CLER : Emerging Project Plan

- **Design and implement pilot site visit activities** (alpha testing)
  - Conduct focus groups and key interviews
  - Develop and refine prototype site visit protocol
  - Test site visit protocol

    (alpha testing: summer 2012, beta testing to start Sept 2012)
  - Develop and refine operations manual
  - Pilot site visit reporting tools

    (surveyor questions and report templates)

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Clinical Learning Environment Review (CLER) Program

- **First full cycle of visits (beta testing)**
  - Targeted to begin September 2012
  - Used solely for feedback, learning, and establishment of baseline information for sponsoring institutions, the Evaluation Committee, and IRC
    - Exception(s): identification of potential egregious violations involving threats to patient safety or resident safety/well being
  - Planned to result in CLER Committee's development and dissemination of salutary practices

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CLER Site Visit

- Very little advance preparation required
- Optional request to DIO to provide copies of existing documents one week prior to visit:
  - Relevant organizational charts, select committee rosters
  - Site's organizational strategies for patient safety and healthcare quality
  - SI/participating site's policies on supervision, transitions in care, duty hours

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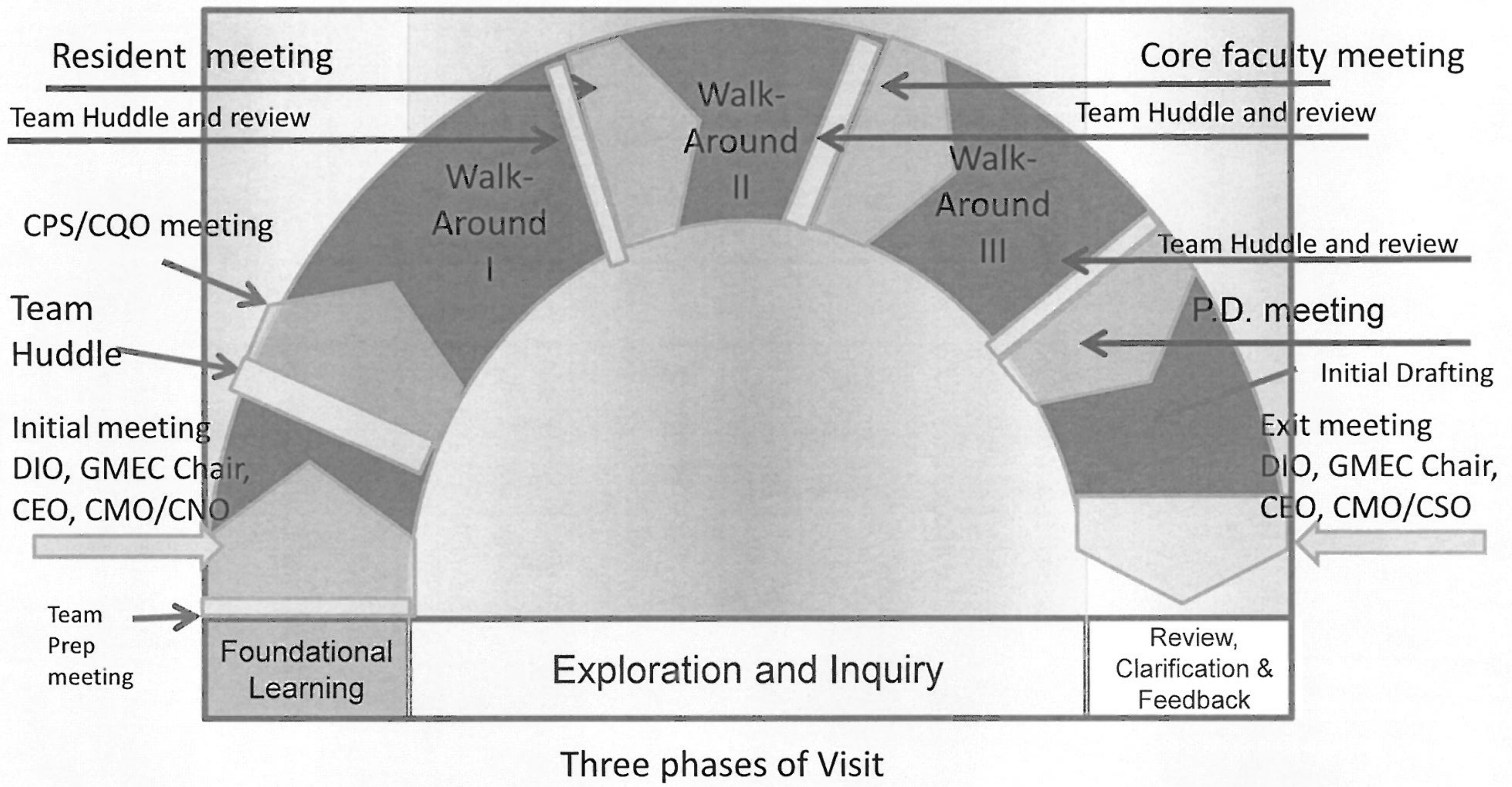
SCHEMATIC OF FLOW OF CLER SITE VISIT
Resident meeting
Team Huddle and review
CPS/CQO meeting
Team Huddle
Initial meeting DIO, GMEC Chair, CEO, CMO/CNO
Team Prep meeting
Walk-Around I
Walk-Around II
Walk-Around III
Core faculty meeting
Team Huddle and review
Team Huddle and review
P.D. meeting
Initial Drafting
Exit meeting DIO, GMEC Chair, CEO, CMO/CSO
Foundational Learning
Exploration and Inquiry
Review, Clarification & Feedback
Three phases of Visit
Note: each walk around with resident host/escort, opportunity for nursing staff and patient contact (future). Also as yet not certain on role of a governance interview.

Clinical Learning Environment Review (CLER) Program

- CLER Site Visit Program
- CLER Evaluation Committee
- Support of Faculty Development related to CLER

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CLER Evaluation Committee

- Board approved majority of initial committee members in June 2012
- Committee includes national expertise in GME and the six focus areas
- Currently seeking several additional members (targeted for completion by end of 2012)
- Committee to begin meeting Oct 2012

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CLER Evaluation Committee

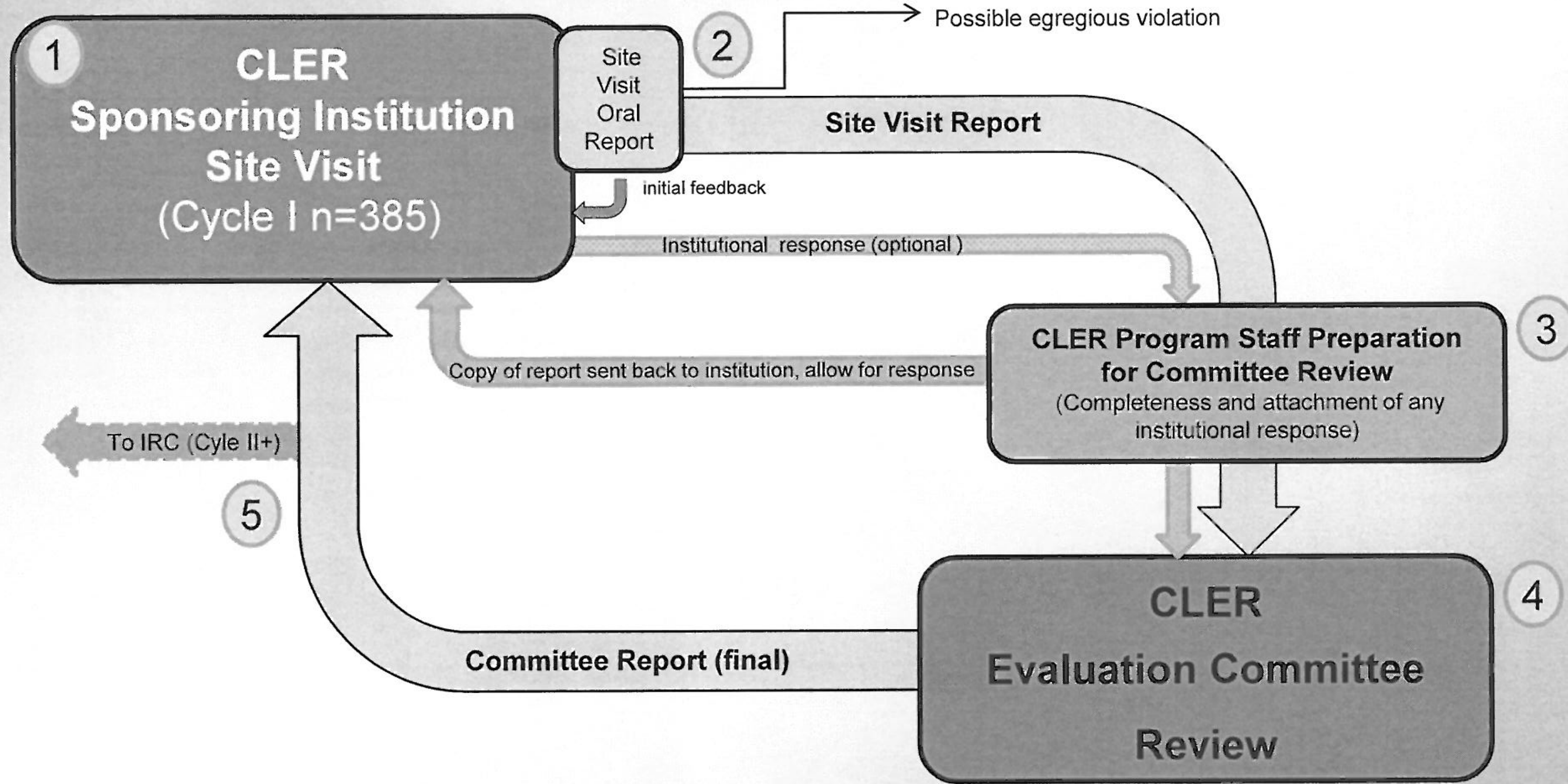
Co-Chairs:

James Bagian, MD

Kevin Weiss, MD

Members: (partial listing as of 10/1/12)

Saurabha Bhatnagar, MD
William Barron, MD
Terry Cline, PhD
John Duval, MBA
Rosemary Gibson, MSc
Diane Hartmann, MD
Linda Headrick, MD
Marcia Hutchinson, MD
Jason Intri, MD
Douglas Paull, MD
Russell Postier, MD
Andrew Thomas, MD


Proposed CLER Evaluation Process*
1
CLER
Sponsoring Institution
Site Visit
(Cycle I n=385)
Site
Visit
Oral
Report
2
Possible egregious violation
Site Visit Report
initial feedback
Institutional response (optional)
3
CLER Program Staff Preparation
for Committee Review
(Completeness and attachment of any
institutional response)
Copy of report sent back to institution, allow for response
To IRC (Cyle II+)
5
4
CLER
Evaluation Committee
Review
Committee Report (final)
* To be reviewed by CLER Committee
Clear Process Map Ver 2.0, 3.27.2012

CLER Evaluation

- Evaluation based on expectations not requirements
- Likely to develop a series of expectations that are classified in order of increasing GME/institutional integration
- Expectations to be set by CLER Evaluation Committee

Example of possible template for categorizing CLER expectations

- ***Basic***
  - All residents/fellows must have the opportunity to report errors, unsafe conditions, and near misses
  - All residents/fellows must have the opportunity to participate in inter-professional quality improvement or root cause analysis teams
- ***Advanced***
  - Institutionally approved patient safety goals derived from National/Regional recommendations defined and communicated across the residents and faculty
  - Residents and core faculty on institutional safety/quality committees
  - Comprehensive involvement across multiple programs
  - Occasional sporadic involvement of faculty and residents in patient safety activities (resident, faculty meeting, and walk around)
- ***Role Model:***
  - All the above, and faculty and resident leadership in Patient Safety activities (ascertainment from senior leadership meeting with verification)
  - All residents/fellows having experiences in safety related activities
  - Direct Engagement of CEO/Exec Leadership Team with residents over Patient Safety Issues
  - Participate in broad dissemination of output in PS from Core Faculty and Residents

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Clinical Learning Environment Review (CLER) Program

- CLER Site Visit Program
- CLER Evaluation Committee
- Support of Faculty Development related to CLER

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Faculty Development

- ACGME in a convening role
- Exploring and encouraging alignments and collaborations among national efforts:
  - AAMC, AHME, AIAMC, IHI, AHA, ACPE, ACMQ, OPDA and others
- Addressing inter-professional education across the UME/GME continuum
  - Includes development of educational initiatives aimed at executive leadership

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CLER Early Development Lessons Learned (alpha phase)

- General insights
- From perspective of Sponsoring Institution
- From perspective of CLER Program/ACGME
- Some of the real-time challenges ahead

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CLER Lessons Learned (alpha testing phase)

WA OR CA NV ID MT WY UT AZ CO NM ND SD NE KS OK TX MN IA MO AR LA WI IL MI IN OH KY TN MS AL GA FL SC NC VA WV MD DE PA NJ NY CT RI MA VT NH ME AK HI

CLER Lessons Learned (alpha testing phase)

- Alpha testing served as successful proof of concept
- Early experience well received
- Easily distinguished from an accreditation site visit
- Joint meetings of GME and hospital executive team is largely a new experience

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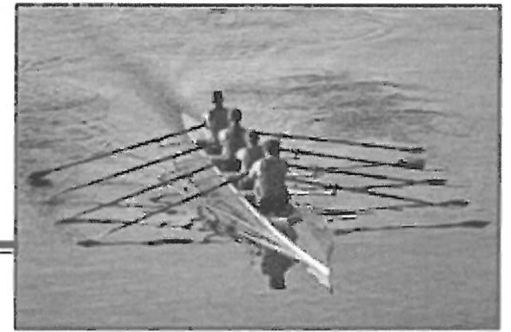
CLER Lessons Learned

(alpha testing phase)



- From the perspective of the SI
  - Very different interaction with ACGME
  - Short notice challenge but doable and important
  - Very positive feedback on site visit protocol (meetings and 'walk arounds')....still with volunteer SIs
  - Positive feedback at exit meeting -- critical need for presence of hospital executive leadership (CEO)
  - No 'gotcha's, a number of "aha's" and affirmation
  - Some informal unsolicited positive feedback from both CEO/Exec and residents

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CLER Lessons Learned (alpha testing phase)

- From the perspective of CLER/ACGME
  - Very workable protocol (long days)
  - Rapid learning at each site visit
  - Importance of balance of meetings (with ARS) and walk-arounds
  - Believe we are getting good insights to institutional environments
  - Gaining baseline information to gage impact
  - Need experienced physicians to lead these site visits

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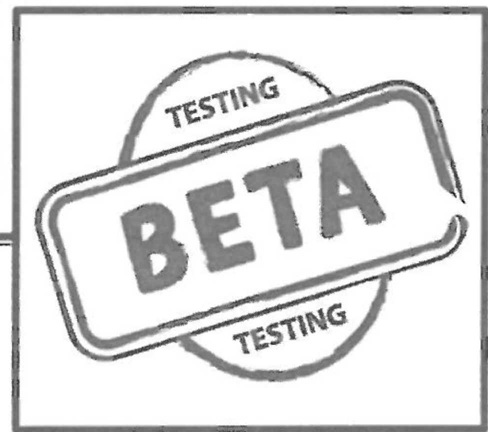
Some of the practical issues for Sponsoring Institutions

- Background documents
  - Hospital/Med Center v. System v. SI
- Short notice scheduling
  - CEO and other senior leadership of participating site
  - Peer-selected residents/fellows (broad range of core programs and larger fellowships)
- Meeting rooms
  - Multiple meetings of up to 35 persons
  - Screen or clean wall for projection
- Walk arounds
  - HIPAA/BAA agreements
  - ID badges

ACGME

CLER: Next Beta Testing



- Started September 2012 will continue through 380+ SI's.
- Final shaping of protocol
  - Refining questions, "walk around" protocols
  - Possible patient and perhaps governance interactions
- Scaling
- Evaluation/quality control

ACGME

Longer Term Challenges

- Sampling Multiple Participating Sites per SI
- Visits to Single Program Sponsoring Institutions
- Visits to special/unique participating sites
  VA, specialty-care sponsoring institutions

ACGME

Clinical Learning Environment Review (CLER) Program

For questions, please contact:

Kevin Weiss, MD
Senior Vice President, Institutional Review
kweiss@acgme.org

Robin Wagner, RN, MHSA
Vice President, CLER
rwagner@acgme.org

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ANNUAL PROGRAM EVALUATION

Academic Year ending June 30, 20_____

Program:

	Name	e-mail address	Phone number
Program Director			
Program Coordinator			
Division/Department Chair			

Trainees:

Training Year	1	2	3	4	5	6	7
ACGME Approved number:							
Actual number of trainees:							

Other learners:	Total Number this Academic Year	Maximum Number at any time
Residents from other programs		
Medical Students		
Subspecialty Fellows		

Do you have	Yes	No
A written supervision policy for each activity and level of training?		
A written trainee selection policy?		
Documentation of prior training for each trainee?		

If no, please explain:

PROGRAM CHANGES

Describe any changes that have occurred to the program during the past year.

RESIDENT/FELLOW PERFORMANCE

Documented Evaluations
used: check all that apply

Faculty	Peers
Nursing	Medical Students
Social Worker	Residents from Outside Program
Patient	Fellows
Self	Other(specify)
Other(specify)	Other(specify)

Other Evaluation Methods Used: Yes or No

In-Service Exam	Portfolio
Formal Oral Exam	Record Review
OSCE	Patient Survey
Simulation/Models	Case Logs
Patient Safety Data	Evaluation of Presentations
Other(specify)	Other(specify)

For the most recent year:

Number of Trainee Presentations at Regional or National Meetings

Number of Accepted Publications by Trainees

FACULTY DEVELOPMENT ACTIVITIES

Describe your faculty development activities during the past year

TRAINEE QUALITY IMPROVEMENT ACTIVITIES

Describe your trainees involvement in quality improvement activities:

GRADUATE PERFORMANCE

Does your program lead to board or certificate eligibility? Yes No

If yes, please describe results for graduates from the last 3 years:

Other indicators of graduate quality:

PROGRAM QUALITY

In addition to the above data, program quality has been assessed through:

Annual written program evaluation by trainees

Annual written program evaluation by faculty

Most recent RRC letter

Most recent Internal Review

Trainee evaluation of faculty

Trainee evaluations of rotations/clinical activities/didactic program

Resident/Fellow scholarly activity

Duty Hour compliance

ACGME Resident Survey, if done

Other(specify)

ANNUAL PROGRAM REVIEW MEETING

Date of meeting:

Names of Faculty Present at Meeting:

Name(s) of Trainee(s) Present at Meeting
(minimum of 1):

Outcome:

Planned program changes:

Identified deficiencies:

Plan for correction of identified deficiencies:

Common Program Requirements

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

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.

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. (Core)*

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. (Core)

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. (Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and

supervisory responsibilities for residents; (Detail)

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

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

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

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). (Core)

[As further specified by the Review Committee]

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. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

[As further specified by the Review Committee]

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. (Detail)

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; (Core)

II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and, (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment. (Core)

[As further specified by the Review Committee]

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. (Core)

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; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is 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. (Core)

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; (Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; (Detail)

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, (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; (Detail)

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

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. (Detail)

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; (Detail)

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; (Detail)

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; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.4.n).(2) changes in resident complement; (Detail)

II.A.4.n).(3) major changes in program structure or length of training; (Detail)

II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)

II.A.4.n).(5) responses to all proposed adverse actions; (Detail)

II.A.4.n).(6) requests for increases or any change to resident duty hours; (Detail)

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(8) requests for appeal of an adverse action; (Detail)

II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and, (Detail)

II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches. (Detail)

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: (Detail)

II.A.4.o).(1) program citations, and/or, (Detail)

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)

[As further specified by the Review Committee]

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. (Core)

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, (Core)

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

II.B.2. The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[As further specified by the Review Committee]

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

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

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

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

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; (Detail)

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

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, (Detail)

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

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

[As further specified by the Review Committee]

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. (Core)

[As further specified by the Review Committee]

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. (Core)

[As further specified by the Review Committee]

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. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

[As further specified by the Review Committee]

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific

requirements. (Core)

[As further specified by the Review Committee]

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. (Detail)

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

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. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

[As further specified by the Review Committee]

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 make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

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, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is

compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

[As further specified by the Review Committee]

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: (Outcome)

[As further specified by the Review Committee]

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. (Outcome)

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; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

[As further specified by the Review Committee]

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. (Outcome)

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; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

[As further specified by the Review Committee]

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

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. (Outcome)

[As further specified by the Review Committee]

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. (Outcome)

Residents are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

[As further specified by the Review Committee]

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. (Core)

IV.B.2. Residents should participate in scholarly activity. (Core)

[As further specified by the Review Committee]

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

[As further specified by the Review Committee]

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. (Core)

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

V.A.1.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

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

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

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

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

V.A.2. Summative Evaluation

V.A.2.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.2.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.2.b).(1) 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; (Detail)

V.A.2.b).(2) document the resident's performance during the final period of education; and, (Detail)

V.A.2.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

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

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. (Detail)

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

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. (Core)

The program must monitor and track each of the following areas:

V.C.1.a) resident performance; (Core)

V.C.1.b) faculty development; (Core)

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

V.C.1.d) program quality. (Core)

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

V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. (Core)

V.C.2.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. (Core)

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, (Core)

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations. (Core)

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.A.6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)

VI.A.6.b) provision of patient- and family-centered care; (Outcome)

VI.A.6.c) assurance of their fitness for duty; (Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)

VI.A.6.f) attention to lifelong learning; (Outcome)

VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. (Outcome)

VI.A.7. All residents and faculty members must demonstrate responsiveness to

patient needs that supersedes self-interest. They 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. (Outcome)

VI.B. Transitions of Care

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

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. (Core)

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

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. (Detail)

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; (Core)

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

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. (Detail)

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. (Core)

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. (Core)

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. (Core)

VI.D.1.a) This information should be available to residents, faculty

members, and patients. (Detail)

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care. (Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. (Core)

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. (Detail)

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: (Core)

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)

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. (Core)

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. (Core)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

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. (Core)

VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be