ACGME

Common Program Requirements

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Senior Vice President, Surgical Accreditation
ACGME

SAU Program Directors, Coordinators & Academicians Mtg
Miami, FL
8 February 2018
Disclosures

• In recovery:
  • DIO
  • Program Director
  • General Surgeon

• No financial conflict to disclose
ACGME Requirements

• Institutional
  • *Proposed* by IRC

• Common Program
  • *Proposed* by task force of members of:
    ▪ ACGME Board of Directors
    ▪ Council of Review Committee Chairs

• Specialty-Specific
  • *Proposed* by Review Committee

• ALL must be approved by ACGME BoD
Common Program Requirements

• Foundational elements for all GME programs
• First Common Program Requirements 2003
• Major revisions: 2007, 2011, 2017-
• Major revisions are prolonged processes
• This revision done in two parts:
  • Section VI approved 2/6/2017; effective 7/1/2017
  • Sections I-V proposed 2/6/2018
Section VI
CPR VI: Enforcement

- Approved 2/6/2017; Effective 7/1/2017
- Some previous requirements
  - Unchanged
  - Simply re-worded
- Several *new* areas addressed
  - Could *not* expect implementation in 5 months
- Enforcement (by citation) in *two phases*
### CPR VI: Enforcement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Subject to Citation</th>
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<tbody>
<tr>
<td>VI.A.1.a) Patient Safety</td>
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<tr>
<td>VI.A.1.a).(1).(a)</td>
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<td>X</td>
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<td>The program its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)</td>
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<td>Note: Although this requirement appears in the new Patient Safety section, it is analogous to VI.A.3. in the Common Program Requirements in effect through June 30, 2017, and is thus deemed to be subject to citation on July 1, 2017.</td>
<td></td>
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http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
CPR VI: Enforcement

- Table is 15 pages
- 92 unique program requirements
  - 76 subject to citation 7/1/2017
  - 16 not subject to citation until 7/1/2019

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
NOTE: While some requirements will not be subject to citation until July 1, 2019, it is expected that programs and Sponsoring Institutions will begin implementation efforts immediately.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
Sections I - V
MEMO

DATE: February 6, 2018

FROM: Thomas J. Nasca, MD, MACP, Chief Executive Officer, ACGME

The Phase 2 Common Program Requirements Task Force completed its preliminary work on Sections I-V. The proposed Requirements, along with an Impact Statement, are now available for review and comment through Tuesday, March 22, 2018. Based on input received during this public comment period, the Task Force will submit the final proposed requirements to the ACGME Board of Directors for approval, with implementation targeted for July 1, 2019.

This is the second and final phase of the Common Program Requirements review process. The ACGME Board of Directors initiated this periodic review and revision of the Common Program Requirements in the fall of 2015. Phase 1 was completed with ACGME Board approval of revisions to Section VI in February 2017; those changes became effective July 1, 2017 for both residency and fellowship programs.
• Hot off the press

• These are proposed requirements

• 45-day public comment period

• Task Force will review comments and make any revisions

• Expected to be adopted by BoD 6/10/2018

• Expected to become effective 7/1/2019
Sections I – V: Themes

- Intentionality in program design
- Increased PD authority over program
- Personalized guidance for residents/fellows
- Support for coordinator & PD
- Re-define “core faculty”
- Faculty development
- Separation of residency & fellowship CPRs
- Independent practice in specialty for fellows
- Recognition of ACGME-I in eligibility
- Inclusion of AOA board certification
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Public Comment Period
Sections I-V
6 February – 22 March 2018
Sections I-V Comments

• Encourage you to *carefully* read the proposed requirements and *comment*
  • Concerns
  • Suggestions
  • Support

• Comments **must** be submitted on form
Public Comment CPR I-V

- Link in Dr. Nasca’s letter of 6 February

- [http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/In-Revision](http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/In-Revision)

- Link on Review and Comment page
# ACGME Requirements Review and Comment Form

<table>
<thead>
<tr>
<th>Title of Requirements</th>
<th>Sections I-V of the Common Program Requirements (Residency) and Common Program Requirements (Fellowship)</th>
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## Commenter Information

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## Select [X] only one

- Organization (consensus opinion of membership)*
- Organization (compilation of individual comments)*
- ACGME Review Committee or Council
Thank you!
Proposed CPRs I-V: Specifics
Proposed CPRs I-V (Residency)

Common Program Requirements (Residency)
Sections I-V (Tracked Changes)
Proposed Major Revision

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

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.
Proposed ACGME Common Program Requirements (Fellowship) Sections I-V

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.

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Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, this document is intended to explain the differences.

Introduction

Int.A. Fellowship is advanced graduate medical education for physicians who desire to enter more specialized practice. Fellowship education is up to four years in length beyond a core residency program. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Section I: Major Changes

• Elimination of required elements for PLAs

• Mission-driven, ongoing systematic recruitment and retention of diverse workforce

• New PR for Fellowships: Fellows should contribute to the education of residents in core programs, if present
Section II: Major Changes

• Residency PD: Minimum 20% FTE (8h/week) salary support [RC may further specify]

• Fellowship PD: Must be provided with support adequate for program administration based on program size and configuration [RC must specify]
Section II: Major Changes

• PD qualifications:
  • must include at least 3 years* of educational and/or administrative experience, or qualifications acceptable to RC (NOTE: not included in the fellowship CPRs)
  • AOA certification acceptable
  • must include ongoing clinical activity (not included in the fellowship CPRs)

* Proposed Urology PRs: Four years after residency
Section II: Major Changes

• Program Director responsibilities:
  • Design and conduct program consistent with community needs and mission(s) of the program and SI
Section II: Major Changes

• Program Director responsibilities:
  • Develop and oversee process for evaluation of candidates for program faculty prior to appointment and annually thereafter
  • Have authority to appoint and remove faculty at all sites
  • Have authority to remove residents from supervising interactions that do not meet program standards

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Section II: Major Changes

- Faculty responsibilities:
  - Pursue faculty development at least annually

- Faculty Qualifications:
  - AOA certification acceptable
  - Non-physician faculty members may be designated by the program director
Section II: Major Changes

• Core faculty
  • Defined by on role in resident education and supervision (not number of hours)
  • Includes, at a minimum, CCC and PEC members
  • Non-physician faculty members may be appointed as core faculty
Section II: Major Changes

• There must be a program coordinator

  • Support for the residency coordinator must be at least 50% FTE (at least 20 hours per week) for administrative time [RC may further specify]

  • Fellowship CPRs do not specify minimum level of support for the coordinator – [RCs may specify]
Section III: Major Changes

- Fellowship CPRs provide two options for prerequisite education:
  - Option 1: ACGME or AOA only
  - Option 2: ACGME, AOA, RCPSC, CFPC or ACGME-I Advanced Specialty accreditation*
- RC must specify

* Note effect on Urology subspecialties
Section IV: Major Changes

• Fellowship version: Sub-competencies for Professionalism, PBLI, IPCS, and SBP deleted
Section IV: Major Changes

• New requirements focus on scholarly activity for the program as a whole

• Scholarly activity must be consistent with the mission of the program
Section IV: Major Changes

• Programs must have efforts in at least three of the following seven domains: (Core)
  
  • Research in basic science, education, translational science, patient care, or population health
  
  • Peer-reviewed grants
  
  • QI and/or patient safety initiatives
  
  • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports

continued…
Section IV: Major Changes

- List continued
  - Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
  - Contribution to professional committees, educational organizations, or editorial boards
  - Innovations in education
Section IV: Major Changes

- The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods [RC to choose (1) or (1) and (2)]

  - (1) faculty participation in grand rounds, poster presentations, 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;

  - (2) peer-reviewed publication

[Review Committee may not further specify]
Section IV: Major Changes

• Each graduating resident should have a scholarly activity that is disseminated as further described in IV.D.2.b).(1) or IV.D.2.b).(2).

[Review Committee may further specify]
Section IV: Major Changes

• Independent Practice (Fellowship version only):
  
  • *Fellowship programs may assign fellows to engage in the independent practice of their core specialty during their fellowship.*

  • If programs permit their fellows to utilize the independent practice option, it must not exceed 20 percent of their time per week or 10 weeks of an academic year.

  • [The Review Committee may further specify.]
Section V: Major Changes

- PD or designee must:
  - Assist residents in developing individualized learning plans
  - Develop plans for residents failing to progress
  - Provide summative evaluation of resident’s readiness to progress to the next year of the program
Section V: Major Changes

• PEC must evaluate the program’s mission and aims, strengths, areas for improvement, and threats

• Annual review, including action plan, must be
  • Distributed to/discussed with faculty and residents
  • Reviewed by the GMEC

• Program must complete a Self-Study prior to 10-year accreditation site visit
Section V: Major Changes

• Programs must report (in ADS) board certification rates annually for the cohort of residents that graduated seven years earlier.
CPR Section VI: Highlights
CPR Section VI: Style

- Statements of philosophy, background, intent
- *In italics*
- NOT citable

<table>
<thead>
<tr>
<th>VI.A.1.b).(2)</th>
<th>Quality Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</td>
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| VI.A.1.b).(2).(a) | Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core) |
CPR VI: Areas of Emphasis

VI.A.1.a) Patient Safety

(1) Culture of Safety
(2) Education on Patient Safety
(3) Patient Safety Events
(4) Disclosure of Adverse Events
CPR VI: Areas of Emphasis

VI.A.1.b) Quality Improvement

(1) Education in QI

(2) Quality Metrics

(3) Engagement in QI Activities
CPR VI: Areas of Emphasis

VI.A.2. Supervision and Accountability

- Levels of Supervision unchanged

VI.B. Professionalism
CPR VI: Areas of Emphasis

VI.C. Well-Being
CPR VI: Areas of Emphasis

VI.C.1. Well-Being

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

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

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

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. Well-Being

1.e.) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution must:

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

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. Well-Being

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)
CPR VI: Areas of Emphasis

VI.D. Fatigue Mitigation

VI.E.1. Clinical Responsibilities

VI.E.2. Teamwork

VI.E.3. Transitions of Care
VI.F. Clinical Experience and Education

Duty Hours Clinical and Educational Work Hours

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)
CPR VI: Areas for 2019 Enforcement (all others citable now)
CPR VI: 2019 Enforcement

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

• VI.A.1.a).(3).(a).(iii)  
  Residents, fellows, faculty members, and other clinical staff members must 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)

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf

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CPR VI: 2019 Enforcement

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

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

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
CPR VI: 2019 Enforcement

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

- VI.C.1.
  Programs must provide a professional, respectful, and civil environment … [This responsibility must include:]

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

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
VI.C.1.e) The program, in partnership with its Sponsoring

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; (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)

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/2017CPRSectionVIImplementationTable.pdf
Sections I-V CPR: Other Major Changes
Sections I-V CPR: Major Changes

- Almost all CPRs categorized as “core”
- New Fellowship CPRs
  - *Current* One-year CPRs will be discontinued
Section II: Major Changes

- Faculty scholarly activity to be assessed for the program as a whole, not individual core faculty