

Department of Medicine

UPSTATE
MEDICAL UNIVERSITY
COLLEGE OF MEDICINE

**UPSTATE MEDICAL
UNIVERSITY**

**DEPARTMENT OF
MEDICINE**

**RESIDENCY HANDBOOK
2022—2023**

When in doubt...

The Patient Comes First.

Welcome to your Internal Medicine training at Upstate Medical University. In coming to this program, you have chosen to embark on a three year journey (one year if a preliminary intern) that will develop your skills as a clinician, scholar, and educator. Upon graduation, you will be amongst the best in your profession. However, achieving this milestone will require a strong commitment to all areas of your training and always maintaining your sense of professionalism.

Medical professionalism begins with the patient: When in doubt...The patient comes first. This phrase is sacrosanct and must never be forgotten. While there are governing bodies dictating rules and regulations regarding the likes of duty hours and patient numbers, a patient in urgent need should always be your first priority. As Program Director, I assure you that your rights will always be protected and that the letter of the law will be strictly followed at all times.

I fully appreciate the rigors of residency and, as such, am keenly aware of the need to be mindful of all that is asked of you on a daily basis. There may be times during your residency when unforeseen circumstances arise that may affect your performance. Please know that we are all here for you and will help you through any difficulties that may present themselves. You are never alone at Upstate.

The remainder of this document provides you with the policies and procedures we have in place to ensure that your residency experience at Upstate meets our expectations while exceeding yours. As you read these pages, please remember that you have chosen a career that requires the utmost in character and professionalism.

Again, welcome to Upstate. I look forward to working with you.

Stephen J. Knohl, MD
Residency Program Director
Vice Chair for Education

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The Upstate IM Residency An Overview 2022-2023



DEPARTMENT OF MEDICINE

An Overview of Core Residency Training

2022-2023

**Educational Programs Office
Stephen J. Knohl, MD**

**Office of the Chairman
Stephen J. Knohl, MD (Interim)**

**SUNY Upstate Medical University
750 East Adams Street, Room 6602
Syracuse, New York 13210**

You are responsible for reading and following the policies set forth in this manual. If there are any questions regarding any aspect of your training, you should consult this policy manual. If, thereafter, you feel your questions remain unanswered, please do not hesitate to consult a member of the Education Programs Office.

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1. GENERAL INFORMATION

A. WHO'S WHO IN THE EDUCATIONAL PROGRAMS OFFICE (EPO)

- Department Chair (Interim) – Stephen J. Knohl, MD (knohls@upstate.edu)
- Program Director/Vice Chair Education – Stephen J. Knohl, MD (knohls@upstate.edu)
- Medical Student Program Director – Zachary Shepherd, MD (williamz@upstate.edu)
- Associate Program Directors
 - UH: Harvir Gambhir, MBBS/MD (gambhirh@upstate.edu)
 - UH: Catherine White, MD (whitec@upstate.edu)
 - UH: Sarah Lappin, DO (lappins@upstate.edu)
 - UH: Caitlin Toomey, MD (toomeyc@upstate.edu)
 - VA: Iyerus Tariku (iyerus.tariku@va.gov)
- Program Administrators
 - Core Program – Deb Killian (killiand@upstate.edu)
 - Fellowships – Lisa Schirtz (schirtzl@upstate.edu)
 - Medical Students – Lisa Oliver (oliverl@upstate.edu)
- Administrative Assistants
 - Paula Campion (campionp@upstate.edu)
 - Shanna Brown (browns2@upstate.edu)
- Chief Residents (upstatechiefresident@gmail.com)
 - Dr. Christina DiCorato (Core Chief)
 - Dr. Sonica Patel (Core Chief)
 - Dr. Rachael Proumen (Core Chief)
 - Dr. Philip Chebaya (UH Ambulatory Chief)
 - Dr. Joshua Sweet (UH Quality Chief)
 - Dr. Moeed Chohan (VA Quality Chief)
 - Dr. Basel Abuzuaiter (Medical Education Chief)

B. ACADEMIC APPOINTMENT

The State of New York recognizes you as a “Clinical Assistant Instructor”; your role in that title is to serve as teachers and role models for your peers and the students from Upstate Medical University. As such, the highest level of professionalism is required at all times. Regarding your year-specific roles, please see “The Residency Curriculum”.

C. SALARY AND BENEFITS

Your annual salary will be reported to you in advance of the beginning of each academic year. Questions regarding salary should be referred to EPO. If EPO is unable to answer the question, EPO will reach out to the Payroll Department (<http://www.upstate.edu/payroll/>) on your behalf.

As a state employee, you are a member of the union, United University Professions (UUP). Your benefits are provided through a contract this union has with New York State and questions should be directed to EPO. If EPO is unable to answer the question, one of the following should be able to help:

UUP (<http://www.uupinfosyr.org/>)

Benefits Department (http://www.upstate.edu/hr/intra/staff_resources/benefits/)

For additional information on benefits provided by the institution and department, please see section titled “Benefits”.

D. ACGME/RRC REQUIREMENTS FOR INTERNAL MEDICINE

The residency program is required to be in compliance with the rules and regulations set forth by the Accreditation Council for Graduate Medical Education (ACGME). The program and institution are reviewed on a regular basis by the ACGME-appointed Residency Review Committee (RRC) and the ACGME-appointed Clinical Learning Environment Review (CLER) group, respectively.

You must review the ACGME/RRC document titled “ACGME Program Requirements for Resident Education in Internal Medicine”. This document is included in this syllabus (section titled “ACGME Program Requirements”) and is also located at the following web address: https://www.acgme.org/globalassets/pfassets/programrequirements/140_internalmedicine_2022v3.pdf.

You must also review the document describing CLER (Clinical Learning Environment Review) which can be found at the following web address: <https://www.acgme.org/globalassets/pdfs/cler/1079acgme-cler2019pte-brochdigital.pdf>.

E. ACGME/NYS DOH 405 DUTY HOUR RULES/SUPERVISION POLICY

Please be mindful of your day-to-day schedule and ensure that you are prompt for all responsibilities/rotations. It is your responsibility to monitor your time at work and to ensure that you are not in violation of the ACGME/NYS 405 Rules; if you feel a violation is pending, you must alert the Chief Resident/s immediately so that the necessary measures can be taken. Failure to comply with these rules could result in termination of your employment and/or loss of program accreditation. Your schedule can be found at www.amion.com (password: upstateim).

The institution requires reporting your duty hours on a daily basis via MedHub; failure to report duty hours in MedHub in a timely fashion may result in Academic Deficiency/Probation. The department also conducts its own review of work hours on a regular basis.

ACGME/NYS 405 Rules Regarding Duty Hours

- The Work Day
 - No shift can be longer than 24 hours for housestaff.
 - An additional 4 hours can be utilized to finish work that does not relate to direct patient care.
 - There must be 10 hours off between shifts (14 hours if working a 24 hour shift).
- The Work Week
 - No work week (Monday through Sunday) can exceed 80 hours under any circumstance.
 - There must be a continuous 24 hours off per week.
 - Moonlighting (for fellows and chief residents only; *core housestaff may not moonlight under any circumstance*) counts toward the 80 hours.
- Remember, urgent patient care always trumps the ACGME and NYS 405 rules on work hours.
- The Educational Programs Office (EPO) and the office of Graduate Medical Education (GME) will conduct routine monitoring of your work hours.
 - You must fill out all forms related to duty hours in a timely manner.

- Failure to do so will lead to disciplinary action, which could include dismissal from the program.

ACGME Rules Regarding Supervision

- *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
- *Oversight*, defined as after-care/procedure review of performance.

Contacting Your Supervisor

For a list of situations that require supervisor notification, please see the section in the syllabus titled "Calling a Supervisor"; *calling is mandatory, not optional, in these situations.*

F. THE SCHEDULE AND REQUEST FOR CHANGES

We have created template schedules to ensure that each member of each training year has a fair and balanced schedule. For PGY-2s and PGY-3s, templates are chosen based on attendance at Noon Conference with tie-breakers determined by lottery. PGY-1s are assigned a template by EPO. Schedules are released and uploaded to our online scheduler at www.amion.com (password: upstateim) in the spring for the following academic year. After uploading the schedule, changes will only be made if there is a compelling reason to do so.

Other than for time-off requests, schedule change requests should be submitted by e-mail (only) to all Chief Residents at least 30 days in advance of the proposed change. Failure to e-mail with at least 30 days notice will most likely result in denial of the request. Requests will be reviewed weekly and the Chief Residents will notify you of the decision. Regarding scheduling time-off, please see the section in this syllabus titled "Time-Off Policy".

G. TIME OFF

Please see the section titled "Time-Off Policy" in the syllabus.

H. JEOPARDY

In order to meet the needs of our patients and your training, we have developed a system termed "Jeopardy" which assigns back-up coverage for busy times and required services. The Chief Residents are in charge of Jeopardy assignments. Because of the need to always maintain Jeopardy coverage throughout the year, it is possible, despite our best efforts, that EPO will have to turn down vacation, interview, conference attendance, and away elective requests if it conflicts with the program's ability to ensure adequate on-site coverage. *If on jeopardy and you do not respond to a Chief Resident's page/call within 20 minutes, you will automatically be assigned a future shift (to be determined by the Chief Residents and based on*

need which could include forfeiture of a golden weekend). If on jeopardy and unavailable, but you have not notified Chief Residents of your unavailability prior to being called, you will be assigned an on-site shift which may require forfeiture of a vacation day, if any available, or a golden weekend (of note, any earned payback can't be requested for this coverage).

I. INTERVIEWING

For an interview request to be granted, you must provide the Chief Residents (via e-mail) the following information at least one (1) week in advance:

- Reason for interview.
- Location of interview.
- The name of the program, contact person, and phone number.
- Date and time of interview.
- Number of days needed for interview.
- A copy of the original invitation.

Approval/denial of an interview request is the purview of EPO; no other individual or institution may make that decision. EPO will evaluate your schedule to determine if the requested time-off is appropriate.

In order to complete your training on time (June 30th of your graduation year), you are only allowed 20 business days off per year. As such, interview days will count as days off if you are gone for your entire day's scheduled work; as such, please be mindful of your vacation time so that appropriate time is left for interviewing. For additional information, please see the section titled "Time-Off Policy" in the syllabus regarding how interview time affects days off allowed in an academic year.

J. MOONLIGHTING

Under no circumstance may a PGY-1, PGY-2, or PGY-3 moonlight. There are no exceptions. If you are found to be moonlighting, you will be immediately dismissed from the program.

K. USMLE STEP 3

You are required to pass (*note "pass", not just take*) and provide EPO the results of the USMLE Step 3 exam prior to June 1st of your PGY-2 year. Failure to do both by this time will lead to dismissal from the program, no certificate of completion, and ineligibility for any residency program at Upstate. It is your responsibility to schedule the exam well in advance of this date (preferably during your intern year) to ensure that results are available by June 1st of your PGY-2 year. *The exam may be taken during elective time or vacation; under no circumstance will you be allowed to take the exam during any other service (i.e inpatient or CC services). Taking the exam during vacation time still counts as vacation time; taking the exam during elective time does not count as vacation time. You may not take Step 3 while on Jeopardy unless you have been granted permission by EPO.*

Preliminary interns must determine their PGY2 institution's requirements and plan accordingly.

L. SIGNATURE REQUESTS

EPO provides a notary public for any documents requiring the same. Additionally, there may be other forms requiring signature by the Residency Program Director. *Under no circumstance will signatures or the notary public be provided if you have not maintained your*

own professional obligations to the medical record (i.e. delinquent charts) and to other forms/evaluations distributed by the institution or department (i.e. MedHub reporting, survey completions, evaluations, etc.).

M. REGULATORY AGENCIES AND OVERSIGHT

The Department of Medicine adheres to the policies and procedures of all appropriate regulatory agencies. Below are web addresses of the following entities involved in the regulation and management of the program and your training:

- Accreditation Council on Graduate Medical Education (ACGME)
<http://www.acgme.org/acgmeweb/>
- New York State Department of Health (NYSDOH)
https://www.health.ny.gov/professionals/doctors/graduate_medical_education/
- Island Peer Review Organization (IPRO)
<http://ipro.org>
- National Integrated Accreditation for Healthcare Organizations (NIAHO)
<http://dnvaccreditation.com/pr/dnv/register-download.aspx>
- American Board of Internal Medicine (ABIM)
www.abim.org/

N. THE RIGORS OF RESIDENCY: FATIGUE, STRESS, BURNOUT

Our program is designed to challenge the mind and body over a three year period with the goal of producing the finest internists in the country. We recognize that these years will not be easy. Not being easy, however, doesn't mean promoting a culture of "malignant" training.

While physician burnout is unfortunately all too common, it is not unavoidable as long as both the program (EPO) and the trainee (you) remain cognizant of the importance of maintaining balance in both the professional and personal arenas. From a program perspective, EPO has developed the 3+1 scheduling system whereby no inpatient experience lasts more than 2 weeks and no night experience lasts more than 1 week. When you are in-house, the institution has provided lounges that include entertainment options, exercise equipment, and rest areas. We have also limited 24 hour call to the PGY-3 level and only while rotating in the Crouse ICU. Furthermore, we have endeavored to provide at least one full weekend every 4 weeks and aimed to reduce weekend coverage while on elective services. There is also a Social Committee, selected by and composed of housestaff, whose mission is to develop events throughout the year that will relax the mind and reenergize the soul. Finally, EPO has monthly meetings with the entire core group, semi-annual class meetings with the Chair, and quarterly individual meetings with the APD/PD to discuss not only your professional development but also your well-being. From a personal perspective, you are encouraged to develop a schedule that incorporates healthy eating habits, adequate exercise, proper sleep, and, perhaps most importantly, fun!

Still, we must recognize that despite our best efforts, fatigue, stress, and burnout may develop. This can be a danger to you, but also to those around you such as your colleagues and your patients. It is your professional duty to identify fatigue, stress, and burnout amongst yourselves and understand what measures our institution has in place to protect you and others should it develop. Within Medhub's *Policies/Guidelines*, there is a section on well-being which you are encouraged to review and also includes a PowerPoint presentation titled "SAFER" which is required viewing prior to beginning training in our program and should be reviewed annually. For more information on fatigue, please see the section in this syllabus named "Are You Fit for Duty?"

We are all fully committed to the well-being of our housestaff. As such, should the need arise that you need to speak with someone about personal or professional issues, do not hesitate to contact a member of the Educational Programs Office or the Department Chair anytime of the day or night. However, if you would prefer to confide in an individual not directly affiliated with the department, there is a confidential counseling service offered through the institution's Employee Assistance Program (EAP) or externally through the Residency and Fellow Counseling Services (RFCS) program. Contact information is as follows:

Internally: Location: Jacobsen Hall, Room 510
 Phone Number: 315-464-5760
 FAX Number: 315-464-5773
 Web Address: <http://www.upstate.edu/eap/>

Externally: Resident and Fellow Counseling Services (RFCS)
 <https://phcnv.com/>
 Phone Number: 315-491-3676

O. THE MEDICAL RECORD

Communication can be either oral or written. Regardless of the modality used or the individual/s with whom you are trying to communicate (health care team member, patient, health care proxy, etc.), effective and clear communication is not only vital in delivering outstanding patient care, but it is a legal requirement as well. Malpractice cases and quality assurance citations often revolve around poor communication. As such, the medical record must be of the highest quality and you must make keeping a thorough and updated medical record a priority in your practice of medicine. Tardiness in record keeping will not be tolerated; disciplinary action will result if this should be a recurring problem, including immediate dismissal. *For sites with an EMR, the "copy and paste" function can only be used if 1)you are copy/pasting your own work and 2)you have updated the record to reflect current medical issues; copy/paste of anyone else's work is prohibited unless you 1)assign appropriate authorship and 2)you have updated the record to reflect current medical issues. Inappropriate use of the copy/paste function may lead to legal and/or professional ramifications, including immediate dismissal.* You must ensure a full note is written on your patient daily (a student's note can be used for this purpose, but it must have an addendum demonstrating oversight and accuracy). Please also remember your role as supervisor and educator to our students; thus, it is a requirement that you are reviewing your assigned students' notes on a daily basis and providing feedback in the following manner:

-PGY-1s are responsible for reviewing records entered by Clerkship Students in addition to writing an addendum (student notes can serve as the "legal" note of the day as long as there is an addendum by a house officer/attending).

-PGY-2s/PGY-3s are responsible for reviewing records entered by Acting-Interns in addition to writing an addendum (student notes can serve as the "legal" note of the day as long as there is an addendum by a house officer/attending).

Communication about patients (written and verbal) and all interactions in public areas (the library, wards, hallways, etc) must be conducted in English as a courtesy to others. HIPAA (Health Insurance Portability and Accountability Act) regulations must be followed at all times; failure to do so could lead to immediate termination. In short, all patient-related communications must be kept private and confidential.

Per New York State law and Hospital Policy (UH, Crouse, and the VAH), the attending physician is ultimately responsible for the care of the patient. PGY-1s should exclusively write orders on their patients but residents, fellows, and attendings may write orders in any case where patient safety and well-being dictates (when writing such orders, these individuals should inform the intern). Please refer to institution's website for acceptable/unacceptable abbreviations in written orders/notes. All orders at UH, Crouse, and VAH are via computer entry; in the event that a handwritten order is necessary, the order requires a date, time, signature, and stamp of the prescribing provider.

P. EVALUATION TOOLS AND FORMAL REVIEWS OF PERFORMANCE

Regardless of the length of the rotation/experience, you will be evaluated by those with whom you work (faculty, peers, students, and, in some cases, ancillary staff and patients). In turn, you will evaluate those with whom you work regardless of the length of the experience. All of these are done online via MedHub (<https://upstate.medhub.com/index.mh>), which provides a protected and confidential system in which to complete evaluations. Paula Campion is in charge of MedHub; thus, any questions regarding MedHub should be directed to her via email: campionp@upstate.edu. Your performance, measured against the Next Accreditation System's curricular milestones, will be reviewed semiannually by the Clinical Competency Committee (comprised of the Program Director and a combination of Associate Program Directors, Core Faculty Members, and Chief Residents) and render a Reporting Milestones report that will determine whether training may proceed on schedule or whether remediation (which could include extension of training) will be required.

You will also have additional reviews of your performance per academic year conducted by your assigned mentor (i.e. APD) and the Residency Program Director. At least one meeting per year will include a self-evaluation of your progress. Additional areas covered at these meetings include:

- Reporting Milestones report
- Performance in the following competencies
 - Patient care (to include Procedure Credentialing)
 - Medical knowledge
 - Interpersonal and communication skills
 - Professionalism
 - Systems-based practice
 - Practice-based improvement
- In-training exam results (annual requirement for categorical housestaff)
- Step 3 verification (by June 1st of PGY-2 year)
- Hopkins Online Course progress/verification (by June 1st of PGY-2 year)
- Society of Hospital Medicine modules (PGY-2s)
- Institute for Healthcare Improvement modules (by June 1st of PGY-1 year)
- Malpractice Course progress (annual requirement)
- Didactic attendance (annual requirement)
- Scholarly accomplishments
- Future career planning (fellowships or jobs after residency)

An additional evaluation tool utilized by our program is the ACP In-Service Training Exam (administered in August/September of each year). This test provides you with performance measures in each specialty of internal medicine and also serves as an indicator of your ability to pass the ABIM certifying exam. Categorical housestaff will take this exam annually. The exam is proctored and must be treated with proper respect. Tardiness will not be tolerated. Cheating on the exam will lead to immediate dismissal from the program. This exam is mandatory unless on vacation; however, we strongly encourage that those on vacation make arrangements to sit

for the exam. The exam itself can't be used as a means for promotion/termination; however, we have implemented the following policy as it relates to performance on the exam:

-PGY-2s with a PGY-2 ITE percentile rank of $\leq 25\%$ will be placed into Medical Knowledge improvement whereby they will work with their APD on a program that aims to improve upon weaker-performing subjects.

-PGY-3s on Medical Knowledge remediation as PGY-2s with a PGY-3 ITE percentile rank of $\leq 25\%$ will continue with Medical Knowledge remediation. There will also be a discussion with the Clinical Competency Committee about whether extension of training is necessary to satisfy the Medical Knowledge competency.

-PGY-3s with a first-time PGY-3 ITE percentile rank of $\leq 25\%$ will be placed into Medical Knowledge remediation whereby they will work with their APD on a program that aims to improve upon weaker-performing subjects.

-Irrespective of prior year results, PGY-3s with a PGY-3 ITE percentile rank of $\geq 80\%$ will be excused from Noon Didactics except for Thursday Department Conference for the remainder of their PGY-3 year.

-PGY-1/2s with a PGY-1/2 ITE percentile rank of 80-89% will receive one extra "interview day"/Personal Development Day with no vacation penalty during their PGY-3 year.

-PGY-1/2s with a PGY-1/2 ITE percentile rank of $\geq 90\%$ will receive two extra "interview days"/Personal Development Days with no vacation penalty during their PGY-3 year.

Academic Deficiency is a departmental-based citation and is not communicated to any other inter-institutional entity nor is it meant to be a part of your permanent record; this citation can result from any infraction of Institutional or Departmental policies as well as for poor performance in any of the six ACGME competencies. An Academic Deficiency citation may result in extension of training. Failure to meet the provisions of Academic Deficiency or infractions deemed too egregious for Academic Deficiency will result in *Academic Probation*, an institutional-based designation that will become a permanent part of your personnel file and be reported on any future correspondence to potential employers, certifying boards, and licensing or regulatory agencies. Receiving an Academic Probation citation may result in extension of training, non-renewal of training, or termination of training. For more details, please refer to the Standard Operating Procedure in the institution's GME Resident and Fellow Handbook.

Q. DUE PROCESS

House officers are under the immediate supervision of the Residency Program Director and his/her designees (e.g. Associate Program Directors and Chief Residents) with regard to their residency training. They, in addition to the Clinical Competency Committee and Program Evaluation Committee, routinely review resident progress and program structure. Failure to meet minimum standards may result in non-promotion to the next level (please see "Evaluations and Formal Reviews of Performance" further down in this document for details). The Residency Program Director has the final decision regarding matters related to resident training within the Department, but the trainee may appeal the decision to the Associate Dean of Graduate Medical Education. For more details, please refer to the Standard Operating Procedure in the institution's GME Resident and Fellow Handbook.

Upstate Medical University does not discriminate on the basis of race, sex, sexual orientation, color, religion, age, national origin, handicap, marital status, or veteran status in the recruitment and employment of faculty and staff, in the recruitment of residents, or in the operation of any of its programs or activities, as specified by Federal and State laws and regulations.

The Department of Medicine adheres to all policies and procedures as outlined in the Graduate Medical Education (GME) policy manual for residents. This information is available on MedHub (<https://upstate.medhub.com/index.mh>).

R. COMPLAINTS AND PROGRAM DEFICIENCIES

House officers who feel that they have legitimate programmatic complaints or feel that they have identified deficiencies amongst faculty or colleagues should report them to the Residency Program Director; if you feel that anonymous reporting is more appropriate, you may go to our website (<http://www.upstate.edu/medresidency/current/>) and enter information under “Anonymous Feedback Form”. All complaints will be investigated and, if necessary, corrected. Failure to report such deficiencies will only lead to their perpetuation.

Complaints against the Residency Program Director should be referred to the Chairman of the Department of Medicine or the Associate Dean of Graduate Medical Education.

Complaints about the Chairman should be referred to the Residency Program Director or the Associate Dean of Graduate Medical Education.

Complaints about the Associate Dean of Graduate Medical Education should be reported to the Residency Program Director or the Dean of the Medical School.

S. AMENDMENTS

Amendments to this Policy Manual will be made electronically and posted on our website (<http://www.upstate.edu/medresidency/current/program.php>) and/or be included in the Chief Resident weekly e-mail to the housestaff. Changes/updates to the policies will be dated. They will also be announced at HS meetings. The PGY-1s will review the Policy Manual with the Program Director during orientation and sign an attestation stating they have reviewed the manual and agree to abide by it. The PGY-2s and PGY-3s will be asked to review the policy manual electronically annually and sign an attestation stating they have read the manual and agree to abide by it. EPO will not accept not reading this manual as an allowable explanation for an infraction to the policies outlined; you are responsible for reading and following everything contained within the manual. Questions can be directed to EPO...thank you.

2. INPATIENT INFORMATION

A. TEAM DESCRIPTIONS

University Hospital:

There are currently nine (9) inpatient teams, an ACS service, and a MICU service covered by housestaff at UH:

Team 1 – General Medicine (one resident, two interns)

Team 2 – General Medicine (one resident, two interns)

Team 3 – General Medicine (one resident, two interns)

Team 4 – General Medicine (one resident, two interns)

Team 5 – General Medicine (one resident, two interns)

Team 6 – General Medicine (one resident, two interns)

Team 7 – General Medicine (one resident, two interns)

Team 8 – Hematology (two interns)

Team 9 – Oncology (one resident, two interns)

Team 11/ED – Admitted Patients in ED (Hospitalist, MAR, MAI)

ACS – one resident, at least one IM intern

MICU – four residents, four interns, two night residents

Crouse Hospital:

There is a CICU service at Crouse Hospital:

CICU – 3 residents, 3 interns +/- 1 ED intern, one night resident

VA Hospital:

There are currently four (4) inpatient teams and a VICU service covered by housestaff at VAH:

Team 1 – General Medicine (one resident, two interns)

Team 2 – General Medicine (one resident, two interns)

Team 3 – General Medicine (one resident, two interns)

Team 4 – General Medicine (one resident, two interns)

VICU – one resident

B. ADMISSIONS / TEAM SIZE

ACGME Rules Regarding Inpatient Numbers per Intern and Resident

Interns (PGY-1)

- Interns can follow no more than 10 patients at any one time.
- No more than 5 new patients + 2 transfers can be assigned to an intern during a routine day of work.
- No more than 8 total patients (news + transfers) can be assigned to an intern over a 2-day period.

Senior Residents (PGY-2 and 3)

- With 1 intern on the team:
 - The supervising resident can follow no more than 14 patients at any one time.
 - The supervising resident can only have 5 new patients + 2 transfers assigned to the team during a routine work day.
 - No more than 8 total patients (news + transfers) can be assigned to the team over a 2-day period.
- With 2 interns on the team:

- The supervising resident can follow no more than 20 patients at any one time.
- The supervising resident can only have 10 new patients + 4 transfers assigned to the team during a routine work day.
- No more than 16 total patients (news + transfers) can be assigned to the team over a 2-day period.

With these rules serving as our guide, our own policy will be that any team with two interns can have no more than 16 patients total (20 at VA) for the resident (with no more than 8 for either intern (10 at VA)). When patient demand exceeds our total inpatient capacity, teams can flex to no more than 20 patients (10 per intern), but this should be the exception rather than the rule (and only with EPO's approval). Any team staffed with only a resident can have 8 patients, but may flex to 14 patients if necessary. Any team with a resident with less than 2 interns can have no more than 14 patients (with up to 10 patients allowed for the intern). Beyond flex, overflow will be handled by either an advanced practitioner (with attending supervision), the attending directly, or a separate uncovered service. Overnight coverage will be provided by housestaff night services for all covered (by housestaff) Gen Med and Heme/Onc patients; uncovered (no housestaff) Gen Med patients are covered by the Nocturnist/APPs; uncovered (no housestaff) Heme/Onc patients are covered by housestaff as long as a signout/handoff has occurred. All of the intern-staffed night services include an in-house supervising senior resident and nocturnist attending so that any level of supervision is always available. The Chief Residents will keep track of team numbers daily to the best of their ability. Ultimately, though, it is your responsibility to immediately report an infraction of the above rules to the Chief Residents. Failure to do so could lead to loss of program accreditation (which ultimately will affect your residency training).

Remember, however, no rule nor regulation should ever come before urgent patient care.

C. DAILY FLOOR TEAM SCHEDULE

University Hospital, VA Hospital, Crouse Hospital:

- By 7AM daily:
 - All day services will have received signout from the night services.
- Between 8AM-12PM:
 - Housestaff work with attendings doing discharges and attending to any acute issues.
 - After discharges and acute issues have been dealt with, teams will complete rounds on their patients which should include patient presentations (by housestaff and students), patient exams, plans/orders for the day, and teaching (preferably via the "Teaching Techniques that are Quick" document).
- Between 12-1PM
 - All interns will attend Noon Didactic/Department Conference.
 - faculty will provide 1st-page support during this time.
 - All team residents will attend Noon Report/Department Conference.
- Between 1-4PM
 - Patient Care
- Unless on call, floor team signout may occur at 4PM if work is complete on weekdays; on weekends, signout may occur at 2PM if work is complete (ICU services may have different signout/handoff times).

- The Rotation X resident supervises signout weekdays and we encourage Level 1 faculty supervision of signout on Tuesday afternoons.
- On-call team takes admissions until 7PM and may sign out anytime after 7PM when work is complete.

D. INPATIENT CALL SCHEDULES

UH:

- *All Teams Except Team 5*
 - Floor call is every 4th day 7AM-7PM.
 - Off-call teams stop getting admissions and may sign out (if work is completed) at 4PM on weekdays; Off-call team stops getting admissions and may sign out (if work is completed) at 2PM on weekends.
 - Teams 1,4; 2,6; 3,8; 7,9 will share call together.
 - On Weekends, one intern will work with the resident one day while the other intern will work the other day (see Amion).
 - On Weekends when Team 8 Interns are on long-call, they will be supervised from 2PM-7PM (when providing cross-coverage) by the MAR (or another senior resident on-call designee determined by the MAR depending on workload).
- *Team 5 (Does Not Participate In Regular Call System)*
 - Monday-Friday is 7AM-4PM for whole team; may sign out anytime after 4PM.
 - Team 5 Resident will always serve as the MAR on Sundays 7AM-7PM with no Team 5 responsibilities.
 - Saturday 7AM-7PM for Team 5B Intern; this individual will have 24 hours off starting 7PM Saturday; no admissions after 7PM.
 - This intern signs out at 2PM; serves as Afternoonist MAI until 7PM (supervised by MAR).
 - Sunday 7AM-7PM for Team 5A Intern; this intern has Saturday off; no admissions after 7PM.
 - This intern signs out at 2PM; serves as Afternoonist MAI until 7PM (supervised by MAR).
- *ICU Day Residents*
 - five (5) 12 hour rotations M-F 7AM-7PM
 - one (1) 12 hour rotation Sat or Sun 7AM-7PM; check Amion for details
- *ICU Night Residents*
 - five (5) 12 hour rotations M-F 7PM-7AM
 - one (1) 12 hour rotation Sat or Sun 7PM-7AM; check Amion for details
- *ICU Resident Jeopardy*
 - two (2) 12 hour rotations Saturday and Sunday 7AM-7PM
 - will be responsible for all (and only) admissions and consults
 - one (1) 5 hour rotation on Wednesday to cover Anesthesia Resident's absence (contact Anesthesia resident for exact time)
- *ICU Interns*
 - Mondays-Fridays from 7AM-7PM
 - Saturdays
 - MICU 1/3 7PM-7AM on alternating Saturdays
 - MICU 2/4 7PM-7AM on alternating Saturdays
 - Sundays

- Lettered Electives Intern x 2 7PM-7AM
- *ACS Service*
 - Resident
 - Weekdays and Saturdays
 - 7AM-7PM
 - Sundays
 - 7AM-7PM (coverage provided by MSR or elective resident at the discretion of EPO; See Amion)
 - Interns
 - Weekdays 7AM-7PM
 - Weekends 7AM-7PM, one intern will work with the resident one day while the other intern will work the other day (see Amion).
- *Day MAR*
 - Weekdays and Saturday
 - 7AM-7PM
 - Sundays
 - 7AM-7PM covered by Team 5 Resident
- *Night MAR*
 - Sundays and Weekdays
 - 7PM-7AM
 - Saturdays
 - 7PM-7AM (covered by VA SNF)
- *MSR (Medical Supervising Resident) July-December Only (Elective Thereafter)*
 - Monday-Friday is 12PM-12AM and will supervise all intern admissions and provide back-up admitting support as deemed necessary by the MAR.
 - An addendum must accompany every supervised admission.
 - When Team 8 Interns are on weekday call, the MSR will serve as the Team 8 Resident from 4PM-7PM.
- *Rapid Response Team (backup provided ACS Resident)*
 - Resident
 - Mondays-Saturdays 7AM-7PM
 - Sundays 7AM-7PM covered by VA MAR
 - Intern
 - Monday-Friday 12PM-12AM (except only 7PM on Fridays)
 - Noon Conference Participant from 12PM-1PM
 - Rapid Response Team Member from 1PM-5PM
 - Admitting Manpower 5PM-12AM (Fridays until 7PM)
 - Provides Night MAI support on Saturdays (See Amion)
 - Sundays off
- *Senior Night Float # 1 (also serves as admitting support, med consult, and RRT/Code backup; serves as Tele Triage Mon-Thu 12AM-7AM and Fri-Sun 7PM-7AM)*
 - Sundays-Fridays
 - 7PM-7AM
 - Saturdays
 - 7PM-7AM shift covered by VA Quality/PCMH/Rotation X PGY-3
- *Senior Night Float #2/ Night Rapid Response Team (also serves as admitting support and ACS)*
 - Sundays-Fridays
 - 7PM-7AM
 - Saturdays
 - 7PM-7AM shift covered by VA Quality/PCMH/Rotation X PGY-3
- *Day Medical Admitting Intern (MAI)/ Team ED Intern*

- Weekdays
 - 7AM-7PM Admissions
- No Coverage on Weekends
- *Rotation X Intern*
 - Monday-Friday 8AM-8PM
 - Rotation X from 8AM-12PM
 - Attends Noon Didactics
 - Admitting Manpower 1PM-8PM
 - Provides Night MAI support on Saturdays (See Amion)
 - Sundays off
- *Night Medical Admitting Intern (MAI)/ Team ED Intern*
 - Sunday Night-Friday Night
 - 7PM-7AM
 - Saturday Night 7PM-7AM (covered by RRT or Rotation X Intern or designated elective intern; see Amion)
- *Intern Night Float # 1*
 - Sunday Night-Friday Night
 - 7PM-7AM
 - Saturday Night 7PM-7AM (covered by "Lettered Elective")
- *Intern Night Float #2*
 - Sunday Night-Friday Night
 - 7PM-7AM
 - Saturday Night 7PM-7AM (covered by "Lettered Elective")
- *Medicine Consult (covers Dermatology Consults at UH only)*
 - Weekdays
 - 7AM-7PM (in house)
 - Weekends covering both UH and VA (1st Sat-UH; 1st Sun-VA / 2nd Sat-VA; 2nd Sun-UH)
 - Saturdays and Sundays (covers Tele Triage for entire shift)
 - 7AM-7PM (in house; may also serve as back-up for admissions after 2PM)
 - Covers Tele-Triage when UHCC is closed during the weekdays and only provides coverage from 7AM-7PM.
 - Night Coverage (covered by Senior Night Float #1)
 - All Nights 7PM-7AM
- *ER Service: PGY-3s (covers Crouse NF on Saturday Night)*
 - Mondays-Friday
 - shift as determined by University ED Department.
 - No coverage provided on weekends

Crouse:

ICU Service:

- PGY-2/3s (Golden Mondays/Tuesdays are during week #2 to ensure duty hour compliance; please review with Crouse Chief for details)
 - *When ED Resident is available for CICU #1, the assigned CICU #1 IM Resident becomes jeopardy for all Crouse services.*
 - *ICU call is every third day for 24 hours beginning at 7AM*
 - 24 hour resident may finish work up to 9AM Mon-Sat.
 - 24 hour resident must leave by 7AM on Sundays.
 - *ICU Night Float (must leave at end time of shift)*
 - Sunday and Weekday Nights
 - 9PM-9AM Sunday PM through Saturday AM
 - Saturday Nights

- 9PM Sat-11AM Sun shift covered by University ER Resident (if no Crouse ER Resident available, please see www.amion.com; password: upstateim for schedule).

PGY-1s:

-Weekdays and Weekends

- Every third day from 7AM-9PM (no exceptions); off whichever weekend day you are not on call.
- Non-call days from 7AM-5PM (or until excused by Crouse Attending)

VA:

- *Floor Call is every 4th day from 7AM-7PM*
 - Off-call teams stop getting admissions and may sign out (if work is completed) at 4PM on weekdays; Off-call team stops getting admissions and may sign out (if work is completed) at 2PM on weekends.
 - On Weekends, the Team Resident and one of the interns work call together on one day while the other intern works the same call the other day.
- *ICU service has no call; the workday is 7AM-7PM, Monday-Saturday; Sundays off.*
- *Senior Night Float (Floors & ICU)/MAR*
 - Monday Night-Friday Night
 - 7PM-7AM
 - No coverage provided on Saturday and Sunday nights.
- *Intern Night Float*
 - Sunday Nights-Friday Night
 - 7PM-7AM
 - Saturday Nights 7PM-7AM (covered by VA MAI)
- *Medicine Consult*
 - Weekdays
 - 7AM-5PM
 - On campus
 - 5PM-7PM
 - Home Call (may be UH or VA Med Consult Resident)
 - Weekends covering both UH and VA (1st Sat-UH; 1st Sun-VA / 2nd Sat-VA; 2nd Sun-UH)
 - Saturdays and Sundays (covers Tele Triage for shift)
 - 7AM-7PM (in house; may also serve as back-up for admissions after 2PM))
 - Night Coverage (covered by Senior Night Float or Nocturnist)
 - All Nights 7PM-7AM
- *Day MAR*
 - 7AM-7PM Monday through Friday.
 - Long call senior resident provides coverage on weekends.
- *VA Medical Admitting Intern*
 - 12PM-10PM Monday through Friday (except 7PM on Fridays).
 - No coverage provided on weekends
- *VA PACT/PCMH and Quality*
 - Weekdays 8AM-4PM (mornings in VA Clinic; afternoons with VA Quality Chief)
 - No coverage provided on weekends
- *VA Procedures (Weekdays only)*

E. CONSULTATIVE SERVICES

While not every elective rotation requires call, some do (either for the rotation itself or as coverage for another service); it is your responsibility to check your schedule to determine whether you are needed for call/coverage and must contact the fellow/attending on your 1st day of service. For those with no call/coverage requirement, please don't assume you are free as you may be assigned to Jeopardy service. It is therefore, imperative, that you regularly check your schedule on www.amion.com (password: [upstateim](#)) and refer to the posted Jeopardy schedule; we recommend checking at least weekly. If you are on a service in which weekend coverage (for any period of time) for that service or another rotation is not expected, please verify with the Chief Residents that you in fact have the entire weekend. While you will have at least one consecutive 24 hour period off on a Monday-Sunday cycle, MedHub assumes a Sunday-Saturday work week which may lead MedHub to report a violation (such as a Saturday off during week #1 and a Sunday off during week #2) when one does not exist; we are aware of this issue, but unfortunately at this time there is no way to align MedHub's work week with ours.

F. NON-TEACHING SERVICES

There are patients routinely covered by attendings and advanced practitioners with no direct housestaff involvement; they are typically termed "uncovered services". At UH, each uncovered service is denoted by the letters "OF". For patients being admitted to "OF" from 12PM-8PM (8 hour period), housestaff are not to do the admission; the MAR should assign the patient to the "OF" attending who will then manage the patient's care. From 7PM-12PM (17 hour period), housestaff will admit to "OF" services. Ongoing care of "OF" patients during 7AM-7PM is not by housestaff except during RRT/Code situations; housestaff will provide coverage from 7PM-7AM as long as housestaff night services have received a signout/handoff from the "OF" services.

G. SIGNOUTS/HANDOFFS

Please see section in syllabus titled "Signouts/Handoffs".

3. OUTPATIENT INFORMATION

A. THE CONTINUITY CARE (CC) BLOCK

The ACGME mandates a robust continuity clinic experience over 30 contiguous months of training and with each clinic separated by no more than 4 “working” weeks. All core housestaff will participate in continuity clinic care at University Health Care Center (UHCC) via the “CC Block”.

Housestaff will be a part of the “3 and 1” system in which one week in 4 will be dedicated to the “CC Block” in which there will be four or more continuity clinics Mondays-Fridays; the remaining half-days will be spent in assigned specialty clinics or education sessions. Those on the “CC Block” will participate in their own AM and Noon Conferences at UHCC except for Department Conference on Thursdays where they will attend in WKH 2231. Noon Report (with lunch provided) will be Monday-Friday (except Thursdays) 12PM-1PM at UHCC. Educational sessions include Online Learning Modules, Procedure and Code Simulation Training, Learning To TALK, and Education Through Theater Arts. It is your responsibility to review AMION and UHCC e-mails so that you are on-time wherever you are assigned. Your subspecialty clinic assignments are assigned by the Ambulatory Chief; these assignments can’t be changed without prior approval of the Ambulatory Chief.

Continuity clinic is a vital part of your outpatient internal medicine education and, thus, must be given the same respect as your inpatient experience. Some experiences may be off-campus. You are responsible for providing your own transportation to and from any off-campus experience. Unexcused absences are unprofessional and will be met with forfeiture of CC weekend time-off; repeated unexcused absences will result in Academic Probation which may lead to termination or non-renewal. Only a member of EPO may excuse housestaff from a CC-related responsibility.

You will be supervised by an attending physician or Chief Resident for every clinic you attend. You are expected to present every patient to your supervisor.

Clinic schedules can be accessed at www.amion.com (password: upstateim).

Please see the section “The CC Block” in the Handbook for more details.

B. CONSULTATIVE SERVICES

Certain consult/elective services require that you participate in their respective clinics. Please see “The Residency Curriculum” for further details.

4. ELECTIVES/CONSULTS/RESEARCH

During your three (3)-year training period, it is required that you complete at least one elective week in every Division within the Department of Medicine (Cardiology, Dermatology, Endocrinology, Gastroenterology, General Medicine, Geriatrics, Heme/Onc, Infectious Disease, Nephrology, Pulmonary/Critical Care, and Rheumatology) as well as rotations in Neurology and Palliative Care; Preliminary Interns are exempt from this requirement and are permitted to utilize their elective time in any division or department. Categorical housestaff are allowed to do electives in specialties outside the Department of Medicine, but may spend no more than 2 weeks in any non-Department of Medicine specialty over the entirety of their core training. All elective/consult/research opportunities must be performed at Upstate Medical University or an approved affiliate. Your schedule will include predetermined blocks (based primarily on your schedule requests) of elective/consult/research. However, if your schedule includes blocks titled “elective time” (which indicates that this block of time was left unfilled when the official schedule was released), you must e-mail the EPO at least one (1) month (i.e. 30 days) in advance of the block with your service request and, additionally, complete the following:

- Regarding an on-site research block, you are responsible for seeking out permission from the faculty investigator; if approval is granted, you must fill out a research request form (they are located in EPO or online) and turn it in to EPO at least one (1) month in advance of the rotation. Failure to do this will result in reassignment to a different service for that block. Research time is not fixed with actual time depending on your level of competence in the clinical arena.
- Regarding an on-site consult block, you may choose from Departmental-approved rotations. Failure to do this will result in reassignment to a different service for that block. There are elective opportunities in Medicine-related specialties such as Ophthalmology, Radiology, PM&R, etc.; if interested, please let EPO know at least 30 days in advance and we will do our best to accommodate your request.
- For any other on-site institutional elective, you are responsible for making all arrangements; if the receiving party approves, you must fill out an elective-request form and turn it in to EPO one (1) month in advance of the rotation. Failure to do this will result in reassignment to a different service for that block.

In the rare circumstance that Upstate Medical University or an approved affiliate is unable to fulfill your elective/consult/research request and doing this away rotation is necessary to fulfill your role as a general internist and doing this away rotation will not prevent you from meeting your graduation requirements and being away will not affect the program’s ability to adequately provide for patient care coverage, you may ask for an off-site elective/consult/research experience. If a resident wishes to do an off-site elective/consult/research block, he/she must provide a curriculum, a letter from his/her sponsor, and the reason why the elective/research can’t be done at Upstate (or an approved affiliate), utilizing the form provided by the Upstate’s Graduate Medical Education Office (this form is available in EPO and on the Medhub website under “Recourses/Documents”). Away electives may require the house officer to self-fund his/her own malpractice. *The Chief Residents must first authorize the requested time away (to ensure adequate coverage is in place during your requested absence from the program); if the Chief Residents do authorize the request, the next step is to submit the formal elective request to EPO front office staff who will then aide you in completing whatever is necessary prior to submission to the Program Director. This information is required at three months in advance to ensure that the elective sponsorships are appropriate, meet RRC requirements, and will allow you to receive the required elective credit needed to sit for the Boards. Failure to provide notification in the required time frame will result in the*

elective being denied. The Program Director, the Department Chairman, and the Associate Dean of GME authorize final approval of all off-site electives. At the conclusion of the elective, the elective/research site will do an evaluation. Failure to obtain this documentation may result in credit being denied for the elective/research block. Unless the off-site rotation is program-initiated (as opposed to resident-initiated), the Department of Medicine does not provide funding to cover expenses for off-site experiences; thus, it is the house officer's responsibility to cover all expenses related to the off-site experience. However, the annual \$300 educational allotment you receive would be reasonable to use for such endeavors.

PGY-1s are not eligible for off-site electives under any circumstances

PGY-2s/PGY-3s are not eligible for off-site electives who are not meeting performance standards (which must include receiving a > 25% percentile rank on the most recent in-training exam).

Elective/consult/research time is not considered "relaxation" time. Attendance to your assigned post is mandatory. Failure to demonstrate regular attendance will lead to disciplinary action. You must carry your pager while on elective/consult/research rotations.

While not every elective rotation requires call, some do (either for the rotation itself or as coverage for another service); it is your responsibility to check your schedule to determine whether you are needed for call/coverage. For those with no call/coverage requirement, please don't assume you are free as you may be assigned to Jeopardy service. It is therefore, imperative, that you regularly check your schedule on www.amion.com (password: upstateim) and refer to the posted Jeopardy schedule; we recommend checking at least weekly. If you are on a service in which weekend coverage (for any period of time) for that service or another rotation is not expected, please verify with the Chief Residents that you in fact have the entire weekend. While you will have at least one consecutive 24 hour period off on a Monday-Sunday cycle, MedHub assumes a Sunday-Saturday work week which may lead MedHub to report a violation (such as a Saturday off during week #1 and a Sunday off during week #2) when one does not exist; we are aware of this issue, but unfortunately at this time there is no way to align MedHub's work week with ours.

5. SCHOLARSHIP

Scholarship is an essential part of your residency training and is, thus, a requirement for graduation from the program. As such, every PGY-3 resident will present a 20-minute Senior Capstone on a topic of his/her choosing which will be presented to the Department; these topics must be approved by EPO at least six (6) months in advance of the presentation and must also include a faculty mentor. The PGY-2s will be assigned to conduct a quality review/root-cause analysis of a particular case (assigned and mentored by the Vice Chair of Quality) or Controversies in Medicine assignment and provide a 20-minute presentation to the Department. Finally, every categorical PGY-1 will be assigned a topic by the Chief Residents to present at AM Conference or Intern Report; these lectures should be no more than 20 minutes in duration. The Chief Residents will post the schedule for all of these events at the beginning of the academic year.

Additionally, it is strongly encouraged that you participate in other forms of scholarship during your residency training. Research, be it clinical or basic, and case reports are common forms of scholarly activity.

EPO and your mentors will help you in formulating a research project if you so choose. It is encouraged that background work (literature review, IRB submission and approval, budget submission and approval, etc.) be undertaken during your intern year so that you are prepared to conduct your research project during your assigned blocks in your senior years.

Any potential submission requires EPO approval prior to sending to a journal or society; there are no exceptions to this rule.

To be eligible to present at an EPO-approved regional/national conference or publish in a peer-reviewed, pub-med indexed journal, you must be the lead/first author of the accepted work and you must have first received EPO approval allowing for the submission (the presentation/publication request form can be found at the following website:

*<http://www.upstate.edu/medicine/pdf/research/abstract-poster-submission-req.pdf>). **There are no exceptions to this; submissions to publish/present without first receiving EPO approval to submit will absolutely be denied.** The Department provides an annual Scholarship stipend of \$600; expenses beyond \$600 annually are the house officer's responsibility and all expenses must be approved by EPO (i.e. don't assume the \$600 is automatic as EPO will not reimburse for any expense deemed inappropriate or excessive). EPO will provide up to six (6) days of coverage (with no time-off penalty) per academic year; anytime beyond this requires that you arrange coverage and seek approval of EPO as well as subtract this time out of vacation time.*

You are eligible for a one-time per academic year Scholarship stipend (not Education stipend) increase of \$300 should your first-author manuscript (letters to the editor and case reports are not considered manuscripts; book chapters, review articles, and research/quality papers are considered manuscripts) be accepted for publication in a peer-reviewed journal. You may have more than one manuscript published each academic year (we encourage it!), but the \$300 increase will only occur for the first publication of each academic year. The stipend can be utilized until the end of your PGY-3 year, but is forfeited if not used by the end of your core training in Internal Medicine at Upstate.

The annual \$200 Educational stipend can be put towards the annual Scholarship stipend (can't be rolled over year to year, however), but the Scholarship stipend can never be put towards the Educational stipend.

No coverage and/or funding (of any kind) will be provided for any scholarly activity conducted prior to your employment at Upstate.

6. EDUCATIONAL FORMATS

A. NOON DIDACTICS

Noon Didactics will be held weekdays from 12PM-1PM in Weiskotten Hall, 2231 weekdays (or via virtual means if external conditions warrant as such). Lunch will be provided if in-person.

All PGY-1s (Categorical and Preliminary) must attend every conference unless excused by EPO or on CC Rotation (if on CC rotation, you will be provided the opportunity to view the Noon Didactic at UHCC). Unexcused absences risk Academic Probation while also affecting your lottery number (for scheduling). PGY-1s will also be assigned a topic to present to their colleagues at Noon Didactics (called Intern Report); the Chief Residents will be responsible for scheduling these talks.

PGY-2s/3s on non-required inpatient or CC rotations must attend every conference. Unexcused absences risk Academic Probation while also affecting your lottery number (for scheduling).

We have implemented a policy that associates the PGY-3 percentile rank on the In-Training Exam with PGY-3 attendance at Noon Didactics:

-Irrespective of prior year results, PGY-3s with a PGY-3 percentile rank of $\geq 80\%$ will be excused from Noon Didactics except for Thursday Department Conference for the remainder of their PGY-3 year.

The conference schedule can be accessed by looking at Medicine's calendar at www.upstate.edu.

B. DEPARTMENT CONFERENCE

Department Conference will be held in WKH 2231 (or via virtual means if external conditions warrant as such) from 12PM-1PM Thursdays and will include PGY-3 Senior Capstones and PGY-2s Quality/M&M/Controversies in Medicine Conferences. As such, every PGY-3 resident will present a 20-minute Senior Capstone on a topic of his/her choosing which will be presented to the Department; these topics must be approved by EPO at least six (6) months in advance of the presentation and must also include a faculty mentor. The PGY-2s (and rarely a PGY-3) will be assigned to conduct a quality review/root-cause analysis of a particular case (assigned and mentored by the Vice Chair of Quality and/or Chief Resident of Quality) and provide a 20-minute presentation to the Department. All housestaff from all but our Rapid Response/Code and ICU services must attend; this conference is also open to fellows and faculty. Lunch will be provided if in-person.

C. NOON REPORT

Inpatient Noon Report is required for senior housestaff on floor service and MARs (the latter when available), but floor interns do not attend (as they will be at Noon Didactics); lunch will be provided. University Hospital and the VA Hospital conduct their own sessions weekdays (12-1PM at UH and VA or via virtual means if external conditions warrant as such) except Thursdays (as all housestaff gather for Department Conference). At Noon Report, cases will be presented and MKSAP Board Review will occur. The pre-call team is responsible for presenting at Noon Report. Finally, the first and third Fridays at UH will be designated "Combined IM/EM Morning Report" where each Department will be responsible for presenting a case and the

Team 5 Resident is responsible for this. The Chief Residents may designate the other Fridays to other learning opportunities (such as Journal Club).

Outpatient Noon Report is required for all CC Housestaff (including interns) and will occur at UHCC weekdays (or via virtual means if external conditions warrant as such) from 12:15PM-1PM except on Thursdays where all housestaff will attend Department Conference. Lunch will be provided if in-person.

D. EVIDENCE-BASED LEARNING SERIES

Evidence-Based Learning Series will occur during Noon Didactics (primarily for interns), Noon Report (primarily for residents), and CC Conferences (for all). The Chief Residents are responsible for the scheduling which will include Journal Clubs (with faculty oversight) and Statistics education (provided by faculty).

E. MONTHLY HOUSESTAFF BUSINESS MEETING

The Program Director and the Educational Programs Office will host a monthly meeting for all housestaff to attend (unless otherwise excused by EPO) where a variety of topics and relevant information will be covered in addition to providing an open-forum to address questions/concerns from the housestaff.

F. CLINICAL EXERCISES (Mini CEXs)

During each academic year, all housestaff (categorical and preliminary) are required to complete two (2) “clinical exercises” (CEXs), one (1) inpatient and one (1) outpatient. These are designed to evaluate your history and physical exam skills and must be supervised by an attending. You must fill out the “mini-CEX” form on MedHub and it must be signed by the supervising attending and returned to EPO. You can’t be promoted to your next year of training or graduate without completing your annual CEX requirement.

G. JOHNS HOPKINS MEDICINE INTERNET LEARNING CENTER (PEAC MODULES)

All housestaff are enrolled in the online course provided by Johns Hopkins (<http://www.hopkinsilc.org/>). The curriculum content is excellent providing you with case-based education on a multitude of subjects. Housestaff are required to complete the Hopkins online course curriculum by June 1st of the PGY-2 year; failure to complete the assigned modules will lead to Academic Probation and delay in promotion to the PGY-3 year.

H. SOCIETY OF HOSPITAL MEDICINE (SHM) CONSULTS

As modules designed to improve knowledge and care of patients in consultative and peri-operative medicine, all PGY-2s are required to register for this online course (<http://www.shmconsults.com/>) and complete two modules per Med Consult rotation (generally, four 1-week rotations during the PGY-2 year; thus, a total of 8 modules) and provide EPO with a hard-copy certificate of the two modules completed at the end of each Med Consult Rotation. Failure to complete the assigned modules will lead to Academic Probation and delay in promotion to the PGY-3 year.

I. INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI) OPEN SCHOOL

As modules designed to enhance understanding of quality and patient safety measures, housestaff are required to register for this online course upon starting internship and have until June 1st of the PGY-1 year to complete the course for the basic certificate; additional courses can be completed if so desired. The course can be accessed at the following site: (<http://www.ihl.org/offerings/IHIOpenSchool/Courses/Pages/default.aspx>). Failure to complete the assigned modules will lead to Academic Probation and delay in promotion to the PGY-2 year.

Preliminary Interns are required to complete this course as well; failure to do so will lead to Academic Probation and delay in promotion to the Advanced training program.

J. BIOETHICS TRAINING

We have partnered with the Department of Bioethics and Humanities at Upstate to provide you with an annual forum on bioethics. At this retreat, you will receive some formal instruction on medical ethics, but the majority of your time will be spent on role playing ethical dilemmas. Prior to and after the completion of each annual retreat you may be asked to fill out the MERJT/DIT evaluation tool.

K. SIMULATION TRAINING AND PROCEDURE CREDENTIALLING

Simulation training has become an integral part of residency training. While we continue to expand simulation training at our institution, our current modes of simulation include procedure and mach code practice at the Simulation Center and VA Simulation Center, POCUS training at the Simulation Center and UH/UHCC, role playing during the annual Bioethics Retreat and Education Through Theater Arts (ETTA) program, and the standardized patient encounters during the Learning to TALK (Treat All Like Kin) sessions.

ABIM Position on Procedures

The performance of all invasive procedures requires the ability to facilitate an effective discussion with patients regarding risk and benefit of the procedure before obtaining consent, a critical task that all internists must effectively perform. Internists who perform any invasive procedures must be able to initiate a standardized preparation beforehand including hand washing, donning of sterile gloves, preparation of the procedural field, and application of some form of anesthetic.

Program-Required Procedures

Our residency program recommends or requires you be credentialed in the following procedures in order to graduate: ACLS (required every 2 years), arterial blood gas (3), pelvic exam (3), central line placement (5 from the same site: IJ, Subclavian, or Femoral), arterial or venous central line removal (3), arterial line placement (5), nasogastric tube placement, either Keofeed or non-Keofeed (3), lumbar punctures (3), thoracentesis (3), and abdominal paracentesis (3). Failure to achieve competency in these procedures could have an impact on your ability to graduate as well as secure an after-graduation job.

For any procedure listed above, you must log the procedure into MedHub; the supervising proceduralist will be notified that procedure verification/sign-off is requested. You can log in to our Upstate MedHub site which provides a written description of each required procedure as well as, where available, a video tutorial.

L. ANNUAL BOARD REVIEW

The Chief Residents coordinate an annual Board Review series in which invited faculty will present high-yield, essential information relevant to their specialty in preparation for the ABIM certifying exam. The Board Review series is conducted in May and June each year and is specifically designed for the graduating residents. Interns and 2nd year residents are, of course, welcome to attend.

EPO will not provide coverage for this or external board review courses.

M. ONLINE MALPRACTICE COURSE

Med-IQ's Online Risk & Patient Safety Education can be accessed via the following URL:
<https://uumas.elmexchange.com/ccc/intro.asp?p=lo>
Housestaff are required to complete this annual requirement.

7. BENEFITS

A. EDUCATIONAL STIPEND

The program provides annual ACP membership to all categorical housestaff, MKSAP digital for all PGY-2s and PGY-3s, and an annual \$200 educational stipend for all housestaff that may be used for anything relating to your residency education (please reach out to EPO if uncertain if desired purchase would qualify); however, the Department will not reimburse for phone/PDA combinations (i.e. I-Phone or Smartphone); PDAs alone (i.e. no phone) are reimbursable. For items purchased, you must submit your original receipt to the Business Office (c/o Barbara Murphy, 550 East Genesee Street, 2nd Floor; phone number 464-4525) for reimbursement.

Unused money does not carry over to the following year (i.e. use it or lose it).

B. SCHOLARSHIP STIPEND AND CONFERENCE ATTENDANCE

Any potential submission requires EPO approval prior to sending to a journal or society; there are no exceptions to this rule.

To be eligible to present at an EPO-approved regional/national conference or publish in a peer-reviewed, pub-med indexed journal, you must be the lead/first author of the accepted work and you must have first received EPO approval allowing for the submission (the presentation/publication request form can be found at the following website: <http://www.upstate.edu/medicine/pdf/research/abstract-poster-submission-req.pdf>). There are no exceptions to this; submissions to publish/present without first receiving EPO approval to submit will absolutely be denied. The Department provides an annual Scholarship stipend of \$600; expenses beyond \$600 annually are the house officer's responsibility and all expenses must be approved by EPO (i.e. don't assume the \$600 is automatic as EPO will not reimburse for any expense deemed inappropriate or excessive). EPO will provide up to six (6) days of coverage (with no time-off penalty) per academic year; anytime beyond this requires that you arrange coverage and seek approval of EPO as well as subtract this time out of vacation time.

You are eligible for a one-time per academic year Scholarship stipend (not Education stipend) increase of \$300 should your first-author manuscript (letters to the editor and case reports are not considered manuscripts; book chapters, review articles, and research/quality papers are considered manuscripts) be accepted for publication in a peer-reviewed journal. You may have more than one manuscript published each academic year (we encourage it!), but the \$300 increase will only occur for the first publication of each academic year. The stipend can be utilized until the end of your PGY-3 year, but is forfeited if not used by the end of your core training in Internal Medicine at Upstate.

The annual \$200 Educational stipend can be put towards the annual Scholarship stipend (can't be rolled over year to year, however), but the Scholarship stipend can never be put towards the Educational stipend.

No coverage and/or funding (of any kind) will be provided for any scholarly activity conducted prior to your employment at Upstate.

C. LIBRARY SERVICES

As a member of the Upstate community, you have full access to the institution's library in Weiskotten Hall. Please see the Upstate website for library hours (www.upstate.edu).

The Department of Medicine also has a library located on the 5th floor of University Hospital (room 5342; code 5342). Computers with on-line capability, institutional library

access, UpToDate, and printing capability are available for your use. Your mailboxes are also located here; the staff will organize and sort your mail for you. The Department's library, however, is not your personal locker; as such, no personal items should be stored here and any such items found will be delivered to University Hospital's Lost and Found. The Department is not responsible for any lost/stolen items left in this room (or any area that is not your locker for that matter).

D. COMPUTER SERVICES

Computers are available throughout the hospital, most of which have on-line access as well as UpToDate subscriptions. Additionally, you will be assigned an Upstate e-mail account that can be accessed from within or outside the institution. The username is typically the first 7 letters of your last name plus your first name initial. The password will be assigned upon arrival to Upstate. Please be advised that e-mail is the most utilized form of communication at this institution; therefore, you should be checking your Upstate e-mail account daily. It is not an acceptable excuse to indicate you didn't know something because you didn't check e-mail.

E. PAGERS

The program provides you with a text pager when you arrive. You must turn in your text pager at the end of your training at Upstate. Failure to do so will prohibit you from graduating.

F. WHITE COATS

The program provides you with two (2) white coats free of charge in your intern year, and one (1) coat per year thereafter. You will be measured during the Intern Orientation Week. Your name and department will be embroidered. As the white coats don't become available until a few weeks after your training begins, it would be advisable to bring a white coat when you first arrive. Laundry service is also provided free of charge. Drop off and pick-up are in UH 6701 and the code to enter the room is 44503.

G. LOCKERS

The program provides you with an on-campus locker to store your personal belongings. Personal belongings should not be kept in public areas as there is no guarantee of their safety.

H. CALL ROOMS

For those services that require 24-hour call or night-service, call rooms are provided. Please make every effort to keep these rooms clean. At University Hospital, the rooms (E6416 A, D, and E) are located on the 6K wing and can be accessed via the following code: 123. There is an additional lounge with call rooms on the West Wing, 8th floor with card access; code 5342. The VA call rooms are located in the 9th floor of VA and is password-protected. Crouse ICU call rooms are located near the waiting areas on the 3rd floor.

I. NOTARY PUBLIC

EPO provides free notary public services, but you may only use this service if your professional obligations have been met (i.e. no delinquent charts, dictations, signatures, etc.).

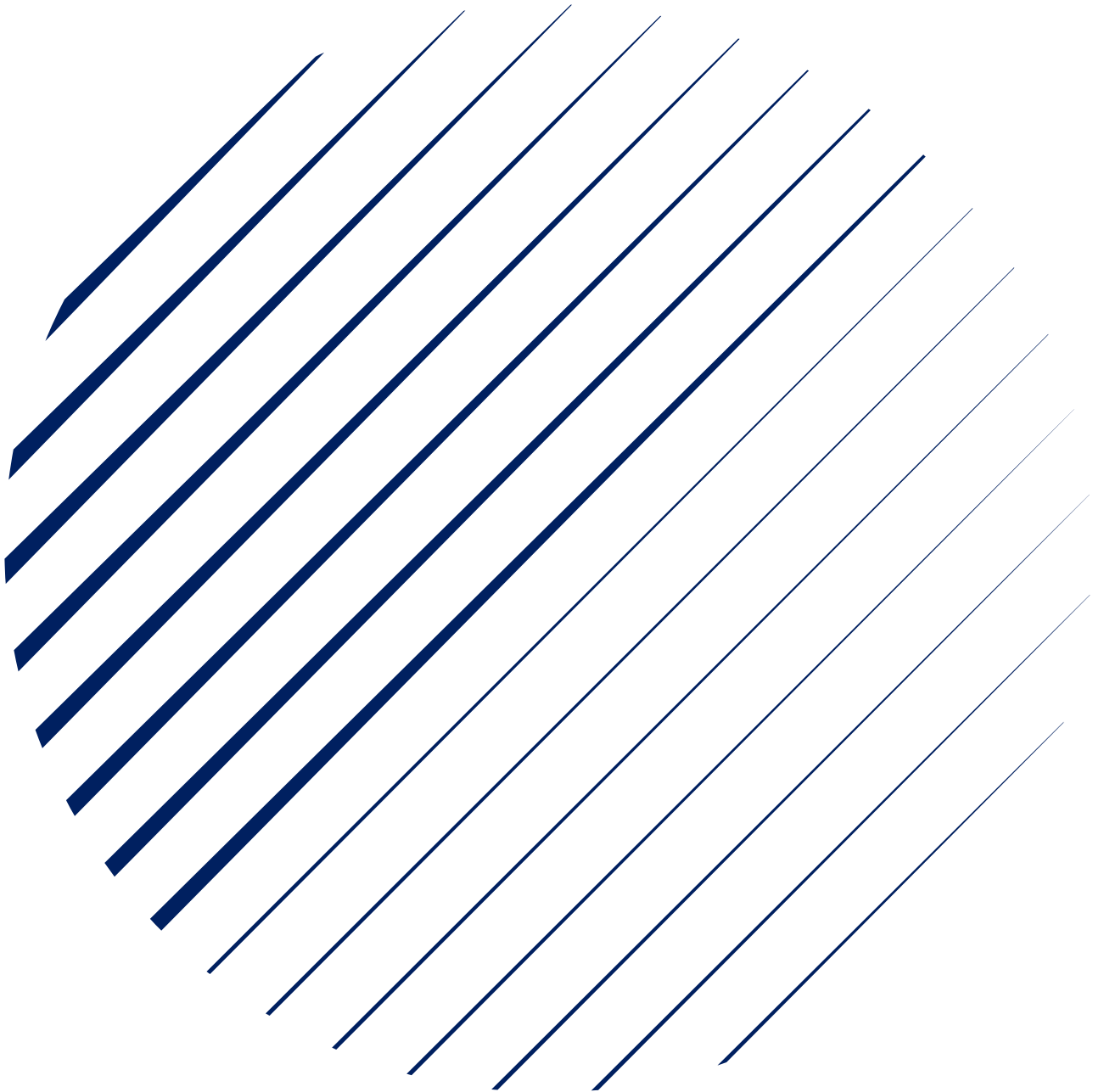
Residency Policy Manual Attestation

I have thoroughly read and understand the Residency Policy Manual and pledge to uphold and honor all that is contained within the document.

Your Signature

Date Signed

Are You Fit For Duty



Department of Medicine

Are You Fit For Duty?

EPO must ensure a culture of professionalism that supports patient safety and personal responsibility. The following is taken directly from the ACGME's Common Program Requirements:

VI.C. Well-Being

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

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

VI.C.1. This responsibility of the program, in partnership with the Sponsoring institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

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

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

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including

means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

Our programs are designed to challenge the mind and body during your training period with the goal of producing the finest internists and subspecialists in the country. We recognize that these years will not be easy. Not being easy, however, doesn't mean

promoting a culture of “malignant” training.

While physician burnout is unfortunately all too common, it is not unavoidable as long as both the program (EPO) and the trainee (you) remain cognizant of the importance of maintaining balance in both the professional and personal arenas. From a core program perspective, EPO has developed the 3+1 scheduling system for categorical housestaff whereby no inpatient experience lasts more than 2 weeks and no night experience lasts more than 1 week. We have employed the same rules for preliminary interns although advanced program requirements have necessitated that preliminary schedules be adjusted such that there may be back-to-back inpatient experiences. When you are in-house, the institution has provided lounges that include entertainment options, exercise equipment, and rest areas. We have also limited 24 hour call to the PGY-3 level and only while rotating in the Crouse ICU. All have a guaranteed 24 hours off each week; furthermore, we have endeavored to provide at least one full weekend every 4 weeks (this is the case for categorical housestaff; we have the same goal for preliminary interns, but advanced program requirements have made this difficult to achieve in every 4 week period) and aimed to reduce weekend coverage while on elective services. There is also a Social Committee, selected by and composed of housestaff, whose mission is to develop events throughout the year that will relax the mind and reenergize the soul. Finally, EPO has monthly meetings with the entire core group, semi-annual class meetings with the Chair, quarterly individual meetings with the APD/PD to discuss not only your professional development but also your well-being, and resources on our website to promote wellness and resilience. From a personal perspective, you are encouraged to develop a schedule that incorporates healthy eating habits, adequate exercise, proper sleep, and, perhaps most importantly, fun!

Still, we must recognize that despite our best efforts, fatigue, stress, and burnout may develop. This can be a danger to you, but also to those around you such as your colleagues and your patients. It is your professional duty to identify fatigue, stress, and burnout amongst yourselves and understand what measures our institution has in place to protect you and others should it develop. Within our Blackboard on-line education site, there is “Fatigue Training” listed under the course “Graduate Medical Education”. Part of this training includes a PowerPoint presentation titled “SAFER” which is required viewing prior to beginning training in our program and should be reviewed annually.

We are all fully committed to the well-being of our housestaff. As such, should the need arise that you need to speak with someone about personal or professional issues, do not hesitate to contact your supervisor, a member of the Educational Programs Office, or the Department Chair anytime of the day or night. However, if you would prefer to confide in an individual not directly affiliated with the department, there is a confidential counseling service offered through the institution’s Employee Assistance Program (EAP) or externally through the Residency and Fellow Counseling Services (RFCS) program. Contact information is as follows:

Internally: Location: Jacobsen Hall, Room 510
 Phone Number: 315-464-5760
 FAX Number: 315-464-5773
 Web Address: <http://www.upstate.edu/eap/>

Externally: Resident and Fellow Counseling Services (RFCS)
 <https://phcnyc.com/>
 Phone Number: 315-491-3676

“Know thy Body”

While we all share a responsibility in monitoring fitness for duty for any employee/student at Upstate, there is no more important “fitness evaluator” than the individual him/herself.

You are unfit for work if under the influence of any illicit substance or alcohol; I would also argue that it is unprofessional (and, thus, grounds for Academic Deficiency/Probation) to be imbibing on any legal or illegal substance that you know will prohibit you from carrying out your responsibilities in a safe manner. You must also remain cognizant of legally prescribed or over-the-counter medications as they too can adversely impact your abilities to carry out your job via their effects on your physical and mental well-being.

In addition to legal or illegal substances affecting fitness for duty, there are “every-day” situations that may affect your ability to work, and they don’t necessarily have to have a negative connotation. Obvious “negatives” would include loss/illness of a loved one, the ending of a relationship, your own acute illness, an exacerbation of an underlying chronic condition, or suicidal/homicidal ideations. Other situations, that most would consider “positive” in their overall impact but a stress just the same would include marriage, having a baby, and moving into a new home. You need to look within yourself to determine whether any of these situations could impact your ability to work and, if so, you must reach out to program leadership such that patient care and/or your own well-being is never compromised.

We must remain vigilant in determining fitness for duty as lives hang in balance, namely your patients’ and your own

This policy is designed to:

- a. Provide guidance to both residents/fellows and supervisors when a resident/fellow is unfit for duty
- b. Provide a schedule of available coverage so that pulls can be made in a fair and equitable manner when needing to relieve those deemed unfit for work.
- c. Delineate the resident’s responsibility for coverage.
- d. It is not designed to change definitions of time off for human resources/payroll purposes. These remain unchanged.**

PROCEDURE WHEN NOT FIT FOR DUTY:

If a post-graduate trainee does not feel fit for duty, the following should be done:

- For Core Housestaff:
 - o The house officer must contact the on-call Chief Resident (which can be determined by either looking at Amion or contacting the hospital operator).
 - o The Chief Resident will provide counsel/guidance when needed to the unfit house officer as well as make arrangements for coverage, if needed. Under some circumstances (if signout/handoff is needed), the Chief Resident will ask the unfit house officer to contact the pulled/covering house officer.
- For Fellows:
 - o The fellow must contact the Subspecialty Program Director.
 - o The Subspecialty Program Director will provide counsel/guidance when needed to the unfit fellow as well as make arrangements for

coverage, if needed. Under some circumstances (if signout/handoff is needed), the Subspecialty Program Director will ask the unfit fellow to contact the pulled/covering individual.

- For Chief Residents:
 - o The Chief Resident will contact the Core Program Director.
 - o The Core Program Director will provide counsel/guidance when needed and ensure that the Chief Resident's responsibilities are covered by the other Chief Residents or by the Program Director.

If a supervisor feels a house officer is unfit for duty, the following should be done:

- For Core Housestaff:
 - o The supervisor will contact the Chief Resident who will then determine if the house officer is unfit for work, and, if so, will do as above.
- For Fellows:
 - o The supervisor will contact the Subspecialty Program Director who will then determine if the fellow is unfit for work, and, if so, will do as above.
- For Chief Residents:
 - o The supervisor will contact the Core Program Director who will then determine if the Chief Resident is unfit for work, and, if so, will do as above.

If a non-supervising colleague/peer feels a house officer is unfit for duty, the following should be done:

- For Core Housestaff:
 - o The Chief Resident will be contacted who will then determine if the fellow is unfit for work, and, if so, will do as above.
- For Fellows:
 - o The Subspecialty Program Director will be contacted who will then determine if the fellow is unfit for work, and, if so, will do as above.
- For Chief Residents:
 - o The Core Program Director will be contacted who will then determine if the Chief Resident is unfit for work, and, if so, will do as above.

In all situations, it is the responsibility of the unfit individual to contact their supervisor as outlined above and it is the responsibility of the contacted supervisor to determine if and what institutional resources may be needed to aide the unfit individual. For all of the above, the Core Program Director, the Chair of Medicine, and/or the Associate Dean for Graduate Medical Education are available to discuss "fitness for work" for any member of the housestaff.

TIME-OFF POLICY:

Please see the section titled "Time-Off Policy" in the syllabus.

ADDITIONAL NOTIFICATIONS FROM GME:

1. As a general rule, each resident/fellow will be expected to complete an equal share of weekend and holiday calls. If the resident/fellow is unable to meet this responsibility due to illness or another situation as listed above, the resident/fellow will complete the requisite number of calls at a later date as determined by the Program Director or Chief. It should be understood that

receiving return coverage is a courtesy but is not an absolute requirement and may not be possible in all situations. SUNY Upstate Medical University's institutional policy allows employees to be out for a number of sick days without consequences. It is in this regard that professionalism and courtesy should exist.

NOTE: Repayment of coverage may never result in an ACGME or New York State duty hours regulation violation, no matter what the circumstances.

2. If a resident/fellow is out sick greater than three days, documentation must be brought to the Program Director's attention within 24 hours of returning to work. Documentation needs to show the name, date, time, and place where the resident/fellow was seen. Diagnosis does not need to be disclosed as this information is confidential. Failure to comply with the documentation requirement could lead to comments regarding professionalism in the final evaluation of the resident/fellow or disciplinary action.
3. For extended absences/illness, please refer to the institutional policy on Leaves of Absence available on SUNY Upstate's website. Residents and fellows should be mindful of individual Board requirements that may set limits on the amount of leave one may take at any level. In most cases, vacation time cannot be forfeited for leave.
4. While every attempt will be made to cover a resident or fellow with another resident or fellow, the final authority for patient care and supervision lies with the attending. In all cases when another resident or fellow cannot cover or cannot be reached, the attending on service will provide this coverage.

Department of Medicine

Are You Fit for Duty?

Additional Thoughts on Fatigue

I suspect we have all been fatigued at some point in our lives, either physically, mentally, or both. While the career we have chosen requires that we operate under conditions of stress, we must be mindful that there comes a point where we need to step back and recognize our professional limitations. It is critically important, therefore, that fatigue be recognized and, more importantly, avoided as your education and, most importantly, the care of your patients may suffer.

Situations that Lend Themselves to Fatigue

- Abrupt changes in your work schedule
- Changes in your diurnal cycle (i.e. night shifts)
- Extended call beyond your normal sleep-wake cycle
- Challenging work conditions (i.e. busy service, complex patients)

Signs and Symptoms of Fatigue

- Feeling tired
- Inability to focus or concentrate on your job
- Drifting/nodding off to sleep
- Impairment in cognition
- Personality changes
- Emotional lability
- Poor work performance

The Potential Complications of Fatigue

- Harm to yourself (i.e. work-related injury or while driving a vehicle)
- Harm to your patients (i.e. procedure-related complication, medication errors)
- Alterations in lifestyle choices (i.e. alcohol or illicit drug abuse)
- Difficulty with mood management (i.e. anger, depression)
- Poor work performance

If You Are Fatigued

- You should immediately ask for help from a colleague.
- You should immediately contact a member of the Educational Programs Office (Chief Resident, Associate Program Director, Residency Program Director) so that arrangements can be made to relieve you from your duties.
- YOU SHOULD NOT DRIVE!!!

If You Recognize Fatigue in Another Individual

- You should ask that individual if they are indeed fatigued.
 - If the individual answers yes, you should ask that individual to relieve him/herself from his/her responsibilities.
 - If the individual refuses to do, you should contact his/her superior.
 - If the individual answers no, but you are still concerned, you should contact the individual's superior.

For further information on fatigue, please go the GME course on MedHub

DIKE DRUMMOND, MD

PHYSICIAN BURNOUT

Its Origin,
Symptoms, and
Five Main Causes



Burnout is everywhere, but you can't
fight an enemy unless you recognize it.

There is an epidemic of physician burnout in the United States, and it has a pervasive negative effect on all aspects of medical care, including your career satisfaction. According to one researcher, “Numerous global studies involving nearly every medical and surgical specialty indicate that one in every three physicians is experiencing burnout at any given time.”¹ The 2015 Medscape Physician Lifestyle Survey reported an even higher burnout rate – 46 percent of physicians, up from 39.8 percent in the 2013 survey.²

At your next physician staff meeting, take note of your colleagues sitting on either side of you. At least one of you is likely experiencing burnout.

Burnout is directly linked to an impressive list of undesirable consequences.³⁻⁸

- Lower patient satisfaction and care quality,
- Higher medical error rates and malpractice risk,
- Higher physician and staff turnover,
- Physician alcohol and drug abuse and addiction,
- Physician suicide.

Yes, burnout can be a fatal disorder. Suicide rates for both men and women are higher in physicians than the general population and widely underreported.⁹

So, before we go on, let’s agree that physician burnout is bad on multiple levels – bad for doctors and their families, bad for staff and patients, and bad for organizations. And burnout is everywhere, all the time.

Unfortunately, although physician burnout is incredibly common and damaging, it remains a taboo subject in the workplace. Stress management and burnout prevention are not covered in detail in medical school or residency training.

In this article, we will fill this hole in your medical education by exploring burnout’s origin, cardinal symptoms, and five main causes. In future articles, we will explore multiple, field-tested burnout prevention tools to help you lower your stress level and build more life balance and a more ideal practice.

The origin of physician burnout

Burnout originates from a disorder of energy metabolism. This is not the Krebs cycle. It is more like “the force” in *Star Wars*. A common metaphor for burnout is *the battery*. Physicians often discuss exhaustion and burnout as a state where, “My batteries are just run down.” This battery metaphor is at odds with reality for the following reasons.

When a toy’s battery runs out, what does the toy do? It stops working. When did you ever stop working – ever? The answer is likely “never” because if you had stopped working at any time during medical school, residency, or practice, it would have had a negative effect on your career.

A much more accurate and useful metaphor for burnout is *the energy account*. Like a bank account, it can have a positive or negative balance. You withdraw energy from this account for the activities of your life and medical practice. You deposit energy into this account during times of rest and rebalance. When you dip into a negative balance, the account does not get closed. You keep spending (or working) despite the fact that your energy account is depleted. (See “Your energy account: full or empty?” page 45.)

Burnout is the constellation of symptoms that occur when your energy account has a negative balance over time. You can continue to function in this depleted state; however, you are a shadow of the doctor you are when your account has a positive balance.

There are actually three types of energy accounts inside each of us:

1. Your physical energy account. You make energy deposits here by taking care of your physical body with rest, exercise, nutrition – all the things we learned not to do in our training.

2. Your emotional energy account. You make energy deposits here by maintaining healthy relationships with the people you love – your friends and immediate family. Recharge here is essential if you are to have the energy necessary to be emotionally available for your patients, staff, family, and friends.

3. Your spiritual energy account. You make deposits here by regularly connecting with your personal sense of purpose. In your practice, this occurs when you have an ideal patient interaction. This is the visit where you say to yourself afterwards, “Oh yeah, that is why I became a doctor.” You can connect with purpose outside of work as well. One example for me is when I coach my children’s youth soccer teams. If you go long periods without connecting with purpose, this account is drained and you may have a lot of trouble seeing a reason to carry on.

As physicians, we each have a moral imperative to keep our energy accounts in a positive balance because of a physical reality I consider to be the first law of physician burnout: **“You can’t give what you ain’t got.”** If you remember nothing else from this article, please remember this law. ➤

About the Author

Dr. Drummond is a family physician, CEO of TheHappyMD.com (www.TheHappyMD.com), author of *Stop Physician Burnout: What to Do When Working Harder Isn’t Working*, and developer of the “Burnout Proof” mobile app for physicians. He was a general session speaker at the 2014 AAFP Scientific Assembly. Author disclosure: Dr. Drummond is an author, speaker, and consultant on the subject of physician burnout. © 2015 Dike Drummond, MD.

Your best work and your best life depend on your ability to manage these energy levels. Your leadership skills, quality patient care, empathy, your skills as a spouse and parent – all of these rely on a positive energy balance. And yet we are not trained to notice or care for our energy levels. Instead, we are conditioned to ignore our physical, emotional, and spiritual energy levels and carry on despite complete exhaustion of our energy reserves, placing us at very high risk for burnout.

Burnout's three cardinal symptoms

The accepted standard for burnout diagnosis is the Maslach Burnout Inventory, developed by Christina Maslach and her colleagues at the University of San Francisco in the 1970s. She later described burnout as “an erosion of the soul caused by a deterioration of one’s values, dignity, spirit, and will.”¹⁰ Here are the three main symptoms (which correspond with the three energy accounts we just discussed):

1. Exhaustion. The physician’s physical and emotional energy levels are extremely low and in a downward spiral. A common thought process at this point is, “I’m not sure how much longer I can keep going like this.”

2. Depersonalization. This is signaled by cynicism, sarcasm, and the need to vent about your patients or your job. This is also known as “compassion fatigue.” At this stage, you are not emotionally available for your patients, or anyone else for that matter. Your emotional energy is tapped dry.

3. Lack of efficacy. You begin to doubt the meaning and quality of your work and think, “What’s the use? My work doesn’t really serve a purpose anyway.” You may worry that you will make a mistake if things don’t get better soon.

SERIES OVERVIEW

In this three-part article series, we will explore the following:

- **Part 1:** Burnout’s symptoms and causes,
- **Part 2:** Proven methods to lower physician stress levels,
- **Part 3:** Proven methods to recharge and create more life balance.

Recent research shows that men and women suffer from exhaustion and compassion fatigue equally. However, symptom three, “lack of efficacy,” is much less common in men. Male physicians are far less likely than female physicians to doubt the meaning and quality of their work, no matter how burned out they are.¹¹

Burnout can happen slowly over time in a chronic grinding fashion – the classic “death by 1,000 paper cuts.” It can also crash down on you in a matter of minutes when it is triggered by a traumatic outcome, lawsuit, devastating medical error, or equally tragic circumstance in your personal life.

The five main causes of burnout

In more than 1,500 hours of one-on-one coaching experience with burned out physicians, here are the five causes of burnout I see most often.

1. The practice of clinical medicine. Being a physician has been and always will be a stressful job. This is a fundamental feature of our profession for a simple reason. We are dealing with hurt, sick, scared, dying people, and their families. Our work takes energy even on the best of days. Our practice is the classic high-stress combination of great responsibility and little control. This stress is inescapable as long as you are seeing patients, no matter what your specialty. As you read on, note that this is the only one of the five causes of burnout we actually learn to cope with in our training.

2. Your specific job. On top of the generic stress of caring for patients, noted above, your specific job has a set of unique stresses. They include the hassles of your personal call rotation, your compensation formula, the local health care politics associated with the hospital(s) and provider group(s), the personality clashes in your department or clinic, your leadership, your personal work team, and many, many more.

You could change jobs to escape your current stress matrix, but your next position would have all the same stressors at different levels of intensity. It is tempting to believe a different practice model would be less stressful. However, moving from an insurance-based practice model to concierge or direct pay, or from an independent setting to an employed setting, simply switches one set of stressors for another.

3. Having a life. In an ideal world, your personal life is the place where you recharge

Studies indicate that one in every three physicians is experiencing burnout.

Burnout occurs when your physical, emotional, or spiritual energy reserves are depleted.

Burnout is often characterized by exhaustion, cynicism, and self-doubt.

from the energy drain at work. Two major factors can prevent this vital activity:

- We are not taught life balance skills in our medical education. In fact, our residency training teaches us just the opposite. We learn and practice ignoring our physical, emotional, and spiritual needs to unhealthy levels and then carry these negative habits into our career. You work until you can't go any longer, and then you keep going. To do otherwise could be seen as a sign of weakness. (See cause No. 4 below.)

- Multiple situations could arise at home that eliminate the opportunity to recharge your energy account. Your life outside your practice then switches from a place of recharge and recuperation to an additional source of stress. The causes range widely from simple conflicts with your spouse to illness in a child, spouse, or parent to financial pressures and many more. You may have seen this in a colleague who suffered the downward spiral of burnout at work in the absence of any new work stress. If you reach out to a colleague who appears to be burned out, you must ask, "How are things at home?" to reveal this burnout cause.¹²

4. The conditioning of our medical education. Several important character traits

essential to graduating from medical school and residency emerge during the premed years. Over the seven-plus years of our medical education, they become hard wired into our day-to-day physician persona, creating a double-edged sword. The same traits responsible for our success as physicians simultaneously set us up for burnout down the road. Here are the top four character traits I see in my physician coaching practice and how to identify this programming when you are in its grip:

- **Workaholic** – Your only response to challenges or problems is to work harder,
- **Superhero** – You feel like every challenge or problem sits on your shoulders and you must be the one with all the answers,
- **Perfectionist** – You can't stand the thought of making a mistake – *ever* – and hold everyone around you to the same standard,
- **Lone ranger** – You must do everything yourself and end up micromanaging everyone around you.

In addition, we physicians absorb two prime directives. One is conscious and quite visible: "**The patient comes first.**" This is a natural, healthy, and necessary truth when we are with patients. However, we are never shown the off switch. If you do not build the habit of putting yourself first when you are not with patients, burnout is inevitable.

The second prime directive is never stated, deeply unconscious, and much more powerful: "**Never show weakness.**" To understand this programming, try this thought experiment. Imagine you are back in your residency. A faculty member walks up to you and says, "You look really tired. Is everything OK?" How would you respond – and how quickly would that response come out of your mouth? Most of us would immediately answer that we are "fine." This knee-jerk defense makes it difficult to help physician colleagues even when their burnout is clear to everyone on the team.

Put the five personality traits together with the two prime directives, and you have the complete conditioning of a well-trained physician. Combine this with a training process that is very much like a gladiator-style sur-

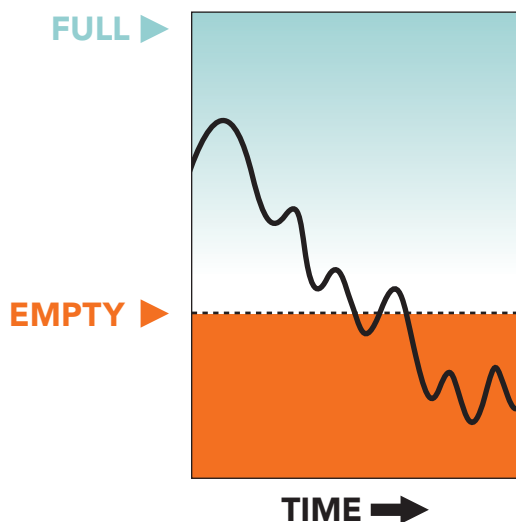
The stresses of caring for patients and working in your particular job situation can contribute to burnout.

Life outside of medicine should recharge your energy levels, but that isn't always the case.

Traits encouraged in physician training and responsible for our success (e.g., perfectionism) may make us more susceptible to burnout.

YOUR ENERGY ACCOUNT: FULL OR EMPTY?

We *withdraw* energy from this account for the activities of our life and work. We *deposit* energy to this account during times of rest and rebalance. Burnout occurs when there is a negative balance over time.



vival contest, and doctors become hard wired for self-denial and burnout.

5. The leadership skills of your immediate supervisors. Outside of health care, there is a management saying, “People don’t quit companies; they quit their boss.” There is wide acceptance that your work satisfaction and stress levels are powerfully affected by the leadership skills of your immediate supervisor.

We know this is true for physicians too. A recent study shows a direct relationship between the quality of your boss and your burnout and job satisfaction levels.¹³ In this era in which physician groups are forming much more quickly than they can find trained doctors for their leadership positions, having either an unskilled or, worse, an absent boss to report to is common. This fifth cause of burnout has only recently joined the classic four above. It is a significant source of stress for many employed physicians.

■ Although the patient must come first in the office, physicians must learn to put themselves first at times.

■ Fear of showing weakness may lead to chronic defensiveness that eventually leads to burnout.

■ There is a direct relationship between the quality of your boss and your burnout and satisfaction levels.

How can you recognize when you are burning out?

When our energy accounts drop into negative balance, most physicians react by going into “survival mode” at work. Instead of finding adventure, challenge, and enjoyment in your practice, you find yourself putting your head down and simply churning through the patients and paperwork, focused on simply making it through the day and getting back home. A common thought at this point is, “I am not sure how much longer I can go on like this.” Survival mode and this voice in your head are signs that you are well into burnout’s downward spiral. It is time to take different actions to lower stress and get some meaningful energy deposits ASAP.

How can we stop or prevent physician burnout?

There are two fundamental mechanisms to drive a positive balance in your energy accounts and avoid burnout:

1. Lower your stress levels and the drain they produce,
2. Improve your ability to recharge your energy accounts.

Most physicians will use a combination of both methods to treat and prevent burnout. We will discuss multiple tools in both cat-



IN THE AUTHOR’S OWN WORDS

Dr. Drummond explains the concept of an energy account and its role in physician burnout in a video available with the online version of this article: <http://www.aafp.org/fpm/2015/0900/p42.html>.

egories in two upcoming articles. (See “Series overview,” page 44.)

But before we end this introductory article, let me remind you of two things that stop many physicians from preventing burnout:

1. The comprehension trap: The tendency to study a concept until you understand it, and then fail to put it into action. Because of our long history in the educational system, most physicians will study until we feel confident we could answer a multiple-choice question like the ones on our board exam. Then we often fail to translate this new knowledge into new actions. Do not let this happen to you. As you read the articles in this series, pick an action step that makes sense and take it. The only way to tell what will work for you is to take new actions and notice your results. Expecting a different result from new comprehension alone is insanity; see below.

2. Einstein’s definition of insanity: “Doing the same things over and over and expecting a different result.”¹⁴ Free yourself from your workaholic conditioning. If you notice your own burnout and simply double down on the things you are already doing to get more done in the office or hospital, your workaholic conditioning has trapped you

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2015/0900/p42.html>.

here in Einstein's insanity definition. Once again, the only way to get different results is to take action – different actions than you are taking right now. You don't necessarily need to take more actions, just different ones.

This is article one in a three-part series on preventing physician burnout. The first step in prevention is to recognize burnout as it arises. You now know burnout's causes, effects, prevalence, and pathophysiology. In future articles, I will show you multiple tools to lower stress and create life balance. Each of these techniques has been tested in the real world by physicians just like you.

You can see your programming now. You are awake and able to recognize the burnout all around you. Your best next step is to pick a new tool from this article series and try it out. Remember, you can't give what you ain't got. It is time to start managing your energy accounts intentionally and on purpose. Your patients, staff, and family are counting on you. **FPM**

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Fundamentals of Wellness

By Kaushal Nanavati, MD, Assistant Professor of Family Medicine, Upstate Medical University

You have one life with two choices. You can choose to be at peace or you make the other choice, but it is always your choice. Don't point the finger at anyone else!



Nutrition: Keep it simple!

Refer to the "Food Plate" (USDA or Harvard) as a guide or follow this information:

- a) 7-9 servings of vegetables daily.
 - b) 1-2 servings of fruit daily (1 serving for diabetics earlier in the day or split into ½ serving twice a day).
 - c) Protein with each meal (10 grams minimum)
Beans/legumes as your primary source of protein. If you are going to eat meat, eat fish, turkey, chicken. Try to get organic, grass-fed meat when possible. Limit red meat due to increased risk of certain cancers. Avoid processed meats (cold cuts), bacon, sausage, ham.
 - d) Grains (oats, whole grains, barley, quinoa, etc.)
 - e) Nuts (walnuts and almonds are better for cholesterol than peanuts or cashews).
 - f) Dairy – primarily yogurt or smoothie/buttermilk (yogurt diluted with water)
 - g) Drink – water as your primary drink. Limit juice (better to eat the fruit than to just have juice as eating the fruit gives some insoluble fiber that can help with bowel movement regularity and keep your intestines clean).
- Meat comes on the plate after you've loaded the vegetables, grain, beans, and fruit on the plate and placed the water and yogurt/buttermilk on the side.
- Bread, rice potato, pasta, cheese – don't have these after lunch. Dinner should be vegetables, protein (legumes/beans primarily or meat such as fish, turkey, chicken in that order), nuts (almonds, walnuts), yogurt/buttermilk and water.

Physical Exercise: Make it a daily appointment!

- get 30-60 minutes on most days even walking at a brisk pace. Get a pedometer and walk:
 - a) 10,000 steps a day to roughly maintain weight
 - b) 12-14,000 steps a day to burn more calories
 - c) Working out first thing when you wake up, before you eat, will give you a better chance of fat burning for the same amount of time compared to other times of the day.
 - If you're going to lift weights and do cardiovascular exercise as part of a workout, then after you have stretched, do the weights first and then do the cardio. During the cardio, do an interval workout as this will lead to greater calorie burning and a higher metabolism for a longer time after you're done versus going at the same pace.
 - e) Make sure to stretch after the workout as this is as important as stretching before to prevent injury. Also, get at least 10-15 grams of protein and not more than 20-25 grams within 30 minutes of finishing the workout as this will help with muscle recovery.
- Make sure you do something you enjoy and can do regularly.
- Tai Chi is one of the most complete forms of mind, body, spirit strengthening and balancing exercise systems. Choose what you enjoy!

Stress Management: Know what's really yours!

- Remember that there is only one person that can truly balance your life and that, my friend is YOU! Get 7-9 hours of sleep every night.
- There are two kinds of stresses: things that you can do something about and things that you cannot control. So do the following exercise:
- a) take a sheet of paper and make a list of all of the things that give you stress, tension, worry, anxiety or concern.
 - b) On a second sheet of paper make two columns. Label the first column "stress that I can do something about" and label the second column "stresses that I cannot control."
 - c) Now take the list that you first made and sort out the list into the two columns on the second sheet
 - d) The stresses you cannot control will remain on the list until someone else takes care of them as you can do nothing about them (for example, what other people say or do. You can control what you say or do but you cannot control other people's reaction to it or their expectations).
 - e) The stresses you can do something about are truly yours to deal with! Take one item at a time and make a written 'action' plan to get it off your list and resolved. Then when it's done, cross it off your list. This act of physically crossing it off will give you a sense of control over your stressors as well.

Spiritual Wellness: Peace and Contentment!

This term may scare some people into not reading further. But that would be your loss. This term can mean many things to many people. I define it here as meaning the achievement of peace. This word, peace, can mean different things to different people and you have to figure out what it means for you. Once you define it, make a plan to get to that place in your life where you have a sense of peace. Then, and this is the important but tricky part, don't let anyone get you out of this place. There will be give and take and you will have to figure out what is important and what is not so important to you.

Breathing exercise: it is well known that deep slow abdominal breathing can do everything from reducing anxiety, averting anxiety attacks, and reducing blood pressure, to increasing focus and concentration. 10-12 minutes per day of deep breathing: breathe in through the nose for a count of 5-10. When you breathe in, your shoulders shouldn't rise but your abdomen should push out. When you breathe out, the abdomen sucks back in.

Circles of Peace



**Well-Being Policy
Graduate Medical Education
SUNY Upstate Medical University**

The Department of Graduate Medical Education is committed to ensuring that residents and fellows (collectively trainees) remain physically and emotionally fit while training at Upstate. The GME Office knows that post-graduate training can be a very stressful time and Upstate wants trainees to be able to optimize educational experiences.

PURPOSE: This policy defines the ways in which trainees are supported in their efforts to become competent, caring and resilient physicians while completing Accreditation Council for Graduate Medical Education (ACGME) accredited training programs at Upstate Medical University.

STATEMENT: Trainees' physical, psychological and emotional well-being is extremely important to Upstate Medical University. Trainees are supported by Upstate and are encouraged to lead healthy lives and make healthy choices for their personal and professional development. To that end, the institution provides the following strategies to support trainee well-being:

- An Employee Health Office that provides various wellness programs including: diet and nutrition resources, smoking cessation, mindfulness training, meditation, onsite trainee gym, wellness walking programs, and healthy luncheons.
- Access to Well-Being Index for all employees (<https://www.mededwebs.com/well-being-index>) that is a resource to screen for burnout and supply resources.
- An Employee Assistance Program (EAP): Confidential and free counseling services.
- NexGen ENI: A trainee EAP service funded by the Office of the President which offers a virtual concierge service to help employees balance competing demands of life and work balance, immediate connection to a qualified counselor available 24/7, personalized online resources offering self-help tools, work/life articles and videos to promote personal and professional development, and a comprehensive wellness program that includes health coaching, fitness and nutrition services <http://www.eniweb.com/nexgen-eap/>
- Occurrence Reporting: Patient and employee safety reporting for actual events and near misses.
- Trainees have access to healthy food and beverage options at the Upstate cafeteria and from other on-campus food purveyors, including 24/7 service at the café in Golisano Children's Hospital.

The GME Office is a safe place where trainees can ask for and receive help with departmental disciplinary issues, immigration and payroll issues, work hour regulations, etc. The GME Office

provides an anonymous feedback email system to report situations that are impeding work/life balance. The GME Office does provide the following to support trainee well-being:

- An annual Resident and Fellow Appreciation Day where trainees have the opportunity to participate in shared meals and receive a token of appreciation for their work at Upstate.
- GME Grand Rounds series dedicated to topics of interest to a trainee's professional life.
- Individual trainees from all programs are peer selected to become members the Resident Advisory Council. Issues affecting trainee life such as call rooms, changes to Upstate policies, parking, etc. are discussed in this forum.
- An on-call meal allowance is provided for trainees taking overnight in-house call
- During onboarding, trainees complete a learning module on sleep alertness and fatigue mitigation.
- A list of primary care providers and therapists that participate in Upstate insurance plans that a trainee may contact for care.

Programs are also in a position to provide additional support to help a trainee's well-being. Additional program policies (in conjunction with institutional policies) cover the following topics:

- A trainee's inability to attend work, including but not limited to fatigue, illness, and family emergencies. Policies will be implemented to provide coverage without fear of retaliation for the trainee that is unable to provide clinical work.
- Accommodations for trainees to attend medical, dental and mental health appointments, including those scheduled during their work hours.
- Trainees are encouraged to alert their Program Director, Program Administrator, faculty mentor, Chief or the GME Office if they have a concern regarding a colleague, faculty member or themselves displaying signs of substance abuse, depression, burnout, and/or potential for violence.

August, 2019

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Taking Care of Your Mental Health

We recognize the challenges of our profession and further appreciate the rigors of post-graduate training. While we have designed the program to foster work-life balance, we know there will be ups and downs and, thus, encourage you to reach out to those you trust (family, friends, peers, program leadership, etc.) in addition to utilizing the following tools to help promote both resilience and wellness:

Employee Assistance Program (Free)

SUNY Upstate Medical University has an Employee Assistance Program to offer help from a professional and confidential source for those going through a personal struggle, problem or concern. Reach out to the EAP office at 315-464-5760 for more information.

Resident and Fellow Counseling Services (Free)

SUNY Upstate Medical University has contracted with a private mental health service to provide confidential counseling services offsite for interns, residents, and fellows. For more details, please visit <https://phcnyc.com/> or call 315-491-3676.

Sanvello App (Free)

Sanvello was rated the best stress relief app in 2019. This app provides many self-help tools for stress such as; meditation, guided journeys, ways to reframe your thoughts, tracking your health and daily mood. It also provides a discussion board where others may share quotes, music, books, movies that lift you up and even a place to share stories of the stress in your life.

MoodMission App (Free)

MoodMission uses a survey you fill out to help you better cope with your moods. Each day it will ask you how you are feeling and give you 5-10 mission objective options to help improve your mood. Each mission objective gives a section called "why this helps" to show evidence-based research of how they can help improve your mood.

Moodfit App (Free)

Moodfit allows you to create a personalized goal list to improve your moods. The goal options range from mood, exercise, mindfulness exercises, sunlight, gratitude, sleep, nutrition and socializing. Setting goals and achieving them can help you to feel accomplished. Moodfit will track how your mood can be positively or negatively affected by your daily activities. The app will also provide tools to boost your mood through breathing techniques, mindfulness audio/readings, gratitude, and send you custom inspirational reminders.

Talkspace App (\$)

It can be intimidating to discuss your issues with someone in person you have never met before and being able to text can help you become more relaxed. Talkspace has over 5,000 licensed therapists. After signing up, Talkspace will match you with a therapist that you will work with every time. You will be able to text, send audio messages or even talk through videochat.

Hope for Bereaved (free)

There are many support groups through "Hope for Bereaved" in Central New York that can help through different types of grief and loss. The organization was setup for people who are going through similar experiences to share their stories and how you can go from grief to hope. For more information or to find a group that best fits you, go to Hope for Bereaved.

Time Off Policy



Department of Medicine

Time-Off Policy

You are allowed a total of 20 days off per academic year (this includes interview time, vacation time, and any additional personal time exceeding 4 days); unused time-off can not be carried over to the following year (i.e. you must use your annual allotment of 20 days). Anytime beyond the mandated annual allotted time off may need to be made up (or must be made up depending on total time away from training); this decision rests with the Program Director and is based on overall performance and total time away from training. Any additional time will require extension of training beyond the original 36 months (or 12 months if a Preliminary Intern) which means your residency end date will be after June 30th of your final year which a) could impact your ABIM exam eligibility for that calendar year and b) will impact your fellowship or employment start date (until sometime after July 1st).

Incoming PGY-2s and PGY-3s will be required to submit in advance of the academic year all planned days off based on their schedules with no more than 10 days taken during CC Blocks (but not contiguous CC Blocks) and time-off during non-elective, non-CC time requires that the PGY-2/3 find coverage that is subsequently approved by the Educational Programs Office. All time-off requests require approval of the Educational Programs Office. Incoming PGY-1s will have vacation time assigned to them in advance of the academic year; these can only be changed with approval of the Educational Programs Office.

**Please note that while we fully support the Family Medical Leave Act, any time taken on FMLA beyond the above-described annual allotment may require extension of training (whether that delays promotion and/or graduation depends on a number of factors such as total time away and overall performance; this decision rests with the program director).*

**All time off, regardless of reason, requires prior approval from EPO. Time off taken without prior EPO approval can lead to Academic Probation.*

**Vacation requests are on a first come, first serve basis.*

I. **PGY-2s and PGY-3s**

- a. **Vacation Days – you must find your own coverage (when needed)**
 - i. If you want to take vacation time while on a “CC” block, you must submit your request 90 days in advance to EPO for review; vacation time on CC can’t be changed with less than 90 days notice.
 - 1. No more than 6 residents may be gone from any one CC Block, but this number will decrease to 4 during Fellowship Interview Season.
 - 2. No more than 10 vacation days can be taken on “CC”, but this time can be taken as individual days or as a complete block; however, all time must be used within 3 CC blocks.
 - a. Taking contiguous CC vacation blocks in their entirety, however, is not allowed.
 - b. CC time may not be taken off for a PGY-2/PGY-3’s final CC block of the year.
 - c. If you elect to take time off during a CC block in which UHCC Adult Medicine Clinic is scheduled to be closed, your vacation request must include that closed day at Adult Medicine Clinic.
 - ii. If you want to take vacation time while on a required floor/critical care/night/admitting/jeopardy service, you must find your own coverage and submit your request with coverage at least 30 days in advance to EPO for review; changes to vacation can’t occur with less than 30 days notice.
 - iii. If you want to take vacation while on any other rotation, you must submit your request at least 30 days in advance to EPO for review; changes to vacation can’t occur with less than 30 days notice.
 - iv. Weekend days count as time off if you had required weekend duties (i.e. call or jeopardy).
 - v. Vacation begins when your shift has come to a complete end; you may not make plans to begin vacation before a shift has concluded.
 - vi. Failure to follow any of the above protocols will result in Academic Deficiency +/- additional coverage requirements.
- b. **Interview Days – EPO will provide and contact coverage for you**
 - i. 1 full day off = 1 day off (i.e. as long as you work for part of a day, the day will not be counted as one of the allotted 20 days off).
 - ii. Please see “An Overview of Core Residency Training” in the Residency Handbook regarding requirements for an Interview request.
 - iii. Days off for this purpose will decrease vacation time except under these circumstances:
 - 1. For every 1st author PubMed-indexed publication with a PubMed ID# available (“Letters” do not count) done as a house officer at Upstate (to a maximum of 6 publications in total), an additional Interview Day (or Personal Development Day; see below) without penalty will be added to your docket (to a maximum of 6 Interview Days in total); this can only be used for an Interview Day, not a Vacation Day.
 - 2. PGY-1/2s with a PGY-1/2 ITE percentile rank of 80-89% will receive one extra “interview day”/Personal Development Day with no vacation penalty.
 - 3. PGY-1/2s with a PGY-1/2 ITE percentile rank of $\geq 90\%$ will receive two extra “interview days”/Personal Development Days with no vacation penalty.
- c. **Unfit/Unwell/Personal Development Days – EPO will provide coverage for you, but you may need to notify coverage**

- i. The Chief Residents should be contacted via a phone discussion (per the Chief Admin number listed on Amion) at least 2 hours prior to the start of work; failure to do so may require that you come into work until coverage can be provided.
- ii. The first two (2) missed sessions/shifts of the academic year will not require "payback".
- iii. The next two (2) missed sessions/shifts will not require payback if a non-trainee provider note justifies the missed time.
- iv. All missed session/shifts thereafter (or if no note justifying the time taken under I.c.iii above) while on any service will require "payback".
 - 1. An entire day away will count as 24 hours off which may require forfeiting your scheduled 24 hours off during the same week.
- v. "Payback" requires that an individual utilizing Jeopardy coverage make up that time at some point during the remaining academic year with the pulled (Jeopardy) colleague **unless the time taken becomes included in FMLA-approved time off or additional coverage was deemed necessary by EPO.**
 - 1. The individual utilizing Jeopardy will provide notice to the Chief Residents within 14 days of the pull date on the agreed-upon make up shift (which, again, must be arranged during the current academic year) which will then be reviewed by EPO for approval.
 - 2. Failure to provide notice to the Chief Residents within the required 14 day period will result in forfeiture of payback for the specific situation.
- vi. Missed session/shifts exceeding three (3) consecutive days must be accompanied by a non-trainee provider note documenting the needed time off.
- vii. If annual missed sessions/shifts days exceed 4 days, "vacation" days will be tapped into; if no "vacation" days remain, residency training may need to be extended.
- viii. If on jeopardy and unavailable, but you have not notified Chief Residents of your unavailability prior to being called, you will be assigned an on-site shift which may require forfeiture of a vacation day, if any available, or a golden weekend (of note, any earned payback can't be requested for this coverage).
- ix. Days earned via publishing/ITE performance (see section I.b.iii.1-3 above) can also be used as Personal Development Days, but only on non-jeopardy elective services.
- d. Approved Conference/ACLS/Licensing Exam Days
 - 1. Licensing exams (i.e. USMLE and COMLEX) can't be taken during required service time (floors, units, admits, night rotations, med consult, CC weeks, jeopardy assignment); **exams can be taken during elective/research/vacation time only.**
 - a. Taking licensing exams does not count towards your time off except if you have chosen to take it during your vacation period.
 - 2. No other exams (i.e. non-U.S. licensing exams) may be taken during work time; vacation time will need to be used for this purpose.
 - 3. The ACLS recertification course does not count as time off unless you had the option of taking it during a non-required service, but you instead chose to take it during a required service.
 - 4. If presenting at EPO-approved Regional or National Conferences (this requires having been approved via the "Abstract/Poster Submission Request" form located at

<http://www.upstate.edu/medicine/research/>), EPO will provide up to 6 days of coverage per academic year.

- a. Anytime beyond 6 days will be deducted from vacation time and you must find your own coverage for those additional days.
- b. International travel is not allowed under any circumstance (this includes Canada).
- c. Up to 10 housestaff can be gone at Conference at any one time during Fellowship Interview Season; at other times of year, this number may increase.
 - i. In situations where there are more than 10 possible attendees, priority will be given to those who have not attended a conference in the current academic year; otherwise, attendees will be decided via lottery.

II. **PGY-1s**

a. Vacation Days

- i. Selected in blocks prior to beginning (not during) academic year.
 - 1. No CC blocks allowed for vacation until mid-December (actual date will be provided by Chief Residents); after mid-December but excluding the last 4 CC weeks in June (no CC vacation allowed during those 4 CC weeks), no more than one CC block can be taken for vacation per intern.
 - a. No CC block vacation changes are allowed within 90 days of starting vacation.
 - 2. No vacation allowed during the 3 consecutive (lettered) elective weeks for Categorical PGY-1s
- ii. Requests for changes must be made 30 days in advance; please note there is no guarantee this will be approved.
- iii. Vacation begins when your shift has come to a complete end; you may not make plans to begin vacation before a shift has concluded
- iv. Failure to follow any of the above protocols will result in Academic Deficiency +/- additional coverage requirements.

b. Interview Days – **EPO will provide and contact coverage for you**

- i. See above under “PGY-2s and PGY-3s”.

c. Unfit/Unwell/Personal Development Days – **EPO will provide coverage for you, but you may need to notify coverage**

- i. See above under “PGY-2s and PGY-3s”.

d. Approved Conference/ACLS/Licensing Exam Days

- i. See above under “PGY-2s and PGY-3s”.

RRC-IM and CLER Requirements



**ACGME Program Requirements for
Graduate Medical Education
in Internal Medicine**

ACGME-approved Focused Revision: February 7, 2022; effective July 1, 2022

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ACGME Program Requirements for Graduate Medical Education in Internal Medicine

Common Program Requirements (Residency) are in BOLD

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

Introduction

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

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

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

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

Int.B. Definition of Specialty

Internists are specialists who care for adult patients through comprehensive, clinical problem solving. They integrate the history, physical examination, and all available data to deliver, direct, and coordinate care across varied clinical

settings, both in person and remotely through telemedicine. Internists are diagnosticians who manage the care of patients who present with undifferentiated, complex illnesses, and comorbidities; promote health and health equity in communities; collaborate with colleagues; and lead, mentor, and serve multidisciplinary teams. Internists integrate care across organ systems and disease processes throughout the adult lifespan. They are expert communicators, creative and adaptable to the changing needs of patients and the health care environment. They advocate for their patients within the health care system to achieve the patient's and family's care goals. Internists embrace lifelong learning and the privilege and responsibility of educating patients, populations, and other health professionals. The discipline is characterized by a compassionate, cognitive, scholarly, relationship-oriented approach to comprehensive patient care.

The successful, fulfilled internist maintains this core function and these core values. Internists find meaning and purpose in caring for individual patients with increased efficiency through well-functioning teams, and are equipped and trained to manage change effectively and lead those teams. They understand and manage the business of medicine to optimize cost-conscious care for their patients. They apply data management science to population and patient applications and help solve the clinical problems of their patients and their community. Internists communicate fluently and are able to educate and clearly explain complex data and concepts to all audiences, especially patients. They collaborate with patients to implement health care ethics in all aspects of their care. Internists display emotional intelligence in their relationships with colleagues, team members, and patients, maximizing both their own and their teams' well-being. They are dedicated professionals who have the knowledge, skills, and attitudes to effectively use all available resources, and bring intellectual curiosity and human warmth to their patients and community.

Specialty-Specific Background and Intent: The Review Committee developed this definition to clearly articulate the core functions and values of internal medicine and describe what is needed to move the specialty forward through program requirements. They express what the Review Committee aspires to see in the graduates of internal medicine residency programs, faculty members, and the broader internal medicine community.

Int.C. Length of Educational Program

An accredited residency program in internal medicine must provide 36 months of supervised graduate medical education. ^(Core)

Specialty-Specific Background and Intent: While internal medicine residency must be completed within a 36-month supervised educational framework (barring remediation and extended leaves), the requirements were written to be flexible and allow program directors the opportunity to create more individualized educational experiences for residents who have achieved, or are on a trajectory to achieve, competence in the foundational areas of internal medicine. This was a guiding principle for the revision process. The requirements for the foundational areas of internal medicine and individualized educational experiences are located in Section IV.C.: Curriculum Organization and Resident Experiences.

I. Oversight

I.A. Sponsoring Institution

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

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

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

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)*

I.B. Participating Sites

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

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.1.a) The program, in partnership with its Sponsoring Institution, must ensure that there is a reporting relationship between the internal medicine subspecialty programs and the residency program director. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a).(1) be renewed at least every 10 years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. ^(Core)

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

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

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

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). ^(Core)

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. ^(Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. ^(Core)

I.D.1.a) The program, in partnership with its Sponsoring institution, must:

- 158
159 I.D.1.a).(1) provide the broad range of facilities and clinical support
160 services necessary to provide comprehensive and timely
161 care of adult patients; (Core)
162
163 I.D.1.a).(2) ensure that the program has adequate space available,
164 including meeting rooms, classrooms, examination rooms,
165 computers, visual and other educational aids, and office
166 space; (Core)
167
168 I.D.1.a).(3) ensure that appropriate in-person or remote/virtual
169 consultations, including those done using
170 telecommunication technology, are available in settings in
171 which residents work; (Core)
172
173 I.D.1.a).(4) provide access to an electronic health record; and, (Core)
174

Specialty-Specific Background and Intent: An electronic health record (EHR) can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to include every element of patient care information. However, a system that simply reports laboratory or imaging results does not meet the definition of an EHR.

- 175
176 I.D.1.a).(5) provide residents with access to training using simulation
177 to support resident education and patient safety. (Core)
178

Specialty-Specific Background and Intent: The Review Committee does not expect each program to own a simulator or to have a simulation center. "Simulation" is used broadly to mean learning about patient care in settings that do not include actual patients. This could include objective structured clinical examinations (OSCEs), standardized patients, patient simulators, or electronic simulation of resuscitation, procedures, and other clinical scenarios.

- 179
180 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
181 **ensure healthy and safe learning and working environments that**
182 **promote resident well-being and provide for: (Core)**
183

- 184 **I.D.2.a) access to food while on duty; (Core)**
185

- 186 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
187 **and accessible for residents with proximity appropriate for**
188 **safe patient care; (Core)**
189

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may

be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

- I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

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

- I.D.2.d) security and safety measures appropriate to the participating site; and, (Core)

- I.D.2.e) accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

- I.D.3. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

- I.D.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

- I.D.4.a) The program must provide residents with a patient population representative of both the broad spectrum of clinical disorders and medical conditions managed by internists, and of the community being served. (Core)

- I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)

- I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)

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

224
225 **II. Personnel**
226

227 **II.A. Program Director**
228

229 **II.A.1. There must be one faculty member appointed as program director**
230 **with authority and accountability for the overall program, including**
231 **compliance with all applicable program requirements.** (Core)
232

233 **II.A.1.a) The Sponsoring Institution's GMEC must approve a change in**
234 **program director.** (Core)
235

236 **II.A.1.b) Final approval of the program director resides with the**
237 **Review Committee.** (Core)
238

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

239
240 **II.A.1.c) The program must demonstrate retention of the program**
241 **director for a length of time adequate to maintain continuity**
242 **of leadership and program stability.** (Core)
243

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

244
245 **II.A.2. The program director and, as applicable, the program's leadership**
246 **team, must be provided with support adequate for administration of**
247 **the program based upon its size and configuration.** (Core)
248

249 **II.A.2.a) At a minimum, the program director must be provided with the**
250 **dedicated time and support specified below for administration of**
251 **the program:**
252

<u>Number of Approved Resident Positions</u>	<u>Minimum Support Required (FTE)</u>
<u>≤7</u>	<u>.2</u>
<u>7-10</u>	<u>.4</u>
<u>>10</u>	<u>.5</u>

253
254 ~~At a minimum, the program director must be provided with the~~
255 ~~salary support required to devote 50 percent FTE of non-clinical~~
256 ~~time to the administration of the program.~~ (Core)
257

258 II.A.2.b)

259 Programs with more than 15 residents must appoint an associate
 260 program director(s). The associate program directors(s) must be
 261 provided with support equal to a dedicated minimum time for
 262 administration of the program as follows:

<u>Number of Approved Resident Positions</u>	<u>Minimum Support Required (FTE)</u>
<u><15</u>	<u>0</u>
<u>16-20</u>	<u>.1</u>
<u>21-25</u>	<u>.2</u>
<u>26-30</u>	<u>.3</u>
<u>31-35</u>	<u>.4</u>
<u>36-40</u>	<u>.5</u>
<u>41-45</u>	<u>.6</u>
<u>46-50</u>	<u>.7</u>
<u>51-55</u>	<u>.8</u>
<u>56-60</u>	<u>.9</u>
<u>61-65</u>	<u>1.0</u>
<u>66-70</u>	<u>1.1</u>
<u>71-75</u>	<u>1.2</u>
<u>76-80</u>	<u>1.3</u>
<u>81-85</u>	<u>1.4</u>
<u>86-90</u>	<u>1.5</u>
<u>91-95</u>	<u>1.6</u>
<u>96-100</u>	<u>1.7</u>
<u>101-105</u>	<u>1.8</u>
<u>106-110</u>	<u>1.9</u>
<u>111-115</u>	<u>2.0</u>
<u>116-120</u>	<u>2.1</u>
<u>121-125</u>	<u>2.2</u>
<u>126-130</u>	<u>2.3</u>
<u>131-135</u>	<u>2.4</u>
<u>136-140</u>	<u>2.5</u>
<u>141-145</u>	<u>2.6</u>
<u>146-150</u>	<u>2.7</u>
<u>151-155</u>	<u>2.8</u>
<u>156-160</u>	<u>2.9</u>
<u>161-165</u>	<u>3.0</u>
<u>166-170</u>	<u>3.1</u>
<u>171-175</u>	<u>3.2</u>
<u>176-180</u>	<u>3.3</u>
<u>181-185</u>	<u>3.4</u>
<u>186-190</u>	<u>3.5</u>
<u>191-195</u>	<u>3.6</u>
<u>196-200</u>	<u>3.7</u>
<u>201-205</u>	<u>3.8</u>
<u>206-210</u>	<u>3.9</u>

<u>211-215</u>	<u>4.0</u>
<u>216-220</u>	<u>4.1</u>
<u>221-225</u>	<u>4.2</u>
<u>226-230</u>	<u>4.3</u>

Additional salary support must be provided for an associate program director(s) to devote non-clinical time to the administration of the program as follows: ^(Core)

Number of Approved Resident Positions	Minimum Number of ABIM- or AOBIM- certified Associate Program Directors	Minimum Aggregate FTE Salary Support for Associate Program Director Duties
24-40	1	0.5
41-79	2	1.0
80-119	3	1.5
120-159	4	2.0
>159	5	2.5

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

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

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

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

~~Specialty Specific Background and Intent: The Review Committee believes that salary support can be shared among multiple associate program directors, as delegated, and at the discretion of, the program director. Associate program directors are expected to assist the program director in performance of administrative activities required to maintain the educational program. The percentage of FTE support is based on a 40-hour work week. As was discussed in the Background and Intent related to salary support, a 50 percent FTE is~~

~~defined as two and one half days per week of salary support, which can be shared or split among multiple associate program directors. Programs can also redistribute the FTE back to the program director. For instance, a program with 28 residents can split the 50 percent FTE so that one associate program director receives 25 percent and the program director receives 75 percent FTE (50 percent along with the remaining 25 percent from the associate program director FTE).~~

For instance, a program with an approved complement of 36 residents is required to have 50% FTE support for the program director and 50 percent FTE support for the associate program director(s). The Review Committee decided not to specify how the support should be distributed among associate program directors to allow programs, in partnership with their sponsoring institution, to allocate the support as they see fit. Further, the program could redistribute the FTE back to the program director; for example, in this instance, the associate program director(s) could receive 25 percent FTE support and the program director could receive 75 percent FTE support (50 percent plus the remaining 25 percent from the associate program director FTE support).

II.A.3. Qualifications of the program director:

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; ^(Core)

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

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

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

II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of Internal Medicine (ABIM) or by the American Osteopathic Board of Internal Medicine (AOBIM), or specialty qualifications that are acceptable to the Review Committee; ^(Core)

II.A.3.b).(1) The Review Committee only accepts current certification in internal medicine from the ABIM or AOBIM. ^(Core)

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; ^(Core)

II.A.3.d) must include ongoing clinical activity; and, ^(Core)

291
292 II.A.3.e) must have experience working as part of an interdisciplinary, inter-
293 professional team to create an educational environment that
294 promotes high-quality care, patient safety, and resident well-being.
295 (Core)
296

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

297
298 **II.A.4. Program Director Responsibilities**
299

300 The program director must have responsibility, authority, and
301 accountability for: administration and operations; teaching and
302 scholarly activity; resident recruitment and selection, evaluation,
303 and promotion of residents, and disciplinary action; supervision of
304 residents; and resident education in the context of patient care. (Core)
305

306 **II.A.4.a) The program director must:**
307

308 **II.A.4.a).(1) be a role model of professionalism; (Core)**
309

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

310
311 **II.A.4.a).(2) design and conduct the program in a fashion**
312 **consistent with the needs of the community, the**
313 **mission(s) of the Sponsoring Institution, and the**
314 **mission(s) of the program; (Core)**
315

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

316
317 **II.A.4.a).(3) administer and maintain a learning environment**
318 **conducive to educating the residents in each of the**
319 **ACGME Competency domains; (Core)**
320

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

- 321
322 **II.A.4.a).(4)** develop and oversee a process to evaluate candidates
323 prior to approval as program faculty members for
324 participation in the residency program education and
325 at least annually thereafter, as outlined in V.B.; (Core)
326
327 **II.A.4.a).(5)** have the authority to approve program faculty
328 members for participation in the residency program
329 education at all sites; (Core)
330
331 **II.A.4.a).(6)** have the authority to remove program faculty
332 members from participation in the residency program
333 education at all sites; (Core)
334
335 **II.A.4.a).(7)** have the authority to remove residents from
336 supervising interactions and/or learning environments
337 that do not meet the standards of the program; (Core)
338

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

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

- 339
340 **II.A.4.a).(8)** submit accurate and complete information required
341 and requested by the DIO, GMEC, and ACGME; (Core)
342
343 **II.A.4.a).(9)** provide applicants who are offered an interview with
344 information related to the applicant's eligibility for the
345 relevant specialty board examination(s); (Core)
346
347 **II.A.4.a).(10)** provide a learning and working environment in which
348 residents have the opportunity to raise concerns and
349 provide feedback in a confidential manner as
350 appropriate, without fear of intimidation or retaliation;
351 (Core)
352
353 **II.A.4.a).(11)** ensure the program's compliance with the Sponsoring
354 Institution's policies and procedures related to
355 grievances and due process; (Core)
356

II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

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

II.A.4.a).(13) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(13).(a) Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; (Core)

II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; and, (Core)

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

II.A.4.a).(16) obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. (Core)

II.B. Faculty

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

the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

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

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

II.B.1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. ^(Core)

II.B.1.a) Faculty members with credentials appropriate to the care setting must supervise all clinical experiences. ^(Core)

II.B.1.a).(1) There must be physicians with certification in internal medicine by the ABIM or AOBIM to teach and supervise internal medicine residents while they are on internal medicine inpatient and outpatient rotations. ^(Core)

Specialty-Specific Background and Intent: The Review Committee believes the best role models for internal medicine residents are internal medicine physicians with certification in internal medicine from the ABIM or AOBIM. Providing such faculty members ensures specialty-specific educators with significant experience managing and providing comprehensive patient care to complex patients. However, the Review Committee recognizes there are circumstances and clinical settings in which a non-internist who has been approved by the program director would be an appropriate supervisor. Examples include but are not limited to the following:

- On inpatient medicine ward rotations, it is appropriate for a family medicine physician with the American Board of Family Medicine’s Designation of Focused Practice in Hospital Medicine to teach and supervise internal medicine residents.
- On inpatient medicine rotations in the critical care setting, it would be appropriate for a non-internist who has been approved by the program director and the medical intensive care unit director to teach and supervise internal medicine residents. For example, it would be appropriate for emergency medicine physicians with certification in internal medicine-critical care medicine to supervise internal medicine residents on critical care medicine rotations. It is also appropriate for physicians with certification in critical care from other disciplines to teach and supervise in limited circumstances, such as evening or weekend cross-coverage.
- On outpatient medicine rotations/experiences, it is appropriate for a non-internist with documented expertise (e.g., a family medicine physician with extensive outpatient/ambulatory experience or procedural proficiency) to teach and supervise

internal medicine residents provided the non-internist is approved by the site director and the program director.

II.B.1.a).(2) Physicians certified by the ABIM or the AOBIM in the relevant subspecialty must be available to teach and supervise internal medicine residents while they are on internal medicine subspecialty rotations. (Core)

II.B.1.a).(3) Physicians certified by an ABMS or AOA board in the relevant subspecialty should be available to teach and supervise internal medicine residents while they are on multidisciplinary subspecialty rotations. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in geriatric medicine by the ABIM, AOBIM, American Board of Family Medicine, or American Osteopathic Board of Family Medicine to teach and supervise internal medicine residents on geriatric medicine rotations.

II.B.1.a).(4) Physicians certified by an ABMS or AOA board in the relevant specialty should be available to teach and supervise internal medicine residents while they are having non-internal medicine experiences. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry to teach and supervise internal medicine residents on neurology rotations.

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

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

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

- 458 **II.B.2.f)** regularly participate in organized clinical discussions,
459 rounds, journal clubs, and conferences; and, ^(Core)
460
461 **II.B.2.g)** pursue faculty development designed to enhance their skills
462 at least annually: ^(Core)
463

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

- 464
465 **II.B.2.g).(1)** as educators; ^(Core)
466
467 **II.B.2.g).(2)** in quality improvement and patient safety; ^(Core)
468
469 **II.B.2.g).(3)** in fostering their own and their residents' well-being;
470 and, ^(Core)
471
472 **II.B.2.g).(4)** in patient care based on their practice-based learning
473 and improvement efforts. ^(Core)
474

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

- 475
476 **II.B.2.h)** There must be a subspecialty education coordinator (SEC) in
477 each of the subspecialties of internal medicine and in the
478 multidisciplinary subspecialty of geriatric medicine. ^(Core)
479

Specialty-Specific Background and Intent: An SEC is necessary in each of the following subspecialties of internal medicine: cardiovascular disease; critical care medicine; endocrinology, diabetes, and metabolism; gastroenterology; hematology; infectious disease; nephrology; medical oncology; pulmonary disease; and rheumatology.

- 480
481 **II.B.2.h).(1)** Each SEC must be accountable to the program director for
482 coordination of all educational experiences in the
483 subspecialty area. ^(Core)
484
485 **II.B.2.h).(2)** Each SEC must be certified in the relevant subspecialty by
486 the ABIM or the AOBIM, except that the geriatric medicine
487 SEC must be certified in the subspecialty by the relevant
488 ABMS member board or AOA certifying board. ^(Core)
489

Specialty-Specific Background and Intent: SECs are responsible for developing the educational content and curriculum for the subspecialty area. An associate program director or core faculty member can also function as an SEC with adequate additional administrative resources. Double-boarded SECs can act as education coordinators for two specialties (e.g., hematology-medical oncology and pulmonary disease-critical care medicine). The SEC for geriatric medicine can be certified by the ABIM, the AOBIM, the American Board of Family Medicine, or the American Osteopathic Board of Family Medicine. The Review Committee encourages programs that cannot identify an SEC for a particular subspecialty area to consider the option of sharing one with a program that does have one. The SEC can be remotely located and associated with multiple residency programs.

- II.B.2.i) There must be faculty members with expertise in the analysis and interpretation of practice data, data management science and clinical decision support systems, and managing emerging health issues. (Core)

Specialty-Specific Background and Intent: Advances in technology are likely to significantly impact and redefine patient care, and this requirement is intended to ensure that residents are provided with access to faculty members with knowledge, skills, or experience in the analysis and interpretation of practice data, and who are able to analyze and evaluate the validity of decisions from advanced data management and clinical decision support systems. Faculty members with expertise in this area can be physicians or non-physicians, core or non-core faculty members. Institutions may already have such experts assisting programs in meeting the Common Program Requirement to systematically analyze practice data to improve patient care [IV.B.1.d).(1).(d)]. The Review Committee encourages programs that cannot identify an existing internal candidate with expertise in this area to consider the option of sharing one with a program that does. The faculty member can be remotely located and associated with multiple residency programs.

- II.B.2.j) Faculty members must have experience working in interdisciplinary, interprofessional team-based health care delivery models. (Core)

Specialty-Specific Background and Intent: The Review Committee believes that interdisciplinary, interprofessional, team-based care is the foundation of care delivery. Individuals working within such teams are essential to resident education.

II.B.3. Faculty Qualifications

- II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

- II.B.3.b) Physician faculty members must:

- II.B.3.b).(1) have current certification in the specialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director. ^(Core)

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

II.B.4. Core Faculty

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

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

II.B.4.a) Core faculty members must be designated by the program director. ^(Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. ^(Core)

II.B.4.c) In addition to the program director and associate program director(s), programs must have the minimum number of ABIM- or AOBIM-certified core faculty members based on the number of approved resident positions, as follows. ^(Core)

II.B.4.d At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of .1 FTE for educational and administrative responsibilities that do not involve direct patient care. ^(Core)

<u>Number of Approved Resident Positions</u>	<u>Minimum number of ABIM- or AOBIM-certified Core Faculty Members</u>
<u><30</u>	<u>3</u>
<u>30-39</u>	<u>4</u>
<u>40-49</u>	<u>5</u>
<u>50-59</u>	<u>6</u>
<u>60-69</u>	<u>7</u>
<u>70-79</u>	<u>8</u>
<u>80-89</u>	<u>9</u>
<u>90-99</u>	<u>10</u>
<u>100-109</u>	<u>11</u>
<u>110-119</u>	<u>12</u>
<u>120-129</u>	<u>13</u>
<u>130-139</u>	<u>14</u>
<u>140-149</u>	<u>15</u>
<u>150-159</u>	<u>16</u>
<u>160-169</u>	<u>17</u>
<u>170-179</u>	<u>18</u>
<u>180-189</u>	<u>19</u>
<u>190-199</u>	<u>20</u>
<u>200-209</u>	<u>21</u>

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 36 residents is required to have a minimum of four ABIM- or AOBIM-certified core faculty members, each with 10 percent FTE support. The duties of the program director, associate program director(s), and internal medicine core faculty members are separate and distinct. As such, the minimum required internal medicine core faculty members are in addition to the program director and the associate program director(s). One individual cannot “count” as both an associate program director and internal medicine core faculty member.

Educational responsibilities for the minimum required internal medicine core faculty members: The requirement related to support for core internal medicine faculty members is intended to ensure these faculty members have sufficient protected time to meet the following educational responsibilities:

- Membership on the Clinical Competency Committee
- Participation in the annual program review as Chair or member of the Program Evaluation Committee
- Implementation and analysis of the outcome of action plans developed by the Program Evaluation Committee
- Significant participation in recruitment and selection, including efforts related to the program’s commitment to diversity

- Advising, mentoring, and coaching residents (co-creating, implementing, and monitoring individualized learning plans)
- Designing and overseeing remediation plans
- Supporting/overseeing residents in the development/assessment of quality improvement/patient safety projects
- Supporting/overseeing residents in the conduct of their scholarly work, including the dissemination of such work through presentations, posters/abstracts, and peer-reviewed publications
- Significant participation in educational activities (didactics, lab, or simulation)
- Overseeing faculty development for the program's faculty members
- Designing and implementing simulation and/or standardized patients for teaching and assessment
- Developing, implementing, and assessing one or more of the major components of the curriculum, such as patient safety, quality, health disparities, or core didactics
- Designing and implementing the program's assessment strategies, making certain there are robust methods used to assess each competency, and ensuring they provide meaningful information by which the Clinical Competency Committee can judge resident performance on the Milestones
- Leading the program's efforts related to resident and faculty member well-being

Each core faculty member does not need to participate in every listed educational responsibility.

- 548
549 II.B.5. Associate Program Directors
550
551 Associate program directors assist the program director in the
552 administrative and clinical oversight of the educational program.
553
- 554 II.B.5.a) Associate program directors must:
555
- 556 II.B.5.a).(1) have current certification from the ABIM or AOBIM in either
557 internal medicine or a subspecialty of internal medicine;
558 (Core)
559
- 560 II.B.5.a).(2) report directly to the program director; (Core)
561
- 562 II.B.5.a).(3) participate in academic societies and in educational
563 programs designed to enhance their educational and
564 administrative skills; and, (Core)
565
- 566 II.B.5.a).(4) take an active role in curriculum development, resident
567 teaching and evaluation, continuous program
568 improvement, and faculty development. (Core)
569
- 570 II.C. Program Coordinator
571
- 572 II.C.1. There must be a program coordinator. (Core)
573
- 574 II.C.2. The program coordinator must be provided with dedicated time and
575 support adequate for administration of the program based upon its
576 size and configuration. (Core)

II.C.2.a)

At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: ^(Core)

<u>Number of Approved Resident Positions</u>	<u>Minimum FTE Required for Coordinator Support</u>	<u>Additional Aggregate FTE Required for Administration of the Program</u>
<u>≤7</u>	<u>.5</u>	<u>0</u>
<u>7-10</u>	<u>.5</u>	<u>.2</u>
<u>10-15</u>	<u>.5</u>	<u>.3</u>
<u>16-20</u>	<u>.5</u>	<u>.4</u>
<u>21-25</u>	<u>.5</u>	<u>.5</u>
<u>26-30</u>	<u>.5</u>	<u>.6</u>
<u>31-35</u>	<u>.5</u>	<u>.7</u>
<u>36-40</u>	<u>.5</u>	<u>.8</u>
<u>41-45</u>	<u>.5</u>	<u>.9</u>
<u>46-50</u>	<u>.5</u>	<u>1.0</u>
<u>51-55</u>	<u>.5</u>	<u>1.1</u>
<u>56-60</u>	<u>.5</u>	<u>1.2</u>
<u>61-65</u>	<u>.5</u>	<u>1.3</u>
<u>66-70</u>	<u>.5</u>	<u>1.4</u>
<u>71-75</u>	<u>.5</u>	<u>1.5</u>
<u>76-80</u>	<u>.5</u>	<u>1.6</u>
<u>81-85</u>	<u>.5</u>	<u>1.7</u>
<u>86-90</u>	<u>.5</u>	<u>1.8</u>
<u>91-95</u>	<u>.5</u>	<u>1.9</u>
<u>96-100</u>	<u>.5</u>	<u>2.0</u>
<u>101-105</u>	<u>.5</u>	<u>2.1</u>
<u>106-110</u>	<u>.5</u>	<u>2.2</u>
<u>111-115</u>	<u>.5</u>	<u>2.3</u>
<u>116-120</u>	<u>.5</u>	<u>2.4</u>
<u>121-125</u>	<u>.5</u>	<u>2.5</u>
<u>126-130</u>	<u>.5</u>	<u>2.6</u>
<u>131-135</u>	<u>.5</u>	<u>2.7</u>
<u>136-140</u>	<u>.5</u>	<u>2.8</u>
<u>141-145</u>	<u>.5</u>	<u>2.9</u>
<u>146-150</u>	<u>.5</u>	<u>3.0</u>
<u>151-155</u>	<u>.5</u>	<u>3.1</u>
<u>156-160</u>	<u>.5</u>	<u>3.2</u>
<u>161-165</u>	<u>.5</u>	<u>3.3</u>
<u>166-170</u>	<u>.5</u>	<u>3.4</u>
<u>171-175</u>	<u>.5</u>	<u>3.5</u>
<u>176-180</u>	<u>.5</u>	<u>3.6</u>
<u>181-185</u>	<u>.5</u>	<u>3.7</u>
<u>186-190</u>	<u>.5</u>	<u>3.8</u>

<u>191-195</u>	<u>.5</u>	<u>3.9</u>
<u>196-200</u>	<u>.5</u>	<u>4.0</u>
<u>201-205</u>	<u>.5</u>	<u>4.1</u>
<u>206-210</u>	<u>.5</u>	<u>4.2</u>
<u>211-215</u>	<u>.5</u>	<u>4.3</u>
<u>216-220</u>	<u>.5</u>	<u>4.4</u>
<u>221-225</u>	<u>.5</u>	<u>4.5</u>
<u>226-230</u>	<u>.5</u>	<u>4.6</u>

At a minimum, the program coordinator must be supported at 50 percent FTE for the administration of the program. ^(Core)

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

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

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

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

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 36 residents is required to have 130 percent FTE for coordinator support. The Review Committee decided not to specify how the support should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit.

II.D. Other Program Personnel

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

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

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: ^(Core)

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, ^(Core)

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: ^(Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, ^(Core)

III.A.1.b).(2) holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. ^(Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. ^(Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. ^(Core)

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

milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

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

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

III.B.1.a) There must be a sufficient number of residents to allow peer-to-peer interaction and learning. (Core)

III.B.1.a).(1) The program should offer a minimum of nine positions. (Detail)

Specialty-Specific Background and Intent: The Review Committee believes that peer-to-peer interactions and learning are extremely important components of residency education and has set the minimum number of residents to nine. While three residents per educational year is suggested, it is not required as long as there is relative balance per level. To ensure that resident education is not compromised by having too few residents, the number of residents in a program will be monitored at each review, particularly for those programs with significant decreases in complement. However, this requirement is categorized as a “detail” as there may be programs that have specific circumstances that allow them to function with a smaller resident complement. This categorization allows the establishment of residency education programs in rural and medically underserved areas and populations when the Review Committee determines that the program has sufficient resources to ensure substantial compliance with accreditation requirements.

III.C. Resident Transfers

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

IV. Educational Program

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

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

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

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

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

IV.A.1.a) The program's aims must be made available to program applicants, residents, and faculty members. (Core)

IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)

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

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

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

IV.A.4. a broad range of structured didactic activities; (Core)

IV.A.4.a) Residents must be provided with protected time to participate in core didactic activities. (Core)

711

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

712

713 **IV.A.5.** advancement of residents' knowledge of ethical principles
714 foundational to medical professionalism; and, (Core)

715

716 **IV.A.6.** advancement in the residents' knowledge of the basic principles of
717 scientific inquiry, including how research is designed, conducted,
718 evaluated, explained to patients, and applied to patient care. (Core)

719

720 **IV.B.** ACGME Competencies

721

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

722

723 **IV.B.1.** The program must integrate the following ACGME Competencies
724 into the curriculum: (Core)

725

726 **IV.B.1.a)** Professionalism

727

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

730

731 **IV.B.1.a).(1)** Residents must demonstrate competence in:

732

733 **IV.B.1.a).(1).(a)** compassion, integrity, and respect for others;
734 (Core)

735

736 **IV.B.1.a).(1).(b)** responsiveness to patient needs that
737 supersedes self-interest; (Core)

738

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

739

740 **IV.B.1.a).(1).(c)** respect for patient privacy and autonomy; (Core)

741

742	IV.B.1.a).(1).(d)	accountability to patients, society, and the
743		profession; (Core)
744		
745	IV.B.1.a).(1).(e)	respect and responsiveness to diverse patient
746		populations, including but not limited to
747		diversity in gender, age, culture, race, religion,
748		disabilities, national origin, socioeconomic
749		status, and sexual orientation; (Core)
750		
751	IV.B.1.a).(1).(f)	ability to recognize and develop a plan for one's
752		own personal and professional well-being; and,
753		(Core)
754		
755	IV.B.1.a).(1).(g)	appropriately disclosing and addressing
756		conflict or duality of interest. (Core)
757		
758	IV.B.1.b)	Patient Care and Procedural Skills
759		

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

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

760		
761	IV.B.1.b).(1)	Residents must be able to provide patient care that is
762		compassionate, appropriate, and effective for the
763		treatment of health problems and the promotion of
764		health. (Core)
765		
766	IV.B.1.b).(1).(a)	Residents must demonstrate the ability to manage
767		the care of patients:
768		
769	IV.B.1.a).(1).(a).(i)	using clinical skills of interviewing and
770		physical examination; (Core)
771		
772	IV.B.1.a).(1).(a).(ii)	in a variety of roles within a health system
773		with progressive responsibility, including
774		serving as the direct provider, a member, or
775		leader of an interprofessional team of
776		providers; as a consultant to other
777		physicians; and as a teacher to the patient,
778		the patient's family, and other health care
779		workers; (Core)

780
 781 IV.B.1.a).(1).(a).(iii) including the prevention, counseling,
 782 detection, diagnosis, and treatment of adult
 783 diseases; (Core)
 784
 785 IV.B.1.a).(1).(a).(iv) in a variety of health care settings, including
 786 the inpatient ward, critical care units, and
 787 various ambulatory settings; (Core)
 788

Specialty-Specific Background and Intent: Emerging models of care and needs of populations served by programs will result in residents having educational experiences in novel or non-traditional settings. Examples of non-traditional educational settings include rotations on mobile buses that travel to areas of increased need, and “pop-up” health clinics within community centers.

789
 790 IV.B.1.a).(1).(a).(v) for whom they have limited or no physical
 791 contact, through the use of telemedicine;
 792 (Core)
 793
 794 IV.B.1.a).(1).(a).(vi) in the subspecialties of internal medicine;
 795 (Core)
 796
 797 IV.B.1.a).(1).(a).(vii) using population-based data; (Core)
 798

Specialty-Specific Background and Intent: Understanding population health within the context of prevention is an important competency for the physician practicing medicine in the future. Residents need experience using, understanding, and analyzing population health data so that they can develop health care plans to improve health outcomes for their patients. For instance, residents may be provided experience in analyzing and interpreting data from health registries, and understanding the local impact of infectious and non-infectious epidemics (e.g., obesity or opioid) and pandemics, and the important role social determinants of health have when developing and applying health care and preventive care decisions.

799
 800 IV.B.1.a).(1).(a).(viii) using critical thinking and evidence-based
 801 tools. (Core)
 802

803 **IV.B.1.b).(2)** **Residents must be able to perform all medical,**
 804 **diagnostic, and surgical procedures considered**
 805 **essential for the area of practice. (Core)**
 806

807 IV.B.1.b).(2).(a) Residents must demonstrate the ability to:

808
 809 IV.B.1.b).(2).(a).(i) use and/or perform point-of-care laboratory,
 810 diagnostic, and/or imaging studies relevant
 811 to the care of the patient; (Core)
 812

Specialty-Specific Background and Intent: The Review Committee intentionally did not identify specific laboratory, diagnostic, and/or imaging studies that residents must perform because it believes that scientific advances will be constant and ongoing, and whatever is codified in the requirements quickly becomes outdated. Additionally, the decision to not specifically denote

studies in the requirements aligns with the Committee's overall position that residents should perform and develop expertise with those procedures appropriate to their future practice needs, as noted in the requirement below. However, the Committee acknowledges that offering point-of-care ultrasonography to residents who believe this will be relevant for their future career practice may be one way to meet the above-mentioned requirement.

IV.B.1.b).(2).(a).(ii)

perform diagnostic and therapeutic procedures relevant to their specific career paths; and, (Core)

IV.B.1.b).(2).(a).(iii)

treat their patients' conditions with practices that are patient-centered, safe, scientifically based, effective, timely, and cost-effective. (Core)

IV.B.1.c)

Medical Knowledge

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

IV.B.1.c).(1)

Residents must demonstrate a level of expertise in the knowledge of the broad spectrum of clinical disorders seen by an internist, including: (Core)

IV.B.1.c).(1).(a)

the core content of general internal medicine, which includes the internal medicine subspecialties, the multidisciplinary subspecialties of geriatric medicine, hospice and palliative medicine and addiction medicine, and neurology. (Core)

IV.B.1.c).(2)

Residents must demonstrate sufficient knowledge in the following areas:

IV.B.1.c).(2).(a)

evaluation of patients with an undiagnosed and undifferentiated presentation; (Core)

IV.B.1.c).(2).(b)

pharmacotherapeutic and non-pharmacotherapeutic treatment of the broad spectrum of medical conditions and clinical disorders managed by internists; (Core)

IV.B.1.c).(2).(c)

provision of preventive care; (Core)

IV.B.1.c).(2).(d)

interpretation of clinical tests and images; (Core)

IV.B.1.c).(2).(e)

recognition and initial management of urgent medical problems; and, (Core)

858 IV.B.1.c).(2).(f) application of technology appropriate for the clinical
859 context, including evolving techniques. (Core)
860

Specialty-Specific Background and Intent: Advances in technology will likely continue to make substantive changes in patient diagnosis and management. This requirement ensures that residents will be able to gain experience and become familiar with emerging technologies, such as intensive care units managed remotely or the use of personalized or precision medicine.

861
862 **IV.B.1.d) Practice-based Learning and Improvement**
863
864 **Residents must demonstrate the ability to investigate and**
865 **evaluate their care of patients, to appraise and assimilate**
866 **scientific evidence, and to continuously improve patient care**
867 **based on constant self-evaluation and lifelong learning. (Core)**
868

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

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

869
870 **IV.B.1.d).(1) Residents must demonstrate competence in:**
871
872 **IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in**
873 **one's knowledge and expertise; (Core)**
874
875 **IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)**
876
877 **IV.B.1.d).(1).(c) identifying and performing appropriate learning**
878 **activities; (Core)**
879
880 **IV.B.1.d).(1).(d) systematically analyzing practice using quality**
881 **improvement methods, and implementing**
882 **changes with the goal of practice improvement;**
883 **(Core)**
884
885 **IV.B.1.d).(1).(e) incorporating feedback and formative**
886 **evaluation into daily practice; (Core)**
887
888 **IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence**
889 **from scientific studies related to their patients'**
890 **health problems; and, (Core)**
891
892 **IV.B.1.d).(1).(g) using information technology to optimize**
893 **learning. (Core)**
894

895	IV.B.1.e)	Interpersonal and Communication Skills
896		
897		Residents must demonstrate interpersonal and
898		communication skills that result in the effective exchange of
899		information and collaboration with patients, their families,
900		and health professionals. <small>(Core)</small>
901		
902	IV.B.1.e).(1)	Residents must demonstrate competence in:
903		
904	IV.B.1.e).(1).(a)	communicating effectively with patients,
905		families, and the public, as appropriate, across
906		a broad range of socioeconomic and cultural
907		backgrounds; <small>(Core)</small>
908		
909	IV.B.1.e).(1).(b)	communicating effectively with physicians,
910		other health professionals, and health-related
911		agencies; <small>(Core)</small>
912		
913	IV.B.1.e).(1).(c)	working effectively as a member or leader of a
914		health care team or other professional group;
915		<small>(Core)</small>
916		
917	IV.B.1.e).(1).(d)	educating patients, families, students,
918		residents, and other health professionals; <small>(Core)</small>
919		
920	IV.B.1.e).(1).(e)	acting in a consultative role to other physicians
921		and health professionals; and, <small>(Core)</small>
922		
923	IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible
924		medical records, if applicable. <small>(Core)</small>
925		
926	IV.B.1.e).(2)	Residents must learn to communicate with patients
927		and families to partner with them to assess their care
928		goals, including, when appropriate, end-of-life goals.
929		<small>(Core)</small>
930		

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

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

931		
932	IV.B.1.f)	Systems-based Practice
933		
934		Residents must demonstrate an awareness of and
935		responsiveness to the larger context and system of health
936		care, including the social determinants of health, as well as

the ability to call effectively on other resources to provide optimal health care. ^(Core)

IV.B.1.f).(1)

Residents must demonstrate competence in:

IV.B.1.f).(1).(a)

working effectively in various health care delivery settings and systems relevant to their clinical specialty; ^(Core)

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

IV.B.1.f).(1).(b)

coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; ^(Core)

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

IV.B.1.f).(1).(c)

advocating for quality patient care and optimal patient care systems; ^(Core)

IV.B.1.f).(1).(d)

working in interprofessional teams to enhance patient safety and improve patient care quality; ^(Core)

IV.B.1.f).(1).(e)

participating in identifying system errors and implementing potential systems solutions; ^(Core)

IV.B.1.f).(1).(f)

incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and, ^(Core)

IV.B.1.f).(1).(g)

understanding health care finances and its impact on individual patients' health decisions. ^(Core)

IV.B.1.f).(2)

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

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. ^(Core)

IV.C.1.a) Rotations must be of sufficient length to provide longitudinal relationships with faculty members to allow for meaningful assessment and feedback. ^(Core)

IV.C.1.b) Rotations must be structured to allow residents to function as part of effective interprofessional teams that work together towards the shared goals of patient safety and quality improvement. ^(Core)

IV.C.1.c) Rotations must be structured to minimize conflicting inpatient and outpatient responsibilities. ^(Core)

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

Specialty-Specific Background and Intent: The Review Committee encourages programs to think of ways to balance the inherent conflicts between inpatient and outpatient responsibilities, including using an effective hand-off process. For example, programs may want to consider schedules that allow members of the interprofessional health care team to provide coverage for the inpatient service when residents are in continuity clinics. Alternatively, programs may consider creating schedules that either provide more continuity clinic experiences or an exclusive continuity clinic experience when residents are not on inpatient rotations to allow them to have less or no clinic during inpatient rotations.

IV.C.2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction. ^(Core)

IV.C.3. The educational program for all residents must include: ^(Core)

IV.C.3.a) at least 30 months of clinical experiences; ^(Core)

IV.C.3.b) a longitudinal team-based continuity experience for the duration of the program; ^(Core)

IV.C.3.c) foundational experience in internal medicine, including:

IV.C.3.c).(1) at least 10 months of clinical experiences in the outpatient setting; ^(Core)

Specialty-Specific Background and Intent: Clinical experiences in the following settings may be used to fulfill this requirement: general internal medicine continuity clinics; internal medicine subspecialty clinics (e.g., HIV clinic); non-medicine clinics (e.g., dermatology or

physical medicine and rehabilitation clinic); walk-in clinics; neighborhood health clinics; home care visit programs; urgent care clinics; and ambulatory block rotations.

Time devoted to the longitudinal continuity experience can count towards the minimum required 10 months of foundational experiences in the outpatient setting. For the purposes of this calculation, a month is equivalent to four weeks, 20 days, or 40 half-days. For example, 40 half-day continuity clinic sessions would equal one month of outpatient experience.

IV.C.3.c).(2) at least 10 months of clinical experiences in the inpatient and critical care settings; (Core)

IV.C.3.c).(2).(a) Critical care experiences must be a minimum of two months and a maximum of six months and must not occur solely in the PGY-1. (Core)

IV.C.3.c).(3) clinical experiences in each of the internal medicine subspecialties; and, (Core)

Specialty-Specific Background and Intent: Clinical experiences in the each of the subspecialties can be used to fulfill either the minimum required number of months in the inpatient or outpatient setting, depending on the setting the experience is provided. For instance, a month rotation on a hematology-oncology service would count towards meeting the inpatient minimums whereas a month in an oncology clinic would count towards outpatient.

IV.C.3.c).(4) clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, emergency medicine, and neurology. (Core)

IV.C.3.d) at least six months of individualized educational experiences to participate in opportunities relevant to their future practice or to further skill/competency development in the foundational areas. (Core)

Specialty-Specific Background and Intent: The Review Committee views these four components of internal medicine residency (at least 30 months of clinical experience, longitudinal continuity experience, foundational internal medicine experience, and at least six months of individualized experience) as distinct but overlapping. For example, the longitudinal continuity experience could be obtained through discrete blocks or interspersed among other clinical experiences. Time in an outpatient clinic may be part of the continuity experience or may be part of a subspecialty experience, or both, and it would count towards the minimum for both foundational outpatient experience and the 30 months of clinical experience. Additional time in that clinic may be part of a resident's individualized learning experiences, which would also count towards the 30-month minimum. The six months of individualized learning experiences may be all clinical experiences that would count towards the 30-month minimum, or they may include non-clinical experiences.

The requirements acknowledge that in addition to providing residents with broad foundational educational experiences in ambulatory and hospital-based internal medicine, programs must ensure residents have educational experiences that take into account their future plans and

the different paces and trajectories at and on which residents will learn and demonstrate competence in the foundational areas.

Individualized educational experiences will be determined by the program director and take into account demonstrated competence in the foundational areas noted above, resources, program aims, and the residents' future practice plans. Although six months can be devoted to individualized experiences, some residents may require more time to achieve competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some residents may need to devote the entirety of residency to achieve competence in the foundational areas. The converse may be possible. Programs may have the opportunity to allocate more than six months of individualized educational opportunities for residents who have achieved or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences for those interested in hospitalist medicine careers, or more experiences in a subspecialty for those interested in subspecializing. Individualized educational experiences may be integrated throughout the 36 months of the educational program and do not need to be consecutive.

The Review Committee is interested in programs pursuing innovations in internal medicine education and training. Additional information on the development of the Program Requirements and the Review Committee's interest in exploring innovative proposals that will guide future versions of the Program Requirements can be found on the [Internal Medicine section of the ACGME website](#).

- 1032
- 1033 IV.C.4. While on inpatient rotations:
- 1034
- 1035 IV.C.4.a) residents' responsibilities must be limited to patients for whom the
- 1036 teaching team has diagnostic and therapeutic responsibility; (Core)
- 1037
- 1038 IV.C.4.b) programs must monitor and limit the number of resident-attending
- 1039 relationships to ensure that communication and education is not
- 1040 compromised; (Core)
- 1041
- 1042 IV.C.4.c) non-physician faculty members must not supervise internal
- 1043 medicine residents on inpatient rotations; (Core)
- 1044

Specialty-Specific Background and Intent: While it is important for residents to acquire experience in leading and participating in interprofessional, interdisciplinary health care teams, the overall supervision of all clinical care provided by residents is the responsibility of the members of the physician faculty. A physician faculty member may delegate an appropriately qualified non-physician to assist a resident in discrete activities, such as performing procedures.

- 1045
- 1046 IV.C.4.d) residents from other specialties must not supervise internal
- 1047 medicine residents on any internal medicine inpatient rotation;
- 1048 (Core)
- 1049
- 1050 IV.C.4.e) the resident team and each attending physician must have the
- 1051 responsibility to make management rounds on their patients and

1052 communicate effectively with each other at a frequency
 1053 appropriate to the changing care needs of the patients; (Core)
 1054
 1055 IV.C.4.f) residents must write all orders for patients under their care, with
 1056 appropriate supervision by the attending physician; (Core)
 1057
 1058 IV.C.4.f).(1) In those circumstances when another attending physician
 1059 or consultant writes an order on a resident's patient, the
 1060 attending or consultant must communicate the action to the
 1061 resident in a timely manner. (Core)
 1062
 1063 IV.C.4.g) PGY-1 residents must not be assigned more than five new
 1064 patients per admitting day; (Core)
 1065
 1066 IV.C.4.g).(1) an additional two patients may be assigned if they are in-
 1067 house transfers from the medical services. (Core)
 1068
 1069 IV.C.4.h) PGY-1 residents must not be assigned more than eight new
 1070 patients in a 48-hour period; (Core)
 1071
 1072 IV.C.4.i) PGY-1 residents must not be responsible for the ongoing care of
 1073 more than 10 patients; (Core)
 1074
 1075 IV.C.4.j) when supervising more than one PGY-1 resident, the PGY-2 or
 1076 PGY-3 supervising resident must not be responsible for the
 1077 supervision or admission of more than 10 new patients and four
 1078 transfer patients per admitting day or more than 16 new patients in
 1079 a 48-hour period; (Core)
 1080
 1081 IV.C.4.k) when supervising one PGY-1 resident, the PGY-2 or PGY-3
 1082 supervising resident must not be responsible for the ongoing care
 1083 of more than 14 patients; and, (Core)
 1084
 1085 IV.C.4.l) when supervising more than one PGY-1 resident, the PGY-2 or
 1086 PGY-3 supervising resident must not be responsible for the
 1087 ongoing care of more than 20 patients. (Core)
 1088

Specialty-Specific Background and Intent: The Review Committee cannot prescriptively and explicitly assign patient census limits for every possible educational scenario or circumstance given the variability in these settings and the complexity and acuity of the patients. Instead, the committee asks program and institutional leadership teams to proactively and regularly monitor the census, complexity, and acuity of patients assigned to resident-comprised health care teams, and the structure and composition of the team, particularly the knowledge, skills, and abilities of the team members, to determine the appropriate patient team size for the situation. Although the Review Committee limits the number of new patients PGY-2 and PGY-3 residents can be assigned per admitting day (Program Requirements IV.C.4. j)-l)), programs can exercise flexibility and deviate from these limits for PGY-3 residents who have significant experience in the inpatient setting and are interested in hospitalist medicine careers in the future. The leadership team will need to carefully review institutional patient safety outcome data when determining patient census team limits in such scenarios. The census limits noted above apply to all inpatient experiences during the 36 months of supervised graduate medical

education regardless of whether an inpatient rotation is part of the foundational educational experiences in internal medicine or part of the individualized experiences.

IV.C.5. While on outpatient rotations:

IV.C.5.a) residents must have clinical experiences in chronic disease management, preventive health, patient counseling, and common acute ambulatory problems; and, (Core)

IV.C.5.b) residents must have a longitudinal, team-based, continuity experience for the duration of the educational program through which they develop a long-term therapeutic relationship with a panel of patients. (Core)

Specialty-Specific Background and Intent: The Review Committee believes that residents can only achieve a long-term therapeutic relationship with a panel of patients if the continuity clinic experience takes place for the entirety of the educational program. This will allow patients to understand that the resident is “their” primary care doctor, and residents to see the continuity clinic patients as “their” patients. While new patients will be added to the panel (and others will leave) throughout the course of the program, the Review Committee suggests that residents will remain in the same clinic throughout the 36 months to maintain continuity of care for their patient panel.

The committee believes this requirement can be best met through assigning residents to a general internal medicine clinic. However, to allow for residents to pursue post-residency interests during residency, programs may assign residents to subspecialty or specialized continuity clinics (e.g., an HIV clinic) if these assignments achieve the desired outcome noted in the requirement: that residents develop a long-term therapeutic relationship with a panel of patients.

IV.C.5.b).(1) Residents must serve as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients. (Core)

IV.C.5.b).(2) Residents must participate in the coordination of care of patients across health care settings and between outpatient visits. (Core)

IV.C.5.b).(3) Residents must be supervised and taught by faculty members with whom they have developed a longitudinal relationship. (Core)

IV.C.5.b).(4) Faculty members must maintain a ratio of residents or other learners to faculty preceptors not to exceed four to one; (Detail)

IV.C.5.b).(4).(a) Faculty members must not have other patient care responsibilities while supervising more than two residents or other learners. (Detail)

1123	IV.C.6.	Required Didactic Experiences
1124		
1125	IV.C.6.a)	The educational program must include didactic instruction based
1126		upon the core knowledge content of internal medicine. (Core)
1127		
1128	IV.C.6.a).(1)	Residents must participate in diverse teaching conferences
1129		or didactic sessions, including those dedicated to quality
1130		improvement. (Core)
1131		
1132	IV.C.6.a).(2)	The program must ensure that residents have the
1133		opportunity to review all knowledge content from
1134		conferences they could not attend. (Core)
1135		

Specialty-Specific Background and Intent: Core knowledge content presented during conferences will need to be made available for residents who missed the conference due to clinical responsibilities. This can include repeating the conference, recording and making it available electronically, or making the content provided during the conference available electronically.

1136		
1137	IV.C.6.a).(3)	Residents' educational experience must include didactic
1138		sessions in which residents interact with other residents
1139		and faculty members. (Core)
1140		
1141	IV.C.6.a).(3).(a)	The frequency of these sessions must be sufficient
1142		for peer-to-peer and peer-to-faculty member
1143		interaction. (Core)
1144		
1145	IV.C.6.a).(4)	Residents must be provided a patient or case-based
1146		approach to clinical teaching:
1147		
1148	IV.C.6.a).(4).(a)	on all inpatient, outpatient, telemedicine, and
1149		consultative services; (Core)
1150		
1151	IV.C.6.a).(4).(b)	with a frequency and duration sufficient to ensure a
1152		meaningful and continuous teaching relationship
1153		between the assigned teaching faculty member and
1154		the resident; and, (Core)
1155		
1156	IV.C.6.a).(4).(c)	that includes interactions between resident and the
1157		teaching faculty member, bedside teaching,
1158		discussion of pathophysiology, and the application
1159		of current evidence in diagnostic and therapeutic
1160		decisions. (Core)

1161		
1162	IV.D.	Scholarship
1163		
1164		<i>Medicine is both an art and a science. The physician is a humanistic</i>
1165		<i>scientist who cares for patients. This requires the ability to think critically,</i>
1166		<i>evaluate the literature, appropriately assimilate new knowledge, and</i>
1167		<i>practice lifelong learning. The program and faculty must create an</i>
1168		<i>environment that fosters the acquisition of such skills through resident</i>

1169 *participation in scholarly activities. Scholarly activities may include*
1170 *discovery, integration, application, and teaching.*

1171
1172 *The ACGME recognizes the diversity of residencies and anticipates that*
1173 *programs prepare physicians for a variety of roles, including clinicians,*
1174 *scientists, and educators. It is expected that the program's scholarship will*
1175 *reflect its mission(s) and aims, and the needs of the community it serves.*
1176 *For example, some programs may concentrate their scholarly activity on*
1177 *quality improvement, population health, and/or teaching, while other*
1178 *programs might choose to utilize more classic forms of biomedical*
1179 *research as the focus for scholarship.*

1180
1181 **IV.D.1. Program Responsibilities**

1182
1183 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1184 **activities consistent with its mission(s) and aims. (Core)**

1185
1186 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1187 **must allocate adequate resources to facilitate resident and**
1188 **faculty involvement in scholarly activities. (Core)**

1189
1190 **IV.D.1.c) The program must advance residents' knowledge and**
1191 **practice of the scholarly approach to evidence-based patient**
1192 **care. (Core)**
1193

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan
- Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature
- When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)
- Improving resident learning by encouraging them to teach using a scholarly approach

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

1194
1195 **IV.D.2. Faculty Scholarly Activity**
1196

1197 **IV.D.2.a)** Among their scholarly activity, programs must demonstrate
1198 accomplishments in at least three of the following domains:
1199 (Core)

- 1200
- 1201 • Research in basic science, education, translational
- 1202 science, patient care, or population health
- 1203 • Peer-reviewed grants
- 1204 • Quality improvement and/or patient safety initiatives
- 1205 • Systematic reviews, meta-analyses, review articles,
- 1206 chapters in medical textbooks, or case reports
- 1207 • Creation of curricula, evaluation tools, didactic
- 1208 educational activities, or electronic educational
- 1209 materials
- 1210 • Contribution to professional committees, educational
- 1211 organizations, or editorial boards
- 1212 • Innovations in education
- 1213

1214 **IV.D.2.b)** The program must demonstrate dissemination of scholarly
1215 activity within and external to the program by the following
1216 methods:
1217

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

1218

1219 **IV.D.2.b).(1)** faculty participation in grand rounds, posters,
1220 workshops, quality improvement presentations,
1221 podium presentations, grant leadership, non-peer-
1222 reviewed print/electronic resources, articles or
1223 publications, book chapters, textbooks, webinars,
1224 service on professional committees, or serving as a
1225 journal reviewer, journal editorial board member, or
1226 editor. (Outcome)‡
1227

1228 **IV.D.3. Resident Scholarly Activity**

1229

1230 **IV.D.3.a) Residents must participate in scholarship. (Core)**

1231

1232 **IV.D.3.a).(1)** A program's graduates must demonstrate dissemination of
1233 scholarship within or external to the program by any of the
1234 following methods: (Core)

1235

1236 **IV.D.3.a).(1).(a)** presenting in grand rounds, poster sessions,
1237 leading conference presentations (journal club,

1238 morbidity and mortality, case conferences);
1239 workshops; quality improvement presentations;
1240 podium presentations; grant leadership; non-peer-
1241 reviewed print/electronic resources; articles or
1242 publications; book chapters; textbooks; webinars;
1243 service on professional committees; or serving as a
1244 journal reviewer, journal editorial board member, or
1245 editor. (Core)
1246

1247 **V. Evaluation**

1248
1249 **V.A. Resident Evaluation**

1250
1251 **V.A.1. Feedback and Evaluation**
1252

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

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

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

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

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

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

1253
1254 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1255 **frequently provide feedback on resident performance during**
1256 **each rotation or similar educational assignment. (Core)**
1257

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty

members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

- V.A.1.b)** Evaluation must be documented at the completion of the assignment. ^(Core)
- V.A.1.b).(1)** For block rotations of greater than three months in duration, evaluation must be documented at least every three months. ^(Core)
- V.A.1.b).(2)** Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. ^(Core)
- V.A.1.c)** The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: ^(Core)
- V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, ^(Core)
- V.A.1.c).(2)** provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. ^(Core)
- V.A.1.d)** The program director or their designee, with input from the Clinical Competency Committee, must:
- V.A.1.d).(1)** meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; ^(Core)
- V.A.1.d).(2)** assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, ^(Core)
- V.A.1.d).(3)** develop plans for residents failing to progress, following institutional policies and procedures. ^(Core)

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

in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

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

1299		
1300	V.A.1.e)	At least annually, there must be a summative evaluation of
1301		each resident that includes their readiness to progress to the
1302		next year of the program, if applicable. (Core)
1303		
1304	V.A.1.f)	The evaluations of a resident's performance must be
1305		accessible for review by the resident. (Core)
1306		
1307	V.A.1.g)	The program must assess residents' skills in data gathering and
1308		analysis, physical examination, clinical reasoning, patient
1309		management, and procedures in all clinical settings. (Core)
1310		
1311	V.A.2.	Final Evaluation
1312		
1313	V.A.2.a)	The program director must provide a final evaluation for each
1314		resident upon completion of the program. (Core)
1315		
1316	V.A.2.a).(1)	The specialty-specific Milestones, and when applicable
1317		the specialty-specific Case Logs, must be used as
1318		tools to ensure residents are able to engage in
1319		autonomous practice upon completion of the program.
1320		(Core)
1321		
1322	V.A.2.a).(2)	The final evaluation must:
1323		
1324	V.A.2.a).(2).(a)	become part of the resident's permanent record
1325		maintained by the institution, and must be
1326		accessible for review by the resident in
1327		accordance with institutional policy; (Core)
1328		
1329	V.A.2.a).(2).(b)	verify that the resident has demonstrated the
1330		knowledge, skills, and behaviors necessary to
1331		enter autonomous practice; (Core)
1332		
1333	V.A.2.a).(2).(c)	consider recommendations from the Clinical
1334		Competency Committee; and, (Core)
1335		
1336	V.A.2.a).(2).(d)	be shared with the resident upon completion of
1337		the program. (Core)
1338		

- 1339 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
1340 **program director.** ^(Core)
1341
1342 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must**
1343 **include three members of the program faculty, at least one of**
1344 **whom is a core faculty member.** ^(Core)
1345
1346 **V.A.3.a).(1)** **Additional members must be faculty members from**
1347 **the same program or other programs, or other health**
1348 **professionals who have extensive contact and**
1349 **experience with the program's residents.** ^(Core)
1350

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

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

- 1351
1352 **V.A.3.b)** **The Clinical Competency Committee must:**
1353
1354 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
1355 ^(Core)
1356
1357 **V.A.3.b).(2)** **determine each resident's progress on achievement of**
1358 **the specialty-specific Milestones; and,** ^(Core)
1359
1360 **V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations**
1361 **and advise the program director regarding each**
1362 **resident's progress.** ^(Core)
1363
1364 **V.B.** **Faculty Evaluation**
1365
1366 **V.B.1.** **The program must have a process to evaluate each faculty**
1367 **member's performance as it relates to the educational program at**
1368 **least annually.** ^(Core)
1369

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members

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

- 1370
1371 **V.B.1.a)** This evaluation must include a review of the faculty member's
1372 clinical teaching abilities, engagement with the educational
1373 program, participation in faculty development related to their
1374 skills as an educator, clinical performance, professionalism,
1375 and scholarly activities. (Core)
1376
1377 **V.B.1.b)** This evaluation must include written, anonymous, and
1378 confidential evaluations by the residents. (Core)
1379
1380 **V.B.2.** Faculty members must receive feedback on their evaluations at least
1381 annually. (Core)
1382
1383 **V.B.3.** Results of the faculty educational evaluations should be
1384 incorporated into program-wide faculty development plans. (Core)
1385

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

- 1386
1387 **V.C.** Program Evaluation and Improvement
1388
1389 **V.C.1.** The program director must appoint the Program Evaluation
1390 Committee to conduct and document the Annual Program
1391 Evaluation as part of the program's continuous improvement
1392 process. (Core)
1393
1394 **V.C.1.a)** The Program Evaluation Committee must be composed of at
1395 least two program faculty members, at least one of whom is a
1396 core faculty member, and at least one resident. (Core)
1397
1398 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
1399

1400	V.C.1.b).(1)	acting as an advisor to the program director, through
1401		program oversight; (Core)
1402		
1403	V.C.1.b).(2)	review of the program's self-determined goals and
1404		progress toward meeting them; (Core)
1405		
1406	V.C.1.b).(3)	guiding ongoing program improvement, including
1407		development of new goals, based upon outcomes;
1408		and, (Core)
1409		
1410	V.C.1.b).(4)	review of the current operating environment to identify
1411		strengths, challenges, opportunities, and threats as
1412		related to the program's mission and aims. (Core)
1413		

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

1414		
1415	V.C.1.c)	The Program Evaluation Committee should consider the
1416		following elements in its assessment of the program:
1417		
1418	V.C.1.c).(1)	curriculum; (Core)
1419		
1420	V.C.1.c).(2)	outcomes from prior Annual Program Evaluation(s);
1421		(Core)
1422		
1423	V.C.1.c).(3)	ACGME letters of notification, including citations,
1424		Areas for Improvement, and comments; (Core)
1425		
1426	V.C.1.c).(4)	quality and safety of patient care; (Core)
1427		
1428	V.C.1.c).(5)	aggregate resident and faculty:
1429		
1430	V.C.1.c).(5).(a)	well-being; (Core)
1431		
1432	V.C.1.c).(5).(b)	recruitment and retention; (Core)
1433		
1434	V.C.1.c).(5).(c)	workforce diversity; (Core)
1435		
1436	V.C.1.c).(5).(d)	engagement in quality improvement and patient
1437		safety; (Core)
1438		
1439	V.C.1.c).(5).(e)	scholarly activity; (Core)
1440		
1441	V.C.1.c).(5).(f)	ACGME Resident and Faculty Surveys; and,
1442		(Core)
1443		
1444	V.C.1.c).(5).(g)	written evaluations of the program. (Core)

1445		
1446	V.C.1.c).(6)	aggregate resident:
1447		
1448	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
1449		
1450	V.C.1.c).(6).(b)	in-training examinations (where applicable);
1451		^(Core)
1452		
1453	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
1454		
1455	V.C.1.c).(6).(d)	graduate performance. ^(Core)
1456		
1457	V.C.1.c).(7)	aggregate faculty:
1458		
1459	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
1460		
1461	V.C.1.c).(7).(b)	professional development. ^(Core)
1462		
1463	V.C.1.d)	The Program Evaluation Committee must evaluate the
1464		program's mission and aims, strengths, areas for
1465		improvement, and threats. ^(Core)
1466		
1467	V.C.1.e)	The annual review, including the action plan, must:
1468		
1469	V.C.1.e).(1)	be distributed to and discussed with the members of
1470		the teaching faculty and the residents; and, ^(Core)
1471		
1472	V.C.1.e).(2)	be submitted to the DIO. ^(Core)
1473		
1474	V.C.2.	The program must complete a Self-Study prior to its 10-Year
1475		Accreditation Site Visit. ^(Core)
1476		
1477	V.C.2.a)	A summary of the Self-Study must be submitted to the DIO.
1478		^(Core)
1479		

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

1480		
1481	V.C.3.	<i>One goal of ACGME-accredited education is to educate physicians</i>
1482		<i>who seek and achieve board certification. One measure of the</i>
1483		<i>effectiveness of the educational program is the ultimate pass rate.</i>
1484		

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

- V.C.3.a)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.b)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.c)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.d)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

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

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

V.C.3.f)

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

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

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

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

VI. The Learning and Working Environment

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

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

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

accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

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

1586 VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows
1587 must actively participate in patient safety
1588 systems and contribute to a culture of safety.
1589 (Core)

1590
1591 VI.A.1.a).(1).(b) The program must have a structure that
1592 promotes safe, interprofessional, team-based
1593 care. (Core)

1594
1595 VI.A.1.a).(2) Education on Patient Safety

1596
1597 Programs must provide formal educational activities
1598 that promote patient safety-related goals, tools, and
1599 techniques. (Core)

1600
Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

1601
1602 VI.A.1.a).(3) Patient Safety Events

1603
1604 *Reporting, investigation, and follow-up of adverse*
1605 *events, near misses, and unsafe conditions are pivotal*
1606 *mechanisms for improving patient safety, and are*
1607 *essential for the success of any patient safety*
1608 *program. Feedback and experiential learning are*
1609 *essential to developing true competence in the ability*
1610 *to identify causes and institute sustainable systems-*
1611 *based changes to ameliorate patient safety*
1612 *vulnerabilities.*

1613
1614 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
1615 clinical staff members must:

1616
1617 VI.A.1.a).(3).(a).(i) know their responsibilities in reporting
1618 patient safety events at the clinical site;
1619 (Core)

1620
1621 VI.A.1.a).(3).(a).(ii) know how to report patient safety
1622 events, including near misses, at the
1623 clinical site; and, (Core)

1624
1625 VI.A.1.a).(3).(a).(iii) be provided with summary information
1626 of their institution's patient safety
1627 reports. (Core)

1628
1629 VI.A.1.a).(3).(b) Residents must participate as team members in
1630 real and/or simulated interprofessional clinical
1631 patient safety activities, such as root cause
1632 analyses or other activities that include
1633 analysis, as well as formulation and
1634 implementation of actions. (Core)

1635		
1636	VI.A.1.a).(4)	Resident Education and Experience in Disclosure of Adverse Events
1637		
1638		
1639		<i>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.</i>
1640		
1641		
1642		
1643		
1644		
1645	VI.A.1.a).(4).(a)	All residents must receive training in how to disclose adverse events to patients and families. ^(Core)
1646		
1647		
1648		
1649	VI.A.1.a).(4).(b)	Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^{(Detail)†}
1650		
1651		
1652		
1653	VI.A.1.b)	Quality Improvement
1654		
1655	VI.A.1.b).(1)	Education in Quality Improvement
1656		
1657		<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
1658		
1659		
1660		
1661		
1662	VI.A.1.b).(1).(a)	Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1663		
1664		
1665		
1666	VI.A.1.b).(2)	Quality Metrics
1667		
1668		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1669		
1670		
1671		
1672	VI.A.1.b).(2).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1673		
1674		
1675		
1676	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1677		
1678		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1679		
1680		
1681		
1682	VI.A.1.b).(3).(a)	Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1683		
1684		
1685		

1686	VI.A.1.b).(3).(a).(i)	This should include activities aimed at
1687		reducing health care disparities. (Detail)
1688		
1689	VI.A.2.	Supervision and Accountability
1690		
1691	VI.A.2.a)	<i>Although the attending physician is ultimately responsible for</i>
1692		<i>the care of the patient, every physician shares in the</i>
1693		<i>responsibility and accountability for their efforts in the</i>
1694		<i>provision of care. Effective programs, in partnership with</i>
1695		<i>their Sponsoring Institutions, define, widely communicate,</i>
1696		<i>and monitor a structured chain of responsibility and</i>
1697		<i>accountability as it relates to the supervision of all patient</i>
1698		<i>care.</i>
1699		
1700		<i>Supervision in the setting of graduate medical education</i>
1701		<i>provides safe and effective care to patients; ensures each</i>
1702		<i>resident's development of the skills, knowledge, and attitudes</i>
1703		<i>required to enter the unsupervised practice of medicine; and</i>
1704		<i>establishes a foundation for continued professional growth.</i>
1705		
1706	VI.A.2.a).(1)	Each patient must have an identifiable and
1707		appropriately-credentialed and privileged attending
1708		physician (or licensed independent practitioner as
1709		specified by the applicable Review Committee) who is
1710		responsible and accountable for the patient's care.
1711		(Core)
1712		
1713	VI.A.2.a).(1).(a)	This information must be available to residents,
1714		faculty members, other members of the health
1715		care team, and patients. (Core)
1716		
1717	VI.A.2.a).(1).(b)	Residents and faculty members must inform
1718		each patient of their respective roles in that
1719		patient's care when providing direct patient
1720		care. (Core)
1721		
1722	VI.A.2.b)	<i>Supervision may be exercised through a variety of methods.</i>
1723		<i>For many aspects of patient care, the supervising physician</i>
1724		<i>may be a more advanced resident or fellow. Other portions of</i>
1725		<i>care provided by the resident can be adequately supervised</i>
1726		<i>by the appropriate availability of the supervising faculty</i>
1727		<i>member, fellow, or senior resident physician, either on site or</i>
1728		<i>by means of telecommunication technology. Some activities</i>
1729		<i>require the physical presence of the supervising faculty</i>
1730		<i>member. In some circumstances, supervision may include</i>
1731		<i>post-hoc review of resident-delivered care with feedback.</i>
1732		

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision

is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

- VI.A.2.b).(1)** The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. ^(Core)
- VI.A.2.b).(2)** The program must define when physical presence of a supervising physician is required. ^(Core)
- VI.A.2.c)** Levels of Supervision
- To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)
- VI.A.2.c).(1)** Direct Supervision:
- VI.A.2.c).(1).(a)** the supervising physician is physically present with the resident during the key portions of the patient interaction; or, ^(Core)
- VI.A.2.c).(1).(a).(i)** PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). ^(Core)
- VI.A.2.c).(1).(a).(i).(a)** A supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision. ^(Core)
- VI.A.2.c).(1).(b)** the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. ^(Core)
- VI.A.2.c).(2)** Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. ^(Core)

1779		
1780	VI.A.2.c).(3)	Oversight – the supervising physician is available to
1781		provide review of procedures/encounters with
1782		feedback provided after care is delivered. (Core)
1783		
1784	VI.A.2.d)	The privilege of progressive authority and responsibility,
1785		conditional independence, and a supervisory role in patient
1786		care delegated to each resident must be assigned by the
1787		program director and faculty members. (Core)
1788		
1789	VI.A.2.d).(1)	The program director must evaluate each resident’s
1790		abilities based on specific criteria, guided by the
1791		Milestones. (Core)
1792		
1793	VI.A.2.d).(2)	Faculty members functioning as supervising
1794		physicians must delegate portions of care to residents
1795		based on the needs of the patient and the skills of
1796		each resident. (Core)
1797		
1798	VI.A.2.d).(3)	Senior residents or fellows should serve in a
1799		supervisory role to junior residents in recognition of
1800		their progress toward independence, based on the
1801		needs of each patient and the skills of the individual
1802		resident or fellow. (Detail)
1803		
1804	VI.A.2.e)	Programs must set guidelines for circumstances and events
1805		in which residents must communicate with the supervising
1806		faculty member(s). (Core)
1807		
1808	VI.A.2.e).(1)	Each resident must know the limits of their scope of
1809		authority, and the circumstances under which the
1810		resident is permitted to act with conditional
1811		independence. (Outcome)
1812		

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

1813		
1814	VI.A.2.f)	Faculty supervision assignments must be of sufficient
1815		duration to assess the knowledge and skills of each resident
1816		and to delegate to the resident the appropriate level of patient
1817		care authority and responsibility. (Core)
1818		
1819	VI.B.	Professionalism
1820		
1821	VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must
1822		educate residents and faculty members concerning the professional
1823		responsibilities of physicians, including their obligation to be
1824		appropriately rested and fit to provide the care required by their
1825		patients. (Core)
1826		

- VI.B.2. The learning objectives of the program must:**
- VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)**
- VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)**

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

- VI.B.2.c) ensure manageable patient care responsibilities. (Core)**

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

- VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)**
- VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:**
- VI.B.4.a) provision of patient- and family-centered care; (Outcome)**
- VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)**

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

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

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

- 1856
1857 **VI.B.4.c).(1)** management of their time before, during, and after
1858 clinical assignments; and, (Outcome)
1859
- 1860 **VI.B.4.c).(2)** recognition of impairment, including from illness,
1861 fatigue, and substance use, in themselves, their peers,
1862 and other members of the health care team. (Outcome)
1863
- 1864 **VI.B.4.d)** commitment to lifelong learning; (Outcome)
1865
- 1866 **VI.B.4.e)** monitoring of their patient care performance improvement
1867 indicators; and, (Outcome)
1868
- 1869 **VI.B.4.f)** accurate reporting of clinical and educational work hours,
1870 patient outcomes, and clinical experience data. (Outcome)
1871
- 1872 **VI.B.5.** All residents and faculty members must demonstrate
1873 responsiveness to patient needs that supersedes self-interest. This
1874 includes the recognition that under certain circumstances, the best
1875 interests of the patient may be served by transitioning that patient's
1876 care to another qualified and rested provider. (Outcome)
1877
- 1878 **VI.B.6.** Programs, in partnership with their Sponsoring Institutions, must
1879 provide a professional, equitable, respectful, and civil environment
1880 that is free from discrimination, sexual and other forms of
1881 harassment, mistreatment, abuse, or coercion of students,
1882 residents, faculty, and staff. (Core)
1883
- 1884 **VI.B.7.** Programs, in partnership with their Sponsoring Institutions, should
1885 have a process for education of residents and faculty regarding
1886 unprofessional behavior and a confidential process for reporting,
1887 investigating, and addressing such concerns. (Core)
1888
- 1889 **VI.C.** Well-Being
1890
- 1891 *Psychological, emotional, and physical well-being are critical in the*
1892 *development of the competent, caring, and resilient physician and require*
1893 *proactive attention to life inside and outside of medicine. Well-being*
1894 *requires that physicians retain the joy in medicine while managing their*
1895 *own real-life stresses. Self-care and responsibility to support other*
1896 *members of the health care team are important components of*
1897 *professionalism; they are also skills that must be modeled, learned, and*
1898 *nurtured in the context of other aspects of residency training.*
1899

1900 *Residents and faculty members are at risk for burnout and depression.*
 1901 *Programs, in partnership with their Sponsoring Institutions, have the same*
 1902 *responsibility to address well-being as other aspects of resident*
 1903 *competence. Physicians and all members of the health care team share*
 1904 *responsibility for the well-being of each other. For example, a culture which*
 1905 *encourages covering for colleagues after an illness without the expectation*
 1906 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
 1907 *clinical learning environment models constructive behaviors, and prepares*
 1908 *residents with the skills and attitudes needed to thrive throughout their*
 1909 *careers.*
 1910

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

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

- 1911
 1912 **VI.C.1.** The responsibility of the program, in partnership with the
 1913 Sponsoring Institution, to address well-being must include:
 1914
- 1915 **VI.C.1.a)** efforts to enhance the meaning that each resident finds in the
 1916 experience of being a physician, including protecting time
 1917 with patients, minimizing non-physician obligations,
 1918 providing administrative support, promoting progressive
 1919 autonomy and flexibility, and enhancing professional
 1920 relationships; (Core)
 1921
- 1922 **VI.C.1.b)** attention to scheduling, work intensity, and work
 1923 compression that impacts resident well-being; (Core)
 1924
- 1925 **VI.C.1.c)** evaluating workplace safety data and addressing the safety of
 1926 residents and faculty members; (Core)
 1927

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

1928
1929
1930
1931

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, ^(Core)

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

1932
1933
1934
1935
1936
1937

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

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

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VI.C.1.e) attention to resident and faculty member burnout, depression, and substance use disorders. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

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

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

Background and Intent: Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the

department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

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

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

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. ^(Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. ^(Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. ^(Core)

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

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

1987	VI.D.1.a)	educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; ^(Core)
1988		
1989		
1990	VI.D.1.b)	educate all faculty members and residents in alertness management and fatigue mitigation processes; and, ^(Core)
1991		
1992		
1993	VI.D.1.c)	encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)
1994		
1995		
1996		

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

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

1997		
1998	VI.D.2.	Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. ^(Core)
1999		
2000		
2001		
2002		
2003	VI.D.3.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. ^(Core)
2004		
2005		
2006		
2007	VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care
2008		
2009	VI.E.1.	Clinical Responsibilities
2010		
2011		The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. ^(Core)
2012		
2013		
2014		
2015	VI.E.1.a)	Programs must ensure that residents' clinical responsibilities on inpatient rotations are consistent with the requirements in IV.C.4. ^(Core)
2016		
2017		
2018		

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an

environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

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

VI.E.2.a) The program must provide educational experiences that allow residents to interact with and learn from other health care professionals, including physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, in order to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)

Specialty-Specific Background and Intent: Physician and non-physicians, core and non-core faculty members, are part of the different teams that form depending on the health care situation and on patients' health status and circumstances. The intent of the requirement is to ensure that residents will have access to the appropriate health care personnel as defined by the circumstances, and that interdisciplinary, interprofessional teams will be constituted as appropriate and as needed.

VI.E.3. Transitions of Care

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

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

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

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

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may

2058 be unable to perform their patient care responsibilities due to
2059 excessive fatigue or illness, or family emergency. (Core)
2060

2061 **VI.F. Clinical Experience and Education**
2062

2063 *Programs, in partnership with their Sponsoring Institutions, must design*
2064 *an effective program structure that is configured to provide residents with*
2065 *educational and clinical experience opportunities, as well as reasonable*
2066 *opportunities for rest and personal activities.*
2067

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

2068
2069 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
2070

2071 Clinical and educational work hours must be limited to no more than
2072 80 hours per week, averaged over a four-week period, inclusive of all
2073 in-house clinical and educational activities, clinical work done from
2074 home, and all moonlighting. (Core)
2075

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

Scheduling

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

Oversight

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

of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

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

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

PGY-1 and PGY-2 Residents

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

2076
2077
2078
2079
2080

VI.F.2. Mandatory Time Free of Clinical Work and Education

- VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational**

2081 opportunities, as well as reasonable opportunities for rest
 2082 and personal well-being. ^(Core)
 2083
 2084 **VI.F.2.b)** Residents should have eight hours off between scheduled
 2085 clinical work and education periods. ^(Detail)
 2086
 2087 **VI.F.2.b).(1)** There may be circumstances when residents choose
 2088 to stay to care for their patients or return to the
 2089 hospital with fewer than eight hours free of clinical
 2090 experience and education. This must occur within the
 2091 context of the 80-hour and the one-day-off-in-seven
 2092 requirements. ^(Detail)
 2093

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

2094
 2095 **VI.F.2.c)** Residents must have at least 14 hours free of clinical work
 2096 and education after 24 hours of in-house call. ^(Core)
 2097

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

2098
 2099 **VI.F.2.d)** Residents must be scheduled for a minimum of one day in
 2100 seven free of clinical work and required education (when
 2101 averaged over four weeks). At-home call cannot be assigned
 2102 on these free days. ^(Core)
 2103

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

2104

2105 **VI.F.3. Maximum Clinical Work and Education Period Length**
 2106
 2107 **VI.F.3.a) Clinical and educational work periods for residents must not**
 2108 **exceed 24 hours of continuous scheduled clinical**
 2109 **assignments. (Core)**
 2110

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

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

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

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

2111
 2112 **VI.F.3.a).(1) Up to four hours of additional time may be used for**
 2113 **activities related to patient safety, such as providing**
 2114 **effective transitions of care, and/or resident education.**
 2115 **(Core)**
 2116
 2117 **VI.F.3.a).(1).(a) Additional patient care responsibilities must not**
 2118 **be assigned to a resident during this time. (Core)**
 2119

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, ^(Detail)

VI.F.4.a).(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

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

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the resident work week.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. ^(Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

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

VI.F.6. In-House Night Float

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

VI.F.6.a) Residents must not be assigned more than two months of night float during any year of the educational program, or more than four months of night float during the course of the residency. (Core)

VI.F.6.b) Residents must not be assigned to more than one month of consecutive night float rotation. (Core)

Specialty-Specific Background and Intent: Night float rotations are designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and will not have daytime assignments or ongoing primary responsibility for these patients. The Committee has limited the number a program can assign because it believes too many such rotations can negatively affect resident well-being and contribute to burnout and fatigue. Overnight shifts occurring during critical care rotations (in the medical intensive care unit or the critical care unit) do not count towards night float, but towards the maximum six months of required critical care time. Overnight emergency medicine assignments do not count towards night float.

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

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

2190
2191 **VI.F.8.a).(1)**

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

2194
2195 **VI.F.8.b)**

Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)

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

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

2200
2201 ***

2202 ***Core Requirements:** Statements that define structure, resource, or process elements
2203 essential to every graduate medical educational program.

2204
2205 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for
2206 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2207 substantial compliance with the Outcome Requirements may utilize alternative or innovative
2208 approaches to meet Core Requirements.

2209
2210 **‡Outcome Requirements:** Statements that specify expected measurable or observable
2211 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2212 graduate medical education.

2213
2214 **Osteopathic Recognition**

2215 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
2216 Requirements also apply (www.acgme.org/OsteopathicRecognition).



**Accreditation Council for
Graduate Medical Education**

ACGME Common Program Requirements (Residency)

ACGME-approved focused revision: February 3, 2020; effective July 1, 2020

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Common Program Requirements (Residency)

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

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

Introduction

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

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

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

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

Int.B. **Definition of Specialty**

[The Review Committee must further specify]

Int.C. **Length of Educational Program**

[The Review Committee must further specify]

I. Oversight

I.A. Sponsoring Institution

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

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

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

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)*

I.B. Participating Sites

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

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

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

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a).(1) be renewed at least every 10 years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

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

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

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

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)

[The Review Committee may further specify]

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.
(Core)

[The Review Committee must further specify]

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

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

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

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

I.D.2.d) security and safety measures appropriate to the participating site; and, (Core)

I.D.2.e) accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

I.D.3. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

- I.D.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)**

[The Review Committee may further specify]

- I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)**

- I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)**

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

II. Personnel

II.A. Program Director

- II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**

- II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)**

- II.A.1.b) Final approval of the program director resides with the Review Committee. (Core)**

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

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

[The Review Committee may further specify]

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

- II.A.2.** At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE of non-clinical time to the administration of the program. ^(Core)

[The Review Committee may further specify. If the Review Committee specifies support greater than 20 percent, II.A.2. and the accompanying Background and Intent will be modified to reflect the level of support specified by the Review Committee]

[The Review Committee may further specify regarding support for associate program director(s)]

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

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

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

- II.A.3.** Qualifications of the program director:

- II.A.3.a)** must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; ^(Core)

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

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

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

- II.A.3.b)** must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty

qualifications that are acceptable to the Review Committee;
(Core)

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

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; and, (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

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

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

II.A.4. Program Director Responsibilities

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

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; (Core)

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

II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social

determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

- II.A.4.a).(3) administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)

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

- II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in V.B.; (Core)

- II.A.4.a).(5) have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)

- II.A.4.a).(6) have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)

- II.A.4.a).(7) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

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

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

- II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)

- II.A.4.a).(9) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

- II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and

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

II.A.4.a).(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

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

II.A.4.a).(13) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(13).(a) Residents must not be required to sign a non-competition guarantee or restrictive covenant.
(Core)

II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; (Core)

II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; and, (Core)

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

II.A.4.a).(16) obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. (Core)

II.B. Faculty

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

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

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

- II.B.1.** **At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. ^(Core)**

[The Review Committee may further specify]

- II.B.2.** **Faculty members must:**

- II.B.2.a)** **be role models of professionalism; ^(Core)**

- II.B.2.b)** **demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; ^(Core)**

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

- II.B.2.c)** **demonstrate a strong interest in the education of residents; ^(Core)**

- II.B.2.d)** **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; ^(Core)**

- II.B.2.e) administer and maintain an educational environment conducive to educating residents; ^(Core)
- II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, ^(Core)
- II.B.2.g) pursue faculty development designed to enhance their skills at least annually: ^(Core)

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

- II.B.2.g).(1) as educators; ^(Core)
- II.B.2.g).(2) in quality improvement and patient safety; ^(Core)
- II.B.2.g).(3) in fostering their own and their residents' well-being; and, ^(Core)
- II.B.2.g).(4) in patient care based on their practice-based learning and improvement efforts. ^(Core)

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

[The Review Committee may further specify additional faculty responsibilities]

II.B.3. Faculty Qualifications

- II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)

[The Review Committee may further specify]

II.B.3.b) Physician faculty members must:

- II.B.3.b).(1) have current certification in the specialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. ^(Core)

[The Review Committee may further specify additional qualifications]

II.B.3.c)

Any non-physician faculty members who participate in residency program education must be approved by the program director. ^(Core)

[The Review Committee may further specify]

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

II.B.4.

Core Faculty

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

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

II.B.4.a)

Core faculty members must be designated by the program director. ^(Core)

II.B.4.b)

Core faculty members must complete the annual ACGME Faculty Survey. ^(Core)

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

[The Review Committee may further specify requirements regarding support for core faculty members]

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

II.C.

Program Coordinator

II.C.1. **There must be a program coordinator.** ^(Core)

II.C.2. **At a minimum, the program coordinator must be supported at 50 percent FTE for the administration of the program.** ^(Core)

[The Review Committee may further specify. If the Review Committee specifies support greater than 50 percent, II.C.2. and the accompanying Background and Intent will be modified to reflect the level of support specified by the Review Committee]

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

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

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

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

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

II.D. **Other Program Personnel**

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

[The Review Committee may further specify]

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

III. **Resident Appointments**

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: ^(Core)

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, ^(Core)

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: ^(Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, ^(Core)

III.A.1.b).(2) holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. ^(Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. ^(Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. ^(Core)

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

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

III.A.3. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited

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

III.A.4. Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: ^(Core)

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

III.A.4.a) An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but who does meet all of the following additional qualifications and conditions: ^(Core)

III.A.4.a).(1) evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and, ^(Core)

III.A.4.a).(2) review and approval of the applicant's exceptional qualifications by the GMEC; and, ^(Core)

III.A.4.a).(3) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. ^(Core)

III.A.4.b) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. ^(Core)

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

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

[The Review Committee may further specify minimum complement numbers]

III.C. Resident Transfers

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

[The Review Committee may further specify]

IV. Educational Program

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

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

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

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

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

IV.A.1.a) The program's aims must be made available to program applicants, residents, and faculty members. ^(Core)

IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; ^(Core)

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

- IV.A.3.** delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; ^(Core)

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

- IV.A.4.** a broad range of structured didactic activities; ^(Core)

- IV.A.4.a)** Residents must be provided with protected time to participate in core didactic activities. ^(Core)

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

- IV.A.5.** advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, ^(Core)

- IV.A.6.** advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B. ACGME Competencies

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

- IV.B.1.** The program must integrate the following ACGME Competencies into the curriculum: ^(Core)

- IV.B.1.a)** Professionalism

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

- IV.B.1.a).(1)** Residents must demonstrate competence in:

IV.B.1.a).(1).(a) compassion, integrity, and respect for others;
(Core)

IV.B.1.a).(1).(b) responsiveness to patient needs that
supersedes self-interest; (Core)

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

IV.B.1.a).(1).(c) respect for patient privacy and autonomy; (Core)

IV.B.1.a).(1).(d) accountability to patients, society, and the
profession; (Core)

IV.B.1.a).(1).(e) respect and responsiveness to diverse patient
populations, including but not limited to
diversity in gender, age, culture, race, religion,
disabilities, national origin, socioeconomic
status, and sexual orientation; (Core)

IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's
own personal and professional well-being; and,
(Core)

IV.B.1.a).(1).(g) appropriately disclosing and addressing
conflict or duality of interest. (Core)

IV.B.1.b) Patient Care and Procedural Skills

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

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

IV.B.1.b).(1) Residents must be able to provide patient care that is
compassionate, appropriate, and effective for the
treatment of health problems and the promotion of
health. (Core)

[The Review Committee must further specify]

IV.B.1.b).(2)

Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Core)

[The Review Committee may further specify]

IV.B.1.c)

Medical Knowledge

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

[The Review Committee must further specify]

IV.B.1.d)

Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. ^(Core)

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

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

IV.B.1.d).(1)

Residents must demonstrate competence in:

IV.B.1.d).(1).(a)

identifying strengths, deficiencies, and limits in one's knowledge and expertise; ^(Core)

IV.B.1.d).(1).(b)

setting learning and improvement goals; ^(Core)

IV.B.1.d).(1).(c)

identifying and performing appropriate learning activities; ^(Core)

IV.B.1.d).(1).(d)

systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; ^(Core)

IV.B.1.d).(1).(e)

incorporating feedback and formative evaluation into daily practice; ^(Core)

IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and, ^(Core)

IV.B.1.d).(1).(g) using information technology to optimize learning. ^(Core)

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

IV.B.1.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. ^(Core)

IV.B.1.e).(1) Residents must demonstrate competence in:

IV.B.1.e).(1).(a) communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; ^(Core)

IV.B.1.e).(1).(b) communicating effectively with physicians, other health professionals, and health-related agencies; ^(Core)

IV.B.1.e).(1).(c) working effectively as a member or leader of a health care team or other professional group; ^(Core)

IV.B.1.e).(1).(d) educating patients, families, students, residents, and other health professionals; ^(Core)

IV.B.1.e).(1).(e) acting in a consultative role to other physicians and health professionals; and, ^(Core)

IV.B.1.e).(1).(f) maintaining comprehensive, timely, and legible medical records, if applicable. ^(Core)

IV.B.1.e).(2) Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. ^(Core)

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

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

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

IV.B.1.f) Systems-based Practice

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

IV.B.1.f).(1) Residents must demonstrate competence in:

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

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

IV.B.1.f).(1).(b) coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; ^(Core)

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

IV.B.1.f).(1).(c) advocating for quality patient care and optimal patient care systems; ^(Core)

IV.B.1.f).(1).(d) working in interprofessional teams to enhance patient safety and improve patient care quality; ^(Core)

IV.B.1.f).(1).(e) participating in identifying system errors and implementing potential systems solutions; ^(Core)

IV.B.1.f).(1).(f) incorporating considerations of value, cost awareness, delivery and payment, and risk-

benefit analysis in patient and/or population-based care as appropriate; and, (Core)

IV.B.1.f).(1).(g)

understanding health care finances and its impact on individual patients' health decisions. (Core)

IV.B.1.f).(2)

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

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

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

[The Review Committee must further specify]

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

IV.C.2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction. (Core)

[The Review Committee may further specify]

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

IV.D. Scholarship

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

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians,

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

IV.D.1. Program Responsibilities

- IV.D.1.a)** The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. ^(Core)
- IV.D.1.b)** The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. ^(Core)
- [The Review Committee may further specify]
- IV.D.1.c)** The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. ^(Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan
- Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature
- When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)
- Improving resident learning by encouraging them to teach using a scholarly approach

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

IV.D.2. Faculty Scholarly Activity

- IV.D.2.a)** Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: ^(Core)

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

IV.D.2.b)

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

[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

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

IV.D.2.b).(1)

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

IV.D.2.b).(2)

peer-reviewed publication. (Outcome)

IV.D.3.

Resident Scholarly Activity

IV.D.3.a)

Residents must participate in scholarship. (Core)

[The Review Committee may further specify]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

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

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

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

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

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

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

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

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

- V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)**

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

- V.A.1.b).(2)** Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. ^(Core)
- V.A.1.c)** The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: ^(Core)
- V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, ^(Core)
- V.A.1.c).(2)** provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. ^(Core)
- V.A.1.d)** The program director or their designee, with input from the Clinical Competency Committee, must:
- V.A.1.d).(1)** meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; ^(Core)
- V.A.1.d).(2)** assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, ^(Core)
- V.A.1.d).(3)** develop plans for residents failing to progress, following institutional policies and procedures. ^(Core)

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

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

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. ^(Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. ^(Core)

[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. ^(Core)

V.A.2.a).(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. ^(Core)

V.A.2.a).(2) The final evaluation must:

V.A.2.a).(2).(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; ^(Core)

V.A.2.a).(2).(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; ^(Core)

V.A.2.a).(2).(c) consider recommendations from the Clinical Competency Committee; and, ^(Core)

V.A.2.a).(2).(d) be shared with the resident upon completion of the program. ^(Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. ^(Core)

V.A.3.a) At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. ^(Core)

V.A.3.a).(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. ^(Core)

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

V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)
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V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. ^(Core)

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

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

- V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
- V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
- V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)
- V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

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

V.C. Program Evaluation and Improvement

- V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
- V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)
- V.C.1.b) Program Evaluation Committee responsibilities must include:
- V.C.1.b).(1) acting as an advisor to the program director, through program oversight; (Core)
- V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; (Core)
- V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)
- V.C.1.b).(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

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

- V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:**
- V.C.1.c).(1) curriculum; (Core)**
 - V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s); (Core)**
 - V.C.1.c).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)**
 - V.C.1.c).(4) quality and safety of patient care; (Core)**
 - V.C.1.c).(5) aggregate resident and faculty:**
 - V.C.1.c).(5).(a) well-being; (Core)**
 - V.C.1.c).(5).(b) recruitment and retention; (Core)**
 - V.C.1.c).(5).(c) workforce diversity; (Core)**
 - V.C.1.c).(5).(d) engagement in quality improvement and patient safety; (Core)**
 - V.C.1.c).(5).(e) scholarly activity; (Core)**
 - V.C.1.c).(5).(f) ACGME Resident and Faculty Surveys; and, (Core)**
 - V.C.1.c).(5).(g) written evaluations of the program. (Core)**
 - V.C.1.c).(6) aggregate resident:**
 - V.C.1.c).(6).(a) achievement of the Milestones; (Core)**
 - V.C.1.c).(6).(b) in-training examinations (where applicable); (Core)**
 - V.C.1.c).(6).(c) board pass and certification rates; and, (Core)**
 - V.C.1.c).(6).(d) graduate performance. (Core)**
 - V.C.1.c).(7) aggregate faculty:**

- V.C.1.c).(7).(a) evaluation; and, (Core)
- V.C.1.c).(7).(b) professional development. (Core)
- V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
- V.C.1.e) The annual review, including the action plan, must:
- V.C.1.e).(1) be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)
- V.C.1.e).(2) be submitted to the DIO. (Core)
- V.C.2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)
- V.C.2.a) A summary of the Self-Study must be submitted to the DIO. (Core)

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

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

- V.C.3.b)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.c)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.d)** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

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

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

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

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

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

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

VI. The Learning and Working Environment

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

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

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

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

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

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

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

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

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

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

[The Review Committee may further specify]

VI.A.1.a).(3)

Patient Safety Events

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

VI.A.1.a).(3).(a)

Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i)

know their responsibilities in reporting patient safety events at the clinical site;
^(Core)

VI.A.1.a).(3).(a).(ii)

know how to report patient safety events, including near misses, at the clinical site; and, ^(Core)

VI.A.1.a).(3).(a).(iii)

be provided with summary information of their institution's patient safety reports. ^(Core)

VI.A.1.a).(3).(b)

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

VI.A.1.a).(4)

Resident Education and Experience in Disclosure of Adverse Events

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

VI.A.1.a).(4).(a)	All residents must receive training in how to disclose adverse events to patients and families. ^(Core)
VI.A.1.a).(4).(b)	Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^{(Detail)†}
VI.A.1.b)	Quality Improvement
VI.A.1.b).(1)	Education in Quality Improvement
	<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
VI.A.1.b).(1).(a)	Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
VI.A.1.b).(2)	Quality Metrics
	<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
VI.A.1.b).(2).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
VI.A.1.b).(3)	Engagement in Quality Improvement Activities
	<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
VI.A.1.b).(3).(a)	Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
	[The Review Committee may further specify under any requirement in VI.A.1.b)-VI.A.1.b).(3).(a).(i)]
VI.A.2.	Supervision and Accountability

VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

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

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.
(Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

<p>Background and Intent: There are circumstances where direct supervision without physical presence does not fulfill the requirements of the specific Review Committee. Review Committees will further specify what is meant by direct supervision without physical presence in specialties where allowed. "Physically present" is defined as follows: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.</p>

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

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

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

the supervising physician is physically present with the resident during the key portions of the patient interaction; or, (Core)

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

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

[The Review Committee will choose to require either VI.A.2.c).(1).(a), or both VI.A.2.c).(1).(a) and VI.A.2.c).(1).(b)]

- VI.A.2.c).(2)** **Indirect Supervision:** the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. ^(Core)
- VI.A.2.c).(3)** **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)
- VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** ^(Core)
- VI.A.2.d).(1)** **The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones.** ^(Core)
- VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** ^(Core)
- VI.A.2.d).(3)** **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** ^(Detail)
- VI.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** ^(Core)
- VI.A.2.e).(1)** **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** ^(Outcome)

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

- VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** ^(Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. ^(Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, ^(Core)

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

VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)

[The Review Committee may further specify]

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

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)

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

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

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

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

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

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

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

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

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

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

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

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

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require

proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

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

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

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

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

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

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, ^(Core)

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

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

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

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

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

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)

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

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

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

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

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements.

Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

- VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)**
- VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)**
- VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)**

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

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

- VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)**
- VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)**

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

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

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

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

VI.E.2. Teamwork

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

[The Review Committee may further specify]

VI.E.3. Transitions of Care

- VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**
- VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)**
- VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)**
- VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)**
- VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)**

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with

educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

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

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)

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

Scheduling

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

Oversight

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

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements

acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

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

PGY-1 and PGY-2 Residents

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

VI.F.2. Mandatory Time Free of Clinical Work and Education

- VI.F.2.a)** The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)
- VI.F.2.b)** Residents should have eight hours off between scheduled clinical work and education periods. ^(Detail)
- VI.F.2.b).(1)** There may be circumstances when residents choose to stay to care for their patients or return to the

hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

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

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

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

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

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

VI.F.3. Maximum Clinical Work and Education Period Length

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

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of

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

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

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

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

VI.F.3.a).(1)

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
(Core)

VI.F.3.a).(1).(a)

Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4.

Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, ^(Detail)

VI.F.4.a).(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

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

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. ^(Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. ^(Core)

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

- VI.F.5.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. ^(Core)
- VI.F.5.b)** Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. ^(Core)
- VI.F.5.c)** PGY-1 residents are not permitted to moonlight. ^(Core)

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

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. ^(Core)

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

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

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). ^(Core)

VI.F.8. At-Home Call

- VI.F.8.a)** Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. ^(Core)
- VI.F.8.a).(1)** At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. ^(Core)
- VI.F.8.b)** Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established

patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)

[The Review Committee may further specify under any requirement in VI.F.-VI.F.8.b)]

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

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

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

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

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

Osteopathic Recognition

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

Overview

As a component of its next accreditation system, the ACGME has established the CLER program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites. CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 ACGME Common Program Requirements. The intent of CLER is “to generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.”¹

CLER provides frequent on-site sampling of the learning environment that will:

- Permit lengthening the interval for standard ACGME site visits of individual programs if other parameters of program performance are at the expected level;
- Emphasize elements of “new” competencies demanded by the public; and,
- Provide the opportunity for sponsoring institutions to demonstrate leadership in patient safety, quality improvement, and reduction in health care disparities.

The CLER program’s ultimate goal is to move from a major targeted focus on duty hours to that of broader focus on the GME learning environment and how it can deliver both high-quality physicians and higher quality, safer, patient care. In its initial phase, CLER data will not be used in accreditation decisions by the Institutional Review Committee (IRC).

CLER consists of three related activities:

- The **CLER site visit program** is used solely for providing feedback, learning, and helping to establish baselines for sponsoring institutions, the Evaluation Committee, and the IRC. The first cycle of visit findings will result in dissemination of salutary practices by the Evaluation Committee.
- The **CLER Evaluation Committee** includes a broad cross-section of individuals with expertise related to the aim of the CLER program. The Committee provides input to the design and implementation of CLER site visit activities and conducts evaluation review of sponsoring institutions that are visited during each cycle.
- The ACGME recognizes the great interest by sponsoring institutions to support **faculty development** in those areas on which the CLER program will focus (e.g., patient safety, health care quality, transitions of care, etc.). Therefore, as part of the CLER program, the ACGME will develop a program to support faculty development.

CLER assesses sponsoring institutions in the following six focus areas:

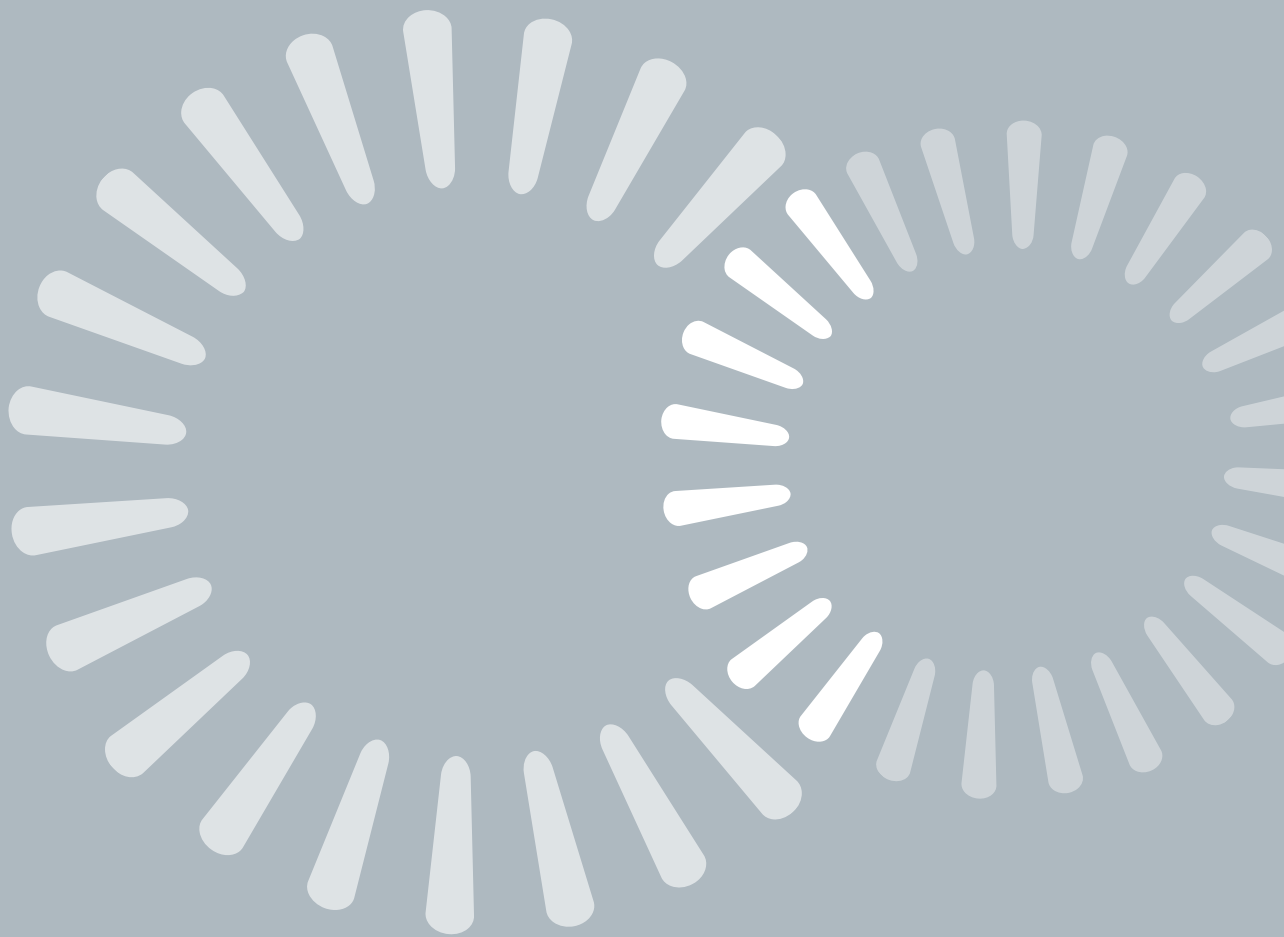
- **Patient Safety** – including opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.

- **Quality Improvement** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
- **Transitions in Care** – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.
- **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
- **Duty Hours Oversight, Fatigue Management and Mitigation** – including how sponsoring institutions: (i) demonstrate effective and meaningful oversight of duty hours across all residency programs institution-wide; (ii) design systems and provide settings that facilitate fatigue management and mitigation; and (iii) provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.
- **Professionalism**—with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of residents and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

The initial round of CLER evaluations will seek answers to the following central questions:

- **Who and what form the infrastructure of a Sponsoring Institution’s clinical learning environment?** What organizational structures and administrative and clinical processes do the SI and its major participating sites have in place to support GME learning in each of the six focus areas?
- **How integrated is the GME leadership and faculty within the SI’s current clinical learning environment infrastructure?** What is the role of GME leadership and faculty to support resident and fellow learning in each of the six areas?
- **How engaged are the residents and fellows in using the SI’s current clinical learning environment infrastructure?** How comprehensive is the involvement of residents and fellows in using these structures and processes to support their learning in each of the six areas?
- **How does the SI determine the success of its efforts to integrate GME into the quality infrastructure?** From the perspective of the SI and its major participating sites, what are the measures of success in using this infrastructure and what was the level of success?
- **What areas have the Sponsoring Institution identified as opportunities for improvement?** From the perspective of the SI and its major participating sites (if different), what are seen as the opportunities for improving the quality and value of the current clinical learning environment infrastructure to support the six focus areas?

¹Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. N Engl J Med. 2012;366(11):1051-1056. [Epub 2012 Feb 22.] 06/10/2012 Ver. 1.0



CLER PATHWAYS TO EXCELLENCE

EXPECTATIONS FOR AN OPTIMAL
CLINICAL LEARNING ENVIRONMENT TO ACHIEVE
SAFE AND HIGH-QUALITY PATIENT CARE

VERSION 2.0



ACGME

Accreditation Council for
Graduate Medical Education

CLER Pathways Version 2.0

The Clinical Learning Environment Review (CLER) Program is pleased to present Version 2.0 of *CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High-Quality Patient Care*. The *Pathways* document continues to serve as a tool for promoting discussions and actions to optimize the clinical learning environment (CLE). This version frames each of the pathways and properties from the health system's perspective, recognizing that health care organizations create and are therefore primarily responsible for the CLE. This focus emphasizes the importance of the interface between graduate medical education (GME) and the hospitals, medical centers, and ambulatory sites that serve as CLEs.

This version of the *Pathways* also places greater emphasis on the clinical care team (and resident and fellow physicians as members of the team). In addition to noting the role of the clinical care team throughout the document, Version 2.0 introduces a new CLER Focus Area called Teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals. It also recognizes the benefits of purposeful interactions that allow team members to quickly identify and capitalize on their various professional strengths –coordinating care that is both safe and efficient. This new Focus Area also expressly recognizes and explores the CLE's perspective on the patient's role in teaming. Teaming replaces the previous Focus Area called Care Transitions; the properties from Care Transitions were either retired or redistributed as properties of the other five CLER Focus Areas.

These updates reflect the CLER Program's commitment to continuous improvement toward the goal of optimizing the delivery of safe, high-quality patient care.

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Introduction

In the late 1990s, the National Academy of Medicine (formerly the Institute of Medicine) conducted a multiyear project to examine the quality of health care in the United States.¹ The result of that effort was a series of reports^{2,3} that highlighted serious patient safety concerns, variability in the quality of care, and continuing health care disparities. More than 20 years after the release of those reports, the overall progress in improving the nation's health care has been slow.

The physician workforce is one of the key levers to improving health care. A 2012 survey of hospital leaders conducted by the American Hospital Association found that newly trained physicians were deficient in the areas of communication, use of systems-based practices, and interprofessional teamwork and highlighted the need to educate US physicians, residents, and fellows to address quality improvement.⁴

More than 135,000 resident and fellow physicians train in US teaching hospitals, medical centers, and other clinical settings.⁵ These individuals work on the front lines of patient care. In this role, they need to be prepared to recognize patient safety events and intervene when appropriate, to champion performance improvement efforts, and to work effectively in interprofessional^a teams on systems-based issues such as transitions in patient care. This next generation of physicians needs the skills to be able to lead changes in our nation's health care organizations, both large and small.

The ACGME recognizes the public's need for a physician workforce capable of meeting the requirements of a rapidly evolving health care environment. Efforts to address those needs began in the late 1990s when the ACGME, collaborating with the American Board of Medical Specialties, established six core competencies and designed and implemented a framework for attaining the skills needed for the modern practice of medicine. This framework drives both the educational curriculum and the evaluation of outcomes for residents and fellows. As a subsequent step in the evolution of GME, the ACGME implemented the Next Accreditation System as its current model of accreditation.⁶ The Next Accreditation System emphasizes outcomes of resident and fellow learning, assessed through a set of performance measures, including the Milestones, which indicate the individual's progress toward independent practice. Other examples of these measures include: clinical experience as evidenced through the Case Logs, scholarly activity, and pass rates for specialty certification.

^a The CLER Program considers "interprofessional" as interactions (e.g., patient care, learning) that involve individuals from two or more clinical professions.

The CLER Program

The ACGME established the CLER Program in 2012⁷ to provide GME leaders and executive leaders of hospitals, medical centers, and other clinical settings with formative feedback aimed at improving patient care while optimizing the CLE in six important cross-cutting areas such as patient safety and health care quality.

The CLER Program conducts site visits to the hospitals, medical centers, and other clinical settings of ACGME-accredited institutions that host residency and fellowship programs.⁸ During these visits, CLER Field Representatives meet with the organization's executive leadership (e.g., chief executive officer, chief medical officer, chief nursing officer); the organization's leaders in patient safety, health care quality, and well-being; leaders of GME; and groups of residents and fellows, faculty members, and program directors. Additionally, the CLER site visit teams conduct Walking Rounds on various patient floors, units, and service areas to gather input from other members of the clinical care team regarding how the organization functions as a learning environment.

At the conclusion of each visit, the CLER Field Representatives meet with the organization's executive leadership to share their observations of resident and fellow engagement in the Focus Areas. It is through this feedback that the ACGME seeks to improve both physician education and the quality of patient care within these organizations.

The CLER Program is separate and distinct from nearly all accreditation activities. Two essential elements connect the CLER Program with the rest of the accreditation process: (1) each Sponsoring Institution is required to periodically undergo a CLER site visit every 24 (± 6) months; and (2) the chief executive officer and the leader of GME (specifically the designated institutional official) of the clinical site must attend the opening and closing sessions of the CLER site visit.

The CLER Program is built on a model of continuous quality improvement. Its purpose is to evaluate, encourage, and promote improvements in the CLE. The CLER Program provides sites with three types of formative feedback: (1) an oral report at the end of the site visit; (2) a written narrative report summarizing the observations of the CLER Field Representative(s); and (3) reports that provide

national aggregated and de-identified data displayed along a continuum of progress toward achieving optimal resident and fellow engagement in the CLER Focus Areas.

The individual CLER site visit reports are kept confidential. The National Reports of aggregated, de-identified CLER Program data are shared publicly and used to inform future US residency and fellowship accreditation policies, procedures, and requirements.

Developing the CLER Pathways

The *CLER Pathways to Excellence*⁹ document serves a tool to promote discussions and actions to optimize the CLE, furthering the aim of the CLER Program. The ACGME presents the CLER pathways as expectations rather than requirements, anticipating that CLEs will strive to meet or exceed these expectations in their efforts to provide the best care to patients and to produce the highest quality physician workforce.

The ACGME's CLER Evaluation Committee, a group that provides oversight and guidance on all aspects of the CLER Program, develops each version of the *CLER Pathways to Excellence*. The committee's members represent a broad range of perspectives and are selected based on their national and international expertise in areas of patient safety, health care quality, hospital leadership, GME, and patient perspectives. Their continued input, combined with that of the CLER Field Representatives, GME leadership, the executive leadership of Sponsoring Institutions and other clinical sites, and the community—as well as what is learned from the data generated by the CLER site visits—helps to evolve each version of the *CLER Pathways to Excellence* to reflect the current state of GME and the health care system.

Using the CLER Pathways' Framework

The *CLER Pathways to Excellence* provides a framework for clinical sites to use in their continuing efforts to prepare the clinical care team to deliver consistently safe, high-quality patient care. Central to the document is a series of pathways for each of the six CLER Focus Areas, which are essential to creating an optimal CLE. In turn, each pathway has a series of key properties that can be used to assess resident, fellow, and faculty member engagement within the learning environment.

For example, the Patient Safety Focus Area has seven defined pathways. The first is:

PS Pathway 1: Education on patient safety

Five properties are attached to this pathway—each designed to assess the GME connection to the structures and processes the CLE has put in place to promote safe, high-quality patient care. The first is:

The clinical learning environment:

- a. Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.*

In total, Version 2.0 of the *Pathways* document presents six Focus Areas, 34 pathways, and 139 properties. Because the scope and number of pathways and properties are more than can be covered at one time, the CLER Program will not assess all of these elements on every CLER site visit. The CLER Program and the CLER Evaluation Committee hope that CLEs will find valuable guidance in all of the items, regardless of whether they are formally assessed.

Version 2.0 of *Pathways* recognizes the CLE is a shared space, encompassing both early and lifelong learners across the professions. As such, the document focuses on the clinical care team and emphasizes the interdependence of roles and the importance of modeling optimal behaviors for early learners. It also recognizes the key role of patients and caregivers in partnering with the care team to achieve optimal outcomes.

The majority of the pathways and their properties cannot be achieved without a close partnership between the GME leadership and the highest level of executive leadership at the clinical site. The feedback from the CLER Program will assist institutions in prioritizing and acting on opportunities to improve the CLE for resident and fellow physicians and—ultimately—the quality of patient care.

Informing the Accreditation Process

As noted earlier, the CLER Program provides formative feedback—to individual clinical sites, the ACGME, and the public. The *CLER Pathways to Excellence* document is a tool for assessing the present and simultaneously envisioning and planning for the future. By setting expectations for an optimal CLE, the

pathways and properties serve to stimulate conversations that lead to innovation and improvements in service of both patients and learners. The *CLER Pathways* differ from the ACGME Common Program Requirements and the Institutional Requirements in that they are not utilized to determine the accreditation status of Sponsoring Institutions and their residency programs.

The CLER Program is designed to inform the Common Program Requirements and Institutional Requirements in aggregate. The CLER Evaluation Committee periodically reviews the cumulative data from the CLER site visits, along with emerging research in the six Focus Areas, and uses the information to reassess the pathways, revise them as needed, and make recommendations, as appropriate, regarding potential changes to GME accreditation requirements. As elements of the *CLER Pathways to Excellence* migrate to requirements, these elements are removed from future versions of the document and replaced with new areas for exploration. In this manner, the CLER Program serves as a catalyst to continually inform accreditation, while striving for excellence in patient safety and health care quality.

Striving for Excellence

The CLER Evaluation Committee and, ultimately, the ACGME Board of Directors continually monitor the progress of the CLER Program. Success associated with the *CLER Pathways to Excellence* is assessed by tracking aggregated data over time and mapping progress along the pathways toward the goal of achieving optimal engagement.

The *CLER Pathways to Excellence* is intended to accelerate national conversations among educators, health care leadership, policy makers, and patients as to the importance of continually assessing and improving the environments in which the US physician workforce trains, as well as the role of GME in promoting safe, high-quality patient care.

Patient Safety (PS)

The optimal clinical learning environment continually provides experiences that residents and fellows need to engage with the clinical site's efforts to address patient safety. It is important that the clinical site has processes to identify and implement sustainable, systems-based improvements to address patient safety vulnerabilities and that such processes engage interprofessional teams as part of ongoing efforts to deliver the safest and highest quality patient care.²

PS Pathway 1: Education on patient safety

The clinical learning environment:

- a. Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.
- b. Ensures that faculty members are proficient in the application of principles and practices of patient safety.
- c. Engages residents and fellows in patient safety educational activities in which the clinical site's systems-based challenges are presented and techniques for designing and implementing system changes are discussed.
- d. Provides residents, fellows, and faculty members with education on the clinical site's proactive risk assessments (e.g., failure mode and effects analysis).
- e. Ensures that the clinical site's patient safety education program is developed collaboratively by patient safety officers, residents, fellows, faculty members, nurses, and other members of the clinical care team.

PS Pathway 2: Culture of safety

The clinical learning environment:

- a. Regularly conducts a culture of safety survey with all members of the clinical care team to identify opportunities for improvement and shares results across the organization.
- b. Establishes formal risk-based mechanisms to identify hazards, monitor for potential vulnerabilities, and ensure patient safety.
- c. Creates and sustains a fair and just culture for reporting patient safety events for the purposes of systems improvement.
- d. Maintains mechanisms to provide second-victim emotional support to the clinical care team involved in patient safety events.
- e. Directly reaches out to residents and fellows involved in patient safety events to provide second-victim emotional support.

PS Pathway 3: Reporting of adverse events, near misses/close calls, and unsafe conditions

The clinical learning environment:

- a. Provides the clinical care team, including residents, fellows, and faculty members, with education on the types of vulnerabilities and range of reportable patient safety events.
- b. Ensures that the clinical care team, including residents, fellows, and faculty members, knows the benefits of reporting patient safety events to improve patient care at the clinical site.
- c. Ensures that residents, fellows, and faculty members know that it is their responsibility to report patient safety events into the clinical site's central reporting system rather than delegating this responsibility.
- d. Captures patient safety events reported by residents, fellows, and faculty members via any mechanism (e.g., online, telephone calls, chain of command) in the clinical site's central reporting system.
- e. Provides GME leadership (routinely) and the clinical site's governing body (at least annually) with information on patient safety events reported by residents, fellows, and faculty members.

PS Pathway 4: Experience in patient safety event investigations and follow-up

The clinical learning environment:

- a. Ensures that residents and fellows engage in interprofessional, experiential patient safety event investigations that include analysis, implementation of an action plan, and monitoring for continuous improvement related to patient care.
- b. Provides direct feedback to members of the clinical care team, including residents and fellows, on the outcomes resulting from personally reporting a patient safety event.
- c. Shares lessons learned from patient safety investigations across the organization with all members of the clinical care team, including residents and fellows.

PS Pathway 5: Clinical site monitoring of resident, fellow, and faculty member engagement in patient safety

The clinical learning environment:

- a. Monitors resident, fellow, and faculty member reporting of patient safety events.
- b. Monitors resident, fellow, and faculty member participation in patient safety event investigations.
- c. Uses data from monitoring resident, fellow, and faculty member patient safety reports to develop and implement actions that improve patient care.
- d. Monitors resident, fellow, and faculty member participation in implementing action plans resulting from patient safety event investigations.

PS Pathway 6: Resident and fellow education and experience in disclosure of events

The clinical learning environment:

- a. Provides residents and fellows with experiential training with their faculty members (e.g., simulated or authentic patient care experience) in the clinical site's process for disclosing patient safety events to patients and families.
- b. Ensures that residents and fellows are involved with faculty members in disclosing patient safety events to patients and families at the clinical site.

PS Pathway 7: Resident, fellow, and faculty member engagement in care transitions

The clinical learning environment:

- a. Provides residents, fellows, and faculty members with simulated or real-time interprofessional training on communication to optimize transitions of care at the clinical site.
- b. Ensures that residents, fellows, and faculty members use a common clinical site-based process for change-of-duty hand-offs.
- c. Ensures that residents, fellows, and faculty members use a standardized direct verbal communication process for patient transfers between services and locations at the clinical site.
- d. Involves residents, fellows, and program directors in the development and implementation of strategies to improve transitions of care.
- e. Monitors transitions of patient care managed by residents and fellows.

Health Care Quality (HQ)

The optimal clinical learning environment provides experiential and interprofessional training in all phases of quality improvement aligned with the quality goals of the clinical site.³ In this way, it ensures that residents and fellows engage with the entire cycle of quality improvement—from planning through implementation and reassessment.

HQ Pathway 1: Education on quality improvement

The clinical learning environment:

- a. Ensures that residents, fellows, and faculty members are familiar with the clinical site's priorities and goals for quality improvement.
- b. Provides the clinical care team, including residents, fellows, and faculty members with ongoing education and training on quality improvement that involves experiential learning and interprofessional teams.
- c. Engages residents, fellows, and faculty members in quality improvement educational activities where the clinical site's systems-based challenges are presented, and techniques for designing and implementing systems changes are demonstrated.
- d. Ensures that the clinical site's quality improvement education program is developed collaboratively by quality officers, residents, fellows, faculty members, nurses, and other members of the clinical care team to reflect the clinical site's quality program's priorities and goals.
- e. Ensures the integration of quality improvement processes and lessons learned into the daily workflow of clinical care.

HQ Pathway 2: Resident and fellow engagement in quality improvement activities

The clinical learning environment:

- a. Provides opportunities for residents and fellows to actively engage in interprofessional quality improvement.
- b. Ensures that residents and fellows actively engage in interprofessional quality improvement that is aligned and integrated with the clinical site's priorities for sustained improvements in patient care.
- c. Maintains a central repository for all quality improvement projects, including resident- and fellow-led projects, to monitor progress and assess the quality of the projects.
- d. Shares quality improvement outcomes with all members of the clinical care team, including residents and fellows, across the organization.

HQ Pathway 3: Data on quality metrics

The clinical learning environment:

- a. Provides the clinical care team, including residents and fellows, with clinical site-level quality metrics and benchmarks.
- b. Provides the clinical care team, including residents and fellows, with aggregated data on quality metrics and benchmarks related to their patient populations.
- c. Provides the clinical care team, including residents and fellows, with data on quality metrics and benchmarks specific to the patients for whom they provide direct patient care.
- d. Ensures that the clinical care team, including residents, fellows, and faculty members, can interpret data on quality metrics and benchmarks.

HQ Pathway 4: Resident and fellow engagement in the clinical site's quality improvement planning process

The clinical learning environment:

- a. Engages residents, fellows, and faculty members in strategic planning for quality improvement.
- b. Engages residents, fellows, and faculty members in interprofessional service-line, departmental, and clinical site-wide quality improvement committees.
- c. Periodically reviews resident and fellow quality improvement projects to integrate with the clinical site's quality improvement planning process.

HQ Pathway 5: Resident, fellow, and faculty member education on eliminating health care disparities

The clinical learning environment:

- a. Provides the clinical care team, including residents, fellows, and faculty members with education on the differences between health disparities and health care disparities.
- b. Ensures that residents, fellows, and faculty members know the clinical site's priorities for addressing health care disparities.
- c. Educates residents, fellows, and faculty members on identifying and eliminating health care disparities among specific patient populations receiving care at the clinical site.
- d. Maintains a process that informs residents, fellows, and faculty members on the clinical site's process for identifying and eliminating health care disparities.

HQ Pathway 6: Resident, fellow, and faculty member engagement in clinical site initiatives to eliminate health care disparities

The clinical learning environment:

- a. Engages residents, fellows, and faculty members in defining strategies and priorities to eliminate health care disparities among its patient population.
- b. Identifies and shares information with residents, fellows, and faculty members on the social determinants of health for its patient population.
- c. Provides residents, fellows, and faculty members with quality metrics data on health care disparities grouped by its patient population.
- d. Provides opportunities for residents, fellows, and faculty members to engage in interprofessional quality improvement projects focused on eliminating health care disparities among its patient population.
- e. Monitors the outcomes of quality improvement initiatives aimed at eliminating health care disparities among its patient population.

HQ Pathway 7: Residents, fellows, and faculty members deliver care that demonstrates cultural humility

The clinical learning environment:

- a. Provides residents, fellows, and faculty members continual training in cultural humility relevant to the patient population served by the clinical site.
- b. Ensures that the clinical care team, including residents, fellows, and faculty members, delivers care that incorporates the views of culturally diverse patient populations.

Teaming (T)

The optimal clinical learning environment supports high-performance teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals.¹⁰ Teaming recognizes the benefits of purposeful interactions in which team members quickly identify and capitalize on their various professional strengths—coordinating care that is both safe and efficient. The team members collaborate and share accountability to achieve outstanding results.

T Pathway 1: Clinical learning environment promotes teaming as an essential part of interprofessional learning and development

The clinical learning environment:

- a. Maintains an organizational strategy to promote interprofessional learning on teaming.
- b. Provides continual interprofessional educational programming on teaming that engages residents, fellows, and faculty members.
- c. Ensures the development and maintenance of interprofessional skills on teaming that engages residents, fellows, and faculty members.
- d. Ensures continual interprofessional learning on teaming that engages residents, fellows, and faculty members across the continuum of patient care and at all care delivery sites.
- e. Engages in continual goal-setting and monitoring of interprofessional learning on teaming.

T Pathway 2: Clinical learning environment demonstrates high-performance teaming

The clinical learning environment:

- a. Ensures that patient care planning by residents, fellows, and faculty members (e.g., diagnostic and treatment strategies) is conducted in the context of interprofessional teams.
- b. Ensures that transitions in care conducted by residents, fellows, and faculty members (e.g., change-of-duty hand-offs, transfers of patients between services and locations) involves, as appropriate, interprofessional teams.
- c. Engages residents, fellows, and faculty members in interprofessional performance improvement activities, including patient safety and quality improvement, across service lines and health care settings.
- d. Ensures that patient care processes are designed with interprofessional collaborative input, including the GME community.

T Pathway 3: Clinical learning environment engages patients* to achieve high-performance teaming

The clinical learning environment:

- a. Maintains a strategy to engage patients as part of its effort to ensure high-performance teaming.
- b. Ensures that patients are engaged with their clinical care team in decisions related to their care.
- c. Engages patients in the development and revision of the clinical site's policies and procedures on patient care in which residents and fellows are involved (e.g., duty hours, supervision, informed consent).
- d. Ensures that patients are involved, as appropriate, in resident and fellow care transitions (e.g., change-of-duty hand-offs).

T Pathway 4: Clinical learning environment maintains the necessary system supports to ensure high-performance teaming

The clinical learning environment:

- a. Provides professional development resources to ensure interprofessional learning and high-performance teaming that includes residents, fellows, and faculty members.
- b. Provides interprofessional resources to support teaming activities within and across service lines and health care settings.
- c. Monitors the use of interprofessional resources to support high-performance teaming.
- d. Ensures that information technology personnel are integrated into interprofessional teams and that resources are available to support high-performance teaming.
- e. Demonstrates how it engages the clinical care team, including residents, fellows, and faculty members, in integrating artificial intelligence (e.g., decision support) to support high-performance teaming.
- f. Monitors the degree of patient engagement in the design and practice of teaming.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

Supervision (s)

The optimal clinical learning environment provides all members of the clinical care team and patients with mechanisms to raise supervision concerns. It also continuously monitors resident and fellow supervision to implement actions that enhance patient safety.¹¹ For each resident and fellow, GME encompasses progressive levels of supervision throughout the educational program.

S Pathway 1: Education on supervision

The clinical learning environment:

- a. Educates the clinical care team, including residents, fellows, and faculty members, on GME expectations for supervision and progressive autonomy throughout the residency and fellowship experience.
- b. Educates residents, fellows, and faculty members on the clinical site's expectations on how GME provides effective supervision of patient care.

S Pathway 2: Culture of supervision

The clinical learning environment:

- a. Ensures that residents and fellows receive adequate supervision as defined by the clinical site.
- b. Maintains a culture of supervision such that residents and fellows feel safe and supported in requesting assistance in the delivery of patient care.
- c. Fosters a supportive and nonpunitive culture of supervision for members of the clinical care team to report concerns about resident and fellow supervision.
- d. Ensures that mechanisms are in place for the clinical care team, including residents and fellows, to escalate supervision concerns in real-time.
- e. Establishes expectations for and monitors the quality of supervision of consultative services provided by residents and fellows.

S Pathway 3: Roles of clinical staff members other than physicians in resident and fellow supervision

The clinical learning environment:

- a. Ensures that clinical staff members other than physicians act on concerns related to the supervision of residents and fellows.
- b. Ensures that clinical staff members other than physicians are knowledgeable about the clinical site's expectations for supervision and progressive autonomy throughout the residency and fellowship experience.
- c. Periodically assesses the perceptions of clinical staff members other than physicians that the clinical site provides residents and fellows with a supportive culture for requesting assistance from supervising physicians.
- d. Ensures that clinical staff members other than physicians escalate concerns when supervision policies and procedures are not followed at the clinical site.

S Pathway 4: Patient* perspectives on graduate medical education supervision

The clinical learning environment:

- a. Ensures that patients understand the roles and are able to identify the names of attending physicians, residents, and fellows caring for them at the clinical site.
- b. Ensures that patients have adequate contact with the resident and fellow team caring for them at the clinical site.
- c. Communicates to patients the mechanism for them to directly contact the attending physician in charge of their care about concerns with supervision.
- d. Includes patients' perceptions in monitoring adequate supervision of residents and fellows.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

S Pathway 5: Clinical site monitoring of resident and fellow supervision and workload

The clinical learning environment:

- a. Maintains information systems, accessible by the clinical care team, to verify the level of supervision required for residents and fellows to perform specific patient procedures.
- b. Monitors the use of systems to verify the level of supervision required for residents and fellows to perform specific patient procedures.
- c. Ensures that mechanisms are in place to systematically monitor and expeditiously address potential patient care vulnerabilities due to resident and fellow supervision.
- d. Monitors for patient care vulnerabilities due to the impact of faculty workload on resident and fellow supervision to formulate and implement strategies to mitigate the vulnerabilities.
- e. Monitors and assesses faculty member supervision of resident and fellow transfers of patient care, including change-of-duty and between services and locations at the clinical site.

Well-being (WB) – SELECTED TOPICS

The optimal clinical learning environment is engaged in systematic and institutional strategies and processes to cultivate and sustain the well-being of both its patients and its clinical care team.¹² The delivery of safe and high-quality patient care on a consistent and sustainable basis can be rendered only when the clinical learning environment ensures the well-being of clinical care providers. The following pathways and properties reflect selected topics in this area.

WB Pathway 1: Clinical learning environment promotes well-being across the clinical care team to ensure safe and high-quality patient care

- a. The clinical site creates a supportive clinical care community that is free of stigma, that is safe, and that embraces, promotes, and supports well-being.
- b. Leadership engages front-line health care providers in designing and developing priorities and strategies that support well-being.
- c. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of fatigue in the context of patient care specific to the clinical site.
- d. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of burnout in the context of patient care specific to the clinical site.
- e. Clinical learning environment and GME leadership demonstrate behaviors that promote well-being, thereby serving as role models for the clinical care team.

WB Pathway 2: Clinical learning environment demonstrates specific efforts to promote the well-being of residents, fellows, and faculty members

- a. Leadership engages residents, fellows, and faculty members in designing, developing, and continually stewarding priorities and strategies that support well-being.
- b. The clinical learning environment demonstrates continuous effort to support programs and activities that enhance the physical and emotional well-being of residents, fellows, and faculty members.

WB Pathway 3: Clinical learning environment promotes an environment where residents, fellows, and faculty members can maintain their personal well-being while fulfilling their professional obligations

The clinical learning environment:

- a. Establishes organizational expectations for resident, fellow, and faculty member workload—duration and intensity—consistent with safe and high-quality care for their patients and the educational needs of GME.
- b. Identifies and monitors patient care activities by residents, fellows, and faculty members that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.
- c. Demonstrates continued improvement efforts to eliminate work-related activities that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.
- d. Seeks and implements longitudinal approaches to enhance residents, fellows, and faculty members' ability to balance their personal needs with that of their work-related responsibilities.

WB Pathway 4: Clinical learning environment demonstrates system-based actions for preventing, eliminating, or mitigating impediments to the well-being of residents, fellows, and faculty members

The clinical learning environment:

- a. Promotes resilience training that is interprofessional and includes residents, fellows, and faculty members to ensure the safe and effective care of their patients.
- b. Ensures that systems are in place to actively recognize and mitigate fatigue among residents, fellows, and faculty members.
- c. Ensures that systems are in place to actively recognize and alleviate burnout among residents, fellows, and faculty members.
- d. Identifies GME-related systems and processes that may impede well-being in the clinical learning environment and works with the Sponsoring Institution to eliminate these impediments.
- e. Identifies clinical site-related systems and processes that may impede well-being in the clinical learning environment and works to eliminate these impediments.

WB Pathway 5: Clinical learning environment demonstrates mechanisms for identification, early intervention, and ongoing support of residents, fellows, and faculty members who are at risk of or demonstrating self-harm

The clinical learning environment:

- a. Builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of those who are at risk of or demonstrating self-harm.
- b. Ensures confidentiality and actively facilitates early detection of residents, fellows, and faculty members at risk of or demonstrating self-harm.
- c. Establishes systems or processes that provide residents, fellows, and faculty members at risk of or demonstrating self-harm confidential access to treatment and other related services that are commensurate with occupational and personal needs.
- d. Effectively addresses the emotional needs of its residents, fellows, and faculty members in relation to catastrophic work-related events (in the course of patient care or among the members of the clinical care team).

WB Pathway 6: Clinical learning environment monitors its effectiveness at achieving the well-being of the clinical care team

The clinical learning environment:

- a. Actively monitors and assesses the effectiveness of its efforts to promote the optimal integration of work with personal needs related to self, family, friends, and community.
- b. Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician fatigue.
- c. Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician burnout.
- d. Actively monitors and assesses the effectiveness of its efforts to assess and provide care for those who are at risk of or demonstrating self-harm.

Professionalism (PR) – SELECTED TOPICS

The optimal clinical learning environment recognizes that attitudes, beliefs, and skills related to professionalism directly impact the quality and safety of patient care. It has mechanisms in place for reporting concerns around professionalism, periodic assessment of concerns and identification of potential vulnerabilities, and the provision of feedback and education related to resulting actions.¹³ The following pathways and properties reflect selected topics in this area.

PR Pathway 1: Education on professionalism

The clinical learning environment:

- a. Educates the clinical care team, including residents, fellows, and faculty members, on the clinical site's expectations for professional conduct in an interprofessional environment.
- b. Educates the clinical care team, including residents, fellows, and faculty members, on clinical site, regional, and national issues of professionalism (e.g., appropriate use of copyrighted material, documentation practices).

PR Pathway 2: Culture of professionalism

The clinical learning environment:

- a. Promotes a culture of professionalism that supports honesty, integrity, and respectful treatment of others.
- b. Ensures that residents and fellows follow the clinical site's policies, procedures, and professional guidelines when documenting (e.g., work hours, moonlighting, Case Log reporting).
- c. Ensures that residents, fellows, and faculty members follow the clinical site's policies, procedures, and professional guidelines when documenting in the electronic medical record—with special attention to documentation of clinical information that is based on direct assessment or appropriately attributed information.
- d. Ensures a culture of professionalism in which residents and fellows immediately report any unsafe conditions in patient care, drawing the clinical care team's attention to unsafe events in progress (e.g., "stop the line").
- e. Provides mechanisms for members of the clinical care team, including residents, fellows, and faculty members, to report concerns about professionalism without retaliation.
- f. Ensures that residents, fellows, and faculty members engage in timely, direct, and respectful communication in the development of patient care plans among primary and consulting teams.

PR Pathway 3: Conflicts of interest

The clinical learning environment:

- a. Educates residents and fellows on its conflict of interest policies and potential issues related to patient care, including the clinical site's conflicts of interest.
- b. Educates residents and fellows on how the clinical site supports residents and fellows in managing conflicts of interests that they encounter.
- c. Ensures that residents, fellows, and faculty members disclose potential conflicts of interest throughout resident and fellow education and patient care.
- d. Maintains databases on resident, fellow, and faculty member potential conflicts of interest (e.g., research funding, commercial interests) that are accessible to the clinical care team.
- e. Assesses patient safety events for issues related to resident, fellow, and faculty member conflicts of interest.

PR Pathway 4: Patient* perceptions of professional care

The clinical learning environment:

- a. Educates residents, fellows, and faculty members on how patient experience data on professionalism are used to improve patient care.
- b. Routinely provides residents, fellows, and faculty members with patient experience data on professionalism at the clinical site.

PR Pathway 5: Clinical site monitoring of professionalism

The clinical learning environment:

- a. Routinely assesses the culture of professionalism and uses that information to continuously improve the clinical site.
- b. Monitors documentation practices related to resident, fellow, and faculty member use of the electronic medical record and other sources of patient health information.
- c. Monitors for the appropriate use of copyrighted material available to the public as part of education efforts around in-service and board examinations.
- d. Monitors for accurate reporting of resident and fellow work hours.
- e. Effectively addresses reported behaviors of unprofessionalism and ensures that the clinical site is absent of chronic, persistent unprofessional behavior.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

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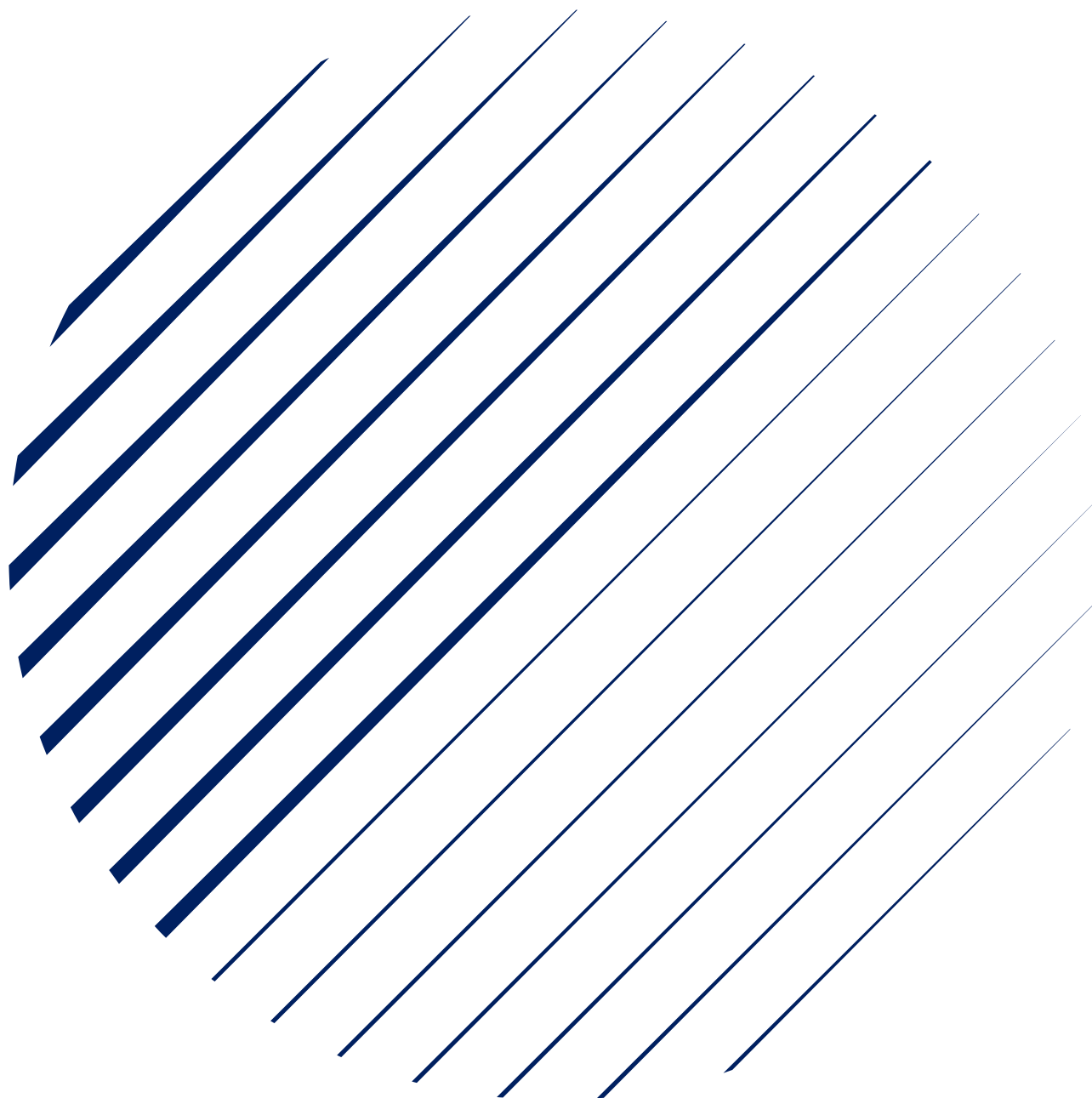
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NAS, Milestones, Competencies





Milestones Guidebook for Residents and Fellows

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INTRODUCTION

Welcome to the second edition of the *Milestones Guidebook for Residents and Fellows*!

This guidebook was written by the resident and fellow members of the ACGME's Milestones Development Working Groups to provide the learner perspective on what the Milestones represent and how they might be used to facilitate progress during residency/fellowship education and training. Understanding the purpose and intent behind the Milestones will help residents and fellows have a background in how and why things are structured the way they are in graduate medical education. Residents and fellows can also learn how the Milestones can be used to improve their abilities in medicine through constructive feedback and coaching. The key points to be discussed include:

- Competency-based medical education
- What the Milestones are and why are they important to you
- Assessment of residents/fellows by the program and subsequent reporting to the ACGME
- Giving and receiving feedback

SUMMARY RECOMMENDATIONS FOR RESIDENTS AND FELLOWS

1. Be sure to review your specialty Milestones on an ongoing basis, especially at the start of each academic year, to help in your own professional development.
2. Perform a self-assessment twice a year around the same time your program's Clinical Competency Committee (CCC) meets.
3. Review and compare your self-assessment with the CCC's Milestone ratings with your program director, faculty advisor, or mentor.
4. Write an individualized learning plan at least twice a year, and discuss it with your program director, faculty advisor, or mentor.
5. Be an active participant in your regular assessment and feedback.

COMPETENCY-BASED MEDICAL EDUCATION (CBME)

Key Points

- CBME uses key ability areas (i.e., the Competencies) to design curriculum and assessment of programs.
- Rather than being based on a specific amount of time required to reach certification, CBME focuses on reaching a standard level of competence for medical practice.
- Content, progression, and assessment are based on the abilities an individual learner demonstrates.
- CBME creates a shared model for residents, fellows, faculty members, programs, accrediting bodies, and the public at large.
- CBME allows for better feedback, coaching, and reflection for residents and fellows to create their own action plans for improvement.

What is CBME?

CBME has been used to educate residents and fellows, including the implementation of the Core Competencies and the Milestones.

The literature defines CBME as, “an outcomes-based approach to the design, implementation, assessment and evaluation of medical education programs, using an organizing framework of competencies” (Frank et al. 2010). A competency describes a key set of abilities required for someone to do their job. For example, all future doctors must have a basic level of knowledge and ability to provide patient care. Without these critical skills, one could not perform their job.

CBME aims for all graduating learners to achieve basic abilities in key areas to care for patients in practice. Residents, fellows, and other physicians should be able to show they have obtained these abilities. Notably, this is a different model from one where education and training are purely based on how many years you have completed (e.g., three years for internal medicine).

A comparison of Traditional versus Competency-Based Medical Education

Variable	Traditional Educational Model	CBME
Driving force for curriculum	Knowledge acquisition	Knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchical	Non-hierarchical
Responsibility of content	Teacher	Teacher and student
Goal of educational encounter	Knowledge and skill acquisition	Knowledge and skill application
Type of assessment tool	Single assessment measure (e.g., test)	Multiple assessment measures (e.g., direct observation)
Assessment tool	Proxy	Authentic (mimics real profession)
Setting for evaluation	Removed	In clinical and professional settings
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

Adapted from Carraccio, 2002

Why CBME?

CBME is about ensuring doctors have attained an adequate level of skill or knowledge (i.e., abilities) in key areas important to the practice of medicine for a given specialty. This is critical to the safe care of patients as we ensure their future doctors can practice without the help of supervising attending physicians. CBME also aims to ensure that education and training have standard practices across institutions and programs throughout the United States.

Using CBME as a framework centers the educational mission on the learner and what abilities that learner has obtained. Educational content, tools for feedback and assessment, and evaluation of programs in CBME are learner-centered and based on performance. Other evaluation systems often use Likert-type scales that rely too heavily on faculty members' frames of reference and are more subject to rater bias. CBME emphasizes using evidence-based criteria to judge ability and relies more on directly observed behaviors and performance (demonstrated competence).

CBME rests on creating a shared roadmap for growth and progression during medical education and training. Ideally, this roadmap and shared model can be used by all important members of the educational program: the learners (residents, fellows), the teachers (faculty members, program leadership), and accrediting bodies (the ACGME).

Creating public transparency about the Core Competencies and the roadmap of growth also promotes trust and clarity with patients and the public as they enter the care of residents and fellows.

How Has CBME Been Implemented in Medical Education? What Is it to Me?

The Core Competencies

The ACGME and the American Board of Medical Specialties developed the six Core Competencies necessary for a practicing physician:

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

Just like a standardized physical exam may use an anatomic approach, the Core Competencies provide a systematic framework to think about both curriculum and assessment in medical education. Each specialty was tasked with crafting specific milestones within each Competency. We will dive further into the Milestones in the next section.

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MILESTONES: WHAT YOU NEED TO KNOW

Key Points

Milestones 2.0

- Describe the development of specific skills, knowledge, and attitudes (i.e., abilities) organized within the six Core Competencies through the course of education in a specialty/subspecialty
- Represent a shared model for how a resident/fellow can get to the next stage towards mastery
- Created for patients, residents and fellows, faculty members, program leadership, and accrediting and specialty organizations
- Assessed through peer and health professions faculty members (including non-physicians) assessments and synthesized by the Clinical Competency Committee before submission to the ACGME
- Written by key stakeholders and revised after public comment

The Milestones Are a Roadmap for Growth and Development during Residency/Fellowship

The Milestones represent a roadmap for the development of residents and fellows as they advance in clinical skills, knowledge, and values. The Milestones are divided into the six Core Competencies of Patient Care, Medical Knowledge, Professionalism, Interpersonal and Communication Skills, Practice-based Learning and Improvement, and Systems-based Practice. Each Core Competency is divided into Subcompetencies laid out in five levels.

Each specialty has been tasked with crafting its own Milestones. Indeed, the patient care skills for an internal medicine resident will differ from those for an interventional radiology fellow. The specialty-specific Milestones guide the learning and assessment of learners in that specialty or subspecialty.

From Level 1 to Level 5, the Milestones describe a stepwise progression towards achieving mastery using the Dreyfus Model of Development as a foundation. Level 1 describes what would be expected of a novice in the specialty (a starting resident or fellow). Level 4 is a graduation target (i.e., proficiency in the Dreyfus schema), but not a requirement of the ACGME; each program or institution sets the requirements for graduation. Level 5 describes aspirational performance for a resident or fellow who is acting as a role model or coach for others.

Dreyfus Stage	Description (Clinical reasoning example)
Novice	Rule driven; analytic thinking; little ability to prioritize information
Advanced beginner	Able to sort through rules based on experience; analytic and non-analytic for some common problems
Competent	Embraces appropriate level of responsibility; dual processing of reasoning for most common problems; can see big picture; complex problems default to analytic reasoning; performance can be exhausting
Proficient	More fully developed non-analytic and dual process thinking; comfortable with evolving situations; able to extrapolate; situational discrimination; can live with ambiguity
Expert	Experience in subtle variations; distinguishes situations

Milestones Can Help with Assessing Yourself and Growing as a Physician

Residents and fellows should use the Milestones as they consider where they are in their educational program, to identify areas to grow, and to understand what each stage looks like. Often the Milestones describe a progression from common or basic abilities to more complex and nuanced ones.

Imagine setting off on a hike in a park where you have never been. A map and mile markers are essential to helping you get to the end of the trail. Similarly, for any profession, knowing where you are now in your abilities and what you need to focus on next helps you along a path to mastery. The Milestones can help residents and fellows intentionally focus on each step in becoming the best physicians they can be.

The Milestones can also provide a common language to use with faculty members and program leadership. Residents/fellows can specifically ask about how they are doing in a specific competency area (e.g., patient care) or subcompetency (e.g., clinical reasoning). Having a common language and model can help the resident/fellow and the clinical coach work together.

Like a swimmer getting coached on how to push off the wall, or a pianist on intonation, having a shared understanding and language for getting better improves the learning experience.

In addition to the Milestones for each specialty/subspecialty, Supplemental Guides, written by each specialty-specific Milestones Work Group, are designed to provide additional clarity and examples.

Milestones Were Created for Multiple Stakeholders

The Milestones were created for several critical stakeholders within health care and medical education. Ultimately, creating a shared model for growth and development for future physicians is critical to maintain transparency and engender trust with patients and the public.

Residents and fellows are the next key critical stakeholders as they are assessed on these milestones throughout their educational program.

Clarity, transparency, and standardization of common educational specialty-specific Milestones creates a more fair and equitable system for learners. *These assessments will also help program directors determine whether a resident or fellow is ready to be promoted or advanced to the next stage of their educational program.*

Milestones are also designed to assist programs in utilizing an evidence-based, learner-centered assessment model. The Milestones provide a framework approach to assessing residents and fellows. Finally, the Milestones are reported to the ACGME and assist in continued evaluation and institutional accreditation.

The Purpose and Function of the Milestones

Constituency or Stakeholder	Purpose/Function
Residents and Fellows	<ul style="list-style-type: none">• Provide a descriptive roadmap for training• Increased transparency of performance requirements• Encourage informed self-assessment and self-directed learning• Facilitate better feedback to the resident or fellow• Guide personal action plans for improvement
Residency and Fellowship Programs	<ul style="list-style-type: none">• Guide curriculum and assessment tool development• Provide more explicit expectations of residents and fellows• Provide a meaningful framework for the Clinical Competency Committee (e.g., help create shared mental model of evaluation)• Support better systems of assessment• Enhance opportunity for early identification of under-performers so as to support early intervention
ACGME	<ul style="list-style-type: none">• Accreditation – enable continuous monitoring of programs and lengthening of site visit cycles• Public Accountability – report at an aggregated national level on competency outcomes• Community of practice for evaluation and research, with a focus on continuous improvement

Adapted from Holmboe, 2015

Determination of Residents'/Fellows' Current Milestone Levels Is Performed by the Clinical Competency Committee

More will be described regarding assessment in the next section. Beyond a shared model for resident/fellow development, the Milestones are also reported by programs to the ACGME, which provides continued monitoring and accreditation. This allows fellowship programs to view the Milestones of an individual learner reported by the prior residency program.

Milestones 2.0 Were Written by Key Stakeholders and Revised after Public Comment

Representatives representing patients/the public, residents and fellows, faculty members, program directors, and specialty organizations were invited to participate in the writing of the Milestones. Each specialty group met in person multiple times to draft their Milestones. Editors at the ACGME then reviewed the working drafts to ensure consistency. The subsequent draft was then put forth to the community for public comment before ultimately being finalized for implementation by each specialty.

Harmonized Milestones

An additional update to the Milestones in version 2.0 is the creation of Harmonized Milestones for the Practice-based Learning and Improvement, Systems-based Practice, Interpersonal and Communication Skills, and Professionalism Competencies. Because many of these abilities are shared and universal across subspecialties, the ACGME convened an interdisciplinary work group to create consistency throughout GME.

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ASSESSMENT FOR RESIDENTS AND FELLOWS

Why Assessment Matters

Assessment is used both for giving feedback and for making decisions about level of competence or progression to the next level of education. There are two primary types of assessment: norm-referenced and criterion-referenced.

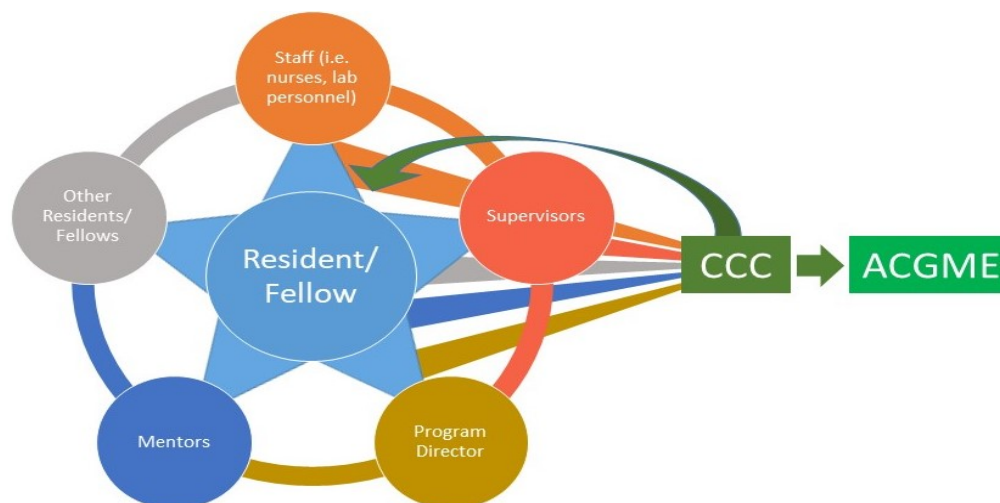
In a norm-referenced assessment, the standard compares the individual to other residents and fellows, i.e., “*Does this resident (fellow) look like other residents (fellows) at this stage of education?*” However, this has the potential to introduce bias and be variable over time.

Criterion-referenced assessment compares the individual to a specific standard or criteria, i.e., the Milestones.

Each program has a set of tools that faculty members and other health care professionals use to assess residents’ and fellows’ competence in the six Core Competencies, and each specialty has a unique set of subcompetencies under each. Ideally, every preceptor should be in a position to observe residents and fellows in the clinical setting and to rate their competence according to objective criteria for each subcompetency.

The Process of Milestone Assessment

Each program has a Clinical Competency Committee (CCC) that collates and reviews all assessments for every resident or fellow in the program to produce a judgment (i.e., rating) on each milestone. The CCC must meet twice a year to discuss the ratings for each resident or fellow. At a minimum, assessment from attending physicians who supervise residents’ and fellows’ work should include direct observation of clinical encounters with patients and probing of clinical reasoning skills. It is also recommended that the CCC obtain multi-source feedback assessments (e.g., 360-degree evaluations) from all others with whom a resident or fellow may have interacted during a rotation. This provides a more complete picture of areas (competency domains, skills) that may be more difficult to assess, such as communication and professionalism skills. The Milestone assessments are then shared with the program director who reviews and reports the data to ACGME.



The Importance of Self-Assessment

Self-assessment using the Milestones will enable residents/fellows to critically evaluate their abilities. Self-assessments can then be compared with the results from the CCC meetings for a more meaningful evaluation. If a particular milestone is not clear, the Supplemental Guide can provide further explanation and examples.

The Resident's/Fellow's Role in the Assessment Process

Residents/fellows should take an active role in their assessment. If a resident/fellow feels that attending faculty members are not taking the time to observe their performance in each of the subcompetencies, they should ask for specific feedback to help them improve their performance. This feedback will help the resident/fellow develop their abilities in a meaningful and productive manner.

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RESIDENT/FELLOW FEEDBACK

Regardless of job title and experience, we are all simultaneously educators and learners, both giving and receiving feedback on a daily basis. Thus, competence in giving and receiving feedback is crucial to the delivery and maintenance of excellent patient care (Jug, Jiang, and Bean 2019).

*Remember, feedback is an **ACTIVE** process, both for those GIVING the feedback and for those RECEIVING it.*

Features of High-Quality Feedback

Feature	Evaluator	Learner
Timeliness	Feedback should be given at a point when the recipient would be able to implement corrective behavior or learn from the <i>specific</i> feedback.	<i>Timeliness</i> is key in order to recognize and improve weaknesses. ASK for feedback early to implement corrective actions.
Specificity	Feedback is most useful when it is <i>specific</i> . General feedback is not helpful for directed learning or professional development.	PREPARE for a feedback session. REFLECT honestly on yourself, and ask SPECIFIC questions about your performance.
Balance	Feedback should have a <i>balance</i> of both “reinforcing” and “corrective” comments, without one dominating the other. Deliver feedback with empathy in mind.	If the deliverer of feedback is giving too much reinforcing or corrective feedback, probe them with questions about what you could improve or your successes.
Recipient feedback/reflection	It is important to allow time for the recipient to process and reflect on the feedback throughout the session.	Reflect on what was told in order to create an “action plan” together with those delivering the feedback.
Action plans	Create and develop a plan during the session by setting goals for the recipient, giving timelines, and following-up!	Set goals and timelines for yourself. Check in frequently with advisors to ensure you are on the right track to meet your goals.

1. Types of Feedback

Formal feedback. Formal feedback is the most easily recognized type of feedback. It can be structured and often uses a documented formal evaluation method, such as an end-of-rotation form. Formal feedback often occurs at specified intervals (e.g., mid-rotation, end-of-rotation). This type of feedback can be thorough.

Informal feedback. Informal feedback should occur a couple of times throughout a rotation and often involves observations of skills and/or interactions. Generally,

this type of feedback involves a short meeting when both parties are able to focus on the conversation at hand. This feedback can be given/asked for in the moment or after a particular patient encounter.

2. Barriers to Feedback

- a. **Evaluator.** Common barriers include time constraints, limited understanding of the recipient's expected competence level, discomfort that may be associated with giving negative feedback, and fear of retribution. This is important to keep in mind when giving feedback to more junior residents/fellows, peers, or faculty members/supervisors (upward feedback).

How to Work Around This

- Set aside time to actively give feedback, preferably in a quiet, private space.
- Balance corrective feedback with reinforcing feedback, being sure not to provide too much feedback and overwhelm the receiver.
- Practice giving feedback to colleagues or other trusted individuals.
- Ask a mentor how to effectively give upward feedback.

- b. **Recipient.** Common barriers include time constraints, unknown expectations, and unease asking for feedback from particular evaluators. Recipients may also feel that they are “bothering” the evaluator by asking for feedback.

How to Work Around This

- Be an active learner and take charge of your education.
- Ask for time for feedback.
- Self-reflect prior to the conversation and come prepared with specific questions.

3. How to Receive or Seek Out Feedback

- a. **Self-reflect.** Take time for critical self-reflection and identify personal weaknesses.
- b. **Develop “active” questions.**

How to Seek Feedback

Vague - AVOID!	More specific	Even better	Other examples
How am I doing?	What should I do differently to improve my technique in X? OR What can I do differently next time to improve my presentation?	How can I make this presentation more concise?	What suggestions do you have on how I can improve on X? I have a goal of X- what do you recommend to ensure I achieve goal X?

- c. **Ask early!** Be sure to ask for feedback early and often.
- d. **Express Gratitude.** The fact that someone took their time to give you thoughtful feedback means they care about your success and patient care.

4. How to Give Feedback

- a. **Do your research.** Ensure you understand the role of the person you are evaluating. You do not want to have specific expectations for someone who isn't yet expected to be able to do something; similarly, you do not want to miss any crucial expectations of the person you are evaluating. Take time to reflect on their performance. If you know that you are expected to evaluate someone, it may be helpful to make a physical or mental checklist of their performance over time, so that you can refer back when it is time to give feedback.
- b. **Give feedback early.** Just as you appreciate early feedback and identification of weaknesses so that you can improve, offer the same to others to allow them enough time to correct their behavior.
- c. **Set aside quiet, uninterrupted time.** No one likes to give or receive feedback in a public area. Ensure privacy and try to minimize interruptions.
- d. **Use techniques that you have admired in role models who have given you critical and useful feedback.** Perhaps you really appreciated one mentor who gave a "balance" of reinforcing and corrective honest feedback.
- e. **Provide guidance or tips when delivering negative feedback.** If you are delivering corrective feedback, ensure the person you are evaluating has time to reflect. It is often difficult for people to hear corrective feedback, and even more difficult for people to take the negative feedback and use it in a useful manner. Provide guidance, tips, or action items on how to improve or correct behavior.
- f. **Practice.** Ask a colleague to run through scenarios, including those in which the recipient disagrees or becomes defensive. If you practice remaining calm and focusing on the message, you will be confident in any feedback situation.

References

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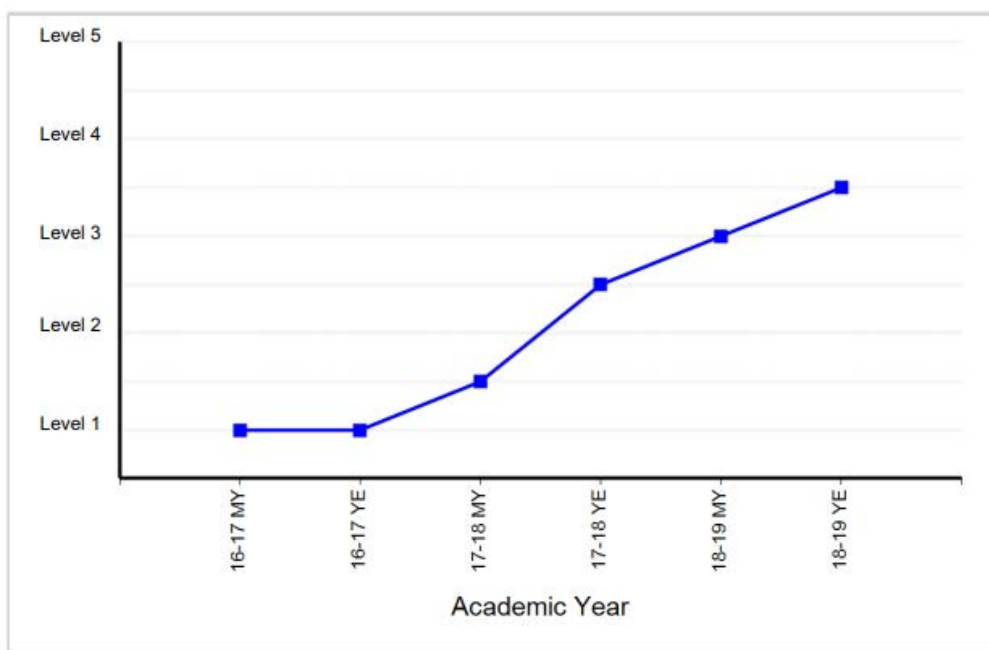
MILESTONES REPORTS AVAILABLE IN ADS

When program directors submit Milestones evaluations twice each year, they can also download several reports on resident/fellow Milestones data. These reports may be provided to residents/fellows as a stand-alone evaluation, or in conjunction with their semi-annual evaluation. The examples below are from a third-year anesthesiology resident.

Report 1: Individual Milestone Trends

This report includes a graph showing the individual's progression for each subcompetency. Notice how the resident begins at Level 1 and steadily progresses to Level 3.5. This is preferred over maintaining the same level status throughout residency, suggesting lack of self-improvement or growth.

1. Patient Care - Patient Care 1: Pre-anesthetic Patient Evaluation, Assessment, and Preparation



Report 2: Individual Milestone Summary

This report provides a snapshot of the individual's most recent evaluation for each subcompetency in Interpersonal and Communication Skills. While the resident effectively communicates with patients, the resident could improve these skills with other professionals.

Interpersonal and Communication Skills

	Level 1 Not Yet Achieved	Level 1	Level 2	Level 3	Level 4	Level 5
a). Interpersonal Communication Skills 1: Communication with patients and families				●		
b). Interpersonal Communication Skills 2: Communication with other professionals			●			
c). Interpersonal Communication Skills 3: Team and leadership skills					●	

Report 3: Individual Milestone Evaluation

This report provides the text of the level assigned for each subcompetency. When an individual's evaluation is between levels, the text for both levels are displayed with the higher level test identifying that the resident has achieved certain, but not all of the requirements. In Patient Care 7, below, the resident is between Levels 4 and 5.

7 Patient Care	Patient Care 7: Acute, chronic, and cancer-related pain consultation and management
<p>Dr. Name is between Level 3 and Level 4.</p> <p>Formulates differential diagnoses of acute and chronic pain syndromes; identifies appropriate diagnostic evaluation.</p> <p>Participates in complex procedures (e.g., thoracic ESI, medial branch blocks, radiofrequency procedures, sympathetic blocks) for alleviating acute, chronic, or cancer-related pain, under direct supervision.</p> <p>Prescribes initial therapy for pain medication, and adjusts ongoing medication regimens with indirect supervision; uses ultrasound and fluoroscopy with direct supervision.</p> <p>In addition, Dr. Name has achieved certain, but not all, elements of the competency level listed below:</p> <p>Acts as consultant for acute pain management to junior residents and other health care providers with conditional independence.</p> <p>Consults with non-anesthesiologist specialists regarding pain management as appropriate.</p> <p>Recognizes treatment failures and obtains appropriate consultations, including with a pain medicine specialist.</p>	

SCENARIOS AND SUGGESTIONS

1: What to do if you are being considered for remediation

- Meet with an advisor, an associate program director, or the program director to better understand the situation.
- Before the meeting, review your written evaluations and the Milestones for your specialty.
- The Milestones can provide a common language to talk about areas for improvement and what next steps you can take.
- Create a plan on what steps you can take to reach the next level of the Milestones.
- In future clinical care, take the opportunity to identify what you would like to work on with your attending physician or supervising resident, and ask for direct observation and coaching.
- Take time to reflect on how you are doing and where you are on the Milestones. It can be helpful to reflect with your attending physician and advisors.

2: Striving for mastery

- The Milestones detail what an exemplary resident or fellow looks like in Level 5 of each subcompetency.
- Consider the subcompetency for which you would like to demonstrate mastery.
- Work with advisors and faculty members to make an individual plan on how you might achieve higher levels toward mastery.

In both cases, the Milestones can provide a shared model for how to advance in your education and training, offering a tool to navigate conversations and self-reflect for improvement.

OTHER RESOURCES

The ACGME provides many resources for residents, fellows, faculty members, and program administration and leadership, and new resources are developed regularly. Visit the Milestones section of the ACGME website to review available resources and tools.

Currently available resources include:

- *Milestones Guidebook*
The *Milestones Guidebook* was written to aid with programs' understanding of the Milestones. Included is a look back at how and why the Milestones were created, tips for implementation, and ideas for giving better feedback.
- *Clinical Competency Committee Guidebook*
The *Clinical Competency Committee Guidebook* was designed for all stakeholders, and includes information and practical advice regarding the structure, implementation, function, and utility of a well-functioning CCC.
- *ACGME Milestones National Report*
This annual report is a snapshot of Milestones ratings and is available each fall for the preceding academic year. It is intended to highlight both central tendencies and meaningful variation within and across specialties.

Department of Medicine

NAS, Milestones, Competencies

When does a House Officer become an Internist? A brief primer on the Next Accreditation System (NAS)

Entrustable Professional Activities (EPAs)

Attributes expected of an Internist in independent practice

EPAs are a set of basic expectations that must be met by a graduating resident in order to practice independently (i.e. become an Internist); these have been developed by AAIM (Academic Alliance of Internal Medicine) and ABIM (American Board of Internal Medicine). Residency education, is, thus, designed to ensure these EPAs are met by graduation; while it is not necessary that an individual rotation incorporate experiences to support every EPA, the sum experience of all rotations during residency must.

Curricular Milestones (CMs)

Level-appropriate expectations that define what it means to be a competent Internist

To demonstrate a graduating resident has met the EPAs, criteria have been developed by AAIM and ABIM for each EPA that should be evaluated at regular intervals so trainees can follow their growth trajectory; these criteria are termed Curricular Milestones and are Competency-based. While milestones provide valuable information on a trainee's development, a set level for each milestone is not necessary for advancement or graduation; determination of eligibility for graduation and the Boards rests with the program director.

Competencies

Domains containing the curricular milestones which in sum define the autonomously-functioning Internist

The Curricular Milestones have been developed based on the ACGME-mandated six (6) core competencies: Patient Care (PC), Medical Knowledge (MK), Practice-Based Learning and Improvement (PBLI), Interpersonal and Communication Skills (ICS), Professionalism (P), Systems-Based Practice (SBP).

Putting it All Together

An Example

End-of-Training EPA	Step 1 Description and Tasks	Step 2 Related Curricular Milestones (Abbreviations on AAIM Website)	
1. Manage the care of patients with acute common diseases across multiple care settings	Internal medicine physicians entering into unsupervised practice are able to diagnose and manage common acute medical symptoms (e.g., joint pain, chest pain, and headache) and conditions (e.g., uncontrolled HTN, decompensated HF, and COPD exacerbation) in community, ambulatory, and hospital settings. The tasks required: <ul style="list-style-type: none"> Obtain accurate and complete information sufficient to develop differential diagnosis and inform care plan; Knowledge of diseases common to internal medicine; Communicate plans of care to patients, families and care givers Adapt care plans to changing clinical information 	Patient Care (PC)	A2, A3, B1, B2, C2, C3, D1, E1, F8
		Medical Knowledge (MK)	A2, A3, B1, B3
		Practice-Based Learning & Improvement (PBLI)	B1, B2, B3, D4, E1, E2
		Interpersonal & Communication Skills (ICS)	A3, A4, A5, A7, B1, B3, D3, F1
		Professionalism (P)	B1, B3, D2, E1, F1, F2, F3 G2, H1, I1, I2, K3
		Systems-Based Practice (SBP)	A3, B2, D2, D4, E1, E3

Letters: designate the milestone within the competency

Numbers: designate the interval by which the milestone should be met

An Example of a Curricular Milestone (from Milestones 2.0)

Systems-based Practice 1: Patient Safety and Quality Improvement				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Role models or mentors others in the disclosure of patient safety events
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., community vaccination rate, infection rate, smoking cessation)	Participates in local quality improvement initiatives	Demonstrates skills required to identify, develop, implement, and analyze a quality improvement project	Designs, implements, and assesses quality improvement initiatives at the institutional or community level
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

How to Think About Each Milestone Level When Evaluating a Trainee

Competency: Subcompetency				
Level 1	Level 2	Level 3	Level 4	Level 5
Novice Resident/Fellow	Advanced Beginner Resident/Fellow	Competent Resident/Fellow	Proficient Resident/Fellow	Resident/Fellow Expert
Brand new to the specialty	Performs some tasks with limited autonomy	Performs common tasks with autonomy	Target for graduation (not a requirement)	Exceeds their peers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Entrustable Professional Activities (EPAs)

1. Manage care of patients with acute common diseases across multiple care settings.
2. Manage care of patients with acute complex diseases across multiple care settings.
3. Manage care of patients with chronic diseases across multiple care settings.
4. Provide age-appropriate screening and preventative care.
5. Resuscitate, stabilize, and care for unstable or critically ill patients.
6. Provide perioperative assessment and care.
7. Provide general internal medicine consultation to nonmedical specialties.
8. Manage transitions of care.
9. Facilitate family meetings.
10. Lead and work within interprofessional health care teams.
11. Facilitate the learning of patients, families, and members of the interdisciplinary team.
12. Enhance patient safety.
13. Improve the quality of health care at both the individual and systems level.
14. Advocate for individual patients.
15. Demonstrate personal habits of lifelong learning.
16. Demonstrate professional behavior.

The Curricular Milestones (CMs)

Based on Competency 1: Patient Care (PC)

Taking a History

PC-A1: 6 months

Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion

PC-A2: 9 months

Seek and obtain appropriate, verified, and prioritized data from secondary sources (e.g. family, records, pharmacy)

PC-A3: 18 months

Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient

PC-A4: 30 months

Role model gathering subtle and reliable information from the patient for junior members of the healthcare team

Performing a Physical Exam

PC-B1: 6 months

Perform an accurate physical examination that is appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities using common maneuvers.

PC-B2: 12 months

Accurately track important changes in the physical examination over time in the outpatient and inpatient settings

PC-B3: 24 months

Demonstrate and teach how to elicit important physical findings for junior members of the healthcare team

PC-B4: 30 months

Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable

Clinical Reasoning

PC-C1: 12 months

Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem

PC-C2: 12 months

Develop prioritized differential diagnoses, evidence-based diagnostic and therapeutic plan for common inpatient and ambulatory conditions

PC-C3: 24 months

Modify differential diagnosis and care plan base on clinical course and data as appropriate

PC-C4: 36 months

Recognize disease presentations that deviate from common patterns and that require complex decision making

Invasive Procedures

PC-D1: 18 months

Appropriately perform invasive procedures and provide post-procedure management for common procedures

Diagnostic Tests

PC-E1: 12 months

Make appropriate clinical decisions based on the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic

studies, coagulations tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids

PC-E2: 18 months

Make appropriate clinical decisions based upon the results of more advanced diagnostic tests

Patient Management

PC-F1: 6 months

Recognize situations with a need for a need for urgent or emergent medical care, including life-threatening conditions

PC-F2: 6 months

Recognize when to seek additional guidance

PC-F3:

Provide appropriate preventive care and teach patient regarding self-care

PC-F4: 6 months

With minimal supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine

PC-F5: 12 months

With supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine

PC-F6: 12 months

Initiate management and stabilize patients with emergent medical conditions

PC-F7: 36 months

Manage patients with conditions that require intensive care

PC-F8: 36 months

Independently manage patient with a broad spectrum of clinical disorders seen in the practice of general internal medicine

PC-F9: 36 months

Manage complex or rare medical conditions

PC-F10: 36 months

Customize care in the context of the patient's preferences and overall health

Consultative Care

PC-G1: 24 months

Provide specific, responsive consultation to other services

PC-G2: 36 months

Provide internal medicine consultation for patients with more complex clinical problems require detailed risk assessment

The Curricular Milestones (CMs)

Based on Competency 2: Medical Knowledge (MK)

Core Content

- MK-A1: 6 months
Understand the relevant pathophysiology and basic science for common medical conditions
- MK-A2: 12 months
Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization
- MK-A3: 18 months
Demonstrate sufficient knowledge to evaluate common ambulatory conditions
- MK-A4: 18 months
Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions
- MK-A5: 18 months
Demonstrate sufficient knowledge to provide preventive care
- MK-A6: 24 months
Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care
- MK-A7: 36 months
Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions
- MK-A8: 36 months
Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions
- MK-A9: 36 months
Demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics and medical education

Diagnostic Tests

- MK-B1: 12 months
Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation studies, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids
- MK-B2: 18 months
Understand indications for and has basic skills in interpreting more advanced diagnostic tests
- MK-B3: 18 months
Understand prior probability and test performance characteristics

The Curricular Milestones (CMs)

Based on Competency 3: Practice-Based Learning & Improvement

(PBLI)

Patient Panel Quality Improvement

PBLI-A1: 12 months

Appreciate the responsibility to assess and improve care collectively for a panel of patients

PBLI-A2: 24 months

Perform or review audit of a panel of patients using standardized, disease-specific, and evidence-based criteria

PBLI-A3: 24 months

Reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor-related, system-related, and patient-related factors

PBLI-A4: 36 months

Identify areas in resident's own practice and local system that can be changed to improve the processes and outcomes of care

PBLI-A5: 36 months

Engage in a quality improvement intervention

Asking Appropriate Clinical Questions

PBLI-B1: 12 months

Identify learning needs (clinical questions) as they emerge in patient care activities

PBLI-B2: 24 months

Classify and precisely articulate clinical questions

PBLI-B3: 24 months

Develop a system to track, pursue, and reflect on clinical questions

Finding Appropriate Evidence to answer Clinical Questions

PBLI-C1: 12 months

Access medical information resources to answer clinical questions and support decision making

PBLI-C2: 12 months

Effectively and efficiently search NLM databases for original clinical research articles

PBLI-C3: 24 months

Effectively and efficiently search evidence-based summary medical information resources

PBLI-C4: 36 months

Appraise the quality of medical information resources and select among them based on the characteristics of the clinical question

Critically Appraising Evidence

PBLI-D1: 12 months

With assistance, appraise study design, conduct, and statistical analysis in clinical research papers

PBLI-D2: 24 months

With assistance, appraise clinical guideline recommendations for bias

PBLI-D3: 36 months

Independently appraise study design, conduct and statistical analysis in clinical research papers

PBLI-D4: 36 months

Independently appraise clinical guideline recommendations for bias and cost-benefit considerations

Applying Evidence to Patient Care

PBLI-E1: 12 months

Determine if clinical evidence can be generalized to an individual patient

PBLI-E2: 24 months

Customize clinical evidence for an individual patient

PBLI-E3: 36 months

Communicate risks and benefits to alternative to patients

PBLI-E4: 36 months

Integrate clinical evidence, clinical context, and patient preferences into decision-making

Improvement with Evaluation and Feedback

PBLI-F1: 12 months

Respond welcomingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients and their advocates

PBLI-F2: 18 months

Actively seek feedback from all members of the health care team

PBLI-F3: 24 months

Calibrate self-assessment with feedback and other external data

PBLI-F4: 24 months

Reflect on feedback in developing plans for improvement

Improvement with Self-Reflection

PBLI-G1: 24 months

Maintain awareness of the situation in the moment, and respond to meet situational needs

PBLI-G2: 36 months

Reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflects (on action) back on the process

Education of Self and Other Healthcare Personnel

PBLI-H1: 12 months

Actively participate in teaching conferences

PBLI-H2: 24 months

Integrate teaching, feedback and evaluation with supervision of interns' and students' patient care

PBLI-H3: 36 months

Take a leadership role in the education of all members of the health care team

The Curricular Milestones (CMs)

Based on Competency 4: Interpersonal & Communication Skills (ICS)

Effective Communication

- ICS-A1: 12 months
Provide timely and comprehensive verbal and written communication to patients/advocates
- ICS-A2: 12 months
Effectively use verbal and nonverbal skills to create rapport with patients/families
- ICS-A3: 12 months
Use communication skills to build a therapeutic relationship
- ICS-A4: 24 months
Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios
- ICS-A5: 24 months
Utilize patient centered educational strategies
- ICS-A6: 36 months
Engage patient/advocates in shared decision-making for difficult, ambiguous or controversial scenarios
- ICS-A7: 36 months
Appropriately counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation
- ICS-A8: 36 months
Role model effective communication skills in challenging situations

Cultural Sensitivity

- ICS-B1: 6 months
Effectively use an interpreter to engage patient in the clinical setting, including patient education
- ICS-B2: 12 months
Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs
- ICS-B3: 30 months
Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team

Transitions of Care

- ICS-C1: 12 months
Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care
- ICS-C2: 24 months
Role model and teach effective communication with next caregivers during transitions of care

Team Communication

- ICS-D1: 6 months
Deliver appropriate, succinct, hypothesis-driven oral presentations
- ICS-D2: 12 months
Effectively communicate plan of care to all members of the health care team
- ICS-D3: 30 months
Engage in collaborative communication with all members of the health care team

Consultation

ICS-E1: 6 months

Request consultative services in an effective manner

ICS-E2: 12 months

Clearly communicate the role of consultant to the patient, in support of the primary care relationship

ICS-E3: 36 months

Communicate consultative recommendations to the referring team in an effective manner

Record Keeping

ICS-F1: 6 months

Provide legible, accurate, complete, and timely written communication that is congruent with medical standards

ICS-F2: 24 months

Ensure succinct, relevant and patient-specific written communication

The Curricular Milestones (CMs)

Based on Competency 5: Professionalism (P)

Being Ethical

- P-A1: 1 month
Document and report clinical information truthfully
- P-A2: 1 month
Follow formal policies
- P-A3: 6 months
Accept personal errors and honestly acknowledge them
- P-A4: 36 months
Uphold ethical expectations of research and scholarly activity

Compassion and Respect

- P-B1: 3 months
Demonstrate empathy and compassion to all patients
- P-B2: 3 months
Demonstrate a commitment to relieve pain and suffering
- P-B3: 24 months
Provide support (physical, psychological, social and spiritual) for dying patients and their families
- P-B4: 24 months
Provide leadership for a team that respects patient dignity and autonomy

Timely Evaluation and Feedback

- P-C1: 12 months
Communicate constructive feedback to other members of the health care team
- P-C2: 18 months
Recognize, respond to and report impairment in colleagues or substandard care via peer review process

Being Accessible

- P-D1: 1 month
Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages
- P-D2: 6 months
Carry out timely interactions with colleagues, patients, and their designated caregivers

Conflicts of Interest

- P-E1: 6 months
Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients
- P-E2: 30 months
Maintain ethical relationships with industry
- P-E3: 30 months
Recognize and manage subtler conflicts of interest

Personal Accountability

- P-F1: 1 month
Dress and behave appropriately
- P-F2: 1 month
Maintain appropriate professional relationships with patients, families and staff
- P-F3: 6 months
Ensure prompt completion of clinical, administrative and curricular tasks
- P-F4: 12 months
Recognize and address personal, psychological, and physical limitations that may affect professional performance

P-F5: 12 months
Recognize the scope of his/her abilities and ask for supervision and assistance appropriately

P-F6: 30 months
Serve as a professional role model for more junior colleagues (e.g. medical students, interns)

P-F7: 30 months
Recognize the need to assist colleagues in the provision of duties

Patient Advocacy

P-G1: 6 months
Recognize when it is necessary to advocate for individual patient needs

P-G2: 30 months
Effectively advocate for individual patient needs

Compliance with Public Health Care Policies

P-H1: 24 months
Recognize and take responsibility for situations where public health supersedes individual health (e.g. reportable infectious diseases)

Respect of All People Regardless of Gender, Race, Religion, Ethnicity

P-I1: 1 month
Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status

P-I2: 30 months
Recognize and manage conflict when patient values differ from their own

Confidentiality

P-J1: 1 month
Maintain patient confidentiality

P-J2: 18 months
Educate and hold others accountable for patient confidentiality

Disparities in Health Care

P-K1: 12 months
Recognize that disparities exist in health care among populations and that they may impact care of the patient

P-K2: 36 months
Embrace physicians' role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering

P-K3: 36 months
Advocates for appropriate allocation of limited health care resources

The Curricular Milestones (CMs)

Based on Competency 6: Systems-Based Practice (SBP)

Effectively Working in Various Health-Care Systems

SBP-A1: 12 months

Understand unique roles and services provided by local health care delivery systems

SBP-A2: 24 months

Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation and skilled nursing

SBP-A3: 36 months

Negotiate patient-centered care among multiple care providers

Effectively Working with Members of Health-Care Personnel

SBP-B1: 6 months

Appreciate roles of a variety of health care providers, including but not limited to consultants, therapists, nurses, home care workers, pharmacists, and social workers

SBP-B2: 6 months

Work effectively as a member within the interprofessional team to ensure safe patient care

SBP-B3: 12 months

Consider alternative solutions provided by other teammates

SBP-B4: 36 months

Demonstrate how to manage the team by utilizing the skills and coordinating the activities of interprofessional team members

System Errors and Improvement

SBP-C1: 12 months

Recognize health system forces that increase the risk for error including barriers to optimal care

SBP-C2: 12 months

Identify, reflect on, and learn from critical incidents such as near misses and preventable medical errors

SBP-C3: 24 months

Dialogue with care team members to identify risk for and prevention of medical error

SBP-C4: 24 months

Understand the mechanisms for analysis and correction of systems errors

SBP-C5: 36 months

Demonstrate ability to understand and engage in a system level quality improvement initiative

SBP-C6: 36 months

Partner with other healthcare team professionals to identify, propose improvement opportunities within the system

Health-Care Costs

SBP-D1: 12 months

Reflect awareness of common socio-economic barriers that impact patient care

SBP-D2: 12 months

Understand how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines)

SBP-D3: 24 months

Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers and consumers and their varied impact on the cost of and access to health care

SBP-D4: 24 months

Understand coding and reimbursement principles

Cost-Effectiveness

SBP-E1: 6 months

Identify costs for common diagnostic or therapeutic tests

SBP-E2: 6 months

Minimize unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters

SBP-E3: 18 months

Demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision-making

SBP-E4: 36 months

Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios

Department of Medicine

NAS, Milestones, Competencies

The Teaching and Evaluating of the Competencies

General Competencies	How We Teach It	How We Evaluate It
Patient Care	Faculty Modeling Inpatient Supervision Outpatient Supervision Hopkins Online Course SHM Online Course Simulation Training Self-Directed Learning RRT/Code SWAT Senior Capstones	Multi-Source Evaluations Patient Evaluations Mini-CEX Quarterly Review with PD/APD Learning To TALK Evaluations Reporting Milestones
Medical Knowledge	Bedside Teaching Daily Didactic Conferences Daily MKSAP Review Annual Internal Boards Review SHM Online Course Hopkins Online Course Simulation Training Self-Directed Learning RRT/Code SWAT Senior Capstones Quality/M&M Conference	Multi-Source Evaluations Mini-CEX Annual In-Training exams Quarterly Review with PD/APD Learning To TALK Evaluations Senior Capstone Evaluations Quality/M&M Evaluations Reporting Milestones
Interpersonal and Communication Skills	Faculty Modeling Inpatient Supervision Outpatient Supervision Simulation Training Self-Directed Learning Assigned Didactic Presentations RRT/Code SWAT Senior Capstones Quality/M&M Conference	Multi-Source Evaluations Patient Evaluations Quarterly Review with PD/APD Learning To TALK Evaluations Senior Capstone Evaluations Quality/M&M Evaluations Reporting Milestones
Professionalism	Faculty Modeling Inpatient Supervision Outpatient Supervision Simulation Training Annual Bioethics Training Self-Directed Learning Malpractice Online Course	Multi-Source Evaluations Patient Evaluations Quarterly Review with PD/APD Learning To TALK Evaluations Senior Capstone Evaluations Quality/M&M Evaluations Reporting Milestones
Practice Based Improvement	Faculty Modeling Evidence-Based Conferences Best-Case Practice Self-Directed Learning Simulation Training SHM Online Course Malpractice Online Course Quality/M&M Conference	Multi-Source Evaluations Quarterly Review with PD/APD Clinic Quality Measures Reporting Milestones
Systems Based Practice	Monthly Business Meetings Didactic Conferences Self-Directed Learning Simulation Training Malpractice Online Course Elective X RRT/Code SWAT Quality/M&M Conference	Multi-Source Evaluations Quarterly Review with PD/APD Learning To TALK Evaluations Reporting Milestones

Department of Medicine

NAS, Milestones, Competencies

PGY-1 Core Competency and Curricular Milestone Expectations

The following document is an important description of the competency and milestone expectations for residents at different levels of training based on the six core competencies: **1) patient care, 2) medical knowledge, 3) interpersonal communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.** These learning objectives are collected for the convenience of our residents and faculty and are intended to allow for rapid review of expectations at different levels of training. Please note that the stated objectives should never limit our achievement expectations. Residents at all levels of training should strive to continuously improve their competency in the diverse skills that define excellence for internists. All clinical activities are supervised by faculty with direct supervision being required for all non-credentialed housestaff procedures and indirect supervision being required for all other housestaff clinical responsibilities.

- **ACGME Rules Regarding Supervision**

- *Level 1/Direct Supervision*, defined by immediate, in-person supervision, is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Level 2A/Indirect Supervision*, defined as immediate on-site availability, is required of faculty between 7AM-4PM daily for housestaff clinical responsibilities and is required of senior housestaff 24 hours a day for PGY-1s.
- *Level 2B/Indirect Supervision*, defined as immediate availability from off-site faculty, is required of faculty between 4PM-7AM daily for housestaff clinical responsibilities.

Patient Care

Inherent in good patient care is a resident's ability to demonstrate integrity, respect, compassion and empathy for patients and their families. Residents at all levels of training will demonstrate sensitivity and responsiveness to patient's age, culture, gender and disabilities.

PGY-1 Skill Set: PGY-1 residents will:

1. Gather essential and accurate information.
2. Organize and record medical information accurately.
3. Synthesize and interpret data from other providers and diagnostic testing.
4. Develop skills of focused history taking based on the established diagnosis or differential diagnosis.
5. Perform complete physical exams with consistent sequence.

6. Describe and interpret abnormal findings.
7. Identify problems and prioritize the differential diagnosis.
8. Begin to formulate clinical plans of action that are guideline or evidence-based.
9. With experience, develop the appropriate use of diagnostics and therapeutic choices.
10. Begin to prioritize the care of unstable patients.
11. Address acute and chronic problems, as well as addressing issues of prevention and health promotion.
12. Demonstrate an understanding of the indications, contraindications and techniques for procedures.
13. Participate in informed consent with patients.
14. Be supervised for all procedures until clinical competency is achieved.
15. Clearly document all procedures.
16. Attend Learning To TALK and Education Through Theater Arts sessions.

Medical Knowledge

At this level of professional development most learning is self-directed. It is advised that residents read daily and teach daily the things that they are learning. A spirit of intellectual curiosity and scientific inquiry is desirable. Residents must demonstrate knowledge about established and evolving biomedical sciences, clinical care topics and the social sciences.

PGY-1 Medical Knowledge: PGY-1 residents will:

1. Demonstrate knowledge of common medical conditions and procedures.
2. Demonstrate satisfactory management of common conditions with minimal supervision by completion of PGY-1 year.
3. Take the In-Service Training exam.
4. Complete the online Hopkins Ambulatory/Outpatient Curriculum by then end of the PGY-2 year.
5. Complete the annual online Academic/ELM Malpractice Course.
6. Complete the IHI course by the end of the PGY-1 year
7. Attend all required conferences (as outlined in the Policy Manual)
8. Demonstrate level-appropriate competence in interpreting diagnostic EKG's, pulmonary function testing, common radiologic studies, lab medicine, including hematologic, infectious, chemical and microscopic diagnostic studies.
9. Pass the USMLE Step 3 by June 1st of the PGY-2 as criteria for promotion to PGY-3 year.
10. Present a 20-minute lecture at AM Conference/Intern Report on an assigned clinical topic.
11. Attend Learning To TALK sessions.

Interpersonal and Communication Skills

Patients often judge their physicians by their interpersonal skills. As physicians we also judge each other by how clearly we communicate. Residents at all levels of training should be able to do the following:

1. Articulately present full histories and physicals.
2. Summarize relevant aspects of history, physical, diagnostic testing and assessment and plan.
3. Should welcome, mentor and teach learners of all levels.
4. Display empathy and competence while interviewing and examining patients.

5. Attend Learning to TALK and Education Through Theater Arts sessions.

PGY-1 Interpersonal and Communication Skills: PGY-1 residents will:

1. Provide complete and accurate documentation of patient care that is legible and timely.
2. Demonstrate appropriate verbal and nonverbal skills in patient and colleague interaction.
3. Respect appropriate boundaries of patients and colleagues that follow the tenets of ethics in patient care and professionalism.
4. Show ability to work in teams with junior and senior colleagues, attendings, students, nurses and social workers.
5. Supervise, teach and give constructive feedback to students.
6. Participate in videotaped patient and teaching encounters to improve communication skills.

Practice-Based Learning and Improvement

Residents are expected to be intellectually curious. They should use patient care experiences, reading and evidence-based medicine as a foundation for practice improvement and lifelong learning. Residents should understand the limits of their knowledge and experience and ask for help when needed. Self-improvement comes from regular assessments of all competencies and receiving balanced and honest feedback.

PGY-1 Practice-Based Learning and Improvement: PGY-1 residents will:

1. Show motivation to learn.
2. Use medical literature to support decision-making.
3. Begin skills of:
 - a. Asking relevant and accurate clinical questions.
 - b. Understanding the difference between background and foreground information.
 - c. Efficiently using technology to access the medical literature.
4. Participate in best-case practice project each year. The goal is to assess the quality of patient care and to effect continuous quality improvement in the outpatient clinics.
5. Perform periodic chart audits to review quality of documentation in patient care and outcomes.
6. Participate in videotaped encounters as communicator and educator (for the purpose of continuous quality improvement).
7. Participate in Learning to TALK standardized patient cases.
8. Participate in simulation training for procedures.

Professionalism

This competency is difficult to define by level of training. There are many qualities and characteristics that are fundamental to the practice of medicine. All physicians must be competent. This includes being timely in regard to patient care needs. In work related activities, patient care must always come first. Intrinsic to the competency of Professionalism is honesty. Residents at all levels should be trustworthy and should tell the truth. This includes 1) in reporting and presenting patient communications 2) documentation 3) admitting areas of deficiency and 4) billing. The practice of medicine has historically been synonymous with a spirit of compassion and respect for others. A resident's attitude should manifest an

interest in helping their patients, demonstrating respect and compassion for all patients and understanding the need for patient confidentiality. Physicians also have a responsibility for the safety and well being of their patients, colleagues and staff. Residents should not be unduly influenced by any outside forces including the pharmaceutical industry, insurers or patients' families. Under no circumstances should the quality of care, nor the specific care offered, be unduly influenced by these outside forces.

PGY-1 Professionalism:

PGY-1 residents will be expected to adhere to the principles that are outlined above. In addition, residents will participate in the Annual Bioethics Conference and attend Learning To TALK and Education Through Theater Arts sessions.

Systems-Based Practice Objectives

Modern medicine is practiced in a complex series of interwoven systems including insurers, hospitals, health care providers, private and public practitioners and the legal system. The residents must demonstrate an awareness of the larger context and system on health care delivery and the ability to effectively call on system resources to provide care that is of optimum value.

PGY-1 Systems-Based Practice: The PGY-1 resident will:

1. Demonstrate the ability to work well within their core clinical team.
2. Participate in multidisciplinary rounds utilizing the different services (nursing, social work, respiratory therapy, physical therapy, case managers, etc.) to improve efficiency and patient outcomes.
3. Show understanding of cost-effective patient care and resource utilization.
4. Participate in evaluation of the systems we work in to improve patient outcomes, efficiency and physician satisfaction; this would include reporting events into UHC's SI Event portal.
5. When assigned, but not on vacation, participate in Elective X.
6. When assigned, but not on vacation, participate in RRT/Code SWAT.
7. Use best-case practice project, housestaff liaison committee, and housestaff meetings to change inefficiencies in the system and below standard care.
8. Participate in the monthly Housestaff Meetings with the Program Director.

Department of Medicine

NAS, Milestones, Competencies

PGY-2 Core Competency and Curricular Milestone Expectations

The following document is an important description of the competency and milestone expectations for residents at different levels of training based on the six core competencies: **1) patient care, 2) medical knowledge, 3) interpersonal communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.** These learning objectives are collected for the convenience of our residents and faculty and are intended to allow for rapid review of expectations at different levels of training. Please note that the stated objectives should never limit our achievement expectations. Residents at all levels of training should strive to continuously improve their competency in the diverse skills that define excellence for internists. All clinical activities are supervised by faculty with direct supervision being required for all non-credentialed housestaff procedures and indirect supervision being required for all other housestaff clinical responsibilities.

- **ACGME Rules Regarding Supervision**

- *Level 1/Direct Supervision*, defined by immediate, in-person supervision, is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Level 2A/Indirect Supervision*, defined as immediate on-site availability, is required of faculty between 7AM-4PM daily for housestaff clinical responsibilities and is required of senior housestaff 24 hours a day for PGY-1s.
- *Level 2B/Indirect Supervision*, defined as immediate availability from off-site faculty, is required of faculty between 4PM-7AM daily for housestaff clinical responsibilities.

Patient Care

Inherent in good patient care is a resident's ability to demonstrate integrity, respect, compassion and empathy for patients and their families. Residents at all levels of training will demonstrate sensitivity and responsiveness to patient's age, culture, gender and disabilities.

PGY-2 Patient Care: In addition to the PGY-1 objectives, PGY-2 residents will:

1. Improve on the interpretation of history and improve their efficiency.
2. Correctly detect subtle findings on physical exam.
3. Teach physical exam skills to peers and students.

4. Incorporate patient preference, cost, and risk and benefit when considering specific treatment and diagnosis.
5. Change the course of care for unexpected side effects or undesired outcomes of a treatment plan.
6. Supervise junior residents in procedures when competency has been achieved.
7. Improve procedural skills through repetition.
8. Minimize risk and discomfort of patients.

Medical Knowledge

At this level of professional development most learning is self-directed. It is advised that residents read daily and teach daily the things that they are learning. A spirit of intellectual curiosity and scientific inquiry is desirable. Residents must demonstrate knowledge about established and evolving biomedical sciences, clinical care topics and the social sciences.

PGY-2 Medical Knowledge: In addition to the PGY-1 objectives, PGY-2 residents will:

1. Demonstrate improved knowledge and analytical thinking in complex patients.
2. Demonstrate understanding of psychosocial issues, statistical analysis and their application to patient care.
3. Show evidence of continued reading and improvement in medical knowledge.
4. Present a 20-minute Quality Review/M&M at AM Conference.

Interpersonal and Communication Skills

Patients often judge their physicians by their interpersonal skills. As physicians we also judge each other by how clearly we communicate. Residents at all levels of training should be able to do the following:

1. Articulately present full histories and physicals.
2. Summarize relevant aspects of history, physical, diagnostic testing and assessment and plan.
3. Should welcome, mentor and teach learners of all levels.
4. Display empathy and competence while interviewing and examining patients.
5. Attend Learning to TALK and Education Through Theater Arts sessions.

PGY-2 Interpersonal and Communication Skills: In addition to the PGY-1 objectives, PGY-2 residents will:

1. Engage patients in difficult discussions (examples include end-of-life-care) and successfully negotiate with “difficult” patients.
2. Evaluate and give constructive feedback to junior team members about their presenting skills.
3. Successfully manage, take charge and coordinate care when they are the senior resident on an inpatient team. This includes setting expectations, encouraging academic discussions and insuring that patients are well informed about their medical conditions and clinical plan of action.
4. Communicate clearly with team members, consultants, primary care physicians, patients and families.
5. Provide a formal presentation to the Department on a Quality/M&M topic.

Practice-Based Learning and Improvement

Residents are expected to be intellectually curious. They should use patient care experiences, reading and evidence-based medicine as a foundation for practice improvement and lifelong learning. Residents should understand the limits of their knowledge and experience and ask for help when needed. Self-improvement comes from regular assessments of all competencies and receiving balanced and honest feedback.

PGY-2 Practice-Based Learning and Improvement: In addition to the PGY-1 objectives, PGY-2 residents will:

1. Demonstrate an understanding and use of an evidenced-based medicine approach in providing patient care.
2. Teach colleagues and students how to research relevant literature.
3. Participate in "PICO" (or similarly-structured) projects while on ward rotations.
4. Display self-initiative to stay current with new medical knowledge.
5. Use consult time to practice integrating evidenced-based medicine with expert opinion and professional judgment.

Professionalism

This competency is difficult to define by level of training. There are many qualities and characteristics that are fundamental to the practice of medicine. All physicians must be competent. This includes being timely in regard to patient care needs. In work related activities, patient care must always come first. Intrinsic to the competency of Professionalism is honesty. Residents at all levels should be trustworthy and should tell the truth. This includes 1) in reporting and presenting patient communications 2) documentation 3) admitting areas of deficiency and 4) billing. The practice of medicine has historically been synonymous with a spirit of compassion and respect for others. A resident's attitude should manifest an interest in helping their patients, demonstrating respect and compassion for all patients and understanding the need for patient confidentiality. Physicians also have a responsibility for the safety and well being of their patients, colleagues and staff. Residents should not be unduly influenced by any outside forces including the pharmaceutical industry, insurers or patients' families. Under no circumstances should the quality of care, nor the specific care offered, be unduly influenced by these outside forces.

PGY-2 Professionalism: In addition to the PGY-1 objectives, PGY-2 residents will:

1. Continue to improve their knowledge with self-directed learning.
2. Improve in their ability to deliver bad news.
3. Understand the patient care issues involving advanced directives, DNR status, futility, withholding or withdrawing care.
4. Show appropriate sensitivity to issues of culture, age, sex, sexual orientation and disability.
5. Show concern for the educational development of colleagues and students.
6. Provide leadership on teams and throughout the residency.
7. Volunteers for activities that are good for the community and the institution overall.

Systems-Based Practice Objectives

Modern medicine is practiced in a complex series of interwoven systems including insurers, hospitals, health care providers, private and public practitioners and the legal system. The

residents must demonstrate an awareness of the larger context and system on health care delivery and the ability to effectively call on system resources to provide care that is of optimum value.

PGY-2/3 Systems-Based Practice: In addition to the PGY-1 objectives, the PGY-2/3 will:

1. Coordinate multidisciplinary care and provide leadership in the management of complex patients.
2. Demonstrate an understanding of the multi-layered medical delivery systems (including hospitals, ambulatory sites, rehab medicine, and in-home care resources).
3. Show the ability to work with extended care providers, especially with longitudinal chronic care in the outpatient setting.
4. Demonstrate an understanding of managed care, federal versus private insurers and the social consequences of the uninsured.
5. Present cases with our Department Quality Officer in our M&M/Quality Review conferences; specifically, the resident will conduct a root-cause analysis of the issue and review his/her findings at the conference.

Department of Medicine

NAS, Milestones, Competencies

PGY-3 Core Competency and Curricular Milestone Expectations

The following document is an important description of the competency and milestone expectations for residents at different levels of training based on the six core competencies: **1) patient care, 2) medical knowledge, 3) interpersonal communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.** These learning objectives are collected for the convenience of our residents and faculty and are intended to allow for rapid review of expectations at different levels of training. Please note that the stated objectives should never limit our achievement expectations. Residents at all levels of training should strive to continuously improve their competency in the diverse skills that define excellence for internists. All clinical activities are supervised by faculty with direct supervision being required for all non-credentialed housestaff procedures and indirect supervision being required for all other housestaff clinical responsibilities.

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Patient Care

Inherent in good patient care is a resident's ability to demonstrate integrity, respect, compassion and empathy for patients and their families. Residents at all levels of training will demonstrate sensitivity and responsiveness to patient's age, culture, gender and disabilities.

PGY-3 Patient Care: In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

1. Appropriately conduct focused exams.
2. Demonstrate sound reasoning in ambiguous situations.

3. Assist junior residents/students in improving skill of effective decision-making.
4. Serve as lead provider on the RRT/Code SWAT service.

Medical Knowledge

At this level of professional development most learning is self-directed. It is advised that residents read daily and teach daily the things that they are learning. A spirit of intellectual curiosity and scientific inquiry is desirable. Residents must demonstrate knowledge about established and evolving biomedical sciences, clinical care topics and the social sciences.

PGY-3 Medical Knowledge: In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

1. Exhibit knowledge and competency of effective teaching methods.
2. Present a 20-minute lecture on a topic of his/her choosing at Senior Capstones.
3. Participate in the RRT/Code SWAT service and demonstrate understanding of the ACLS algorithms.

Interpersonal and Communication Skills

Patients often judge their physicians by their interpersonal skills. As physicians we also judge each other by how clearly we communicate. Residents at all levels of training should be able to do the following:

1. Articulately present full histories and physicals.
2. Summarize relevant aspects of history, physical, diagnostic testing and assessment and plan.
3. Should welcome, mentor and teach learners of all levels.
4. Display empathy and competence while interviewing and examining patients.
5. Attend Learning to TALK and Education Through Theater Arts sessions.

PGY-3 Interpersonal and Communication Skills: In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

1. Be able to negotiate most difficult patient situations with minimal direction.
2. Function as team leaders with decreasing reliance upon attending physicians.
3. Develop skills for effective public speaking and teaching.
4. Demonstrate the ability to articulate/advocate for issues of ethical concern, quality improvement, and patient safety.
5. Serve as lead provider on the RRT/Code SWAT service managing high-intensity situations amongst many stake-holders.

Practice-Based Learning and Improvement Objectives

Residents are expected to be intellectually curious. They should use patient care experiences, reading and evidence-based medicine as a foundation for practice improvement and lifelong learning. Residents should understand the limits of their knowledge and experience and ask for help when needed. Self-improvement comes from regular assessments of all competencies and receiving balanced and honest feedback.

PGY-3 Practice-Based Learning and Improvement: In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

1. Apply knowledge of study design and statistics to relevant literature.
2. Present a thoroughly researched didactic presentation that demonstrates an in-depth knowledge of a clinical topic of their choosing.
3. Show mastery of the use of technology and its applications to patient care, acquisition of medical knowledge and educational presentations.
4. Review performance measures on the RRT/Code SWAT service.

Professionalism

This competency is difficult to define by level of training. There are many qualities and characteristics that are fundamental to the practice of medicine. All physicians must be competent. This includes being timely in regard to patient care needs. In work related activities, patient care must always come first. Intrinsic to the competency of Professionalism is honesty. Residents at all levels should be trustworthy and should tell the truth. This includes 1) in reporting and presenting patient communications 2) documentation 3) admitting areas of deficiency and 4) billing. The practice of medicine has historically been synonymous with a spirit of compassion and respect for others. A resident's attitude should manifest an interest in helping their patients, demonstrating respect and compassion for all patients and understanding the need for patient confidentiality. Physicians also have a responsibility for the safety and well being of their patients, colleagues and staff. Residents should not be unduly influenced by any outside forces including the pharmaceutical industry, insurers or patients' families. Under no circumstances should the quality of care, nor the specific care offered, be unduly influenced by these outside forces.

PGY-3 Professionalism: In addition to the above noted objectives, the PGY-3 resident will:

1. Show leadership in improving all of the above noted activities personally and in mentoring that with their colleagues.
2. The most experienced resident class sets the tone of the training experience for all residents. It is desirable that senior residents work hard at setting a high standard, enjoy their work, and bring that enthusiasm to their profession.
3. Serve as lead provider on the RRT/Code SWAT service managing high-intensity situations amongst many stake-holders.

Systems-Based Practice Objectives

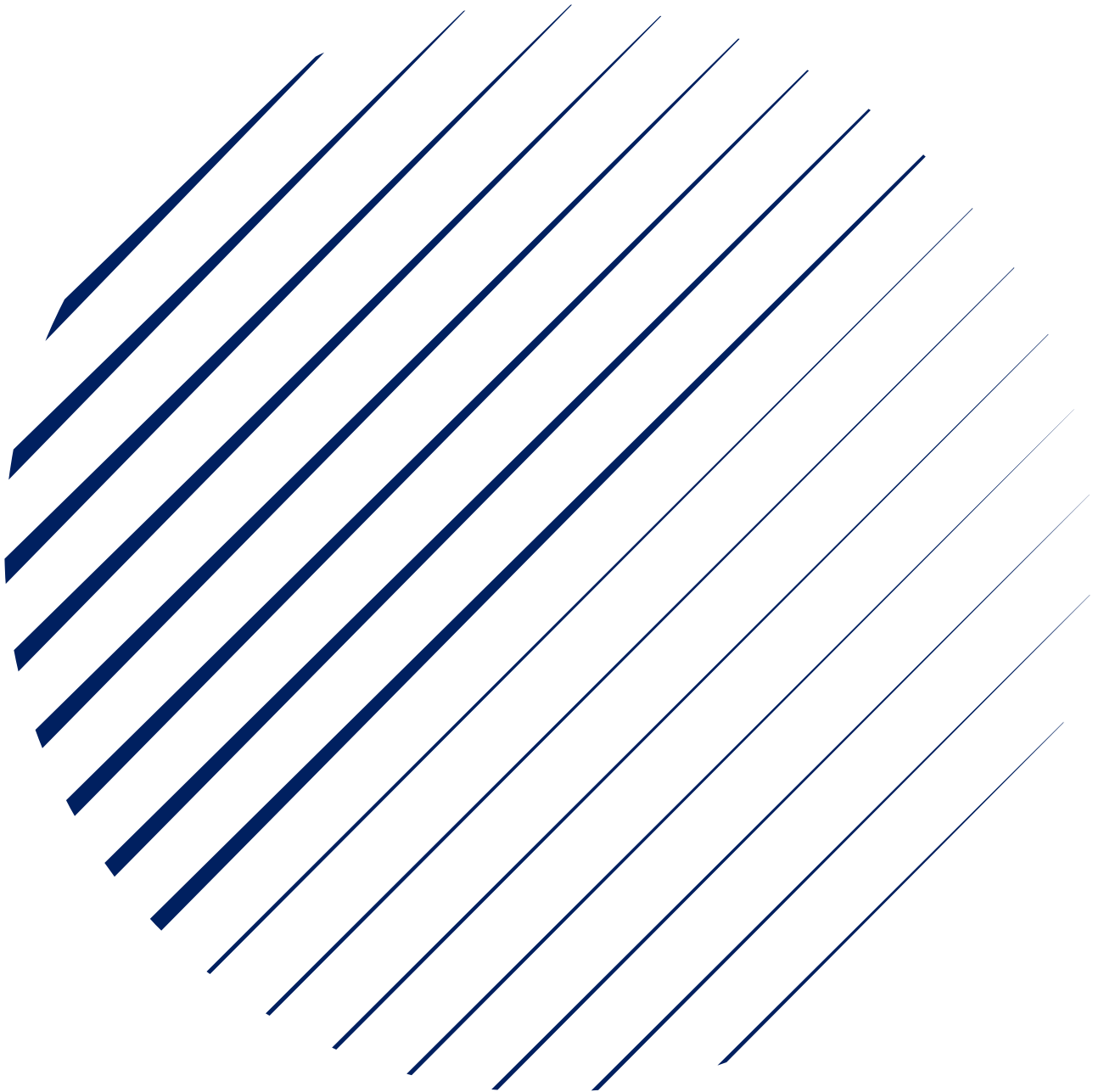
Modern medicine is practiced in a complex series of interwoven systems including insurers, hospitals, health care providers, private and public practitioners and the legal system. The residents must demonstrate an awareness of the larger context and system on health care delivery and the ability to effectively call on system resources to provide care that is of optimum value.

PGY-2/3 Systems-Based Practice Objectives - In addition to the PGY-1 objectives, the PGY-2/3 will:

1. Coordinate multidisciplinary care and provide leadership in the management of complex patients.
2. Demonstrate an understanding of the multi-layered medical delivery systems (including hospitals, ambulatory sites, rehab medicine, and in-home care resources).

3. Show the ability to work with extended care providers, especially with longitudinal chronic care in the outpatient setting.
4. Demonstrate an understanding of managed care, federal versus private insurers and the social consequences of the uninsured.
5. Present cases with our Department Quality Officer in our monthly M&M/Quality Review conferences; specifically, the resident will conduct a root-cause analysis of the issue and review his/her findings at the conference.
6. Work with Nursing Staff on the RRT/Code SWAT service.

The "CC Block Week"



Department of Medicine

The “CC” Block

Your continuity clinic (CC) block is a vastly different experience than your rotations in the hospital. During this important part of your Internal Medicine training, you will be the primary care provider for a panel of patients who you will follow throughout your entire residency. You will learn the basics of ambulatory medicine including how to manage acute illness and chronic disease in an outpatient setting. Being a primary care provider is a huge responsibility that requires hard work, compassion, and thought, but the care you give to patients and the relationships you form with them can be extremely rewarding.

All residents have their continuity clinic in the Adult Medicine Clinic located in the Upstate Health Care Center (UHCC). The CC block occurs every four weeks during your residency and will be divided into two experiences: a recurring continuity clinic experience (with 3-5 half-day sessions during the week) and various specialty-based clinics (with 3-5 half day sessions during the same week). Didactic sessions during your CC weeks include noon conference (lunch is provided for all clinic residents) and a dedicated intern curriculum. During your CC block time throughout the year, you will also participate in simulation training that includes procedural training and simulation cases, Quality Improvement Curriculum, Learning To TALK (Treat All Like Kin), and Education Through Theater Arts (ETTA).

Given the expanding role of a primary care physician and the complexity of patients that we see, the Adult Medicine Clinic is composed of a multidisciplinary group of professionals that are here to help the patient and you in your role as primary care doctor. This includes: advanced practitioners (nurse practitioner or physician assistant), pharmacists, care managers, social workers, nutritionists, RNs, LPNs, and a large administrative staff.

Professionalism during your CC block is expected at all times. This includes but is not limited to:

- Being on-time for ALL scheduled activities, ready to work and/or learn. This includes continuity clinic, subspecialty clinic, didactics, and administrative sessions.
 - Unexcused absences are unprofessional and forfeiture of CC weekend time-off; repeated unexcused absences will result in Academic Probation which may lead to termination or non-renewal.
- Professional attire – scrubs, sweatshirts, and sneakers are not allowed.
- Being respectful of everyone, including your colleagues, clinic staff, and patients – this includes no phone use during conferences or in patient care areas unless it is directly related to patient care
- Taking ownership of your patients and your clinical responsibilities – including completing all clinical tasks in a timely manner
- Taking ownership of your own education – complete any reading or other assignments on time and active participation in conferences.
 - You are expected to attend ALL noon conferences and to contact the Ambulatory Chief Resident if unable to join any of the noon conferences.

The remainder of this document highlights policies and expectations while on the CC Block.

Purpose of Continuity Clinic: The residents are to become the primary care physician of their patients, supported by the advice and guidance of attending physicians.

Tools Needed: stethoscope, reflex hammer

Access Requirements: EPIC, Hopkins/PEAC modules, RHIO, Synapse, Remote Access, and Doximity video chat, Haiku. Access to these programs will be set up before or during your CC block orientation. If trouble with access to any of these programs, contact Susan DeAngelo.

Progress Notes:

Each billed visit diagnosis should have an HPI and an A/P (except health maintenance tasks which are handled separately). Visit/billing diagnoses should not include diagnoses handled completely by specialists unless those diagnoses are those that 1) you are co-managing with specialists or 2) directly impact your management of conditions directly under your purview.

- It is the resident's responsibility to complete the medication reconciliation during each visit. This includes reconciling Outside Medications (the orange banner in EPIC).re
- Every visit should include an appropriate return visit plan and tasks.
- Notes must be **completed on the same day of the visit** unless it is discussed and approved by the supervising attending.

Data Review, Care Planning, and Communications

The resident is responsible for:

Prompt review of test results or consultations performed on your patient.

- Communicating **ALL** results to patient within **24-48 hours** (if unable to communicate with patient within this timeframe, it is essential that you reach out to your **preceptor**) and with appropriate documentation.
 - Significantly abnormal results should be relayed to the patient via phone or during a face-to-face encounter. A letter/My Chart message may also be sent but **ONLY** to request a callback for important results and **NOT** to convey any significantly abnormal results. Incomplete communications regarding significantly abnormal results must be communicated to your supervising attending.
 - Communicating normal results can be performed by the resident via phone, letter, or My Chart (if patient has previously agreed).
- Creating a subsequent plan of care, if needed, in coordination with the appropriate attending or pharmacist. The plan of care is documented and communicated to the patient and appropriate parties (which may include the PCP and mentor).
- Documenting any communication with the patient including the review of results and treatment plans. **Remember, if it isn't in writing, then you didn't do it...period.**
- Handoffs: The resident and/or preceptor seeing a patient on behalf of a PCP/mentor are responsible for addressing the new concern or data, setting up a plan to address it and communicating with the patient. For significant problems, a close follow-up with the PCP should be scheduled to follow-up on any pending results and/or issues. Any pending results and/or issues should be handed-off formally in writing (e.g. a result, document or telephone note, routed to the PCP and mentor) to the PCP and mentor to carry on responsibility going forward.

Faculty and/or Staff requests for action (e. g. clinical care, patient contact, testing, documentation, editing, orders, clarifications) must be addressed at the time of review. These requests may be in telephone encounters, staff messages, progress note addenda, or other in-basket messages and it is the responsibility of the resident to review these carefully and thoroughly.

EPIC In-Basket Responsibilities: When on your CC block, you are responsible for reviewing your in-basket daily, including at the end of the day before you leave for home, and ensuring that all notifications have been appropriately addressed with the necessary documentation. When not on CC Block, you are still required to check your in-basket three times per week (Monday, Wednesday, and Friday) and complete any patient or clinical responsibilities in a timely manner. **When off-site (i.e. vacation, interviews, conference attendance, etc.), you are responsible for finding a colleague to sign-out your in-basket to for coverage.** Proper in-basket management is integral to good patient care. If you feel for some reason you are not able to meet these requirements, you must discuss with your assigned clinic mentor and the Ambulatory Chief.

Admin Jeopardy: As part of the Practice-Based Learning competency, you will have time to review your panel via “Admin Jeopardy sessions” during your CC block. Please note that these “AJ” sessions are not guaranteed every block and may be cancelled depending on clinic and patient needs. Let the Ambulatory Chief Resident know if you are not going to be ready to work during one of these sessions, otherwise it will be considered an absence. There may be assigned readings and various tasks during these sessions throughout the year and you will receive more direction on your CC block:

- **20/20** - Interns during the first half of the year are expected to review **at least FIVE patient charts** per 20/20 session. You will receive more instruction on this when rotating on the CC Block. While the following should be done during any visit with a patient, part of these chart reviews will also include:
 - **Ensuring an Updated and Accurate Problem List:** Includes updating the Overview section of 1) each diagnosis with significant details regarding diagnosis, management, and listing the managing specialty and 2) Health Maintenance tracking. All conditions that are managed by Adult Medicine should be addressed at the time of the general follow up visit for multiple medical problems (not an urgent visit) or assigned as a return visit task.
 - **Medication Review:** All medications we prescribe should be accurately documented in the medical record with rationale for use. Renewals for medications we are prescribing should be completed during routine follow-up visits, if needed, to ensure that there will be enough refills to last until the time of the next Adult Medicine visit or 6 months, whichever comes first.
 - At least one 20/20 per session will be reviewed with interns by the Teaching Resident, Ambulatory Chief Resident, or an attending.
- **Quality/Population Health** – We will be reviewing diabetes and cancer screening quality data throughout the year, on a clinic-wide level and of your own individual patient panel. The main purpose of these reviews is not to “evaluate” you on your screening rates, but rather for you to focus on developing a plan on how to improve the care that we provide our patients. Population Health requires a team-based approach; therefore, you will be working in a multidisciplinary team with other clinic team members including pharmacy, nursing, and social work to help improve your quality metrics and dashboard.

- **Outpatient Guideline/Literature Review** - This session will focus on the topic of the block, discussing relevant guidelines/literature to appropriate outpatient workup, management & follow-up. This may include being assigned to update a preexisting section of the Intern Survival Guide, creating a new section for the Intern Survival Guide, or creating other resources for clinic.
- **Modules** – For residents that have been assigned more than AJ session and have completed all the assigned work for that block will have the opportunity to complete required modules that have been assigned by the program (IHI, PEAC...) or can do QBank questions from True Learn.

Evaluations: Written and formal face-to-face feedback will occur twice yearly with the assigned mentor attending.

Medical Students and Other Learners

Third year medical students are typically here Monday, Wednesdays, and Fridays. Occasionally a fourth-year medical student will rotate through for 2-4 weeks at a time. Additionally, nurse practitioner students may rotate through clinic. These learners will be paired with a second- or third-year resident for a clinic session. Residents who work with a learner are expected to complete a brief evaluation after the clinic session.

Time Off Requests and Wellness Sessions

Time off: All time off requests during clinic week need to be directed to the Ambulatory Chief Resident (or Core Chiefs if Ambulatory Chief is not available). Any approved time off will be relayed to the appropriate clinic staff (continuity clinic or specialty clinic) by the Chief via email. Clinic staff and specialty clinics are **NOT** able to excuse housestaff from clinical duties or change clinic schedules.

Wellness Sessions: The purpose of a wellness session is for you to perform activities that would otherwise be difficult to do as a busy resident. It can be difficult to define what a wellness session would entail, but please utilize this time to catch up on life (eg, schedule a dentist/physician appointment, renew your ID, etc.) Completing program requirements (such as ACLS) will NOT require you to use a wellness session unless you had the opportunity to complete the requirement during a non-required rotation but chose not to.

Wellness sessions can now be taken during ANY specialty clinics **except for women's health services**. Wellness sessions CANNOT be taken during **continuity clinic, admin jeopardy, teaching resident, didactics, or bootcamp**. Each resident is allowed up to 3 wellness sessions per academic year; residents are unable to take **more than 1** wellness session per clinic week. A wellness session can only be requested for one **HALF DAY** per clinic week during a subspecialty rotation (not during continuity clinic). Wellness session requests must be sent to the ambulatory chief at **least 1 month** in advance. If the Wellness session is approved, you are expected to communicate with the specialty clinic program coordinator and faculty member via email to notify them of the day you will not be attending. Unused wellness sessions **CANNOT** be carried over to the following year.

Again, wellness sessions are designed to allow you the opportunity to tend to personal matters that are otherwise difficult to fit into a busy residency schedule. We will certainly consider approval if these personal matters/appointments fall on a Friday afternoon, but Wellness sessions on Friday afternoons will not be approved for the sole purpose of extending a golden weekend by a half-day.

Wellness sessions cannot be utilized for interviews.

2022-2023 SUBSPECIALTY CLINIC ROTATION INFORMATION

- Clinic times are listed for each clinic. Start times may be different for different days on a given rotation so pay close attention to the schedule.
 - **BE ON TIME FOR EVERY CLINIC** – you are excused from conference early in order to get to where you need to go on time. Take travel time into account.
- Dress professionally and wear your white coat for all rotations.

INTERN ROTATIONS

Rotation	Faculty and Email Contact
<u>550 Harrison Primary Care</u> 550 Harrison Street, Suite I Monday, Thursday, & Friday at 8:00 AM Tuesday, Wednesday, & Friday at 1:00 PM	LappinS@upstate.edu - Sarah Lappin, MD WormaldM@upstate.edu – Maria Wormald
<u>Dermatology for Interns</u> Monday 8:00 AM and 1:00 PM – Derm clinic at UHCC, 2 nd Floor Thursday 8:00 AM – Derm clinic at UHCC, 2 nd Floor - Show up to clinic on time at 8:00 AM and 1:00 PM sharp AND sign in - Wear your white coat and have a tidy and neat appearance - Limit cell phone use to patient related matters only and keep your phone hidden in patient care areas - Complete Johns Hopkins on-line dermatology modules while on the derm rotation week on your own time and complete short quizzes - For those so inclined, assist in literature searches regarding interesting cases as they arise	FarahRS@upstate.edu – Ramsey Farah, MD FarahJ@upstate.edu – Joyce Ramsey, MD FaliseK@upstate.edu – Karen Falise
<u>Endocrinology:</u> All sessions at Joslin 3229 E Genesee St, Syracuse, NY 13214 Monday-1: Dr. Dhaliwal/fellows (scheduled w/patients 1 week/month) Tuesday-1: <i>Not @ Joslin d/t didactics</i> Wednesday-1: Education (pump, CGM, nutrition, general) Thursday-1: Dr. Desimone/fellows (e-mail Michelle Haight, not attending, for fellow assignment) Friday-1: Dr. Hopkins/Fellows (e-mail Michelle Haight, not attending, for fellow assignment)	WeinstoR@upstate.edu – Ruth Weinstock, MD HaightM@upstate.edu – Michelle Haight FEUERSTB@upstate.edu – Barb Feuerstein, MD kemmisk@upstate.edu Coordination for Rotation *If any faculty is on vacation/on service, please check with Dr Feuerstein/Dr Acharya. *Starting times are approximate. Please confirm with contact person.
<u>Global Health</u> Monday 1:00 PM Admin Jeopardy Tuesday 1:00 PM CYO on Salina Street (Contact Dr. Shaw for details) Wednesday 1:00 PM 2 nd Floor (contact Dr. Shaw for details)	shawan@upstate.edu Andrea Shaw Cell: 315-727-2825

Thursday 1:00 PM 2 nd Floor (contact Dr. Shaw for details) Friday 1:00 PM 2 nd Floor (contact Dr. Shaw for details)	
<u>Nephrology</u> Monday 1:00 PM – UHCC Nephrology Clinic Tuesday 1:00 PM – UHCC Nephrology Clinic Wednesday 1:15 PM – VA Nephrology Thursday 1:00 PM – DIDACTICS Friday 1:00 PM – UHCC Nephrology Clinic	mobeenh@upstate.edu - Mobeen Harris MD WestML@upstate.edu - Mary Lynn West betchers@upstate.edu – Sylvia Betcher, MD Joan.Mitchell@va.gov – Joan Mitchell, MD ElliottW@upstate.edu – Clay Elliott, MD DiFilipW@upstate.edu - William DiFilippo, MD
<u>Neurology</u> Monday 1:15 PM – VA Clinic, VA 2 West with Dr. Cornelia Mihai Tuesday 1:00 PM – UHCC 4 th Floor Wednesday 1:15 PM - VA Clinic, VA 2 West with Dr. Dragos Mihaila Thursday 1:00 PM – DIDACTICS- 5 th floor Education Room Friday – UHCC 4 th Floor	Cornelia.Mihai@va.gov – Cornelia Mihai, MD BradshaD@upstate.edu – Deb Bradshaw, MD MejicoL@upstate.edu – Luis Mejico, MD Dragos.Mihaila@va.gov – Dragos Mihaila, MD BeachR@upstate.edu – Robert Beach, MD GreineDP@upstate.edu - Deb Greiner BarbierA@upstate.edu -Allesandra Barbieri duleepa@upstate.edu - Dr. Anu Duleep
<u>Quality Rotation</u> Monday 8:00-11:45 AM Tuesday 8:00-11:45 AM-DIDACTICS-5 th floor Education room Wednesday 1-5 PM Thursday 8:00-11:45 AM Friday 8:00-11:45 AM	chebayap@upstate.edu - Philip Chebaya

PGY2 ROTATIONS

<u>AM VA Outpatient Clinic</u> Monday 9:00 am – VA Rheumatology with Dr. Riccardi (was Oncology with Dr. Poudel) Tuesday 9:00 am – ID with Dr. Harausz Wednesday 8:00 am – Cardiology Dr. Ararsu Thursday 8:00 am – Cardiology with Dr. Shridhar Friday 8:00 am - 20:20 (was Oncology with Dr. Poudel)	Joan.Mitchell@va.gov – Joni Mitchell, MD kristin.fusco@va.gov - Kristin Fusco Admin Assistant Fatme.Allam@va.gov – Fatme Allam, MD Pratibha.Kaul@va.gov – Pratibha Kaul, MD betchers@upstate.edu – Sylvia Betcher, MD Svetlana.formin@va.gov -- Dr. Svetlana Fomin Catherine.Vernon@va.gov –Catherine Vernon, MD anshu.shridhar2@va.gov - Anshu Shridhar
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<p><u>Cardiology</u></p> <p>Check-in Monday with Lisa Schirtz before your EKG session to finalize your schedule for the week.</p> <p>Monday 1:00 PM– Cardiology clinic with Dr. Weinberg @ 5112 West Taft Road Suite J, Liverpool NY 13088 Tuesday 1:00 PM – Cardiology Clinic, UHCC, 5th Floor Wednesday 1:00 PM– Cardiology Clinic, UHCC, 5th Floor Thursday 1:30 PM– Upstate Cardiovascular Group with Dr. Weinberg @ 510 Towne Dr. Fayetteville, NY, 13066 Friday 1:30PM – Upstate Cardiovascular Group with Dr. Weinberg @ 510 Towne Dr. Fayetteville, NY, 13066</p>	<p>chaudhud@upstate.edu - Debanik Chaudhuri, MD CarhartR@upstate.edu - Robert Carhart, MD weinbean@upstate.edu - Andy Weinberg (732-996-8399) SchirtzL@upstate.edu - Lisa Schirtz</p>
<p><u>Gastroenterology for R-2's</u></p> <p>Monday 1:15 PM – VA GI Clinic with Dr. Anand Gupta Tuesday 1:15 PM – University Gastroenterology, Hill Medical Building, 1000 Genesee Street or UH Endo Wednesday 1:15 PM– University Gastroenterology, Hill Medical Building, 1000 Genesee Street or UH Endo Thursday 1:15 PM – VA GI Clinic with Dr. Bishnu Sapkota Friday 1:15 PM – University Gastroenterology, Hill Medical Building, 1000 Genesee Street or UH Endo *Please note: The outpatient resident will attend all didactic sessions required by the residency program. In addition, they will attend gastroenterology service conferences. As assigned by the service attending, they will prepare and present mini-lectures, review of the literature, and case-focused reviews. All residents are encouraged to access the core curriculum, which is available via the university web page. Parking at the Hill Medical Bldg: The GI practices at Hill only have a very limited number of physician/extender parking spaces on the 2nd floor ramp of the parking garage. Only attendings and full-time extenders (NP/PA) providers are to be parking in those spots. Residents parking on the 2nd floor ramp run the risk of being towed. Instead, please park in an open, unassigned area for your responsibilities at Hill.</p>	<p>johns@upstate.edu - Savio John, MD, AGAF, FAGG BladholN@upstate.edu – Nikkole Bladholm Michele.Sharp@va.gov – Michele Sharp Anand.Gupta@va.gov- Anand Gupta, MD Bishnu.Sapkota@va.gov –Bishnu Sapkota, MD Joan.Mitchell@va.gov – Joan Mitchell, MD Alyssa.Rioux@va.gov - Alyssa Rioux, admin asst</p>
<p><u>Infectious Disease</u></p> <p>Monday 8:15 AM – IDA Clinic, Crouse CPOB 2nd or 3rd floor Tuesday 8:15 AM– IDA Clinic, Crouse CPOB 2nd or 3rd floor Wednesday 8:15 AM – IDA Clinic, Crouse CPOB 2nd or 3rd floor Thursday 8:15 AM – DAC Clinic, Crouse CPOB 2nd or 3rd floor Friday 8:15 AM – IDA Clinic, Crouse CPOB 2nd or 3rd floor</p>	<p>Thomstep@upstate.edu –Stephen Thomas, MD ScotDani@upstate.edu – Danielle Scott Scottm1C@upstate.edu – Michelle Scott</p> <p>Contact Danielle Scott in suite 311 on your first day to find out where to report each day. Her number is 315-464-7287.</p>
<p><u>Neurology</u></p> <p>Monday 8:00 am – VA Clinic, VA 2 East Dr. Kapur Tuesday 9:00 am – VA Clinic, VA 2 East Dr. Mihai Wednesday 8:00 am - VA Clinic, VA 2 East Dr. Kapur Thursday 8:00 am – VA Clinic, VA 2 East Dr. Kapur Friday 8:00 am– VA Clinic, VA 2 East Dr. Kapur</p>	<p>Cornelia.Mihai@va.gov – Cornelia Mihai, MD Dragos.Mihaila@va.gov – Dragos Mihaila,MD Puneet.Kapur2@va.gov -Puneet Kapur, MD</p>

<p><u>Pulmonary</u></p> <p>Monday 1:00 PM – UHCC Pulmonary Clinic, Firm C Tuesday 1:15 PM – Upstate at Community Hospital, Pulmonary Clinic, Suite 4C, North (315-492-5804) Wednesday 10:45 AM – TOP Clinic C3071 and C3072 at Upstate Cancer Center Bldg. Page the BRONCH fellow at 11:00 A.M. for details Thursday 1:15 PM – Smoking cessation with RT @ cancer center multidisciplinary suite 3rd floor Friday 1:00 PM – Upstate at Community Hospital, pulmonary clinic, suite 4C, North</p>	<p>SaviciD@upstate.edu – Dana Savici, MD hadcocka@upstate.edu – Andrea Hadcock</p>
<p><u>PM VA Outpatient Mix</u></p> <p>Monday 1:15 PM - Rheumatology with Dr. Allam- Tuesday 1:00 PM – Pulmonary/Sleep Clinic with Drs. Kaul, Trikha and Philip Wednesday 1:15 PM – Nephrology clinic with Dr. Betcher Thursday 1:30 PM – GI clinic with Fellows and Drs. Murthy and Sapkota until at least 7/22 (was Endocrine with Dr. Svetlana Fomin) Friday 1:15 – GI clinic with Fellows and Drs. Murthy and Sapkota</p>	<p>Joan.Mitchell@va.gov – Joni Mitchell, MD Fatme.Allam@va.gov – Fatme Allam, MD Pratibha.Kaul@va.gov – Pratibha Kaul, MD Uma.Murthy@va.gov – Uma Murthy, MD betchers@upstate.edu – Sylvia Betcher, MD Catherine.Vernon@va.gov – Catherine Vernon, MD Svetlana.formin@va.gov - Dr. Svetlana Fomin kristin.fusco@va.gov - Kristin Fusco Admin Assistant</p>
<p><u>Rheumatology (AM)</u></p> <p>Monday 8 AM – UHCC Rheumatology Clinic Tuesday 8 AM- VA Rheumatology Wednesday 8 AM Hill Rheumatology Clinic 1000-E. Genesee St, Ste 403 Thursday 10 AM – Hill Rheumatology Clinic 1000 E. Genesee St, Ste 403 Friday 8 AM – Hill Rheumatology Clinic 1000 E. Genesee St, Ste 403</p>	<p>PerlA@upstate.edu – Andras Perl, MD TrpcevsR@upstate.edu -Rosa Trpcevski Fatme.Allam@va.gov – Fatme Allam, MD</p>
<p><u>Rheumatology (PM)</u></p> <p>Monday 1 PM – UHCC Rheumatology Clinic Tuesday 1:15 PM - VA Rheumatology Wednesday 1 PM UHCC Rheumatology Clinic Thursday 1 PM – UHCC Rheumatology Clinic Friday 1:15 PM – Hill Rheumatology Clinic 1000 E. Genesee St, Ste 403</p>	<p>PerlA@upstate.edu – Andras Perl, MD TrpcevsR@upstate.edu -Rosa Trpcevski Fatme.Allam@va.gov – Fatme Allam, MD</p>
<p><u>Women's Health Service</u></p> <p>UHCC, 1st Floor Wednesday pm –20/20 Monday, Tuesday, Thursday. & Friday 12:30 PM – Women's Health, UHCC</p>	<p>KaufmaLe@upstate.edu – Leah Kaufman, MD DrescheE@upstate.edu - Elizabeth Drescher</p>

PGY3 ROTATIONS

<p><u>Addiction Psych</u></p> <p>Monday 1:00 pm – Opioid Bridge Clinic at UHCC Tuesday 1:00 pm – 20/20 Wednesday 1:00 pm – 600 E Genesee St with Dr Aslam/Johnson Thursday 8 am – UH Addiction Med Friday – 20/20</p>	<p>aslama@upstate.edu – Sunny Aslam MD johnsonb@upstate.edu – Brian Johnson MD sullivanr@upstate.edu – Ross Sullivan MD</p>
<p><u>Endocrinology – AM schedule</u></p> <p>Joslin Diabetes Center JDC – 3229 East Genesee Street</p> <p>Monday 8:30AM- JDC Dr. Bansal Tuesday 8:30 AM – JDC Dr. Dhaliwal Wednesday 8:30 AM – JDC Dr. Acharya Thursday 8:30 AM – JDC Dr. Hopkins/fellows Friday 8:30 AM – JDC Dr. Desimone/fellows</p>	<p>WeinstoR@upstate.edu – Ruth Weinstock, MD HaightM@upstate.edu – Michelle Haight FEUERSTB@upstate.edu – Barb Feuerstein, MD kemmisk@upstate.edu Coordination for Rotation</p>
<p><u>Family Care Medical Group</u></p> <p>Upstate Community Campus POB North, Suite 4k 4900 Broad Road, Syracuse, NY 13215 Phone: 315 492-5784 Fax: 315 492-5183</p> <p>Monday 7AM – Dr. Brodey Tuesday 7AM – Dr. Brodey Wednesday 7AM – Dr. Brodey Thursday 8AM– Dr. Kuhn Friday 7AM – Dr. Brodey</p> <p>First portion of the morning will be seeing inpatient ID consults with Dr. Brody. You will then follow him to clinic and see patients with him there.</p>	<p>BrodeyM@upstate.edu – Mitchell Brodey, MD KuhnM@upstate.edu - Michael Kuhn, MD Gjewtraw@fcmg.org -Georgeanne Jewtraw</p>
<p><u>Gastroenterology (on hold)</u></p> <p>CNY Medical Center - 739 Irving Avenue, Suite 400</p> <p>Monday 1:15 PM – Crouse GI Tuesday 1:15 PM – Crouse GI Wednesday 1:15 PM– Crouse GI Thursday 1:15 PM – Crouse GI Friday 1:15 PM – Crouse GI</p>	<p>Sekou Rawlins, MD – 917-593-9910</p>
<p><u>Geriatrics</u> Sharon Brangman, MD</p> <p>Monday 1:15 PM - Geriatrics clinic at 550 Harrison Street, Suite A Tuesday 1:15 PM – Admin jeopardy (WAS Community General Geriatrics ER) Wednesday 1:15 PM – Geriatrics clinic at 550 Harrison Street, Suite A. (WAS Hospice with Dr. Setla at 990 7th North Street, Liverpool, starts at 8 am) Thursday 1:15 PM – Geriatrics clinic at 550 Harrison Street, Suite A Friday 1:15 PM – Geriatrics clinic, 550 Harrison Street, Suite A</p> <ul style="list-style-type: none"> Note the resident will not have a CC in Adult medicine on Wednesday morning when on this sub-specialty rotation 	<p>BrangmaS@upstate.edu – Sharon Brangman, MD LutzA@upstate.edu – Anne Lutz mdevlin@hospicecny.org – Michelle Devlin (Wednesday Hospice) TaylorKe@upstate.edu – Kelly Wheeler</p>
<p><u>Adult Hematology/Oncology</u></p>	<p>grazians@upstate.edu - Stephen Graziano, MD EvansT@upstate.edu – Tina Evans</p>

Upstate Cancer Center Phone: 315 464-8200 Mon – Fri – Upstate Cancer Center Monday - Friday - 8:15am – noon <i>Stop by the 4th floor, Rm 4100 on Monday (or your first day if Monday is a holiday) – Tina Evans will give you a schedule for the week</i>	KnickerL@upstate.edu - Lisa H. Knickerbocker
<u>Wound Care Clinic-</u> 1 st floor UH (West wing) Monday, Tuesday, Thursday & Friday 8:00 AM Wednesday 9:00 AM	HeyboerM@upstate.edu – Marvin Heyboer, MD SeargenS@upstate.edu Sarah Seargent

Educational Activities

<u>Learning to TALK</u> Clinical Skills Center – 502A Setnor Hall	KnohlS@upstate.edu – Steve Knohl, MD HarrisSD@upstate.edu – Steve Harris HindsB@upstate.edu – Barb Hinds Frankk@upstate.edu -Kay Frank
<u>Education Through Theater Arts (ETTA)</u> Syracuse Stage, Syracuse University	srcross@syr.edu – Stephen Cross Frankk@upstate.edu -Kay Frank
<u>Simulation Training</u> Upstate Simulation Center Health Science Library 766 Irving Ave Syracuse, NY 13210	chebayap@upstate.edu - Philip Chebaya upstatechiefresident@gmail.com - Core Chief Residents grahamer@upstate.edu - Erin Graham
<u>Quality Improvement Curriculum</u> UHCC – Education Room	SweetJo@upstate.edu - Josh Sweet chebayap@upstate.edu - Philip Chebaya

Adult Medicine Tele-triage

You will need: remote access to EPIC and/or Haiku (or equivalent); interpreter phone service phone numbers and access codes (Language Line 1-800-523-1786; code 202038), local ER phone numbers (UH downtown 315-464-5612; UH Community 315-492-5535; Crouse 315-470-7340; St. Joe's 315-448-5101); your attending's contact information; the answering service's phone number (315-464-5240), the phone number for the Medical Examiner's Office (for Onondaga County 315-463-3163).

Upstate Connect, whose contact number remains the same (464-5240) will be entering the call under "Patient Calls" for you so your documentation can be in that thread as a new note (remember do not use a "Routing Comment") and remember to route to the attending and PCP and nursing pool(p ad....).

Schedule:

Monday -Friday 7am- 8am and 5pm-7pm: Tele Triage CC

Monday to Friday 7pm-7am: SNF 1

Saturday, Sunday and Holidays 7am- 7pm: Medicine Consult Resident

Saturday, Sunday and Holidays 7pm-7am: SNF1

Workflow:

1. When contacted by answering service you must be prepared at all times to call back within minutes (because these may be emergencies). The call back number is 464-5240 for the UHCC Adult Medicine clinic.
2. Obtain necessary background data: a. Patient Name (with verified spelling), caller's name if the patient did not call), DOB, primary care doctor, patient's or caller's phone number in case the call gets dropped, chief complaint. b. Note time of call from answering service and time of your response to patient as these may be different than the time of documentation. A brief review of medications and diagnoses may help you understand better the context of the call and prompt more concern.
3. Ensure that the patient sees a PCP in Adult Medicine. If the PCP is a provider outside of Adult Medicine, do NOT assume care of this patient. Currently the only non-resident providers inside Adult Medicine are Dr. Cleary, Dr. Shaw and Ayan Mohamed (physician assistant). If the patient uses support services inside Adult Medicine such as pharmacy, but does not have PCP in Adult Medicine again do NOT assume care of this patient. Inform the call center of the mistake and direct them to the correct individual to contact if you are familiar. This will usually be the attending on call if the patient belongs to University Internists.
4. Emergencies (significant possibility of immediate death or disability): to ER via 911 ambulance. Patient or family may call 911 unless disabled; if you are calling 911 you will need patient's address and phone number. Contact an ER

doctor at the ER that the patient prefers and document the name of the doctor you spoke with. [A list of symptoms that often warrant immediate evaluation for serious disease is appended below.]

5. Urgencies: evaluation required or patient requests. Can go to UC or ER without ambulance.
6. Rx renewals of chronic medications the PCP prescribes: can be called in, (but you will need the phone number of the pharmacy). You can also prescribe medications in Epic or Haiku, which is preferable. You may elect to call in only enough to get through the next business day and direct the patient to call the office then for more refills. Note you are not authorized to prescribe controlled substances without first obtaining the advice of the back-up attending.
7. Routine matters: advise the patient to call their PCP office the next business day.
8. Document the call as soon as possible. (For this reason it is important to have remote access to EPIC while on call)

Documentation

1. Use the Telephone Encounter already created by operator.
2. Cite the time that you called back under the "Contact" section in the Call Intake tab using the **outgoing call button**
3. Enter the **reason for call**, under the reason for call section in the call intake tab.
4. **Document your call** by clicking the create note button.
 - Make sure to note time of call if different than the time of documentation or if documenting late.
 - In brief terms, state the patient concern and your response. If the patient declines your advice, explain to the patient the risks of not getting an evaluation and document that the patient "declined understanding the risks and benefits." Under no circumstances should you falsely re-assure the patient about the nature of their concern or pretend that you can diagnose over the phone. If the patient wants to know if they have could have a serious condition, they will usually need to be evaluated by a provider; after hours, that means an UC or ER. If you discuss the case with the attending, note briefly the nature and upshot of that discussion.
5. **Route the note to the nursing staff (p adlt), the attending, and the PCP.** Sign the encounter.
6. CONTACT THE ATTENDING IMMEDIATELY in the following circumstances: referrals to ER (but do not delay the instructions to the patient); uncertainty as to the seriousness of the patient concern; any significant uncertainty; requests for acute meds or controlled substances; death certificate calls (usually from the medical examiner's office). The attending must address controlled substances prescriptions, death certificates. You should not be receiving calls from University Internists (550 Harrison); if you do, then ask the answering service to call the attending directly. If in doubt about whether you should contact the attending physician, contact them. In the words of Dr. Harold Husovsky, "Don't worry about bothering the attending on call. We would rather hear from you than not"

Some serious symptoms that warrant emergency evaluation in an emergency room via 911 ambulance. This list of examples is not meant to be an exclusive list.

HEMATOLOGY, GI:

- PERSISTENT BLEEDING FROM ANY SOURCE (nose, rectum, urine...)
- UNUSUAL BRUISING
- VOMITING BLOOD
- SEVERE ABDOMINAL PAIN (INCLUDING HERNIA PAIN)

PULMONARY, CARDIOLOGY

- CHEST PRESSURE OR PAIN
- RAPID OR IRREGULAR HEARTBEAT
- SEVERE LEG EDEMA OR PAIN
- MARKED SHORTNESS OF BREATH
- LOSS OF CONSCIOUSNESS or NEAR FAINT

NEUROLOGY, PSYCHIATRY

- MARKED CHANGE IN LEVEL OF ACTIVITY OR ALERTNESS
- TEMPORARY CHANGE IN VISION OR NUMBNESS
- HEAD TRAUMA (and any motor vehicle accident symptom)
- STROKE, CHANGE IN SPEECH, WEAKNESS OF ONE SIDE OF THE BODY, CHANGE IN SENSATION, BALANCE;
- UNEXPLAINED FALLS
- UNUSUAL. SEVERE OR NEW HEADACHE
- MENINGITIS SYMPTOMS (fever, stiff and painful neck, headache)
- SUICIDALITY OR MARKED CHANGE IN BEHAVIOR

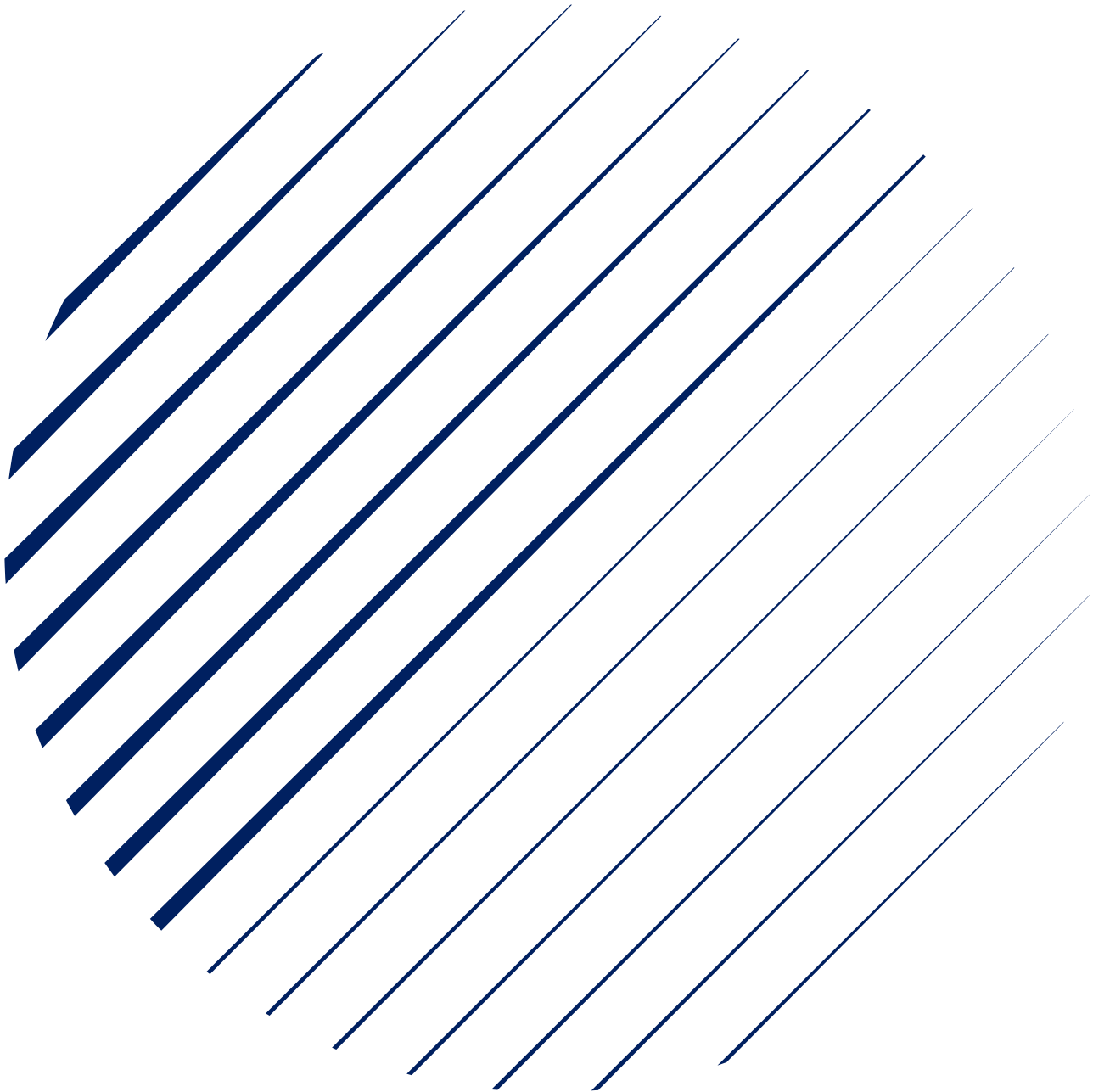
INFECTION, ALLERGY

- FEVER GREATER THAN 101.0 po (or greater than 102.0 pr)
- SHAKING CHILLS
- ALLERGIC REACTIONS (lip or tongue swelling, SOB, generalized hives)

OTHER

- ANYTHING THE PATIENT FEELS IS AN EMERGENCY**
- ANYTHING THAT YOU FEEL COULD BE AN EMERGENCY OR IS VAGUE ENOUGH OR HAS CRITICAL INFORMATION LACKING OR YOU JUST FEEL UNCOMFORTABLY UNCERTAIN**

Signouts / Handoffs



Department of Medicine

Signouts/Handoffs Policy

Transitions of care, if not given due diligence, are associated with adverse events and/or near misses. It is our responsibility as clinicians to ensure that patient care/safety is always given the highest priority. It is, thus, imperative that measures are taken by EPO to ensure that signouts and/or handoffs are performed such that patient safety is assured and the rules of the ACGME (as outlined below) are followed.

VI.E.3. Transitions of Care

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

- By separating the inpatient and outpatient experiences for housestaff, the “3 and 1” system eliminates the need for signout/handoff to attend clinic while on an inpatient service
 - o Transitions of care while on an inpatient service will happen for every team twice daily, once in the morning (from night service to day service) and once in the evening (from cross cover to night service).
 - A third transition of care will occur between day service and cross-cover in the afternoons.
 - While faculty supervision is always required, it is mandatory that faculty provide Level 1/Direct Supervision for the Tuesday Afternoon Signout.
 - o Transitions of care while in the ICU will depend on the ICU setting.
 - UH MICU – morning (from night service to day service) and evening (from day service to night service)
 - VA VICU – morning (from night service to day service) and evening (from day service to night service)
 - Crouse CICU – morning (from 24 hour on-call PGY-3 and overnight PGY-2 to day service) and evening (from day service to 24 hour on-call PGY-3 and overnight PGY-2)
 - o Transitions of care on an elective service are not the primary responsibility of the core housestaff (it is the responsibility of the fellow and/or attending)
 - o Transitions of care in the outpatient continuity clinic setting should be rarely needed as each categorical house officer follows their own patient panel; when needed, however, coverage is by the same-number assigned teammates during each of the four ambulatory/CC weeks (i.e. 1A-1, 1B-1, 1C-1, 1D-1 will cover one another).

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

- University’s EPIC system, the VA’s CPRS system, Crouse’s Soarian system, and WardManager (the latter for some of the consultative

- services) provide a computerized platform to develop concise, yet comprehensive handoff/signout forms.
- Interns are responsible for maintenance and accuracy of information for their patients.
- Residents are responsible for supervision of intern responsibilities and are ultimately held accountable for their intern's performance in this area.
 - o Direct Supervision by the resident is mandated for all afternoon signouts.
- Attendings are ultimately responsible for supervision of signout/handoff.
 - o Direct Supervision by faculty is mandated for Tuesday Afternoon Signout.

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

- On-service attendings and/or residents are responsible for overseeing the signout/handoff process that occurs between interns on inpatient teams.
 - o On-service attendings must directly participate at least once weekly or more frequently if requested to do so by their team or EPO.
- On-service attendings and/or fellows are responsible for overseeing the signout/handoff process that occurs in ICUs.
 - o On-service attendings must directly participate at least once weekly or more frequently if requested to do so by their team or EPO.

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

- Amion (online scheduling system) provides up-to-date schedules.

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

- Please see the section titled "Are You Fit for Duty?" within the syllabus.

What Should Be Included During Any Signout/Handoff?

Signouts or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing your signout/handoff. Signouts/Handoffs must include the following information:

1. Team Assignment
2. Intern/Resident of Record
3. Attending of Record
4. Code Status
5. Hospital Day Number
6. Antibiotic/s Day Number
7. Primary Reason for Admission
8. Secondary Issues of Importance

9. Allergies
10. Active Medications
11. Things to Do

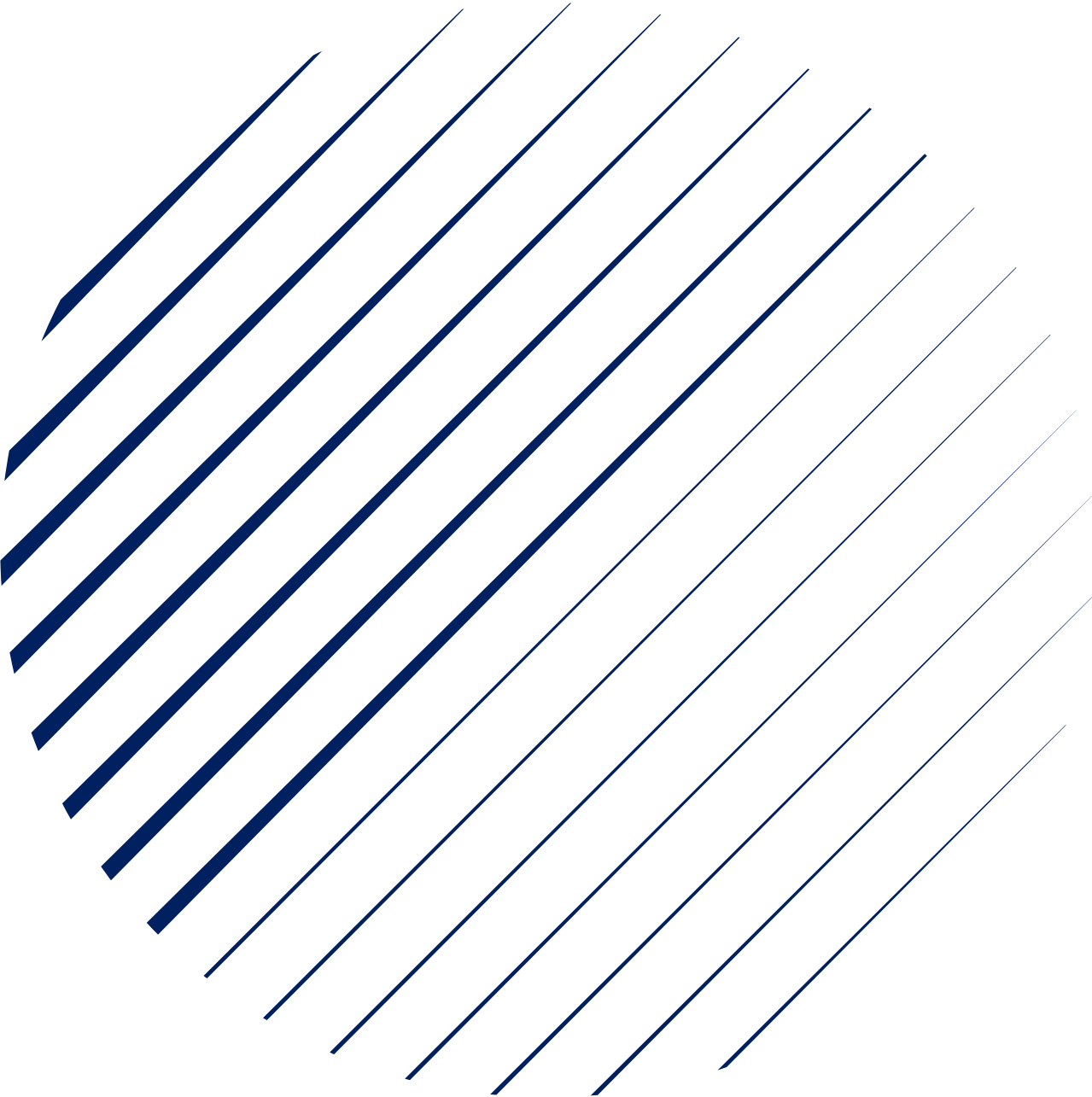
Signout/Handoff Policy

Signout or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing these documents. You are required to use the signout/handoff feature associated with each site; you may not use your own signout feature. The policy is as follows:

- 1)The senior resident (PGY-2, PGY-3) on a service will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean these are the individuals responsible for inputting the information (this can be done by any team member), but the senior resident, as the team leader, will be responsible for what is contained within the signout/handoff.
- 2)The attending on a service without a senior resident and attendings on uncovered services will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean the attending is responsible for inputting the information (this can be done by any team member), but the attending will be responsible for what is contained within signout/handoff. If no signout is provided for uncovered Heme/Onc services, there will be no housestaff coverage provided and coverage will fall to the Heme/Onc attending/s.
- 3)Members of EPO and/or Site Leadership will randomly review patient information in the site's system to ensure that the information contained is accurate and up to date. If information is found to be outdated or inaccurate, the senior resident on that service will be given a warning with some instruction on how to improve. A 2nd and 3rd infraction will be result in Academic Deficiency and Academic Probation, respectively, for an infraction of the Professionalism, Interpersonal and Communication Skills, and Patient Care competencies.
- 4)If information on an uncovered service is found to be outdated or inaccurate, the attending will need to answer to their respective supervisor. If after instructions on how to improve there are additional infractions noted on future reviews, these services will be at risk for losing housestaff involvement in all aspects of uncovered patient care (except RRT/Code situations).
- 5)The individual completing the admission history/physical for a patient is responsible for inputting that patient's pertinent information onto the right service; this is true regardless of time of day (i.e. overnight admitters are responsible for inputting this information).
- 6)When a cross-covering service comes across pertinent changes (a new fever, new abx, a new diagnosis, etc.), the cross-covering service is responsible for updating the signout.
- 7)Significant events mandate a phone call to the attending providing oversight/coverage of the patient (see "Calling Your Supervisor" section for examples).

8)All paperwork related to signouts/handoffs/transfers should be disposed of in a HIPAA-appropriate manner.

Calling Your Supervisor



Department of Medicine

Calling Your Supervisor

- **ACGME Rules Regarding Supervision**

- *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
- *Oversight*, defined as after-care/procedure review of performance.

Regardless of the above ACGME rules regarding supervision, which primarily define the level of supervision required for procedures and routine clinical care, there will undoubtedly be difference of opinion as to whether a supervisor should be notified of a particular situation. While we certainly encourage freedom of thought and autonomy, we must also be mindful of situations that could bring about adverse patient outcomes. For this reason, we have come up with situations that require notification to your supervisor (intern→resident or fellow or attending; resident→fellow or attending).

All activities, including those performed by credentialed housestaff, are always under some level of supervision by the responsible faculty member; it is the faculty member's responsibility to determine what level of supervision is necessary.

While not an exhaustive list, the below situations are examples of what would mandate contacting the supervisor:

Cardiac Issues

- Any situation where ACLS is required
- Hemodynamic Collapse/Shock
- Urgent/Malignant Hypertension
- Chest Pain concerning for ACS, Pneumonia, PE, PTX, Pericarditis, Aortic Dissection

Dermatologic Issues

- New or worsening Skin Rash

Endocrine Issues

- New Hyper/Hypoglycemia
- Thyroid Storm
- Myxedema Coma
- Adrenal Crisis

GI Issues

- Hematemesis
- Melena/Hematochezia/BRBPR
- Surgical Abdomen
- New or Worsening Vomiting/Diarrhea

Hematology/Oncology Issues

- Neutropenic Fever
- Falling Hemoglobin/Hematocrit
- New Blood Dyscrasias
- Transfusion Requirement or Reaction

ID Issues

- Concern of new infection or amending a current antimicrobial regimen

Neurologic Issues

- New Seizure
- Status Epilepticus
- New CVA (or signs/symptoms suggestive of the same)
- New Coma
- New Delirium

Pulmonary Issues

- Respiratory Distress/Arrest
- Any situation in which NIPPV or intubation required.
- Dyspnea concerning for same disease processes listed above under Chest Pain + CHF, Obstructive Lung Disease
- Hypoxia
- Hemoptysis

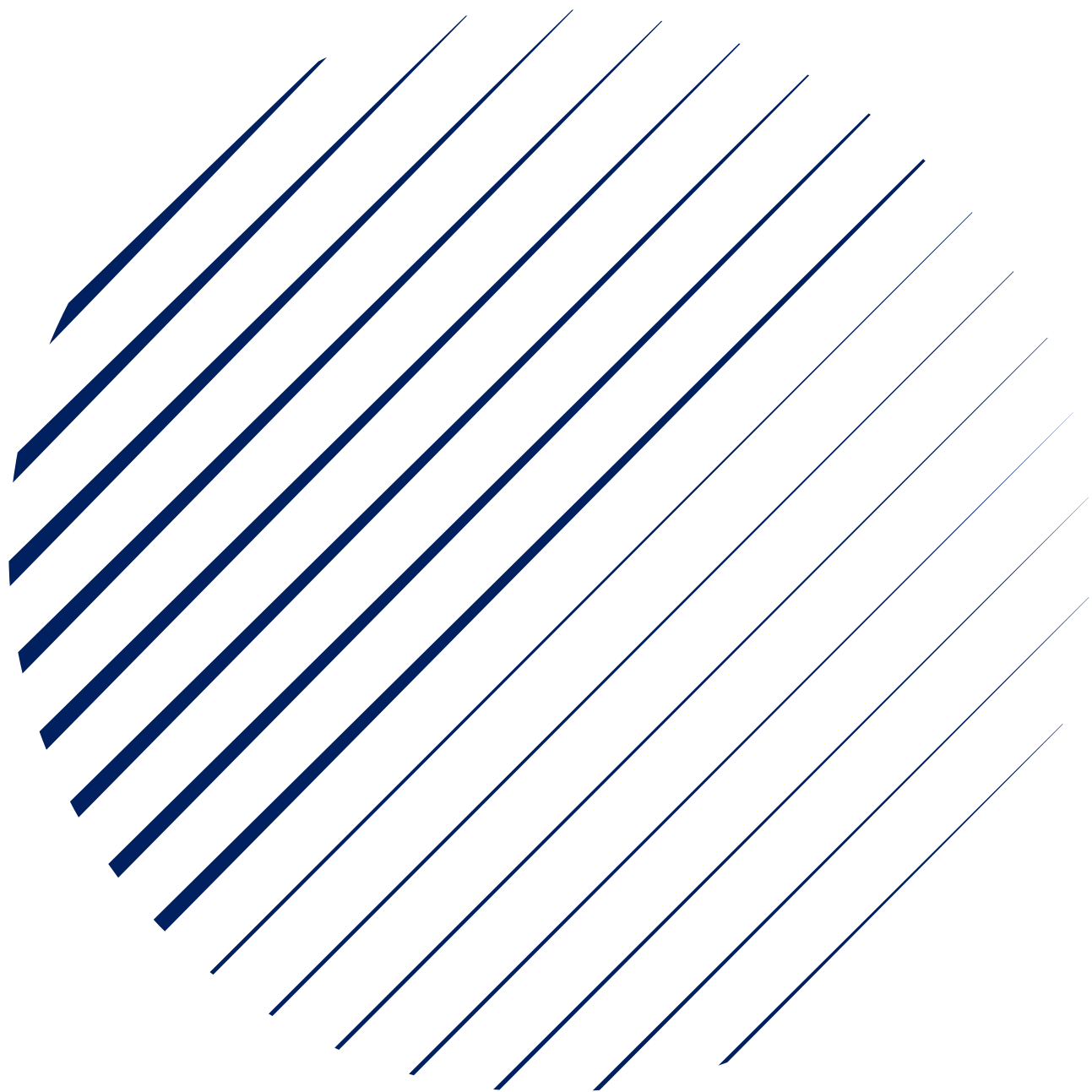
Renal Issues

- New Oliguria/Anuria
- New Renal Failure
- New Electrolyte Dyscrasia that requires urgent attention
- Gross Hematuria

Miscellaneous Issues

- Patient signing out AMA
- Patient being transferred to a different level of care or a different service
- Death of patient
- A procedure is required
- New Hyper/Hypothermia
- Adverse Drug Reaction
- Pain that is new or in which a narcotic is added or increased
- Danger to self or others
- Consultation required
- Change or Decline in Mental Status from baseline
- Fall
- Change in Code Status

University Hospital Policies



Department of Medicine

University Hospital Policies: Internal Medicine

University Hospital Services

- Seven (7) Covered General Medicine Teams
- Two (2) Covered Heme/Onc Teams
- One (1) Covered "Team ED"
- Two (2) Day ICU Services
- Two (2) Night ICU Services
- One (1) ACS Team
- One (1) Day Admitting Team
- One (1) Night Admitting Team
- Two (2) Night Float Teams
- One (1) Med Consult Resident
- One (1) RRT/Code Team
- One (1) Procedure Team

ACGME Rules Applied to University Hospital

- **ACGME Rules Regarding Supervision**
 - *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
 - *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
 - *Oversight*, defined as after-care/procedure review of performance.
- **ACGME Rules Regarding Duty Hours**
 - The Work Day
 - No shift can be longer than twenty-four (24) hours for housestaff.
 - An additional four (4) hours can be utilized to finish work that does not relate to direct patient care.
 - There must be 10 hours off between shifts (14 hours if working a 24 hour shift).
 - The Work Week
 - No work week (Monday through Sunday) can exceed eighty (80) hours under any circumstance.
 - Moonlighting (for fellows and chief residents) counts toward the eighty (80) hours; PGY1s-PGY3s may not moonlight.
 - There must be a continuous twenty-four (24) hours off per week.
- **ACGME Rules Regarding Patient Numbers per Intern and Resident**
 - Interns (PGY-1)
 - *Interns can follow no more than ten (10) patients at any one time.*

- No more than five (5) new patients + two (2) transfers can be assigned to an intern during a routine day of work.
- No more than eight (8) total patients (news + transfers) can be assigned to an intern over a 2-day period.
- Senior Residents (PGY-2/PGY-3)
 - *With one (1) intern on the team, the supervising resident can follow no more than fourteen (14) patients at any one time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients).*
 - With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team during a routine work day.
 - No more than eight (8) total patients (news + transfers) can be assigned to the team over a 2-day period.
 - *With two (2) interns on the team, the supervising resident can follow no more than twenty (20) patients at any one time.*
 - With two (2) interns on the team, the supervising resident can only have ten (10) new patients + four (4) transfers assigned to the team during a routine work day.
 - No more than sixteen (16) total patients (news + transfers) can be assigned to the team over a 2-day period.

With these rules serving as our guide, our own policy will be that any team with two interns can have no more than 16 patients total for the resident (with no more than 8 for either intern). All other patients will be assigned to an overflow/"OF" service which will be handled by either an attending with or without an advanced practice provider. When patient demand exceeds our total inpatient capacity, teams can flex to no more than 20 patients (10 per intern), but this should be the exception rather than the rule. Any team less than 2 interns can have no more than 14 patients (with no more than 8 patients to an intern). Overnight coverage for covered patients will be provided by the housestaff night services with uncovered/OF patients managed by non-housestaff providers (i.e. nocturnist attending and/or advanced practice provider); housestaff, however, will respond to every RRT/Code call for any patient regardless of coverage type. The Chief Residents will keep track of numbers daily to the best of their ability. Ultimately, though, it is your responsibility to immediately report an infraction of the above rules to the Chief Residents. Failure to do so could lead to loss of program accreditation (which ultimately will affect your residency training).

Remember, however, no rule nor regulation should ever come before urgent patient care.

Admitting Schedule and Man-Power at University Hospital

Please see section "The Upstate IM Residency-An Overview"

Guidelines for Admissions/Transfers

Geographic Policy:

Teams 1,2,3 – 6A/B

Teams 4,5 – 5th and 7th floors

Team 6 – 6K

Team 7 – 8th, 9th, and 10th floors

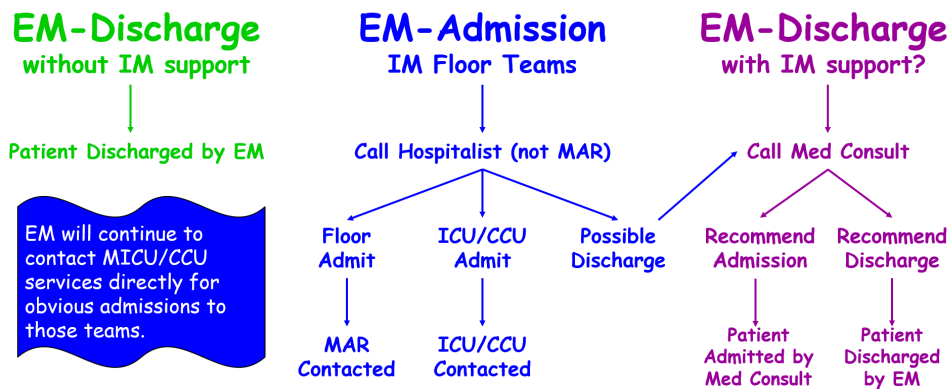
Team 8,9 – 10th floor

Uncovered Gen Med – East Tower (8th, 9th, and 10th floors)

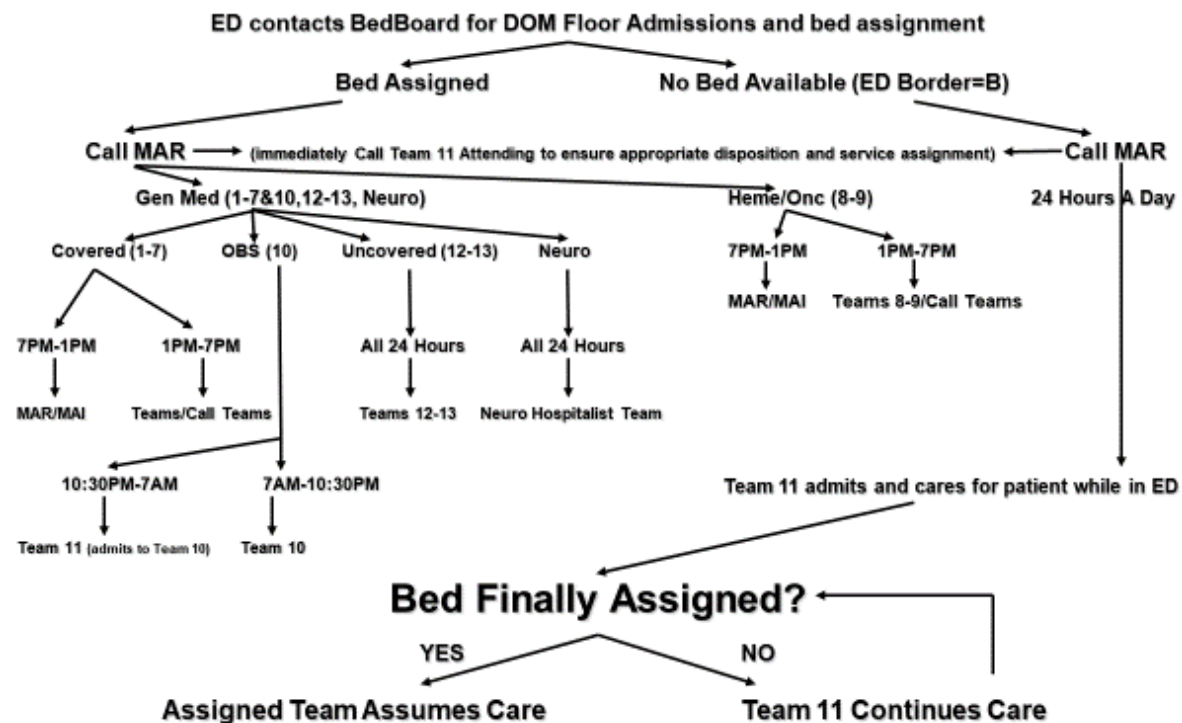
ER admissions:

- The MAR triages all patients admitted to the Medicine service and assigns them to the proper team based on our Geographic Policy.

EM Interface with IM



ED→Floor (Gen Med/Heme-Onc)



- **A patient assigned to Team ED is presented by the admitting house officer to the Team ED attending if Gen Med or the Team 8/9 attending if appropriate for that Heme/Onc.**
- **At 5AM, a night huddle will occur with MAR and Nocturnist to distribute all Team ED patients to a Covered or Uncovered service even if no bed is assigned. Patients admitted after huddle without a bed assignment will remain on Team ED until bed assignment or 5AM the next morning.**
- **A Team ED transfer to a Covered or Uncovered service mandates a communication between the Team ED Hospitalist and the accepting floor hospitalist; the MAR's responsibility will be to contact the accepting team resident.**
- From 07:00-13:00, the Day MAR (with the help of the MAI when available) does all the Covered floor admissions for each team.
- From 13:00-16:00, the Day MAR, after triaging the patient, will assign admissions to the Covered and Uncovered Gen Med services; these services will be responsible for admitting the patient.
- From 16:00-19:00, the Day MAR will assign Covered floor admissions in the following order unless circumstances dictate otherwise (Uncovered Gen Med floor admissions will be handled by the Uncovered Gen Med services):
 - Day MAR (last admission at 6:30PM; flexibility allowed if busy)
 - Day MAI or other assigned MAIs (last admission no later than 1 hour prior to end of shift)
 - All admissions done by the MAI must be supervised by a senior resident or faculty member
 - The MAI admission notes must have an addendum (i.e. a brief synopsis) written by a senior resident or faculty member.
 - On-Call Resident
 - CCU Resident (last admission at 6:30PM; flexibility allowed if busy)
 - Non Cross-Covering Intern (if available)
- From 19:00-07:00, the Night MAR will assign all admissions in the following order unless circumstances dictate otherwise:
 - Night MAR (last admission at 6:30AM)
 - Night MAI (last admission at 6:00AM)
 - All admissions done by the MAI must be supervised by a senior resident or faculty member
 - The MAI admission notes must have an addendum (i.e. a brief synopsis) written by a senior resident or faculty member.
 - Senior Night Floats
 - Nocturnist may be contacted for admission support.
 - ICU Night Float (only if approved by EPO due to extreme circumstances)
- The MAR generally does not do admissions 30 minutes prior to their shift change.
 - However, under certain conditions (such as ER crowding or multiple pending medicine admissions), the Day/Night MAR may be asked by the chief resident to stay an additional amount of time (not to exceed two hours) to help with admissions.
- If additional admitting manpower is needed, the Chief Resident on-call should be contacted.

Direct admissions:

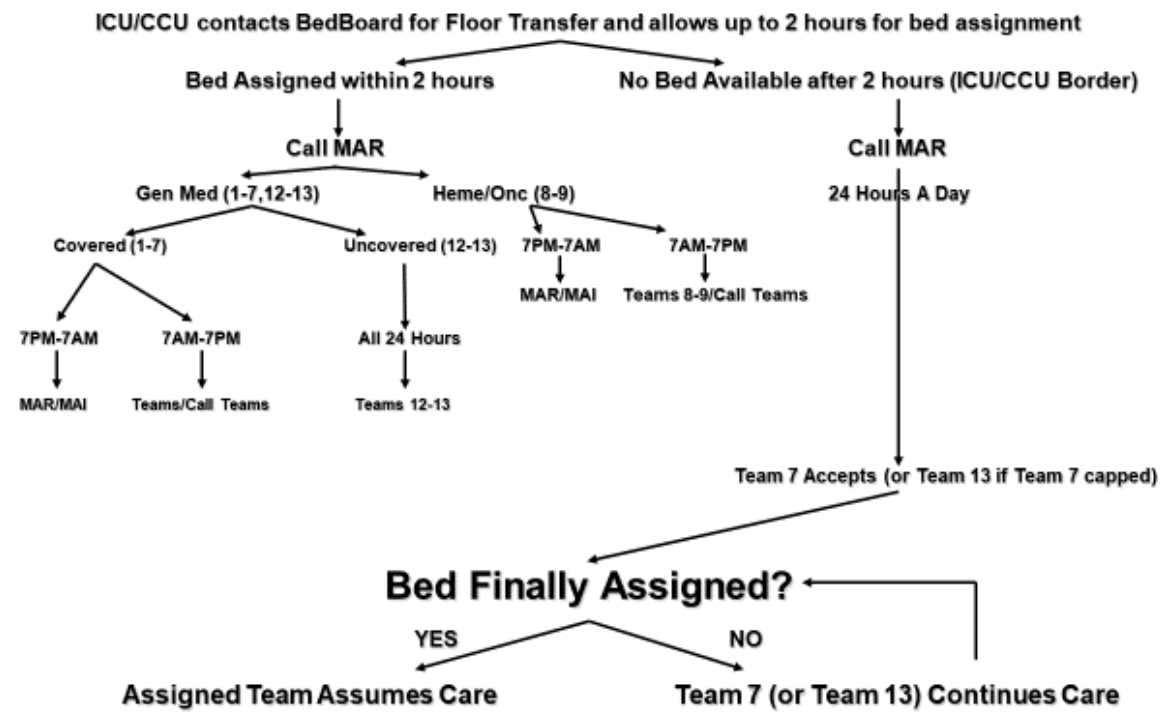
- They are handled in the same manner as above.
- If the patient is stable, they receive less priority than any ER admission.

- The attending desiring admission from an outpatient facility must contact the Team ED attending (for Gen Med patients) or the Team 8/9 attending (for patients appropriate for that service); the accepting attending will contact the MAR about the pending direct admission.

Transfers:

- From the ICU/ACS
 - The ICU/ACS writes an off-service/transfer note and transfer orders (based on the diagram below).
 - The accepting service assumes responsibility of the transferred patient immediately upon the ICU/ACS service's transfer order (based on the diagram below) and writes an acceptance note.

ICU/CCU → Floor



- From an Outside Facility:
 - The outside facility must contact the University Hospital Transfer Center (464-5449).
 - The Transfer Center will coordinate the transfer with an accepting attending.
 - If the transfer is arranged directly with a General Medicine attending, ACS attending, ICU attending, or Hematologist/Oncologist, the accepting attending must alert the MAR.
 - If a consulting service accepts a transfer to one of the General Medicine teams (teams 1-7 and 10), the consulting attending should contact the MAR. While the consulting attending will be the accepting attending initially, the MAR (or designee) will admit

the patient to one of the General Medicine services and reassign the patient to the appropriate General Medicine attending.

- The admission process will occur as outlined above.
- From another Department at University Hospital:
 - Any potential transfer from another department requires either a medicine consult evaluation, subspecialty consult evaluation, or a direct request from the transferring attending to the receiving medical attending.
 - The service that arranges for the transfer to the Medicine service should contact the MAR so that team assignment occurs and accurate team numbers are maintained.
- From within the Department of Medicine:
 - The transferring medical team must inform the MAR of the transfer so that accurate team numbers can be maintained.

1. Weekdays

a. 7AM-1PM

- i. The MAR is responsible for distributing and completing admissions (with the help of the MAI) to all non-ICU/ACS teams; the ICU/ACS services are responsible for their own admissions.
 - 1. Heme/Onc patients are admitted to Team 8,9 based on disease.
 - 2. ACS patients are admitted by the ACS resident.
 - 3. ICU patients are admitted by the ICU team.
 - 4. Gen Med patients are admitted based on our Geographic Policy.
- ii. If help is needed, the MAR may contact the Chief Resident who will then be responsible for finding additional manpower.

b. 1PM-7PM

- i. The MAR is responsible for distributing (and if manpower dictates, completing) admissions to all non-ICU/ACS teams; all covered and uncovered non-ICU/ACS services are responsible for completing their own admissions. The ICU/ACS services are responsible for their own admissions.
 - 1. Heme/Onc patients are admitted to Team 8,9 based on disease.
 - 2. ACS patients are admitted by the ACS resident.
 - 3. ICU patients are admitted by the ICU team.
 - 4. Gen Med patients are admitted based on our Geographic Policy.

c. 7PM-7AM

- i. The MAR is responsible for distributing (and if manpower dictates, completing) admissions to all non-ICU/ACS teams; the ICU/ACS services are responsible for their own admissions; Check www.amion.com to determine other potential admitters.
 - 1. Heme/Onc patients are admitted to Team 8,9 based on disease.
 - 2. ACS patients are admitted by the ACS resident.
 - 3. ICU patients are admitted by the ICU team.
 - 4. Gen Med patients are admitted based on our Geographic Policy.

2. Weekends

a. 7AM-2PM

- i. The MAR is responsible for distributing (and if manpower dictates, completing) admissions to all non-ICU/ACS teams; the ICU/ACS services and the Uncovered Gen Med services are responsible for their own admissions. Check www.amion.com to determine other potential admitters.
 1. Heme/Onc patients are admitted to Team 8,9 based on disease.
 2. ACS patients are admitted by the ACS resident.
 3. ICU patients are admitted by the ICU team.
 4. Gen Med patients are admitted based on our Geographic Policy.
 - ii. If help is needed, the MAR may contact the Chief Resident who will then be responsible for finding additional manpower (for example, jeopardy).
 - b. 2PM-7AM
 - i. The MAR is responsible for distributing (and if manpower dictates, completing) admissions to all non-ICU/ACS teams; the ICU/ACS services are responsible for their own admissions; Check www.amion.com to determine other potential admitters.
 1. Heme/Onc patients are admitted to Team 8,9 based on disease.
 2. ACS patients are admitted by the ACS resident.
 3. ICU patients are admitted by the ICU team.
 4. Gen Med patients are admitted based on our Geographic Policy.
3. ICU/ACS admissions

Weekdays and Weekends, 24 hours a day, admissions to the ICU/ACS are the responsibility of the ICU/ACS service (the ACS service is covered by Senior Night Float #2 from 7PM-7AM weekdays and 7PM-7AM weekends).
4. What About Overflow or Above-the-Cap?
 - a. Unless there is an urgent/emergent patient safety issue, the ACGME rules outlined above may not be violated under any circumstance.
 - b. Do not hesitate to contact EPO with any concerns/questions.

Medicine Consult at University Hospital

Please see section "The Upstate IM Residency-An Overview"

- Consults should be seen within 24 hours unless the patient's clinical condition mandates a sooner visit. If there is a question about timing of the consult, please contact the Consult Attending.

Admission Notes

Admission Notes must be completed using the H&P template provided by University Hospital via EPIC.

Daily Progress Notes

Daily Progress Notes must be completed using the SOAP (Subjective, Objective, Assessment, Plan) format.

1. Clerkship student notes are a vital part of the record and must be reviewed by the intern (preferably) or resident; clerkship student notes can be legally used for billing purposes, but only if the note is reviewed, addended, and cosigned.

2. Acting-Intern student notes are a vital part of the record and must be reviewed by the resident (not the intern); acting-intern student notes can be legally used for billing purposes, but only if the note is reviewed, added, and cosigned.

Discharge Summaries

Discharge Summaries must be completed within 48 hours of discharge and must include the following information:

1. Date of Admission
2. Date of Discharge
3. Primary Discharge Diagnosis
4. Secondary Discharge Diagnoses
5. Significant Procedures Performed During Hospitalization
6. Brief Summary of Hospitalization
7. Discharge Allergy List (drug and reaction)
8. Discharge Medication List (drug, dose, and schedule)
9. Disposition/Code Status/Proxy Status/Follow-Up Requirements
10. CC List

Signouts/Handoffs (See "Signouts/Handoffs Policy" in The Residency Handbook)

Signouts or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing these documents. Signouts/Handoffs in UH's EPIC EMR are through the DOCFISH template and must include the following information (which should be updated as appropriate so that patient data is current and accurate):

1. Team Assignment
2. Intern/Resident of Record
3. Attending of Record
4. Code Status
5. Hospital Day Number
6. Antibiotic/s Day Number
7. Primary Reason for Admission
8. Secondary Issues of Importance
9. Allergies
10. Active Medications
11. Things to Do

The policy is as follows:

1)The senior resident (PGY-2, PGY-3) on covered services/ACS/MICU will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean these are the individuals responsible for inputting the information (this can be done by any team member), but the senior resident, as the team leader, will be responsible for what is contained within the signout/handoff.

2)The attending on a service without a senior resident and attending on Uncovered services will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean the attending is responsible for inputting the information (this can be done by any team member), but the attending will be responsible for what is contained within EPIC. If no signout is provided for Uncovered services, there will be no housestaff coverage provided and coverage will fall to the Nocturnist.

3)The Chair, The Program Director, and the Chief Residents will randomly review patient information in EPIC to ensure that the information contained is accurate

and up to date. If information on a covered/ACS/MICU service is found to be outdated or inaccurate, the senior resident on that service will be given a warning with some instruction on how to improve. A 2nd and 3rd infraction will be result in Academic Deficiency and Academic Probation, respectively, for an infraction of the Professionalism, Interpersonal and Communication Skills, and Patient Care competencies.

4)If information on an uncovered service is found to be outdated or inaccurate, the attending will need to answer to their respective Division Chief and/or Department Chair. If after instructions on how to improve there are additional infractions noted on future reviews, these services will be at risk for losing housestaff involvement in all aspects of Uncovered patient care (except RRT/Code situations).

5)The individual completing the admission history/physical for a patient is responsible for inputting that patient's pertinent information onto the right service in EPIC; this is true regardless of time of day (i.e. overnight admitters are responsible for inputting this information).

6)When a cross-covering service comes across pertinent changes (a new fever, new abx, a new diagnosis, etc.), the cross-covering service is responsible for updating the signout in EPIC.

7)Significant events mandate a phone call to the attending providing oversight/coverage of the patient.

8)All paperwork related to signout/handoff/transfers should be disposed of in a HIPAA-appropriate manner in real time.

For questions or clarifications please page the University Hospital Chief Resident weekdays from 7AM-4PM, and the on-call Chief Resident weekdays after 4PM or anytime on weekends.

[illegible]

UH Floor Call and Admitting Coverage																																		
Monday-Friday Schedule																																		
	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00										
Day MAR																																		
Night MAR																																		
SNF #1 (SuperGroup #1))																																		
INF #1 (SuperGroup#1)																																		
SNF #2 (SuperGroup #2)																																		
INF #2 (SuperGroup#2)																																		
Day MAI																																		
Night MAI																																		
Rotation X Intern	ROTATION X																																	
RRT/Code Intern																							RRT/CODE TEAM											
MSR													SUPERVISES ALL ABOVE INTERN ADMISSIONS																					
Teams 1-9																																		
Call Teams (1/6, 2/7, 3/8, 4/9)																																		
Saturday Schedule																																		
	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00										
Day MAR																																		
Night MAR																																		
SNF #1 (SuperGroup #1))																																		
INF #1 (SuperGroup#1)																																		
SNF #2 (SuperGroup #2)																																		
INF #2 (SuperGroup#2)																																		
Night MAI																																		
Team 5 Intern B																																		
Long Call Residents (x 2) *	I F N E E D E D																																	
Short Call Residents (x 2) *	I F N E E D E D																																	
Sunday Schedule																																		
	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00										
Day MAR (Team 5 Resident)																																		
Night MAR																																		
SNF #1 (SuperGroup #1))																																		
INF #1 (SuperGroup#1)																																		
SNF #2 (SuperGroup #2)																																		
INF #2 (SuperGroup#2)																																		
Night MAI																																		
Team 5 Intern A																																		
Long Call Residents (x 2, except Team 5) *	I F N E E D E D																																	
Short Call Residents (x 2, except Team 5) *	I F N E E D E D																																	
* Weekend Call Schedule																																		
Long Call Day is Resident and Intern B; other weekend day is long call for Intern A; Intern provides cross coverage 2PM-7PM																																		
Short Call (only if not on Long Call for the Weekend)																																		
Teams 1-4 Resident and Intern B are Short Call on Saturdays; Intern A is Short Call on Sundays																																		
Teams 6-9 Resident and Intern B are Short Call on Sundays; Intern A is Short Call on Sundays																																		
**Team 5 Resident doesn't participate in call schedule, but always serves as Day MAR on Sundays																																		
Team 5 Interns don't participate in call system; they only cover on Weekends (own patients until 2PM; MAI from 2PM-7PM)																																		

UH ACS&ICU Call and Admitting Coverage

ACS Monday-Friday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
ACS Resident																								
ACS Intern 1																								
ACS Intern 2																								
SNF #2																								

ACS Saturday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
ACS Resident																								
ACS Intern 1																								
SNF #2																								

ACS Sunday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
ACS Resident (See Amion For Coverage)																								
ACS Intern 2																								
SNF #2 (See Amion For Coverage)																								

MICU Monday-Friday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00	
6H Team																									
MICU 1 Resident (covered by Senior Anesthesia)																									
MICU 2 Resident																									
MICU Intern 1																									
MICU Intern 2																									
MICU J (when Anesthesia at Wed AM Conference)																									
MICU Night Resident 1																									
6I Team																									
MICU 3 Resident																									
MICU 4 Resident																									
MICU Intern 3 (mostly Anesthesia Intern)																									
MICU Intern 4																									
MICU Night Resident 2																									

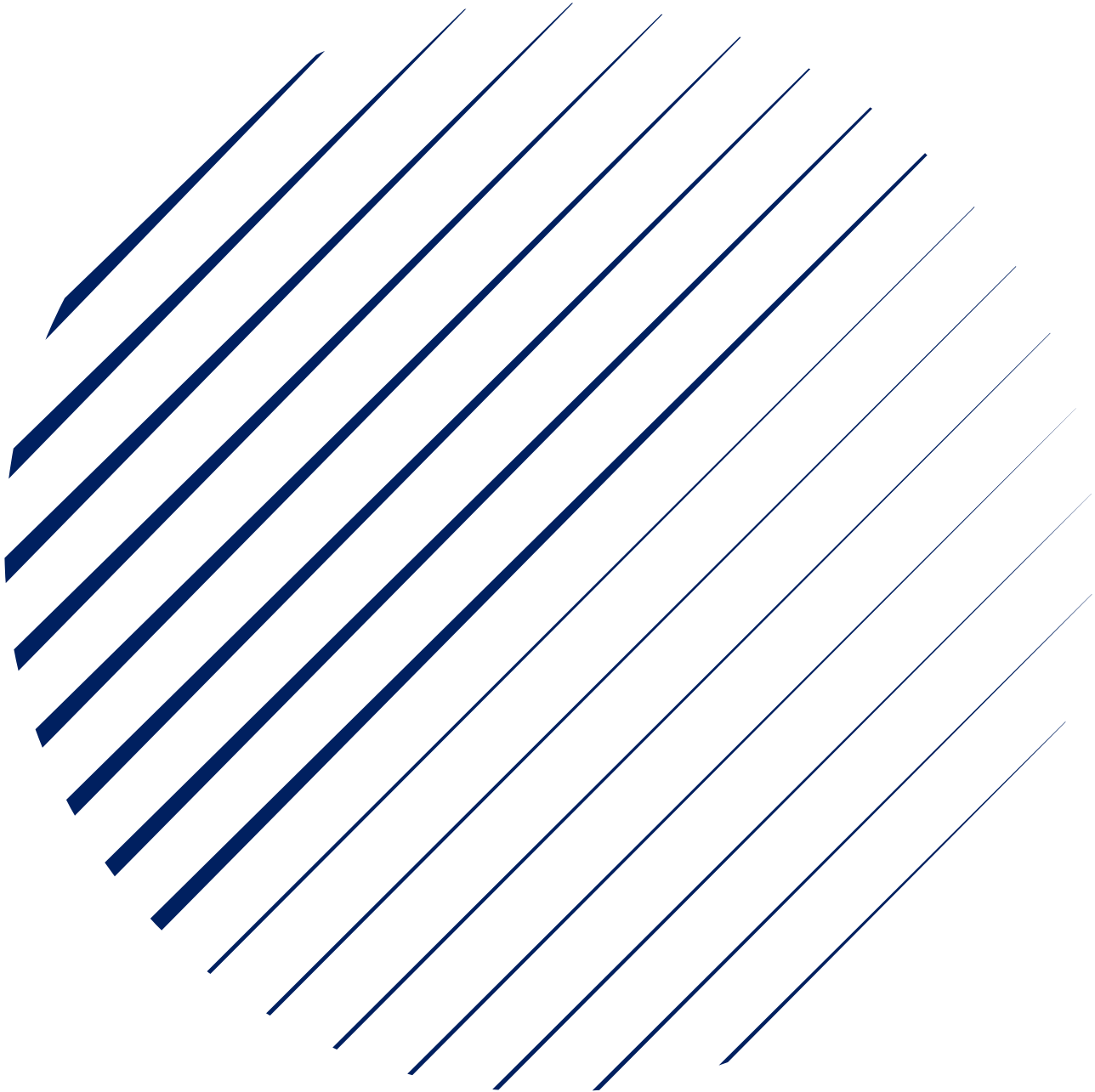
MICU Saturday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
6H Team																								
MICU 2 Resident																								
MICU Intern 2																								
6I Team																								
MICU 3 Resident																								
MICU Intern 3																								
MICU J (covers all new admissions and consults)																								
MICU Night Resident 1 (covers both teams)																								
MICU Day Intern (1 or 4)																								

MICU Sunday Schedule

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
6H Team																								
MICU 1 Resident (covered by Senior Anesthesia)																								
MICU Intern Nights (Lettered Elective 1)																								
6I Team																								
MICU 3 Resident																								
MICU Intern Nights (Lettered Elective 2)																								
MICU J (covers all new admissions and consults)																								
MICU Night Resident 2 (covers both teams)																								
MICU Day Intern (1 or 4)																								

Veteran's Hospital Policies



Department of Medicine

VA Hospital Policies: Internal Medicine

VA Services

Four (4) General Medicine Teams
One (1) ICU Team
One (1) Med Consult Resident
One (1) Day MAR
One (1) Day MAI
One (1) Night Float Resident
One (1) Night Float Intern
Two (2) VA PACT/Quality Residents
One (1) Procedure Team

ACGME Rules Applied to the VA

- **ACGME Rules Regarding Supervision**

- *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
- *Oversight*, defined as after-care/procedure review of performance.

- **ACGME Rules Regarding Duty Hours**

- The Work Day
 - No shift can be longer than twenty-four (24) hours for housestaff.
 - An additional four (4) hours can be utilized to finish work that does not relate to direct patient care.
 - There must be 10 hours off between shifts (14 hours if working a 24 hour shift).
- The Work Week
 - No work week (Sunday through Saturday) can exceed eighty (80) hours under any circumstance.
 - Moonlighting (for fellows and chief residents) counts toward the eighty (80) hours; PGY1s-PGY3s may not moonlight.
 - There must be a continuous twenty-four (24) hours off per week.

- **ACGME Rules Regarding Patient Numbers per Intern and Resident**

- Interns (PGY-1)
 - *Interns can follow no more than ten (10) patients at any one time.*
 - No more than five (5) new patients + two (2) transfers can be assigned to an intern during a routine day of work.
 - No more than eight (8) total patients (news + transfers) can be assigned to an intern over a 2-day period.

- Senior Residents (PGY-2/PGY-3)
 - *With one (1) intern on the team, the supervising resident can follow no more than fourteen (14) patients at any one time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients).*
 - With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team during a routine work day.
 - No more than eight (8) total patients (news + transfers) can be assigned to the team over a 2-day period.
 - *With two (2) interns on the team, the supervising resident can follow no more than twenty (20) patients at any one time.*
 - With two (2) interns on the team, the supervising resident can only have ten (10) new patients + four (4) transfers assigned to the team during a routine work day.
 - No more than sixteen (16) total patients (news + transfers) can be assigned to the team over a 2-day period.

With these rules serving as our guide, our own policy will be that any team with two interns can have no more than 16 patients total for the resident (with no more than 8 for either intern). When patient demand exceeds our total inpatient capacity, teams can flex to no more than 20 patients (10 per intern), but this should be the exception rather than the rule. At no time will any covered team be responsible more than 20 patients. Overnight coverage will be provided by the housestaff night services with a nocturnist attending providing supervision. The Chief Residents will keep track of numbers daily to the best of their ability. Ultimately, though, it is your responsibility to immediately report an infraction of the above rules to the Chief Residents. Failure to do so could lead to loss of program accreditation (which ultimately will affect your residency training).

Remember, however, no rule nor regulation should ever come before urgent patient care.

Admitting Schedule and Man-Power at the VA

Please see section "The Upstate IM Residency-An Overview"

1. Weekdays
 - a. 7AM-1PM
 - i. The MAR will admit and assign ICU transfers in sequence to all 4 teams (except when capped or when bounce-backs).
 1. Bounce-backs (from discharges or the ICU), defined as a patient cared for by a team's current intern or resident, will be assigned to that team.
 2. Capped teams will be skipped until no longer capped.
 3. A team receiving a bounce-back will be skipped during their next turn to accept a patient.
 4. A Med Consult transfer to a team equals an admission to that team.
 - ii. The MAR is responsible for assigning and completing all admissions to the non-ICU medicine services during this time; the MAR may also provide emergency/urgent care to patients in the ER if they are awaiting medicine admission.
 - iii. The ICU resident is responsible for admitting ICU patients.

- iv. If help is needed, the MAR or the ED attending may contact the Chief Resident who will then be responsible for finding additional manpower (for example, jeopardy).
 - b. 1PM-4PM
 - i. The MAR will be responsible for distributing admissions to all services; all services are responsible for completing their own admissions.
 - 1. Assignment of admissions:
 - a. Bounce-backs, defined as a patient cared for by a team's current resident or intern, will be assigned to that team.
 - b. Team numbers at the time of the admission (not in the morning as discharges may have occurred) will determine team assignment otherwise.
 - c. 4PM-7PM
 - i. The MAR and on-call resident (and intern, if available) take all medicine admissions (including ICU admissions) during this time.
 - 1. Bounce-backs, defined as a patient cared for by a team's current intern or resident, will be assigned to that team.
 - 2. The on-call team takes all patients up to their cap.
 - a. Once capped, admissions go back in sequential order (that was in effect before 4PM) skipping those teams that are capped.
 - d. 7PM-7AM
 - i. The VA Night Service (Attending and Resident) will admit all patients.
 - 1. Bounce-backs, defined as a patient cared for by a team's current resident or intern, will be assigned to that team.
 - 2. From 7-8AM, admissions will be presented to the team attending.
2. Weekends
- a. 7AM-2PM
 - i. The on-call resident will fairly distribute admissions during 7AM-2PM between his/her own team and the short-call senior resident; ICU admissions are assigned to the ICU team.
 - 1. The first admission will be assigned to the senior resident on short-call.
 - 2. Bounce-backs, defined as a patient cared for by a team's current resident or intern, will be assigned to that team.
 - b. 2PM-7PM
 - i. The on-call resident (and intern, if available) takes all medicine admissions (including ICU admissions) during this time.
 - 1. Bounce-backs, defined as a patient cared for by a team's current resident or intern, will be assigned to that team.
 - c. 7PM-7AM
 - i. The VA Night Service (Attending and Resident) will admit all patients in sequential order (resuming from the order at 7AM that morning).
 - 1. Bounce-backs, defined as a patient cared for by a team's current resident or intern, will be assigned to that team.
 - 2. Until 7AM, admissions will be presented to the Nocturnist.
 - 3. From 7-8AM, admissions will be presented to the team attending.

3. ICU admissions
 - a. Weekdays
 - i. 7AM-4PM
 1. The ICU resident takes all admissions/transfers to the ICU.
 2. All ICU admissions must be presented to ICU fellow.
 - ii. 4PM-7AM
 1. ICU admissions are done by the MAR or on-call resident.
 2. All ICU admissions must be presented to the on-call attending/nocturnist.
 - b. Saturdays
 - i. 7AM-7PM
 1. The ICU resident takes all admissions/transfers to the ICU.
 2. All ICU admissions must be presented to ICU attending.
 - ii. 7PM-7AM
 1. All ICU admissions are done by the nocturnist until 7AM.
 - c. Sundays
 - i. 7AM-7PM
 1. All ICU admissions are done by the ICU (no core housestaff involvement).
 - ii. 7PM-7AM
 1. All ICU admissions are done by the nocturnist until 7AM.
4. What About Overflow or Above-the-Cap?
 - a. Unless there is an urgent/emergent patient safety issue, the ACGME rules outlined above may not be violated under any circumstance.
 - b. Overflow patients are the responsibility of the on-service attendings (or other VA-appointed health-care providers); housestaff are not to be involved in the care of these patients unless team numbers allow for transfer to a housestaff-covered service or if an urgent/emergent issue requires immediate medical attention.

Medicine Consult at the VA

Please see section "The Upstate IM Residency-An Overview"

Admission Notes

Admission Notes may be typed or dictated and must include the following information:

1. Chief Complaint
2. History of Present Illness
3. Past Medical/Surgical History
4. Allergies (drug and reaction)
5. Current Medications (drug, dose, and schedule)
6. Social History
7. Family History
8. Review of Systems
9. Physical Exam
10. Labwork/Diagnostics
11. Assessment
12. Problem List
13. Plan

14. The last line should indicate that the patient has been discussed with your attending; don't forget to designate the attending as the co-signer of your note.
15. CC List

Daily Progress Notes

Daily Progress Notes must be completed using the SOAP (Subjective, Objective, Assessment, Plan) format.

1. Clerkship student notes are a vital part of the record and must be reviewed by the intern (preferably) or resident; clerkship student notes can be legally used for billing purposes, but only if the note is reviewed, added, and cosigned.

2. Acting-Intern student notes are a vital part of the record and must be reviewed by the resident (not the intern); acting-intern student notes can be legally used for billing purposes, but only if the note is reviewed, added, and cosigned.

Discharge Summaries

Discharge Summaries must be completed within 48 hours of discharge and must include the following information:

1. Date of Admission
2. Date of Discharge
3. Primary Discharge Diagnosis
4. Secondary Discharge Diagnoses
5. Significant Procedures Performed During Hospitalization
6. Brief Summary of Hospitalization
7. Discharge Allergy List (drug and reaction)
8. Discharge Medication List (drug, dose, and schedule)
9. Disposition/Code Status/Proxy Status/Follow-Up Requirements
10. CC List

Signout/Handoffs

Signout or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing these documents. We utilize CPRS's signout/handoff feature. The policy is as follows:

1)The senior resident (PGY-2, PGY-3) on each service will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean these are the individuals responsible for inputting the information (this can be done by any team member), but the senior resident, as the team leader, will be responsible for what is contained within the signout/handoff.

2)The attending on a service without a senior resident and attendings for uncovered patients will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean the attending is responsible for inputting the information (this can be done by any team member), but the attending will be responsible for what is contained within CPRS. If no signout is provided for uncovered patients, there will be no housestaff coverage provided and coverage will fall to the Nocturnist.

3)Members of EPO and/or VA Leadership will randomly review patient information in CPRS to ensure that the information contained is accurate and up to date. If information is found to be outdated or inaccurate, the senior resident on that service will be given a warning with some instruction on how to improve. A 2nd and 3rd infraction will result in Academic Deficiency and

Academic Probation, respectively, for an infraction of the Professionalism, Interpersonal and Communication Skills, and Patient Care competencies.

4) If information for uncovered patients is found to be outdated or inaccurate, the attending will need to answer to their respective VA Supervisor. If after instructions on how to improve there are additional infractions noted on future reviews, these services will be at risk for losing housestaff involvement in all aspects of uncovered patient care (except RRT/Code situations).

5) The individual completing the admission history/physical for a patient is responsible for inputting that patient's pertinent information onto the right service in CPRS; this is true regardless of time of day (i.e. overnight admitters are responsible for inputting this information).

6) When a cross-covering service comes across pertinent changes (a new fever, new abx, a new diagnosis, etc.), the cross-covering service is responsible for updating the signout in CPRS.

7) Significant events mandate a phone call to the attending providing oversight/coverage of the patient.

8) All paperwork related to signout/handoff/transfer should be disposed of in real time in a HIPAA-compliant manner.

For questions or clarifications please page the VA Chief Resident weekdays from 7AM-4PM, and the on-call Chief Resident weekdays after 4PM or anytime on weekends.

VA INPATIENT FLOOR CALL SCHEDULE						
Week #1						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 4	Team 1	Team 2	Team 3	Team 4	LC - 1R, 1AI, 2BI	LC - 2R, 2AI, 1BI
					SC - 4R, 4AI, 3BI	SC - 3R, 3AI, 4BI
Week #2						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 3	Team 4	Team 1	Team 2	Team 3	LC - 4R, 4AI, 1BI	LC - 1R, 1AI, 4BI
					SC - 3R, 3AI, 2BI	SC - 2R, 2AI, 3BI
Week #3						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 2	Team 3	Team 4	Team 1	Team 2	LC - 3R, 3AI, 4BI	LC - 4R, 4AI, 3BI
					SC - 2R, 2AI, 1BI	SC - 1R, 1AI, 2BI
Week #4						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 1	Team 2	Team 3	Team 4	Team 1	LC - 2R, 2AI, 3BI	LC - 3R, 3AI, 2BI
					SC - 1R, 1AI, 4BI	SC - 4R, 4AI, 1BI
1R	Team 1 Resident		Some Useful Rules:			
1AI	Team 1A Intern			1) Call Team for given weekend day is called "Long Call"		
1BI	Team 1B Intern			2) Other Team for given weekend day is called "Short Call"		
2R	Team 2 Resident			3) R and AI always work together on weekends (with Attending)		
2AI	Team 2A Intern			4) BI always works alone on weekends (with Attending)		
2BI	Team 2B Intern			5) BI's call schedule always mirrors R/AI's call schedule		
3R	Team 3 Resident			6) Thursday Long Call is Sunday R/AI Short Call		
3AI	Team 3A Intern			7) Friday Long Call is Saturday R/AI Short Call		
3BI	Team 3B Intern					
4R	Team 4 Resident					
4AI	Team 4A Intern					
4BI	Team 4B Intern					
LC	Long Call (until 7PM) R - Day MAR (Admits until 7PM; signs out to Night MAR or Nocturnist at 7PM) AI - Cross-Coverage except for BI Team; Takes over Cross-Coverage of BI Team at 2PM; signs out to Night Float at 7PM) BI - Covers own team until 2PM; then becomes MAI until 7PM					
SC	Short Call (until 2PM) R - Helps with Admissions until 2PM AI - Covers own team until 2PM; can take admissions if available BI - Covers own team until 2PM					

Crouse Hospital Policies



Crouse Hospital Policies: Internal Medicine

Crouse Hospital Services

Crouse ICU Service
Crouse ICU Night Service
Crouse ER Service

ACGME Rules Applied to Crouse Hospital

- **ACGME Rules Regarding Supervision**

- *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
- *Oversight*, defined as after-care/procedure review of performance

- **ACGME Rules Regarding Duty Hours**

- The Work Day
 - No shift can be longer than twenty-four (24) hours for housestaff.
 - An additional four (4) hours can be utilized to finish work that does not relate to direct patient care.
 - There must be 10 hours off between shifts (14 hours if working a 24 hour shift).
- The Work Week
 - No work week (Sunday through Saturday) can exceed eighty (80) hours under any circumstance.
 - Moonlighting (for fellows and chief residents) counts toward the eighty (80) hours; PGY1s-PGY3s may not moonlight.
 - There must be a continuous twenty-four (24) hours off per week.

- **ACGME Rules Regarding Patient Numbers per Intern and Resident**

- Interns (PGY-1)
 - *Interns can follow no more than ten (10) patients at any one time.*
 - No more than five (5) new patients + two (2) transfers can be assigned to an intern during a routine day of work.
 - No more than eight (8) total patients (news + transfers) can be assigned to an intern over a 2-day period.
- Senior Residents (PGY-2/PGY-3)
 - *With one (1) intern on the team, the supervising resident can follow no more than fourteen (14) patients at any one time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients).*
 - With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team during a routine work day.

- No more than eight (8) total patients (news + transfers) can be assigned to the team over a 2-day period.

Crouse Service Schedules

Please see section “The Upstate IM Residency-An Overview”

Additionally, Crouse ICU housestaff will attend Crouse Educational Conference on Wednesdays and Thursdays 1PM-2PM.

Crouse ICU Policies

Weekdays and Weekends, 24 hours a day, admissions to the ICU are the responsibility of the ICU team/s.

1. What About Overflow or Above-the-Cap?
 - a. Unless there is an urgent/emergent patient safety issue, the ACGME rules outlined above may not be violated under any circumstance.
 - b. Overflow patients are the responsibility of the on-service attendings (or other Crouse-appointed health-care providers); housestaff are not to be involved in the care of these patients unless team numbers allow for transfer to a housestaff-covered service or if an urgent/emergent issue requires immediate medical attention.

Admission Notes

Admission Notes must be written and must include the following information:

1. Chief Complaint
2. History of Present Illness
3. Past Medical/Surgical History
4. Allergies (drug and reaction)
5. Current Medications (drug, dose, and schedule)
6. Social History
7. Family History
8. Review of Systems
9. Physical Exam
10. Labwork/Diagnostics
11. Assessment
12. Problem List
13. Plan
14. The last line should indicate that the patient has been discussed with your attending; don't forget to designate the attending as the co-signer of your note.
15. CC List

Daily Progress Notes

Daily Progress Notes must be completed using the SOAP (Subjective, Objective, Assessment, Plan) format.

1. Clerkship student notes are a vital part of the record and must be reviewed by the intern (preferably) or resident; clerkship student notes can be legally used for billing purposes, but only if the note is reviewed, added, and cosigned.
2. Acting-Intern student notes are a vital part of the record and must be reviewed by the resident (not the intern); acting-intern student notes can be legally used for billing purposes, but only if the note is reviewed, added, and cosigned.

Discharge Summaries

Discharge Summaries must be completed within 48 hours of discharge and must include the following information:

1. Date of Admission
2. Date of Discharge
3. Primary Discharge Diagnosis
4. Secondary Discharge Diagnoses
5. Significant Procedures Performed During Hospitalization
6. Brief Summary of Hospitalization
7. Discharge Allergy List (drug and reaction)
8. Discharge Medication List (drug, dose, and schedule)
9. Disposition, Code Status, Proxy Status, Follow-Up Requirements
10. CC List

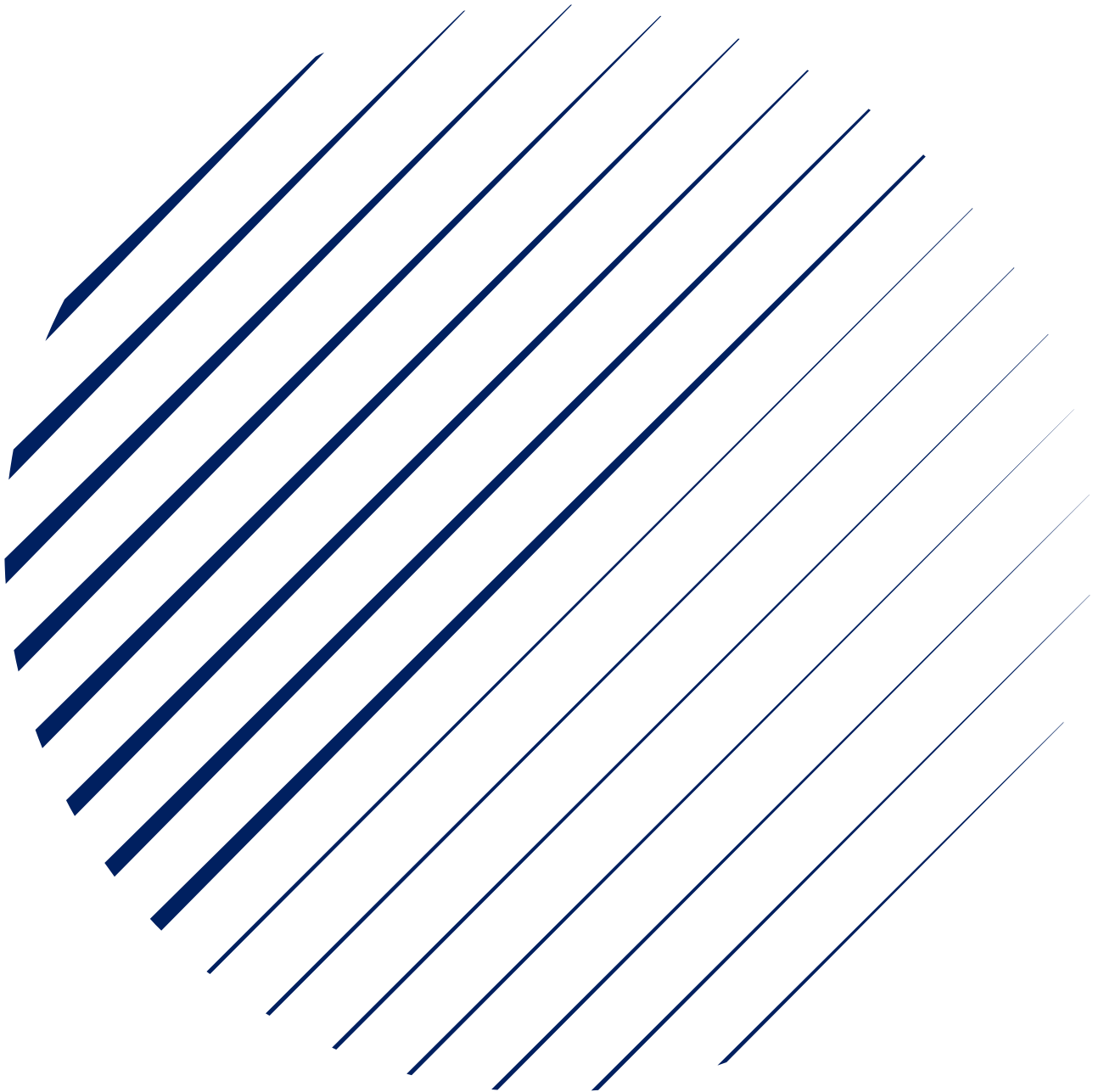
Signout/Handoffs (also see Signouts/Handoffs Policy in Residency Handbook)

Signout or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing these documents. The senior residents are ultimately responsible for ensuring the accuracy of Signouts/Handoffs and failure to do so will lead to a warning with reeducation after a first infraction followed by Academic Deficiency and Academic Probation for a 2nd and 3rd infraction, respectively. Signout/Handoffs must include the following information, should be updated as appropriate so that patient data is current and accurate and all paperwork related to signout/handoff/transfer should be disposed of in real time in a HIPAA-compliant manner:

1. Team Assignment
2. Intern/Resident of Record
3. Attending of Record
4. Code Status
5. Hospital Day Number
6. Antibiotic/s Day Number
7. Primary Reason for Admission
8. Secondary Issues of Importance
9. Allergies
10. Active Medications
11. Things to Do

For questions or clarifications please page the Crouse Hospital Chief Resident weekdays from 7AM-4PM, and the on-call Chief Resident weekdays after 4PM or anytime on weekends.

Your Role as Teacher



Department of Medicine

Your Role as Educator (Teacher)

Teaching Techniques that are Quick!

As we are unable to manufacture more time in a day, it is imperative that we use the time we do have efficiently. There are two teaching techniques that are fast, effective, and validated.

The Five Whys: adopted from Toyota Motor Corporation

Originally developed as a method for root-cause analysis, this technique has been adopted by academia because it can quickly test the depth of knowledge of the learner.

The strategy is simple: Ask a question and then follow-up the learner's answer with a "why?". Repeat for subsequent answers until you feel the learner indeed has provided sound evidence to support the original answer.

Here's an example of a patient with squamous cell lung cancer admitted with mental status changes:

Teacher: What do you think is going on?

Learner: Patient is comatose.

Teacher: Why?

Learner: The patient has hypernatremia.

Teacher: Why?

Learner: The patient is polyuric and nauseated.

Teacher: Why?

Learner: The patient has hypercalcemia.

Teacher: Why?

Learner: Increased bone resorption.

Teacher: Why?

Learner: The patient's squamous cell malignancy is producing PTH-rp.

The One-Minute Preceptor: adapted from Neher, JO, et.al. (1992), Journal of the American Board of Family Practice, 5, 419-424

Developed at the University of Washington, this method, also known as "5-step microskills model" is an effective tool for teaching clinical pearls while evaluating presenting skills and providing feedback.

The 5-steps in this model could also be thought of as "The 5 Ws":

- 1) "What do you think is going on with the patient?" – this gets a commitment from the learner.
- 2) "Why do you think that?" – this probes for supporting data.
- 3) (W)right things you did in your presentation. – we want to point out and reinforce good skills/behaviors.
- 4) (W)rong things you did in your presentation. – we want to point out poor skills/behaviors and offer advice on how to fix them.
- 5) (W)orking Point – provide a clinical pearl.

For a demonstration, please see the following videos on YouTube:

The Wrong Way: <http://www.youtube.com/watch?v=937G0m5SUsl>

The Right Way: <http://www.youtube.com/watch?v=ICeyzpU7PMw>

Department of Medicine

Your Role as Educator (Feedback)

Feedback: Some Advice

Establish Goals and Expectations for the Rotation:

I. For Yourself

- A. Allow the learner to state his/her goals and expectations of you.
- B. Reconcile the learner's goals and expectations with your own and explain to the learner how you will meet these goals and expectations.

Appropriate – *We will meet at these times on these days to discuss these topics*

Inappropriate – *I will teach you*

II. For the Learner

- A. Allow the learner to state his/her goals and expectations of him/herself.
- B. Explain to the learner your goals and expectations of him/her; reconcile any differences the learner's and your expectations and goals and come to an agreement.

Appropriate – *I expect that every morning's presentation will include hospital day#, antibiotic/chemotherapy day# if appropriate, and a SOAP-format presentation*

Inappropriate – *I expect you will know your patients well*

Timeline of Feedback:

I. On-The-Fly Feedback

- A. Please point out strengths and weaknesses on a daily basis in the context of when it happens.

Appropriate – *Great job palpating the liver on Mr. Smith's exam today*

Inappropriate – *Good exam skills on yesterday's rounds*

II. Formally at the Half-Way Point

- A. Discuss with the learner how their performance reconciles with the previously-agreed upon goals and expectations.

Appropriate – *You are forgetting antibiotic day# in your presentation and your stated plans should be organized by organ system*

Inappropriate – *You need to work on your presentation skills*

- B. Allow the learner to critique your performance thus far.

III. Formally on the Final Day

- A. Discuss with the learner their overall performance and how they did relative to the previously agreed-upon goals and expectations.
- B. Render a final grade and narrative with the learner present.
- C. Allow the learner to provide feedback about your performance, but only after you have submitted your final grade/narrative (i.e. the formal evaluation).

Finally:

1. When providing feedback, please try to provide examples of what the learner is doing well as well as what the learner needs to improve upon. Some may call this the sandwich technique: one area of improvement sandwiched between two strengths.
2. STOP to give feedback → be Specific, Timely, Objective, and Plan for future feedback.
3. Deliver feedback in private and always in a respectful, non-threatening manner.
4. Ask for feedback from the learner about your own performance (and encourage them to use the sandwich technique).

Department of Medicine

Your Role as Educator (Evaluation)

Evaluations are based on the Curricular Milestones (different for students and housestaff) of which the following is an example (for assessment of housestaff):

Systems-based Practice 1: Patient Safety and Quality Improvement				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Role models or mentors others in the disclosure of patient safety events
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., community vaccination rate, infection rate, smoking cessation)	Participates in local quality improvement initiatives	Demonstrates skills required to identify, develop, implement, and analyze a quality improvement project	Designs, implements, and assesses quality improvement initiatives at the institutional or community level
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

The Levels are translatable into the RIME (Reporter, Interpreter, Manager, Educator) scheme of evaluation:

Systems-based Practice 1: Patient Safety and Quality Improvement				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Role models or mentors others in the disclosure of patient safety events
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

Think of Levels 2-5 corresponding to R, I, M, E, respectively and apply that to the evaluation in MedHub:

[illegible]

Milestone 2.0-Inpatient Faculty of House Officer

☐ Insignificant contact to evaluate (delete evaluation)

Prior to completing the evaluation of this house officer, please remember you should have provided (at the very least) mid-performance feedback and end-of-rotation feedback so the house officer finds nothing unexpected in this evaluation. As you complete this evaluation, please be very frank about the house officer's performance taking into consideration whether you feel performance in individual areas is at the level of a novice (level 1) through to the level of an expert (level 5); the likelihood is that performance will fall somewhere in between.

Level 1	R Level 2	I Level 3	M Level 4	E Level 5	N/A
<ul style="list-style-type: none"> Elicits and reports a comprehensive history for common patient presentations, with guidance Seeks data from secondary sources, with guidance 	<ul style="list-style-type: none"> Elicits and concisely reports a hypothesis-driven patient history for common patient presentations Independently obtains data from secondary sources 	<ul style="list-style-type: none"> Elicits and concisely reports a hypothesis-driven patient history for complex patient presentations Reconciles current data with secondary sources 	<ul style="list-style-type: none"> Efficiently elicits and concisely reports a patient history, incorporating pertinent psychosocial and other determinants of health Uses history and secondary data to guide the need for further diagnostic testing 	<ul style="list-style-type: none"> Efficiently and effectively tailors the history taking, including relevant historical subtleties, based on patient, family, and system needs Models effective use of history to guide the need for further diagnostic testing 	
<div>⌵ Collapse ⌵</div>					
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1. I would score this house officer's ability to obtain a complete medical history as one who...*

Level 1	Level 2	Level 3	Level 4	Level 5	N/A
<ul style="list-style-type: none"> Performs a general physical examination while attending to patient comfort and safety Identifies common abnormal findings 	<ul style="list-style-type: none"> Performs a hypothesis-driven physical examination for a common patient presentation Interprets common abnormal findings 	<ul style="list-style-type: none"> Performs a hypothesis-driven physical examination for a complex patient presentation Identifies and interprets uncommon and complex abnormal findings 	<ul style="list-style-type: none"> Uses advanced maneuvers to elicit subtle findings Integrates subtle physical examination findings to guide diagnosis and management 	<ul style="list-style-type: none"> Models effective evidence-based physical examination technique Teaches the predictive values of the examination findings to guide diagnosis and management 	
<div>⌵ Collapse ⌵</div>					
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I would score this house officer's ability to perform a syndrome-specific physical exam as one who...*

Rating Errors in Evaluation

1. *Halo Effect* – The tendency to let someone's exemplary performance in one dimension influence your rating of the person in other dimensions; assuming that good performance in one dimension means the person is also as competent in other dimensions.
2. *Leniency Effect* – The tendency to be somewhat less critical than is appropriate in the evaluation process (i.e. to be too easy and forgiving in assigning ratings).
3. *Harshness Error* – The tendency to be more critical than is appropriate in the evaluation process; the opposite of leniency effect.
4. *Recency Error* – This occurs when the learner's performance at the end of the evaluation period is weighted more heavily in the overall evaluation than is appropriate.
5. *Contrast Effects* – This occurs when a rater lets an extremely strong or weak learner become the standard by which other employees are judged.
6. *Central Tendency* – The evaluator rates everyone as average regardless of performance because of the desire not to appear too harsh or lenient. It can also occur when the evaluator has difficulty rating a student accurately because he has observed the student infrequently or briefly.
7. *First Impression Error* – The tendency of a rater to make an initial favorable or unfavorable judgment about a learner that is not justified by the learner's subsequent performance.
8. *Priming Bias* – The tendency to focus on certain aspects of a learner's performance (often to the exclusion of other important aspects), due to a cue that has directed attention towards these aspects of performance. As a result of this, a rater may overestimate the performance they have been prompted (or primed) to attend to, and underestimate the presence of other performance factors.
9. *Stereotyping Bias* – This occurs when a rater assumes something to be true because the individual being rated belongs to a certain group (e.g. male/female).
10. *Availability Bias* – The tendency to rely on information that is most easily accessed in memory or that is most easily collected or retrieved as "hard" data/documentation.

Graduation Competencies and Educational Program Objectives

**Academic Year
2022-2023**

PC: Patient Care

Demonstrate safe, effective, timely, efficient and equitable patient-centered care that promotes health, quality of life, prevention of illness and treatment of disease. Our graduates will:

1. Elicit an accurate history and perform an appropriate physical examination with an organized and respectful approach.
2. Construct a comprehensive problem list and differential diagnosis
3. Conduct focused and comprehensive patient encounters for acute and chronic medical presentations and health maintenance.
4. Develop prioritized intervention and management plans using current scientific knowledge.
5. Interpret clinical, laboratory, radiologic and pathologic data.

MK: Medical Knowledge

Demonstrate and apply knowledge of established and evolving biomedical, clinical, epidemiological, social and behavioral sciences. Our graduates will:

1. Recognize normal structure and function of the human body, and demonstrate knowledge of the underlying scientific principles and mechanisms.
2. Identify the mechanisms of disease and their corresponding effects on the human body.
3. Identify appropriate treatments for common diseases and their mechanisms of action.
4. Integrate knowledge of epidemiology into clinical problem-solving and disease prevention.
5. Assess the determinants of health, and identify interventions that will improve the health of a population.

IICS: Interpersonal and Interprofessional Communication Skills

Demonstrate interpersonal and Interprofessional communication skills with patients, families, communities and professionals in health and other fields that result in effective, patient-centered clinical care. Our graduates will:

1. Demonstrate respect for and appreciation of input from other health care professionals and staff in patient care.
2. Provide timely, clear and accurate written and oral information about patients to other healthcare professionals.

3. Provide information to, and practice shared decision-making and behavioral change techniques with patients and families.
4. Participate as a member of a team and recognize the roles and practices of effective interprofessional teams, including feedback to and from other team members.

PR: Ethics and Professionalism

Demonstrate a commitment to the highest standards of competence, ethics, integrity and accountability to patients and the profession. Our graduates will:

1. Recognize the primacy of the patient's welfare and demonstrate responsiveness to patient needs that supersedes self-interest.
2. Demonstrate honesty, integrity, and compassion in all interactions with patients' families, colleagues, and others with whom physicians must interact in their professional lives.
3. Apply ethical theories and principles pertaining to provision of care, privacy and confidentiality, informed consent, responsible conduct of research, and business practices, including compliance with relevant laws, policies, and regulations.
4. Recognize that physicians are accountable not only to patients, but also to the community, to society, and to the profession.

LI: Practice-Based Learning and Improvement

Demonstrate habits of self-directed learning and self-reflection for acquisition of new knowledge, skills and behaviors to provide optimal patient care. Our graduates will:

1. Demonstrate acceptance and incorporation of feedback.
2. Engage in reflective practice as an intentional learner working toward personal improvement.
3. Identify gaps in knowledge and/or skills, AND
 - a. select appropriate resources and technologies, including current research in evidence-based medicine to fill them.
 - b. demonstrate improvement after self-directed learning.

PH: Systems Based Practice and Population Health

Analyze the complexities of health care systems and work effectively within these systems to advocate for and provide quality patient care. Our graduates will:

1. Describe the structure, delivery and finance of major health care systems.
2. Identify opportunities for stewardship of medical, economic and human resources at both the bedside and the population level.
3. Apply the principles of patient safety, quality assurance, and quality improvement in health care delivery.



COLLEGE OF MEDICINE POLICY MANUAL

Reviewed by Phase 1: 6/2/20	Policy #: COM-36
Reviewed by Phase 2: 6/5/20	Responsible University Officer: Associate Dean for UME
Approved by Curriculum Committee: 6/15/20	Policy Owner: Associate Dean for UME
Dean's Final Approval: 6/18/20	Policy Contact: Director, UME Office

Policy on Professionalism

Review Date:	Change Description:
6/15/20	Reviewed and reapproved with no changes by Curriculum Committee on 6/15/20
Review History	Change Description:
5/13/13	New policy
2/2/16	Reviewed and reapproved
5/21/18	Approved by Curriculum Committee
6/1/18	Reviewed by Phase 2
6/5/18	Reviewed by Phase 1
6/6/18	Reviewed and approved by Dean Licino

POLICY STATEMENT

Professionalism is a cornerstone of the profession of medicine and physicians are held to a high standard of performance. Student enrollment in the College of Medicine demands a level of personal honor and integrity that ensures the provision of quality health care.

The same personal integrity that requires honesty also requires reporting of any infraction of the Professionalism Policy and Code of Student Conduct. Hence, faculty and students have an obligation to report conditions or situations that may lead to violations of either doctrine. Faculty and students must be committed to high ethical standards of behavior, including but not limited to: patient confidentiality; academic integrity; personal behaviors and habits facilitate the ability to meet professional obligations as a medical student; and adherence to guidelines regarding relationship boundaries.

Professionalism is one of the six competencies in which students must demonstrate knowledge, skills and attitudes appropriate to a graduating medical student. Professional behaviors are observed throughout medical school, within courses and clerkships, and in settings outside medical school boundaries. Unprofessional behavior may range from minor to severe, from occasional to frequent, and the College of Medicine has established a tiered method for evaluating and responding to unprofessional behavior which involves a Professionalism Pathway, the Academic Review Boards, and the Judicial Process.

The Professionalism Pathway provides a mechanism for faculty members, staff and students to submit reports about both unprofessional and exemplary professional student behavior to the Associate Dean for Undergraduate Medical Education. The Associate Dean for Undergraduate Medical Education compiles and evaluates both notes of commendation and reports of concern brought to his/her attention.

For cases of exemplary professional behavior, any faculty member or student may submit a Commendation Report to the Associate Dean for Undergraduate Medical Education (UME) who will inform the academic advisors, the appropriate course/clerkship director, if applicable, and the Dean of Student Affairs so that students may receive recognition for their commitment. This may include special notation in the student's Medical Student Performance Evaluation Letter.

REASONS FOR POLICY

LCME Element 3.5: Learning Environment/Professionalism

A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations. The medical school and

its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

PROCEDURES

For reports regarding unprofessional behavior, the Associate Dean may provide an educational and/or counseling intervention, or invoke resolution via the Academic Review Board or the University Judicial Process. In all reports of alleged academic misconduct and unprofessional behavior, the faculty member, staff or student making the charges should follow the following process:

1. Faculty member, staff or student identifies incident and discusses with the course/clerkship director, if applicable, unless there is a conflict of interest.
2. The faculty member and/or course/clerkship director should then discuss the incident with the student and inform them if the issue will be referred to the Associate Dean for Undergraduate Medical Education. Students and/or staff who may not be comfortable with this step can directly discuss it first with the Associate Dean for Undergraduate Medical Education.
3. Faculty member, course/clerkship director, staff or student sends a Professionalism Concern Report to Associate Dean for Undergraduate Medical Education. This report can be found online or obtained from Curriculum Office. The report includes:
 - a. Name of Student
 - b. Name of Individual Submitting Report
 - c. Date of Incident and Report
 - d. Description of Incident
 - e. Description of Any Action Taken

The Associate Dean for Undergraduate Medical Education will first assess the allegation, including its severity or frequency. Based on the assessment, the Associate Dean for Undergraduate Medical Education may choose to:

1. Utilize the Professionalism Pathway for a minor first offense and meet with the student to discuss concerns, provide guidance and set expectations for future behavior. The Associate Dean will then communicate the outcome to the faculty member, staff or student who reported the incident. In addition, the Associate Dean will provide written documentation regarding the incident to the University Judicial Coordinator.
2. Refer the matter to the appropriate Academic Review Board for more significant academic professionalism concerns. Examples of such behavior may include repeated tardiness or absenteeism, lying or misrepresenting the truth, a breach of confidentiality, disregard for safety, disrespectful language or gestures, poor hygiene, and others. The Academic Review Boards may recommend remediation, probation, suspension or dismissal. The Academic Review Boards, which track the competencies of medical students, may also recommend that comments pertaining to the incident be included in the student's Medical Student Performance Evaluation Letter.
3. Refer the matter to the University Judicial Process for offenses as outlined in the Student Code of Conduct.

For each subsequent report, the Associate Dean of Undergraduate Medical Education has each of the above options at their disposal. However, if both a first and second offense was handled utilizing the professionalism pathway, a third offense immediately invokes referral to the Academic Review Board or the University Judicial Process. Refer to Student Code of Conduct and descriptions of the Academic Review Boards for complete process.

Note: In the case of a lapse of academic integrity, referral to the University Judicial Officer will happen upon the second offense (not third). Referral to the University Judicial Process will be communicated to faculty member, staff or student by the Associate Dean for Undergraduate Medical Education.

Scope of Responsibility:

Judicial Process	Professionalism Pathway/ Academic Review Boards
<ul style="list-style-type: none"> • Lapse of Academic Integrity (repeat and/or egregious offense) • Pattern of Unprofessional Behavior which is outside usual course or clerkship academic expectations • Offenses as described in Student Code of Conduct 	<ul style="list-style-type: none"> • Lapse of Academic Integrity (first and/or minor offense) • Inappropriate Attire • Inappropriate use of Cell Phones, etc. • Poor Hygiene • Disrespectful or Ineffective Communication • Ineffective Team Member • Unethical Behavior • Violation of Confidentiality • Poor Attendance • Not Punctual • Unprofessional Demeanor

FORMS/INSTRUCTIONS

Professionalism Commendation/Concern Report

https://www.upstate.edu/ume/pdf/policies_procedures/professionalism_commendation_concern_report.pdf

ADDITIONAL CONTACTS

Dean of Students

University Judicial Officer

DEFINITIONS

Clinical affiliates: Those institutions providing inpatient medical care that have formal agreements with a medical school to provide clinical experiences for the education of its medical students.

RELATED INFORMATION

1. Student Professionalism: College of Medicine Website
https://www.upstate.edu/currentstudents/support/rights/professionalism_com.php
2. Medical Professionalism in the New Millennium-A Physician Charter:
https://www.upstate.edu/ume/pdf/policies_procedures/professionalism_new_millennium.pdf
3. Faculty Code of Professional Conduct:
http://www.upstate.edu/facultydev/pdf/fac_code_conduct.pdf
4. Compact Between Resident Physicians and Their Teachers:
https://www.upstate.edu/ume/pdf/policies_procedures/professionalism_compact_between_residents.pdf
5. Academic Progress, Review and Appeal Committees Policy
<https://upstate.ellucid.com/documents/view/10243/?security=5d6a4081fbba0f4ad668d820f00ef8bab9e2f981>

Reviewed by Phase 1: 7/14/20	Responsible University Officer: Associate Dean of Undergraduate Medical Education
Reviewed by Phase 2: 7/10/20	Policy Owners: Assistant Dean for Foundational Sciences Assistant Dean for Clinical Sciences
Approved by Curriculum Committee: 8/3/20	
Dean's Final Approval: 8/25/20	Policy Contact: Administrative Director, Undergraduate Medical Education

Supervision of Medical Students in Clinical Experiences

POLICY HISTORY	
Review Date:	Change Description:
7/10/20	Reviewed with no changes
Review History:	Change Description:
2/22/13	Initially Approved by CC
4/28/14	Revised by CC
5/22/18	Updated to include
10/1/18	Approved by Curriculum Committee with updates to include procedures and site outside of the institution Reviewed by Phase 1 (6/13/18) and Phase 2 (6/1/18)
10/3/18	Final review and approval by Dean Licinio

POLICY STATEMENT

It is the responsibility of each department and departmental educational leadership team to ensure that medical students in clinical learning situations are appropriately supervised at all times to ensure patient and student safety. This includes ensuring that the level of responsibility delegated to the student is appropriate for his/her level of training, and are appropriately supervised.

REASONS FOR POLICY

LCME Element 9.3 Clinical Supervision of Medical Students

A medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to his or her level of training, and that the activities supervised are within the scope of practice of the supervising health professional.

PROCEDURES

- Expectation is that each department ensure student and patient safety in the clinical experiences in which students participate
- At each clinical experience orientation within the associated course or clerkship, students must be informed of the expectations for their participation and supervision in patient care. Departmental educational leaders are responsible for informing the faculty and/or residents who will supervise students of these same expectations.
- Departmental educational leaders are responsible for assigning students to designated faculty and/or resident supervisors for all clinical experiences and for ensuring that faculty, residents, and the students are made aware of these assignments.

- The amount of supervision required for each student will vary according to the clinical task and clinical status of each patient and should be commensurate with the student's level of training, education, and clinical experience.
- Where clinically and educationally appropriate, physicians who are supervising medical students may delegate responsibility for some elements of teaching and supervision to non-physician care providers within the institution or at affiliated sites outside the institution. It will be the responsibility of each supervising physician to determine which learning experiences are appropriately delegated and to ensure the non-physician providing such supervision are acting within the scope of their practice.
- Students are asked at the end of each course/clerkship evaluation regarding whether they were appropriately supervised at all times to ensure their safety and the safety of their patients. Any concerns will be alerted to the course or clerkship team and curriculum office for appropriate follow-up or investigation.
- Students, faculty, staff who have concerns regarding appropriate supervision of medical students in the clinical setting can also submit a report via the institution's safety event reporting system (SI Events- UHC Safety Intelligence).

DEFINITIONS

There are no definitions associated with this policy.

FAQ

There are no FAQ associated with this policy.

APPENDICES

There are no appendices associated with this policy.

RELATED INFORMATION

LCME Functions and Structure of a Medical School <http://lcme.org/publications/>



UPSTATE
MEDICAL UNIVERSITY

Internal Medicine Clerkship 2021-2022

STUDENT OCCUPATIONAL HEALTH EXPOSURE

Blood and body fluids, immediately treat exposure site

- Wash the exposed skin with soap and water
- Flush exposed mucus membranes with water
- Flush eyes with at least 500 ml of water or normal saline for at least 3–5 minutes
- Do not apply disinfectants, antibiotics, or caustic agents to the wound
- Proceed to the Emergency Department if wound suturing or other first aid is needed

Initiate follow-up without delay

- Weekdays between 7:30 AM – 4:00 PM, call Employee/Student Health (ESH) at (315) 464-4260. Students will be instructed where to follow up
- After hours, weekends, and holidays: 1) Proceed to the Emergency Department at clinical site 2) Proceed to the closest Emergency Department if none at the facility. 3) Notify ESH of the exposure by leaving a voicemail or calling the next day of business.

Chemical or radioactive exposure

- Refer to the Student Occupational Health Exposure for treatment instructions: <https://upstate.ellucid.com/documents/view/3042>

UNITED HEALTH SERVICES

WILSON AND BINGHAMTON GENERAL

After cleansing the exposed area, immediately report to United Occupational Medicine (762-2333), Summit Building, Suite 204, 33 Mitchell Avenue, Binghamton. Clinic hours are 7:20 AM - 4:30 PM weekdays. After hours or on weekends, report to the Emergency Department to receive appropriate attention then follow-up with Occupational Medicine the next business day.

NORWICH

United Occupational Medicine 607-337-4777

170 Broad Street, Norwich

LOURDES HOSPITAL

After cleansing the exposed area go to the Health Clinic (Ground Floor near Pharmacy). Clinic hours are 7:30 a.m. - 3:30 p.m. weekdays. When Clinic is not open call switchboard operator and ask for Clinical Manager on-call.

CLINICAL CAMPUS POLICY ON BLOOD OR BODY FLUID EXPOSURE

In case of blood/body fluid exposure, including needle stick injuries cleanse the area that has been exposed with soap and water. If eyes are involved, flush with saline. Then follow the procedures for the appropriate site on the reverse side of this card. Remember to always identify yourself to hospital personnel as a Clinical Campus Student.

Contact Directory

ZACHARY SHEPHERD, MD

SYRACUSE CLERKSHIP
DIRECTOR

WilliamZ@upstate.edu

315-464-5370

LISA OLIVER

SYRACUSE CLERKSHIP
ADMINISTRATOR

OliverL@upstate.edu

315-464-5370

Thomas Genese, MD
BINGHAMTON SITE
DIRECTOR

GeneseT@upstate.edu

607-763-6042

PENNY HOLT
BINGHAMTON
CLERKSHIP
ADMINISTRATOR

HoltP@upstate.edu

607-763-6042



CLINICAL LOG REQUIRED ROLES

Perform: Student actively participated in obtaining essential part of History and/or Physical Exam for diagnosis listed or participated in essential components of Procedure performed.

Observe: Student is present as History/ Physical Exam when diagnosis is obtained or procedure by others on the team.

Simulate: Alternative experience available on Bb or other simulated setting (only to be used when actual patient experience is not available).

REPORTING

REPORT MEDICAL STUDENT MISTREATMENT

An environment that optimizes learning and is built on respect and dignity is our expectation. The way we treat others (faculty, students, residents, staff) either realizes this expectation or it interferes with the learning process. Discrimination, humiliation and harassment simply can't be tolerated.

To find procedures and report confidentially any incidents or concerns regarding mistreatment or harassment please go to the Upstate website:

<http://www.upstate.edu/currentstudents/support/rights/mistreatment.php>

REPORT A GOLD STAR

The College of Medicine would like to recognize those individuals who exemplify professional behaviors and contribute to a positive learning environment. In order to do so, the Gold Star Report provides a mechanism to identify positive influences on professional standards and the learning environment.

To highlight examples of faculty, students, or staff who have demonstrated exemplary professional behaviors, please go to:

<http://www.upstate.edu/currentstudents/support/rights/goldstar.php>

CLINICAL LOG REQUIREMENTS

DIAGNOSIS	MIN ROLE/MIN # REQUIRED
Abdominal pain	Perform/1
Acute renal failure/CKD	Perform/1
Altered mental status	Perform/1
Anemia	Perform/1
Back pain	Perform/1
Chest pain	Perform/1
CHF	Perform/1
COPD	Perform/1
Cough	Perform/1
Diabetes	Perform/1
Discharge Planning	Perform/1
Dyslipidemia	Perform/1
Dyspnea	Perform/1
Dysuria	Perform/1
Fever	Perform/1
Fluid, electrolyte & acid base disorder	Perform/1
Hypertension	Perform/1
Liver disease	Perform/1
Obesity	Perform/1
Rheumatologic problems	Perform/1
Pneumonia	Perform/1
Smoking cessation	Perform/1
Upper Respiratory Complaints	Perform/1
Venous thromboembolism	Perform/1

Internal Medicine Objectives

PATIENT CARE

Obtain both a focused and comprehensive history and physical examination.	PC1, PC2
Apply a differential diagnosis for patients with a wide range of medical problems.	PC-4
Formulate and explain a management plan for medical patients.	PC4
Care for patients in the inpatient setting addressing both their acute and chronic problems.	PC3
Care for patients in the outpatient setting addressing their acute and chronic problems as well as health maintenance needs.	PC3
Use clinically relevant research to interpret clinical, laboratory, radiologic and pathologic data.	PC5

MEDICAL KNOWLEDGE

Generate a problem list and prioritize its components from patient symptoms and syndromes.	MK3, MK4
Apply knowledge of scientific principles underlying normal function and mechanisms of disease in patient care.	MK1

INTERPERSONAL AND INTERPROFESSIONAL COMMUNICATION SKILLS

Create and sustain therapeutic relationships with patients resulting in effective communication and patient-centered care.	IICS1
Use appropriate listening and verbal skills to communicate empathy and help educate the patient.	IICS1, IICS2
Work with all members of the healthcare team demonstrating respect and teamwork.	IICS2
Carry out professional responsibilities and adhere to ethical principles in the care of a diverse patient population by advocating for the patients' needs and interests.	IICS1
Participate in the development of care plans working with all healthcare team members for inpatients and outpatients.	IICS2

ETHICS AND PROFESSIONALISM

Carry out professional responsibilities and adhere to ethical principles in the care of a diverse patient population by advocating for the patients' needs and interests. (PR-1)	PR1
In all patient encounters, display respect, compassion, integrity and responsiveness to the needs of the patients and society that supersedes self-interest.	PR1, PR3
Work with all members of the healthcare team demonstrating respect and teamwork.	PR1

SYSTEMS BASED PRACTICE AND POPULATION HEALTH

Participate in the development of care plans working with all healthcare team members for inpatients and outpatients.	PH3
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AI Expectations

PATIENT CARE EXPECTATIONS:

- You will be expected to follow a cohort of patients (absolute numbers of patients to follow are not as important as absolute quality given to each patient followed; however, I believe an AI should be able to provide thorough care to at least three patients at a time).
 - You WILL NOT follow any other patient already followed by another intern.
- You will admit patients either directly or from the emergency room AND you will discharge patients from the hospital.
 - You should present your admission to the senior resident as well as the attending.
 - Your admitting notes should be thorough including a detailed assessment and plan of care for your patient.
 - The admission note must be completed on the H&P template form.
- You will pre-round on your patients at a time you set such that you are prepared to provide complete, concise, and accurate presentations to the senior resident and attending during team rounds.
- You will write a daily progress note using the SOAP format (Subjective, Objective, Assessment, and Plan).

EDUCATIONAL EXPECTATIONS:

- Like all interns, you too will be expected to teach students on the service.
- I often hear, "I can't teach students"; I promise you that while there is still much to be learned, you have acquired a significant amount of knowledge that the students will certainly benefit from.
- You will be expected to attend "Noon Didactics" held Monday-Friday either in-person or via virtual means.
- You will be expected to complete a history and physical exam in the presence of your attending.
- During the last week of your rotation, you will be expected to present a 15-minute lecture to your team on a topic approved by your senior resident or attending.

Faculty Responsibilities



Department of Medicine

Faculty Responsibilities

Expectations Policy

For years, the graduating students have cited mentoring as the most important factor that influenced their decision on choice of specialty. This underscores the importance of your interactions with our students and trainees.

To ensure that we are consistent in our approach in providing **the best possible educational experience** to our housestaff and students, and that our trainees attain the ACGME six core competencies, we have created this document to provide guidance for when you are working with trainees in any venue at (or affiliated with) our institution.

The residency program is required to be in compliance with the rules and regulations set forth by the Accreditation Council for Graduate Medical Education (ACGME). The program and institution is reviewed on a regular basis by the ACGME-appointed Residency Review Committee (RRC) and by the ACGME-appointed Clinical Learning Environment Review (CLER) group, respectively.

You are responsible for reviewing the ACGME/RRC document titled “ACGME Program Requirements for Resident Education in Internal Medicine”. This document is included in this syllabus (section titled “ACGME Program Requirements”) and is also located at the following web address:

https://acgme.org/Portals/0/PFAssets/ProgramRequirements/140_InternalMedicine_2020.pdf?ver=2021-05-06-152419-420

You are also responsible for reviewing the document describing CLER (Clinical Learning Environment Review) which can be found at the following web address:

<https://documentcloud.adobe.com/link/review?uri=urn%3Aaaid%3Ascds%3AUS%3A82e1830c-9759-4d81-b898-de0edf91d45c>

- **ACGME Rules Regarding Supervision**

- *Direct Supervision*, defined by immediate on-site supervision (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty

member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).

- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.
- *Oversight*, defined as after-care/procedure review of performance

- **ACGME Rules Regarding Duty Hours**

- The Work Day
 - No shift can be longer than 24 hours for PGY-2/3s
 - No shift can be longer than 16 hours for PGY-1s.
 - An additional 3 hours can be utilized to finish work that does not relate to direct patient care.
 - There must be 10 hours off between shifts.
- The Work Week
 - No work week (Sunday through Saturday) can exceed eighty (80) hours under any circumstance.
 - Moonlighting (for fellows and chief residents) counts toward the eighty (80) hours; PGY1s-PGY3s may not moonlight.
 - There must be a continuous twenty-four (24) hours off per week.

- **ACGME Rules Regarding Patient Numbers per Intern and Resident**

- Interns (PGY-1)
 - *Interns can follow no more than ten (10) patients at any one time.*
 - No more than five (5) new patients + two (2) transfers can be assigned to an intern during a routine day of work.
 - No more than eight (8) total patients (news + transfers) can be assigned to an intern over a 2-day period.
- Senior Residents (PGY-2/PGY-3)
 - *With one (1) intern on the team, the supervising resident can follow no more than fourteen (14) patients at any one time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients).*

- With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team during a routine work day.
- No more than eight (8) total patients (news + transfers) can be assigned to the team over a 2-day period.
- *With two (2) interns on the team, the supervising resident can follow no more than twenty (20) patients at any one time.*
 - With two (2) interns on the team, the supervising resident can only have ten (10) new patients + four (4) transfers assigned to the team during a routine work day.
 - No more than sixteen (16) total patients (news + transfers) can be assigned to the team over a 2-day period.

The Six (6) Core Competencies

1) Medical Knowledge – What is your role?

a. Floor Team Expectations

- i. At least 45 minutes per day should be dedicated to “teaching rounds”.
- ii. At least 60 minutes twice per week should be dedicated to teaching medical students.
- iii. Every member of your team should present at least one topic using evidence-based protocols (one example would be the PICO [Patient, Intervention, Comparison, Outcome] format).
 1. You will formally evaluate their performance on MedHub.
- iv. You will supervise a complete history and physical for each MSIII and MSIV on your service; additionally, you may also be asked to supervise a complete history and physical for a housestaff member of your team.
 1. You will formally evaluate their performance on a Mini CEX form.
- v. Acting Interns
 1. You will assign your AI a topic in which they will present a 15 minute talk to you and your team.
 - a. You will formally evaluate their performance on MedHub.

b. ACS/ICU Expectations

- i. At least 45 minutes per day should be dedicated to “teaching rounds”.
- ii. At least 60 minutes twice per week should be dedicated to teaching medical students.
- iii. You should supervise a complete history and physical for each learner of your team.
 1. You will formally evaluate their performance on a Mini CEX form.
- iv. Acting Interns
 1. You will assign your AI a topic in which they will present a 15 minute talk to you and your team.
 - a. You will formally evaluate their performance on MedHub.

c. Consult Service Expectations

- i. At least 45 minutes per day should be dedicated to “teaching rounds”.
- ii. At least 60 minutes twice per week should be dedicated to teaching medical students.
- iii. You may be asked to supervise part of a or an entire history and physical by learners on your service.

1. If done, you may be asked to evaluate their performance on a Mini-CEX form.
- d. *Continuity Clinic Expectations*
 - i. Every patient encounter should include a clinical pearl.
 - ii. You may be asked to supervise part of or an entire history and physical by learners on your service.
 1. If done, you may be asked to evaluate their performance on a Mini-CEX form.

2) Professionalism – How should you model this?

- a. You will abide by the policies set forth by Upstate Medical University.
- b. You will model behavior that you would expect from your physician.
- c. Feedback will be provided to each trainee at a minimum at the halfway and end points of each rotation. Please see “Your Role as Educator” for additional information on Feedback.
- d. The resident (and student) file is akin to the patient record and should be treated as such; thus, evaluations will be completed within a week of receiving them to ensure that the resident (and student) file remains current. Please see “Your Role as Educator” for additional information on Evaluation.
- e. **You will not nor will you allow housestaff/students to complain or turn down admissions/transfers**
- f. You will promote communication between team members, including the importance of phone calls to you, day or night.
 - i. While not every phone call may have been necessary, please use this as a teaching opportunity rather than a time to chastise.
- g. You will ensure that any housestaff under your supervision abides by the ACGME requirements regarding Duty Hours; you must report any violation of these Duty Hours to the Educational Programs Office immediately. Please see the attached sheet for a summary of the ACGME rules.
- h. You will make every effort to attend Senior Capstones and Quality/M&M Conferences on Thursdays from 12PM-1PM. CME Credits (as well as MOC credits for Quality/M&M Conferences) will be offered.
- i. You will follow the daily rounding times/format outlined on the attached sheet.
 - i. Remember we should aim for hospital discharges by 9AM daily.
 - ii. Remember that residents (not interns) attend Noon Report weekdays from 12PM-1PM while interns attend Noon Didactics during the same time; as such, please

make every effort to excuse housestaff by no later than 11:45AM Monday-Friday.

1. The attending is responsible for urgent patient matters during the 12PM-1PM period Monday-Friday as this one hour block is protected education time for the housestaff.

3) Patient Care – How would you want to be treated?

- a. Nothing less than outstanding clinical care is expected from faculty, housestaff, and students.
- b. If a whiteboard is available in a patient's room, please write your name and title on the board and ask the same of your housestaff.
- c. For patients transferred from surgery to medicine, it is expected that a meeting with family, medicine attending, and surgery attending be conducted within 48 hours after the transfer.

4) Interpersonal and Communication Skills – How you should talk or relate to other individuals?

- a. You will engage all individuals in a friendly, respectful manner and expect the same from them.
- b. If you feel that a house officer is not meeting this expectation, please report this to that house officer's supervisor (i.e. Chief Resident, Fellowship Director, Associate Program Director, Program Director).
- c. If you feel a student is not meeting this expectation, please report this to the student's supervisor (i.e. Clerkship or Course/Elective Director)
- d. If you feel another member of multi-disciplinary team is not meeting this expectation, please report this to that individual's supervisor.
- e. If you feel a patient is not meeting this expectation, please contact Patient Relations.

5) Systems-Based Practice – “The whole is greater than the sum of its parts.”

- a. You will educate the housestaff (and students) about the social and economic forces relative to your field.
- b. You will ensure that the entire team is participating in discharge rounds and effectively communicating with all services relevant to the patient's care.
- c. You will review the importance of accurately recording primary diagnoses and comorbidities as it relates to DRGs, length of stay, and observed vs. expected mortality data.

- d. Regarding ICU/ACS transfers:
 - 1. An off-service/transfer note must be written by the critical care service while an acceptance note must be written by the floor service.
 - 2. The ICU/CCU fellow will contact the MAR for patient downgrades who will in turn provide the fellow a team/attending
 - 3. The ICU/CCU fellow will then call the accepting attending and provide a patient handoff
 - 4. The ICU/CCU service will then place transfer orders for the patient downgrade and write an interim summary for those patients on their service for > 48 hours
 - 5. Once the above has been completed, only then will the accepting team/attending assume responsibility of the transferred patient.
- e. Regarding Inter-Departmental Transfers:
 - 1. An off-service/transfer note must be written if we are the transferring service while an acceptance note must be written if we are the accepting service.

6) Practice-Based Learning and Improvement – “Practice makes perfect.”

- a. You will model appropriate search techniques used in evidence-based medicine.
- b. You will ask each house officer (and student) you work with to formulate medically-relevant questions and then search for the answers using evidence-based protocols (one example would be the PICO [Patient, Intervention, Comparison, Outcome] format).

Finally, you are expected to review the Residency Handbook at least annually so that you remain apprised of program requirements for and expectations of the housestaff; each division/site will receive a copy of the manual annually and all information can also be found on our website. Additionally, you must be aware of and ensure that the ACGME rules on duty hours and patient numbers per team are being strictly followed.

Faculty assigned to inpatient services will meet with members of EPO on a quarterly basis to review policy as well as discuss relevant issues.

Thank You,

Stephen J. Knohl, MD
Residency Program Director
Vice Chair for Education

Zachary Shepherd, MD
Undergraduate Education Director

Sriram S. Narsipur, MD
Department Chair

PS: All activities, including those performed by credentialed housestaff, are always under some level of supervision by the responsible faculty member; it is the faculty member's responsibility to determine what level of supervision is necessary.

Department of Medicine

Faculty Responsibilities

Supervision Policy

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- *Indirect Supervision*, defined as immediate availability (via either physical or telecommunication presence; the choice of which will depend on the situation and time of day), is required on-site by faculty between 7AM-4PM daily, off-site at a minimum by faculty between 4PM-7AM daily, and is required on-site by senior housestaff 24 hours a day for PGY-1s.

- *Oversight*, defined as after-care/procedure review of performance.

Regardless of the above ACGME rules regarding supervision, which primarily define the level of supervision required for procedures and routine clinical care, there will undoubtedly be difference of opinion as to whether a supervisor should be notified of a particular situation. While we certainly encourage freedom of thought and autonomy, we must also be mindful of situations that could bring about adverse patient outcomes. For this reason, we have come up with situations that require notification to the supervisor (intern→resident or fellow or attending; resident→fellow or attending).

While not an exhaustive list, the below situations are examples of what would mandate contacting the supervisor:

Cardiac Issues

- Any situation where ACLS is required
- Hemodynamic Collapse/Shock
- Urgent/Malignant Hypertension
- Chest Pain concerning for ACS, Pneumonia, PE, PTX, Pericarditis, Aortic Dissection

Dermatologic Issues

- New or worsening Skin Rash

Endocrine Issues

- New Hyper/Hypoglycemia
- Thyroid Storm
- Myxedema Coma
- Adrenal Crisis

GI Issues

- Hematemesis
- Melena/Hematochezia/BRBPR
- Surgical Abdomen
- New or Worsening Vomiting/Diarrhea

Hematology/Oncology Issues

- Neutropenic Fever
- Falling Hemoglobin/Hematocrit
- New Blood Dyscrasias
- Transfusion Requirement or Reaction

ID Issues

- Concern of new infection or amending a current antimicrobial regimen

Neurologic Issues

- New Seizure
- Status Epilepticus
- New CVA (or signs/symptoms suggestive of the same)
- New Coma
- New Delirium

Pulmonary Issues

- Respiratory Distress/Arrest
- Any situation in which NIPPV or intubation required.
- Dyspnea concerning for same disease processes listed above under Chest Pain + CHF, Obstructive Lung Disease
- Hypoxia
- Hemoptysis

Renal Issues

- New Oliguria/Anuria
- New Renal Failure
- New Electrolyte Dyscrasia that requires urgent attention
- Gross Hematuria

Miscellaneous Issues

- Patient signing out AMA
- Patient being transferred to a different level of care or a different service
- Death of patient
- A procedure is required
- New Hyper/Hypothermia
- Adverse Drug Reaction
- Pain that is new or in which a narcotic is added or increased
- Danger to self or others
- Consultation required
- Change or Decline in Mental Status from baseline
- Fall

1) Inpatient Floor Teams (General Medicine at UH and VA)**a. 7AM-4PM**

- i. Each team attending will conduct on-site patient-care rounds with the team every morning Monday-Friday as well as on either Saturday or Sunday morning (whichever day the team is present).
 1. If a team attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- ii. Each team attending will be available (within a 20-mile radius to the hospital) to the team's housestaff and students until at least 4PM Monday-Friday and until at least 12PM on Saturday or Sunday (whichever day the team is present).
 1. If a team attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- iii. Each team attending will try to participate in team signout daily, but must supervise at least one signout per week.
 1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- iv. Faculty must be physically present to directly supervise any procedure performed by housestaff or students in which there is no credentialed trainee available to supervise.

1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- b. 4PM-10PM
 - i. Each team attending will be available by phone and will be contacted for any new patients or any significant changes to current patients. If an issue requires the attending to be present in the hospital, the attending has the option of asking the Nocturnist to provide that service.
 1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- c. 10PM-7AM
 1. The Nocturnist will provide supervision and back-up coverage for all covered General Medicine services.
 - a. The Nocturnist may be asked to provide first-call coverage for uncovered General Medicine Services depending on housestaff coverage load.

2) Inpatient Floor Teams (Hematology/Oncology)

- a. 7AM-4PM
 - i. Each team attending will conduct on-site patient-care rounds with the team every morning Monday-Friday as well as on either Saturday or Sunday morning (whichever day the team is present).
 1. If a team attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
 - ii. Each team attending will be available (within a 20-mile radius to the hospital) to the team's housestaff and students until at least 4PM Monday-Friday and until at least 12PM on Saturday or Sunday (whichever day the team is present).
 1. If a team attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
 - iii. Each team attending will try to participate in team signout daily, but must supervise at least one signout per week.
 1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

- iv. Faculty must be physically present to directly supervise any procedure performed by housestaff or students in which there is no credentialed trainee available to supervise.
 - 1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- b. 4PM-7AM
 - i. Each team attending will be available by phone and will be contacted for any new patients or any significant changes to current patients. If an issue requires the attending to be present in the hospital, the the attending has the option of asking the Nocturnist to provide that service.
 - 1. If the team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

3) ICU/ACS Services

- a. 7AM-4PM
 - i. The ICU/ACS attending will conduct on-site patient-care rounds with the ICU/ACS team every morning seven days a week.
 - 1. If the ICU/ACS attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
 - ii. The ICU/ACS attending will be available (within a 20-mile radius to the hospital) to the team's housestaff and students until at least 4PM Monday-Friday and until at least 12PM on Saturday and Sunday.
 - 1. If the ICU/ACS attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
 - iii. The ICU/ACS attending will conduct on-site afternoon/PM rounds seven days a week.
 - iv. The ICU/ACS attending will try to participate in team signout daily, but must supervise at least one signout per week.
 - 1. If the ICU/ACS attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
 - v. The ICU/ACS attending must be physically present to directly supervise any procedure

performed by housestaff or students in which there is no credentialed trainee available to supervise.

1. If the ICU/ACS attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

b. 4PM-7AM

- i. The ICU/ACS attending will be available by phone and will be contacted for any new patients or any significant changes to current patients. The ICU/ACS attending (or credentialed designee) will come into the hospital if necessary to provide direct supervision.
 1. If the ICU/ACS attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

4) Consult Services

c. 7AM-4PM

- v. The consult attending will conduct on-site patient-care rounds with the team seven days a week.
 1. If the consult attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- vi. The consult attending will be available (within a 20-mile radius to the hospital) to the consult team's housestaff and students until at least 4PM Monday-Friday and until at least 12PM on Saturday and Sunday.
 1. If the consult attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.
- vii. The consult attending must be physically present to directly supervise any procedure performed by housestaff or students in which there is no credentialed trainee available to supervise.
 1. If the consult attending is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

d. 4PM-7AM

- i. The consult attending will be available by phone and will be contacted for any new patients or any significant changes to current patients. The consult attending (or a credentialed designee) will come into the hospital if necessary to provide direct supervision.

1. If a team faculty member is not able to fulfill the above requirement, he/she must ensure that there is another faculty member that can.

5) Outpatient and Continuity Clinics

- e. The trainee:faculty ratio may never exceed 4:1.
- f. Every patient seen by housestaff or students will be supervised by an attending on-site.
- g. There must be an attending (or credentialed designee) physically present to directly supervise any procedure performed by housestaff or students in which there is no credentialed trainee available to do so in the clinic.

PS: All activities, including those performed by credentialed housestaff, are always under some level of supervision by the responsible faculty member; it is the faculty member's responsibility to determine what level of supervision is necessary.

Best Practices Guidelines for Inpatient Clinical Teaching

GOAL

To standardize high quality resident education.

DAILY FLOW

Expectations

At the start of the week, attendings should provide verbal or written expectations for the team. Set the expectation of the senior resident as the team leader. Ensure that learners understand a comfortable, safe learning environment exists.

Pre-Rounding

Interns and students should see their patients before daily rounds and chart review thoroughly.

Team Rounds

After multidisciplinary rounds each day, the entire team will meet. The senior resident (expectation for PGY-3 and optional for PGY-2) will function as the "team leader" every day except for the first and last day on service (individual comfort level to be discussed before each rotation and the decision rests with the team attending. They will formulate a plan for the patient with input from the attending and team. The senior resident will lead the team during bedside rounds and the attending will observe their communication and supplement as necessary based on individual comfort level. Plan for the day will be discussed with the patient and the team and all questions will be addressed appropriately. The attending will provide feedback after exiting the room. Bedside rounds are expected at least twice per week with the exception of COVID team(s).

Afternoon

At least twice a week the senior resident should designate a time for a short 15-20 mins teaching session. The team should be made aware ahead of time.

TOOLS

Tips for Teaching

1. Engage prior knowledge by sharing patient personal stories
2. Discuss topics immediately relevant to patients on service using 1-minute clinical pearls
3. Learning should be active - clinical questions are preferred over disease overviews and lectures
4. Focus on bedside teaching with physical exam, "difficult" conversations, POCUS, or a group procedure
5. Take field trips if time to Radiology, Pathology, or peripheral smear
6. Involve learners to create their educational agenda or topics at the start of the rotation
7. Redirect questions to resident first to improve leadership and teaching skills

Feedback

1. Provide feedback regularly and in real-time. Reinforce what the learner did right and help identify mistakes.
2. Conduct end of the rotation feedback in a private and relaxed environment.
3. Ask learners to self-assess and describe their experience.
4. Refer to initial expectations to help guide the discussion.
5. Include specifics instead of generalizations.
6. Establish an action plan and follow up if the feedback is given early in the week.
7. Ask for feedback from the trainees. It would help the attending progress as an educator.

Resources

1. Lecture Database by Upstate HMEC

<https://www.upstate.edu/hospital-medicine/education/lecture-series.php>

2. Written Expectations by Dr. Shepherd

3. TEACH Cards by University of Wisconsin

<https://www.fammed.wisc.edu/files/webfm-uploads/documents/residency/teach-cards/teach-cards-fulldeck.pdf>

4. Clinical Quick Talks by Society of Hospital Medicine

<https://www.hospitalmedicine.org/professional-development/clinical-quick-talks-overview/>