| Roman Numeral Requirement Number | Requirement Language | Reformatted Requirement Number | Requirement Language |
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| Int.A. | ***Definition of Graduate Medical Education***<br><br>***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.***<br><br>***Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.*** | [None] | **Definition of Graduate Medical Education**<br>***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.***<br><br>***Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.*** |
| Int.A. (Continued) | ***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.***<br><br>***Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.*** | [None] - (Continued) | ***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.***<br><br>***Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.*** |

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| Int.B. | **Definition of Specialty**<br>Family physicians are specialists in primary care for individuals of all ages. This personalized care is provided within the context of their families and communities through accessible, comprehensive, continuous, and coordinated care. Family physicians champion holistic, empathic, compassionate, equitable, culturally humble, and relationship-based care to patients across the broad spectrum of society.<br><br>Family physicians provide first contact care. They have expertise in preventive medicine, as well as in managing complexities and co-morbidities through coordinated interdisciplinary and inter-professional care. They advocate for high-quality, cost-effective, and high value care which improves health outcomes and patient satisfaction. Through knowledge of structural determinants of health, family physicians advance equity in health care for all.<br><br>Family physicians provide first contact care within the context of their patients' families and community, often caring for multigenerational members of the same family. This opportunity for contextual care gives family physicians an important perspective for understanding barriers to health. They use critical thinking skills in the service of understanding the patient illness experience to arrive at a common shared therapeutic approach.<br><br>Family physicians are skilled in behavioral health. Recognizing the interrelationship of mental and physical health, they work to address the barriers and challenges of accessing behavioral health care in our complex society. | **[None]** | **Definition of Specialty**<br>*Family physicians are specialists in primary care for individuals of all ages. This personalized care is provided within the context of their families and communities through accessible, comprehensive, continuous, and coordinated care. Family physicians champion holistic, empathic, compassionate, equitable, culturally humble, and relationship-based care to patients across the broad spectrum of society.*<br><br>*Family physicians provide first contact care. They have expertise in preventive medicine, as well as in managing complexities and co-morbidities through coordinated interdisciplinary and inter-professional care. They advocate for high-quality, cost-effective, and high value care which improves health outcomes and patient satisfaction. Through knowledge of structural determinants of health, family physicians advance equity in health care for all.*<br><br>*Family physicians provide first contact care within the context of their patients' families and community, often caring for multigenerational members of the same family. This opportunity for contextual care gives family physicians an important perspective for understanding barriers to health. They use critical thinking skills in the service of understanding the patient illness experience to arrive at a common shared therapeutic approach.*<br><br>*Family physicians are skilled in behavioral health. Recognizing the interrelationship of mental and physical health, they work to address the barriers and challenges of accessing behavioral health care in our complex society.* |

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| **Int.B. - (Continued)** | Family physicians excel at coordinated team-based care and advocate for high value care their partnership with diverse, interprofessional teams. They are superb communicators and serve as teachers to patients, colleagues, and community groups. Family physicians employ respect and compassion with colleagues, allied health professionals, patients, and patients' families. They serve as members and leaders of the multiple teams required to provide complex and coordinated care.<br><br>Family physicians are lifelong learners who engage in self-reflection to become master adaptive learners to address their professional development needs.<br><br>Family physicians advocate for social justice and ethical principles to remove barriers to equitable care for all populations. They advocate for their patients through the development and promotion of health policy by working with local organizations and partnering to promote better health within the intricacies of the health care system.<br><br>Family physicians critically analyze and appropriately apply in-person and remote technology to enhance personalized patient care. | **[None] - (Continued)** | *Family physicians excel at coordinated team-based care and advocate for high value care their partnership with diverse, interprofessional teams. They are superb communicators and serve as teachers to patients, colleagues, and community groups. Family physicians employ respect and compassion with colleagues, allied health professionals, patients, and patients' families. They serve as members and leaders of the multiple teams required to provide complex and coordinated care.*<br><br>*Family physicians are lifelong learners who engage in self-reflection to become master adaptive learners to address their professional development needs.*<br><br>*Family physicians advocate for social justice and ethical principles to remove barriers to equitable care for all populations. They advocate for their patients through the development and promotion of health policy by working with local organizations and partnering to promote better health within the intricacies of the health care system.*<br><br>*Family physicians critically analyze and appropriately apply in-person and remote technology to enhance personalized patient care.* |
| **Int.C.** | **Length of Educational Program**<br>The educational program in family medicine must be 36 months in length. (Core) | **4.1.** | **Length of Educational Program**<br>The educational program in family medicine must be 36 months in length. (Core) |
| **I.** | **Oversight** | **Section 1** | **Section 1: Oversight** |
| **I.A.** | **Sponsoring Institution**<br><br>***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.***<br><br>***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.*** | **[None]** | **Sponsoring Institution**<br>***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.***<br><br>***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.*** |
| **I.A.1.** | **The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)** | **1.1.** | **The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)** |
| **I.B.** | **Participating Sites**<br><br>***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.*** | **[None]** | **Participating Sites**<br>***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.*** |
| **I.B.1.** | **The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)** | **1.2.** | **The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)** |
| I.B.1.a) | Since family medicine programs are dependent in part on other specialties for the education of residents, the ability and commitment of the institution to fulfill these requirements must be documented. (Core) | 1.2.a. | Since family medicine programs are dependent in part on other specialties for the education of residents, the ability and commitment of the institution to fulfill these requirements must be documented. (Core) |

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| **I.B.2.** | **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)** | **1.3.** | **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)** |
| **I.B.2.a)** | **The PLA must:** | **[None]** | |
| **I.B.2.a).(1)** | **be renewed at least every 10 years; and, (Core)** | **1.3.a.** | **The PLA must be renewed at least every 10 years. (Core)** |
| **I.B.2.a).(2)** | **be approved by the designated institutional official (DIO). (Core)** | **1.3.b.** | **The PLA must be approved by the designated institutional official (DIO). (Core)** |
| **I.B.3.** | **The program must monitor the clinical learning and working environment at all participating sites. (Core)** | **1.4.** | **The program must monitor the clinical learning and working environment at all participating sites. (Core)** |
| **I.B.3.a)** | **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)** | **1.5.** | **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)** |
| **I.B.4.** | **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)** | **1.6.** | **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)** |
| I.B.5. | Participating sites should not require excessive travel without appropriate housing provisions, and when daily commuting is required, no more than one hour of travel time each way should be expected. (Detail) | 1.6.a. | Participating sites should not require excessive travel without appropriate housing provisions, and when daily commuting is required, no more than one hour of travel time each way should be expected. (Detail) |
| **I.C.** | **Workforce Recruitment and Retention**<br>**The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)** | **1.7.** | **Workforce Recruitment and Retention**<br>**The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)** |
| **I.D.** | **Resources** | **1.8.** | **Resources**<br>**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)** |
| **I.D.1.** | **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)** | **1.8.** | **Resources**<br>**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)** |
| I.D.1.a) | If multiple FMPs are used for resident education, each must meet the criteria for the primary practice and be approved by the Review Committee prior to use. (Core) | 1.8.a. | If multiple FMPs are used for resident education, each must meet the criteria for the primary practice and be approved by the Review Committee prior to use. (Core) |
| I.D.1.b) | Each FMP must have a mission statement describing dedication to education and the care of patients within the practice as it relates to the greater community and the community served by the residency program. (Core) | 1.8.b. | Each FMP must have a mission statement describing dedication to education and the care of patients within the practice as it relates to the greater community and the community served by the residency program. (Core) |
| I.D.1.c) | The FMP site must support continuous, comprehensive, convenient, accessible, and coordinated care that serves the community. (Core) | 1.8.c. | The FMP site must support continuous, comprehensive, convenient, accessible, and coordinated care that serves the community. (Core) |
| I.D.1.c).(1) | Each FMP must organize patients into panels that link each patient to an identifiable resident and team. (Core) | 1.8.c.1. | Each FMP must organize patients into panels that link each patient to an identifiable resident and team. (Core) |

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| I.D.1.d) | Each FMP site must provide proximate space for residents' clinical work while caring for patients. (Core) | 1.8.d. | Each FMP site must provide proximate space for residents' clinical work while caring for patients. (Core) |
| I.D.1.e) | Each FMP site should have proximate access to space for team-based care, meetings, group visits, or small group counseling. (Detail) | 1.8.e. | Each FMP site should have proximate access to space for team-based care, meetings, group visits, or small group counseling. (Detail) |
| I.D.1.f) | Each FMP site must use an EHR. (Core) | 1.8.f. | Each FMP site must use an EHR. (Core) |
| I.D.1.f).(1) | Residents must have remote access to the EHR used at each FMP from all clinical sites. (Core) | 1.8.f.1. | Residents must have remote access to the EHR used at each FMP from all clinical sites. (Core) |
| I.D.1.g) | Telehealth modalities must be readily available. (Core) | 1.8.g. | Telehealth modalities must be readily available. (Core) |
| I.D.1.h) | Each FMP must have members of the community, in addition to clinical leaders, serve on an advisory committee to assess and address health needs of the community. (Core) | 1.8.h. | Each FMP must have members of the community, in addition to clinical leaders, serve on an advisory committee to assess and address health needs of the community. (Core) |
| I.D.1.h).(1) | The advisory committee should have demographic diversity and lived experiences representative of the community. (Detail) | 1.8.h.1. | The advisory committee should have demographic diversity and lived experiences representative of the community. (Detail) |
| I.D.1.i) | Each FMP should provide, on average, two examination rooms for each faculty member and each resident when they are providing on-site, in-person patient care. (Detail) | 1.8.i. | Each FMP should provide, on average, two examination rooms for each faculty member and each resident when they are providing on-site, in-person patient care. (Detail) |
| I.D.1.j) | Each FMP must ensure that other physician specialists who provide care within the setting contribute to the educational experiences of the residents. (Core) | 1.8.j. | Each FMP must ensure that other physician specialists who provide care within the setting contribute to the educational experiences of the residents. (Core) |
| I.D.1.k) | Each FMP site must participate in ongoing performance improvement, and demonstrate use of outcome data by assessing the following: clinical quality for preventive care and chronic disease; demographics; health inequities; patient satisfaction; patient safety; continuity with a patient panel; referral and diagnostic utilization rates; and financial performance. (Core) | 1.8.k. | Each FMP site must participate in ongoing performance improvement, and demonstrate use of outcome data by assessing the following: clinical quality for preventive care and chronic disease; demographics; health inequities; patient satisfaction; patient safety; continuity with a patient panel; referral and diagnostic utilization rates; and financial performance. (Core) |
| I.D.1.k).(1) | Each FMP should measure and report this data to the FMP care teams and appropriate preceptors at least semi-annually. (Detail) | 1.8.k.1. | Each FMP should measure and report this data to the FMP care teams and appropriate preceptors at least semi-annually. (Detail) |
| I.D.1.l) | Patient Population | 1.8.l. | Patient Population<br>The program must provide residents with a patient population representative of both the broad spectrum of ages, clinical issues, and medical conditions managed by family physicians, including inpatient care; and of the diversity of the community being served. (Core) |
| I.D.1.l).(1) | The program must provide residents with a patient population representative of both the broad spectrum of ages, clinical issues, and medical conditions managed by family physicians, including inpatient care; and of the diversity of the community being served. (Core) | 1.8.l. | Patient Population<br>The program must provide residents with a patient population representative of both the broad spectrum of ages, clinical issues, and medical conditions managed by family physicians, including inpatient care; and of the diversity of the community being served. (Core) |
| **I.D.2.** | **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:** | **1.9.** | **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:** |
| **I.D.2.a)** | **access to food while on duty; (Core)** | **1.9.a.** | **access to food while on duty; (Core)** |
| **I.D.2.b)** | **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)** | **1.9.b.** | **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)** |
| **I.D.2.c)** | **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)** | **1.9.c.** | **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)** |

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| I.D.2.d) | security and safety measures appropriate to the participating site; and, (Core) | 1.9.d. | security and safety measures appropriate to the participating site; and, (Core) |
| I.D.2.e) | accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core) | 1.9.e. | accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core) |
| I.D.3. | Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core) | 1.10. | Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core) |
| I.E. | Other Learners and Health Care Personnel<br>The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core) | 1.11. | Other Learners and Health Care Personnel<br>The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core) |
| II. | Personnel | Section 2 | Section 2: Personnel |
| II.A. | Program Director | 2.1. | Program Director<br>There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core) |
| II.A.1. | There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core) | 2.1. | Program Director<br>There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core) |
| II.A.1.a) | The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core) | 2.2. | The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core) |
| II.A.1.a).(1) | Final approval of the program director resides with the Review Committee. (Core) | 2.2.a. | Final approval of the program director resides with the Review Committee. (Core) |
| II.A.1.b) | The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core) | 2.3. | The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core) |
| II.A.2. | The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core) | 2.4. | The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core) |

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| II.A.2.a) | At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)<br><br>Number of Approved Resident Positions: 1-6 \| Minimum Support Required (FTE) for Program Director:20% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 7-10 \| Minimum Support Required (FTE) for Program Director: 40% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 11-15 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 16-20 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 10%<br><br>Number of Approved Resident Positions: 21-25 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 20% | 2.4.a. | At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)<br><br>Number of Approved Resident Positions: 1-6 \| Minimum Support Required (FTE) for Program Director: 20% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 7-10 \| Minimum Support Required (FTE) for Program Director: 40% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 11-15 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: N/A<br><br>Number of Approved Resident Positions: 16-20 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 10%<br><br>Number of Approved Resident Positions: 21-25 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 20% |

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| II.A.2.a) - (Continued) | Number of Approved Resident Positions: 26-30 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 30%<br><br>Number of Approved Resident Positions: 31-35 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 40%<br><br>Number of Approved Resident Positions: 36-40 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 50%<br><br>Number of Approved Resident Positions: 41-45 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 60%<br><br>Number of Approved Resident Positions: 46-50 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 70%<br><br>Number of Approved Resident Positions: 51-55 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 80%<br><br>Number of Approved Resident Positions: 56-60 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 90% | 2.4.a. - (Continued) | Number of Approved Resident Positions: 26-30 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 30%<br><br>Number of Approved Resident Positions: 31-35 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 40%<br><br>Number of Approved Resident Positions: 36-40 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 50%<br><br>Number of Approved Resident Positions: 41-45 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 60%<br><br>Number of Approved Resident Positions: 46-50 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 70%<br><br>Number of Approved Resident Positions: 51-55 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 80%<br><br>Number of Approved Resident Positions: 56-60 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 90% |
| II.A.2.a) - (Continued) | Number of Approved Resident Positions: 61-65 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 100%<br><br>Number of Approved Resident Positions: 66-70 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 110%<br><br>Number of Approved Resident Positions: 71-75 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 120%<br><br>Number of Approved Resident Positions: 76-80 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 130% | 2.4.a. - (Continued) | Number of Approved Resident Positions: 61-65 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 100%<br><br>Number of Approved Resident Positions: 66-70 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 110%<br><br>Number of Approved Resident Positions: 71-75 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 120%<br><br>Number of Approved Resident Positions: 76-80 \| Minimum Support Required (FTE) for Program Director: 50% \| Additional Minimum Support Required (FTE) for Program Leadership: 130% |
| **II.A.3.** | **Qualifications of the program director:** | **2.5.** | **Qualifications of the Program Director**<br>**The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)** |

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| **II.A.3.a)** | **must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)** | **2.5.** | **Qualifications of the Program Director**<br>**The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)** |
| **II.A.3.b)** | **must include current certification in the specialty for which they are the program director by the American Board of** Family Medicine **or by the American Osteopathic Board of** Family Physicians**, or specialty qualifications that are acceptable to the Review Committee; and, (Core)** | **2.5.a.** | **The program director must include current certification in the specialty for which they are the program director by the American Board of** Family Medicine **or by the American Osteopathic Board of** Family Physicians**, or specialty qualifications that are acceptable to the Review Committee. (Core)** |
| II.A.3.b).(1) | The Review Committee for Family Medicine only accepts ABMS and AOA certification for the program director. (Core) | 2.5.a.1. | The Review Committee for Family Medicine only accepts ABMS and AOA certification for the program director. (Core) |
| **II.A.3.c)** | **must include ongoing clinical activity. (Core)** | **2.5.b.** | **The program director must demonstrate ongoing clinical activity. (Core)** |
| II.A.3.d) | must include previous leadership experience. (Core) | 2.5.c. | The program director must have previous leadership experience. (Core) |
| **II.A.4.** | **Program Director Responsibilities**<br><br>**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)** | **2.6.** | **Program Director Responsibilities**<br>**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)** |
| **II.A.4.a)** | **The program director must:** | **[None]** | |
| **II.A.4.a).(1)** | **be a role model of professionalism; (Core)** | **2.6.a.** | **The program director must be a role model of professionalism. (Core)** |
| **II.A.4.a).(2)** | **design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)** | **2.6.b.** | **The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)** |
| **II.A.4.a).(3)** | **administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)** | **2.6.c.** | **The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)** |
| **II.A.4.a).(4)** | **have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)** | **2.6.d.** | **The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)** |
| **II.A.4.a).(5)** | **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)** | **2.6.e.** | **The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)** |
| **II.A.4.a).(6)** | **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)** | **2.6.f.** | **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)** |
| **II.A.4.a).(7)** | **provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)** | **2.6.g.** | **The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)** |
| **II.A.4.a).(8)** | **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)** | **2.6.h.** | **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident. (Core)** |

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| **II.A.4.a).(9)** | **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)** | **2.6.i.** | **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)** |
| **II.A.4.a).(9).(a)** | **Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)** | **3.1.** | **Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)** |
| **II.A.4.a).(10)** | **document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)** | **2.6.j.** | **The program director must document verification of education for all residents within 30 days of completion of or departure from the program. (Core)** |
| **II.A.4.a).(11)** | **provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)** | **2.6.k.** | **The program director must provide verification of an individual resident's education upon the resident's request, within 30 days. (Core)** |
| **II.A.4.a).(12)** | **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)** | **2.6.l.** | **The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)** |
| **II.B.** | **Faculty**<br>***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***<br><br>***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.*** | **[None]** | **Faculty**<br>***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***<br><br>***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.*** |
| **II.B.1.** | **There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)** | **2.7.** | **There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)** |
| II.B.1.a) | Instruction in the other specialties must be conducted by faculty members with appropriate expertise. (Core) | 2.7.a. | Instruction in the other specialties must be conducted by faculty members with appropriate expertise. (Core) |
| II.B.1.b) | There must be a ratio of residents-to-faculty preceptors in the FMP not to exceed 4:1. (Detail) | 2.7.b. | There must be a ratio of residents-to-faculty preceptors in the FMP not to exceed 4:1. (Detail) |
| II.B.1.b).(1) | If only one resident is seeing patients in the FMP, a single faculty member must devote at least 50 percent time to teaching and supervising that resident. (Detail) | 2.7.b.1. | If only one resident is seeing patients in the FMP, a single faculty member must devote at least 50 percent time to teaching and supervising that resident. (Detail) |
| II.B.1.c) | All programs must have family medicine physician faculty members serving as role models by teaching and providing broad spectrum family medicine care that meets the mission of the program. (Core) | 2.7.c. | All programs must have family medicine physician faculty members serving as role models by teaching and providing broad spectrum family medicine care that meets the mission of the program. (Core) |

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| II.B.1.d) | All programs must have family medicine physician faculty members role modeling competence in their respective scope of practice. (Core) | 2.7.d. | All programs must have family medicine physician faculty members role modeling competence in their respective scope of practice. (Core) |
| II.B.1.d).(1) | Programs must have family medicine physician faculty members teaching and providing adult inpatient medicine care. (Core) | 2.7.d.1. | Programs must have family medicine physician faculty members teaching and providing adult inpatient medicine care. (Core) |
| II.B.1.d).(2) | Programs providing maternity care competency training to the level of independent practice must have family medicine physician faculty members teaching and providing family-centered, pregnancy-related care, including prenatal, intra-partum, vaginal delivery, and post-partum care. (Core) | 2.7.d.2. | Programs providing maternity care competency training to the level of independent practice must have family medicine physician faculty members teaching and providing family-centered, pregnancy-related care, including prenatal, intra-partum, vaginal delivery, and post-partum care. (Core) |
| II.B.1.d).(3) | Programs should have family medicine physician faculty members providing care outside of an FMP, including in inpatient pediatric, pregnancy-related care, skilled nursing, and home-based care facilities and settings. (Detail) | 2.7.d.3. | Programs should have family medicine physician faculty members providing care outside of an FMP, including in inpatient pediatric, pregnancy-related care, skilled nursing, and home-based care facilities and settings. (Detail) |
| **II.B.2.** | **Faculty members must:** | **[None]** | |
| **II.B.2.a)** | **be role models of professionalism; (Core)** | **2.8.** | **Faculty Responsibilities**<br>**Faculty members must be role models of professionalism. (Core)** |
| **II.B.2.b)** | **demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)** | **2.8.a.** | **Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (Core)** |
| **II.B.2.c)** | **demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)** | **2.8.b.** | **Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)** |
| **II.B.2.d)** | **administer and maintain an educational environment conducive to educating residents; (Core)** | **2.8.c.** | **Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)** |
| **II.B.2.e)** | **regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)** | **2.8.d.** | **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)** |
| **II.B.2.f)** | **pursue faculty development designed to enhance their skills at least annually: (Core)** | **2.8.e.** | **Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)** |
| **II.B.2.f).(1)** | **as educators and evaluators; (Detail)** | **2.8.e.1.** | **as educators and evaluators; (Detail)** |
| **II.B.2.f).(2)** | **in quality improvement, eliminating health inequities, and patient safety; (Detail)** | **2.8.e.2.** | **in quality improvement, eliminating health inequities, and patient safety; (Detail)** |
| **II.B.2.f).(3)** | **in fostering their own and their residents' well-being; and, (Detail)** | **2.8.e.3.** | **in fostering their own and their residents' well-being; and, (Detail)** |
| **II.B.2.f).(4)** | **in patient care based on their practice-based learning and improvement efforts. (Detail)** | **2.8.e.4.** | **in patient care based on their practice-based learning and improvement efforts. (Detail)** |
| II.B.2.g) | Each FMP must have family medicine physician faculty members from the accredited program who see patients within that FMP. (Core) | 2.8.f. | Each FMP must have family medicine physician faculty members from the accredited program who see patients within that FMP. (Core) |
| II.B.2.h) | There must be faculty members dedicated to the interprofessional integration of behavioral health into the educational program. (Core) | 2.8.g. | There must be faculty members dedicated to the interprofessional integration of behavioral health into the educational program. (Core) |
| **II.B.3.** | **Faculty Qualifications** | **2.9.** | **Faculty Qualifications**<br>**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)** |
| **II.B.3.a)** | **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)** | **2.9.** | **Faculty Qualifications**<br>**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)** |
| **II.B.3.b)** | **Physician faculty members must:** | **[None]** | |

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| **II.B.3.b).(1)** | **have current certification in the specialty by the American Board of** Family Medicine **or the American Osteopathic Board of** Family Physicians **or possess qualifications judged acceptable to the Review Committee. (Core)** | **2.10.** | **Physician faculty members must have current certification in the specialty by the American Board of** Family Medicine **or the American Osteopathic Board of** Family Physicians **or possess qualifications judged acceptable to the Review Committee. (Core)** |
| II.B.3.b).(1).(a) | Family medicine physician faculty members who are not certified by the American Board of Family Medicine (ABFM), or American Osteopathic Board of Family Physicians (AOBFP) must demonstrate ongoing learning activities equivalent to the ABFM or AOBFP Maintenance of Certification process, including demonstration of professionalism, cognitive expertise, self-assessment and life-long learning, and assessment of performance in practice. (Core) | 2.10.a. | Family medicine physician faculty members who are not certified by the American Board of Family Medicine (ABFM), or American Osteopathic Board of Family Physicians (AOBFP) must demonstrate ongoing learning activities equivalent to the ABFM or AOBFP Maintenance of Certification process, including demonstration of professionalism, cognitive expertise, self-assessment and life-long learning, and assessment of performance in practice. (Core) |
| II.B.3.b).(2) | Physician faculty members from other specialties must have current certification in their specialties by a member board of the American Board of Medical Specialties, or an American Osteopathic Association certifying board, or possess qualifications acceptable to the Review Committee. (Core) | 2.10.b. | Physician faculty members from other specialties must have current certification in their specialties by a member board of the American Board of Medical Specialties, or an American Osteopathic Association certifying board, or possess qualifications acceptable to the Review Committee. (Core) |
| **II.B.4.** | **Core Faculty**<br><br>**Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)** | **2.11.** | **Core Faculty**<br>**Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)** |
| **II.B.4.a)** | **Core faculty members must complete the annual ACGME Faculty Survey. (Core)** | **2.11.a.** | **Core faculty members must complete the annual ACGME Faculty Survey. (Core)** |
| II.B.4.b) | There must be at least one core family medicine physician faculty member, in addition to the program director, for every six residents in programs with 12 or fewer residents, and one core family medicine physician faculty member, in addition to the program director, for every four residents in programs with more than 12 residents. (Core) | 2.11.b. | There must be at least one core family medicine physician faculty member, in addition to the program director, for every six residents in programs with 12 or fewer residents, and one core family medicine physician faculty member, in addition to the program director, for every four residents in programs with more than 12 residents. (Core) |
| II.B.4.c) | Core faculty members in programs with an approved complement of 13 or more residents should devote at least 60 percent time (at least 24 hours per week, or 1200 hours per year) to the program, exclusive of patient care without residents. (Detail) | 2.11.c. | Core faculty members in programs with an approved complement of 13 or more residents should devote at least 60 percent time (at least 24 hours per week, or 1200 hours per year) to the program, exclusive of patient care without residents. (Detail) |
| II.B.4.d) | Core faculty members in programs with an approved complement of 12 or fewer residents should devote at least 40 percent time (at least 16 hours per week or 800 hours per year) to the program, exclusive of patient care without residents. (Detail) | 2.11.d. | Core faculty members in programs with an approved complement of 12 or fewer residents should devote at least 40 percent time (at least 16 hours per week or 800 hours per year) to the program, exclusive of patient care without residents. (Detail) |
| II.B.4.e) | Core faculty members should devote the majority of this professional effort to teaching, administration, scholarly activity, and supervising resident patient care within the program. (Detail) | 2.11.e. | Core faculty members should devote the majority of this professional effort to teaching, administration, scholarly activity, and supervising resident patient care within the program. (Detail) |
| **II.C.** | **Program Coordinator** | **2.12.** | **Program Coordinator**<br>**There must be a program coordinator. (Core)** |
| **II.C.1.** | **There must be a program coordinator. (Core)** | **2.12.** | **Program Coordinator**<br>**There must be a program coordinator. (Core)** |

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| **II.C.2.** | **The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)** | **2.12.a.** | **The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)** |
| II.C.2.a) | At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on program size as follows: (Core)<br><br>Number of Approved Resident Positions: 1-6\| Minimum FTE Required for Coordinator Support: 0.5\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 7-12\| Minimum FTE Required for Coordinator Support: 0.7\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A | 2.12.b. | At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on program size as follows: (Core)<br><br>Number of Approved Resident Positions: 1-6\| Minimum FTE Required for Coordinator Support: 0.5\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 7-12\| Minimum FTE Required for Coordinator Support: 0.7\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A |
| II.C.2.a) - (Continued) | Number of Approved Resident Positions: 13-20\| Minimum FTE Required for Coordinator Support: 0.9\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 21-30\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 31-45\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: 0.25<br><br>Number of Approved Resident Positions: 46 or more\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: 0.5 | 2.12.b. - (Continued) | Number of Approved Resident Positions: 13-20\| Minimum FTE Required for Coordinator Support: 0.9\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 21-30\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: N/A<br><br>Number of Approved Resident Positions: 31-45\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: 0.25<br><br>Number of Approved Resident Positions: 46 or more\| Minimum FTE Required for Coordinator Support: 1\| Minimum Additional Aggregate FTE Required for Administration of the Program: 0.5 |
| **II.D.** | **Other Program Personnel**<br><br>**The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)** | **2.13.** | **Other Program Personnel**<br>**The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)** |
| **III.** | **Resident Appointments** | **Section 3** | **Section 3: Resident Appointments** |
| **III.A.** | **Eligibility Requirements** | **3.2.** | **Eligibility Requirements**<br>**An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)** |
| **III.A.1.** | **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)** | **3.2.** | **Eligibility Requirements**<br>**An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)** |

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| III.A.1.a) | graduation from a medical school in the United States , accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core) | 3.2.a. | graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core) |
| III.A.1.b) | graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) | 3.2.b. | graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)<br><br>• holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)<br><br>• holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core) |
| III.A.1.b).(1) | holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) | 3.2.b. | graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)<br><br>• holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)<br><br>• holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core) |
| III.A.1.b).(2) | holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core) | 3.2.b. | graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)<br><br>• holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)<br><br>• holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core) |
| III.A.2. | All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core) | 3.3. | All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core) |
| III.A.2.a) | Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core) | 3.3.a. | Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core) |

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| **III.B.** | **Resident Complement**<br><br>**The program director must not appoint more residents than approved by the Review Committee. (Core)** | **3.4.** | **Resident Complement**<br>**The program director must not appoint more residents than approved by the Review Committee. (Core)** |
| III.B.1. | The program must offer at least two resident positions at each educational level. (Detail) | 3.4.a. | The program must offer at least two resident positions at each educational level. (Detail) |
| III.B.2. | The program should have at least six actively enrolled residents. (Detail | 3.4.b. | The program should have at least six actively enrolled residents. (Detail |
| **III.C.** | **Resident Transfers**<br><br>**The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)** | **3.5.** | **Resident Transfers**<br><br>**The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)** |
| **IV.** | **Educational Program**<br><br>***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.***<br><br>***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.***<br><br>***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.*** | **Section 4** | **Section 4: Educational Program**<br><br>***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.***<br><br>***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.***<br><br>***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.*** |
| **IV.A.** | **Educational Components**<br>**The curriculum must contain the following educational components:** | **4.2.** | **Educational Components**<br>**The curriculum must contain the following educational components:** |
| **IV.A.1.** | **a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)** | **4.2.a.** | **a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)** |
| **IV.A.2.** | **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)** | **4.2.b.** | **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)** |
| **IV.A.3.** | **delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)** | **4.2.c.** | **delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)** |
| **IV.A.4.** | **a broad range of structured didactic activities; and, (Core)** | **4.2.d.** | **a broad range of structured didactic activities; and, (Core)** |
| **IV.A.4.a)** | **Residents must be provided with protected time to participate in core didactic activities. (Core)** | **4.11.** | **Didactic and Clinical Experiences**<br>**Residents must be provided with protected time to participate in core didactic activities. (Core)** |
| **IV.A.5.** | **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)** | **4.2.e.** | **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)** |

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| **IV.B.** | **ACGME Competencies** | **[None]** | **ACGME Competencies**<br>***The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.*** |
| **IV.B.1.** | **The program must integrate the following ACGME Competencies into the curriculum:** | **[None]** | **The program must integrate all ACGME Competencies into the curriculum.** |
| **IV.B.1.a)** | **Professionalism**<br><br>**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)** | **4.3.** | **ACGME Competencies – Professionalism**<br>**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**<br><br>**Residents must demonstrate competence in:** |
| **IV.B.1.a).(1)** | **Residents must demonstrate competence in:** | **4.3.** | **ACGME Competencies – Professionalism**<br>**Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**<br><br>**Residents must demonstrate competence in:** |
| **IV.B.1.a).(1).(a)** | **compassion, integrity, and respect for others; (Core)** | **4.3.a.** | **compassion, integrity, and respect for others; (Core)** |
| **IV.B.1.a).(1).(b)** | **responsiveness to patient needs that supersedes self-interest; (Core)** | **4.3.b.** | **responsiveness to patient needs that supersedes self-interest; (Core)** |
| **IV.B.1.a).(1).(c)** | **cultural humility; (Core)** | **4.3.c.** | **cultural humility; (Core)** |
| **IV.B.1.a).(1).(d)** | **respect for patient privacy and autonomy; (Core)** | **4.3.d.** | **respect for patient privacy and autonomy; (Core)** |
| **IV.B.1.a).(1).(e)** | **accountability to patients, society, and the profession; (Core)** | **4.3.e.** | **accountability to patients, society, and the profession; (Core)** |
| **IV.B.1.a).(1).(f)** | **respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)** | **4.3.f.** | **respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)** |
| **IV.B.1.a).(1).(g)** | **ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)** | **4.3.g.** | **ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)** |
| **IV.B.1.a).(1).(h)** | **appropriately disclosing and addressing conflict or duality of interest. (Core)** | **4.3.h.** | **appropriately disclosing and addressing conflict or duality of interest. (Core)** |
| **IV.B.1.b)** | **Patient Care and Procedural Skills** | **[None]** | |
| **IV.B.1.b).(1)** | **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)** | **4.4.** | **ACGME Competencies – Patient Care and Procedural Skills (Part A)**<br>**Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)** |
| IV.B.1.b).(1).(a) | Residents must demonstrate competence to independently: | 4.4.a. | Residents must demonstrate competence to independently: |
| IV.B.1.b).(1).(a).(i) | integrate the family medicine approach to patients of all ages and life stages, including: | 4.4.a.1. | integrate the family medicine approach to patients of all ages and life stages, including: |
| IV.B.1.b).(1).(a).(i).(a) | whole person care, family-centeredness, community-focused care, prioritizing continuity of care, first-contact access to care, coordination of complex care, and understanding allostatic load and the structural determinants of health; (Core) | 4.4.a.1.a. | whole person care, family-centeredness, community-focused care, prioritizing continuity of care, first-contact access to care, coordination of complex care, and understanding allostatic load and the structural determinants of health; (Core) |

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| IV.B.1.b).(1).(a).(i).(b) | understanding family dynamics, to include impact of adverse childhood experiences; and, (Core) | 4.4.a.1.b. | understanding family dynamics, to include impact of adverse childhood experiences; and, (Core) |
| IV.B.1.b).(1).(a).(i).(c) | addressing behavioral health and inequities in health and health care. (Core) | 4.4.a.1.c. | addressing behavioral health and inequities in health and health care. (Core) |
| IV.B.1.b).(1).(a).(ii) | diagnose, manage, and integrate the care of patients of all ages in various outpatient settings, including the FMP and home environment, to include common chronic medical conditions and acute medical problems; (Core) | 4.4.a.2. | diagnose, manage, and integrate the care of patients of all ages in various outpatient settings, including the FMP and home environment, to include common chronic medical conditions and acute medical problems; (Core) |
| IV.B.1.b).(1).(a).(iii) | diagnose, manage, and integrate the care of patients of all ages in various inpatient settings, including hospitals, long-term care facilities, and rehabilitation facilities; (Core) | 4.4.a.3. | diagnose, manage, and integrate the care of patients of all ages in various inpatient settings, including hospitals, long-term care facilities, and rehabilitation facilities; (Core) |
| IV.B.1.b).(1).(a).(iv) | diagnose, manage, and integrate care for common mental illness and behavioral issues, including substance use disorders, in patients of all ages; (Core) | 4.4.a.4. | diagnose, manage, and integrate care for common mental illness and behavioral issues, including substance use disorders, in patients of all ages; (Core) |
| IV.B.1.b).(1).(a).(v) | identify risk level of patients in panels and connect with appropriate preventive care coordination through team-based support; (Core) | 4.4.a.5. | identify risk level of patients in panels and connect with appropriate preventive care coordination through team-based support; (Core) |
| IV.B.1.b).(1).(a).(vi) | identify the need for a higher level of care setting and/or subspecialty referral in the undifferentiated patient; (Core) | 4.4.a.6. | identify the need for a higher level of care setting and/or subspecialty referral in the undifferentiated patient; (Core) |
| IV.B.1.b).(1).(a).(vii) | apply the biopsychosocial model of health to patients, specifically to assess behavioral, community, environmental, socioeconomic, and family influences on the health of patients, and integrate those with biomedical influences, appropriately acknowledging racial categories as social constructs as opposed to biologically distinct determinants of health; (Core) | 4.4.a.7. | apply the biopsychosocial model of health to patients, specifically to assess behavioral, community, environmental, socioeconomic, and family influences on the health of patients, and integrate those with biomedical influences, appropriately acknowledging racial categories as social constructs as opposed to biologically distinct determinants of health; (Core) |
| IV.B.1.b).(1).(a).(viii) | use technology to provide accessible care, i.e., via telehealth; (Core) | 4.4.a.8. | use technology to provide accessible care, i.e., via telehealth; (Core) |
| IV.B.1.b).(1).(a).(ix) | provide routine newborn care, including neonatal care following birth; (Core) | 4.4.a.9. | provide routine newborn care, including neonatal care following birth; (Core) |
| IV.B.1.b).(1).(a).(x) | deliver preventive health care to children, including for development, nutrition, exercise, immunization, and addressing social determinants of health; (Core) | 4.4.a.10. | deliver preventive health care to children, including for development, nutrition, exercise, immunization, and addressing social determinants of health; (Core) |
| IV.B.1.b).(1).(a).(xi) | provide the recognition, triage, stabilization, and management of ill children; (Core) | 4.4.a.11. | provide the recognition, triage, stabilization, and management of ill children; (Core) |
| IV.B.1.b).(1).(a).(xii) | provide care to patients who may become pregnant, including: (Core) | 4.4.a.12. | provide care to patients who may become pregnant, including: (Core) |
| IV.B.1.b).(1).(a).(xii).(a) | diagnosing pregnancy and managing early pregnancy complications, to include diagnosis of ectopic pregnancy, pregnancy loss, and options education for unintended pregnancy; (Core) | 4.4.a.12.a. | diagnosing pregnancy and managing early pregnancy complications, to include diagnosis of ectopic pregnancy, pregnancy loss, and options education for unintended pregnancy; (Core) |
| IV.B.1.b).(1).(a).(xii).(b) | low-risk prenatal care; (Core) | 4.4.a.13. | low-risk prenatal care; (Core) |
| IV.B.1.b).(1).(a).(xii).(c) | care of common medical problems arising from pregnancy or coexisting with pregnancy; (Core) | 4.4.a.13.a. | care of common medical problems arising from pregnancy or coexisting with pregnancy; (Core) |
| IV.B.1.b).(1).(a).(xii).(d) | performing an uncomplicated spontaneous vaginal delivery; (Core) | 4.4.a.13.b. | performing an uncomplicated spontaneous vaginal delivery; (Core) |
| IV.B.1.b).(1).(a).(xii).(e) | demonstrating basic skills in managing obstetrical emergencies; and, (Core) | 4.4.a.13.c. | demonstrating basic skills in managing obstetrical emergencies; and, (Core) |
| IV.B.1.b).(1).(a).(xii).(f) | postpartum care, to include screening and treatment for postpartum depression, breastfeeding support, and family planning. (Core) | 4.4.a.13.d. | postpartum care, to include screening and treatment for postpartum depression, breastfeeding support, and family planning. (Core) |

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| IV.B.1.b).(1).(a).(xiii) | provide care to patients undergoing surgical intervention, including: | 4.4.a.14. | provide care to patients undergoing surgical intervention, including: |
| IV.B.1.b).(1).(a).(xiii).(a) | providing pre- and post-operative care; (Core) | 4.4.a.14.a. | providing pre- and post-operative care; (Core) |
| IV.B.1.b).(1).(a).(xiii).(b) | recognizing patients requiring acute surgical intervention; and, (Core) | 4.4.a.14.b. | recognizing patients requiring acute surgical intervention; and, (Core) |
| IV.B.1.b).(1).(a).(xiii).(c) | diagnosing surgical problems. (Core) | 4.4.a.14.c. | diagnosing surgical problems. (Core) |
| IV.B.1.b).(1).(a).(xiv) | use multiple information sources to develop a personal care plan for patients based on current medical evidence and the biopsychosocial model of health; (Core) | 4.4.a.15 | use multiple information sources to develop a personal care plan for patients based on current medical evidence and the biopsychosocial model of health; (Core) |
| IV.B.1.b).(1).(a).(xv) | identify and address significant life transitions in their full biopsychosocial and spiritual dimensions, including birth, the transition to parenthood, and end-of-life, for patients and patients' families; and, (Core) | 4.4.a.16 | identify and address significant life transitions in their full biopsychosocial and spiritual dimensions, including birth, the transition to parenthood, and end-of-life, for patients and patients' families; and, (Core) |
| IV.B.1.b).(1).(a).(xvi) | address suffering in all its dimensions for patients and patients' families. (Core) | 4.4.a.17 | address suffering in all its dimensions for patients and patients' families. (Core) |
| **IV.B.1.b).(2)** | **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)** | **4.5.** | **ACGME Competencies – Patient Care and Procedural Skills (Part B)**<br>**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)** |
| IV.B.1.b).(2).(a) | Residents must learn common procedures and appropriate new technologies benefitting and improving patient care and access. (Core) | 4.5.a. | Residents must learn common procedures and appropriate new technologies benefitting and improving patient care and access. (Core) |
| **IV.B.1.c)** | **Medical Knowledge**<br>**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)** | **4.6.** | **ACGME Competencies – Medical Knowledge**<br>**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)** |
| IV.B.1.c).(1) | Residents must demonstrate proficiency in their knowledge of the broad spectrum of clinical disorders seen in the practice of family medicine. (Core) | 4.6.a. | Residents must demonstrate proficiency in their knowledge of the broad spectrum of clinical disorders seen in the practice of family medicine. (Core) |
| IV.B.1.c).(2) | Residents must recognize the impact of the intersection of social and governmental contexts, including community resources, family structure, trauma, racial inequities, mental illness, and addiction on health and health care received. (Core) | 4.6.b. | Residents must recognize the impact of the intersection of social and governmental contexts, including community resources, family structure, trauma, racial inequities, mental illness, and addiction on health and health care received. (Core) |
| **IV.B.1.d)** | **Practice-based Learning and Improvement**<br><br>**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning; (Core)** | **4.7.** | **ACGME Competencies – Practice-Based Learning and Improvement**<br><br>**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)** |
| **IV.B.1.d).(1)** | **Residents must demonstrate competence in:** | **[None]** | |
| **IV.B.1.d).(1).(a)** | **identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)** | **4.7.a.** | **Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)** |
| **IV.B.1.d).(1).(b)** | **setting learning and improvement goals; (Core)** | **4.7.b.** | **Residents must demonstrate competence in setting learning and improvement goals. (Core)** |

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| **IV.B.1.d).(1).(c)** | **identifying and performing appropriate learning activities; (Core)** | **4.7.c.** | **Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)** |
| **IV.B.1.d).(1).(d)** | **systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)** | **4.7.d.** | **Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement. (Core)** |
| **IV.B.1.d).(1).(e)** | **incorporating feedback and formative evaluation into daily practice; and, (Core)** | **4.7.e.** | **Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)** |
| **IV.B.1.d).(1).(f)** | **locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)** | **4.7.f.** | **Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)** |
| IV.B.1.d).(1).(g) | recognizing and pursuing individual career goals that incorporate consideration of local community needs and resources; and, (Core) | 4.7.g. | Residents must demonstrate competence in recognizing and pursuing individual career goals that incorporate consideration of local community needs and resources. (Core) |
| IV.B.1.d).(1).(h) | demonstrating durable personal processes to respond to indicators of individual practice gaps and opportunities for improvement. (Core) | 4.7.h. | Residents must demonstrate durable personal processes to respond to indicators of individual practice gaps and opportunities for improvement. (Core) |
| **IV.B.1.e)** | **Interpersonal and Communication Skills**<br><br>**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)** | **4.8.** | **ACGME Competencies – Interpersonal and Communication Skills**<br>**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)** |
| **IV.B.1.e).(1)** | **Residents must demonstrate competence in:** | **[None]** | |
| **IV.B.1.e).(1).(a)** | **communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)** | **4.8.a.** | **Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient.** (Core) |
| **IV.B.1.e).(1).(b)** | **communicating effectively with physicians, other health professionals, and health-related agencies; (Core)** | **4.8.b.** | **Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)** |
| **IV.B.1.e).(1).(c)** | **working effectively as a member or leader of a health care team or other professional group; (Core)** | **4.8.c.** | **Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)** |
| **IV.B.1.e).(1).(d)** | **educating patients, patients' families, students, other residents, and other health professionals; (Core)** | **4.8.d.** | **Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)** |
| **IV.B.1.e).(1).(e)** | **acting in a consultative role to other physicians and health professionals; (Core)** | **4.8.e.** | **Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)** |
| **IV.B.1.e).(1).(f)** | **maintaining comprehensive, timely, and legible health care records, if applicable. (Core)** | **4.8.f.** | **Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (Core)** |
| IV.B.1.e).(1).(g) | establishing a trusted relationship with patients and patients' caregivers and/or families to elicit shared prioritization and decision-making. (Core) | 4.8.h. | Residents must demonstrate competence in establishing a trusted relationship with patients and patients' caregivers and/or families to elicit shared prioritization and decision-making. (Core) |
| **IV.B.1.e).(2)** | **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)** | **4.8.g.** | **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)** |

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| IV.B.1.e).(2).(a) | Residents must learn to address end-of-life goals and align with patient treatment preferences in the outpatient setting for advanced or serious illness. (Core) | 4.8.g.1. | Residents must learn to address end-of-life goals and align with patient treatment preferences in the outpatient setting for advanced or serious illness. (Core) |
| **IV.B.1.f)** | **Systems-based Practice**<br><br>**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)** | **4.9.** | **ACGME Competencies - Systems-Based Practice**<br>**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)** |
| **IV.B.1.f).(1)** | **Residents must demonstrate competence in:** | **[None]** | |
| **IV.B.1.f).(1).(a)** | **working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)** | **4.9.a.** | **Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty. (Core)** |
| **IV.B.1.f).(1).(b)** | **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)** | **4.9.b.** | **Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)** |
| **IV.B.1.f).(1).(c)** | **advocating for quality patient care and optimal patient care systems; (Core)** | **4.9.c.** | **Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)** |
| **IV.B.1.f).(1).(d)** | **participating in identifying system errors and implementing potential systems solutions; (Core)** | **4.9.d.** | **Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)** |
| **IV.B.1.f).(1).(e)** | **incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)** | **4.9.e.** | **Residents must demonstrate competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)** |
| **IV.B.1.f).(1).(f)** | **understanding health care finances and its impact on individual patients' health decisions; and, (Core)** | **4.9.f.** | **Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)** |
| **IV.B.1.f).(1).(g)** | **using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)** | **4.9.g.** | **Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)** |
| **IV.B.1.f).(2)** | **Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)** | **4.9.h.** | **Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)** |
| IV.B.1.f).(2).(a) | Residents must recognize and utilize community resources to promote the health of the population and partner with those resources to respond to community needs. (Core) | 4.9.h.1. | Residents must recognize and utilize community resources to promote the health of the population and partner with those resources to respond to community needs. (Core) |

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| **IV.C.** | **Curriculum Organization and Resident Experiences** | **4.10. - 4.12.** | Curriculum Organization and Resident Experiences<br><br>**4.10. Curriculum Structure**<br>**The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**<br><br>**4.11. Didactic and Clinical Experiences**<br>**Residents must be provided with protected time to participate in core didactic activities. (Core)**<br><br>**4.12. Pain Management**<br>**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)** |
| **IV.C.1.** | **The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)** | **4.10.** | **Curriculum Structure**<br>**The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)** |
| IV.C.1.a) | Clinical experiences must be scheduled to maintain continuity in each FMP, expanding and enhancing on the experience in the continuity practice. (Core) | 4.10.a. | Clinical experiences must be scheduled to maintain continuity in each FMP, expanding and enhancing on the experience in the continuity practice. (Core) |
| IV.C.1.b) | Residents must complete the last 24 months of their education in the same family medicine program. (Core) | 4.10.b. | Residents must complete the last 24 months of their education in the same family medicine program. (Core) |
| IV.C.1.c) | Educational experiences should be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. (Core) | 4.10.c. | Educational experiences should be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. (Core) |
| IV.C.1.d) | Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Detail) | 4.10.d. | Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Detail) |
| IV.C.1.d).(1) | This should include integration of multiple non-physician professionals (e.g., behavioral health specialists, certified nurse midwives, clinical nurse specialists, lab technicians, nurse practitioners, pharmacists, physician assistants) to augment education, as well as interprofessional team clinical services. (Detail) | 4.10.d.1. | This should include integration of multiple non-physician professionals (e.g., behavioral health specialists, certified nurse midwives, clinical nurse specialists, lab technicians, nurse practitioners, pharmacists, physician assistants) to augment education, as well as interprofessional team clinical services. (Detail) |
| **IV.C.2.** | **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)** | **4.12.** | **Pain Management**<br>**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)** |
| IV.C.2.a) | The program must provide instruction in a holistic pain management approach that includes pharmacologic and non-pharmacologic methods and an interprofessional team. (Core) | 4.12.a. | The program must provide instruction in a holistic pain management approach that includes pharmacologic and non-pharmacologic methods and an interprofessional team. (Core) |

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| IV.C.3. | Required Clinical and Didactic Experiences | **4.11.** | **Curriculum Organization and Resident Experiences – Didactic and Clinical Experiences**<br>**Residents must be provided with protected time to participate in core didactic activities. (Core)** |
| IV.C.3.a) | The curriculum must include education on the foundational tenets of family medicine and the role of the specialty in the health care system. (Core) | 4.11.a. | Required Clinical and Didactic Experiences<br>The curriculum must include education on the foundational tenets of family medicine and the role of the specialty in the health care system. (Core) |
| IV.C.3.b) | The program must provide a regularly scheduled forum for residents to explore and analyze evidence pertinent to family medicine. (Core) | 4.11.b. | The program must provide a regularly scheduled forum for residents to explore and analyze evidence pertinent to family medicine. (Core) |
| IV.C.3.c) | Each resident must be assigned to a primary FMP that serves as the foundation for that resident's education. (Core) | 4.11.c. | Each resident must be assigned to a primary FMP that serves as the foundation for that resident's education. (Core) |
| IV.C.3.c).(1) | Residents should provide care for patients in an FMP for a minimum of 40 weeks during each year of the educational program. (Detail) | 4.11.c.1. | Residents should provide care for patients in an FMP for a minimum of 40 weeks during each year of the educational program. (Detail) |
| IV.C.3.c).(2) | Residents' other assignments should not interrupt continuity for more than eight weeks at any given time or in any one year of the educational program. (Detail) | 4.11.c.2. | Residents' other assignments should not interrupt continuity for more than eight weeks at any given time or in any one year of the educational program. (Detail) |
| IV.C.3.c).(3) | The periods between interruptions in continuity should be at least four weeks in length. (Detail) | 4.11.c.3. | The periods between interruptions in continuity should be at least four weeks in length. (Detail) |
| IV.C.3.c).(4) | FMP experience must include acute care, chronic care, and wellness care for patients of all ages. (Core) | 4.11.c.4. | FMP experience must include acute care, chronic care, and wellness care for patients of all ages. (Core) |
| IV.C.3.c).(5) | Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. (Core) | 4.11.c.5. | Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. (Core) |
| IV.C.3.c).(5).(a) | Long-term care experiences should occur over a minimum of 24 months. (Detail) | 4.11.c.5.a. | Long-term care experiences should occur over a minimum of 24 months. (Detail) |
| IV.C.3.c).(5).(b) | Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care. (Core) | 4.11.c.5.b. | Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care. (Core) |
| IV.C.3.c).(5).(b).(i) | Programs must ensure that each graduate has completed a minimum of 1,000 hours dedicated to caring for FMP patients. (Core) | 4.11.c.5.c. | Programs must ensure that each graduate has completed a minimum of 1,000 hours dedicated to caring for FMP patients. (Core) |
| IV.C.3.c).(5).(b).(ii) | Annual patient-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. (Detail) | 4.11.c.5.d. | Annual patient-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. (Detail) |
| IV.C.3.c).(5).(b).(iii) | Annual resident-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. (Detail) | 4.11.c.5.e. | Annual resident-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. (Detail) |
| IV.C.3.c).(5).(b).(iv) | Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age). (Core) | 4.11.c.5.f. | Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age). (Core) |
| IV.C.3.c).(5).(b).(v) | Panels must include a minimum of 10 percent older adult patients (older than 65 years of age). (Core) | 4.11.c.5.g. | Panels must include a minimum of 10 percent older adult patients (older than 65 years of age). (Core) |
| IV.C.3.c).(5).(b).(vi) | Panel size and composition for each resident must be regularly assessed and rebalanced as needed. (Core) | 4.11.c.5.h. | Panel size and composition for each resident must be regularly assessed and rebalanced as needed. (Core) |
| IV.C.3.c).(5).(b).(vi).(a) | Resident panels should be calculated and readjusted for the appropriate size and diversity (demographics and medical conditions) required for optimal education, patient access, and continuity of care every 12 months. (Detail) | 4.11.c.5.i. | Resident panels should be calculated and readjusted for the appropriate size and diversity (demographics and medical conditions) required for optimal education, patient access, and continuity of care every 12 months. (Detail) |
| IV.C.3.c).(5).(b).(vi).(b) | The FMP should utilize team-based coverage for patients when the continuity resident is unavailable. (Detail) | 4.11.c.5.j. | The FMP should utilize team-based coverage for patients when the continuity resident is unavailable. (Detail) |

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| IV.C.3.c).(5).(c) | Residents must be able to maintain concurrent commitments to their FMP patients during rotations in other areas/services required by the program. (Core) | 4.11.c.5.k. | Residents must be able to maintain concurrent commitments to their FMP patients during rotations in other areas/services required by the program. (Core) |
| IV.C.3.d) | Residents should participate in appropriate leadership of care teams to coordinate and optimize care for a panel of continuity patients. (Detail) | 4.11.d. | Residents should participate in appropriate leadership of care teams to coordinate and optimize care for a panel of continuity patients. (Detail) |
| IV.C.3.e) | Residents must have experience dedicated to the care of newborns, including well and ill newborns. (Core) | 4.11.e. | Residents must have experience dedicated to the care of newborns, including well and ill newborns. (Core) |
| IV.C.3.e).(1) | This experience should include inpatient and ambulatory settings, including in the continuity practice. (Detail) | 4.11.e.1. | This experience should include inpatient and ambulatory settings, including in the continuity practice. (Detail) |
| IV.C.3.f) | Residents must have 200 hours (or two months) of experience dedicated to the care of children in the ambulatory setting, to include well, acute, and chronic care for infants, pre-school aged children, school-aged children, and adolescents. (Core) | 4.11.f. | Residents must have 200 hours (or two months) of experience dedicated to the care of children in the ambulatory setting, to include well, acute, and chronic care for infants, pre-school aged children, school-aged children, and adolescents. (Core) |
| IV.C.3.g) | Residents must have at least 100 hours (or one month) of experience with the care of acutely ill children in the hospital and/or emergency setting. (Core) | 4.11.g. | Residents must have at least 100 hours (or one month) of experience with the care of acutely ill children in the hospital and/or emergency setting. (Core) |
| IV.C.3.g).(1) | This experience should include a minimum of 50 inpatient encounters with children. (Detail) | 4.11.g.1. | This experience should include a minimum of 50 inpatient encounters with children. (Detail) |
| IV.C.3.g).(2) | This experience should include a minimum of 50 emergency department patient encounters with children. (Detail) | 4.11.g.2. | This experience should include a minimum of 50 emergency department patient encounters with children. (Detail) |
| IV.C.3.h) | Residents must have at least 100 hours (or one month) dedicated to the care of patients with gynecologic issues, including obstetric and gynecologic care, family planning, contraception, and options education for unintended pregnancy. (Core) | 4.11.h. | Residents must have at least 100 hours (or one month) dedicated to the care of patients with gynecologic issues, including obstetric and gynecologic care, family planning, contraception, and options education for unintended pregnancy. (Core) |
| IV.C.3.i) | Residents must have at least 200 hours (or two months) dedicated to participating in pregnancy-related care. (Core) | 4.11.i. | Residents must have at least 200 hours (or two months) dedicated to participating in pregnancy-related care. (Core) |
| IV.C.3.i).(1) | This experience must include a structured curriculum in prenatal, intrapartum, and postpartum care. (Core) | 4.11.i.1. | This experience must include a structured curriculum in prenatal, intrapartum, and postpartum care. (Core) |
| IV.C.3.i).(1).(a) | Residents must care for pregnant patients in the outpatient setting, including prenatal care and the care of medical issues that arise in pregnancy. (Core) | 4.11.i.1.a. | Residents must care for pregnant patients in the outpatient setting, including prenatal care and the care of medical issues that arise in pregnancy. (Core) |
| IV.C.3.i).(1).(b) | Each resident must have experience with a minimum of 20 vaginal deliveries. (Core) | 4.11.i.1.b. | Each resident must have experience with a minimum of 20 vaginal deliveries. (Core) |
| IV.C.3.i).(1).(c) | Each resident should care for postpartum patients, including care for parental-baby pairs. (Detail) | 4.11.i.1.c. | Each resident should care for postpartum patients, including care for parental-baby pairs. (Detail) |
| IV.C.3.i).(1).(d) | Some of the maternity experience should include the prenatal, intrapartum, and postpartum care of the same patient in a continuity care relationship. (Detail) | 4.11.i.1.d. | Some of the maternity experience should include the prenatal, intrapartum, and postpartum care of the same patient in a continuity care relationship. (Detail) |
| IV.C.3.i).(2) | Residents who seek the option to incorporate comprehensive pregnancy-related care, including intrapartum pregnancy-related care and vaginal deliveries into independent practice, must complete at least 400 hours (or four months) dedicated to training on labor and delivery and perform or directly supervise at least 80 deliveries. (Core) | 4.11.i.2. | Residents who seek the option to incorporate comprehensive pregnancy-related care, including intrapartum pregnancy-related care and vaginal deliveries into independent practice, must complete at least 400 hours (or four months) dedicated to training on labor and delivery and perform or directly supervise at least 80 deliveries. (Core) |
| IV.C.3.j) | Residents must have at least 600 hours (or six months) and 750 patient encounters dedicated to the care of hospitalized adults with a broad range of ages and medical conditions. (Core) | 4.11.j. | Residents must have at least 600 hours (or six months) and 750 patient encounters dedicated to the care of hospitalized adults with a broad range of ages and medical conditions. (Core) |
| IV.C.3.j).(1) | Residents must participate in the care of hospitalized patients in a critical care setting. (Core) | 4.11.j.1. | Residents must participate in the care of hospitalized patients in a critical care setting. (Core) |
| IV.C.3.j).(2) | Residents must provide care for hospitalized adults throughout their residency. (Core) | 4.11.j.2. | Residents must provide care for hospitalized adults throughout their residency. (Core) |

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| IV.C.3.j).(3) | The experience should include the care of patients through hospitalization and transition of care to outpatient follow-up of the same patient in a continuity relationship. (Detail) | 4.11.j.3. | The experience should include the care of patients through hospitalization and transition of care to outpatient follow-up of the same patient in a continuity relationship. (Detail) |
| IV.C.3.k) | Residents must have at least 100 hours of emergency department experience and at least 125 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting. (Core) | 4.11.k. | Residents must have at least 100 hours of emergency department experience and at least 125 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting. (Core) |
| IV.C.3.l) | Residents must have dedicated experience in the care of older adults of at least 100 hours or one month and at least 125 patient encounters. (Core) | 4.11.l. | Residents must have dedicated experience in the care of older adults of at least 100 hours or one month and at least 125 patient encounters. (Core) |
| IV.C.3.l).(1) | The experience must include functional assessment, disease prevention, health promotion, and management of adults with multiple chronic conditions. (Core) | 4.11.l.1. | The experience must include functional assessment, disease prevention, health promotion, and management of adults with multiple chronic conditions. (Core) |
| IV.C.3.l).(2) | The experience should incorporate care of older adults across a continuum of sites. (Detail) | 4.11.l.2. | The experience should incorporate care of older adults across a continuum of sites. (Detail) |
| IV.C.3.m) | Residents must have an experience dedicated to the care of surgical patients. (Core) | 4.11.m. | Residents must have an experience dedicated to the care of surgical patients. (Core) |
| IV.C.3.m).(1) | This experience should include pre-operative assessment, post-operative care coordination, and identifying the need for surgery. (Detail) | 4.11.m.1. | This experience should include pre-operative assessment, post-operative care coordination, and identifying the need for surgery. (Detail) |
| IV.C.3.n) | Residents must have an experience dedicated to the care of patients with a breadth of musculoskeletal problems, including: (Core) | 4.11.n. | Residents must have an experience dedicated to the care of patients with a breadth of musculoskeletal problems, including: (Core) |
| IV.C.3.n).(1) | orthopaedic and rheumatologic conditions; (Core) | 4.11.n.1. | orthopaedic and rheumatologic conditions; (Core) |
| IV.C.3.n).(2) | a structured sports medicine experience; and, (Core) | 4.11.n.2. | a structured sports medicine experience; and, (Core) |
| IV.C.3.n).(3) | experience in common outpatient musculoskeletal procedures. (Core) | 4.11.n.3. | experience in common outpatient musculoskeletal procedures. (Core) |
| IV.C.3.o) | Residents must have experience evaluating dermatologic presentations and managing common dermatologic conditions. (Core) | 4.11.o. | Residents must have experience evaluating dermatologic presentations and managing common dermatologic conditions. (Core) |
| IV.C.3.o).(1) | This experience should include training in common dermatologic procedures. (Detail) | 4.11.o.1. | This experience should include training in common dermatologic procedures. (Detail) |
| IV.C.3.p) | The curriculum must incorporate behavioral health into all aspects of patient care, including experience in integrated interprofessional behavioral health care in the FMP. (Core) | 4.11.p. | The curriculum must incorporate behavioral health into all aspects of patient care, including experience in integrated interprofessional behavioral health care in the FMP. (Core) |
| IV.C.3.p).(1) | Residents must have a dedicated experience in the diagnosis and management of common mental illness, including interprofessional training in cognitive behavioral therapy, motivational interviewing, and psychopharmacology. (Core) | 4.11.p.1. | Residents must have a dedicated experience in the diagnosis and management of common mental illness, including interprofessional training in cognitive behavioral therapy, motivational interviewing, and psychopharmacology. (Core) |
| IV.C.3.p).(2) | This experience should include identification and treatment of substance use disorders, including alcohol use disorder and Opioid Use Disorder. (Detail) | 4.11.p.2. | This experience should include identification and treatment of substance use disorders, including alcohol use disorder and Opioid Use Disorder. (Detail) |
| IV.C.3.p).(2).(a) | Treatment should include pharmacologic and non-pharmacologic methods and an interprofessional team. (Detail) | 4.11.p.2.a. | Treatment should include pharmacologic and non-pharmacologic methods and an interprofessional team. (Detail) |
| IV.C.3.q) | There must be a structured experience in which residents address population health, including the evaluation of health problems in the community. (Core) | 4.11.q. | There must be a structured experience in which residents address population health, including the evaluation of health problems in the community. (Core) |
| IV.C.3.q).(1) | Each resident must have experience with providing clinical care to underserved populations. (Core) | 4.11.q.1. | Each resident must have experience with providing clinical care to underserved populations. (Core) |
| IV.C.3.q).(2) | The curriculum should incorporate education and integration of assessment of health inequities and disparities in health care. (Detail) | 4.11.q.2. | The curriculum should incorporate education and integration of assessment of health inequities and disparities in health care. (Detail) |
| IV.C.3.q).(3) | Residents should incorporate community-oriented primary care model, linking their clinical care to the needs of the community and engaging with the FMP’s community and patient/family advisory group. (Detail) | 4.11.q.3. | Residents should incorporate community-oriented primary care model, linking their clinical care to the needs of the community and engaging with the FMP’s community and patient/family advisory group. (Detail) |

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| IV.C.3.r) | There must be a specific subspecialty curriculum to address the breadth of patients seen in family medicine. (Core) | 4.11.r. | There must be a specific subspecialty curriculum to address the breadth of patients seen in family medicine. (Core) |
| IV.C.3.r).(1) | The curriculum should address any gaps in the clinical experience through other required structured rotations and FMP continuity. (Detail) | 4.11.r.1. | The curriculum should address any gaps in the clinical experience through other required structured rotations and FMP continuity. (Detail) |
| IV.C.3.r).(2) | Every resident must have exposure to a variety of medical and surgical subspecialties throughout the educational program. (Core) | 4.11.r.2. | Every resident must have exposure to a variety of medical and surgical subspecialties throughout the educational program. (Core) |
| IV.C.3.s) | Residents must have a dedicated experience in health system management. (Core) | 4.11.s. | Residents must have a dedicated experience in health system management. (Core) |
| IV.C.3.s).(1) | This curriculum should prepare residents to be active participants and leaders in their panel teams, their practices, their communities, and the profession of medicine. (Detail) | 4.11.s.1 | This curriculum should prepare residents to be active participants and leaders in their panel teams, their practices, their communities, and the profession of medicine. (Detail) |
| IV.C.3.s).(2) | Each resident should be a member of a health system or professional group committee. (Detail) | 4.11.s.2 | Each resident should be a member of a health system or professional group committee. (Detail) |
| IV.C.3.s).(3) | Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality. (Core) | 4.11.s.3 | Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality. (Core) |
| IV.C.3.s).(4) | Residents must receive regular data reports of individual/panel and practice patterns, as well as the training needed to analyze these reports. (Core) | 4.11.s.4 | Residents must receive regular data reports of individual/panel and practice patterns, as well as the training needed to analyze these reports. (Core) |
| IV.C.3.s).(4).(a) | Reports should include clinical quality, health inequities, patient safety, patient satisfaction, continuity with patient panel and referral, diagnostic utilization rates, and financial performance. (Detail) | 4.11.s.4.a. | Reports should include clinical quality, health inequities, patient safety, patient satisfaction, continuity with patient panel and referral, diagnostic utilization rates, and financial performance. (Detail) |
| IV.C.3.t) | Residents must have experience in diagnostic imaging interpretation pertinent to family medicine. (Core) | 4.11.t. | Residents must have experience in diagnostic imaging interpretation pertinent to family medicine. (Core) |
| IV.C.3.t).(1) | Residents should have experience in using point-of-care ultrasound in clinical care. (Detail) | 4.11.t.1. | Residents should have experience in using point-of-care ultrasound in clinical care. (Detail) |
| IV.C.3.u) | Residents must have six months dedicated to elective experiences. (Core) | 4.11.u. | Residents must have six months dedicated to elective experiences. (Core) |
| IV.C.3.u).(1) | The curriculum for each elective experience must be approved by the program director and developed in consultation with a member of the faculty who will ensure orientation, supervision, teaching, and timely feedback and evaluation. (Core) | 4.11.u.1. | The curriculum for each elective experience must be approved by the program director and developed in consultation with a member of the faculty who will ensure orientation, supervision, teaching, and timely feedback and evaluation. (Core) |
| IV.C.3.u).(2) | These elective experiences should be driven by each resident’s individualized education plan and address needs of future practice goals. (Detail) | 4.11.u.2. | These elective experiences should be driven by each resident’s individualized education plan and address needs of future practice goals. (Detail) |
| IV.C.3.u).(3) | The elective experiences should be developed with the guidance of a faculty mentor. These experiences should be evaluated through a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, and have systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail) | 4.11.u.3. | The elective experiences should be developed with the guidance of a faculty mentor. These experiences should be evaluated through a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, and have systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail) |

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| IV.D. | **Scholarship**<br><br>***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.***<br><br>***The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.*** | [None] | **Scholarship**<br>***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.***<br><br>***The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.*** |
| IV.D.1. | **Program Responsibilities** | 4.10. | **Program Responsibilities**<br>**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)** |
| IV.D.1.a) | **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)** | 4.10. | **Program Responsibilities**<br>**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)** |
| IV.D.1.b) | **The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)** | 4.10.a. | **The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)** |
| IV.D.1.c) | **The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)** | 4.10.b. | **The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)** |
| IV.D.2. | **Faculty Scholarly Activity** | 4.11. | **Faculty Scholarly Activity**<br>**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)**<br><br>**• Research in basic science, education, translational science, patient care, or population health**<br>**• Peer-reviewed grants**<br>**• Quality improvement and/or patient safety initiatives**<br>**• Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**<br>**• Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**<br>**• Contribution to professional committees, educational organizations, or editorial boards**<br>**• Innovations in education** |

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| IV.D.2.a) | Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)<br><br>• Research in basic science, education, translational science, patient care, or population health<br>• Peer-reviewed grants<br>• Quality improvement and/or patient safety initiatives<br>• Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports<br>• Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials<br>• Contribution to professional committees, educational organizations, or editorial boards<br>• Innovations in education | 4.11. | Faculty Scholarly Activity<br>Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)<br><br>• Research in basic science, education, translational science, patient care, or population health<br>• Peer-reviewed grants<br>• Quality improvement and/or patient safety initiatives<br>• Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports<br>• Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials<br>• Contribution to professional committees, educational organizations, or editorial boards<br>• Innovations in education |
| IV.D.2.b) | The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: | 4.11.a. | The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:<br><br>• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)<br><br>• peer-reviewed publication. (Outcome) |
| IV.D.2.b).(1) | faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome) | 4.11.a. | The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:<br><br>• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)<br><br>• peer-reviewed publication. (Outcome) |

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| **IV.D.2.b).(2)** | **peer-reviewed publication. (Outcome)** | **4.11.a.** | **The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**<br><br>**• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**<br><br>**• peer-reviewed publication. (Outcome)** |
| **IV.D.3.** | **Resident Scholarly Activity** | **4.12.** | **Resident Scholarly Activity**<br>**Residents must participate in scholarship. (Core)** |
| **IV.D.3.a)** | **Residents must participate in scholarship. (Core)** | **4.12.** | **Resident Scholarly Activity**<br>**Residents must participate in scholarship. (Core)** |
| IV.D.3.b) | Residents should complete two scholarly activities, at least one of which should be a quality improvement project. (Detail) | 4.12.a. | Residents should complete two scholarly activities, at least one of which should be a quality improvement project. (Detail) |
| IV.D.3.c) | Residents should work in teams to complete scholarship, partnering with interdisciplinary colleagues, faculty members, and peers. (Detail) | 4.12.b. | Residents should work in teams to complete scholarship, partnering with interdisciplinary colleagues, faculty members, and peers. (Detail) |
| IV.D.3.d) | Residents should disseminate scholarly activity through presentation or publication in local, regional, or national venues. (Detail) | 4.12.c. | Residents should disseminate scholarly activity through presentation or publication in local, regional, or national venues. (Detail) |
| **V.** | **Evaluation** | **Section 5** | **Section 5: Evaluation** |
| **V.A.** | **Resident Evaluation** | **5.1.** | **Resident Evaluation: Feedback and Evaluation**<br>**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)** |
| **V.A.1.** | **Feedback and Evaluation** | **5.1.** | **Resident Evaluation: Feedback and Evaluation**<br>**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)** |
| **V.A.1.a)** | **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)** | **5.1.** | **Resident Evaluation: Feedback and Evaluation**<br>**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)** |
| **V.A.1.b)** | **Evaluation must be documented at the completion of the assignment. (Core)** | **5.1.a.** | **Evaluation must be documented at the completion of the assignment. (Core)** |
| **V.A.1.b).(1)** | **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)** | **5.1.a.1.** | **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)** |
| **V.A.1.b).(2)** | **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)** | **5.1.a.2.** | **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)** |
| V.A.1.b).(3) | Evaluation of the FMP continuity experience should include assessment of quality measures, EHR management, and care coordination. (Detail) | 5.1.a.3. | Evaluation of the FMP continuity experience should include assessment of quality measures, EHR management, and care coordination. (Detail) |
| **V.A.1.c)** | **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)** | **5.1.b.** | **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)** |

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| **V.A.1.c).(1)** | **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)** | **5.1.b.1.** | **The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)** |
| **V.A.1.c).(2)** | **provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)** | **5.1.b.2.** | **The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)** |
| **V.A.1.d)** | **The program director or their designee, with input from the Clinical Competency Committee, must:** | **[None]** | |
| **V.A.1.d).(1)** | **meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)** | **5.1.c.** | **The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)** |
| **V.A.1.d).(2)** | **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)** | **5.1.d.** | **The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)** |
| **V.A.1.d).(3)** | **develop plans for residents failing to progress, following institutional policies and procedures. (Core)** | **5.1.e.** | **The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)** |
| V.A.1.d).(4) | administer an in-training examination annually. (Core) | 5.1.h. | The program director or their designee, with input from the Clinical Competency Committee, must administer an in-training examination annually. (Core) |
| V.A.1.d).(5) | create and document an individualized learning plan at least annually. (Core) | 5.1.i. | The program director or their designee, with input from the Clinical Competency Committee, must create and document an individualized learning plan at least annually. (Core) |
| V.A.1.d).(6) | provide a system to assist residents in the individualized learning plan process, including: (Core) | 5.1.j. | The program director or their designee, with input from the Clinical Competency Committee, must provide a system to assist residents in the individualized learning plan process, including: (Core) |
| V.A.1.d).(6).(a) | faculty mentorship to help residents create learning goals, as well as educational experiences to meet those goals; and, (Core) | 5.1.j.1. | faculty mentorship to help residents create learning goals, as well as educational experiences to meet those goals; and, (Core) |
| V.A.1.d).(6).(b) | systems for tracking and monitoring progress toward completing the individualized learning plan. (Core) | 5.1.j.2. | systems for tracking and monitoring progress toward completing the individualized learning plan. (Core) |
| **V.A.1.e)** | **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)** | **5.1.f.** | **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)** |
| **V.A.1.f)** | **The evaluations of a resident's performance must be accessible for review by the resident. (Core)** | **5.1.g.** | **The evaluations of a resident's performance must be accessible for review by the resident. (Core)** |
| **V.A.2.** | **Final Evaluation** | **5.2.** | **Resident Evaluation: Final Evaluation**<br><br>**The program director must provide a final evaluation for each resident upon completion of the program. (Core)** |
| **V.A.2.a)** | **The program director must provide a final evaluation for each resident upon completion of the program. (Core)** | **5.2.** | **Resident Evaluation: Final Evaluation**<br><br>**The program director must provide a final evaluation for each resident upon completion of the program. (Core)** |

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| V.A.2.a).(1) | The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core) | 5.2.a. | The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core) |
| V.A.2.a).(2) | The final evaluation must: | [None] | |
| V.A.2.a).(2).(a) | become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core) | 5.2.b. | The final 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. (Core) |
| V.A.2.a).(2).(b) | verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core) | 5.2.c. | The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core) |
| V.A.2.a).(2).(c) | be shared with the resident upon completion of the program. (Core) | 5.2.d. | The final evaluation must be shared with the resident upon completion of the program. (Core) |
| V.A.3. | A Clinical Competency Committee must be appointed by the program director. (Core) | 5.3. | Clinical Competency Committee<br>A Clinical Competency Committee must be appointed by the program director. (Core) |
| V.A.3.a) | At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core) | 5.3.a. | At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core) |
| V.A.3.a).(1) | Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core) | 5.3.b. | Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core) |
| V.A.3.b) | The Clinical Competency Committee must: | [None] | |
| V.A.3.b).(1) | review all resident evaluations at least semi-annually; (Core) | 5.3.c. | The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core) |
| V.A.3.b).(2) | determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core) | 5.3.d. | The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core) |
| V.A.3.b).(3) | meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core) | 5.3.e. | The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core) |
| V.B. | Faculty Evaluation | 5.4. | Faculty Evaluation<br>The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core) |
| V.B.1. | The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core) | 5.4. | Faculty Evaluation<br>The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core) |
| V.B.1.a) | This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core) | 5.4.a. | This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core) |
| V.B.1.b) | This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core) | 5.4.b. | This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core) |

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| V.B.2. | Faculty members must receive feedback on their evaluations at least annually. (Core) | 5.4.c. | Faculty members must receive feedback on their evaluations at least annually. (Core) |
| V.B.3. | Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core) | 5.4.d. | Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core) |
| V.C. | Program Evaluation and Improvement | 5.5. | Program Evaluation and Improvement<br>The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core) |
| V.C.1. | The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core) | 5.5. | Program Evaluation and Improvement<br>The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core) |
| V.C.1.a) | The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core) | 5.5.a. | The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core) |
| V.C.1.b) | Program Evaluation Committee responsibilities must include: | [None] | |
| V.C.1.b).(1) | review of the program's self-determined goals and progress toward meeting them; (Core) | 5.5.b. | Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core) |
| V.C.1.b).(2) | guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core) | 5.5.c. | Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core) |
| V.C.1.b).(3) | review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core) | 5.5.d. | Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core) |
| V.C.1.c) | The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core) | 5.5.e. | The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core) |
| V.C.1.d) | The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core) | 5.5.f. | The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core) |
| V.C.1.e) | The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core) | 5.5.g. | The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core) |
| V.C.2. | The program must complete a Self-Study and submit it to the DIO. (Core) | 5.5.h. | The program must complete a Self-Study and submit it to the DIO. (Core) |

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| V.C.3. | ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***<br><br>***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*** | [None] | **Board Certification**<br>***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***<br><br>***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*** |
| V.C.3.a) | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)** | 5.6. | **Board Certification**<br>**For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)** |
| V.C.3.b) | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)** | 5.6.a. | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome) |
| V.C.3.c) | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)** | 5.6.b. | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome) |
| V.C.3.d) | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)** | 5.6.c. | **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome) |
| V.C.3.e) | **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)** | 5.6.d. | **For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** (Outcome) |
| V.C.3.f) | **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)** | 5.6.e. | **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core) |

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| VI. | **The Learning and Working Environment**<br><br>***Residency education must occur in the context of a learning and working environment that emphasizes the following principles:***<br><br>***• Excellence in the safety and quality of care rendered to patients by residents today***<br><br>***• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***<br><br>***• Excellence in professionalism***<br><br>***• Appreciation for the privilege of caring for patients***<br><br>***• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*** | Section 6 | **Section 6: The Learning and Working Environment**<br><br>**The Learning and Working Environment**<br><br>***Residency education must occur in the context of a learning and working environment that emphasizes the following principles:***<br><br>***• Excellence in the safety and quality of care rendered to patients by residents today***<br><br>***• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***<br><br>***• Excellence in professionalism***<br><br>***• Appreciation for the privilege of caring for patients***<br><br>***• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*** |
| VI.A. | Patient Safety, Quality Improvement, Supervision, and Accountability | [None] | |
| VI.A.1. | Patient Safety and Quality Improvement | [None] | |
| VI.A.1.a) | Patient Safety | [None] | |
| VI.A.1.a).(1) | **Culture of Safety**<br><br>***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*** | [None] | **Culture of Safety**<br>***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*** |
| VI.A.1.a).(1).(a) | The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core) | 6.1. | The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core) |
| VI.A.1.a).(2) | **Patient Safety Events**<br><br>***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.*** | [None] | **Patient Safety Events**<br>***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.*** |
| VI.A.1.a).(2).(a) | Residents, fellows, faculty members, and other clinical staff members must: | [None] | |

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| VI.A.1.a).(2).(a).(i) | know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core) | 6.2. | Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core) |
| VI.A.1.a).(2).(a).(ii) | be provided with summary information of their institution's patient safety reports. (Core) | 6.2.a. | Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core) |
| VI.A.1.a).(2).(b) | Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core) | 6.3. | Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core) |
| VI.A.1.a).(3) | Quality Metrics<br><br>*Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.* | [None] | Quality Metrics<br>*Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.* |
| VI.A.1.a).(3).(a) | Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core) | 6.4. | Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core) |
| VI.A.2. | Supervision and Accountability | [None] | Supervision and Accountability<br>*Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*<br><br>*Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.* |
| VI.A.2.a) | *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*<br><br>*Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.* | [None] | Supervision and Accountability<br>*Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*<br><br>*Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.* |

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| VI.A.2.a).(1) | Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core) | 6.5. | Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core) |
| VI.A.2.a).(1).(a) | This information must be available to residents, faculty members, other members of the health care team, and patients. (Core) | 6.5. | Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core) |
| VI.A.2.a).(2) | The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core) | 6.6. | The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core) |
| VI.A.2.b) | Levels of Supervision<br><br>To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: | [None] | Levels of Supervision<br>*To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.* |
| VI.A.2.b).(1) | Direct Supervision: | 6.7. | Direct Supervision<br>*The supervising physician is physically present with the resident during the key portions of the patient interaction.*<br><br>*The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.* |
| VI.A.2.b).(1).(a) | the supervising physician is physically present with the resident during the key portions of the patient interaction; or, | 6.7. | Direct Supervision<br>*The supervising physician is physically present with the resident during the key portions of the patient interaction.*<br><br>*The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.* |
| VI.A.2.b).(1).(a).(i) | PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core) | 6.7.a. | PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core) |
| VI.A.2.b).(1).(b) | the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. | 6.7. | Direct Supervision<br>*The supervising physician is physically present with the resident during the key portions of the patient interaction.*<br><br>*The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.* |
| VI.A.2.b).(2) | Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. | [None] | Indirect Supervision<br>*The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.* |

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| VI.A.2.b).(3) | Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. | [None] | Oversight<br>*The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.* |
| VI.A.2.c) | The program must define when physical presence of a supervising physician is required. (Core) | 6.8. | The program must define when physical presence of a supervising physician is required. (Core) |
| VI.A.2.d) | The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core) | 6.9. | The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core) |
| VI.A.2.d).(1) | The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core) | 6.9.a. | The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core) |
| VI.A.2.d).(2) | Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core) | 6.9.b. | Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core) |
| VI.A.2.d).(3) | Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail) | 6.9.c. | Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail) |
| VI.A.2.e) | Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core) | 6.10. | Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core) |
| VI.A.2.e).(1) | Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome) | 6.10.a. | Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome) |
| VI.A.2.f) | Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core) | 6.11. | Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core) |
| VI.B. | Professionalism | 6.12. | Professionalism<br>Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core) |
| VI.B.1. | Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core) | 6.12. | Professionalism<br>Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core) |
| VI.B.2. | The learning objectives of the program must: | [None] | |
| VI.B.2.a) | be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core) | 6.12.a. | The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core) |
| VI.B.2.b) | ensure manageable patient care responsibilities; and, (Core) | 6.12.b. | The learning objectives of the program must ensure manageable patient care responsibilities. (Core) |

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| VI.B.2.c) | include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core) | 6.12.c. | The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core) |
| VI.B.3. | The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core) | 6.12.d. | The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core) |
| VI.B.4. | Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core) | 6.12.e. | Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core) |
| VI.B.5. | Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core) | 6.12.f. | Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core) |
| VI.B.6. | Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core) | 6.12.g. | Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core) |
| VI.C. | **Well-Being**<br><br>***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.***<br><br>***Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.*** | [None] | **Well-Being**<br>***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.***<br><br>***Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.*** |
| VI.C.1. | The responsibility of the program, in partnership with the Sponsoring Institution, must include: | 6.13. | The responsibility of the program, in partnership with the Sponsoring Institution, must include: |
| VI.C.1.a) | attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core) | 6.13.a. | attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core) |
| VI.C.1.b) | evaluating workplace safety data and addressing the safety of residents and faculty members; (Core) | 6.13.b. | evaluating workplace safety data and addressing the safety of residents and faculty members; (Core) |

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| VI.C.1.c) | policies and programs that encourage optimal resident and faculty member well-being; and, (Core) | 6.13.c. | policies and programs that encourage optimal resident and faculty member well-being; and, (Core) |
| VI.C.1.c).(1) | Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core) | 6.13.c.1. | Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core) |
| VI.C.1.d) | education of residents and faculty members in: | 6.13.d. | education of residents and faculty members in: |
| VI.C.1.d).(1) | identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core) | 6.13.d.1. | identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core) |
| VI.C.1.d).(2) | recognition of these symptoms in themselves and how to seek appropriate care; and, (Core) | 6.13.d.2. | recognition of these symptoms in themselves and how to seek appropriate care; and, (Core) |
| VI.C.1.d).(3) | access to appropriate tools for self-screening. (Core) | 6.13.d.3. | access to appropriate tools for self-screening. (Core) |
| VI.C.1.e) | providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core) | 6.13.e. | providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core) |
| VI.C.2. | There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core) | 6.14. | There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core) |
| VI.C.2.a) | The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core) | 6.14.a. | The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core) |
| VI.C.2.b) | These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core) | 6.14.b. | These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core) |
| VI.D. | Fatigue Mitigation | 6.15. | Fatigue Mitigation<br>Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail) |
| VI.D.1. | Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail) | 6.15. | Fatigue Mitigation<br>Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail) |
| VI.D.2. | The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core) | 6.16. | The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core) |
| VI.E. | Clinical Responsibilities, Teamwork, and Transitions of Care | [None] | |
| VI.E.1. | Clinical Responsibilities<br><br>The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core) | 6.17. | Clinical Responsibilities<br>The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core) |
| VI.E.1.a) | The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident based on that resident's PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services. (Core) | 6.17.a. | The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident based on that resident's PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services. (Core) |

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| VI.E.2. | **Teamwork**<br><br>**Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)** | 6.18. | **Teamwork**<br>**Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)** |
| VI.E.3. | **Transitions of Care** | 6.19. | **Transitions of Care**<br>**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)** |
| VI.E.3.a) | **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)** | 6.19. | **Transitions of Care**<br>**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)** |
| VI.E.3.b) | **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)** | 6.19.a. | **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)** |
| VI.E.3.c) | **Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)** | 6.19.b. | **Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)** |
| VI.F. | **Clinical Experience and Education**<br><br>***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.*** | [None] | **Clinical Experience and Education**<br>***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.*** |
| VI.F.1. | **Maximum Hours of Clinical and Educational Work per Week**<br><br>**Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)** | 6.20. | **Maximum Hours of Clinical and Educational Work per Week**<br>**Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)** |
| VI.F.2. | **Mandatory Time Free of Clinical Work and Education** | 6.21. | **Mandatory Time Free of Clinical Work and Education**<br>**Residents should have eight hours off between scheduled clinical work and education periods. (Detail)** |
| VI.F.2.a) | **Residents should have eight hours off between scheduled clinical work and education periods. (Detail)** | 6.21. | **Mandatory Time Free of Clinical Work and Education**<br>**Residents should have eight hours off between scheduled clinical work and education periods. (Detail)** |
| VI.F.2.b) | **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)** | 6.21.a. | **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)** |
| VI.F.2.c) | **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)** | 6.21.b. | **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)** |
| VI.F.3. | **Maximum Clinical Work and Education Period Length** | 6.22. | **Maximum Clinical Work and Education Period Length**<br>**Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)** |
| VI.F.3.a) | **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)** | 6.22. | **Maximum Clinical Work and Education Period Length**<br>**Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)** |

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| **VI.F.3.a).(1)** | **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)** | **6.22.a.** | **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)** |
| **VI.F.4.** | **Clinical and Educational Work Hour Exceptions** | **6.23.** | **Clinical and Educational Work Hour Exceptions**<br>**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)** |
| **VI.F.4.a)** | **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)** | **6.23.** | **Clinical and Educational Work Hour Exceptions**<br>**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)** |
| **VI.F.4.b)** | **These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)** | **6.23.a.** | **These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)** |
| **VI.F.4.c)** | **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**<br><br>The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week. | **6.24.** | **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**<br><br>The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week. |
| **VI.F.5.** | **Moonlighting** | **6.25.** | **Moonlighting**<br>**Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)** |
| **VI.F.5.a)** | **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)** | **6.25.** | **Moonlighting**<br>**Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)** |
| **VI.F.5.b)** | **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)** | **6.25.a.** | **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)** |
| **VI.F.5.c)** | **PGY-1 residents are not permitted to moonlight. (Core)** | **6.25.b.** | **PGY-1 residents are not permitted to moonlight. (Core)** |
| **VI.F.6.** | **In-House Night Float**<br><br>**Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)** | **6.26.** | **In-House Night Float**<br>**Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)** |
| VI.F.6.a) | Night float experiences must not exceed 50 percent of a resident's inpatient experiences. (Core) | 6.26.a. | Night float experiences must not exceed 50 percent of a resident's inpatient experiences. (Core) |

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| VI.F.7. | Maximum In-House On-Call Frequency<br><br>Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core) | 6.27. | Maximum In-House On-Call Frequency<br>Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core) |
| VI.F.8. | At-Home Call | 6.28. | At-Home Call<br>Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core) |
| VI.F.8.a) | Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core) | 6.28. | At-Home Call<br>Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core) |
| VI.F.8.a).(1) | At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core) | 6.28.a. | At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core) |