

# ACGME Program Requirements for Graduate Medical Education in Family Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

## Introduction

**Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

**The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.**

Int.B. Duration of Training

Residencies in family medicine must offer three years of training after graduation from medical school. Residencies must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

Int.C. Scope of Training

Int.C.1. The goal of the family medicine program is to produce fully competent physicians capable of providing high quality care to their patients.

Int.C.2. Family medicine residency programs should provide opportunity for the residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), those skills and procedures that are within the scope of family medicine. Residencies should prepare residents for lifelong learning.

Int.C.3. Programs using multiple sites and/or tracks must describe a core

curriculum of at least 20 months in which all residents participate. If the remaining months are offered at more than one site, they may differ but each must comply with the requirements.

## **I. Institutions**

### **I.A. Sponsoring Institution**

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

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

I.A.1. Since family medicine programs are dependent in part on other specialties for the training of residents, the ability and commitment of the institution to fulfill these requirements must be documented. Instruction in the other specialties must be conducted by faculty with appropriate expertise. There must be agreement with specialists in other areas/services regarding the requirement that residents maintain concurrent commitment to their patients in the Family Medicine Center (FMC) during these rotations.

### **I.B. Participating Sites**

**I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**The PLA should:**

**I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**

**I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

**I.B.1.c) specify the duration and content of the educational experience; and,**

**I.B.1.d) state the policies and procedures that will govern resident education during the assignment.**

**I.B.2. 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 Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

- I.B.3. Participating hospitals may not be at such a distance from the primary teaching sites that they require excessive travel time or otherwise fragment the educational experience.
- I.B.4. Participation by a participating site that provides six months or more of the 36 months of training in the program must be approved by the Review Committee.
- I.B.5. A program must provide all of the facilities required for the education of residents in sufficient proximity to the primary hospital, particularly the Family Medicine Center(s), to allow for the efficient functioning of the educational program.
- I.B.6. Programs may propose using a non-rotational format for providing resident education in areas usually taught in block rotations. Such proposals must demonstrate that residents will have all of the required experiences during their training, including experience with an adequate volume and mix of patients, the required continuity of care experiences, and appropriate faculty supervision.

## **II Program Personnel and Resources**

### **II.A. Program Director**

- II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.3. Qualifications of the program director must include:**
  - II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
  - II.A.3.b) current certification in the specialty by the American Board of Family Medicine, or specialty qualifications that are acceptable to the Review Committee; and,**
  - II.A.3.c) current medical licensure and appropriate medical staff appointment.**
  - II.A.3.d) active involvement in the care of patients and, prior to assuming this position, a minimum of two years full-time professional activity in family medicine as well as teaching experience in a family

medicine residency.

- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
- II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
  - II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
  - II.A.4.c) approve the selection of program faculty as appropriate;**
  - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
  - II.A.4.e) monitor resident supervision at all participating sites;**
  - II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
  - II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;**
  - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
  - II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
  - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
    - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**
    - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
    - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
    - II.A.4.j).(4) if applicable, monitor the demands of at-home call and**

**adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**

- II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- II.A.4.k).(1) Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.**
- II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
- II.A.4.n).(1) all applications for ACGME accreditation of new programs;**
- II.A.4.n).(2) changes in resident complement;**
- II.A.4.n).(3) major changes in program structure or length of training;**
- II.A.4.n).(4) progress reports requested by the Review Committee;**
- II.A.4.n).(5) responses to all proposed adverse actions;**
- II.A.4.n).(6) requests for increases or any change to resident duty hours;**
- II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8) requests for appeal of an adverse action;**
- II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.**

- II.A.4.n).(11) use of a new or significantly remodeled FMC. The Review Committee will review and approve all proposals prior to use.
- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- II.A.4.o).(1) program citations, and/or**
- II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) devote sufficient time to the residency program (i.e., at least 1400 hours per year spent in resident administration, resident teaching, resident precepting and attending duties, and exclusive of time spent in direct patient care without the presence of residents);
- II.A.4.q) have a specific time commitment to patient care to maintain his or her clinical skills; and,
- II.A.4.r) devise a method by which all procedures are supervised and evaluated. The program director and faculty must also devise a credentialing process to establish whether or not a resident is competent to perform specific procedures. The resident's documentation of procedural learning should include procedure, age and gender of patient, level of performance (e.g., progressing toward independent performance), and number of procedures performed before independent status is granted. Procedural teaching should include didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, management of aftercare and complications, and acquisition and maintenance of skills.
- II.A.4.s) must ensure that educational experiences are provided in either block format or longitudinally. If in block format, no more than five half-days a week may be used for anything other than the focused experience. This includes time in the FMC, nursing home, and lectures. For each month that is accomplished longitudinally, the program must document 100 hours of structured experience.
- II.A.5. In a program that operates in the 1-2 format with year one in a related three year program, there must be a separate site director at the remote site unless that is where the program director is based.
- II.A.6. An acting or interim director must possess the qualifications listed in Section II.A.3.a-d.

**II.B. Faculty**

**II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

**The faculty must:**

**II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

**II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

**II.B.1.c) The faculty must comprise teachers with the diversified interests and expertise necessary to meet the various training responsibilities of the program.**

**II.B.2. The physician faculty must have current certification in the specialty by the American Board of Family Medicine, or possess qualifications acceptable to the Review Committee.**

**II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

**II.B.3.a) Family physician faculty must have admitting privileges in the hospital(s) where the FMC patients are hospitalized. Programs should assess the skills and credentials of individual faculty to perform procedures and care for the types of problems they will be teaching the residents. The professional skills of the teacher should always be documented as up to date and meeting the criteria for credentials and privileges of the primary hospital.**

**II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**

**II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**

**II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**

**II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**

**II.B.5.b).(1) peer-reviewed funding;**

**II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**

**II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**

**II.B.5.b).(4) participation in national committees or educational organizations.**

**II.B.5.c) Faculty should encourage and support residents in scholarly activities.**

II.B.6. The curricula and plans for all rotations and experiences must be developed by the family medicine faculty, and family physicians must be utilized to the fullest extent as teachers consistent with their experience, training, and current competence. Other specialty faculty may be consulted for assistance as needed.

II.B.7. Faculty/Resident Ratio

There must be a sufficient number of hours contributed by a critical mass of family physician faculty to prevent fragmentation of the learning experience. In addition to the program director, there must be at least one full-time equivalent (FTE) family physician faculty for each six residents in the program. Any program in operation must have at least two family physician faculty members, including the director, regardless of resident complement. By the time a program offers all three years of training with the required minimum number of resident positions (i.e., 4-4-4) at least one of the additional family physician faculty must be full time. A full-time commitment is at least 1400 hours per year devoted to the residency spent in resident administration, resident teaching, resident precepting and attending duties, exclusive of time spent in direct patient care without the presence of residents. As the resident complement increases beyond the minimally acceptable size, additional full-time family physician faculty will be needed to provide a core group of family physician faculty. Where part-time faculty members are utilized, there must be evidence of sufficient continuity of teaching and supervision.

II.B.8. Faculty Role Modeling

As is expected of the program director, the family physician faculty should have a specific time commitment to patient care in order to enable them to maintain their clinical skills. Some family physician teaching staff must see patients in each of the FMC's that are used in the program to serve as role models for the residents.

II.B.9. Faculty Development

There must be a structured program of faculty development that involves regularly scheduled faculty development activities. Since family medicine faculty should demonstrate the same skills, knowledge and attitudes that are expected of the residents, faculty skill development and update are an

important part of faculty development. The program is expected to address clinical, educational, administrative, leadership, research and behavioral components of faculty performance. It should involve at least annual departmental, residency and individual faculty needs assessments, and may include structured group and individual activities. Although clinical update is important, faculty development should provide experience to improve teaching in all settings. This should be measurable and documented in evaluations by residents.

II.B.10. Other Specialists

Physicians in the other specialties must devote sufficient time to teaching and supervising, and to providing consultation to the family medicine residents in order to ensure that the program's goals for their specialty areas are accomplished.

**II.C. Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

II.C.1. Additional teaching staff will be needed to provide training in areas such as behavioral science, nutrition, and the use of drugs and their interaction. Mid-level practitioners may teach family medicine residents in conjunction with other faculty in required curricular areas. Their qualifications should be provided.

**II.D. Resources**

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

II.D.1. Patient Population

Each residency must document that a patient population of adequate size, representing a broad spectrum of problems, with sufficient age and gender distribution is cared for in the hospital, in the FMC, and in institutions for long-term care or rehabilitation, as appropriate. A sufficient number of inpatients must be available to provide a broad spectrum of problems in any area listed in these requirements that involves inpatient care. The disease spectrum available for resident education must be that which is common to the general community. These experiences must include the opportunity to attain expertise in emergency initial care of unusual or life-threatening problems.

II.D.2. Family Medicine Center

II.D.2.a) Introduction

- II.D.2.a).(1) The primary setting for training in the knowledge, skills, and attitudes of family medicine is the model office or FMC, where each resident must provide continuing, comprehensive care to a panel of patient families. The facility must be clearly and significantly identified as a Family Medicine Center and must be for the exclusive use of the residency program.
- II.D.2.a).(2) When other learners (e.g. fellows, residents from other specialties, medical students, nurses and other medical professionals) are being trained by family physicians in the FMC, additional personnel and space may be required. Efficiency and education of the family medicine residents must not be compromised by the training of other health care professionals.
- II.D.2.a).(3) An FMC must be in operation on the date the program begins. If a temporary center is used, it must meet these same criteria. If multiple centers are used for training, each must be approved by the Review Committee and must meet the same criteria as the primary center. Although all of the FMCs used in a program need not provide the same experiences, the experiences at each must comply with the requirements. That is, the experiences may differ in various tracks within a program.
- II.D.2.a).(4) Programs that involve training in Community, Migrant Health Centers (C/MHCs) or Federally Qualified Health Centers (FQHC) must provide assurance that these facilities meet the criteria for an FMC, as outlined below, unless an exception is approved by the Review Committee.
- II.D.2.b) Administration and Staffing
- II.D.2.b).(1) The program director must have control of the educational activities that occur in the FMC, and of the activities of the support personnel. The program director must participate in and provide leadership for decisions affecting the FMC.
- II.D.2.b).(2) The FMC must be appropriately staffed with nurses, technicians, clerks, administrative personnel and other health professionals to ensure efficiency of operation and adequate support for patient care and educational requirements.
- II.D.2.c) Location and Access
- II.D.2.c).(1) The FMC must be close enough to the hospital to require minimal travel time. It may not be at such a distance as to require travel that interferes with the residents' educational

opportunities, efficiency, or patient care responsibility.

II.D.2.c).(2) When an FMC is at such a distance from the primary hospital that the patients are hospitalized elsewhere, the program director must demonstrate how the residents will efficiently maintain continuity for their patients at one hospital while having their required rotations at another; the extent to which residents are able to participate in the program's educational activities, such as required conferences must also be demonstrated.

II.D.2.c).(3) The facility must be designed to ensure adequate accessibility and efficient patient flow, be environmentally sensitive to patient care needs, and provide appropriate access and accommodations for the handicapped.

II.D.2.d) Required Areas

II.D.2.d).(1) There must be a reception area, waiting room and business office that are consistent with the patient care and educational needs of the residency.

II.D.2.d).(2) A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Center.

II.D.2.d).(3) Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.

II.D.2.d).(4) Faculty offices, if not in the FMC, must be immediately adjacent to the Center.

II.D.2.d).(5) The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.

II.D.2.e) Equipment

There must be the following:

II.D.2.e).(1) appropriate diagnostic and therapeutic equipment in the

FMC to meet the basic needs of an efficient and up-to-date family medicine office, and an acceptable educational program for residents in family medicine;

II.D.2.e).(2)

diagnostic laboratory and imaging services in the FMC or nearby to afford prompt and convenient access by patients and residents for patient care and education; tests commonly included as waived or point-of-service (e.g., urine analysis and wet mounts) and which may require efficiency of physician interpretation should be available within the FMC.

II.D.2.f)

#### Patient Access to the Family Medicine Center

II.D.2.f).(1)

The FMC must be available for patient services at times commensurate with community medical standards and practice. When the Center is not open, there must be a well-organized plan that ensures continuing access to the patient's personal physician or a designated family physician from the FMC.

II.D.2.f).(2)

Patients of the FMC must receive education and direction as to how they may obtain access to their physician or a substitute family physician for continuity of care during the hours the Center is closed. Patients should have access to printed policies and procedures of the Center.

II.D.2.g)

#### Record System

II.D.2.g).(1)

The FMC patients' records should be maintained in the FMC. However, if a centralized record system is used, easy and prompt accessibility of the records of the FMC patients must be ensured at all times, i.e., during and after hours. The record system should be designed to provide information on patient care and the residents' experience. These records must be well maintained, legible, and up-to-date, and should identify the patient's primary physician.

II.D.2.g).(2)

The record system must provide the data needed for patient care audit and chart review of all facets of family care, including care rendered in the FMC, in the hospital, at home, by telephone, through consultations, and at other sites.

II.D.2.g).(3)

The resident must be taught patterns of record keeping that incorporate a comprehensive information base, retrievable documentation of all aspects of care, and mechanisms for promotion of health maintenance and quality assessment of care. This should include experience with electronic medical records.

II.D.2.g).(4) Programs not currently using an electronic medical record system should document their plans for conversion to one in the near future.

II.D.2.h) Source of Income

The fiscal operation of the FMC must reflect an appropriate balance between education and service. Service demands must not adversely affect educational objectives. A plan should be in place to ensure fiscal stability of the program.

II.D.3. Inpatient Facilities

II.D.3.a) The inpatient facilities must be of sufficient size and have an adequate number of occupied teaching beds to ensure an appropriate patient load and variety of problems for the education of the number of residents and other learners on the services. Inpatient facilities must also provide sufficient physical, human, and educational resources for training in family medicine. In determining the adequacy of the number of occupied beds in the primary and hospitals, the patient census, the types of patients and their availability for residency education, and the range of support services will be considered.

II.D.3.b) The medical staff should be organized so that family physician members may participate in appropriate hospital governance activities on a basis equivalent to that of physicians in other specialties.

II.D.3.c) Where a hospital is departmentalized, there must be a clinical department of family medicine.

**II.E. Medical Information Access**

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

**III Resident Appointments**

**III.A. Eligibility Criteria**

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

**III.B. Number of Residents**

**The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.**

III.B.1. Review Committee Approval

The letters of notification from the Review Committee for Family Medicine do not specify the number of approved positions. Each time a program undergoes review by the Review Committee, the Committee will evaluate the program's resources in relation to the number of resident positions reported by the program.

III.B.2. Minimum size

III.B.2.a) To provide adequate peer interaction, a program should offer at least four positions at each level and should retain, on average, a minimum complement of 12 residents.

III.B.2.b) Except for periods of transition, the program should offer the same number of positions for each of the three levels of training.

III.B.2.c) A family medicine program should endeavor not to function as a transitional year program. Those who are appointed to the program should intend to complete the three years of training in the program.

III.B.2.d) Those accepted into the first year of training should be ensured of a position for the full three years, barring the development of grounds for dismissal.

III.B.2.e) The degree of resident attrition and the presence of a critical mass of residents are factors that will be considered by the Review Committee in the evaluation of a program.

III.B.3. Special Tracks

III.B.3.a) In certain cases, such as programs that operate in the 1-2 format, the Review Committee may approve a smaller resident complement, but this should include at least one resident at each of the second and third levels or two residents at one of these levels to ensure peer interaction.

III.B.3.b) Such programs are encouraged to arrange opportunities for the residents to interact with other residents (e.g., through didactic sessions at the parent program).

III.B.4. Change in Complement

The Review Committee allows programs to implement a modest change in complement without formal Review Committee review. Those desiring to change the resident complement between full program reviews should enter the information regarding the proposed change electronically into ADS for administrative review. If it is determined that Review Committee review is required, additional information may be requested.

**III.C. Resident Transfers**

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

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

**III.D. Appointment of Fellows and Other Learners**

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

**IV Educational Program**

**IV.A. The curriculum must contain the following educational components:**

**IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

**IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**

**IV.A.3. Regularly scheduled didactic sessions;**

**IV.A.3.a) A variety of teaching methods may be used for residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experiences and competence required of physicians in the care of patients and families.**

**IV.A.3.b) Didactic as well as clinical learning opportunities must be provided as part of the curriculum, but the majority of time for any required experience should be clinical. Although lectures and workshops are helpful and may be required to supplement learning, residency experiences should include direct practice experience to enable residents to learn how to implement principles learned in the didactic curriculum.**

IV.A.3.c) Conferences

IV.A.3.c).(1) Conferences should reflect the needs of the program and the residents. At least one faculty should attend each conference given by residents, and residents must not be the majority of presenters.

Each program must have the following:

IV.A.3.c).(1).(a) an educational rationale for use of conferences for the program;

IV.A.3.c).(1).(b) a statement on how conferences are evaluated and how the resultant data are used by the program; and,

IV.A.3.c).(1).(c) an explanation of resident involvement in conference design and presentations.

**IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

**IV.A.5. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**IV.A.5.a) Patient Care**

**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. Residents:**

IV.A.5.a).(1) must receive training to perform those clinical procedures required for their future practices in the ambulatory and hospital environments;

IV.A.5.a).(1).(a) The residency director and family medicine faculty should develop a list of procedural competencies required for completion by all residents in the program prior to their graduation.

IV.A.5.a).(1).(b) This list must be based on the anticipated practice needs of all family medicine residents. In creating this list, the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.

IV.A.5.a).(2) must receive training that focuses on the core principles of

## Family Medicine;

### IV.A.5.a).(2).(a)

#### Continuity of Care

Continuity of care is a recognized core value of the specialty of family medicine and must be a priority in each program. Continuity may pertain to individuals or to the practice in its entirety.

### IV.A.5.a).(2).(a).(i)

Resident panels must include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings.

### IV.A.5.a).(2).(a).(ii)

Nursing home experience must consist of at least two patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation.

### IV.A.5.a).(2).(a).(iii)

Additionally, each resident must perform at least two home visits with at least one being for an older adult continuity patient. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident's level of expertise and competence.

### IV.A.5.a).(2).(a).(iv)

In order to coordinate and integrate each patient's care and to optimize each resident's continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions. In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (i.e., the inpatient team or the physician on-call for the practice). When a substitute

physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to transfer information clearly and expeditiously to the primary continuity physician.

IV.A.5.a).(2).(b)

Family-Oriented Comprehensive Care Experience;

IV.A.5.a).(2).(b).(i)

Comprehensive care is important for the welfare of the patients as they function in the family, the community, and in the health care system. Principles of comprehensive care for patients include physician availability, accessibility, efficiency, and continuity.

IV.A.5.a).(2).(b).(ii)

The family physician assumes responsibility for the total health care of the individual and family, taking into account social, behavioral, economic, cultural, and biologic dimensions. Therefore, residents must learn to demonstrate cultural competence in caring for patients from varied ethnic and cultural backgrounds.

IV.A.5.a).(2).(b).(iii)

Residents must be given the opportunity to achieve high levels of competence in health maintenance and in disease and problem management, and to develop attitudes that reflect expertise in comprehensive patient management and education.

IV.A.5.a).(2).(b).(iv)

The program must provide the opportunity for residents to acquire knowledge and experience in the provision of longitudinal health care to families, including assisting them in coping with serious illness and loss, and in promoting family mechanisms to maintain wellness of its members.

IV.A.5.a).(2).(b).(v)

Essential elements to be integrated into the teaching of family care to residents include for the individual patient: health assessment, health maintenance, preventive care, acute and chronic illness and injury, rehabilitation, behavioral counseling, health education, and human sexuality.

IV.A.5.a).(2).(b).(vi)

Essential elements to be integrated into the teaching of family care to residents include

for the family: family structure and dynamics, genetic counseling, family development, family planning, child rearing and education, aging, end of life issues, epidemiology of illness in families, the role of family in illness care, family counseling and education, nutrition, and safety.

IV.A.5.a).(2).(c)

Family Medicine Center Experience;

IV.A.5.a).(2).(c).(i)

Orientation

First-year residents must have an orientation period in the FMC to introduce the comprehensive approach to health care and to promote resident identity as a family physician. They must also have a regular patient care experience in the FMC throughout this first year.

IV.A.5.a).(2).(c).(ii)

Faculty Supervision

Whenever residents are performing clinical duties in the FMC, there must be an appropriate number of family physician faculty who, without other obligations, are engaged in active teaching and supervision of the residents. The appropriate number of faculty must be determined in relation to the level of training of the residents, the number of patients being seen in a clinic session, and the competency of the residents. In general, there should be at least one supervising family physician faculty member who is freed of all other activities for every four residents working in the clinic at any given time. If only one resident is seeing patients in the FMC, a single faculty member may be engaged in other activities to a maximum of 50%, but the teaching and supervision of the resident must take priority. Faculty time involved with medical students and other learners under the faculty's clinical supervision should not dilute the supervision of residents.

IV.A.5.a).(2).(c).(iii)

Patient Care Experience

IV.A.5.a).(2).(c).(iii).(a)

It must be the goal of the program that residents be scheduled to see their own patients (i.e., those with

whom they have developed an on-going doctor-patient relationship). The program must document the availability of a stable patient population in the FMC of sufficient number and variety to provide all residents with an adequate experience in the comprehensiveness of the specialty. It should be documented that each resident has experience with all age groups having adequate gender distribution, in volumes sufficient to achieve competency in all aspects of family medicine.

IV.A.5.a).(2).(c).(iii).(b)

Residents' FMC assignments over the course of three years of training must include progressive responsibility for increased patient visit volume and visit efficiency.

IV.A.5.a).(2).(c).(iii).(c)

The three-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year. The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these patients are seen in continuity by the residents.

IV.A.5.a).(2).(c).(iii).(d)

Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the residents' panels who are seen at home, at long-term care sites, and patients seen in an OB continuity care setting.

IV.A.5.a).(2).(c).(iii).(e)

In addition to meeting the minimum number of patient encounters noted above, the program must document that by the end of the third year, each resident has achieved the

essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice. This documentation must provide evidence of a variety of patient demographics and diseases, as well as a commitment to continuity.

IV.A.5.a).(2).(c).(iv)

#### FMC Continuity and Accessibility

IV.A.5.a).(2).(c).(iv).(a)

The learning of continuity of care requires stable, protected physician-patient relationships that are structured to enhance both resident learning and patient care. Therefore, assignment of patients to a personal physician in the FMC is required. Whenever possible, residents should see their own patients to develop the doctor-patient relationship. In addition, there should be a team structure to ensure appropriate back-up for the patients to experience continuity of care.

IV.A.5.a).(2).(c).(iv).(b)

A resident must be assigned to one FMC, preferably for all three years, but at least throughout the last two years of training.

IV.A.5.a).(2).(c).(iv).(c)

Residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training. Their other assignments must not interrupt continuity for more than eight weeks at any given time or in any one year. The periods between interruptions in continuity must be at least four weeks in length.

IV.A.5.a).(2).(c).(iv).(d)

The FMC should provide a continuity experience for the residents, and ensure continuity of care and access for the patient. The FMC staffing, scheduling system, and hours of operation must ensure FMC patients access to healthcare by their primary provider or the FMC health care team as backup if the primary

resident is unavailable. The program must document that each resident has provided continuity of care in the FMC. This may be accomplished in a number of ways, and may include monitoring the number or percentage of visits by continuity patients to their continuity physician. The practice must also ensure 24 hour accessibility to care for their patients.

IV.A.5.a).(2).(d)

#### Medical/Surgical Experiences

IV.A.5.a).(2).(d).(i)

The program should implement a plan to ensure that residents retain their identity and commitment to the principles and philosophic attitudes of family medicine throughout the training program, particularly while they rotate on other specialty services.

IV.A.5.a).(2).(d).(ii)

Residents must have on-site supervision by an appropriately-qualified member of the program's faculty when the services or procedures needed exceed the capability of the most senior supervising resident, or when qualified senior residents are unavailable for supervision of more junior residents.

IV.A.5.a).(2).(d).(iii)

While the content of a rotation is more important than the time assigned to it, it is necessary to establish guidelines for the allocation of time segments to provide an objective measure of the opportunity provided for residents to achieve the cognitive knowledge, psychomotor skills, attitudinal orientation, and practical experience required of a family physician in each of the curricular elements. Time spent in the FMC seeing continuity patients may not be included when calculating the duration of the specialty rotations for which a duration is specified. It is understood, however, that FMC time is included in the required rotations that are specified in months. A program that uses a longitudinal format instead of a block rotation must document 100 hours of structured experience in lieu of a block month.

IV.A.5.a).(2).(e)

## Inpatient Experiences

IV.A.5.a).(2).(e).(i)

The resident must develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. Inpatient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service, and must involve teaching and role-modeling by family physician faculty. Daily faculty rounds must occur to ensure appropriate supervision and teaching. Each resident must also receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. Additional experience will occur on other inpatient services.

IV.A.5.a).(2).(e).(ii)

The length, breadth, and intensity of the experience must ensure that every resident becomes competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician. Residents must demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures of medicine, appropriate consultation and discharge planning and continuing care. Residents must demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient's condition.

IV.A.5.a).(2).(e).(iii)

Residents are expected to maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. The residency must foster a team system that ensures continuity of care from the patient's perspective when the primary resident is unable to be present in both inpatient and outpatient settings. The continuity resident is expected to communicate daily with the hospital

resident, and to provide long-term continuity care after discharge.

IV.A.5.a).(2).(e).(iv)

The residency must define and monitor the most common medical problems cared for by family physicians in the hospital where inpatient experience takes place. Residents must receive ample clinical experience in caring for these problems. There must also be a didactic curriculum that covers these common medical problems. This list of common diagnoses should be generally consistent with national data that are published about family medicine. The program must document how the residents' skills are progressing from care that is dependent on supervision by faculty toward unsupervised, independent care at the time of graduation. The program must also document the residents' competency in providing supervision to others in a learning environment.

IV.A.5.a).(2).(e).(v)

Upon completion of training, residents must be competent to provide hospital care. Assessment of resident hospital practice must be included in the required semiannual resident evaluation.

IV.A.5.a).(2).(e).(vi)

By the conclusion of the residency, residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision, and to utilize appropriate consultation by other specialists. Procedural skill documentation should indicate when the resident is capable of independent performance of the procedure.

**IV.A.5.b)**

**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. Residents:**

IV.A.5.b).(1)

Adult Medicine

must receive eight months of adult medicine experience, of which six are inpatient;

- IV.A.5.b).(1).(a) Residents must have the following curricular areas in either longitudinal or block format: cardiovascular, neurologic, endocrinologic, pulmonary, gastrointestinal, rheumatologic, infectious, nephrologic, and hematologic diseases;
- IV.A.5.b).(1).(b) Residents must receive instruction and clinical experience in the prevention, counseling, detection, diagnosis and treatment of gender-specific diseases in women and men:
- IV.A.5.b).(1).(b).(i) Women's Health
- This must include structured experience in non-obstetrical, non-gynecologic care of women that deals with the study of gender differences and the diversity of women's health needs throughout the life cycle. Woman's health conditions are those that are unique or more common to women, including disorders that differ in presentation or treatment of women.
- IV.A.5.b).(1).(b).(ii) Inpatient
- While caring for adults on the inpatient service, each resident is expected to manage the care of at least five patients, on average, at any one time. Senior residents who are functioning in a supervisory role may have direct responsibility for a smaller number of patients.
- IV.A.5.b).(1).(b).(iii) Intensive Care
- All residents must be taught skills in the care of critically ill patients. The program must document that during the three years of training, each resident has managed a substantial portion of the care for at least 15 critically ill patients.
- IV.A.5.b).(1).(b).(iv) The Older Patient
- Educational experiences must be in both common and complex clinical problems of older patients.
- IV.A.5.b).(1).(b).(iv).(a) The training must include the appropriate preventive modalities,

functional assessment, the physiologic and psychologic aspects of senescence, as well as the socio-cultural parameters of the patients and their greater community. The residents must have supervised clinical experiences dealing with common acute and chronic diseases of aging. The resident must learn about, and practically apply, a multidisciplinary approach to the care of older patients in the hospital, the FMC, the long-term care facility, and the home.

IV.A.5.b).(1).(b).(iv).(b)

This experience must result in the competence of residents in preventive healthcare, promotion of independent living, and maximizing function and quality of life. Residents must develop competency in assessing and meeting the healthcare needs of declining elders, episodic, illness-related care, delivery of healthcare in the home, FMC, hospital, and long-term facility, and end-of-life care.

IV.A.5.b).(2)

Care of Neonates, Infants, Children, and Adolescents

must complete four months of structured experience in the care of infants, children and adolescents.

IV.A.5.b).(2).(a)

The time must include experience in the following areas: neonates, infant care (both well-baby and ill), hospitalized children, ambulatory pediatrics, emergency care of children and adolescent medicine. This may include experience gained on the Family Medicine Inpatient Service, in the emergency department, in the pediatric hospital and clinic, and experience in nursery care associated with OB experience, provided that appropriate documentation of such experience is maintained for each resident.

IV.A.5.b).(2).(b)

This experience must involve teaching and role modeling by family medicine faculty in the care of newborns and sick children. Residents and faculty must provide continuity of responsibility for hospitalized infants and children from their Family Medicine Center patient panel.

IV.A.5.b).(3)

Maternity Care

must receive a minimum of two months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care;

IV.A.5.b).(3).(a)

Each resident must become capable of managing a normal pregnancy and delivery. Residents must be provided instruction in the biological and psychosocial impacts on a woman and her family of pregnancy, delivery, and care of the newborn. All programs must demonstrate that each resident acquires competency in the common problems of prenatal and postnatal care.

IV.A.5.b).(3).(b)

Each resident must be trained in the recognition and initial management of the high-risk prenatal patient, including consultation and referral. Additionally, the resident must be taught to recognize and manage complications and emergencies in pregnancy, labor, and delivery. Residents also must receive training in genetic counseling. When appropriate for the resident's future practice and patient care, the resident must be trained in the management of the high-risk prenatal patient.

IV.A.5.b).(3).(c)

Each resident must perform a minimum of 40 deliveries over the three-year program, of which a minimum of ten must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. Two residents may be given credit for the same delivery if one of those residents is supervising. The experience of each resident must be documented as to the role played in the delivery.

IV.A.5.b).(3).(d)

For the minimum of ten continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care during their three years of training. Whenever possible, these patients should be derived from the residents' panels of patients in the FMC. Where this is not possible, the continuity experiences may be met at other clinical sites with appropriate supervision. A list of these patients must be available in the resident's file.

IV.A.5.b).(3).(e)

The program must have at least one family physician faculty who is engaged in providing these

services and who can participate in supervising the residents and serving as a role model for them. Supervision of labor and delivery care must be immediately available. For deliveries, and for labor when risk factors are present, there must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician, a senior resident in an ACGME obstetrics residency, a certified nurse midwife, or a third year family medicine resident who has had sufficient delivery experience. If supervision is provided by anyone other than a faculty member, it must be documented that this supervisor has had sufficient maternity care experience to function competently in this capacity, and this documentation should include the criteria used to make this determination. When the supervisor of the resident is reliant on others for c-section or emergency procedures outside the scope of his or her practice, procedures for emergency consultative relationships and back-up must be documented. Specific details must be available on the service at all times. In judging the adequacy of the supervision provided by a resident, the program director must consider the year of training and previous obstetrical experience, and documented competency of the supervising resident. When a resident provides the direct supervision, there must be on-site physician faculty supervision immediately available in the hospital.

IV.A.5.b).(3).(f)

The program must make available additional training in maternity care as an elective within the 36-month curriculum. This elective experience must include high-risk maternity care, including the opportunity for residents to develop technical proficiency in appropriate operative procedures that may form a part of their future practice. Programs should provide training in ALSO, or similar advanced obstetrical training, for those residents interested in providing maternity care in their future practices.

IV.A.5.b).(4)

Gynecology

must receive one month of structured curriculum in gynecology;

IV.A.5.b).(4).(a)

All residents must be trained to competency in normal gynecological examinations, gynecological cancer screening, preventive health care in women, common STD's and infections, reproductive and

hormonal physiology including fertility, family planning, contraception, options counseling for unintended pregnancy, pelvic floor dysfunction, and disorders of menstruation, perimenopause, and postmenopause, including osteoporosis. In addition, the program should provide adequate instruction and clinical experience in issues of sexual health, management of breast disorders, management of cervical disease. Residents should become competent in the performance of appropriate procedures.

IV.A.5.b).(4).(b)

This structured experience must be in addition to the routine gynecologic care of continuity patients in the FMC and the gynecological experience gained during family medicine call.

IV.A.5.b).(4).(c)

Special sessions dedicated to gynecological care may be arranged in the FMC, provided that the residency can document that these sessions are used for gynecology care above and beyond the routine care provided by the continuity physicians.

IV.A.5.b).(5)

#### Care of the Surgical Patient

must receive instruction with special emphasis on the diagnosis and management of surgical disorders and emergencies and the appropriate and timely referral of surgical cases for specialized care;

IV.A.5.b).(5).(a)

Residents must be taught to appreciate the varieties of surgical treatments and the potential risks associated with them to enable them to give proper advice, explanation, and emotional support to patients and their families. The residents should also be taught to recognize conditions that are preferably managed on an elective basis.

IV.A.5.b).(5).(b)

The program must provide all residents with training in preoperative and postoperative care, basic surgical principles, asepsis, handling of tissue, and technical skills to assist the surgeon in the operating room. The residents should develop technical proficiency in those specific surgical procedures that family physicians may be called on to perform.

IV.A.5.b).(5).(c)

Residents must be required to participate in a structured experience in general surgery of at least two months, including ambulatory care (non-inpatient care: e.g., surgical centers, emergency

room and physician offices), operating room experience, and post-operative experience.

IV.A.5.b).(5).(c).(i)

Experiences in general surgery must be designed to provide opportunity for residents to achieve competency in the diagnosis and management of a wide variety of common surgical problems typically cared for by family physicians. Experiences are usually expected to be with general surgeons. If non-generalist surgeons are used for this experience, the program director must explain how this experience exposes residents to common surgical problems.

IV.A.5.b).(5).(c).(ii)

If surgical experience occurs in conjunction with a family medicine or internal medicine service, the program must document how each resident meets the required surgical experience.

IV.A.5.b).(5).(d)

Surgical Subspecialties: In addition to the general surgery experience, residents must have adequately structured, hands-on educational experiences in the following subspecialty areas: otorhinolaryngology, to include oral health, urology, and ophthalmology. This must be in addition to resident experience with continuity patients during routine care in FMC and must involve disorders that are commonly seen in a family physician's office.

IV.A.5.b).(6)

#### Musculoskeletal and Sports Medicine

must have two months experience in the care of patients with orthopedic and musculoskeletal problems, including experience in sports medicine.

IV.A.5.b).(6).(a)

The curriculum should include non-articular rheumatic disorders, infectious, suppurative and degenerative arthritic conditions, acquired and congenital abnormalities of bones and joints, musculoskeletal and connective tissue disorders, evaluation and management of common sprains, fractures and dislocations, preventive care, rehabilitation and restorative function. Clinical experience should include acute evaluation of musculoskeletal trauma and acute pain syndromes.

IV.A.5.b).(6).(b)

Sports medicine must be a clear and separate curriculum within the two-month/200 hours of

experience and must include non-orthopedic aspects of sports medicine with emphasis on care of athletes of all ages, both genders, and persons active or anticipating exercise activities. The care of the athlete includes performance of pre-participation sports physicals, assessment of common injuries, knowledge of treatment and rehabilitation. Both curricula must include performance of procedures common in the evaluation and care of orthopedic and sports medicine patients and participation in the rehabilitation required for these patients. These include interpretation of radiographs, aspiration and injection of joints, splinting and casting.

IV.A.5.b).(7)

#### Emergency Care

must have a structured educational experience that trains them to deliver emergency care that includes didactic teaching, skills training, and clinical experience in caring for patients of all ages with acute illnesses and injuries in an emergency care setting.

IV.A.5.b).(7).(a)

Residents should receive structured skills training in all standard current life support skills (e.g. ACLS and PALS), and should learn procedures for both trauma and medical emergencies in patients of all ages.

IV.A.5.b).(7).(b)

This clinical experience should encompass 200 hours of emergency medicine training.

IV.A.5.b).(7).(c)

The setting used for this training must offer the full spectrum of emergency services, and on-site faculty supervision must be available at all times. Suitable facilities and adequate support personnel must be present for resident training. The patients seen by family medicine residents should be representative of the patient population served by the emergency care facility overall.

IV.A.5.b).(8)

#### Human Behavior and Mental Health

should acquire knowledge and skills in this area through a program in which behavioral science and psychiatry are integrated with all disciplines throughout the residents' total educational experience.

IV.A.5.b).(8).(a)

Training should be accomplished primarily in an outpatient setting through a combination of longitudinal experiences and didactic sessions.

Intensive short-term experiences in facilities devoted to the care of chronically ill patients should be limited.

IV.A.5.b).(8).(b)

There must be faculty who are specifically designated for this curricular component who have the training and experience necessary to apply modern behavioral and psychiatric principles to the care of the undifferentiated patient. Family physicians, psychiatrists, and behavioral scientists should be involved in teaching this curricular component.

IV.A.5.b).(8).(c)

There must be instruction and development of skills in the diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, the physician/patient relationship, patient interviewing skills, and counseling skills. This should include videotaping of resident/patient encounters or direct faculty observation for assessment of each resident's competency in interpersonal skills. This will require sufficient faculty who participate on an on-going basis in the program, and in the FMC, in particular.

IV.A.5.b).(9)

#### Community Medicine

must receive a structured curriculum in community medicine, including didactic and some experiential components. The curriculum should include:

IV.A.5.b).(9).(a)

assessment of risks for abuse, neglect, and family and community violence;

IV.A.5.b).(9).(b)

reportable communicable disease;

IV.A.5.b).(9).(c)

population epidemiology, and the interpretation of public health statistical information;

IV.A.5.b).(9).(d)

environmental illness and injury;

IV.A.5.b).(9).(e)

school health;

IV.A.5.b).(9).(f)

disease prevention through immunization strategies;

IV.A.5.b).(9).(g)

disaster responsiveness;

IV.A.5.b).(9).(h)

community-based disease screening, prevention,

health promotion; and,

- IV.A.5.b).(9).(i) factors associated with differential health status among sub-populations, including racial, geographic, or socioeconomic health disparities, and the role of family physicians in reducing such gaps.

The program should also require that each resident participate in clinical experiences in community medicine including:

- IV.A.5.b).(9).(j) experience in using community resources appropriately for individual patients who have unmet medical or social support needs;
- IV.A.5.b).(9).(k) structured interaction with the public health system;
- IV.A.5.b).(9).(l) occupational medicine including disability determination, employee health and job-related illness and injury;
- IV.A.5.b).(9).(m) experience in community health assessment;
- IV.A.5.b).(9).(n) experience in developing programs to address community health priorities; and,
- IV.A.5.b).(9).(o) community-based health education of children and adults.

IV.A.5.b).(10) Care of the Skin

must be exposed to diagnosis and management of common dermatologic conditions;

- IV.A.5.b).(10).(a) These must include, but not be limited to, viral, bacterial, allergic and fungal infections, ulcers, rashes, malignant and pre-malignant skin lesions, and dermatologic manifestations of system disease. This training should include experience in the surgical excision of skin lesions and performance of other dermatologic procedures with supervision by a physician with documented competence in this area. This may include experience gained in the FMC, provided that appropriate documentation is maintained for each resident.

IV.A.5.b).(11) Diagnostic Imaging and Nuclear Medicine

must receive a structured opportunity to learn the

appropriate application of techniques and specialty consultations in the diagnostic imaging and nuclear medicine therapy of organs and body systems. Instruction should include the limitations and risks attendant to these techniques.

IV.A.5.b).(11).(a)

The format of the instruction should be adapted to the resources available, but must include radiographic film/diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.

IV.A.5.b).(12)

#### Management of Health Systems

must receive at least 100 hours of management and leadership instruction to include both the didactic and the practical settings.

IV.A.5.b).(12).(a)

This curriculum should prepare residents to assume leadership roles in their practices, their communities, and the profession of medicine. The residency must have specific strategies to demonstrate that residents have mastered these skills.

IV.A.5.b).(12).(b)

The FMC must be considered the primary site for teaching management and leadership skills, and should serve as an example on which residents may model their future practices.

IV.A.5.b).(12).(c)

Each resident must receive reports of individual and practice productivity, financial performance, patient satisfaction and clinical quality, at least quarterly, as well as the training needed to analyze these reports. Residents must attend regular monthly FMC business meetings with staff and faculty to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality.

IV.A.5.b).(12).(d)

They must participate in projects to improve the quality of care and service delivered to the FMC patient population.

IV.A.5.b).(12).(e)

The management curriculum should include current billing practices, designing and managing a budget, assessing practice staffing needs, the impact of new technologies on practice, determining value in the marketplace, assessing customer satisfaction, measurement of clinical quality, tort liability and risk management, office scheduling systems,

computers in practice, alternative practice models, and employment law and procedures. Residents should also learn principles of public relations, media training, and personnel management.

IV.A.5.b).(12).(f)

The leadership curriculum should include training to provide leadership for a clinical practice, a hospital medical staff, professional organizations, and community leadership skills to advocate for the public health.

IV.A.5.b).(13)

Electives

must have a minimum of three and a maximum of six months of appropriately supervised electives. Electives are intended primarily to enrich the residents' training with experiences relevant to their plans for future practice or their interests as family physicians. The choice of electives by the resident, including those for remedial purposes, must be made with the approval of the program director.

**IV.A.5.c)**

**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 life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

**IV.A.5.c).(1)**

**identify strengths, deficiencies, and limits in one's knowledge and expertise;**

**IV.A.5.c).(2)**

**set learning and improvement goals;**

**IV.A.5.c).(3)**

**identify and perform appropriate learning activities;**

**IV.A.5.c).(4)**

**systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**

**IV.A.5.c).(5)**

**incorporate formative evaluation feedback into daily practice;**

**IV.A.5.c).(6)**

**locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**

**IV.A.5.c).(7)**

**use information technology to optimize learning; and,**

**IV.A.5.c).(8)**

**participate in the education of patients, families,**

students, residents and other health professionals.

**IV.A.5.d) 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. Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.

**IV.A.5.e) Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- IV.A.5.e).(1) compassion, integrity, and respect for others;
- IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;
- IV.A.5.e).(3) respect for patient privacy and autonomy;
- IV.A.5.e).(4) accountability to patients, society and the profession; and,
- IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

**IV.A.5.f) Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other

**resources in the system to provide optimal health care. Residents are expected to:**

- IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;**
- IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;**
- IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.**
- IV.A.5.f).(7) be taught to develop the skills necessary for career-long professional learning sufficient to maintain certification in the specialty. These should include:
  - IV.A.5.f).(7).(a) knowledge sufficient to pass the ABFM certification exam;
  - IV.A.5.f).(7).(b) ability to collect a complete initial data base and examination;
  - IV.A.5.f).(7).(c) ability to define and expand the differential diagnoses list;
  - IV.A.5.f).(7).(d) identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities;
  - IV.A.5.f).(7).(e) ability to educate the patient and family about the diagnoses, evaluation and treatment of the disease, to obtain informed consent, and perform appropriate procedures;
  - IV.A.5.f).(7).(f) ability to practice in a team and with a systems-based approach;
  - IV.A.5.f).(7).(g) ability to present data to other members of the team and consultants;

- IV.A.5.f).(7).(h) cost-conscious ordering of diagnostic tests and therapeutics;
- IV.A.5.f).(7).(i) construction of a medical record summary with accuracy and in compliance with expected format and in compliance with the hospital's medical records policies;
- IV.A.5.f).(7).(j) formulate short and long term goals; and,
- IV.A.5.f).(7).(k) the providing of guidance to patients regarding advanced directives, end-of-life issues and unexpected diagnoses/outcomes.

#### **IV.B. Residents' Scholarly Activities**

**IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**

**IV.B.2. Residents should participate in scholarly activity.**

IV.B.2.a) Each program must provide supervised experiences for all residents in scholarly activities such as research, presentations at national, regional, state, or local professional meetings, or presentation and/or publication of review articles and case presentations. Formal instruction and practical experience must ensure that each resident develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care.

IV.B.2.b) The program must provide a supervised, ongoing forum in which residents explore and analyze emerging scientific evidence pertinent to the practice of family medicine.

IV.B.2.c) Additionally, all residents must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

IV.B.2.d) Residents must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

**IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

## **V Evaluation**

### **V.A. Resident Evaluation**

#### **V.A.1. Formative Evaluation**

**V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

**V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,**

**V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.**

**V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

**V.A.1.d) The residency must document the inpatient clinical experiences of the residents and show how this prepares them to care for the patients in their community as defined by the program's written goals. This information should include the patient diagnoses seen and the procedures performed.**

#### **V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

**V.A.2.a) document the resident's performance during the final period of education, and**

**V.A.2.b) verify that the resident has demonstrated sufficient**

**competence to enter practice without direct supervision.**

**V.B. Faculty Evaluation**

**V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**

**V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

**V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.**

**V.B.4. This on-going faculty assessment/evaluation system should facilitate faculty development. Additionally, the program should use resident evaluations of the faculty to help determine their areas of special interest and appropriate teaching.**

**V.C. Program Evaluation and Improvement**

**V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

**V.C.1.a) resident performance;**

**V.C.1.b) faculty development;**

**V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**

**V.C.1.c).(1)** Each program must maintain a system of evaluation of its graduates. The residency should obtain feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, ideas for new areas of curriculum, and identification of which procedures are done in practice. The suggested format is a written survey after one year and every five years thereafter.

**V.C.1.c).(2)** The data from the evaluation of the graduates should be used as part of the program's determination of the degree to which the program's stated goals are being met.

**V.C.1.d) program quality. Specifically:**

**V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**



**VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

**VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;

**VI.A.5.b)** provision of patient- and family-centered care;

**VI.A.5.c)** assurance of their fitness for duty;

**VI.A.5.d)** management of their time before, during, and after clinical assignments;

**VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;

**VI.A.5.f)** attention to lifelong learning;

**VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,

**VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

**VI.A.6.** All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize 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.

**VI.B.** Transitions of Care

**VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care.

**VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

**VI.B.3.** Programs must ensure that residents are competent in communicating with team members in the hand-over process.

**VI.B.4.** The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

**VI.C.** Alertness Management/Fatigue Mitigation

- VI.C.1. The program must:**
- VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**
  - VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**
  - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**
- VI.D. Supervision of Residents**
- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**
    - VI.D.1.a) This information should be available to residents, faculty members, and patients.**
    - VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.**
  - VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.**

**Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.**
  - VI.D.3. Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.**
- VI.D.3.b) **Indirect Supervision:**
  - VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
  - VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. **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.**
  - VI.D.4.a) **The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
  - VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
  - VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of 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.**
- VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
  - VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

**VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

**VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

**VI.E. Clinical Responsibilities**

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident.

**VI.F. Teamwork**

Residents must care for patients in an environment that maximizes effective 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.

**VI.G. Resident Duty Hours**

**VI.G.1. Maximum Hours of Work per Week**

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

**VI.G.1.a) Duty Hour Exceptions**

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

**VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

**VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

**VI.G.2. Moonlighting**

**VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

**VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.**

**VI.G.2.c) PGY-1 residents are not permitted to moonlight.**

**VI.G.3. Mandatory Time Free of Duty**

**Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.**

**VI.G.4. Maximum Duty Period Length**

**VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.**

**VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**

**VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**

**VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

**VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**

**VI.G.4.b).(3).(a)** Under those circumstances, the resident must:

**VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

**VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

**VI.G.4.b).(3).(b)** The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**VI.G.5. Minimum Time Off between Scheduled Duty Periods**

**VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

**VI.G.5.b)** Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

PGY-2 residents are considered to be at the intermediate-level.

**VI.G.5.c)** Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

PGY-3 residents are considered to be in the final years of education.

**VI.G.5.c).(1)** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

**VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

**VI.G.5.c).(1).(b)** The Review Committee defines such

circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

**VI.G.6. Maximum Frequency of In-House Night Float**

**Residents must not be scheduled for more than six consecutive nights of night float.**

VI.G.6.a) Night float experiences must not exceed 50 percent of a resident's inpatient experiences.

**VI.G.7. Maximum In-House On-Call Frequency**

**PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**

**VI.G.8. At-Home Call**

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

**VII. Innovative Projects**

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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