Accreditation Overview

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

As part of the accreditation process, program information is collected from a variety of sources, including: program-specific information provided by the program director and entered into the ACGME-I’s Accreditation Data System (ADS), the Advanced Specialty Program Information Form (AS-PIF); Resident and Faculty Survey question responses; case and procedural logs; and information collected by site visitors as part of the site visit. Information entered into ADS contains questions related to the IFPR and the AS-PIF contains questions related to Advanced Specialty Requirements.

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

This Program Director Guide to the International Foundational Requirements includes explanations of the intent of most foundational requirements, suggestions for implementing requirements, and bulleted guidelines for the types of expected documentation. The explanations and expected documentation in this Guide relate only to the IFPR. Program directors should consult their Advanced Specialty Requirements and AS-PIF for additional information.

To enhance usability, the Guide has been organized to follow the numbering of the IFPR. The Guide is intended to clarify the meaning and expectations of the IFPR. It will be regularly revised based on user feedback, and as requirements change. Please e-mail comments and suggestions to acgme-i@acgme-i.org, with “Foundation Guide” in the subject line.

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# Foundational Requirements Content Outline

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Links to additional useful resources:
- [ACGME-I Glossary of Terms](#)
- [Institutional Requirements](#)
- [Foundational Requirements](#)
This Program Director Guide to the IFPR is prepared by ACGME-I staff members. It is a guide. It does not supplant the Foundational, Advanced Specialty, and Institutional Requirements, which are far more specific, complex, and comprehensive.

This Guide is intended to be consistent with all International Foundational, International Advanced Specialty, and International Institutional Requirements. Insofar as there may be any actual or perceived inconsistencies, the International Foundational, International Advanced Specialty, and International Institutional requirements will control.

Insofar as this Guide may mention a type of verification of facts during the site visit (e.g., interview of residents), it is not intended to limit the mode or source of verification during a site visit or otherwise.
I. Institutions
   A. Sponsoring Institution

Foundational Requirement:

1. One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

2. The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his/her educational and administrative responsibilities to the program.

Explanation:
Since requirements in this section are for institutions, not programs, verification by the ACGME-I site visitor takes place at the time of each program review primarily through the interview with the DIO and Department Chair. Although program directors should be knowledgeable of these requirements, they are not responsible for providing the documentation noted in this section. Requirements cover four areas: institutional information, internal review, physical/clinical facilities, and accreditation for patient care. (See International Institutional Requirements [IIR].)

Institutional information:
An accredited residency program must operate under the authority and control of a single sponsoring institution, and that institution must document its commitment to provide the necessary educational, financial, and human resources to support GME. (See IIR I.A. and IIR I.B.)

Internal review:
The internal review is a formal, mid-cycle review conducted at the institutional level by the Graduate Medical Education Committee (GMEC) and does not substitute for the annual self-evaluation that each program is required to conduct (see IFPR V.D). The GMEC-sponsored internal review group must include at least one faculty member and at least one resident from within the sponsoring institution, but not from within the program being reviewed. Additional internal or external reviewers may be included, as well as administrators from outside the program. (See IIR IV.A for additional information on what is assessed and the types of data used in the review process.) The Internal review report (findings and conclusions) is not shown to the site visitor at any time during a program review. The site visitor needs information about the date of the internal review, composition of the review panel, individuals interviewed, materials reviewed, and when the internal review report was reviewed by the GMEC.

Internal review reports are reviewed by the site visitor only during an institutional accreditation site visit. The reports should not be included with required downloaded documents in ADS, or provided or shown to the site visitor during a program site visit. When the site visitor reviews one or more programs and the sponsoring institution during the same week, the DIO is asked to omit from the institutional review materials
I. Institutions
   A. Sponsoring Institution

sent to the site visitor the internal review report(s) for any of its program(s) being reviewed that same week.

Physical/clinical facilities:
Institutions must provide services that help to ensure that residents do not perform work extraneous to achieving educational goals and objectives. This includes patient support services, such as peripheral IV access placement, phlebotomy, laboratory/pathology/radiology services, messenger and transport services, and medical records systems. Institutions must also provide resources that ensure a healthy and safe work environment for residents. This includes: access to food 24 hours a day; call rooms that are safe, quiet, and private; security and safety measures, including parking facilities, on-call quarters, hospital and institutional grounds, etc. (See IIR II.F.2.) Institutions must also provide both faculty members and residents with ready access to adequate communication resources and technology support, and to specialty-/subspecialty-specific and other appropriate reference material in print or electronic format, including electronic medical literature databases with search capabilities. (See IIR I.B.6-7.)

Patient care:
Sponsoring institutions should be accredited by the Joint Commission International (JC-I) or should be recognized by another entity with reasonably equivalent standards as determined by the ACGME-I. (See IIR I.D.)

- **Documentation of the internal review:** The site visitor will look for evidence that the internal review occurred approximately at the mid-point between the last and the current review, that the review group included a resident/fellow and a representative of institutional administration, that the review included interviews with program faculty members and residents/fellows, and that the GMEC reviewed the report and monitored appropriate follow-up. This information can be provided by the program director or DIO through a cover sheet of the actual internal review report, through copies of the GMEC meeting agendas, or through a single page summary that contains the relevant information. The report itself is *not* reviewed by the site visitor.

- **Documentation for physical/clinical facilities:** The adequacy of physical and clinical facilities will be verified during the site visit through resident interviews. The site visitor may also tour facilities if there were prior citations relating to these areas, if concerns are raised during the site visit, or if the ACGME-I has Advanced Specialty Requirements for the program's patient care or educational facilities. There may be Advanced Specialty Requirements for resources. (See AS-PR II.)

- **Documentation for patient care:** The site visitor may verify patient care accreditation status with JC-I (or another recognized entity) through database information, and may clarify and verify information during the DIO interview by review of the accreditation letter.
II. Program Personnel and Resources
   A. Program Director

   Foundational Requirement:

   1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. The PLA should:
      a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
      b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
      c) specify the duration and content of the educational experience; and,
      d) state the policies and procedures that will govern resident education during the assignment.

   2. The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents through the ACGME-I Accreditation Data System (ADS)

   Explanation:
   Program directors are responsible for Program Letters of Agreement (PLAs), although the DIO may oversee this process. Agreements should be in place for all sites, including those used only for elective assignments and those under the same governance as the sponsoring institution. [Governance is defined as consistent management with cohesive policies, processes, and decision rights for a given area of responsibility; defining expectations, granting power, verifying performance.]

   The primary purposes of PLAs are to ensure an appropriate educational experience and to protect residents from undue service requirements that do not enrich their education. PLAs are intended to be short, less formal documents. A PLA can be a simple letter or memo, signed by the program director and the official at the participating site who is responsible for supervising and overseeing resident education at that location (e.g., the local site director or the medical director). A PLA must include four items of information:
   - The site director(s) (by name or general group) who teach(es) and supervise(s) residents;
   - The responsibilities for teaching, supervising, and formal evaluation of residents;
   - The duration of experience at the site in each year of the program, the specific educational purpose of the experience, and the content (both clinical experiences and formal didactics) of the educational experience. The explanation does not need to be a curriculum document; it can be a descriptive paragraph that identifies the goal(s) and learning outcomes for the assignment or a reference to a more thorough explanation in the resident handbook; and,
   - The policies and procedures governing resident education at this site. (This may be a statement that residents must abide by the policies of the site and those of the program and the GMEC.)
II. Program Personnel and Resources
   A. Program Director

Additions or deletions of a participating site that provides an educational experience must be submitted in ADS. Information to be entered in ADS for each participating site includes the distance (in miles) and time (in minutes) from the primary teaching site.

- **Documentation for PLAs:** On program applications, all current PLAs are uploaded into ADS. For programs seeking Continued Accreditation, the current PLAs should be available for the site visitor. All PLAs should contain the four items listed above (1.a through d), as well as the required signatures and a date more recent than five years old. Agreements should be updated whenever there are changes in program director or site director or resident assignments, or whenever there are revisions to the items specified in the IFPR or the Specialty Requirements.

ADS will request information on whether each site is a primary teaching site, if the site is a required rotation, and if all residents rotate through the site. It will also request information on the number of months residents will spend at the site during each year of the program and the distance the site is from the primary teaching facility. ADS will also ask for a brief description of the content of the educational experience at the site, including faculty coverage, volume and variety of clinical experience, site support, and the impact of the site on the overall education of residents. **Please be sure to indicate in this section who will serve as the site director.** Finally, ADS will ask about resources available at the site, such as sleeping rooms, showers, secure areas, cafeteria etc.
II. Program Personnel and Resources  
A. Program Director

Foundational Requirement:

1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME-I via the ADS.

2. The program director should continue in his/her position for a length of time adequate to maintain continuity of leadership and program stability.

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

4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME-I competency areas. The program director must:
   a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
   b) must dedicate no less that 50% (a minimum of 20 hours per week) of his/her professional effort to the administrative and educational activities of the educational program;
   c) approve a local director at each participating site who is accountable for resident education;
   d) approve the selection of program faculty as appropriate;
   e) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
   f) monitor resident supervision at all participating institutions;
   g) prepare and submit all information required and requested by the ACGME-I, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
   h) provide each resident with documented semiannual evaluation of performance with feedback;
   i) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
   j) provide verification of residency education for all residents, including those who leave the program prior to completion;
   k) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment and must:
      (1) distribute these policies and procedures to the residents and faculty;
      (2) monitor resident duty hours, according to institutional and program
II. Program Personnel and Resources
   A. Program Director

   Explanation:
   The sponsoring institution’s GMEC must first approve a change in program director, and then the program director must submit the change in ADS. Programs that have a history of frequent changes may trigger additional inquiry into the cause(s) in order to determine if the learning environment has been adversely affected. A single person (program director) must have authority for the operation of the program.

   Qualifications:
   Qualifications for program directors include: specialty expertise; educational and administrative experience; current medical licensure; appropriate medical staff policies, with a frequency sufficient to ensure compliance with ACGME-I requirements;
   (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
   (4) monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable.

   l) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
   m) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents.
   n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME-I information or requests for the following:
      (1) all applications for ACGME-I accreditation of new programs;
      (2) changes in resident complement;
      (3) major changes in program structure or length of training;
      (4) progress reports requested by the ACGME-I Review Committee;
      (5) responses to all proposed adverse actions;
      (6) voluntary withdrawals of ACGME-I accredited programs;
      (7) requests for appeal of an adverse action; and,
      (8) appeal presentations to ACGME-I Review Committee.

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

appointment; and current certification in the specialty acceptable to the ACGME-I, such as from the Royal College of Physicians and Surgeons, Arab Board, American board of Medical Specialties (ABMS), American Board of Medical Specialties-International (ABMS-I), etc. An ACGME-I Review Committee will consider alternative specialty qualifications, but approval should be obtained in advance of appointing such a program director.

Responsibilities:
The IFPR contain a list of program director responsibilities (IFPR II.A.4.). This extensive list is intended not only to communicate the specific responsibilities of the position so that the individual will be effective as a program director, but also to communicate to the sponsoring institution (i.e., to the DIO, GMEC, department chair) the role and responsibilities of this position and why the program director needs sufficient protected time and financial support (IFPR I.A.2) to fulfill these responsibilities. By ensuring that each of the listed duties occurs on a regular basis, the program director will facilitate an enhanced learning environment. For example, the program director “must approve the selection of program faculty as appropriate.” Typically, the department chair will make such assignments, but the program director must have input into these decisions so that faculty members with both clinical and teaching expertise are given responsibilities in the program.

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

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

When preparing for a site visit, the program director is cautioned to prepare ADS information and AS-PIF documents carefully to avoid inaccuracies, discrepancies, and/or inconsistencies.

- **Documentation for program director qualifications:** Program director qualifications will be documented through information entered in ADS. Verification that the program director has a current medical license and medical specialty certification occurs through the institutional credentialing process. Site visitors verify that the program director has an appropriate medical staff appointment.
II. Program Personnel and Resources
   A. Program Director

- **Documentation for program director responsibilities:** The site visitor may spot-check information that the program director must provide to residents and faculty members, and use interviews to verify that the program director organizes and oversees the educational activities at all sites, and ensures implementation of fair policies, grievance, and due process procedures. Note the list of 10 items of information that need review and approval by the GMEC/DIO before submitting to the ACGME-I. (See IFPR II.A.4.n.(1)-(8) above.) In addition, any document addressing program citations or program changes that would have significant impact (e.g., change in program director, see IFPR II.A.4.o. (1)-(2)) must have DIO approval by signature. Other information, such as board scores, mid-level examination pass rates, Resident Survey, Case Logs, resident duty hour compliance data, and any resident remediation, may be examined and confirmed during a site visit.

   ADS will request the following information on the program director:
   - Medical school and date of degree
   - Names and dates of graduate medical education programs
   - Licensures with expiration dates
   - Academic appointments for the last 10 years, with dates
   - Concise summary of roles and responsibilities in the program
   - A listing of up to 10 professional activities and committees within the last five years
   - A listing of the most representative peer-reviewed publications from the last five years, limit 10
   - A listing of selected review articles, chapters, and/or textbooks within the last five years, limit 10
   - Participation in local, regional, and national activities/presentations within the last five years, limit 10
II. Program Personnel and Resources  
B. Faculty  
C. Other Program Personnel

Foundational Requirement:

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<th>B. Faculty</th>
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<td>a) There must be a sufficient number of (physician and non-physician) faculty with documented qualifications to instruct and supervise all residents for the program.</td>
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| b) A portion of the faculty must be core physician faculty who:  
  a) are expect evaluators of the competency domains;  
  b) work closely with and support the program director;  
  c) assist in developing and implementing evaluation systems;  
  d) teach and advise residents; and,  
  e) devote a minimum of 15 hours per week to resident education and administration. |
| c) All faculty must:  
  a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and to demonstrate a strong interest in the education of residents;  
  b) administer and maintain an educational environment conducive to educating residents in each of the ACGME-I competency areas;  
  c) participate in faculty development programs designated to enhance the effectiveness of their teaching and to promote scholarly activity;  
  d) establish and maintain an environment of inquiry and scholarship with an active research component.  
  (1) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.  
  (2) Some members of the faculty should also demonstrate scholarship by one or more of the following:  
    a) peer-reviewed funding;  
    b) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;  
    c) publication or presentation of case reports or peer-reviewed educational seminars, or clinical series at local, regional, or national professional and scientific society meetings; or,  
    d) participation in national committees or educational organizations. |
| d) All physician faculty must:  
  a) have current ABMS certification in the program specialty or possess qualifications acceptable to the ACGME-I Review Committee; and possess current medical licensure and appropriate medical staff appointment. |
II. Program Personnel and Resources
   B. Faculty
   C. Other Program Personnel

   Explanation:
   Requirements for faculty members include qualifications in the specialty, time for and dedication to resident education (including the competency areas), and scholarship.

   Qualifications:
   Physician faculty members must have current certification in the specialty, such as by the Royal College, Arab Board, ABMS, or ABMS-I, or possess other qualifications that are acceptable to a Review Committee. When reviewing qualifications, a Review Committee will consider the faculty member’s scholarship, training, teaching experience, and national reputation.

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

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

- Peer-reviewed funding;
- Publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
- Publication or presentation of case reports or clinical series at local, regional, national, or international professional and scientific society meetings; or,
- Participation in national or international committees or educational organizations. Examples include serving on a committee or governing board or serving as a reviewer or editorial board member.

Other Program Personnel:
In addition to faculty members, the program must have adequate support from clerical, research, and technical staff members, and from other health care providers in the delivery of care. Specific requirements for other personnel will vary with the specialty and will be documented as part of the AS-PIF.

- **Documentation for faculty:** Data related to program personnel qualifications, roles, etc. are entered into ADS. This information should be updated as needed. Information requested in ADS is listed below.

  Additionally, questions in the area of Educational Content from the Resident Survey will be used to verify whether the program provides opportunities to participate in research or scholarly activity, and questions in the area of Faculty will be used to verify faculty member interest in teaching and resident education. The Faculty Survey also asks core faculty members questions related to sufficient time for resident supervision and to their involvement with residents on a scholarly project.

Verification by the site visitor includes interviews with faculty members and residents. Non-compliance related to faculty scholarship will be noted if the site visitor discerns a consensus view among residents that lack of scholarship or lack of an environment of inquiry and scholarship is an issue. In such a case, the site visitor would seek corroboration for lack of substantial evidence of faculty participation in rounds, conferences, journal clubs, grant-related activities, peer-reviewed
II. Program Personnel and Resources
   B. Faculty
   C. Other Program Personnel

publications, and/or presentations at national meetings, and for little evidence of resident participation in scholarly activity.

ADS will request the following information on core faculty members:

- Medical school and date of degree
- Names and dates of graduate medical education programs
- Licensures with expiration dates
- Academic appointments for the last 10 years, with dates
- Concise summary of roles and responsibilities in the program
- A listing of up to 10 professional activities and committees within the last five years
- A listing of the most representative peer-reviewed publications from the last five years, limit 10
- A listing of selected review articles, chapters, and/or textbooks within the last five years, limit 10
- Participation in local, regional, and national activities/presentations within the last five years, limit 10
- Number of hours per week the faculty member devotes to the program in each of the following areas, clinical supervision of residents, administration of the program, research/scholarly activity with residents, and didactic teaching with residents as well as the total hours the faculty member devotes each week to the program.

ADS will also request information on certification equivalencies for faculty members who do not have certification from the Royal College, Arab Board, ABMS, or ABMS-I. When completing this information, it is important to provide additional information on the agency or certifying body conferring the certification if that body is not listed in the drop-down menu in ADS. In addition, for program applications, ADS will request a description of how the program will ensure that faculty members have sufficient time to supervise and teach residents, including time spent in activities such as conferences, rounds, and journal clubs.

- **Documentation for Other Program Personnel:** For both program applications and programs seeking Continued Accreditation, ADS will request a listing of all non-physician faculty members who have documented qualifications to instruct and supervise all residents in the program. Information must be entered on each non-physician faculty member’s degree, specialty or field, and number of years teaching in the specialty. For program applications, additional information on academic appointments in the last 10 years, summary of the faculty member’s role in the program, current professional activities, peer-reviewed publications (limit 10), review articles, chapters, or textbooks (limit 10) and participation in local, regional, and nationals activities (limit 10) is also requested.

Non-physician faculty members do not receive the Faculty Survey; however, Resident Survey questions in the area of Faculty will provide the site visitor with
II. Program Personnel and Resources
   B. Faculty
   C. Other Program Personnel

   information on resident satisfaction with education and supervision from staff and non-physician faculty members. The site visitor may have follow-up questions.
II. Program Personnel and Resources
   D. Resources
   E. Medical Information Access

Foundational Requirement:

D. Resources
1. The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

   2. There must be sufficient patient population of different ages and gender, with a variety of ethnic, racial, socio-cultural and economic backgrounds, having a range of clinical problems to meet the program’s educational goals. Insufficient patient experience does not meet educational needs, and excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize their educational experience.

   3. Residents must have software resources to produce presentations, manuscripts, etc.

   [As further specified by Advanced Specialty PRs]

E. Medical Information Access
1. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

Explanation:
The resources listed below represent general requirements contained in the International Institutional Requirements (IIR II.F.2.) that must be available for all programs.

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

Institutions are responsible for providing ready access to reference material in print or electronic format (IIR I.B.7.). Program sites that have online reference materials are expected to provide residents with access. Typically, this means that residents have access to computers with Internet access in rooms that are conveniently located, easily accessible, and secure. If online access is not possible, then access to a collection of specialty-specific print materials is required.

There may be additional specialty-specific requirements in the Advanced Specialty Requirements that address resources such as space/equipment/support services for the educational activities of the program, resources for specific clinical activities, or adequate defined patient population(s) for specific clinical activities. Program directors should consult these requirements.
II. Program Personnel and Resources  
   D. Resources  
   E. Medical Information Access

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

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

- **Documentation for medical information access:** This is provided through the Resident Survey, through questions in the area of Resources. The site visitor may use interviews and inspection of facilities for additional verification.
III. Resident Appointments

A. Eligibility

B. Number of Residents

C. Resident Transfers

D. Appointment of Fellows and Other Learners

Foundational Requirement:

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the ACGME-I Institutional Requirements.

B. Number of Residents

The program director may not appoint more residents than approved by the ACGME-I Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of residents appointed to the program. There should be at least three residents in each year of the program unless otherwise specified by specialty.

C. Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences including their summative competency-based performance evaluation.

2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

Explanation:

Program directors should be familiar and should comply with the sponsoring institution’s written policies and procedures, as well as the ACGME-I International Institutional Requirements, regarding eligibility (IIR II.A.1.), selection (IIR II.A.3.), and appointment (IIR II.D.) of residents. There are also specialty-specific requirements for eligibility.

Prior ACGME-I approval is needed to increase the number of residents. To initiate a change (i.e., increase/decrease) in the approved resident complement, programs must log into ADS and, under “Request Changes” in the menu, select “Approved Positions.” The additional documents/information required to complete a complement change request may vary by specialty. The content of any such additional information is stated within ADS. All complement change requests are sent electronically to the DIO for approval, except when permanent changes are requested during site visit preparation (DIO approval is provided at the time that the ADS
III. Resident Appointments
   A. Eligibility
   B. Number of Residents
   C. Resident Transfers
   D. Appointment of Fellows and Other Learners

information is submitted). After the DIO has approved a complement change request, the materials submitted in ADS are forwarded to the ACGME-I for review and a final decision. Consult the Advanced Specialty Requirements or contact the ACGME-I for more information or guidance.

Residents are considered as transferring residents under several conditions, which include: when moving from one program to another within the same or different sponsoring institution; when entering at the PGY-2 to a program requiring a preliminary year, even if the resident was simultaneously accepted into the prelim PGY-1 and the PGY-2 as part of a match (e.g., accepted to both programs right out of medical school). Before accepting a transferring resident, the “receiving” program director must obtain written or electronic verification of prior education from the current program director. Verification includes evaluations, rotations completed, procedural/operative experience, and, if the resident is transferring from an ACGME-I-accredited program, a summative competency-based performance evaluation. Neither the term “transferring resident” nor the responsibilities of the two program directors noted here apply to a resident who has successfully completed a specialty residency program and is then accepted into a subspecialty fellowship program.

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

• Documentation for eligibility: The site visitor will review the written policies for selection and promotion of residents/fellows. For example, selection based on medical students who have passed the USMLE Step 1 and 2 Clinical Knowledge examination, or secure examinations of equivalent reliability that measure similar basic science and clinical competencies, and have similar standards.

• Documentation for number of residents: Information is documented in ADS on the number of ACGME-I-approved positions for each year of the program, and the number of filled positions, as well as information on current residents, including their program start dates, expected completion dates, years of prior ACGME-I or internationally-approved GME (and specialty if applicable), medical school, and date of medical school graduation. This information is verified by the site visitor.

• Documentation for resident transfers: Programs are required to have files of current residents who have transferred into the program from both a non-ACGME-I-accredited program and from a program accredited by ACGME-I. These files should contain written verification of prior educational experience and, if the resident transferred from an ACGME-I-accredited program, a summative competency-based performance evaluation. If applicable, files of
III. Resident Appointments
   A. Eligibility
   B. Number of Residents
   C. Resident Transfers
   D. Appointment of Fellows and Other Learners

residents who transferred into or out of the program should be available to the site visitor during the site visit.

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

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

Aggregate data on residents/fellows completing or leaving the program in the last three years is documented in ADS. All residents are listed according to their year in the program and their status (active full-time, off-cycle, left program, completed training, or inactive). Site visitors verify reasons for transfers and program responses during interviews.

In addition, for program applications, ADS will ask for a description of how the residents will be informed about their assignments and duties during the residency. The description should confirm that there are skills and competencies for each assignment and for each year, and that the descriptions of these are available to all residents via paper or electronic means.

- **Documentation of Fellows and Other Learners:** For program applications, ADS requests a list of other learners who will share program resources with residents and a description of the impact those learners will have on the educational program. Site visitors will verify the impact of the presence of fellows or other learners on the educational opportunities available to residents through review of Resident Survey results and interviews during the site visit.
### IV. Educational Program

#### A. Educational Program Curriculum Components

**Foundational Requirement:**

<table>
<thead>
<tr>
<th>A. The curriculum must contain the following educational components:</th>
</tr>
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<tbody>
<tr>
<td>1. Overall educational goals for the program must distribute to residents and faculty annually in either written or electronic form;</td>
</tr>
<tr>
<td>2. Competency-based goals and objectives for each assignment at each educational level must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;</td>
</tr>
<tr>
<td>3. The core curriculum must include a didactic program based upon the core knowledge content and the areas defined as resident outcomes in the specialty. Regularly scheduled didactic sessions including but not limited to:</td>
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<td>- multidisciplinary conferences;</td>
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<td>- morbidity and mortality conferences;</td>
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<td>- journal or evidence-based reviews;</td>
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<tr>
<td>- case-based planned didactics;</td>
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<tr>
<td>- seminars and workshops to meet specific competencies;</td>
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<td>- computer-aided instruction; and</td>
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<tr>
<td>- grand rounds.</td>
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<tr>
<td>4. Delineation of educational experiences ensuring the program continues to provide each resident increased responsibility in patient care and management, leadership, supervision, teaching and administration.</td>
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</tbody>
</table>

**Explanation:**

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

Each assignment in which a resident is expected to participate must have a defined set of **competency-based goals and objectives**. "Assignment" refers to any rotation; a scheduled recurring session, such as M&M, journal club, or grand rounds; a simulated learning experience; and any required resident project, such as a quality improvement project, that is not explicitly part of a recurring session or rotation. The goal(s) communicate the general purpose and direction of the assignment; the objectives are the intended results of the instructional process or activity, that communicate to residents, faculty members, and others involved the expected results in terms of resident outcomes, and that typically form the basis for items within evaluation instruments.
IV. Educational Program
  A. Educational Program Curriculum Components

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

Sample goal for a simulated learning experience:
  Improve performance in communicating effectively with patients.

Sample objectives for this simulation experience:
  Provide precise information to a patient that is clearly understood.
  Express openness to feedback from patients.
  Pay close attention to patients and actively listen to them.

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

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

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

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

- Documentation for overall educational goals: The program’s overall educational goals are a required download to the program application. Verification that residents
IV. Educational Program
   A. Educational Program Curriculum Components

review the learning objectives will be accomplished through the Resident Survey questions in the area of Educational Content, as well as through site visitor interviews.

- **Documentation for competency-based goals and objectives:** Documentation of a sample of competency-based goals and objectives for one assignment at each educational level must be downloaded to the program application. During the site visit, overall educational goals of the program, as well as the competency-based goals and objectives for each assignment at each educational level should be available for the site visitor to review. Inclusion of these in a well-organized program handbook, is not required: however, having the competency-based goals and objectives in one place will simplify the documentation requirement. Verification that residents review the learning objectives will be accomplished through the Resident Survey questions in the area of Educational Content, as well as through site visitor interviews.

- **Documentation for didactic sessions:** A list of scheduled didactic sessions is a required attachment to both program applications and the materials submitted for Continued Accreditation in most AS-PIFs. Conference schedules, hand-outs, session evaluations, or attendance records (check Advanced Specialty Program Requirements) may also be requested for review during the site visit. Verification of the information will be accomplished through the Resident Survey questions in the area of Faculty, from responses of core faculty members on the Faculty Survey, and during site visit interviews.

- **Documentation for resident responsibilities:** Documentation may consist of written information for each rotation or assignment. A program’s supervision policy addressing progressive responsibilities for patient care and faculty member responsibility for supervision is a required attachment to program applications, and should also be available for the site visitor to review for programs seeking Continued Accreditation. Verification will be accomplished through the Resident Survey questions in the area of Faculty, from responses of core faculty members on the Faculty Survey, and during site visit interviews.
IV. Educational Program
   B. Residents’ Scholarly Activities

Foundational Requirement:

<table>
<thead>
<tr>
<th>B. Residents’ Scholarly Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>The curriculum must advance residents’ knowledge of the basic principles of research,</strong> including how research is conducted, evaluated, explained to patients, and applied to patient care.</td>
</tr>
<tr>
<td>2. <strong>Residents should participate in scholarly activity.</strong></td>
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<tr>
<td>[As further specified by the Advanced Specialty Program Requirements]</td>
</tr>
<tr>
<td>3. <strong>The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.</strong></td>
</tr>
<tr>
<td>[As further specified by the Advanced Specialty Program Requirements]</td>
</tr>
</tbody>
</table>

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

- **Documentation for residents’ scholarly activities:** Evidence for how the program supports the development of specific skills needed by residents for scholarly activity may be provided through written goals and objectives that should be available for site visitor review. Other such evidence could include availability of financial and technical support for research and other scholarly activity. Scholarly activity of residents is documented in ADS on the Resident Scholarship table for programs seeking Continued Accreditation. Verification by the site visitor that residents have opportunities for research or scholarly activity includes review of Resident Survey responses in the area of Faculty and Educational Content, in Faculty Survey questions, and during on-site interviews.
V. Evaluation

A. Required Committees

1. Clinical Competence

2. Program Evaluation

Foundational Requirement:

A. The program director must appoint the Clinical Competency Committee and the Program Evaluation Committee.

1. The Clinical Competency Committee should:
   a) be composed of members of the residency faculty;
   b) have a written description of its responsibilities including its responsibility to the sponsoring institutions and to the program director;
   and
   c) participate actively in:
      (1) reviewing the evaluations of both the faculty and residents; and,
      (2) making recommendations to the program director for resident progress, including promotion, remediation, and dismissal.

2. The Program Evaluation Committee should:
   a) be composed of members of the residency faculty and include representation from the residents;
   b) have a written description of its responsibilities including its responsibility to the sponsoring institution and to the program director;
   and
   c) participate actively in:
      (1) planning, developing, implementing, and evaluating all significant activities of the residency program,
      (2) developing competency-based curriculum goals and objectives;
      (3) reviewing annually the program as noted in Section V.D below;
      (4) reviewing the GMEC internal review of the residency program with recommended action plans; and,
      (5) assuring that areas of non-compliance with ACGME-I standards are corrected.

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

The primary purposes of the Program Evaluation Committee, which is composed of the program’s core faculty members, key personnel, and a resident representative, is to annually review all the evaluations of the program from faculty members and residents, to judge the current adequacy of the curriculum, to plan, develop, and implement any required changes to improve the quality of the educational program, to address any areas of non-compliance with ACGME-I standards; and to review and act on the GMEC internal review of the residency program with recommended action plans. The Committee’s responsibilities must be documented.
V. Evaluation
   A. Required Committees
      1. Clinical Competence
      2. Program Evaluation

   • Documentation of Committees Activities: For program applications, ADS will request the following information for both the Clinical Competency Committee and the Program Evaluation Committee:
     ➢ List of members
     ➢ Description of each committee’s responsibilities

     Additionally, programs seeking Continued Accreditation should have sample documents of program evaluations and written improvement plans available for the site visitor to review at the time of the visit.

     Documentation of both committees’ routine meetings, such as minutes that include agenda items and actions taken that are consistent with their charges, should be available at the time of the site visit for review.
V. Evaluation
B. Resident Evaluation
1. Formative Evaluation

Foundational Requirement:

<table>
<thead>
<tr>
<th>B. Resident Evaluation</th>
</tr>
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<tbody>
<tr>
<td>1. Formative Evaluation</td>
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<tr>
<td>a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.</td>
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<tr>
<td>b) The program must:</td>
</tr>
<tr>
<td>(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;</td>
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<tr>
<td>(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);</td>
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<tr>
<td>(3) document progressive resident performance improvement appropriate to educational level; and,</td>
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<tr>
<td>(4) provide each resident with a documented semi-annual evaluation of performance with feedback.</td>
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<tr>
<td>c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.</td>
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<tr>
<td>d) Assessment must include a review of case volume, and breadth and complexity of patient cases.</td>
</tr>
<tr>
<td>e) Assessment should specifically monitor resident knowledge by use of formal in-service cognitive exams.</td>
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</tbody>
</table>

Explanation:
Formative evaluation or assessment\(^1\) includes both informal ‘on-the-spot’ feedback\(^2\) and feedback based on the planned collection of information using assessment forms. Written formative assessment provides a mechanism through which programs can document progressive resident performance improvement. Self-assessment is an important component of formative assessment, both to compare with data from other evaluators and also to develop this important lifelong learning skill.

The primary purpose of formative assessment is to help residents recognize a learning gap (e.g., in knowledge, skills, behaviors). Routine constructive feedback is the keystone for reaching proficiency. It should help residents answer the fundamental questions: Where am I now? Where am I going? How do I get to where I am going? How will I know when I get there? Am I on the right track for getting there? Formative assessment is successful if it leads the resident to proactively close the gap, thus also

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\(^1\) The terms “evaluation” and “assessment” are often used interchangeably. “Evaluation” is more often applied to curricula and programs, while “assessment” is applied almost always only to learners. Some reserve the term “evaluation” for summative (end-of-learning period or high stakes) decisions, while using the term “assessment” only for formative purposes. For this document, the terms are assumed to be interchangeable and the reader should focus on the distinction between formative and summative.

\(^2\) Feedback: Communication of responses and reactions with the aim of enabling improvements to be made.
V. Evaluation
B. Resident Evaluation
1. Formative Evaluation

building lifelong learning skills. This is less likely to occur if the formative assessment data are given to residents without discussion of what the data mean and without inviting the residents to plan strategies to improve (often called an ‘independent learning plan’).

Formative assessment is also an effective way to identify the need for formal remediation as it provides a ‘developmental history’ of the resident’s work, efforts, responses to feedback, and outcomes. Remediation then becomes a process that partners the program director or faculty advisor and resident in planning, implementing, and evaluating the remediation. (See IFPR IV.A.5.e.) Thus, ongoing discussions between residents and teaching faculty members about the meaning of formative assessments may be part of the assessment system.

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

Effective assessment systems include these core principles: assessment based on identified learning objectives/outcomes related to the six competency domains; use of multiple tools by multiple evaluators on multiple occasions; and tools with descriptive criterion-based anchors for the rating scale to aid in fairer and more consistent evaluations. The assessment system must be monitored to ensure timely completion of evaluations and that the required semiannual reviews with feedback take place and are documented.

Formative assessment data is not intended for use in major decisions about a resident (promotion, dismissal, graduation). Rather, this kind of data should be discussed with the resident, who can provide more meaning to the context of the situation, and be used to guide planning for further learning. Formative assessment data can also identify the need for remediation. Because so many data points are collected with formative evaluation, patterns begin to emerge that allow a more accurate picture of the resident’s gaps and capabilities – in addition to the interpretation the resident might give to the data.

The assessment system may include faculty development activities which focus on resident assessment. Time could be set aside during faculty meetings to discuss topics such as the assessment tools and methods for using them effectively, and how best to distribute and collect completed evaluations in a timely manner. In addition, the assessment system may also include scheduled meetings with residents so that they know and understand the performance criteria on which they will be assessed and the performance standards for a given level of training or learning experience. The goals
V. Evaluation

B. Resident Evaluation

1. Formative Evaluation

are that both faculty members and residents will share a common understanding of what is expected and how it will be evaluated, and that they perceive assessments as a fair and close approximation of actual ability. IFPR V.B.1.c states that evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

Examples of assessment methods:
Direct observation (Mini-CEX), videotaped/recorded assessment, multisource assessment, objective structured clinical examination, patient survey, in-training examination, global assessment, simulations/models, record/chart review, standardized patient examination, project assessment, in-house written examination, oral exam, structured case discussions, anatomic or animal models, role-play, formal oral exam, practice/billing audit, review of case or procedure log, review of patient outcomes, review of drug prescribing, resident experience narrative, and any other applicable assessment method.

Examples of types of evaluators:
Self, program director, nurse, faculty supervisor, medical student, faculty member, attending, preceptor, faculty member during consultations, allied health professional, chief resident, junior resident, resident supervisor, patient, family, peer, technician, clerical staff member, evaluation committee, program coordinator, or consultant.

Examples of ways evaluators are educated to use the assessment methods:
Workshop or special training on assessment, informal or formal discussion, retreat topic, faculty review assessments and comparison of evaluations, program director or responsible core faculty member instructing or educating on assessment, or group or committee discussion designed to reach consensus or calibrate assessment.

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

In general, there should be evidence of multiple methods and multiple evaluators, as well as alignment between the methods of assessment and the skill being assessed. Programs being reviewed for Continued Accreditation must have current resident files, available for the site visitor to review, that contain completed assessments and completed evaluations showing use of multiple evaluators. Questions on the Resident Survey in the area of Evaluation and on the Faculty Survey will also provide information on assessment. Planned assessment forms are required to be included as attachments with program applications. The site visitor will spot-check resident files and conduct interviews. Programs using an electronic evaluation system may obtain more information from the ACGME website section on the Electronic Evaluation Systems.

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

- **Documentation for timely completion:** For program applications, ADS requests a description of how the program ensures the timely completion of evaluations. This description may include a structured mechanism with ongoing monitoring by a designated individual. Questions on the Resident Survey in the area of Evaluation and on the Faculty Survey pertaining to estimating the time faculty members take to provide end-of-rotation assessment is also reviewed. The site visitor may use interviews for added verification.

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

- **Documentation for accessibility of evaluations:** Documentation for this requirement is obtained through questions on the Resident Survey in the area of Evaluations, and is verified by the site visitor through resident interviews.
V. Evaluation  
B. Resident Evaluation  
2. Summative Evaluation

Foundational Requirement:

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

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

- Decisions that are based on pre-established criteria and thresholds, not as measured against performance of past or current residents
- Decisions that are based on current performance, not on formative assessments, which capture the process of developing abilities
- Informing residents that an assessment is for summative rather than formative purposes
- Written summative evaluation that is discussed with the resident and is available for his/her review

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

If the program director does not feel comfortable signing such a statement for a resident, that resident should not be allowed to graduate, even if the specified time for residency education has expired. Such a situation is less likely if ACGME-I requirements for evaluation have been systematically and fully implemented. Problems will have been identified much earlier, opportunities for remediation provided, and dismissal decisions considered well before the end of residency/fellowship education. Both the end-of-program summative evaluation and the end-of-program verification statement for all graduates should be retained in perpetuity in a site that conforms to reasonable document security standards. To ensure that the institution can demonstrate
V. Evaluation
   B. Resident Evaluation
      2. Summative Evaluation

appropriate due process for dismissed residents, the program director should seek the
direction of the DIO on which documents to keep for dismissed residents.

- **Documentation for summative evaluation:** For programs seeking Continued
  Accreditation, copies of the summative evaluations for the most recent year’s
  graduates must be available to the site visitor. The site visitor will review these
  evaluations to determine if the program is in compliance with the requirements. In
  addition, the site visitor will interview residents to verify Resident Survey responses
  concerning availability of current and previous evaluations.

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

Foundational Requirement:

<table>
<thead>
<tr>
<th>C. Faculty Evaluation</th>
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</thead>
<tbody>
<tr>
<td>1. The program must evaluate faculty performance, as it relates to the educational program at least once per year.</td>
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<tr>
<td>2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.</td>
</tr>
<tr>
<td>3. This evaluation must include the confidential evaluations written by the residents each year.</td>
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</table>

Explanation:

Regular evaluation of faculty members is critical to maintaining and improving the quality and effectiveness of a residency program. The system of faculty member evaluation should include a structured mechanism for the distribution and collection of evaluations, along with identified personnel to ensure that the system is working, confidential resident input, and provision of feedback to faculty members at least annually. The IFPR require that faculty members be evaluated on their clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

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

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

Faculty member evaluations completed by residents must be confidential. This means, at a minimum, that faculty members have no way of identifying how any individual resident evaluated them. In practice, faculty members can view only aggregated numerical ratings (mean and range) and narrative comments from which all identifying information has been removed, including who made the comment and any comments.
V. Evaluation  
C. Faculty Evaluation

that pertain to other individuals. Institutions may have additional requirements for confidentiality. "Confidential" should not be confused with "anonymous." It is expected that some individual, perhaps the program coordinator, would collect/collate faculty member evaluations in order to manage residents' compliance. Thus, these evaluations would be confidential but not anonymous. Some programs may have developed a set of principles that guide evaluation of faculty members; if present, this may be included in the written faculty evaluation plan.

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

D. Program Evaluation and Improvement

Foundational Requirement:

D. Program Evaluation and Improvement
1. The program must document formal, systematic evaluation of the curriculum at least once per year. The program must monitor and track each of the following areas:
   a) resident performance;
   b) faculty development;
   c) graduate performance, including performance of program graduates on the certification examination; and,
   d) program quality. Specifically:
      (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at a minimum of once per year, and
      (2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.
2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Explanation:

The program director is expected to lead an ongoing effort to monitor and improve the quality and effectiveness of the program. This annual evaluation is unrelated to the GMEC internal review that must take place midway during the accreditation cycle, although results of that review may become part of this annual program evaluation. At a minimum, methods must be developed and implemented for systematically collecting and analyzing data in the following areas: resident performance; faculty development; graduate performance; and program quality, including faculty member and resident evaluations of the program. A written plan for program evaluation and improvement will help to ensure that a systematic evaluation takes place annually, that results are used to identify what is working well and what needs to be improved, and that needed improvements are implemented.

Resident performance:
Results of in-training exams or other resident assessments, case and procedure logs, and presentations/publications are examples of resident performance data that could be used as part of the program evaluation.

Faculty development:
Faculty member participation in faculty development activities should be monitored and recorded. Data may be collected by annual review of updated CVs or by a separate annual survey. Activities should, over time, include not only continuing medical
V. Evaluation
  D. Program Evaluation and Improvement

Education (CME)-type activities directed toward acquisition of clinical knowledge and skills, but also activities directed toward developing teaching abilities, professionalism, and abilities for incorporating practice-based learning and improvement, systems-based practice, and interpersonal and communication skills into practice and teaching. The types of activities could include both didactic (conferences, grand rounds, journal clubs, lecture-based CME events) and experiential (workshops, directed QI projects, practice-improvement self-study) experiences.

Graduate performance:
Results of performance on board certification, intermediate, or advanced specialty examinations are possible measures of graduate performance. Data can also be collected by annual surveys of graduates. Typically, such surveys target physicians one year and five years after graduation. Forms used may be provided by the institution, developed locally, or adapted from the published literature (or unpublished but available online). Survey questions may inquire about such items as current professional activities of graduates and perceptions on how well-prepared they are as a result of the program.

Program quality:
Annually, current residents and faculty members must have the opportunity to evaluate the program. To ensure confidentiality, responses should be de-identified. An appropriate staff member (e.g., program coordinator, institutional quality improvement staff member, GME office staff member, etc.) should collect completed written information, remove any identifiers, and collate responses. The program director and faculty members may then analyze and review the collated information.

Programs may have residents complete confidential, written evaluations of rotations, specific assignments, or learning experiences as part of a targeted improvement plan. The residents’ confidential evaluations of the teaching faculty members may also be used as part of this evaluation. To ensure confidentiality of such evaluations in programs with a small number of residents, the responses should be collected over a sufficient period of time so that the collated information contains responses from several residents and cannot be linked to specific respondents. Some programs periodically evaluate other areas that impact program quality, including the resident selection process, graduates’ practice choices, the curriculum, assessment system (including self-assessment), remediation, and linking patient outcomes to resident performance.

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

- Documentation for program evaluation and improvement: For applications, ADS asks several questions about program evaluation and improvement that will help to
V. Evaluation  
D. Program Evaluation and Improvement

demonstrate if the program is in compliance with these requirements, including requesting the names of the members of the Program Evaluation Committee, and a description of the committee’s responsibilities. Important components include an annual comprehensive review of the program in which representative faculty members and residents engage in an interactive discussion of collected data. The site visitor will review on-site samples of documents either planned or already in use as part of the program evaluation. For programs seeking Continued Accreditation, documentation of Program Evaluation Committee meeting minutes and the written improvement action plan prepared after a review of the aggregated results of program evaluation information should be available on-site. This written action plan may be based on one or more outcome measure(s) and reflective of a Plan, Do, Study, Act (PDSA) cycle, and must be available for the site visitor. The site visitor may use interviews for added verification.
VI. Resident Duty Hours in the Learning and Working Environment
A. Principles

Foundational Requirement:

A. Principles

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

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

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

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

- **Documentation for Learning Environment**: Programs applying for ACGME-I accreditation will be asked in ADS to describe how they handle (or plan to handle) resident complaints and concerns in a confidential or protected manner, and how they have (or plan to) minimize residents’ fear of intimidation or retaliation. ADS will also ask for a description of how the programs plan to ensure that resident education is not adversely affected by heavy service obligations. The site visitor will review
VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

Resident Survey responses to questions in the areas of Faculty and Resources, and responses on the Faculty Survey related to appropriate resident workload and program provisions for patient safety. Information will also be collected during on-site interviews with residents and faculty members.
VI. Resident Duty Hours in the Learning and Working Environment
   B. Supervision of Residents
   C. Fatigue

Foundational Requirement:

B. Supervision of Residents
   The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities. All residents must have supervision commensurate to their level of training. Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty.

C. Fatigue
   Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

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

The intent of the requirement on fatigue is not only to raise faculty members’ and residents’ awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care, but also to provide them with tools for recognizing when they are at risk and strategies to minimize the effects of fatigue. Programs must educate faculty members and residents on the signs of fatigue and sleep deprivation, and must implement policies to prevent and counteract potential effects on patient care and learning. This may be done by the program or by the sponsoring institution for all of its programs. Note the inclusion of faculty members in this requirement.

The most effective curriculum will include both didactic and experiential components, such as a combination of readings, presentations, case-based discussions, and role plays.

- Documentation for supervision: Program applications require that the written resident supervision policy is uploaded into ADS. This policy should address resident responsibility for patient care, progressive responsibility for patient management, and faculty member responsibility for supervision. For all programs, ADS asks for a description of how the members of the faculty provide appropriate supervision of residents during patient care. The site visitor will verify, through
VI. Resident Duty Hours in the Learning and Working Environment
   B. Supervision of Residents
   C. Fatigue

   review of supervision policies, Resident Survey responses to questions in the area of Faculty, and Faculty Survey responses to questions on resident supervision. The site visitor may also use interviews for additional verification.

   • Documentation for fatigue requirements: For program applications, ADS asks for a description of how the program will ensure that residents recognize the signs of fatigue and sleep deprivation. In addition to Resident and Faculty Survey responses as noted above, on-site interviews will focus on knowledge of policies and procedures, monitoring practices for signs of fatigue and sleep deprivation, and evidence that schedules are adjusted appropriately when necessary.
VI. Resident Duty Hours in the Learning and Working Environment  
D. Duty Hours

Foundational Requirement:

D. Duty Hours (the terms in this section are defined in the ACGME-I Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of in-house call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

Explanation:

Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, short call, home call, night float and day float, transfer of patient care, and administrative activities related to patient care.

Both the program and its sponsoring institution are required to monitor resident duty hours. There is no requirement for how monitoring and tracking should be accomplished. Programs and institutions report using a variety of approaches to reduce resident hours, including scheduling changes (e.g., short call, night float, redesigning patient care and education systems) and using nurse practitioners, physician assistants, or hospitalists to assume some patient care responsibilities formerly done by residents.

The sponsoring institution must have written formal policies and procedures governing resident duty hours that provide guidance for programs to meet the duty hour requirements.

- **Documentation for duty hour requirements:** For program applications, ADS contains several duty hours-related questions, including requesting the projected average number of duty hours per week per resident and the projected average number of days per week of in-house call, and a description of how the program will ensure that residents comply with ACGME-I duty hour standards. Programs seeking Continued Accreditation will be asked to provide information on average duty hours per week, days per week of in-house call, number of hours for the longest shift (excluding call from home), and if duty hours are appropriate when residents rotate on other clinical services. Residents report their perceptions on compliance with the duty hour requirements on the Resident Survey. The aggregated results of the
VI. Resident Duty Hours in the Learning and Working Environment
   D. Duty Hours

   Resident Survey are available to program directors and DIOs through ADS if 70% of
   the residents/fellows complete the survey. Programs can use this information to
   determine if compliance problems are suggested by the data. Programs can use the
   aggregated data to pinpoint compliance problems and to address them before their
   next ACGME-I site visit.

   • Note on determining compliance with duty hour requirements: Programs and
     sponsoring institutions should examine any data suggesting non-compliance with
     duty hour requirements in order to determine underlying causes. The site visitor will
     interview residents in order to verify and clarify all questions where the responses
     suggested non-compliance related to duty hours. The ACGME-I does not specify
     what, if any, systems programs or institutions might use for monitoring compliance
     with duty hour requirements.
VI. Resident Duty Hours in the Learning and Working Environment

E. On-call Activities

Foundational Requirement:

E. On-call Activities

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

3. No new patients may be accepted after 24 hours of continuous duty.

4. At-home call (or pager call)
   a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
   b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
   c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

Explanation:
On-call duty is defined as a continuous duty period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home. At-home call (pager call) may be overnight or may be for a longer period, such as a weekend. Assignment of at-home call must be appropriate to the service intensity and frequency of being called, and it should not be used for high intensity settings. At-home call also needs to be compliant with the requirement that one day out of seven must be free from all program assignments and duties. Regular duty shifts, such as those worked in the Intensive Care Unit (ICU), on emergency medicine rotations, and during “night float,” used instead of in-house call to reduce the continuous duty period, are exempt from the requirement that call be scheduled no more frequently than every third night.

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

The goal of the added hours at the end of the on-call period is to promote didactic learning and continuity of care of return patients, including ambulatory and surgical continuity.
VI. Resident Duty Hours in the Learning and Working Environment
   E. On-call Activities

- **Documentation for on-call activities:** ADS contains a duty hour question, which specifically address requirements related to on-call activities. (See question below.) For programs with four or more residents, residents report their perceptions of how well they believe they have met these requirements by responding to several survey questions. (See survey questions below.) Additional documentation includes work and call schedules and written policies and procedures for resident duty hours, night float (if present), and the working environment. The aggregated results of the Resident Survey are available to program directors and DIOs through ADS if 70% of the residents/fellows complete the survey. Programs can use this information to determine if there are compliance problems suggested by the data, and can also use the data to pinpoint compliance problems and address them before their next ACGME-I site visit.

- **Verification of compliance:** The site visitor will review Resident Survey results, spot-check documents, and interview faculty members and residents. The site visitor will look for evidence that resident activities are monitored, and that there are systems to provide back-up support when patient care responsibilities are prolonged or unexpected circumstances create resident fatigue.