

**3.3.** **All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.** **(Core)**

**3.3.a.** **Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.** **(Core)**

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

**3.4.** **Resident Complement**


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

**Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.**

3.4.a. There should be a total of at least 18 residents in the program. (Core)

Specialty-Specific Background and Intent: A minimum of 18 residents is needed to foster a sense of both the program's and the department's identities. Additionally, 18 residents ensures a major impact in the emergency department to allow for meaningful attendance at emergency medicine conferences, provide progressive resident responsibility, and create an impact as resident teachers.

The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year.

The Review Committee also understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by Year 3 in a three-year program and by Year 4 in a four-year program.

**3.5. Resident Transfers**

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

3.5.a. For information concerning the transfer of residents between emergency medicine residencies with differing educational formats and advanced placement credit for education in other specialties, contact the ABEM and/or the AOBEM prior to the resident entering the program.

## Section 4: Educational Program

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

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

***It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-***


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***specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***

**4.1. Length of Program**

Residency programs in emergency medicine are configured in 36-month and 48-month formats, and must include a minimum of 36 months of clinical education. (Core)

4.1.a. Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met, and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration. (Core)

**4.2. Educational Components**

**The curriculum must contain the following educational components:**

**4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)**

**4.2.b. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)**

**Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.**

**4.2.c. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)**

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


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**4.2.d.** **a broad range of structured didactic activities; and,** (Core)

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

**4.2.e.** **formal educational activities that promote patient safety-related goals, tools, and techniques.** (Core)

**ACGME Competencies**

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

**The program must integrate all ACGME Competencies into the curriculum.**

**4.3.** **ACGME Competencies – Professionalism**

**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.** (Core)

**Residents must demonstrate competence in:**

**4.3.a.** **compassion, integrity, and respect for others;** (Core)

**4.3.b.** **responsiveness to patient needs that supersedes self-interest;** (Core)

**4.3.c.** **cultural awareness;** (Core)

**4.3.d.** **respect for patient privacy and autonomy;** (Core)

**4.3.e.** **accountability to patients, society, and the profession;** (Core)

**4.3.f.** **respect and responsiveness to heterogeneous patient populations, including but not limited to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;** (Core)

**4.3.g.** **ability to recognize and develop a plan for one's own personal and professional well-being; and,** (Core)

**4.3.h.** **appropriately disclosing and addressing conflict or duality of interest.** (Core)


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

**4.4. ACGME Competencies – Patient Care and Procedural Skills (Part A)**
**Residents must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.** (Core)

**Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.**

4.4.a. Residents must demonstrate competence in synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations. (Core)

4.4.b. Residents must demonstrate competence in generating an appropriate differential diagnosis. (Core)

4.4.c. Residents must demonstrate competence in applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management. (Core)

4.4.d. Residents must demonstrate competence in narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data. (Core)

4.4.e. Residents must demonstrate competence in implementing an effective patient management plan. (Core)

4.4.f. Residents must demonstrate competence in selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug-food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department. (Core)


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4.4.g. Residents must demonstrate competence in progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department. (Core)

4.4.h. Residents must demonstrate competence in providing health care services aimed at preventing health problems or maintaining health. (Core)

4.4.i. Residents must demonstrate competence in working with health care professionals to provide patient-focused care. (Core)

4.4.j. Residents must demonstrate competence in identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information. (Core)

4.4.k. Residents must demonstrate competence in establishing and implementing a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions. (Core)

4.4.l. Residents must demonstrate competence in re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)

**4.5. ACGME Competencies – Patient Care and Procedural Skills (Part B)**
**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**

4.5.a. Residents must demonstrate competence in performing diagnostic and therapeutic procedures and emergency stabilization. (Core)

4.5.b. Residents must demonstrate competence in managing critically ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention. (Core)

4.5.c. Residents must demonstrate competence in properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient. (Core)

4.5.d. Residents must demonstrate competence in mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients. (Core)

4.5.e. Residents must demonstrate competence in performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)


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4.5.f. Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

4.5.g. Residents must demonstrate competence in performing the following key index procedures:

4.5.g.1. adult medical resuscitation; (Core)

4.5.g.2. adult trauma resuscitation; (Core)

4.5.g.3. anesthesia and pain management; (Core)

4.5.g.3.a. Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)

4.5.g.4. cardiac pacing; (Core)

4.5.g.5. chest tubes; (Core)

4.5.g.6. cricothyrotomy; (Core)

4.5.g.7. dislocation reduction; (Core)

4.5.g.8. emergency department bedside ultrasound; (Core)

4.5.g.8.a. Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)

4.5.g.9. intubations; (Core)

4.5.g.9.a. Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly-defined anatomy, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

4.5.g.10. lumbar puncture; (Core)

4.5.g.11. pediatric medical resuscitation; (Core)

4.5.g.12. pediatric trauma resuscitation; (Core)


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4.5.g.13. pericardiocentesis; (Core)

4.5.g.14. procedural sedation; (Core)

4.5.g.15. vaginal delivery; (Core)

4.5.g.16. vascular access; and, (Core)

4.5.g.16.a. Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)

4.5.g.17. wound management. (Core)

4.5.g.17.a. Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (Core)

**4.6. ACGME Competencies – Medical Knowledge**
**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**

4.6.a. Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients. (Core)

4.6.b. Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)

**4.7. ACGME Competencies – Practice-Based Learning and Improvement**
**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)**

**4.7.a. Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)**

**4.7.b. Residents must demonstrate competence in setting learning and improvement goals. (Core)**

**4.7.c. Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)**

**4.7.d. Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement. (Core)**

**4.7.e. Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)**


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**4.7.f. Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.** **(Core)**

4.7.g. Residents must demonstrate competence in applying knowledge of study design and statistical methods to critically appraise the medical literature. (Core)

4.7.h. Residents must demonstrate competence in using information technology to improve patient care. (Core)

4.7.i. Residents must demonstrate competence in evaluating teaching effectiveness. (Core)

4.7.j. Residents must demonstrate competence in teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)

**4.8. ACGME Competencies – Interpersonal and Communication Skills**
**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.** **(Core)**

**4.8.a. Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient.** **(Core)**

**4.8.b. Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies.** **(Core)**

**4.8.c. Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group.** **(Core)**

**4.8.d. Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals.** **(Core)**

**4.8.e. Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals.** **(Core)**

**4.8.f. Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable.** **(Core)**

**4.8.g. Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** **(Core)**

4.8.h. Residents must demonstrate competence in communicating sensitive issues or unexpected outcomes, including: (Core)

4.8.h.1. diagnostic findings; (Core)


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4.8.h.2. end-of-life issues and death; and, (Core)

4.8.h.3. medical errors. (Core)

4.8.i. Residents must demonstrate competence in leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)

**4.9. ACGME Competencies – Systems-Based Practice**
**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**

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

**4.9.a. Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty. (Core)**

**4.9.b. Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)**

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

**4.9.c. Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)**

**4.9.d. Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)**

**4.9.e. Residents must demonstrate competence in incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)**

**4.9.f. Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)**

**4.9.g. Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**


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**4.9.h. Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals.** **(Core)**

4.9.i. Residents must demonstrate competence in participation in performance improvement to optimize self-learning, emergency department function, and patient safety. (Core)

4.9.j. Residents must demonstrate competence in using technology to accomplish and document safe health care delivery. (Core)

**Curriculum Organization and Resident Experiences**

**4.10. Curriculum Structure**

**The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events.** **(Core)**

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

4.10.a. Clinical experiences should be structured to facilitate learning in a manner that allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Detail)

4.10.b. The emergency medicine program director is responsible for determining the duration of the clinical experiences for the emergency medicine residents on all rotations. (Core)

**4.11. Didactic and Clinical Experiences**

**Residents must be provided with protected time to participate in core didactic activities.** **(Core)**

4.11.a. Didactics

Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)

4.11.a.1. These didactic experiences should include joint conferences co-sponsored with other disciplines. (Core)


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4.11.a.2. Educational methods should include problem-based learning, evidence-based learning, and computer-based instruction. (Core)

4.11.a.3. The majority of didactic experiences must occur at the primary clinical site. (Core)

4.11.a.4. There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)

4.11.a.5. Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)

4.11.a.6. All planned didactic experiences must be supervised by core physician faculty members. (Core)

4.11.a.7. Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)

4.11.a.8. Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)

4.11.a.9. Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)

4.11.a.10. All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)

4.11.b. Curriculum
The curriculum must include four months of dedicated critical care experiences, including critical care of infants and children. (Core)

4.11.b.1. At least two months of these experiences must be at the PGY-2 level or above. (Core)

4.11.c. The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings. (Core)

4.11.c.1. At least 50 percent of the five months should be in an emergency setting. (Core)

4.11.c.2. This experience must include the critical care of infants and children. (Core)

4.11.d. The curriculum must include at least 10 low-risk normal spontaneous vaginal deliveries. (Core)

4.11.e. The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in


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the emergency department under the supervision of emergency medicine faculty members. (Core)

4.11.e.1. Residents should treat a significant number of critically ill or critically injured patients at participating sites. (Core)

4.11.e.1.a. These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)

4.11.f. Resident Experiences
Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)

4.11.f.1. The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)

4.11.f.2. Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)

4.11.f.3. Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Review Committee where indicated. (Core)

4.11.g. Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)

4.11.g.1. EMS experiences must include ground unit runs and should include direct medical oversight. (Core)

4.11.g.2. This should include participation in multi-casualty incident drills. (Core)

4.11.g.3. If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)

4.11.g.3.a. Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)

**4.12. Pain Management**
**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**

**Scholarship**

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


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

**4.13. Program Responsibilities**
**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims.** **(Core)**

**4.13.a. The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.** **(Core)**

**4.13.b. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.** **(Core)**

**4.14. Faculty Scholarly Activity**
**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:** **(Core)**

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

**4.14.a. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

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


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- **peer-reviewed publication.** **(Outcome)**

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

Specialty-Specific Background and Intent: The Review Committee will evaluate the faculty scholarly activity based on scholarly output by the faculty as a whole averaged over five years. It is the Review Committee's expectation that the program demonstrate scholarly activity that is not limited to the efforts of one or two prolific researchers with multiple scholarly works and publications.

**4.15. Resident Scholarly Activity**
**Residents must participate in scholarship.** **(Core)**

4.15.a. The curriculum must advance the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

4.15.b. At the time of graduation, each resident should demonstrate:

- active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome)
- presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core)
- grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome)
- peer-reviewed publications. (Outcome)

Specialty-Specific Background and Intent: Examples of scholarly activity categories:

1. Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in a journal indexed in PubMed, and original contributions of knowledge published in journals indexed in


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other formally recognized peer-reviewed databases. Abstracts, editorials, or letters to the editor do not qualify. Submissions to online venues, with the exception of MedEdPORTAL, do not qualify.

2. Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, letters to the editor of peer-reviewed journals, educational videos, DVDs, and podcasts.

3. Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author.

4. Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader.

## Section 5: Evaluation

**5.1. Resident Evaluation: Feedback and Evaluation**
**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.** **(Core)**

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

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

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

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

**End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when**

**residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.**

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

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

**5.1.a.** **Evaluation must be documented at the completion of the assignment.** **(Core)**

**5.1.a.1.** **For block rotations of greater than three months in duration, evaluation must be documented at least every three months.** **(Core)**

**5.1.a.2.** **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.** **(Core)**

**5.1.b.** **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones.** **(Core)**

**5.1.b.1.** **The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members).** **(Core)**

**5.1.b.2.** **The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.** **(Core)**

**5.1.c.** **The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones.** **(Core)**

5.1.c.1. The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)

**5.1.d.** **The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.** **(Core)**

**5.1.e.** **The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures.** **(Core)**

5.1.e.1. A plan to remedy deficiencies must be in writing and on file. (Core)

5.1.e.1.a. Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core)

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

**Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.**

**5.1.f.** **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** **(Core)**

5.1.f.1. At least annually, each resident's competency in procedures and resuscitations must be formally evaluated by the program director. (Core)

**5.1.g.** **The evaluations of a resident's performance must be accessible for review by the resident.** **(Core)**

**5.2.** **Resident Evaluation: Final Evaluation**
**The program director must provide a final evaluation for each resident upon completion of the program.** **(Core)**

**5.2.a.** **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** **(Core)**


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**5.2.b.** **The final 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.** **(Core)**

**5.2.c.** **The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.** **(Core)**

**5.2.d.** **The final evaluation must be shared with the resident upon completion of the program.** **(Core)**

**5.3. Clinical Competency Committee**
**A Clinical Competency Committee must be appointed by the program director.** **(Core)**

**5.3.a.** **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** **(Core)**

**5.3.b.** **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** **(Core)**

> Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.
>
> Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

**5.3.c.** **The Clinical Competency Committee must review all resident evaluations at least semi-annually.** **(Core)**

**5.3.d.** **The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones.** **(Core)**


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**5.3.e.** **The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** **(Core)**

**5.4. Faculty Evaluation**

**The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually.** **(Core)**

| **Background and Intent: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the varied operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.** |
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| Specialty-Specific Background and Intent: The Review Committee believes that other important aspects for faculty evaluations may include the faculty member's administrative and interpersonal skills, quality of feedback and mentoring for residents, and participation in and contributions to resident conferences. |
|---|

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

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

**5.4.c.** **Faculty members must receive feedback on their evaluations at least annually.** **(Core)**

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


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

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

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

**5.5.b. Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.** **(Core)**

**5.5.c. Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** **(Core)**

**5.5.d. Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** **(Core)**

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

**5.5.e. The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program .** **(Core)**

**Background and Intent: Other data to be considered for assessment include:**

- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**

- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

**5.5.f.** **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.** (Core)

**5.5.g.** **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO.** (Core)

**5.5.h.** **The program must complete a Self-Study and submit it to the DIO.** (Core)

**Board Certification**
***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***

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

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

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

**5.6.c.** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's**


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**aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

**5.6.d.** **For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

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

**There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and 5.6.d. is designed to address this.**

**5.6.e.** **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** **(Core)**

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

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

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

## Section 6: The Learning and Working Environment

**The Learning and Working Environment**

***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***


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- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***
- ***Excellence in professionalism***
- ***Appreciation for the privilege of caring for patients***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

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

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

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

**6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)**

**6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)**

**6.3. Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**

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

**6.4. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**

**Supervision and Accountability**
***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely***


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***communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

***Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.***

**6.5. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)

> **Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.**

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

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

**Levels of Supervision**

***To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***

**6.7. Direct Supervision**

***The supervising physician is physically present with the resident during the key portions of the patient interaction.***

***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***

**6.7.a. PGY-1 residents must initially be supervised directly, only as described in the above definition.** (Core)


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**Indirect Supervision**
***The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.***

**Oversight**
***The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.***

**6.8. The program must define when physical presence of a supervising physician is required.** (Core)

**6.9. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

**6.9.a. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

**6.9.b. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** (Core)

**6.9.c. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

**6.10. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

**6.10.a. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

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

**6.11. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** (Core)

**6.12. Professionalism**
**Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)


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**Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.**

**6.12.a.** **The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations.** (Core)

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

**6.12.b.** **The learning objectives of the program must ensure manageable patient care responsibilities.** (Core)

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

**6.12.c.** **The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.** (Core)

**6.12.d.** **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** (Core)


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**Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.**

**6.12.e.** **Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.** **(Core)**

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

**Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.**

**The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.**

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

**Well-Being**

***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 residency training.***

***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 the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.***


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**6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:**

**6.13.a. attention to scheduling, work intensity, and work compression that impacts resident well-being;** (Core)

**6.13.b. evaluating workplace safety data and addressing the safety of residents and faculty members;** (Core)

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

**6.13.c. policies and programs that encourage optimal resident and faculty member well-being; and,** (Core)

> **Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.**

**6.13.c.1. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.** (Core)

**6.13.d. education of residents and faculty members in:**

**6.13.d.1. identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions;** (Core)

**6.13.d.2. recognition of these symptoms in themselves and how to seek appropriate care; and,** (Core)

**6.13.d.3. access to appropriate tools for self-screening.** (Core)

> **Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).**


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

**6.13.e.** **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.** (Core)

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

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

**6.14.** **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** (Core)

**6.14.a.** **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.** (Core)

**6.14.b.** **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.** (Core)

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

**6.15.** **Fatigue Mitigation**


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**Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.** (Detail)

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

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

**6.16. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** (Core)

**6.17. Clinical Responsibilities**

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

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

6.17.a. When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)

6.17.a.1. While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)

6.17.a.2. There must be at least one equivalent period of continuous time off between scheduled work period. (Core)


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6.17.a.3. A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)

6.17.a.4. Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)

**6.18. Teamwork**

**Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)**

**Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.**

6.18.a. Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)

Specialty-Specific Background and Intent: Examples of professional personnel who may be part of interprofessional teams, all members of which must participate in the education of residents, include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.

**6.19. Transitions of Care**

**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**

**6.19.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)**

**6.19.b. Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)**

**Clinical Experience and Education**

***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***


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**Background and Intent: The terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These terms are used in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.**

**6.20. Maximum Hours of Clinical and Educational Work per Week**
**Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, including all in-house clinical and educational activities, clinical work done from home, and all moonlighting.** (Core)

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

***Work from Home***

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

**Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program’s responsibility is ensuring that residents**

**report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.**

**6.21. Mandatory Time Free of Clinical Work and Education**
**Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)

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

**6.21.a. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.** (Core)

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

**6.21.b. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.** (Core)

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

**off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."**

**6.22. Maximum Clinical Work and Education Period Length**

**Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

**6.22.a. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

**Background and Intent: The additional time referenced in 6.22.a. should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.**

**6.23. Clinical and Educational Work Hour Exceptions**

**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events.** (Detail)

**6.23.a. These additional hours of care or education must be counted toward the 80-hour weekly limit.** (Detail)

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

**6.24. A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.


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**6.25. Moonlighting**
**Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.** **(Core)**

**6.25.a. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** **(Core)**

**6.25.b. PGY-1 residents are not permitted to moonlight.** **(Core)**

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

**6.26. In-House Night Float**
**Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** **(Core)**

**6.27. Maximum In-House On-Call Frequency**
**Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** **(Core)**

**6.28. At-Home Call**
**Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.** **(Core)**

**6.28.a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.** **(Core)**

| Background and Intent: As noted in 6.20., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.<br><br>In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time. |
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# Emergency Medicine Defined Key Index Procedure Minimums
## Review Committee for Emergency Medicine

The following are key index procedures identified by the Review Committee as essential to the independent practice of emergency medicine (based on the Program Requirements, the Emergency Medicine Milestones, and the Model of the Clinical Practice for Emergency Medicine).

Residents are required to perform the minimum numbers indicated for each key index procedure below by the time of graduation from the program.

| Procedure | Minimum |
|---|---|
| Adult Medical Resuscitation | 45 |
| Adult Trauma Resuscitation | 35 |
| Cardiac Pacing | 6 |
| Central Venous Access | 20 |
| Chest Tubes | 10 |
| Cricothyrotomy | 3 |
| Dislocation Reduction | 10 |
| ED Bedside Ultrasound | 150 |
| Intubations | 35 |
| Lumbar Puncture | 15 |
| Pediatric Medical Resuscitation | 15 |
| Pediatric Trauma Resuscitation | 10 |
| Pericardiocentesis | 3 |
| Procedural Sedation | 15 |
| Vaginal Delivery | 10 |

No more than 30 percent of required logged procedures performed in simulated settings can count toward the required minimum, with the exception of rare procedures, namely pericardiocentesis, cardiac pacing, and cricothyrotomy. One hundred percent of these rare procedures may be performed in the lab.



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# Frequently Asked Questions: Emergency Medicine
## Review Committee for Emergency Medicine
## ACGME

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td colspan="2">Introduction</td></tr>
<tr><td>What should be included in the educational rationale for programs seeking a 48-month program format?<br><br>[Program Requirement: 4.1]</td><td>The educational rationale for a 48-month program format should describe:<br>1. A more in-depth curriculum in areas related to emergency medicine, not just additional clinical rotations<br>• Examples: Focused experiences in ultrasound (US), Emergency Medical Services (EMS), health administration, research, toxicology, critical care, etc.<br>2. The expected skillset/outcome residents will obtain by completing the additional 12 months of the program<br>• Examples: US certification, global health, increased scholarly activity, including work toward a Master of Public Health or Master of Education degree, etc.<br>3. Graduated responsibilities for fourth-year residents<br>• Example: Supervision of junior residents by fourth-year emergency medicine residents on critical care rotations</td></tr>
<tr><td colspan="2">Oversight</td></tr>
<tr><td>Should the Designated Institutional Official (DIO) from the institution sending learners to a site or from the institution receiving learners from another site sign the Program Letter of Agreement (PLA)?<br><br>[Program Requirement: 1.3.b.]</td><td>Although the requirements do not specify that the PLA include the signature of the designated institutional official (DIO), institutions may find it prudent to include the signature of at least the DIO from the sending program’s institution.</td></tr>
<tr><td>If a program uses a multi-hospital system that includes separate emergency departments located at separate sites, but references these separate sites under one hospital name, how should the program represent this configuration?<br><br>[Program Requirement: 1.6.b.]</td><td>Each emergency department location is considered an additional participating site, and programs should list and describe each emergency department separately. Additionally, the annual patient volumes and critical care volumes at each site cannot be aggregated under one hospital name and should also be listed separately with their respective site.</td></tr>
</table>


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| Question | Answer |
|---|---|
| If a program wants to establish a rotation at a site that is not in close geographic proximity to the Sponsoring Institution, what accommodations should be made?<br><br>*[Program Requirements: 1.6.d. and 1.6.e.]* | If a program establishes an affiliation with a site which is geographically distant from the Sponsoring Institution due to special resources provided at the site:<br>1) The program should provide a rationale for why this site has been designated for the rotation over other potential sites that are closer in proximity.<br>2) The program should consider the social impacts of resident removal from family, life, and the day-to-day community of the residency program. The program should ensure that major burdens residents may experience in traveling to and from the site, including the financial impact are addressed. If the site is of such distance that daily travel between the site and the Sponsoring Institution is unfeasible or burdensome, the program may need to provide transportation options and/or housing arrangements for residents while on rotation there. |
| What other specialty programs should be present at the Sponsoring Institution to demonstrate the availability of educational resources that includes the presence of residents in other specialties?<br><br>*[Program Requirement: I.D.1.a)]* | Residents' educational experience will be enhanced by exposure to other specialties and their academically-focused educational programs, particularly as related to faculty education and supervision, and through promotion of peer-to-peer collaboration and team building among specialties. The Review Committee does not require any specific specialty be present at the Sponsoring Institution. |
| What should a written consultation protocol include?<br><br>*[Program Requirement: 1.8.e.1.]* | Such a protocol should include written agreements for the transfer of patients to a designated hospital that provides the needed clinical services. |
| How can programs calculate their critical care numbers?<br><br>*[Program Requirement: 1.8.g.1.]* | As programs determine their critical care patient volume at the primary site, resources can include: Emergency Department billing and coding numbers for critical care, admission data to step down unit, intensive care unit (ICU), operating room, or morgue. |


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| Question | Answer |
|---|---|
| Does every participating site need to have all resource amenities listed?<br><br>*[Program Requirements: 1.9.a.-e]* | The Review Committee expects most participating sites in ADS to demonstrate all site resources listed in the requirements to ensure healthy and safe learning and working environments that promote resident well-being. However, if the site is a non-clinical rotation outside of a university or hospital setting (i.e., high school, sports training facility, wilderness, firehouse, etc.) the Review Committee will not expect all areas delineated in the requirements to be static on-site (i.e. lactation facilities, refrigeration for human milk storage, sleep/rest facilities), but there should be a provision that accommodations will be made if/when needed. |
| **Personnel** | |
| What salary support is the institution/department expected to provide for the program director's non-clinical time for administration of the program?<br><br>*[Program Requirements: 2.4.a. and 2.4.b.]* | The program director must receive no less than 35 percent support if their program is approved for 18-35 residents and no less than 50 percent support if their program is approved for 36 or more residents. This does not mean 50 percent of the **aggregate** support delineated in the support table in requirement (II.A.2.a), but rather a pure 0.5 FTE support or 0.35 FTE. |
| How can a program identify and demonstrate adequate APD and program coordinator support for the number of residents in the program?<br><br>*[Program Requirements: 2.4.a. and 2.12.b.]* | When reviewing a program, the Review Committee would expect to see the required FTE program coordinator and support personnel for the number of approved residents in the program as indicated under "Program Leadership" in ADS.<br><br>If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see at least two program coordinator names listed in ADS. To add support personnel in ADS, click on "+ add personnel" in the "Program Profile, Program Leadership" section.<br><br>To identify the required APD(s) for the program, add this title under "Program Specific Title" in their faculty profile to reflect it on the Faculty Roster. |


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| Question | Answer |
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| What faculty and coordinator support is a new program applying for initial accreditation expected to have in place at the time of the application?<br><br>*[Program Requirements: 2.4.a., 2.11.c., and 2.12.b.]* | When the Review Committee reviews a new program application, it would expect to see a program director in place with the required protected support (a minimum of either 0.35 or 0.50 depending on program size), core faculty in a 1:3 ratio with the number of residents for at least the initial cohort of first year residents being requested, and the required FTE program coordinator for the number of approved resident positions in the program.<br><br>If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see additional program coordinator names listed in ADS.<br><br>Programs applying for initial accreditation may identify an interim program coordinator on the application, but the Review Committee will expect the program to fully meet the requirement by having a permanent program coordinator in place no later than 90 days prior to matriculation of the inaugural class on June 30th.<br><br>Support personnel whose time is divided across several programs (such as emergency medical services, toxicology, and the core emergency medicine program) must have the time devoted to each program as described in each of the respective sets of Program Requirements.<br><br>Example: If a Sponsoring Institution has an emergency medicine program approved for 24 residents, requiring a 1.0 FTE program coordinator, and also has a fellowship program in emergency medical services, requiring at least 0.2 FTE program coordinator time for the fellowship program, both programs must meet the requirements. Therefore, the EMS fellowship program cannot use the 1.0 FTE emergency medicine program coordinator to provide support to the fellowship. |
| | Example: For a new EM program requesting 30 residents (10 per year for a three-year format), the program would be expected to have at least 10 core faculty (nine plus the PD) in place at the time of the application. The Review Committee would expect there to be one PD (minimum 0.35 FTE) and one APD (minimum 0.25 FTE) designated. |


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| When a program requests a permanent increase in resident complement, what is the timeline for demonstrating a parallel increase in the required program resources to match the increased program size?<br><br>*[Program Requirements: 2.4.a.-b., 2.11.b., and 2.12.b.]* | If a program requests a complement increase that will require an increase in program resources (i.e. program director support, number of APDs, program coordinator support, and the number of core faculty), the Review Committee would expect the program to outline a detailed plan for increasing the program's resources accordingly once the extra work of having the additional residents begins.<br><br>Example: If a Sponsoring Institution has an emergency medicine program currently approved for 24 residents and requests to increase to 36 residents, the program will need to increase resources to add one additional APD, increase the PD support to at least 0.50 FTE, increase the number of core faculty from 8 to 12, and increase program coordinator support from 1.0 FTE to 1.30 FTE. The Review Committee will need to see a commitment and plan to increase the resources in the educational rationale. |
| Why must a program director have at least three years' experience as a core faculty member in an ACGME-accredited emergency medicine program?<br><br>*[Program Requirement: 2.5.]* | The administration of a program is so complex, that experience with and understanding of program operations are necessary for program director candidates. This is why the Review Committee believes that to ensure that programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents an optimal learning experience, the program director should have a minimum of three years' experience as a core faculty member in an ACGME-accredited emergency medicine program. The Committee will also accept core faculty experience in a former American Osteopathic Association (AOA)-approved program. It is desirable that the core faculty experience occurred within the most recent three-year period and in the program the program director will lead. |


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| When considering a new program director candidate, how does the Review Committee determine that an individual meets the qualification requirements?<br><br>*[Program Requirements: 2.5.-2.5.e.]* | The Review Committee will look for the following when evaluating new program director candidates submitted for approval:<br><br>II.A.3.a) and II.A.3.e) Educational and administrative experience(s) acceptable to the Review Committee – While many types of leadership experience may be qualifying, the Review Committee expects this experience to be recently acquired and within the three years preceding a proposed appointment. In the case of a new program application, the Review Committee recommends this experience to have been acquired in the three years preceding the submission of the new 6application.<br>The Review Committee will consider the following types of experiences as acceptable:<br>• Experience as an assistant/associate program director, fellowship director or site director within EM or an EM subspecialty<br>• Administrative program experience, such as serving on the program's Clinical Competency Committee (CCC), Program Evaluation Committee (PEC), or Graduate Medical Education Committee<br>• Leadership role in the program, such as Chair of the department, Chair of the CCC, Research Director, etc.<br><br>II.A.3.b) and b).(1) Board Certification – The Review Committee accepts only ABMS and AOA board certifications in Emergency Medicine.<br><br>II.A.3.c) Ongoing clinical activity – The Committee expects the majority of the candidate's prior clinical activity to involve residents. The Committee will evaluate the amount of time the candidate will devote weekly to clinical supervision to determine whether the amount of time is sufficient to gain an independent understanding of any resident's clinical skills.<br><br>II.A.3.e) Demonstrated leadership role - While many types of leadership experience may be qualifying, the Review Committee expects this experience to be recently acquired and within the three years preceding a proposed appointment. In the case of a new program application, the Review Committee expects the experience to have been acquired in the three years preceding the submission of the new application.<br><br>II.A.3.f) Scholarly activity including peer-reviewed publications - The candidate must have peer-reviewed publications and acceptable scholarship within the five years preceding the proposed program director appointment. Peer-reviewed publications must have an associated PMID to be considered for this requirement. |


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| What faculty qualifications are acceptable to the Review Committee for faculty supervising EM residents in the ED?<br><br>*[Program Requirement: 2.8.f.]* | The Review Committee would accept faculty members' certification by the American Osteopathic Board of Emergency Medicine (AOBEM), or certification by a subspecialty board sponsored or co-sponsored by the American Board of Emergency Medicine (ABEM). It would also accept, for faculty appointment, recent residency or fellowship graduates (within the past three years) actively working toward certification by these boards. |
| Are there any other qualification requirements specific to faculty members providing supervision in an ED (either Adult or Pediatric ED)?<br><br>*[Program Requirement: 2.9.a.]* | Faculty members providing supervision to emergency medicine residents on emergency medicine rotations must have appropriate qualifications relative to the patient population for which they are providing the supervision.<br><br>For example, a faculty member certified in pediatrics and pediatric emergency medicine would be qualified to supervise emergency medicine residents on pediatric cases, but not adult cases.<br><br>Emergency medicine residents rotating in a pediatric emergency department where there are also pediatric emergency medicine fellows in an ACGME-accredited program are subject to the pediatric emergency medicine requirements related to faculty qualifications and supervision. Faculty qualifications for supervision in an ACGME- accredited pediatric emergency medicine program include certification in pediatric emergency medicine, pediatrics, or emergency medicine.<br><br>In all other instances, faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the Emergency Department. |
| Can non-ABEM-/non-AOBEM-certified faculty members see patients in the Emergency Department?<br><br>*[Program Requirements: 2.10. and 2.10.a.]* | The presence of non-ABEM/non-AOBEM-certified faculty members in the Emergency Department is acceptable; however, they cannot directly supervise emergency medicine residents. They are allowed to see patients primarily or work with other provider groups, such as Advance Practice Providers (APPs). |


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| Which physician faculty members are included in the required core faculty-to-resident ratio of 1-to-3?<br><br>*[Program Requirement: 2.11.b.]* | Only core faculty members certified by the ABEM or AOBEM, or certified in pediatric emergency medicine by the ABP or AOBP will be considered towards the required 1:3 faculty-to-resident ratio.<br><br>The ADS system will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member towards the 1:3 ratio. |
| **Resident Appointments** | |
| Why does the Review Committee review resident attrition?<br><br>*[Program Requirement: 3.4.]* | Resident attrition may impact residents' work and learning environment, and may serve as an indicator for an unstable educational environment. |
| Why is the minimum number of approved resident positions in a training program 18?<br><br>*[Program Requirement: 3.4.a.]* | A minimum of 18 residents is needed to foster a sense of identity within the program and the department. Additionally,18 residents ensures a major impact in the Emergency Department to allow for meaningful attendance at emergency medicine conferences, to provide for progressive resident responsibility, and impact as resident teachers.<br><br>The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year. |
| How can a new program meet the requirement for a minimum of 18 residents?<br><br>*[Program Requirement: 3.4.a.]* | The Review Committee understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by the end of the first graduating class, whether three or four years. |


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| Can a program accept a resident transferring from another program?<br><br>*[Program Requirements: 3.5. and 3.5.a.]* | Yes, the program can accept a transfer resident. For resident transfers, the Review Committee does not obtain verification of training or grant credit for prior training required for board eligibility. Programs should contact the ABEM and/or the AOBEM to verify previous experiences and determine what credit, if any, will be given for the resident's prior training. |
| **Educational Program** | |
| Can programs use the Emergency Medicine Milestones as goals and objectives or as a primary evaluation tool?<br><br>*[Program Requirement: 4.2.b.]* | The required goals and objectives are **not** the Milestones. The Milestones are a competency assessment tool and should not be the only measure or primary evaluation tool used in conducting resident evaluations as the Milestones do not cover every aspect of training. The program's 360-degree evaluation tools are used by the program director and the Clinical Competency Committee to map the resident's longitudinal progress on the Milestones. Program evaluation tools can be Milestones-based, but the Milestones themselves do not meet the criteria for goals and objectives. |
| How does the Review Committee define a major resuscitation?<br><br>*[Program Requirement: 4.5.e.]* | A major resuscitation is patient care for which prolonged physician attention is needed at the bedside, and interventions—such as defibrillation, cardiac pacing, treatment of shock, including emergent transfusion of blood products, intravenous use of drugs (e.g., thrombolytics, vasopressors, antiarrhythmics), or invasive procedures (e.g., central line insertion, tube thoracostomy, endotracheal intubations)—are necessary for stabilization and treatment.<br><br>Each resident is provided the opportunity to make admission recommendations and direct resuscitations. Patients may experience a "major resuscitation" but may improve before disposition to a critical care area occurs. Programs are encouraged to measure the resident's resuscitation experience rather than focusing on the patient's disposition location. |
| What types of experiences *do not* qualify as didactic experiences?<br><br>*[Program Requirement: 4.11.a.]* | Daily experiences, such as morning report or change of shift teaching, which are informal and at which not all residents are consistently present, do not meet the requirements for didactic experiences. |


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| Can residents from my program attend the conferences at the site where their rotation is located or must they come back to our home institution for conferences?<br><br>*[Program Requirement: 4.11.a.3.]* | The requirements for the didactic experiences allow for joint conferences co-sponsored with other disciplines, so if residents joined the participating site's conferences, this could count towards requirement: IV.C.3.a).(1). However, attendance at the participating site's conferences cannot count towards the five hours per week of planned didactic experiences since these must be developed by and supervised by the program's core faculty (IV.C.3.c) and IV.C.3.c).(2)). The program could also consider video conferencing while rotating at the participating site to allow those residents to participate in the home institution's conferences synchronously. |


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| How much individualized interactive instruction is acceptable and what qualifies?<br><br>*[Program Requirement: 4.11.a.5.]* | Programs may utilize individualized interactive instruction, such as web-based learning, for up to 20 percent of the planned educational experiences or didactics (i.e., on average, one hour out of the five hours per week of planned educational activity).<br><br>The goal of individualized interactive instruction is to allow program directors to adjust curricular needs to the individual needs of each resident. It is important to note that simply reading or answering questions does not meet the requirements for planned educational activities. Watching pre-recorded conferences also does not count, given the activity is simply asynchronous, but not individualized for the learner.<br><br>In order for an activity to qualify as individualized interactive instruction, the following four criteria should be met:<br><br>1. The program director must monitor resident participation and track attendance.<br>2. There must be an evaluation component.<br>3. There must be active faculty oversight and interaction.<br>4. The activity must be monitored for effectiveness.<br><br>Examples of individualized interactive instruction include:<br><br>• A resident prepares for and takes a quiz or test, and receives timely feedback about his or her performance from a faculty member.<br>• A resident spends additional time in the simulation lab or cadaver/animal lab because he or she needs more practice with a certain procedure.<br>• Residents who are doing poorly on quizzes/tests participate in board review study sessions with colleagues or faculty members.<br><br>Attestation and completion pages are not acceptable to the Review Committee as evaluation. Use of audio, video, or podcasts alone constitutes passive learning and is not considered interactive learning unless an individualized study plan has been created with faculty, there is oversight, and there is an evaluative component. Proprietary systems that allow for real-time questions and answers qualify as active/interactive participation. |


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| Why is there a requirement that each core faculty member attend, on average per year, at least 20 percent of planned didactic experiences?<br><br>*[Program Requirement: 4.11.a.7.]* | Core faculty members' attendance at conferences and other resident didactics gives residents the opportunity to benefit from their perspective, experience, and discussion. It also demonstrates their commitment to the educational program. |
| What considerations are taken when calculating the 70 percent resident conference attendance?<br><br>*[Program Requirements: 4.11.a.4. and 4.11.a.9.]* | The expectation is that residents will attend at least 70 percent of the total planned didactic experiences per year. The program will determine the denominator for the number of "planned" didactic experiences per year.<br><br>The denominator should include all conferences offered and not a reduced amount by the number of conferences missed due to vacation, off-service rotations, etc. as the lowered 70 percent attendance requirement already takes these absences into account.<br><br>For example, if a program schedules five hours of weekly conference for 48 weeks, the total planned didactic experience per year is 240 hours. Each resident is expected to attend 168 hours of planned didactic experiences each academic year. The missed 72 hours can occur during vacation, illness, specific off-service rotation, or when work requirements preclude conference.<br><br>Finally, residents can attend conference virtually, in an active, synchronous format using online platforms such as Zoom or Teams. Watching a recorded version of conference asynchronously does NOT count towards the 70 percent requirement. |
| How does the Review Committee verify resident attendance at 70 percent of the planned emergency medicine didactic experiences?<br><br>*[Program Requirement: 4.11.a.9.]* | Programs are to report the resident conference attendance in the Emergency Medicine Specialty Data section of the ADS. Verification should be crosschecked by reviewing an eight-week conference block and averaging resident attendance for that eight-week period. |


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| In meeting the requirement for four months of critical care, can programs consider experiences in step-down units, Emergency Department critical care units, critical care transport teams or anesthesiology rotations?<br><br>*[Program Requirement: 4.11.b.]* | No, experiences in step-down units, critical care/trauma units in the Emergency Department, critical care transport teams, and anesthesiology rotations do not count toward the critical care requirement. The intent of the requirement is for the resident to learn acute decision making and resuscitative skills outside the Emergency Department that can be applied in future Emergency Department patient care. |
| How can a program ensure their critical care experiences meet the requirement for "including the critical care of infants and children?"<br><br>*[Program Requirement: 4.11.b.]* | The Review Committee expects there to be a minimum of four weeks or one block of time dedicated to the care of infants AND children. This can be met with either:<br>• Four weeks or one block of PICU<br>• At least two weeks or a half-block of PICU, plus two weeks or a half- block of NICU<br><br>Given the lack of children in the NICU, time in the NICU alone does not satisfy this requirement. Rotation on pediatric transport teams outside of the PICU/NICU also does not meet this requirement. |
| Can pediatric critical care months count toward the four months of required critical care?<br><br>*[Program Requirements: 4.11.b. and 4.11.c.]* | Yes, months spent in the PICU or NICU setting count toward both the four-month critical care requirement and the five-month pediatric requirement. |
| Can residents take vacation time when assigned to Emergency Medicine, Critical Care, or Pediatric rotations?<br><br>*[Program Requirements: 4.11.b.; 4.11.c. and 4.11.e.]* | Yes, however, the expectation is that residents satisfy the minimum training time stipulated in the requirements for the designated experiences:<br>• 60 percent time in the emergency department<br>• Four months critical care<br>• Five months pediatrics<br><br>If vacation is taken during these rotations or if residents are pulled from these rotations to cover back-up call in the ED, it is up to the program director to ensure that the minimum time is met by the resident(s). |


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| How are longitudinal pediatric experiences calculated?<br><br>*[Program Requirement: 4.11.c.]* | To calculate longitudinal pediatric patient encounters, multiply the number of general Emergency Department months or four-week blocks by the percent of pediatric patients from the annual patient volume of the ED where the rotation is located.<br><br>For example, if the annual patient volume of the ED includes 15 percent pediatric patients and the resident spends 20 months in the Emergency Department (i.e., 20 months x .15 = 3 or the equivalent of 3 months), the resident would need two additional months of dedicated pediatric experiences to meet the five-month minimum. This calculation should be completed for the primary site and all participating sites to which the residents rotate. Using this calculation assumes that pediatric patients are not periodically sequestered in a separate pediatric ED or pediatric treatment area.<br><br>Programs that have a separate "pediatric ED" or area configured in or near the main ED must clearly describe what portion of the resident's assignment to the ED is in this area.<br><br>Programs that split ED rotations between emergency departments must clearly describe the assigned fraction to each ED on the block diagram to facilitate the calculation of the pediatric experience. |


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| Can a rotation assignment in an Observation Unit or non-ED based urgent care center satisfy the requirement that at least 60 percent of each resident’s clinical experience must take place in the emergency department?<br><br>*[Program Requirement: 4.11.e.]* | No. Resident assignments to an Observation Unit or non-ED based urgent care center (i.e. for-profit locations such as Patient First) cannot be counted toward the requirement that 60 percent of the resident's clinical experience take place in the emergency department.<br><br>Experiences that can be counted toward the 60 percent requirement require residents to:<br>• Evaluate undifferentiated emergency department patients<br>• Perform an appropriate history and physical examination<br>• Order and interpret appropriate diagnostics tests<br>• Assist in determining the patient's disposition<br><br>While patients placed in Observation Units are often considered outpatients, not inpatients, and the Observation Unit may be under the control of the EM residency faculty, patients placed in observation status have already had a history and physical examination performed and sufficient diagnostic testing completed to determine that "observation status" is an appropriate disposition. Rotations in an Observation Unit should be represented on the Block Diagram as "Observation" and not as an emergency medicine rotation. |
| Can an ultrasound rotation be counted towards the 60 percent EM requirement?<br><br>*[Program Requirement: 4.11.e.]* | Yes, an ED- based ultrasound rotation can be counted towards the 60 percent EM requirement provided the rotation occurs in the ED and with ED patients. Rotations based in radiology would not satisfy this requirement. |


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| What are examples of acceptable scholarly activity for faculty members?<br><br>*[Program Requirements: 4.14. – 4.14.a.]* | It is critical that faculty members participate in scholarly activity in order to appropriately mentor residents and enhance the educational program.<br><br>Acceptable faculty scholarly activity includes:<br><br>1. Peer Review - This includes original contributions of knowledge published in journals indexed in PubMed or MEDLINE®. Submissions to peer-reviewed online venues and Med Ed PORTAL also count. This does not include abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process.<br><br>2. Non-Peer Review - This includes all submissions to journals or online venues that do not fulfill peer-review criteria. This also includes abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process. This category |


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| | also includes educational videos, social media posts, and podcasts.<br><br>3. Textbooks/Chapters - This includes submissions for which the faculty member served as editor, section editor, or chapter author.<br><br>4. Presentation at Local/Regional/National Organizations - This includes invited presentations, such as abstracts (posters), expert panel discussions, serving as a forum leader, grand rounds presentations, or interdisciplinary grand rounds presentations within the Sponsoring Institution. Grand rounds or other didactic presentations do not qualify unless presented at a department other than emergency medicine. The expectation is that this presentation is of original work. Instruction of, or participation in certification courses, such as Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support (ATLS), or Pediatric Advanced Life Support (PALS), do not qualify.<br><br>5. Committee Leadership - This includes elected or appointed positions in nationally recognized organizations. Membership alone does not qualify.<br><br>6. Editorial Services - This includes serving as an editor, editorial board member, reviewer, or content expert. Serving as an abstract reviewer or grant reviewer also qualifies.<br><br>7. Grants - The awarding of a grant or participation in grants for which the faculty had a leadership role such as the PI, Co-PI, or site director. |
| Are there any Review Committee considerations in meeting the faculty scholarly requirement?<br><br>*[Program Requirements 4.14. – 4.14.a.]* | The Review Committee expects the program's core faculty members to lead the scholarly efforts by demonstrating significant contributions in the form of accomplishments in at least three of the domains listed in the program requirements, including peer-reviewed publications related to the specialty or subspecialty areas of emergency medicine.<br><br>It is the Review Committee's expectation that this scholarly requirement be fulfilled by participation by multiple faculty members, specifically by at least half of the faculty (in particular the core faculty), and not by one or two prolific researchers/ authors with multiple publications, grants, etc. Faculty scholarly activity will be evaluated over a five-year interval. |


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| What are the Review Committee's expectations for resident scholarly activity?<br><br>*[Program Requirement: 4.15.]* | The Review Committee expects all residents to participate in scholarly activity by the end of residency.<br><br>Examples of acceptable resident scholarly activity include:<br><br>1. Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in journals indexed in PubMed, including original contributions of knowledge published in journals indexed in PubMed or MEDLINE®. Submissions to peer-reviewed online venues and Med Ed PORTAL also count. Submissions to online venues, abstracts, editorials, or letters to the editor do not qualify.<br><br>2. Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, letters to the editor of peer-reviewed journals, educational videos, social media, and podcasts.<br><br>3. Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author.<br><br>4. Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader.<br><br>5. Participation in Research – This refers to active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an Emergency Department quality improvement project. |


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## Evaluation


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| What does the Review Committee expect for multi-source resident evaluations?<br><br>*[Program Requirement: 5.1.b.1.]* | The Review Committee expects ALL of the following evaluators to be used for multi-source evaluations:<br>• faculty members<br>• peers<br>• patients<br>• the residents themselves<br>• other professional staff members (i.e.- RNs, Social Workers) |
| How will resident advancement be affected if a resident needs remediation?<br><br>*[Program Requirement: 5.1.e.1.]* | Deficiencies in specific areas do not necessarily mean a resident should be held back in progressing to the next year or level of education; however, plans must be in place to support such residents in achieving the required competencies. |
| Is there specific language that must appear on the resident's final evaluation form?<br><br>*[Program Requirement: 5.2.c.]* | Yes, the form used to facilitate the final evaluation of the residents must include the verification language as stated in the requirements:<br><br>"…the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice" |
| Can the program coordinator and/or residents be members of the Program Evaluation Committee (PEC) or the Clinical Competency Committee (CCC)?<br><br>*[Program Requirements: 5.3.b. and 5.5.a.]* | The Program Evaluation Committee (PEC) must include at least one resident and can include the program coordinator.<br><br>The Clinical Competency Committee (CCC) may not allow residents (except post-grad Chief Residents) or program coordinators to serve as members, as the requirement is for those faculty members or other health professionals who have extensive contact with the residents. |
| How can a program demonstrate that resident evaluations of the faculty are anonymous?<br><br>*[Program Requirement: 5.4.b.]* | The Review Committee recognizes that many programs use residency management systems to facilitate evaluations, and that the form may include a field for the evaluator name even when the settings are set to not show the evaluator name in certain instances. Should the evaluation form template not accurately represent that the form is anonymous, the program can either:<br>• Print a copy and cross out the evaluator name to alert the committee that the program is aware of this requirement<br>• Complete a dummy evaluation and print it as an example to the committee of how the template looks when viewed |


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| **The Learning and Working Environment** | |
| Can residents be supervised by licensed independent practitioners?<br><br>*[Program Requirement: 6.7.]* | The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a physician faculty member during these situations is required. |
| Who can supervise EM residents in urgent care/fast track settings?<br><br>*[Program Requirements: 2.8.f. and 6.6.]* | If an EM resident is assigned to an area of any ED where undifferentiated and less urgent patients are seen (i.e. fast track, quick care, urgent care) and the experience is counted toward the 60 percent required EM rotations, the EM resident must be supervised by EM certified physician faculty.<br>If an EM resident is assigned to a freestanding facility geographically distinct from any acute care hospital that treats undifferentiated "urgent care" patients and would not thus qualify as a full freestanding ED, the EM resident can be supervised by any credentialed provider in this site, but this experience cannot count toward the 60 percent required EM rotations. |
| Can residents from other specialties supervise emergency medicine residents?<br><br>*[Program Requirement:* 6.7.] | Residents from other specialties must not supervise emergency medicine residents on any rotation in the Emergency Department. Residents from other specialties can supervise emergency medicine residents on rotations in clinical areas related to their graduate medical education training and expertise, but the program director must monitor supervision on off-service rotations and ensure that the supervision is appropriate. |
| Under what circumstances can a first-year resident be supervised indirectly with direct supervision immediately available?<br><br>*[Program Requirement: 6.8.]* | Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with direct supervision immediately available.<br><br>Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with direct supervision immediately available while rotating in the Emergency Department, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as medical intensive care unit (MICU) or trauma surgery. |


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| What types of circumstances and events should be included in the supervision policy to demonstrate when residents should communicate with the supervising faculty members?<br><br>*[Program Requirement: 6.10.]* | For clarity, the supervision policy should include examples of circumstances and events for when residents should communicate with their supervising attending. Such examples could include:<br>• Discussion of end-of-life/DNR decisions<br>• Change in patient clinical status<br>• Patients wishing to leave against medical advice |
| What does the Review Committee consider an optimal clinical workload?<br><br>*[Program Requirement: 6.17.]* | A resident in the Emergency Department at the very beginning of the program should have a smaller workload than a resident at the same level in the same rotation at the end of that academic year. Each program must adhere to its graduated responsibility policy. This may vary by area of service, and is based upon each individual's level of achieved competence (knowledge, skills, and attitudes) and upon patient acuity. The Milestones must be used to assess each resident's competence.<br><br>Both insufficient patient experiences and excessive patient loads may jeopardize the quality of resident education. |


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| Question | Answer |
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| How much time should a resident have off between emergency medicine shifts?<br><br>*[Program Requirements: 6.17.a.1.-6.17.a.2.]* | In emergency medicine, the scheduled clinical shift is the basis for the required time off and considers additional clinical time after the assigned shift is completed toward the total clinical and educational work hours each week (finishing documentation, transitions in care, etc.).<br><br>A resident must have at minimum a scheduled break equal to the scheduled length of the shift within the 24-hour period that includes the shift.<br><br>All time (clinical and educational) counts toward the total average time cap per week. Didactic and other educational experiences count toward weekly clinical and educational work hour limits but are not considered when calculating time off between clinical shifts.<br><br>Example:<br>If a resident works a 10-hour shift (9:00 p.m. to 7:00 a.m.) and then attends a conference until 11:00 a.m., he/she must have 10 hours off before returning to his/her next clinical shift (starting from the 11:00 a.m. end time of the conference, meaning that the resident should not return to clinical work until 9:00 p.m. If the resident chooses not to attend the conference, the 10-hour break begins at 7:00 a.m. when the clinical shift ends). Conference time is added in the calculation of clinical and educational work hours for the week when the resident is present. |

| | | | |
|---|---|---|---|
| 4:00 p.m.-12:00 a.m. | (8 hours) | 8:00 a.m.-12:00 p.m. | 4:00 p.m.-12:00 a.m. |

| **Clinical Shift in the Emergency Department Tuesday** | **Break Wednesday** | **Conferences Wednesday** | **Clinical Shift in the Emergency Department Wednesday** |
|---|---|---|---|
| 9:00 p.m.-7:00 a.m. | (10 hours) | 7:00 -11:00 a.m. | 9:00 p.m.-7:00 a.m. |


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| Question | Answer |
| --- | --- |
| | Example:<br>If a resident works from 4:00 p.m. to midnight, has a conference from 8:00 a.m. to noon, and then works again at 4:00 p.m., this is compliant, since there is a scheduled eight-hour break in a 24-hour period. There is no expectation for an additional eight-hour break after the conference.<br><br>The Review Committee does not have an expectation regarding time off between block didactic sessions followed by a clinical shift; however, programs must review the appropriateness of resident attendance at conferences following an evening or night shift based on the duration of the program's clinical shifts, didactic schedule, and resident fatigue. Residents should be provided the opportunity to adjust their individual attendance at didactic sessions scheduled between clinical shifts when necessary to mitigate excessive fatigue. The program should ensure the required time off between clinical shifts to allow adequate rest for each resident based on his/her individual schedule. |
| Are residents permitted to moonlight?<br><br>*[Program Requirements: 6.17.a.3., and 6.25.a. and 6.25.b.]* | Emergency medicine residents may moonlight. However, the hours spent moonlighting in the Emergency Department count toward the 72 total hours per week on emergency medicine rotations. Hours spent moonlighting outside of the Emergency Department count toward the 80-hour weekly limit. PGY-1 residents are not permitted to moonlight. |
| Who should be included in interprofessional teams?<br><br>*[Program Requirement: 6.18.a.]* | Interprofessional team members must participate in the education of residents, and may include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists,<br>pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers. |
| When determining the one-day-off in seven, how should at-home call be considered?<br><br>*[Program Requirement: 6.28.]* | At-home call, including sick call or back-up call, should not be assigned during the required one day free from clinical experience and education every week. |
| What are considered on-call hours and how should they be factored when determining clinical and educational work hours?<br><br>*[Program Requirement: 6.28.]* | On-call hours include scheduled sick call or back-up call. When determining clinical and educational work hours, only the hours spent in the hospital after being called in to provide patient care are considered. The clinical and educational work period begins at the time the resident reports for duty. |


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| Question | Answer |
| --- | --- |
| **Other** | |
| Which faculty members should be included in the ADS Faculty Roster? | At a minimum, the program must list the following core faculty members: program director, associate/assistant program director(s) (if applicable), and all other core physician faculty members board certified in emergency medicine to demonstrate the 1:3 ratio of one core faculty member for every three resident positions (II.B.4.c).)<br><br>The ADS system will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member towards the 1:3 ratio.<br><br>Additional core faculty and non-core faculty may be added to the faculty roster at the discretion of the program.<br><br>Note: The program will be required to report scholarly activity for all faculty on the roster, both core and non-core. |
| How must a request for a permanent change in resident complement be submitted? | A request for a change in resident complement must be submitted through ADS. The designated institutional official (DIO) of the Sponsoring Institution must sign off on the change in ADS before it can be processed and acted upon by the Review Committee.<br><br>Additional data that must be submitted with the ADS request may be requested by the Review Committee staff and/or are outlined in the "Requests for Changes in Resident Complement" document posted on the Documents and Resources page of the Emergency Medicine section of the ACGME website. |
| How long does it take for the Review Committee to communicate its decisions regarding complement change requests? | Complement change requests are reviewed in an ad hoc fashion. Typically, the Committee is able to provide a response to a complement change request in approximately two to four weeks. Occasionally, responses to a request may take longer if it is determined that the request will need to be reviewed at the time of the Committee's next meeting.<br><br>Complement increase requests will not be reviewed between the agenda closing date for an upcoming Committee meeting and the last date of that meeting. In order to be reviewed within two to four weeks of submission, all complement increase requests must be submitted through ADS, and approved by the DIO in ADS prior to the agenda closing dates posted on the bottom right-hand side of the Emergency Medicine webpage on the ACGME website. |


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| Question | Answer |
| --- | --- |
| Are emergency medicine residents required to obtain or maintain life support certification(s)? | No, the Review Committee believes residency education in emergency medicine establishes expertise in acute cardiac life support beyond that which is taught in an Advanced Cardiac Life Support, Advanced Trauma Life Support, Basic Life Support, or Pediatric Advanced Life Support certification course. |


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Evaluation Form

Printed on Dec 23, 2025

**ED Block Evaluation of Resident**

Evaluator: ______________________

Evaluation of: ______________________

Date: ____________

| | Below Expect… | Meets Expect… | Exceeds Expect… | NA/Uns… |
|---|---|---|---|---|
| 1. Medical Knowledge* | ☐ | ☐ | ☐ | ☐ |
| 2. Patient Care - Medical Interviewing:* | ☐ | ☐ | ☐ | ☐ |
| 3. Patient Care - Physical/Mental Examination* | ☐ | ☐ | ☐ | ☐ |
| 4. Patient Care - Procedure Skills* | ☐ | ☐ | ☐ | ☐ |
| 5. Trainee's Technical Skills:* | ☐ | ☐ | ☐ | ☐ |
| 6. Use of Lab and Radiologic Tests: Judicious ordering of appropriate and necessary laboratory and radiologic tests in an orderly manner* | ☐ | ☐ | ☐ | ☐ |
| 7. Practice-Based Learning:* | ☐ | ☐ | ☐ | ☐ |
| 8. Continuing Scholarship:* | ☐ | ☐ | ☐ | ☐ |
| 9. Communication and Inerpersonal Skills:* | ☐ | ☐ | ☐ | ☐ |
| 10. Documentation Qualities: Timeliness and content of notes, follow-up comments, treatment summaries:* | ☐ | ☐ | ☐ | ☐ |
| 11. Presentations: Accuracy and thoroughness of presentation* | ☐ | ☐ | ☐ | ☐ |
| 12. Professionalism:* | ☐ | ☐ | ☐ | ☐ |

13. Ethical Behavior: Ethical behavior in the clinical setting* ☐ ☐ ☐ ☐

14. System-Based Practice:* ☐ ☐ ☐ ☐

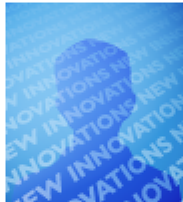
15. Competence: overall competence* ☐ ☐ ☐ ☐

| | No | Yes |
|---|---|---|
| 16. Face to Face Feedback: I have discussed the information within this evaluation with the resident/fellow.* | ☐ | ☐ |
| 17. Supervision - Serious Changes in Clinical Status: The trainee informed me in a timely manner of any serious changes in the clinical status of my patients during this rotation.* | ☐ | ☐ |
| 18. Supervision - Reviewed tests and Interventions Prior to Ordering: The trainee reviewed decisions regarding invasive diagnostic tests, consultations and therapeutic interventions with me prior to ordering, or appropriately as the clinical situation required.* | ☐ | ☐ |
| 19. Supervision - Sought my Advice: The trainee appropriately sought my advice regarding issues in care of my patients.* | ☐ | ☐ |

Strengths: For comments to be effective as feedback, please be directed, specific and constructive. Global adjectives or remarks, such as "good resident" or "bad resident" do not provide meaningful feedback. *

Suggested Areas for Improvement: For any component that needs attention or was rated at a 2 or less, please provide specific comments and recommendations. Be as specific as possible, including reports of critical incidents. Global adjectives or remarks, such as "good resident" or "bad resident" do not provide meaningful feedback. *

Confidential comments to Program Director



**Subject Name**
Status
Employer
Program
Rotation
Evaluation Dates

**Evaluated by:** **Evaluator Name**
Status
Employer
Program

# Resident Peer Evaluation

**Instructions:**
*Please complete the following confidential peer evaluation only if you have worked directly with the resident. If you have not spent enough time with the resident, please mark it NET (not enough time) and you will not receive any reminders. If you have any questions, please contact Jana Ricker at rickej1@mmc.org or 662-7050. Thank you.*

## INTERPERSONAL AND COMMUNICATION SKILLS

**1 Communicates clearly with senior residents**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Comment

## PROFESSIONALISM

**2 Arrives on time and ready to work**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Comment

**3 Maintains a strong pace throughout a shift**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Comment

**4 Responds prompty when called or paged**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**5 Treats co-workers, consultants, and support staff with respect**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

## GENERAL

**6 Commendations and opportunities for improvement**

*Commendations and Opportunities for Improvement:*

*Thank you for taking the time to complete this peer evaluation.*

# Preview Form

medhub

Resident 360 Evaluation

Insufficient contact to evaluate (delete evaluation)

1. Role of person providing evaluation* — Peer

2. Evaluator Name *

49. PGY Year* — 1

51. Evaluation Date *

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 52. Responds appropriately responds to overhead pages* | ○ | ○ | ○ | ○ | ○ |
| 53. Transition of care is thorough yet concise* | ○ | ○ | ○ | ○ | ○ |
| 54. I can call on my peer for support or help on shift* | ○ | ○ | ○ | ○ | ○ |
| 55. Peer has helped me learn* | ○ | ○ | ○ | ○ | ○ |
| 56. Peer serves as a role model as a physician* | ○ | ○ | ○ | ○ | ○ |
| 57. Demonstrates professional behavior towards staff members (RN, tech, social work, case manager, etc.) at all times | ○ | ○ | ○ | ○ | ○ |

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

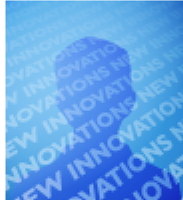
| | | | | | |
|---|---|---|---|---|---|
| 58. Demonstrates professional behavior towards patients and families at all times* | ◯ | ◯ | ◯ | ◯ | ◯ |
| | Always | Some… | Occas… | Never | N/A |
| 59. Peer is compassionate and respectful.* | ◯ | ◯ | ◯ | ◯ | ◯ |
| | Always | Some… | Occas… | Never | N/A |
| 60. Peer is receptive to feedback* | ◯ | ◯ | ◯ | ◯ | ◯ |
| | Always | Some… | Occas… | Never | N/A |
| 61. Peer adjusts behavior based on situation* | ◯ | ◯ | ◯ | ◯ | ◯ |

62. What does the resident do well? *

63. What opportunities for improvement for the resident? *

* Required fields Option description (place mouse over field to view)

Submit Completed Evaluation



**Subject Name**
Status
Employer
Program
Rotation
Evaluation Dates

**Evaluated by:** **Evaluator Name**
Status
Employer
Program

# Resident Evaluation of EM Faculty

**Instructions:**
*These evaluations are completely anonymous.*
*For each of the questions below, please rate the faculty member on a scale of 1-5 and provide written feedback. Comments are highly encouraged.*

**1* The faculty member provides high quality clinical bedside teaching (e.g. practices evidence based medicine, provides teaching during shift, supervises procedures appropriately, etc.) Please state in comment section what the faculty should continue/change/consider.**

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | N/A= Not applicable/Not observed |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**2* The faculty member provides me timely and constructive feedback. Please state in comment section what the faculty should continue/change/consider.**

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | N/A= Not applicable/Not observed |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**3* The faculty member models professional and respectful patient and team interactions. Please state in comment section what the faculty should continue/change/consider.**

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | N/A= Not applicable/Not observed |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**4* The faculty member provides an appropriate balance between supervision and autonomy in the emergency department. Please state in comment section what the faculty should continue/change/consider.**

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | N/A= Not applicable/Not observed |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**5* The faculty member is an active team member with respect to patient care in the emergency department (e.g. helping with notes, following up on results, doing discharges, etc.). Please state in comment section what the faculty should continue/change/consider.**

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | N/A= Not applicable/Not observed |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**6* The faculty member is engaged in residency activities and is an active member of the residency community. What should the faculty continue/change/consider?**

**7 Please feel free to add any additional comments below (e.g. what the faculty member does well, what the faculty member may improve, etc.) All feedback is greatly appreciated.**

**Subject Name**
Status
Employer
Program
Rotation
Evaluation Dates

**Evaluated by:** **Evaluator Name**
Status
Employer
Program

# Resident Evaluation of ED rotation

**Instructions:**
*Please complete this rotation evaluation on the ED rotation you have just completed. Thank you!*

1 **The expectations for this Emergency Department rotation were clear?**

| Not Really | Partially | Most of the Time | All of the Time |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

2 **Faculty and Senior Residents were available to get assistance from with a patient question and/or concern?**

| No Contact with Teaching Faculty and/or Senior Resident | Not Really | Partially | Most of the Time | All of the Time |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

3 **How would you rate the clinical teaching you received during this month long ED rotation?**

| Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Comment

4* **What were the best aspects of this ED rotation?**

5* **Please add any suggestions for improvement or comments regarding your ED rotation experience.**

# Preview Form

medhub

Resident 360 Evaluation

Insufficient contact to evaluate (delete evaluation)

1. Role of person providing evaluation* — ED Staff (RN, RT, Social Worker, Case Managen

2. Evaluator Name *

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 3. Performs initial assessment and necessary patient reassessment in a timely manner* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 4. Explains patient care plan in easy to understand terms* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 5. Responds quickly to patient needs* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 6. Responds to overhead pages* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 7. Responds and intervenes on unstable patient presentations* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 8. Possesses a broad fund of knowledge* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 9. Applies medical knowledge at the bedside* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|---|
| 10. Demonstrates professional behavior towards patients and families* | ○ | ○ | ○ | ○ | ○ |

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

11. Responds to members of the medical team with respect*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

12. Responds calmly in stressful or complex situations*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

13. Takes responsibility for actions*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

14. Listens without interrupting*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

15. Demonstrates compassion and respect*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

16. Establishes rapport easily with patients and families*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

17. Demonstrates effective communication as the leader of the health care team*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

18. Demonstrates receptiveness to feedback*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

19. Adjusts behavior based on situation*

| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

20. Performs patient centered care*

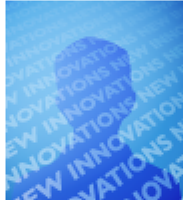
| Always | Some… | Occas… | Never | N/A |
|---|---|---|---|---|

21. Uses available resources to help coordinate patient care*

46. Any additional information or constructive feedback

* Required fields Option description (place mouse over field to view)

Submit Completed Evaluation



**Subject Name**
Status
Employer
Program
Rotation
Evaluation Dates

**Evaluated by:** **Evaluator Name**
Status
Employer
Program

# Resident Self-Evaluation

## 1 Patient Care 1: Emergency Stabilization

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Detects when a patient's vital signs are abnormal<br><br>Assesses a patient's ABCs and performs basic interventions | Identifies a patient who is unstable and requires immediate intervention<br><br>Addresses the unstable vital signs and initiates advanced resuscitation procedures and protocols | Identifies a patient with occult presentation that is at risk for instability or deterioration<br><br>Reassesses the patient's status after implementing a stabilizing intervention | Ascertains, in a timely fashion, when further clinical intervention for a patient is futile<br><br>Integrates hospital support services into the management of critically-ill or -injured patients | Manages patients with rare or complex presentations requiring emergency stabilization |
| ◯ | ◯ ◯ | ◯ ◯ | ◯ ◯ | ◯ ◯ | ◯ |

◯ Not yet assessable

Comment

## 2 Patient Care 2: Performance of a Focused History and Physical Exam

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Elicits and communicates a reliable comprehensive patient history and performs a physical exam | Elicits and communicates a focused patient history and performs a focused physical exam that effectively address the patient's chief complaint and urgent issues | Prioritizes essential components of a patient history and physical exam, given a limited or dynamic circumstance | Using all potential sources of data, gathers those that are necessary for the beneficial management of patients | Models the effective use of a patient history and physical exam to minimize the need for further diagnostic testing |
| ◯ | ◯ ◯ | ◯ ◯ | ◯ ◯ | ◯ ◯ | ◯ |

◯ Not yet assessable

Comment

### 3 Patient Care 3: Diagnostic Studies

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Determines the need for diagnostic studies | Selects appropriate diagnostic studies and reviews the risks, benefits, and contraindications of them | Given a limited or dynamic circumstance, prioritizes the diagnostic studies that are essential | Practices cost-effective ordering of diagnostic studies | Proposes alternatives when barriers exist to specific diagnostic studies |
| | Demonstrates understanding of diagnostic testing principles | Interprets results of diagnostic testing (e.g., electrocardiogram (EKG), diagnostic radiology, point-of-care ultrasound) | Orders and performs diagnostic testing, considering the pre-test probability of disease and the likelihood of test results altering management | Considers the factors that impact post-test probability | In the context of the patient presentation, discriminates between subtle and/or conflicting diagnostic results |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ Not yet assessable

Comment

### 4 Patient Care 4: Diagnosis

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Constructs a list of potential diagnoses based on the patient's chief complaint and initial assessment | Provides a prioritized differential diagnosis | Provides a diagnosis for common medical conditions and demonstrates the ability to modify a diagnosis based on a patient's clinical course and additional data | Provides a diagnosis for patients with multiple comorbidities or uncommon medical conditions, recognizing errors in clinical reasoning | Serves as a role model and educator to other learners for deriving diagnoses and recognizing errors in clinical reasoning |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ Not yet assessable

Comment

**5 Patient Care 5: Pharmacotherapy**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Describes the different classifications of pharmacologic agents<br><br>Consistently asks patients for drug allergies | Selects appropriate agent for therapeutic intervention<br><br>Evaluates for potential adverse effects of pharmacotherapy and drug-to-drug interactions | Considers array of drug therapy and selects appropriate agent based on mechanism of action and intended effect<br><br>Recognizes and acts upon common adverse effects and interactions | Selects the appropriate agent based on patient preferences, allergies, cost, policies, and clinical guidelines<br><br>Recognizes and acts upon uncommon and unanticipated adverse effects and interactions | Participates in developing departmental and/or institutional policies on pharmacy and therapeutics |

○ Not yet assessable

Comment

### 6 Patient Care 6: Reassessment and Disposition

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Describes basic resources available (e.g., follow-up care, rehabilitation, transfer centers) | Makes a disposition decision for patients with routine conditions needing minimal resources | Makes a disposition decision for patients with routine conditions, with resource utilization | Makes disposition decision for patients with complex conditions, with resource utilization | Participates in institutional committees to develop systems that enhance safe patient disposition and maximizes resources |
| | Describes basic patient education plans | Educates patients on simple discharge and admission plans | Educates patients regarding diagnosis, treatment plan, medication review and primary care physician/consultant appointments | Educates patients on complex discharge and admission plans, including complex transfers | Participates in the development of protocols to enhance patient safety |
| | Identifies the need for patient re-evaluation | Monitors that necessary diagnostic and therapeutic interventions are performed | Identifies which patients will require ongoing emergency department evaluation and evaluates the effectiveness of diagnostic and therapeutic interventions | Evaluates changes in clinical status during a patient's emergency department course | |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ Not yet assessable

Comment

### 7 Patient Care 7: Multitasking (Task-Switching)

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Manages a single patient amidst distractions | Task-switches between different patients of similar acuity | Employs task-switching in an efficient manner to manage multiple patients of varying acuity and at varying stages of work-up | Employs task-switching in an efficient manner to manage the emergency department | Employs task switching in an efficient manner to manage the emergency department under high-volume or surge situations |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ Not yet assessable

Comment

**8 Patient Care 8: General Approach to Procedures**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Identifies indications for a procedure and pertinent anatomy and physiology<br>Performs basic therapeutic procedures (e.g., suturing, splinting) | Assesses indications, risks, benefits, and alternatives and obtains informed consent in low-to moderate-risk situations<br>Performs and interprets basic procedures, with assistance<br>Recognizes common complications | Assesses indications, risks, and benefits and weighs alternatives in high-risk situations<br>Performs and interprets advanced procedures, with guidance<br>Manages common complications | Acts to mitigate modifiable risk factors in high-risk situations<br>Independently performs and interprets advanced procedures<br>Independently recognizes and manages complex and uncommon complications | Teaches advanced procedures and independently performs rare, time-sensitive procedures<br>Performs procedural peer review |

Not yet assessable

Comment

**9 Medical Knowledge 1: Scientific Knowledge**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates scientific knowledge of common presentations and conditions | Demonstrates scientific knowledge of complex presentations and conditions | Integrates scientific knowledge of comorbid conditions for complex presentations | Integrates scientific knowledge of uncommon, atypical, or complex comorbid conditions for complex presentations | Pursues and integrates new and emerging knowledge |

Not yet assessable

Comment

### 10 Medical Knowledge 2: Treatment and Clinical Reasoning

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates knowledge of treatment of common conditions | Demonstrates knowledge of treatment of patients with complex conditions | Demonstrates knowledge of the impact of patient factors on treatment | Demonstrates comprehensive knowledge of the varying patterns of disease presentation and alternative and adjuvant treatments of patients | Contributes to the body of knowledge on the varying patterns of disease presentation, and alternative and adjuvant treatments of patients |
| | Identifies types of clinical reasoning errors within patient care, with substantial guidance | Identifies types of clinical reasoning errors within patient care | Applies clinical reasoning principles to retrospectively identify cognitive errors | Continually re-appraises one's clinical reasoning to prospectively minimize cognitive errors and manage uncertainty | Coaches others to recognize and avoid cognitive errors |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ Not yet assessable

Comment

### 11 Systems-Based Practice 1: Patient Safety

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates knowledge of common patient safety events | Identifies system factors that lead to patient safety events | Participates in analysis of patient safety events (simulated or actual) | Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual) | Actively engages teams and processes to modify systems for preventing patient safety events |
| | Demonstrates knowledge of how to report patient safety events | Reports patient safety events through institutional reporting systems (simulated or actual) | Participates in disclosure of patient safety events to patients and families (simulated or actual) | Discloses patient safety events to patients and families (simulated or actual) | Acts as a role model and/or mentor for others in the disclosing of patient safety events |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Comment

**12 Systems-Based Practice 2: Quality Improvement**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates knowledge of basic quality improvement methodologies and metrics | Describes local quality improvement initiatives (e.g., emergency department throughput, testing turnaround times) | Participates in local quality improvement initiatives | Demonstrates the skills required for identifying, developing, implementing, and analyzing a quality improvement project | Creates, implements, and assesses quality improvement initiatives at the institutional or community level |

Comment

**13 Systems-Based Practice 3: System Navigation for Patient-Centered Care**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates knowledge of care coordination | In routine clinical situations, effectively coordinates patient care integrating the roles of interprofessional teams | In complex clinical situations, effectively coordinates patient care by integrating the roles of the interprofessional teams | Serves as a role model, effectively coordinates patient-centered care among different disciplines and specialties | Analyzes the process of care coordination and leads in the design and implementation of improvements |
| | Identifies key elements for safe and effective transitions of care and hand-offs | In routine clinical situations, enables safe and effective transitions of care/hand-offs | In complex clinical situations, enables safe and effective transitions of care/hand-offs | Serves as a role model, advocates for safe and effective transitions of care/hand-offs within and across health care delivery systems, including outpatient settings | Improves quality of transitions of care within and across health care delivery systems to optimize patient outcomes |
| | Demonstrates knowledge of population and community health needs and disparities | Identifies specific population and community health needs and inequities for their local population | Effectively uses local resources to meet the needs of a patient population and community | Participates in changing and adapting practice to provide for the needs of specific populations | Leads innovations and advocates for populations and communities with health care inequities |

Comment

## 14 Systems-Based Practice 4: Physician Role in Health Care Systems

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Identifies key components of the complex health care system (e.g., hospital, skilled nursing facility, finance, personnel, technology) | Describes how components of a complex health care system are interrelated, and how this impacts patient care | Discusses how individual practice affects the broader system (e.g., length of stay, readmission rates, clinical efficiency) | Manages various components of the complex health care system to provide efficient and effective patient care and the transition of care | Advocates for or leads systems change that enhances high value, efficient, and effective patient care, and the transition of care |
| | Describes basic health payment systems, including (e.g., government, private, public, uninsured care) practice models | Delivers care with consideration of each patient's payment model (e.g., insurance type) | Engages patients in shared decision making, informed by each patient's payment models | Advocates for patient care needs with consideration of the limitations of each patient's payment model | Participates in health policy advocacy activities |
| | | Identifies basic knowledge domains required for medical practice (e.g., information technology, legal, billing, coding, financial, and personnel aspects) | Demonstrates efficient integration of information technology required for medical practice (e.g., electronic health record, documentation required for billing and coding) | Describes core administrative knowledge needed for the transition to practice (e.g., contract negotiation, malpractice insurance, government regulation, compliance) | Analyzes individual practice patterns and professional requirements |

Comment

## 15 Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates how to access and use available evidence | Articulates the clinical questions that are necessary to guide evidence-based care | Locates and applies the best available evidence, integrating it with patient preference, to the care of complex patients | Critically appraises and applies evidence even in the face of uncertainty and of conflicting evidence to guide care that is tailored to the individual patient | Coaches others to critically appraise and apply evidence for complex patients, and/or participates in the development of guidelines |

Comment

**16 Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates an openness to performance data (feedback and other input) | Demonstrates an openness to performance data and uses it to develop personal and professional goals | Seeks and accepts performance data for developing personal and professional goals | Using performance data, continually improves and measures the effectiveness of one's personal and professional goals | Acts as a role model for the development of personal and professional goals |
| | | Identifies the factors that contribute to the gap(s) between expectations and actual performance | Analyzes and reflects upon the factors that contribute to gap(s) between expectations and actual performance | Analyzes, reflects on, and institutes behavioral change(s) to narrow the gap(s) between expectations and actual performance | Coaches others on reflective practice |

Comment

**17 Professionalism 1: Professional Behavior and Ethical Principles**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Demonstrates professional behavior in routine situations and in how to report professionalism lapses | Identifies and describes potential triggers and takes responsibility for professionalism lapses | Exhibits professional behavior in complex and/or stressful situations | Sets apart those situations that might trigger professionalism lapses and intervenes to prevent them in oneself and others | Coaches others when their behavior fails to meet professional expectations |
| | Demonstrates knowledge of the ethical principles underlying patient care | Analyzes straightforward situations using ethical principles | Analyzes complex situations using ethical principles, and recognizes the need to seek help in managing and resolving them | Uses appropriate resources for managing and resolving ethical dilemmas | Identifies and addresses system-level factors that either induce or exacerbate ethical problems or impede their resolution |

Comment

**18 Professionalism 2: Accountability/Conscientiousness**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | In routine situations, performs tasks and responsibilities with appropriate attention to detail | In routine situations, performs tasks and responsibilities in a timely manner with appropriate attention to detail | In complex or stressful situations, performs tasks and responsibilities in a timely manner with appropriate attention to detail | Recognizes situations that might impact others' ability to complete tasks and responsibilities | Takes ownership of system outcomes |
| | Responds promptly to requests and reminders to complete tasks and responsibilities | Takes responsibility for failure to complete tasks and responsibilities | Recognizes situations that might impact one's own ability to complete tasks and responsibilities in a timely manner, and describes strategies for ensuring timely task completion in the future | Proactively implements strategies to ensure that the needs of patients, teams, and systems are met | |

Comment

**19 Professionalism 3: Self-Awareness and Well-Being**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Recognizes, with assistance, the status of one's personal and professional well-being | Independently recognizes the status of one's personal and professional well-being and engages in help-seeking behaviors | With assistance, proposes a plan to optimize personal and professional well-being | Independently develops a plan to optimize one's personal and professional well-being | Coaches others when their emotional responses or level of knowledge/skills fail to meet professional expectations |

Comment

**20** **Interpersonal and Communication Skills 1: Patient- and Family-Centered Communication**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Uses language and non-verbal behavior to reflect respect and establish rapport while accurately communicating one's own role within the health care system | Establishes a therapeutic relationship in straightforward encounters with patients using active listening and clear language | Establishes a therapeutic relationship in challenging patient encounters | Easily establishes therapeutic relationships with patients, regardless of the complexity of cases | Acts as a mentor to others in situational awareness and critical self-reflection with the aim of consistently developing positive therapeutic relationships and minimizing communication barriers |
| | Identifies common barriers to effective communication (e.g., language, disability) | Identifies complex barriers to effective communication (e.g., health literacy, cultural, technology) | When prompted, reflects on one's personal biases, while attempting to minimize communication barriers | Independently recognizes personal biases of patients, while attempting to proactively minimize communication barriers | Acts as a role model to exemplify shared decision making in patient/family communication that embodies various degrees of uncertainty/conflict |
| | With insight gained through an assessment of patient/family expectations coupled with an understanding of their health status and treatment options, adjusts one's communication strategies | Organizes and initiates communication with a patient/family by clarifying expectations and verifying one's understanding of the clinical situation | With guidance, sensitively and compassionately delivers medical information to patients, elicits patient/family values, learns their goals and preferences, and acknowledges uncertainty and conflict | Independently uses shared decision making with a patient/family to align their values, goals, and preferences with potential treatment options and ultimately to achieve a personalized care plan | |

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Comment

**21 Interpersonal and Communication Skills 2: Interprofessional and Team Communication**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Respectfully requests a consultation | Clearly and concisely requests a consultation or other resources for patient care | Integrates recommendations made by various members of the health care team to optimize patient care | Acts as a role model for flexible communication strategies, i.e., those strategies that value input from all health care team members and that resolve conflict when needed | Acts as a role model for communication skills necessary to lead or manage health care teams |
| | Uses language that reflects the values all members of the health care team | Communicates information effectively with all health care team members | Engages in active listening to adapt to the communication styles of the team | Uses effective communication to lead or manage health care teams | In complex situations, facilitates regular health care team-based feedback |
| | Receives feedback in a respectful manner | Solicits feedback on performance as a member of the health care team | Communicates concerns and provides feedback to peers and learners | Communicates feedback and constructive criticism to superiors | |

Comment

**22 Interpersonal and Communication Skills 3: Communication within Health Care Systems**

| Not Yet Completed Level 1 | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| | Accurately documents information in the patient's record and safeguards the patient's personal information | Demonstrates organized diagnostic and therapeutic reasoning through the patient record in a timely manner | Concisely reports diagnostic and therapeutic reasoning in the patient record | Communicates clearly, concisely, and contemporaneously in an organized written form, including anticipatory guidance | Models feedback to improve others' written communication |
| | Communicates through appropriate channels as required by institutional policy (e.g., patient safety reports, cell phone/pager usage) | Respectfully communicates concerns about the system | Uses appropriate channels to offer clear and constructive suggestions for improving the system | Initiates difficult conversations with appropriate stakeholders to improve the system | Facilitates dialogue regarding systems issues among larger community stakeholders (e.g., institution, the health care system, and/or the field) |

Comment

**23*** **List your area(s) of strength:**

**24*** **List your area(s) that need improvement:**

**25*** **Describe/list your goals for the next 6 months.**

Overall Comment

# Preview Form

medhub

Resident 360 Evaluation

Insufficient contact to evaluate (delete evaluation)

1. Role of person providing evaluation* — Self

| Question | Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|---|
| 64. Identify patients with occult presentation that are at risk for instability or deterioration* | ○ | ○ | ○ | ○ | ○ |
| 65. I always gather all necessary data from all potential sources in order to manage the patient's condition* | ○ | ○ | ○ | ○ | ○ |
| 66. I always prioritize the diagnostic tests that are essential, even under limited or dynamic circumstances* | ○ | ○ | ○ | ○ | ○ |
| 67. I always provide a diagnosis for patients with multiple comorbidities or uncommon medical conditions* | ○ | ○ | ○ | ○ | ○ |
| 68. I always select the appropriate medication based on patient preferences, allergies, cost, policies, and clinical guidelines* | ○ | ○ | ○ | ○ | ○ |
| 69. I always educate patients regarding diagnosis, treatment plan, medication review, and primary care/specialist appointments* | ○ | ○ | ○ | ○ | ○ |
| 70. I always make appropriate disposition decisions for patients with complex conditions* | ○ | ○ | ○ | ○ | ○ |
| 71. I always task-switch in an efficient manner to manage multiple patients of varying acuity and at varying stages of workup* | ○ | ○ | ○ | ○ | ○ |

| | Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|---|
| 72. I am comfortable with my knowledge about relevant medical illnesses* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 73. I am comfortable with my ability to generate a complete differential diagnosis* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 74. I am comfortable with my own limitations in medical knowledge and seek consultation when appropriate* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 75. I am comfortable with my own limitations in procedural skills and seek consultation when appropriate* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 76. I am able to, and frequently do analyze feedback and my patient care experiences to make improvements in patient care* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 77. I am able to, and frequently do use evidence-based medicine as it relates to my patient's condition and diagnosis* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 78. I am able to, and frequently do consult the medical literature to support my education and improve patient care* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 79. I am able to, and frequently do assist in the education of medical students* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 80. I am able to, and frequently do assist in the education of my physician colleagues* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 81. I am able to, and frequently do assist in the education of other health care professionals (nursing, ancillary staff, etc)* | ◯ | ◯ | ◯ | ◯ | ◯ |
| 82. I am able to, and frequently do apply knowledge of study designs and statistical methods when | ◯ | ◯ | ◯ | ◯ | ◯ |

reviewing scientific studies*

| | Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|---|
| 83. I make a concerted effort to create a personal relationship with every patient* | ○ | ○ | ○ | ○ | ○ |
| 84. I make a concerted effort to communicate the diagnosis, treatment outcomes and expected course with each patient* | ○ | ○ | ○ | ○ | ○ |
| 85. I make a concerted effort to use effective nonverbal and listening skills in every patient encounter* | ○ | ○ | ○ | ○ | ○ |
| 86. I make a concerted effort to communicate with patients and their families in a timely manner* | ○ | ○ | ○ | ○ | ○ |
| 87. I make a concerted effort to communicate in a respectful manner to all professional colleagues, ancillary staff, and hospital personnel* | ○ | ○ | ○ | ○ | ○ |
| 88. I make a concerted effort to complete written and electronic communication that is comprehensive, timely, legible, and easy to follow* | ○ | ○ | ○ | ○ | ○ |
| 89. At all times I demonstrate respect, compassion, and integrity for my patients* | ○ | ○ | ○ | ○ | ○ |
| 90. At all times I demonstrate commitment to ethical principles* | ○ | ○ | ○ | ○ | ○ |
| 91. At all times I demonstrate responsiveness to the needs of my patients and their families* | ○ | ○ | ○ | ○ | ○ |
| 92. At all times I demonstrate commitment to maintaining confidentiality and obtaining informed consent* | ○ | ○ | ○ | ○ | ○ |

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

93. At all times I demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

94. At all times I demonstrate accountability to the needs of society*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

95. At all times I demonstrate accountability to the needs of the profession*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

96. At all times I demonstrate commitment to excellence*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

97. At all times I identify myself to patients and their families*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

98. At all times I am well-groomed and wear professional attire (including name badge)*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

99. At all times I respond to pages or secure chat in a timely manner*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

100. At all times I complete duties necessary to my training and patient care (evaluations, chart completion, on boarding requirements, GME requirements) in an honest and timely manner*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

101. At every opportunity I consider how my practices affect other health care professionals and the hospital system*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

102. At every opportunity I consider how my practices affect the society as a whole*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

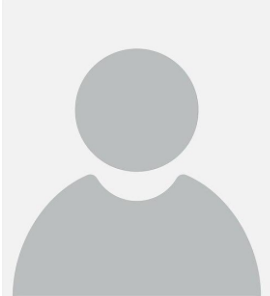
103. At every opportunity I practice cost-effective care and resource allocation that does not compromise quality of care*

| Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|

| | Always | Some… | Occa… | Never | N/A |
|---|---|---|---|---|---|
| 104. At every opportunity I assist patients in managing the complexities of the health care system* | ○ | ○ | ○ | ○ | ○ |
| 105. At every opportunity I look for ways to improve the health care system* | ○ | ○ | ○ | ○ | ○ |

## NURSING EVALUATION FORM

We *appreciate your cooperation in completing this form. Please evaluate the abilities of the resident named below. The purpose of this exercise is to a) rate residents on several dimensions of competence; and b) provide residents with educational feedback.*



**Resident Name**: ______________________________ **PGY Year:** _______

**Nurse: (*optional*)** ____________________________________ **Date of Evaluation:** ______________________

| **PATIENT CARE:** | **Below** | **Meets** | **Exceeds** | **N/A** |
|---|---|---|---|---|
| Listens to patients effectively and allows patients to ask questions | ☐ | ☐ | ☐ | ☐ |
| Educates patient regarding condition, tests, management, and treatment in words patient can understand | ☐ | ☐ | ☐ | ☐ |
| If procedures were performed, were they done safely? | ☐ | ☐ | ☐ | ☐ |
| Updates nurses, patients and families on the status (changes, delays) of the care plan | ☐ | ☐ | ☐ | ☐ |
| **INTERPERSONAL & COMMUNICATION SKILLS/PROFESSIONALISM:** | **Below** | **Meets** | **Exceeds** | **N/A** |
| Communicates clearly | ☐ | ☐ | ☐ | ☐ |
| Is willing to answer questions and provide explanations | ☐ | ☐ | ☐ | ☐ |
| Treats coworkers, consultants, and support staff with respect | ☐ | ☐ | ☐ | ☐ |
| Responds promptly when called or paged | ☐ | ☐ | ☐ | ☐ |

**COMMENTS:** (mandatory for below expectations)

**Subject Name**
Status
Employer
Program
Rotation
Evaluation Dates

**Evaluated by:** **Evaluator Name**
Status
Employer
Program

# Resident Evaluation of Off-Service Rotation

**Instructions:**
*Please complete this rotation evaluation on the rotation you just completed. Thank you!*

**1 The expectations for your off service rotation were clear?**

| Not Really | Partially | More So Than Not | Almost Entirely | Perfectly Clear | N/A |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**2 How would you rate the clinical teaching you received during this rotation?**

| No Contact with Teaching Faculty and/or Senior Resident | Inadequate | Borderline | Good | Excellent | Outstanding |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**3 Learning opportunities were sufficient for the rotation (i.e. conferences, group discussions)?**

| Not Really | Partially | Most of the Time | All of the Time | | | N/A |
|---|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**4 Feedback about my performance was helpful?**

| Not Really | Partially | Most of the Time | All of the Time | | | N/A |
|---|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Comment

**5* What were the best aspects of this off service rotation?**

6* **What suggestions for improvement do you have or comments on this rotation? Please list the rotation and be specific.**

7 **Resident duty hours: please check off the one that best applies to the average number of work hours PER WEEK for the block.**

| Under 40 hours/week | Between 40-50 hours/week | Between 50-60 hours/week | Between 60-70 hours/week | Between 70-80 hours/week | More than 80 hours/week |
|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

8 **If your worked more than 80 hours per week, how many more and why?**

9 **During this rotation, did you work more than 30 consecutive hours?**

◯ Yes
◯ No

10 **During this rotation, did you have at least 10 hours off between shift assignments?**

◯ Yes
◯ No

# Preview Form

medhub

Resident 360 Evaluation

Insufficient contact to evaluate (delete evaluation)

1. Role of person providing evaluation* — Patient - English

22. Date of the visit to the Emergency Department *

| Question | Yes, definit... | Yes, some... | No, some... | No | Not applic... |
|---|---|---|---|---|---|
| 23. Did this doctor listen carefully to you?* | ○ | ○ | ○ | ○ | ○ |
| 24. Did this doctor explain things in a way that was easy to understand?* | ○ | ○ | ○ | ○ | ○ |
| 25. Did this doctor tell you what your medical problem was?* | ○ | ○ | ○ | ○ | ○ |
| 26. Did this doctor tell you the results of any medical tests or x-rays?* | ○ | ○ | ○ | ○ | ○ |
| 27. Did this doctor tell you how to improve your medical condition?* | ○ | ○ | ○ | ○ | ○ |
| 28. Did this doctor ask about your preferences for treatment choices?* | ○ | ○ | ○ | ○ | ○ |
| 29. Did this doctor ask about your known medical conditions, medications, or allergies?* | ○ | ○ | ○ | ○ | ○ |

| | Yes, definit… | Yes, some… | No, some… | No | Not applic… |
|---|---|---|---|---|---|
| 30. Did this doctor spend enough time with you?* | ○ | ○ | ○ | ○ | ○ |

| | Yes, definit… | Yes, some… | No, some… | No | Not applic… |
|---|---|---|---|---|---|
| 31. Did this doctor show you respect and treat you with dignity?* | ○ | ○ | ○ | ○ | ○ |

| | Yes, definit… | Yes, some… | No, some… | No | Not applic… |
|---|---|---|---|---|---|
| 32. Did this doctor ask if you had any questions?* | ○ | ○ | ○ | ○ | ○ |

| | Yes, definit… | Yes, some… | No, some… | No | Not applic… |
|---|---|---|---|---|---|
| 33. Did this doctor ask you about your pain?* | ○ | ○ | ○ | ○ | ○ |

46. Any additional information or constructive feedback

* Required fields Option description (place mouse over field to view)

Submit Completed Evaluation

## PATIENT EVALUATION FORM

We *appreciate your cooperation in completing this form. Please evaluate the abilities of the resident named below. The purpose of this exercise is to a) rate residents on several dimensions of competence; and b) provide residents with educational feedback.*

**Resident Name**: ________________________________ **PGY Year: _____**

**Date of Evaluation:** ____________________

1. Did your doctor introduce herself/himself to you? ___Yes ___No

2. Did your doctor discuss the plan of care for you and tell you what to expect before leaving the room? ___Yes ___No

3. Did your doctor ask you if you had any questions? ___Yes ___No

4. Did your doctor treat you with respect? ___Yes ___No

**COMMENTS:**

{Date}

This is the final summative evaluation for {resident name, MD/DO}.  {Name} entered training on 6/30/2021 and successfully completed all training requirements at Loma Linda University Medical Center on 6/30/2024. There were no disruptions in training.

Our residents perform clinical emergency medicine training at both Loma Linda University Medical Center & Children's Hospital and St. Bernardine Medical Center. The combined emergency department census of our three training sites is over 240,000 per year and provides extensive experience in all facets of emergency medicine including pediatrics. Additional training EMS, ultrasound, critical care and international emergency medicine is also offered to our residents during their training with us.

.

Dr. {name}'s Emergency Medicine related procedural competency meets or exceeds expectations (see attached procedure log).  In the 6 general competencies {name}'s final assessments were as follows:

Patient Care - {marginal/competent/outstanding}
Medical Knowledge - {marginal/competent/outstanding}
Interpersonal and Communication Skills - {marginal/competent/outstanding}
Systems Based Practice - {marginal/competent/outstanding}
Practice Based Learning Improvement - {marginal/competent/outstanding}
Professionalism-{marginal/competent/outstanding}

Dr. {name} completed a scholarly activity regarding {topic} resulting in {publication/presentation/submission}.  Dr. {name} gave presentations on {PEM/senior} during training.  Dr. {name} was a member of the EM Quality Improvement Committee and Program Evaluation Committee while a resident.

{Notable skills, extracurriculars, chief, other}

{Probation/extension of training/other}

I verify Dr. {name} has successfully completed all requirements of the Loma Linda University Emergency Medicine Residency training program and has demonstrated the knowledge, skills and behaviors necessary to enter autonomous practice.

(PD Signature Line)

PGY-1 Spring Personalized Performance Improvement Plan
Name
Date

Dr. X and I met today for his/her PGY-1 Spring Personalized Performance Improvement plan. We have recently had our CCC meeting, and we thoroughly discussed his/her portfolio at that meeting. Dr. X is mapped to the milestones and her progress is documented in New Innovations.

Administrative Comments:

Conference attendance: ___%, _______ cumulative average over residency.

ROSH Review: ___ %, ____current through

Step 3 Complete:

QI:
EM Guidelines:

Procedure logs: ______, Class Range: _______

PSQI Requirement: ______; ___/19 steps completed.

In-Service Scores: Raw, Percentile, Chance of Passing
PGY1: ____%, _____% chance of passing.

Educational Strategy:

Academic Project Status:

Patients per shift:
Average patients per shift for the class:

Mentor:

Future Plans:

Milestones

Areas of strength:

1)

Areas of opportunity:

1)

CCC Reviewer:

Overall milestone average:

Milestone Range:

Overall, Dr. X is at the expected level of competency and is making adequate progress through all the Milestones. The CCC unanimously agrees that Dr. xxxxx has achieved sufficient progress on the milestones in EM for the promotion to PGY-2 year.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Name | Name |
| Emergency Medicine Resident | Residency Program Director |
| ______________________________ | ______________________________ |
| Date | Date |

{Date}

This is the final summative evaluation for {resident name, MD/DO}.  {Name} entered training on 6/30/2021 and successfully completed all training requirements at Loma Linda University Medical Center on 6/30/2024. There were no disruptions in training.

Our residents perform clinical emergency medicine training at both Loma Linda University Medical Center & Children's Hospital and St. Bernardine Medical Center. The combined emergency department census of our three training sites is over 240,000 per year and provides extensive experience in all facets of emergency medicine including pediatrics. Additional training EMS, ultrasound, critical care and international emergency medicine is also offered to our residents during their training with us.
.

Dr. {name}'s Emergency Medicine related procedural competency meets or exceeds expectations (see attached procedure log).  In the 6 general competencies {name}'s final assessments were as follows:

Patient Care - {marginal/competent/outstanding}
Medical Knowledge - {marginal/competent/outstanding}
Interpersonal and Communication Skills - {marginal/competent/outstanding}
Systems Based Practice - {marginal/competent/outstanding}
Practice Based Learning Improvement - {marginal/competent/outstanding}
Professionalism-{marginal/competent/outstanding}

Dr. {name} completed a scholarly activity regarding {topic} resulting in {publication/presentation/submission}.  Dr. {name} gave presentations on {PEM/senior} during training.  Dr. {name} was a member of the EM Quality Improvement Committee and Program Evaluation Committee while a resident.

{Notable skills, extracurriculars, chief, other}

{Probation/extension of training/other}

I verify Dr. {name} has successfully completed all requirements of the Loma Linda University Emergency Medicine Residency training program and has demonstrated the knowledge, skills and behaviors necessary to enter autonomous practice.

(PD Signature Line)

Final Personalized Performance Improvement Plan
Name
Date

Dr. x and I met today for his/her PGY-3 Final Personalized Performance Improvement Plan. We have recently had our CCC meeting, and we thoroughly discussed his/her portfolio at that meeting. Dr. x is mapped to the milestones and her progress is documented in New Innovations.

Administrative Comments:

Conference attendance:.

ROSH Review:

Step 3 Complete:

QI

EM Guidelines-

Procedure logs:

PSQI Requirement

In-Service Scores: Raw, Percentile, Chance of Passing
PGY1:
PGY2:
PGY3:

Academic Project Status:

Patients per shift
Average patients per shifts for class

Mentor:

Milestones

Areas of strength:

1)

Areas of opportunity:

1)

CCC Reviewer:
Summative Comments:

Overall milestone average:
Milestone Range:

Overall, Dr. x is at the expected level of competency and is making adequate progress through the Milestones. The CCC unanimously agrees that Dr x has achieved sufficient progress on the milestones in EM for the promotion of graduation. Dr. x has achieved professional ability to practice competently and independently.

Dr. x has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice of Emergency Medicine.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Name | Name |
| Emergency Medicine Resident | Residency Program Director |
| ______________________________ | ______________________________ |
| Date | Date |

# Orientation List

| GME/Institutional | Date |
| --- | --- |
| • GME Orientation contains<br>  • PALS<br>  • ACLS<br>  • ATLS<br>  • Institutional E-learns<br>  • EPIC trainings<br>  • Central Line course | |

## Department Specific | Date

- Shadow shifts
  - 1 hour w/ RN
  - 3 hours w/ EM Resident
  - Complete scavenger hunt while in ED
- Lunch meeting w/ Residency Leadership
  - PD, APD, & PC
- Dinner w/ Chief Residents
- Procedure bootcamp
- US bootcamp
- Meetings w/ key faculty members (examples)
  - PD & APD
  - Chief of ED
  - EM documentation
  - Research & Opioids
  - Class Assistant Program Director
  - EMS team
  - QI
  - Residents

## Department Specific — Date

- Teamwork, consults, efficiency, and what I wish I knew as an Intern
- Child Life advocates
- ED Nursing leadership
- PT, OT, and Speech
- ED Care Coordinators
- Program Coordinator

## Fun Events

- Graduation
- Intern Welcome Picnic

| Date | 8:00- | Program Overview- w/ PD | | | | | |
|---|---|---|---|---|---|---|---|
| Applicant Names & Medical School | | **9:15-9:40 am** | **9:45-10:10 am** | **10:15-10:40 am** | | | **10:50-11:15 am** |
| Applicant 1 | **Faculty** | 1 | 7 | 9 | | **Facult** | 11 |
| Applicant 2 | **Faculty** | | | | | **Facult** | |
| Applicant 3 | **Faculty** | 2 | 8 | 10 | | **Facult** | 12 |
| Applicant 4 | **Faculty** | | | | | **Facult** | |
| Applicant 5 | **Faculty** | 3 | 1 | 7 | | **Facult** | 9 |
| Applicant 6 | **Faculty** | | | | | **Facult** | |
| Applicant 7 | **Faculty** | 4 | 2 | 8 | | **Facult** | 10 |
| Applicant 8 | **Faculty** | | | | | **Facult** | |
| Applicant 9 | | **9:15-9:45** | **9:45-10:15** | **10:15-10:45** | | | **10:50-11:20** |
| Applicant 10 | **PD** | 5/ 6 | 3/ 4 | 1/ 2 | | **PD** | 7/ 8 |
| Applicant 11 | **APD** | 6/ 5 | 4/ 3 | 2/ 1 | | **APD** | 8/ 7 |
| Applicant 12 | | | | | | | |
| | **Break** | 7 | 9 | 11 | | **Break** | 5 |
| | **Break** | 8 | 10 | 12 | | **Break** | 6 |
| | **Break** | 9 | 11 | 5 | | **Break** | 3 |
| | **Break** | 10 | 12 | 6 | **5 min. Break** | **Break** | 4 |
| | **Break** | 11 | 5 | 3 | | **Break** | |
| | **Break** | 12 | 6 | 4 | | **Break** | |

| | |
|---|---|
| **To** | |
| **Cc** | |
| **Bcc** | PersonPersonPersonPersonPersonPersonPersonPerson |
| **Subject** | Program Name Interview Decisions |

Your application to the Emergency Medicine Residency training program at Program Name has been reviewed. We believe you have a solid application and would be a good candidate for our Residency program. Unfortunately, at this time our interview schedule is full.

To this point we have received over 1,000 applications to the program and have scheduled approximately 100 individuals out of that group for interviews.

*<u>Because of your strong credentials and candidate portfolio, we would like to put you on our waiting list for an interview slot.</u>* If an opening occurs, we would contact those on the list and fill the vacancy on a first-come, first-served basis. Please note that this is a very select group on our waiting list, and that if an opening occurs you are considered to be on equal standing with anyone else we interview. Interviewers are not aware whether an applicant came in off the waiting list or not.

If you are interested in a spot on the waiting list, please respond to xxx ASAP. We make every effort to broadcast openings at the earliest possible time so that candidates can make travel arrangements well ahead of the date.

Thank you,