Introduction

Welcome to GME
General Overview

“All of us perform better and more willingly when we know why we're doing what we have been told or asked to do”
Zig Ziglar
Welcome to Graduate Medical Education!

Welcome to the University of Colorado Denver School of Medicine Graduate Medical Education! We are excited to have you join us and we are confident that you will be an asset to your program and to GME! The Office of Graduate Medical Education (GME) and the Graduate Medical Education Committee (GMEC), provide the institutional oversight for all residencies and fellowships. At the University of Colorado Denver School of Medicine (UCDSOM) GME provides services for residents/fellows in 80 ACGME accredited residencies and fellowships and 62 non ACGME accredited fellowships.

Academic medicine is rather unique and if you are new to this environment there are a few things to keep in mind to help you along the way. For the most part, everything we do is based on the academic year- July through June. Typically everything runs in a cycle- orientation, recruitment season, preparation for new residents/fellows and graduation, then right back into orientation. Once we digest all the details accompanying these items, there are more things to incorporate: accreditation cycles, resident call and block schedules, evaluations, clinical schedules, and so on. The list goes on and can be daunting but just remember: everything here generally repeats itself. Learn the current systems, revise them to fit your style or create new ones if there isn’t something already in place and you will be doing yourself a huge favor. Don’t be afraid to ask questions- you will find that people here are happy to help you as you acclimate and though we all work in different departments we share many of the same experiences.

Please don’t hesitate to ask questions- we are here to help in any way we can!

The Office of Graduate Medical Education
Accreditation Council for Graduate Medical Education (ACGME)

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“Nothing is too high for a man to reach, but he must climb with care and confidence.”
Hans Christian Andersen
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“Achievement is largely the product of steadily raising one’s levels of aspiration...and expectation.” Jack Niklaus
Above: The ACGME home page (http://www.acgme.org)

The ACGME website is full of information for both the program director and program coordinator. Whether you are looking for your program requirements, completing your Program Information Form (PIF), or looking for information about your site visitor, you will be able to find this information on the ACGME website. Though daunting at first, the ACGME website is very well organized and easy to navigate.

- For general information pertaining to Program Directors and Program Coordinators, such as the Guide to the Common Program Requirements, head to that subpage.
- For information specific to a specialty such as program requirements and PIFs, head to the Review Committee page (left navigation bar).
- WebADS is a valuable tool for the program. From the navigation bar, select “Data Collection Systems” then “ADS”. Using your 10 digit program ID number (found on your accreditation letter) to log in, you will be able to view previous correspondence from the RRC, respond to your program’s citations, and update your faculty roster.
- The Meetings and Workshops page is where you will find all information pertaining to the Annual Educational conference as well as the Basics of Accreditation for New Program Coordinators Workshops which the ACGME holds.
Accreditation Council for Graduate Medical Education

Overview
The Accreditation Council for Graduate Medical Education (ACGME) is a private, nonprofit council that evaluates and accredits medical residency and fellowship programs in the United States. Established in 1981, the ACGME accredits programs in 130 specialties and subspecialties. Residency Review Committees (RRC) each consist of 6 to 15 volunteer physicians and there are 28 RRCs within the ACGME.

Overview of Accreditation Cycle

Requirements

Institutional Requirements: The GMEC is responsible for ensuring compliance with the institutional requirements, and we have included them here for your information.

Common Program Requirements: (Included here) These are a set requirements common to all programs regardless of specialty. They are typically included in the specialty and subspecialty requirements and are in a bold font. They focus on areas of program personnel and resources, resident/fellow appointments, general educational program, evaluation, duty hours and experimentation and innovation.

Common Program Requirements- One Year Fellowships: (Included here) These are a set of requirements which are common only to one year fellowships. The focus is still on the general areas mentioned above.

Each of these documents may be accessed electronically on the ACGME website under both the Program Directors and Coordinators page as well as the individual Review Committee (RC) pages.
Common Program Requirements

Effective: July 1, 2011

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

Introduction

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

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

I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

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

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

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

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

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

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

[As further specified by the Review Committee]

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

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

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

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

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

[As further specified by the Review Committee]
II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

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

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

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

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

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

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

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

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

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

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

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

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

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

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

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

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

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

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

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

II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

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

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

[As further specified by the Review Committee].
II.B. Faculty

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

The faculty must:

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

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

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

[As further specified by the Review Committee]

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

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

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

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

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

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

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

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

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

II.B.5.c) Faculty should encourage and support residents in scholarly activities.
II.C. Other Program Personnel

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

II.D. Resources

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

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

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

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.
III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

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

[As further specified by the Review Committee]

IV. Educational Program

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

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

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

IV.A.3. Regularly scheduled didactic sessions;

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

IV.A.5. ACGME Competencies

IV.A.5.a) The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.b) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

[As further specified by the Review Committee]

IV.A.5.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:
IV.A.5.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.d).(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;

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

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

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

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

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

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

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

IV.A.5.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

IV.A.5.e).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.5.e).(2) communicate effectively with physicians, other health professionals, and health related agencies;
IV.A.5.e).(3) work effectively as a member or leader of a health care team or other professional group;

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

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

[As further specified by the Review Committee]

IV.A.5.f) Professionalism

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

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

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

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

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

IV.A.5.f).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

[As further specified by the Review Committee]

IV.A.5.g) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

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

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

IV.A.5.g).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
IV.A.5.g).(4) advocate for quality patient care and optimal patient care systems;

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

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

[As further specified by the Review Committee]

IV.B. Residents’ Scholarly Activities

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

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

[As further specified by the Review Committee]

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

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

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

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

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

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

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,
V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

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

V.A.2. Summative Evaluation

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

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

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

V.B. Faculty Evaluation

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

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

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

V.C. Program Evaluation and Improvement

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

V.C.1.a) resident performance;

V.C.1.b) faculty development;

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

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

V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
V.C.1.d).(2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

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

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

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

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

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

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

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

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

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

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

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

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

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;
VI.A.5.f) attention to lifelong learning;

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

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

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

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

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

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

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

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

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

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

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to
safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.

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

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

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

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

VI.D.3. Levels of Supervision

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

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

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

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

VI.E. Clinical Responsibilities

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

[Optimal clinical workload will be further specified by each Review Committee.]
VI.F. Teamwork

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

[Each Review Committee will define the elements that must be present in each specialty.]

VI.G. Resident Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

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

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

VI.G.2. Moonlighting

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

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

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

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
VI.G.4. Maximum Duty Period Length

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

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

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

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

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

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

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

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

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

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

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

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

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

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

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

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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

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

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

VII. Experimentation and Innovation

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

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ACGME-approved: September 26, 2010 Effective: July 1, 2011
Common Requirements for One-Year Fellowships

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I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

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

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;
I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;
I.B.1.c) specify the duration and content of the educational experience; and,
I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.
II.A.2. Qualifications of the program director must include:

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.2.b) current certification in the specialty by the American Board of ________, or specialty qualifications that are acceptable to the Review Committee; and,

II.A.2.c) current medical licensure and appropriate medical staff appointment.

[As further specified by the Review Committee]

II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:

II.A.3.a) prepare and submit all information required and requested by the ACGME;

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.3.c) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.3.c).(1) all applications for ACGME accreditation of new programs;

II.A.3.c).(2) changes in fellow complement;

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

II.A.3.c).(4) progress reports requested by the Review Committee;

II.A.3.c).(5) responses to all proposed adverse actions;

II.A.3.c).(6) requests for increases or any change to fellow duty hours;

II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;

II.A.3.c).(8) requests for appeal of an adverse action; and,

II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.

II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
II.A.3.d).(1) program citations, and/or

II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

[As further specified by the Review Committee]

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification in the specialty by the American Board of ________, or possess qualifications acceptable to the Review Committee.

[As further specified by the Review Committee]

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

[As further specified by the Review Committee]

II.C. Other Program Personnel

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

[As further specified by the Review Committee]

II.D. Resources

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

[As further specified by the Review Committee]

II.E. Medical Information Access

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

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

[As further specified by the Review Committee]

III.B. Number of Fellows

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

[As further specified by the Review Committee]

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:

[Further specified by the Review Committee]

IV.A.2.b) Medical Knowledge

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

[Further specified by the Review Committee]
IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;

[As further specified by the Review Committee]

IV.A.2.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

[As further specified by the Review Committee]

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

[As further specified by the Review Committee]

IV.A.2.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

[As further specified by the Review Committee]

IV.B. Fellows’ Scholarly Activities

[As further specified by the Review Committee]

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate fellow performance in a timely manner.
[As further specified by the Review Committee]

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

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

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

V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.

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

V.A.2. Summative Evaluation

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

V.A.2.a) document the fellow’s performance during their education, and

V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

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

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

[As further specified by the Review Committee]

V.C. Program Evaluation and Improvement

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

V.C.1.a) fellow performance, and
V.C.1.b) faculty development

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

[As further specified by the Review Committee]

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Principles

VI.A.1. The program must be committed to and be responsible for promoting patient safety and fellow well-being and to providing a supportive educational environment.

VI.A.2. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.

[As further specified by the Review Committee]

VI.B. Supervision of Fellows

The program must ensure that qualified faculty provide appropriate supervision of fellows in patient care activities.

VI.C. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

VI.C.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.C.2. Fellows must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

VI.C.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

VI.D. On-call Activities

VI.D.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
VI.D.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.D.3. No new patients may be accepted after 24 hours of continuous duty.

VI.D.4. At-home call (or pager call)

VI.D.4.a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each fellow.

VI.D.4.b) Fellows taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

VI.D.4.c) When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit.

VI.E. Moonlighting

Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

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Program Director Guide to the Common Program Requirements

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III. Resident Appointments

A. Eligibility
B. Number of Residents
C. Resident Transfers
D. Appointment of Fellows and Other Learners

Common Program Requirement:

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<td>The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.</td>
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<th>B. Number of Residents</th>
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<td>The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of residents appointed to the program.</td>
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<th>C. Resident Transfers</th>
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<td>1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.</td>
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<td>2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.</td>
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<th>D. Appointment of Fellows and Other Learners</th>
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<td>The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.</td>
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<td>[As further specified by the Review Committee]</td>
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Explanation:

Program directors should be familiar with and should comply with the sponsoring institution’s written policies and procedures as well as the ACGME Institutional Requirements for eligibility (IR II.A.1.), selection (IR II.A.2.), and appointment (IR II.B-D.) of residents. There are also specialty-specific requirements for eligibility.

Program directors should avoid increasing the number of residents without obtaining prior Review Committee approval. To initiate a change (i.e., increase/decrease) in the approved resident complement, programs must login to the ADS and under “Request Changes” select “Approved Positions” from the menu. Specialties differ in the additional DAC_SPM_5/19/2008
III. Resident Appointments
   A. Eligibility
   B. Number of Residents
   C. Resident Transfers
   D. Appointment of Fellows and Other Learners

documents/information required to complete a complement change request. The content of this additional information is provided within ADS. All complement change requests are sent electronically to the DIO for approval except when permanent changes are requested during site visit preparation (DIO approval is provided via signature on the PIF). After the DIO has approved the complement change request, the materials submitted in ADS are forwarded to the Review Committee for review and a final decision. Consult specialty-specific requirements or contact the Review Committee executive director for more information or guidance.

Residents are considered as **transferring residents** under several conditions which include: when moving from one program to another within the same or different sponsoring institution; when entering a PGY2 program requiring a preliminary year, even if the resident was simultaneously accepted into the prelim PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). Before accepting a transferring resident, the “receiving” program director must obtain written or electronic verification of prior education from the current program director. Verification includes evaluations, rotations completed, procedural/operative experience, and a summative competency-based performance evaluation. The term ‘transfer resident’ and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

The presence of **other learners** in the program can benefit resident education by providing opportunities for interprofessional teamwork skill development and increasing appreciation and respect for other health professionals. There is also the potential that the presence of other learners can dilute the resources available for resident training, thus negatively impacting the learning environment. Program directors should follow their institutional guidelines as well as communicate with the DIO and GMEC on the number and impact of other learners.
V. Evaluation
A. Resident Evaluation
1. Formative Evaluation

Common Program Requirement:

1. Formative Evaluation
   a. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
   b. The program must:
      (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
      (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
      (3) document progressive resident performance improvement appropriate to educational level; and
      (4) provide each resident with documented semianual evaluation of performance with feedback.
   c. The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

Explanation:

Formative evaluation or assessment\(^1\) includes both informal 'on-the-spot' feedback\(^2\) and feedback based on the planned collection of information using assessment forms. Written formative assessment provides a mechanism through which programs can document progressive resident performance improvement. Self-assessment is an important component of formative assessment, both to compare with data from other evaluators and also to develop this important lifelong learning skill.

The primary purpose of formative assessment is to help residents recognize a learning gap (e.g., knowledge, skills, behaviors). It should help residents answer their fundamental questions: Where am I now? Where am I going? How do I get where I am going? How will I know when I get there? Am I on the right track for getting there? Formative assessment is 'successful' if it leads the resident to proactively close the gap, thus also building lifelong learning skills. This is less likely to occur if the formative

\(^1\) The terms “evaluation” and “assessment” are often used interchangeably. “Evaluation” is more often applied to curricula and programs, while “assessment” is applied almost always only to learners. Some reserve the term “evaluation” for summative (end-of-learning period or high stakes) decisions, while using the term “assessment” only for formative purposes. For this document, the terms are assumed to be interchangeable and the reader should focus on the distinction between formative and summative.

\(^2\) Feedback: Communication of responses and reactions with the aim of enabling improvements to be made.
V. Evaluation
   A. Resident Evaluation
      1. Formative Evaluation

Assessment data are given to residents without discussion of what the data mean and without inviting the resident to plan strategies to improve (often called an ‘independent learning plan’).

Formative assessment is also an effective way to identify the need for formal remediation as it provides a ‘developmental history’ of the resident’s work, efforts, responses to feedback, and outcomes. Remediation then becomes a process that partners the program director or faculty advisor and resident in planning, implementing and evaluating the remediation. (See CPR IV.A.5.e.) Thus, ongoing discussions between residents and teaching faculty about the meaning of formative assessments may be part of the assessment system.

Programs need to demonstrate planning for and use of an assessment system that includes both formative and summative evaluations and identifies the methods used to assess each competency domain and who the evaluators are for each. Effective assessment systems are based on a few core principles: assessment based on identified learning objectives/outcomes related to the six competency domains; use of multiple tools by multiple evaluators on multiple occasions; tools with descriptive criterion-based anchors for the rating scale to aid in fairer and more consistent evaluations. The assessment system must be monitored to assure timely completion of evaluations and to assure that the required semiannual reviews with feedback take place and are documented.

Data derived from formative assessments should not be used to make high stakes decisions (promotion, graduation). Such data should be discussed with the resident, who can provide more meaning to the context of the situation, and used to guide planning for further learning and to identify the need for remediation. Because so many data points are being collected with formative evaluation, patterns begin to emerge that allow a more accurate ‘diagnosis’ of the resident’s gaps and capabilities – regardless of any ‘spin’ the resident might put on the results.

The assessment system may include faculty development activities such as scheduled faculty meetings. Time could be set aside during faculty meetings to discuss topics such as the assessment tools and methods for using them effectively; and how best to distribute and collect completed evaluations in a timely manner. In addition, the assessment system may also include scheduled meetings with residents so that they know and understand the performance criteria on which they will be assessed and the performance standards (i.e., ‘how much is enough’ for a given level of training or learning experience). The goal is that both faculty and residents will share a common understanding of what is expected and how it will be evaluated and that they perceive assessments as a fair and close approximation of actual ability.

CPR V.A.1.c states that evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
V. Evaluation
   A. Resident Evaluation
      2. Summative Evaluation

Common Program Requirement:

2. **Summative Evaluation**
   The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
   a) document the resident’s performance during the final period of education, and
   b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

Explanation:

Summative evaluations are needed when critical “high stakes” decisions must be made. Currently in GME, these decisions are related to promotion and graduation, and so they are typically made at the end of each residency year (for progression or promotion to the next year) and at the completion of the program. In addition to the principles for formative assessment (assessment based on identified learning objectives/outcomes related to the six competency domains; use of multiple tools by multiple evaluators on multiple occasions; and tools with descriptive criterion-based anchors for the rating scale to aid in ‘fairer’ evaluations), the psychometric characteristics of summative evaluation tools are important. That is, both the evaluator and resident should believe that an assessment tool used for summative evaluations provides evidence that can be used to make valid and reliable decisions.

The program director must provide a summative evaluation for each resident at the completion of the program. Characteristics of good summative assessments include:

- decisions are based on pre-established criteria and thresholds, not as measured against performance of past or current residents;
- decisions are based on current performance, not based on formative assessments, which capture the process of developing abilities;
- residents are informed when an assessment is for summative purposes rather than formative purposes; and
- written summative evaluation is discussed with the resident and is available for his/her review.

The end-of-program verification statement that the ACGME requires all program directors to record has changed in the new CPR. Rather than verifying that the resident has “demonstrated sufficient professional ability to practice competently and independently,” program directors must now verify that the resident has “demonstrated sufficient competence to enter practice without direct supervision.” The new statement clearly applies only to the resident’s abilities at the time of graduation. It summarizes in
V. Evaluation
   A. Resident Evaluation
      2. Summative Evaluation

very succinct language the goal of all GME programs. If the program director does not feel comfortable signing such a statement for a resident, that resident should not be allowed to graduate, even if the specified time for residency education has expired. Such a situation is less likely if ACGME requirements for evaluation have been systematically implemented. Problems will have been identified much earlier, opportunities for remediation provided, and dismissal decisions considered well before the end of residency/fellowship education.

Both the end-of-program summative evaluation and the end-of-program verification statement for all graduates should be retained in perpetuity in a site that conforms to reasonable document security standards (protected from fire, flood, and theft). To ensure that the institution can demonstrate appropriate due process for dismissed residents, program directors should seek the advice of the DIO on the documents to keep for dismissed residents.
V. Evaluation
   C. Program Evaluation and Improvement

Common Program Requirement:

<table>
<thead>
<tr>
<th>C. Program Evaluation and Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:</td>
</tr>
<tr>
<td>a) resident performance;</td>
</tr>
<tr>
<td>b) faculty development;</td>
</tr>
<tr>
<td>c) graduate performance, including performance of program graduates on the certification examination; and,</td>
</tr>
<tr>
<td>d) program quality. Specifically:</td>
</tr>
<tr>
<td>(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and</td>
</tr>
<tr>
<td>(2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.</td>
</tr>
<tr>
<td>2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.</td>
</tr>
</tbody>
</table>

Explanation:

Program directors are expected to lead an ongoing effort to monitor and improve the quality and effectiveness of the program. This annual evaluation is unrelated to the GMEC internal review that must take place midway during the accreditation cycle, although results of that review may become part of this annual program evaluation. At a minimum, methods must be developed and implemented for systematically collecting and analyzing data in the following areas: resident performance, faculty development, graduate performance, and program quality. A written plan for program evaluation and improvement will help to assure that a systematic evaluation takes place annually, that results are used to identify what is working well and what needs to be improved, and that needed improvements are implemented.

Resident performance:
Results of in-training exams or other resident assessments and presentations/publications are examples of resident performance data that could be used as part of the program evaluation. As the ACGME Learning Portfolio becomes widely used and more data are collected by specialties using the same set of tools, it may be possible to establish national standards for competency-based resident outcomes by specialty/subspecialty. Such standards could be used to evaluate program performance in much the same way that certification exam scores or pass rates are currently used to provide insight into how well a program is supporting resident learning.
V. Evaluation
C. Program Evaluation and Improvement

of medical knowledge.

Faculty development:
Faculty participation in faculty development activities should be monitored and recorded. Data may be collected by annual review of updated CVs or by a separate annual survey. Activities should – over time – include not only CME-type activities directed toward acquisition of clinical knowledge and skills, but also activities directed toward developing teaching abilities, professionalism, and abilities for incorporating PBLI, SBP, and IPCS into practice and teaching. The types of activities could include both didactic (conferences, grand rounds, journal clubs, lecture-based CME events) and experiential (workshops, directed QI projects, practice-improvement self study).

Graduate performance:
Results of performance on board certification examinations is one measure of graduate performance. Data can also be collected by annual surveys of graduates. Typically, such surveys target physicians one year and five years after graduation. Forms used may be provided by the institution, developed locally or adapted from the published literature (or unpublished but available online). Survey questions may inquire about such items as current professional activities of graduates and perceptions on how well prepared they are as a result of the program.

Program quality: Annually, current residents and faculty must have the opportunity to evaluate the program. Such evaluation could include planning/organization, support/delivery, and quality. To assure confidentiality responses should be de-identified. Clerical staff should collect completed written information, remove any identifiers and collate responses. The program director and faculty may then analyze and review the collated information.

Programs may have residents complete a confidential written evaluation of rotations or specific assignments or learning experiences as part of a targeted improvement plan. The residents’ confidential evaluation of the teaching faculty may also be used as part of this evaluation. To assure confidentiality of such evaluations in small programs, the responses should be collected over a sufficient period of time so that the collated information contains responses from several residents (or students) and cannot be linked to specific respondents. Some programs periodically evaluate other areas that impact program quality, including resident selection process, graduates’ practice choices, the curriculum, assessment system (including self assessment), remediation, and linking patient outcomes to resident performance. A recent issue of the ACGME Bulletin included several articles describing such efforts.¹

The deidentified data collected in these areas may be analyzed by the program director and selected faculty and residents (if it is a large program) or by all if it is a small

¹ April, 2006 ACGME Bulletin http://www.acgme.org/acWebsite/bulletin/bulletin04_06.pdf
V. Evaluation
   C. Program Evaluation and Improvement

program. A program evaluation committee may be formed to identify outstanding features of the program and areas that could be improved. If the program personnel determine areas for improvement, they should develop a written plan of action for review/approval by the teaching faculty.
Applications and Site Visits

- Applications for Initial Accreditation
- Preparation
- During the Site Visit
- After the Site Visit

“Define your business goals clearly so that others can see them as you do.” George F. Burns
Applications for GMEC Approval and Initial Accreditation of a New Program

A meeting between the program director and program coordinator and Dr. Rumack and the Director of Compliance (DAC) regarding the new program will be scheduled by Dr. Rumack’s assistant, Alisha Horton. Prior to the meeting, please refer to the ACGME program requirements which may be located on the ACGME website (www.acgme.org) on the Review Committee page.

The process for approval of new programs is:

1. Complete the new program template* and send a copy to the DAC prior to the scheduled meeting. This will also be the form used when the program is presented to GMEC for approval.
2. Meet with Dr. Rumack and the DAC to review the request to start or restart the program.
3. Attend a GMEC meeting to present the new program.
4. GMEC meeting materials include
   a. Letter of support from the department chair and core residency program director. The letter needs to state the department supports the new program, the new program director and identifies the financial support for the program.
   b. Copy of the new program template with signatures.
   c. Signature page for the PIF if applying for accreditation.
   d. CV for the PD
5. If ACGME accreditation is available, you will be expected to apply. To do so, you will need to complete the PIF for “new applications” which is found on the ACGME website on the specific Review Committee page.
6. Your PIF must be submitted to the ACGME Review Committee for approval. Check the date of the Review Committee meetings on the ACGME website.
7. Prior to submission to ACGME, your program and program director must be approved by the GMEC and your draft PIF must be reviewed by Dr. Rumack and the DAC.

*The application for GME sponsorship of a new program may be found in this handbook under the GMEC section. The electronic document may be obtained on the GME website under Program Directors/Coordinators; Forms and Templates.
Time line for Site Visits

1. Determining the estimated site visit date
   a. Found on RRC letter from prior site visit. You can find your program accreditation letter in webADS https://www.acgme.org/ADS/default.asp?useraction=logout. Log in and select “site visit results” then “notification letters”. Your next survey date is the approximate date of next survey (month and year).

2. Ongoing
   Six – Twelve months (or earlier)
   a. Annually update the faculty roster and faculty CV’s in webADS.
   b. All physician faculty who devote 15 or more hours to the residency program are designated as core faculty on the faculty roster in ADS. All core faculty must have CV’s entered in ADS.
   c. Update your responses to prior citations under “citation responses”.

3. Notification letter from ACGME field staff
   110 - 90 days prior to site visit
   a. Program director will receive an email notifying the program for the site visit date.
   b. An ACGME letter will follow with the name of the field representative. For information about your reviewer, go to: http://www.acgme.org/acWebsite/fieldStaff/fs_fieldStaff.asp
   c. Approximately 60 days prior to the site visit, the program director will receive a letter/email from the site reviewer with any specific instructions and/or requests.
   d. Send copy of the letter from the site reviewer to your Director of Accreditation and Compliance (DAC) in the GME Office.

4. Mock Site Visit
   6 wks – 1 month prior to site visit
   a. Alisha Horton will schedule time for the Program Director and Program Coordinator 6 weeks – one month prior to scheduled site visit.
   b. Submit copy of the completed PIF (both Part I and Part II) to Dr. Rumack and your DAC no later than one week prior to the scheduled mock site visit.
   c. Program Coordinator to meet with your DAC to go over the program files/documentation prior to the mock site visit.
   d. Dr. Rumack and your DAC will review the PIF and all documents to be sent to the site reviewer with the program director and program coordinator at the mock site visit.

5. Site Visit Documents
   minimum 14 days prior to site visit
   a. One copy of the PIF must be sent to the site visitor a minimum of 14 before the scheduled visit.
   b. The PIF must be signed by Carol M. Rumack, MD (DIO) –Please make sure you check with the GME office to make sure she is available to the sign the document.
   c. Have copies of PIF and supporting documentation.
   d. Make sure program and resident files are complete

6. Site Visit Day
   a. Decide who will host/meet site visitor. Make sure room is ready, provide coffee, etc. Reconfirm meeting times with residents & faculty. Make extra copies of the itinerary, including program contact information.
   b. Site visit day – meet site visitor, provide coffee/pastries, provide logistics, ask site visitor how they wish to stay on schedule (knock on the door)
FAQs on Site Visits
Taken from the ACGME website

Who will conduct the site visit?
The ACGME uses two types of site visitors – Field Representatives and Specialist Site Visitors (SSVs). The ACGME Field Staff is made up of professional site visitors employed by the ACGME. SSVs are members of the discipline who conduct a small number of visits annually. Of the approximately 2,000 site visits conducted annually, more than 1,900 are performed by members of Field Staff, and around 80 involve SSVs. Biographical sketches for the ACGME Field Representatives, outlining their background, can be found on the ACGME web site. The RC in your specialty decides whether a member of the Field Staff or an SSV will do a given visit. A number of RCs do not use specialists, and others use them only for specific circumstances (such as new program applications).

The role of both types of site visitors is identical – to produce a report that verifies and clarifies the information the program submitted in the Program Information Form (PIF). To collect the information for this report, the site visitor interviews the program director, faculty, residents, and the designated institutional official (DIO) and/or other administrative representatives. For some specialties, the site visit also includes interviews with representatives from other departments the program interacts with.

Our program currently has no residents. Will we be site visited?
If a site visit is due, the ACGME may visit your program, even if there currently are no residents in the program. Please contact your RC team, or staff in the Department of Field Activities to discuss.

If a program does not plan on taking residents and would like to voluntarily withdraw the program, a request for voluntary withdrawal should be made on-line through the Accreditation Data System (ADS). You may find this option under your ADS menu.

If you have been notified of a site visit and are planning to seek voluntary withdrawal, notify Jane Shapiro (312/755-5015) or Penny Iverson-Lawrence (312/755-5014) in the Department of Field Activities as soon as possible of your plans. Failure to do so may result in the program being fined $1,375 for late notice of seeking voluntary withdrawal.

How do I download the PIF?
To download the PIF for your site visit, on the ACGME's web site, access the menu option “Review Committees” to bring up a directory showing all RCs. Probing the line for the given RC will bring up a menu that includes the option to download the program requirements, the PIFs for the core program and any subspecialties, and the instructions for downloading the document in WordPerfect or Microsoft Word. Follow the detailed instructions on the web page to download and complete the PIF and any associated documents. Programs in Internal Medicine and its subspecialties will have received specific software for completing the PIF and other site visit documents. For an institutional review, the Institutional Review Document (IRD) and the Institutional Requirements can be accessed by probing the option in the main menu entitled “Institutional Review” If you encounter problems in accessing or downloading documents from the web, contact the Computer Help Desk either by sending a message to helpdesk@acgme.org or calling 312/755-7464.

What should be done with the completed PIF?
After completing the PIF, you should print four (4) hard copies. One copy should be sent to the address of the Field Representative assigned to your program (shown in the ACGME's letter announcing the site visit date). This
copy must be sent to arrive at the Field Representative's address a minimum of 14 days before the date of the site visit. The three remaining copies are turned over to the site visitor on the day of the visit. All four hard copies of the PIF must be identical and must be final. Draft copies are not acceptable to the Field Representative or the ACGME. Failure to send the copy to the Field Representative at least 14 days before the visit can result in cancellation of the site visit at the discretion of the Field Representative (the program is charged a $2,750 fine for cancellation under these circumstances and the visit is rescheduled). All copies should not be bound or stapled and should be held together with a strong rubber band.

**How should residents be selected to meet with the site visitor?**
The resident interview is crucial to the site visit. Please follow these guidelines: if the program has ten or fewer residents, the Field Representative will want to speak with all residents who are on duty on the day of the visit. If the program has more than ten residents, the Field Representative will want to speak with 10 to 12 residents. Residents must be selected by their peers, with representation from each year of the program. Chief residents beyond the required years of residency (e.g., a fourth-year internal medicine chief) may not participate in the resident interview (they may be included in the faculty interview). If your program operates a combined program track, such as internal medicine-pediatrics or internal medicine-psychiatry, residents from the combined program should be represented in the interview group. Residents should be made available for the entire interview period, with their pagers and cell phones turned off.
UCD SOM
Office of Graduate Medical Education
Program Documentation
Internal Reviews and Site Visits

☐ Program Manual including required policies on:
  ☐ Duty Hours
  ☐ Evaluation
  ☐ Leave
  ☐ Moonlighting
  ☐ Selection & Eligibility
  ☐ Supervision*
  ☐ Disciplinary Action (Institutional)
  ☐ Grievance (Institutional)

*ACGME 2011 supervision language (CPR VI.D.2) “The program must demonstrate that the appropriate level of supervision is in place for all patients cared for by all residents”. “Levels of supervision must ensure oversight of resident supervision and graded authority and responsibility…” (CPR VI.D.3)

☐ Competency-based goals and objectives for each experience at each educational level

☐ Overall educational goals for the program

☐ Evaluations
  ☐ Evaluations of residents at the completion of each assignment
  ☐ Evaluations showing use of multiple evaluators (e.g., faculty, peers, other professional staff, patients, self evaluation)
  ☐ Rotation evaluations completed by residents/fellows
  ☐ Documentation of residents’ semiannual evaluations of performance with feedback
  ☐ Final, summative evaluation upon completion of the program. The evaluation must document the resident’s performance during the final period of education, and include a statement that the resident has demonstrated sufficient competence to enter practice without direct supervision.
  ☐ Completed annual written confidential evaluations of faculty by the residents
  ☐ Completed annual written confidential evaluations of the program by the residents
  ☐ Completed annual written confidential evaluations of the program by the faculty

Annual Program Evaluation and Improvement
  ☐ Minutes from annual program review meeting, to include:
    ☐ Evidence/documentation that residents/fellows provided input
    ☐ At least one resident/fellow participated in the meeting
  ☐ Self-assessment, to include but is not limited to the following:
    ☐ Program’s written curriculum and rotation-specific competency based goals and objectives.
    ☐ All resident, faculty and program evaluation forms used in the training program.
    ☐ The educational value and effectiveness of rotations at each participating institution.
    ☐ The aggregate competency-based resident performance evaluations.
    ☐ The scholarly activity and research participation of the residents.
    ☐ Resident performance on in-service training exams (if applicable) and board certification exams.
    ☐ The resident’s aggregate evaluations of the teaching faculty with special attention paid to their teaching ability, commitment to the educational program, clinical expertise, and scholarly activity.
    ☐ The faculty’s participation in faculty development programs.
    ☐ An aggregate summary of the individual resident and faculty evaluations of the overall program and provide feedback to the program.
Program Improvement Plan- Based on the program’s annual self-assessment, the program director will develop a written quality improvement action plan to be presented to the program education committee. The approval of this plan should be recorded in the committee minutes.

Review Trainee files– must include:
- Completed semi-annual evaluations and year-end evaluations. Evaluations must provide feedback and objective assessments in the ACGME competencies.
- Final, summative evaluation upon completion of the program. The evaluation must document the resident’s performance during the final period of education, and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- Training Agreement for each year in the program
- Proof of licensure (training or full)
- Proof of completion of core residency program (Fellowships only-should be the summary evaluation letter from the previous program verifying prior educational experience and a summative competency-based performance evaluation).
- For a transfer into your program- a letter from the previous program director verifying prior education. Verification includes evaluations, rotations completed, procedural/operative experience, and a summative competency-based performance evaluation.
- For a transfer out of your program- a letter you have written that verifies educational experiences and summative competency-based performance evaluations for residents who leave the program prior to completion. Letter to be sent to receiving program director.
- USMLE/COMLEX Scores (USMLE Step 3 must be passed by the midpoint of the PGY II year and must be presented prior to beginning a fellowship)

- Duty Hour documentation that demonstrates program monitoring and oversight
- Program Letters of Agreement (current and for all sites appearing on a block rotation schedule in the PIF)
- Call Schedules
- Conference Schedules to include topics, dates and presenters
  - Conference Attendance
- Case/Procedure Logs
- Data on Board pass rates (since last site visit- sometimes required in PIF)
- Scholarly Work
Semi-Annual Evaluations
V. Evaluation A. Resident Evaluation

Common Program Requirement:
Documentation for assessment system: The Common PIF requests information on the frequency of assessment as well as the assessment methods and types of evaluators the program uses to evaluate each of the six competency domains. In general, there should be evidence of multiple methods and multiple evaluators as well as alignment between the methods of assessment and the skill being assessed.

1. Formative Evaluation
   a. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
   b. The program must:
      (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
      (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
      (3) document progressive resident performance improvement appropriate to educational level; and
      (4) provide each resident with documented semiannual evaluation of performance with feedback.
   c. The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

Documentation for semiannual reviews: The Common PIF requests a description of the process used by the program for the semiannual evaluation of all residents. The process involves the program director or a designee who meets with the resident semi-annually to provide some continuity in guiding the resident through the assessment process. Written documentation of each evaluation will enable the resident to more clearly see developmental progress over time. Designating an individual to monitor semiannual reviews will help assure that they take place as scheduled. Site visitors may spot check resident files and use interviews for added verification.

GME Requirement
1. The date the 1st semi-annual evaluation, 2nd semi-annual evaluation and final (summative) evaluation for each resident/fellow is completed must be entered in New Innovations.
2. The data will be monitored by the Director of Compliance. The 1st semi-annual evaluation must be completed no later than February 15th. The 2nd semi-annual evaluation must be completed no later than June 15th.

Entering data in New Innovations:
Go to Main > Personnel Data.
Hover over the name of the first demographics record and wait for a down arrow to appear to the right of the name. Click the down arrow for the drop down of all department personnel.
Select desired Resident from the drop down.
Click the Custom Data link (located among the personal information or first quadrant).
Enter dates into the following fields in the custom data for each Resident:
Semi-Annual Review – 1st – 2010 (Enter the date of the first semi-annual review for 2010-11).
Semi-Annual Review – 2nd – 2010 (Enter the date of the second semi-annual review for 2010-11).
Final “Summative” Letter (Enter the date on the final “summative” letter if the Resident is completing training). Click Save and Return.
University of Colorado Denver School of Medicine
Office of Graduate Medical Education

Semi-Annual Evaluation Required Elements Checklist
(1st six-months and 2nd six-months)

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Evaluation Time Period</th>
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<tbody>
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</tbody>
</table>

Evaluations
- Faculty
- Rotation
- Multiple evaluators (identify other members of the team: NP, PA, PT, Nurses, clinic staff, etc)
- Patients (some RRC requirements may specify a minimum number of patient evaluations from clinic encounters)
- Peer and Self
- Other:
  - ACGME Competencies (aggregate scores from evaluations)
  - Duty Hour Compliance (indicate the program method for monitoring)
  - Procedure/Case/Patient Logs
  - Conference Attendance- percent attended
  - Quality Improvement project
    - Topic
    - Date presented
  - Scholarly/Research project:
    - Date Topic determined (sign off by mentor)
    - Topic/Title
    - Mentor
    - Presentation date
    - Where presented
    - Other dates or deadlines
  - In-service scores (you may want to look at where they rank within their PGY class)
  - Modules completed (if other than those required by GME)
  - ACLS/PALS or other required certifications, etc.
  - USMLE Step 3/COMLEX 3 (3 digit score required to advance to PGY 3 level)
  - Personal Goals/ Plans
  - Other areas relevant for your specialty

Program Director Name: ____________________________
Resident/Fellow Name: ____________________________

Review Date: ____________________________
<table>
<thead>
<tr>
<th>Categories 1</th>
<th>Sub Category 2</th>
<th>Title</th>
<th>Date(s) Presented</th>
<th>Presenter</th>
<th>Faculty, Resident, Other</th>
<th>R,RS</th>
<th>Frequency</th>
<th>Faculty Attend / Residents Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Problem Solving</td>
<td></td>
<td>Medicine</td>
<td>1/8/2009</td>
<td>Gordon Ehlers, M.D.</td>
<td>F</td>
<td>R</td>
<td>Q1-3 yrs</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Adult Medicine</td>
<td>Cardiology</td>
<td>Atrial Fibrillation</td>
<td>5/4/2010</td>
<td>Suri Sundaram, M.D.</td>
<td>O</td>
<td>R</td>
<td>Q1-3 yrs</td>
<td>Yes / No</td>
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<td>Adult Medicine</td>
<td>Cardiology</td>
<td>Antithrombotic Therapy in ACS and Stroke</td>
<td>4/16/2008</td>
<td>Mary Omyso, PharmD</td>
<td>F</td>
<td>R</td>
<td>Q1-3 yrs</td>
<td>Yes / No</td>
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<tr>
<td>Adult Medicine</td>
<td>Cardiology</td>
<td>Atrial fibrillation</td>
<td>7/15/2010</td>
<td>Debra Milner, M.D.</td>
<td></td>
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<tr>
<td>Adult Medicine</td>
<td>Cardiology</td>
<td>Atrial fibrillation</td>
<td>7/15/2010</td>
<td>Debra Milner, M.D.</td>
<td></td>
<td></td>
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</tbody>
</table>

1 The category can be the categories under the competencies identified in the special specific program requirements
2 The sub category can be used if your program requirements have specific requirements under key categories

This document may be found on the GME website under Program Directors/Coordinators; Resources and Toolkits
### Didactic Schedule

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Location</th>
<th>Book/Journal</th>
<th>Chapters (pages)</th>
<th>Topic</th>
<th>Title</th>
<th>Moderator/Facilitator</th>
<th>MK</th>
<th>PC</th>
<th>IPC</th>
<th>Prof</th>
<th>BPLI</th>
<th>SBP</th>
<th>Basic Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>8/3/2009</td>
<td>ACP</td>
<td>Lecture</td>
<td></td>
<td>This should tie to the educational requirements in the program requirements</td>
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<tr>
<td>Tuesday</td>
<td></td>
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<td>article</td>
<td>provide name of source for article</td>
<td>Insights Hyperpigmentation etc</td>
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<tr>
<td>Friday</td>
<td>8/7/2009</td>
<td>ACP</td>
<td>Name of text</td>
<td>Ch 3</td>
<td>Embryology</td>
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</table>

### Conference Schedule

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Location</th>
<th>Type</th>
<th>Topic</th>
<th>Title</th>
<th>Moderator/Facilitator</th>
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<tbody>
<tr>
<td>Monday</td>
<td>8/10/2009</td>
<td>DH</td>
<td>Journal Club</td>
<td>This should tie to the educational requirements in the program requirements</td>
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<td></td>
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<td>Morning conference</td>
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<td>M&amp;M</td>
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<td></td>
<td></td>
<td></td>
<td>Grand Rounds</td>
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</tbody>
</table>
Key to Standard Notification Letter for Status of Continued Accreditation
(Text in italics provides explanations of the sections in the letter; non-italicized text is standard text of the letter)

Date
Program Director Name
Director, Residency Program
Program Name
Address Line 1
Address Line 2
City State Zip

Dear Dr. Program Director:

The Residency Review Committee for X, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Specialty
Name of Program
Sponsoring Institution
City, ST

Program 1000000000

Based on all of the information available to it at the time of its recent meeting, the Review Committee accredited the program as follows:

**Status:** This is the accreditation status assigned to the program or institution by the Review Committee following review of the program or institution.

**Length of Training:** This is the number of postgraduate years of resident education that the program is accredited to provide.

**Maximum Number of Residents:** If the Review Committee approves resident complement, this section lists the maximum number of residents that may be appointed to the program at any given time.

**Residents per Level:** If the Review Committee approves resident complement by year, this section specifies the maximum number of residents that may be appointed at each level of the program.

**Effective Date:** This is the effective date of the accreditation action and, per ACGME policy, is the date of Review Committee Meeting.
Approximate Date of Next Site Visit: This is the target date (month and year) for the next site visit of the program or institution, based on the length of the accreditation cycle specified by the Review Committee and will include whether the site visit will be performed by a member of the ACGME Field Staff (FS) or by a Specialist Site Visitor (SSV). Programs generally are scheduled in a 90-120 day window around the next site visit month. On occasion, a site visit may occur on an earlier or later date because each Field Staff visits three programs per week and the date can be moved forward or moved back to allow three programs to be scheduled in a given city. In addition, Transitional Year (TY) programs and some subspecialties with one required year of education are generally scheduled during the last nine months of the academic year in order to give the residents/fellows an opportunity to gain experience with the program prior to participating in the resident/fellow interview at the time of the site visit. Approximately 90-110 days before the scheduled site visit, the Department of Field Activities staff will send to the program director and institutional DIO information about the actual site visit date and logistics for the site visit.

Cycle Length: This is the number of years between the Review Committee meeting at which the accreditation action was confirmed and the approximate date of the next site visit of the program or institution.

Approximate Date of the Mid-Cycle Internal Review: This is the approximate date when internal reviews must be documented in the GMEC minutes as being in process. This date is calculated using the effective date (see above) and the approximate date of the next site visit (see above).

Progress Report Due: If the review committee requests a progress report, the due date is included in this section.

Areas Not in Substantial Compliance (Citations) (Required Section)
- Each letter will include this section, listing areas in which the program is not in compliance with ACGME Requirements for Graduate Medical Education. These areas of noncompliance are also referred to as citations. Each citation will include a descriptive heading, the actual institutional or program requirement for the area that is not in compliance and the Review Committee’s brief explanation of non-compliance.
- If no citations were identified by the Review Committee, this section will include a statement of commendation to the program or institution for demonstrating substantial compliance with the requirements without citation.
- If the program received a 4 or 5 year review cycle, this section will include a commendation for demonstrating substantial compliance with the ACGME Requirements for Residency Education, as well as a list of areas of noncompliance, or citations.
- If the program received a 1 or 2 year review cycle, this section will include a list of the areas of noncompliance, or citations, as well as a statement warning that the program’s or institution’s accreditation will be in jeopardy at the time of the next review if these areas have not been adequately addresses, and/or other major areas warranting citation develop.
Standard format for the text for each citation:

- Line 1: Descriptive Header for topic:
- Line 2: Institutional or Program Requirement Number
- Line 3: Texts of the Institutional or Program Requirement
- Next line is a space
- Next line provides the Review Committee’s explanation of non-compliance
- Next line includes sources listed in parentheses (e.g., pages from the Institutional Review Document or Program Information Form, Site Visitor Report, case logs, ACGME Resident Survey)

**Reduction in Resident Complement:** If the Review Committee approves resident complement, and the Review Committee determines that a reduction in the number of residents is necessary; this section includes the citations for the proposed reduction in resident complement and the following statements.

Before final action is taken to reduce resident complement, the program director has the opportunity to respond to the citations by submitting written information for review by the Review Committee. The program director may provide information revising, correcting or expanding factual information previously submitted; rebutting the interpretation of the Review Committee; demonstrating that areas cited as not in compliance did not exist when the Review Committee initially reviewed the program and proposed an adverse action (i.e., the date of the Review Committee meeting); and contending that the program has demonstrated the capacity to provide each resident with a sufficient educational experience.

The response must be reviewed and approved by the sponsoring institution’s Graduate Medical Education Committee and co-signed by the Designated Institutional Official prior to submission to the ACGME. In order to be considered by the Review Committee, the response must be received, in triplicate, by the date indicated above. If the program director chooses not to respond, the reduction in resident complement will be confirmed by the Review Committee. Guidelines on responding to the proposed reduction in resident complement, “Procedures for Proposed Adverse Actions”, and a copy of the Site Visitor’s Report (SVR) will be included with the letter of notification.

**Program Strengths** *(Optional Section)*: If the program or institution received a 3, 4, or 5 year review cycle, the Review Committee may highlight program strengths or acknowledge areas in which the program or institution has improved substantially since the last review.

**Resident Complement Updates:** If the Review Committee approves resident complement by year, this section provides greater detail and directions for how the program will accomplish the increase.

**Request for Progress Report**
- If a progress report is requested, this section will include a list of citations which must be addressed, including detail regarding the specific type of
information requested in response to a particular citation, such as resident case logs.

• If the Review Committee determines that the information submitted by the program or institution in response to the progress report request does not adequately address the citations included in the progress report, the Review Committee may shorten the program or institution’s review cycle.

Additional Text: The letter may include additional text such as:

• Approval of a change in participating institutions.
• Comment on recent or anticipated changes in the program.
• A list of areas that will receive attention during the next accreditation review, sometimes referred to as areas for improvement. These are typically areas in which the program or institution is marginally in compliance, and the Review Committee is concerned that the program or institution is in jeopardy of falling below the threshold of compliance in these areas. While not citations, because the program/institution is in compliance, the program or institution may be advised to monitor compliance in this area, and the Review Committee will follow up at the time of the program/institution’s next accreditation review.

Closing Statement:
It is the policy of the ACGME and of the Review Committee that each time an action is taken regarding the accreditation status of a program, the residents and applicants (those invited for interviews) must be notified. This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above. Changes in participating institutions and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.

Sincerely yours,

Executive Director
Residency Review Committee for X

cc: Designated Institutional Official
    Core Program Director for letters about dependent subspecialty program
    Dependent Subspecialty Program Director for letters about core program

Participating Sites
This section includes a list of all regular and routine participating sites listed in the ACGME Accreditation Data System (ADS).
Sample of Notification Letter for Continued Accreditation

October 15, 2007

Jane Doe, M.D.
Department of Neurosurgery
Jasper University Hospital
Metropolis, IL  60606

Dear Dr. Doe:

The Residency Review Committee for Neurological Surgery, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Neurological Surgery
Jasper University Program
Metropolis, IL
Program Number:  1234567890

Based on all of the information available to it at the time of its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Length of Training: 6
Maximum Number of Residents: 9
Residents Per Level: 2.00 - 1.00 - 2.00 - 1.00 - 2.00 -1.00
Effective Date: 09/27/2007
Approximate Date of Next Survey: 09/2009  FS
Cycle Length:  2.0 Year(s)
Progress Report Due: 01/01/2008
Approximate Date for Internal Review: 10/01/2008

AREAS NOT IN SUBSTANTIAL COMPLIANCE (CITATIONS)

The Review Committee cited the following areas as not in substantial compliance with the ACGME requirements for Graduate Medical Education:

Citation #1

Program Director Qualifications
Program Requirement II.A.3.
“Qualifications of the program director must include a requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee.”

The credentials reported for Dr. Doe, program director, show no recent academic participation in academic neurosurgery prior to appointment to the University. In addition, Dr. Smith, another key faculty member reports one
publication, and no review articles, chapters, or textbooks from the last five years. His specialty certification in neurosurgery expired January 2007. (Program Information Form, pages 8 and 9; Site Visit Report, page 4)

Citation #2

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

Dr. Jones is listed as based mainly at University Hospital, and is reported as the only faculty member assigned to this participating site. The credentials reported for Dr. Jones list no current professional activities or committees, peer-reviewed publications or journal articles, review articles, chapters or textbooks, or participation in local, regional, and national organizations, or funded grants from the last five years. (Program Information Form, pages 7, 10 and 11; Site Visit Report, pages 4 and 5)

Citation #3

Faculty Qualifications
Program Requirement II.B.2:
“The physician faculty must have current certification in the specialty by the American Board of Neurological Surgery, or possess qualifications acceptable to the Review Committee.”

Dr. Smith and Dr. Jones do not indicate any certification. (Program Information Form, pages 12 and 13)

Citation #4

Resident Operative Experiences
Program Requirement IV.A.5.a.11
“Residents must participate in the management (including critical care) and surgical care of adult and pediatric patients and experience should include the full spectrum of neurosurgical disorders.”

The program offers an inadequate experience in five operative categories (head trauma, spinal instrumentation, peripheral nerve, pediatric brain tumor, transsphenoidal). (Program Information Forms, pages 59 through 66)

REQUEST FOR PROGRESS REPORT

The Review Committee requests a progress report in which each of the following citations is addressed. This information is requested in triplicate by the date given above. As specified in the ACGME Institutional Requirements, the report should be reviewed and approved by the sponsoring institution’s
Graduate Medical Education Committee and co-signed by the Designated Institutional Official prior to submission to the ACGME. The Review Committee warned that an inadequate response to the following issues could result in a shortened review cycle. If you have concerns about the due date for the progress report, please contact the Review Committee Executive Director.

Citation(s) #1; #2; #3; #4

It is the policy of the ACGME and of the Review Committee that each time an action is taken regarding the accreditation status of a program, the residents and applicants (those invited for interviews) must be notified. This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by name and number as indicated above. Changes in participating sites and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.

Sincerely yours,

Andrew Landers, PhD, MPH
Residency Review Committee for Neurological Surgery

Cc: Nancy Drew, MD, Designated Institutional Official

Participating Sites:
University Hospital
Veterans Administration Medical Center
County Children's Hospital
ACGME | Accreditation Council for Graduate Medical Education

Directors & Coordinators | DIOs | Public

ACGME is responsible for the Accreditation of programs within the United States. Accreditation is accomplished through a peer review process based upon established standards and guidelines. Please note our new zip code: 60654 (P.O. Box zip code remains the same).


Events:
- New - Leadership Skills Training Program for Chief Residents (Registration is open)
- ACGME Board Meetings
- 2009 RC Meetings
- 2010 RC Meetings

HIPAA Business Regulations (2/25/2010)
- Pathology
- Pediatrics
- Physical Med & Rehab
- Plastic Surgery
- Preventive Medicine
- Psychiatry
- Diagnostic Radiology
- Radiation Oncology
Internal Medicine Menu

- Staff & RC Member Listing
- Program Requirements
- Common & Institutional Requirements
- PIF
- Program Resources
- Updates from the RRC
- Site Visit
- FAQ

Staff & RC Member Listing:
- Find Staff Contacts by Subject (MS Word)
- RRC Members

Program Requirements:
- Program Requirements
- Institutional Requirements (PDF)
- Common Program Requirements (PDF)
- Program Director Guide to the Common Program Requirements

Common & Institutional Requirements:
- Requirements for use by all RRC's

Program Information Forms:
- Program specific forms and documentation
- Program Information Forms (PIFs)

Internal Medicine Milestones Project
- Milestones for Internal Medicine Residency Training
Internal Reviews

- Internal Review Process
- Required Documents
- Templates and Examples

“Always bear in mind that your own resolution to succeed is more important than any other.”
Abraham Lincoln
A. Overview

The GMEC goals for ACGME required Internal Reviews are to assess each program’s:

1. Compliance with the ACGME Common Program Requirements (all programs), Program, and Institutional Requirements;
2. Educational objectives and effectiveness in meeting those objectives;
3. Educational and financial resources;
4. Effectiveness in addressing
   a. Citations (areas of non-compliance and concerns) from ACGME accreditation/notification letters.
   b. Recommendations from previous Internal Reviews;
5. Effectiveness of educational outcomes in the ACGME general competencies;
6. Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the ACGME general competencies; and,
7. Annual program improvement efforts in:
   (1) Resident performance using aggregated resident data;
   (2) Faculty development;
   (3) Graduate performance including performance of program graduates on the Board certification examination; and,
   (4) Program quality. (Refer to Common Program Requirements, V.C.)

B. General Process

1. The GME Office notifies the Program Director of the program being reviewed at least 3-6 months prior to the month the internal review is to be conducted. Schedules of the Program Director and the review team members are coordinated by the GME office to establish the date, time, and location. The date must be as close as possible to the approximate date for the Internal Review on the ACGME accreditation/notification letter.
2. The Internal Review Committee/Team includes:
   a. Chair- Program Director from another program,
   b. GME Office Representatives (DIO and Director of Accreditation and Compliance)
   c. Resident selected by the program director chairing the review.
3. The GME Office sends the Program Director the required internal review documents once the internal review date is determined. The Program Director must return the documents to the GME Office at least 3-2 weeks prior to the review.
4. The internal review packet is distributed to the review team one week prior to the internal review date. The review team receives the following information in the packet.
   a. Current PIF
   b. Program Self Study
   c. Program Requirements
   d. ACGME correspondence including the last accreditation letter
   e. Previous internal review reports
   f. Goals and Objectives for the overall program and each rotation
   g. Surveys: ACGME Resident Survey, GME Survey, Housestaff Association Survey
   h. Annual Program Evaluation and Action Plan
5. The Director of Accreditation and Compliance will meet with the Program Coordinator of the program being reviewed at least 2-3 weeks prior to the review to conduct a document review of the following:
   a. Evaluation forms,
   b. Program/resident manual,
   c. PLA’s,
   d. Resident and Graduate files,
   e. Program policies,
   f. Program duty hour monitoring.

C. Internal Review Meeting
The Internal Review is scheduled for approximately 3 ½ to 4 hours. If the chair of the department would like to participate, a separate meeting time on the date of the review is established.

1. Review/clarify with program director and coordinator…(1 to 2 hours)
   a. Concerns relating to program requirements
   b. Concerns and progress in addressing RC citations in the most recent Letter of Notification
   c. Submitted PIF
   d. Submitted Self-Study
   e. Rotation objectives, assessment methods and competencies
   f. Completed online surveys (ACGME, GME and Housestaff Association)

2. Review with key program faculty(include faculty from all sites) (1/2 to 1 hour)
   a. Objectives, assessment and competencies
   b. Supervision and call practices
   c. RC citations and progress/changes to address items
   d. Information contained in completed online surveys
   e. Program strengths and weaknesses

3. Review with residents (at least one resident from each PGY level) (1/2 to 1 hour)
   a. Overall program review including, supervision, evaluations, duty hours, curriculum.
   b. Feedback from the ACGME, GME and Housestaff Association online surveys
   c. Clarify program concerns identified by residents/fellows
   d. ACGME citations and progress/changes to address items
   e. Program strengths and weaknesses

D. Internal Review Team Responsibilities
Team members review all materials and must be prepared to lead in the following areas:

1. Chair: PD from other program:
   a. Select and submit the name and PGY level of the resident/fellow reviewer
   b. Take the lead on questions regarding the PIF, self study, and interview with the faculty.
   c. Make sure any problems are documented which are of concern so that these notes can be used to check the accuracy of the draft report.

2. Resident/Fellow Reviewer:
   a. Interview residents/fellows using resident questions handout and ACGME resident survey results (if available).
   b. Please take notes of issues and concerns. Write a summary of the residents’ responses to be included in the internal review report.
3. GME Representatives:
   a. Explain the process of the review.
   b. Review the program requirements which are new or concerning from the documents submitted for review and, ACGME accreditation letter, citations, progress reports and quality improvement activities.
   c. Provide information regarding findings from the program document review and institutional duty hour oversight.

E. Internal Review Report and Follow-up
1. The GME representatives will draft a report utilizing the GME Internal Review Report template. The review team and the program director being reviewed will receive the draft report approximately two weeks prior to the GMEC meeting to review for accuracy and to include comments.
2. The final draft report will be presented at the first GMEC meeting following the internal review. The Program Director Chair will present the report and the Program Director of the program being reviewed must attend the meeting to respond to any issues raised.
3. The GMEC will approve the report and note in the GMEC minutes. The final approved internal review report will be sent to the Program director, Chair of the academic department, and all committee members.
4. A progress report addressing the internal review recommendations is required. A due date will be noted at the end of the Internal Review report (approximately 3 months) following the internal review. The program director will present the progress report at the specified GMEC meeting.
5. The DIO and GMEC monitor the responses to the progress report. The GME Office will provide follow-up as directed by GMEC until all citations and recommendations are addressed adequately. If further follow-up is needed, an updated progress report to GMEC will be required.

Note:
For programs without a resident enrolled at the accreditation cycle mid-point, a modified internal review will be conducted that will not include interviewing the residents. Upon enrollment of at least one resident, an interview with residents will occur within the second six-month period of the resident(s) first year in the program.
Using the subjects below as topics, label dividers and organize your documentation in a three ring binder in the following order. Submit to the GME office two weeks prior to your program internal review:

<table>
<thead>
<tr>
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<th>Table of Contents</th>
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<tbody>
<tr>
<td>1*</td>
<td>PIF Part 1</td>
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<tr>
<td>2*</td>
<td>PIF Part 2</td>
</tr>
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<td>3</td>
<td>Self Study</td>
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<tr>
<td>4**</td>
<td>Evaluation Forms</td>
</tr>
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<td>5</td>
<td>Annual Program Review Meeting Minutes</td>
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<tr>
<td>6</td>
<td>Goals and Objectives</td>
</tr>
<tr>
<td>7</td>
<td>Conference Schedule</td>
</tr>
<tr>
<td>8</td>
<td>Duty Hour Policy/Process</td>
</tr>
<tr>
<td>9</td>
<td>Supervision Policy</td>
</tr>
<tr>
<td>10</td>
<td>Procedure Logs</td>
</tr>
<tr>
<td>11</td>
<td>Additional Program Documentation (optional)</td>
</tr>
</tbody>
</table>

**PIF:**
- **Part 1 – Common PIF** - log into ACGME WebADs to complete
- **Part 2 – Specialty Specific PIF** - Go to [http://www.acgme.org/acWebsite/home/home.asp](http://www.acgme.org/acWebsite/home/home.asp), select Review Committee, then your specialty PIF (this is the subspecialty section).
  
  *Please note: some specialties are moving toward the entire PIF being completed in WebADs*

**Evaluation Forms:** Include a blank copy of the following with the checklist at the beginning of the section:
- resident evaluation of attending,
- attending evaluation of resident,
- resident evaluation of the rotation,
- resident evaluation of the program,
- faculty evaluation of the program,
- multi-source evaluations, etc.
- The resident semi-annual evaluation and resident summative evaluation forms should include the date of the meeting between the program director and resident and a signature line for the resident and program director indicating the review occurred.
• **Evaluation** forms should be competency based and confidential and/or anonymous when required. Please see the GMEC Policy on Evaluation.

• **Annual program evaluation** meeting minutes, accompanied by the Annual Program Evaluation and Action Plan Form, should include attendance and together these items should demonstrate the program has done the following:
  o Included both residents and faculty in the meeting
  o Systematically and formally reviewed the curriculum
  o Reviewed resident performance
  o Monitored faculty development
  o Monitored graduate performance (ex, on board certification examinations)
  o Reviewed resident and faculty confidential annual program evaluations from the previous year

• **Goals and objectives** should be competency based and organized by PGY level, including:
  o Overall program goals and objectives
  o Rotation goals and objectives

• **Conference Schedule** should demonstrate the following information:
  o Date and title of the talk
  o Speaker credentials (ie, faculty or resident)

• **Duty Hour** policy and process should include:
  o Program process for monitoring resident duty hours
  o Single patient exception form

• **Supervision** policy should:
  o Outline resident graduated levels of responsibility by PGY level
  o Define common circumstances requiring faculty involvement (ex, care of a complex patient, ICU transfer, DNR or other end of life decisions)
University of Colorado Denver School of Medicine  
Office of Graduate Medical Education  
Program Documentation Review

Program:  
PC Name:  
Date:  
Location:

**Required program documentation:**

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<thead>
<tr>
<th>Resident evaluation of:</th>
<th>Faculty evaluation of:</th>
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<tr>
<td>Faculty (at least annually)</td>
<td>Completed ex.</td>
</tr>
<tr>
<td>Rotation</td>
<td>Completed ex.</td>
</tr>
<tr>
<td>Program (at least annually)</td>
<td>Completed ex.</td>
</tr>
</tbody>
</table>

**Program Director summative review of residents with required language** *(Template)*

- Multisource evaluations of residents  
  - Type(s):  
    - NI  
    - Paper/ other method

- Program letters of agreement (PLA) for all rotations (including electives)

**Goals and Objectives for:**

- Overall Program  
- all PG levels  
- all rotations  
- competency- based

**Conference Schedules**  
% attendance for key conferences (including faculty and residents)

**Completed procedure/case/patient logs, if applicable**

**Notes:**

---

**Policy and Program Manual:**

<table>
<thead>
<tr>
<th>Duty Hour documentation:</th>
<th>Written policy</th>
<th>Written process for monitoring incl. action plan for violations</th>
</tr>
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<tbody>
<tr>
<td>Moonlighting Policy</td>
<td>Call guidelines/policy</td>
<td></td>
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<tr>
<td>Impairment (substance abuse policy)</td>
<td>Leave policy, including program process for leave requests</td>
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<tr>
<td>Resident Evaluation policy</td>
<td>Selection policy with criteria</td>
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<tr>
<td>Promotion/advancement/Graduation Criteria</td>
<td>Complaint process (program level)</td>
<td></td>
</tr>
</tbody>
</table>

**Grievance policy**

**Supervision policy incl. levels of responsibility for invasive procedures**

**Notes:**

*The required language is as follows: the resident “has demonstrated sufficient competence to enter practice without direct supervision”*
### Current Resident/Fellow Files:

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<th>Name:</th>
<th>Name:</th>
<th>Name:</th>
<th>Name:</th>
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<tr>
<td>PGY level:</td>
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<td>FMG? □ Y □ N</td>
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<td>Faculty evals of residents (completed): □</td>
<td>Faculty evals of residents (completed): □</td>
<td>Faculty evals of residents (completed): □</td>
<td>Faculty evals of residents (completed): □</td>
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### Graduates:

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Internal Review Program Self-Study

Program Name: ____________________________ Review Date: _____________

<table>
<thead>
<tr>
<th>The ACGME requires that internal reviews should assess each program’s:</th>
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<tbody>
<tr>
<td>IV.A.4.a) Compliance with the Common, specialty/subspecialty-specific Program, and Institutional Requirements; including:</td>
</tr>
<tr>
<td>IV.A.4.a) (1) Professionalism, Personal Responsibility, and Patient Safety</td>
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<tr>
<td>IV.A.4.a) (2) Transitions of Care</td>
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<tr>
<td>IV.A.4.a) (3) Alertness Management/Fatigue Mitigation</td>
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<td>IV.A.4.a) (4) Supervision of Residents</td>
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<td>IV.A.4.a) (5) Clinical Responsibilities</td>
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<tr>
<td>IV.A.4.a) (6) Teamwork</td>
</tr>
<tr>
<td>IV.A.4.a) (7) Resident Duty Hours</td>
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<tr>
<td>IV.A.4.b) Educational objectives and effectiveness in meeting those objectives;</td>
</tr>
<tr>
<td>IV.A.4.c) Educational and financial resources;</td>
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<tr>
<td>IV.A.4.d) Effectiveness in addressing areas of non-compliance and concerns in previous ACGME accreditation letters of notification and previous internal reviews;</td>
</tr>
<tr>
<td>IV.A.4.e) Effectiveness of educational outcomes in the ACGME general competencies;</td>
</tr>
<tr>
<td>IV.A.4.f) Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the ACGME general competencies; and,</td>
</tr>
<tr>
<td>IV.A.4.g) Annual program improvement efforts in:</td>
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<tr>
<td>IV.A.4.g) (1) resident performance using aggregated resident data;</td>
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<tr>
<td>IV.A.4.g) (2) faculty development;</td>
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<tr>
<td>IV.A.4.g) (3) graduate performance including performance of program graduates on the certification examination; and,</td>
</tr>
<tr>
<td>IV.A.4.g) (4) program quality. (See Common Program Requirements, V.C.)</td>
</tr>
</tbody>
</table>

INSTRUCTIONS: Please complete questions 1-5 of this self study and attach a copy of the following:

1. Your program’s most recent GMEC Annual Program Evaluation and Action Plan that includes:
   a. Program Duty Hour Monitoring Policy/Process
   b. Program Supervision Policy
   c. Fellow/Resident Graduated Job Responsibilities, by PGY level, that include defining common circumstances requiring faculty involvement (care of a complex patient, ICU transfer, DNR or other end of life decision).
   d.
2. The current Program Information Form (PIF) from ACGME WebADS.
   a. Part 1 - Common PIF and
   b. Part 2 - Specialty/Sub-specialty PIF

Please note: some specialties are moving toward the entire PIF being completed in WebADS.

The PIF must accompany the Self Study. Both parts need to be completed with all questions answered, and all required C/Vs included. Add page numbers when finished and complete the table of contents.
Your responses will be reviewed by the Internal Review team and integrated into the report prepared for the GMEC. The report will be presented at the GMEC meeting following the internal review.

### Program Director and Coordinator Support

1. What is the current percentage of protected time for the program director to administer the program?

2. What is the percentage of time allocated for the coordinator to support the program?

### Internal Review Recommendations

3. Referring to the most recent internal review report: Review each recommendation listed and provide specific information how the program addressed/resolved each item.

### Professionalism & Personal Responsibilities

4. Give an example of how the program educates and assesses residents regarding professionalism and personal responsibilities? Examples:

   **Education**
   - Review of related GME and program related policies with residents
   - Review of subspecialty requirements, standards, materials, information
   - Grand round/ course/seminar topics
   - Others

   **Assessment**
   - Track timeliness of medical record completion
   - Track conference attendance
   - Included as a component in evaluation forms and process
   - Others?

### Resident Teaching

5. Describe how you educate and assess residents on teaching skills. (Grand round education, assessment included in the evaluation process – medical student/resident evaluation, others?)
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Internal Review Report

Sponsoring Institution: University of Colorado School of Medicine
Program Reviewed: Program Name and ACGME #
ACGME Midpoint Date:
Internal Review Date:
GMEC Review Date:

Date of original accreditation by ACGME:
Length of training:
Most recent accreditation effective date:
Accreditation status:
Length of accreditation cycle:
Approximate date of next site visit:
ACGME approved positions:
Number of filled positions:

Internal Review Committee

Team members appointed by the Chair of the GME Committee to review this program:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Program/Depart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carol Rumack, MD</td>
<td>Program Director</td>
<td></td>
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<tr>
<td></td>
<td>PD/APD Resident, PGY</td>
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<tr>
<td></td>
<td>DIO &amp; Associate Dean</td>
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<td></td>
<td>Director of Accreditation &amp; Compliance</td>
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Materials Used

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<tr>
<th>Program Information Form (PIF)</th>
<th>Required Program Documentation Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent ACGME Common, specialty/subspecialty-specific, program &amp; inst. reqs</td>
<td>Internal Review Checklist – Institutional Requirements for Internal Reviews</td>
</tr>
<tr>
<td>Most recent ACGME accreditation letter of notification (progress reports if applicable)</td>
<td>Program policies</td>
</tr>
<tr>
<td>Previous Internal Review Report</td>
<td>Resident/Fellow Worksheet</td>
</tr>
<tr>
<td>Internal Review Self-Study Report</td>
<td>Faculty Worksheet</td>
</tr>
<tr>
<td>Resident evaluations of the faculty and the overall program</td>
<td>Results from most recent ACGME online resident and faculty surveys as available</td>
</tr>
<tr>
<td>Annual program evaluation and action plan report with minutes from most recent annual program evaluation review meeting</td>
<td>Results from most recent institutional GME/Housestaff Association annual surveys (as applicable)</td>
</tr>
</tbody>
</table>
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Process

Each member of the IR team reviewed materials submitted by the program. A separate review of program documentation occurred (details below). The review team met with the program director and coordinator, residents representing each PGY level/year of training (where applicable) and faculty representing each major rotation/service in a separate meeting.

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE/ROLE/SERVICE/PGY LEVEL</th>
</tr>
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<tbody>
<tr>
<td>Program Director</td>
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<tr>
<td>Program Coordinator</td>
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<td>Resident, PGY</td>
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<td>Resident, PGY</td>
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</table>

A draft report was prepared to reflect input from all review team members. A final report with recommendations was shared with the program director and then submitted to the GMEC for review and approval.

Accreditation History and Status Please summarize the following

Brief overview of program accreditation history and changes (i.e. any changes in program length, change in program director or coordinator, new program status, 1st resident/fellow, etc.)

ACGME Citations/Concerns – Effectiveness in addressing areas of noncompliance and concerns in previous ACGME accreditation letters of notification.
Citation/Concern:
Program Response/Action:
Internal Review Team Comment:

Recommendations from Previous Internal Review - Unless specifically noted below, the program has effectively addressed all recommendations from the previous internal review.
Recommendation:
Program Response/Action:
Internal Review Team Comment:

Internal Review Findings – Review Team Assessment

I. Summary of Program Documentation Review

<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Program Coordinator Name</th>
<th>Reviewed by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GME Director Accreditation &amp; Compliance</td>
</tr>
</tbody>
</table>
A. *Resident/Fellow/Graduate Files contain all required information?*
Unless specifically noted below the program is compliant with relevant ACGME and GME requirements regarding training files. *(annual training agreement; medical school diploma, residency completion certificate, Transfer letter from program director; evaluations, semi-annual evaluations, summative letter; USMLE, ECFMG; licensing, certification).*

B. *Program has all required documentation*
Unless specifically noted below the program is compliant with relevant ACGME and GME requirements regarding program documentation.
*Evaluations, PLAs, G&Os, conference schedules and attendance, case/procedure logs, Annual Evaluation and Action Plan, Annual Meeting Minutes*

C. *Program Manual and Policies*
Unless specifically noted below the program is compliant with relevant ACGME and GME manual requirements and current policies. *[Program Personnel (Names and Telephone); Program Curriculum – including goals and objectives; List of all program faculty (including their clinical and research interests); Selection Criteria for entering residents (including prerequisites, if any); Promotion Criteria for next level of training and graduation; Electives available and how to do an elective, if any; ACGME specific Program Requirements; Duty hours policy (adapted and consistent with GMEC policy); On-call guidelines including how is call taken, responsibilities while on call, chain of command, and support systems; Process for faculty evaluation by residents including how confidentiality is assured; Process for resident evaluation by faculty; Process for residents to communicate any complaints or resolve any issues within the program or department; Supervision Policy or Guidelines for each level of training that show progressive responsibility and clinical responsibility; Leave Protocol including how to requesting vacation/leave, and the effects of the leave on the training program; Moonlighting policy (adapted and consistent with GMEC policy); Substance abuse/impairment policy (adapted and consistent with GMEC policy); Information on how fatigue and stress are monitored and addressed by the resident and program director]*

The program is compliant with reviewing and distributing the manual and policies to the residents/fellows and faculty. Yes- if No explain

II. **Compliance with Requirements:**

A. **Institutional Requirements:** unless specifically noted below the program is in substantial compliance with relevant institutional requirements.

A. **Common Program Requirements:** unless specifically noted below the program is in substantial compliance with relevant institutional requirements.

1) *Program Director Support*

2) *Faculty Participation (teaching and scholarly)*

3) *Other Program Personnel*

4) *Professionalism, Personal Responsibility, and Patient Safety*
   *How does the program teach residents regarding professionalism and personal responsibility? How residents are involved in addressing patient safety issues/projects?*
5) **Quality Improvement** – Do all residents participate in QI projects?  
   If yes, provide example  
   If no, explain

6) **Transitions of Care** - Is there a structured hand over process?  
   If yes, provide example  
   If no, explain

7) **Alertness Management/Fatigue Mitigation** – Do all residents/fellows and faculty complete the GME required educational modules?  Other program education?  
   Yes- the program is compliant with requirement(s).  If not compliant explain

8) **Supervision of Residents** – program has a supervision policy and fellow/resident job descriptions by PGY that detail Clinical Responsibilities and progressive responsibility.  
   The program is compliant with requirement(s).  If not compliant explain

9) **Teamwork (Interdisciplinary teams)**  
   If yes, provide example  
   If no, explain

10) **Resident Duty Hours** –  
    The program has a written duty hour monitoring process.  Yes – if No explain  
    The program is compliant with duty hour requirements.  Yes – if No explain

11) **Evaluation Processes and Methods**  
    The program utilizes New Innovations and has all required evaluation components - attending evaluation of resident and program, resident evaluation of attending and program self-evaluation, multisource (type), (others). All evaluation forms are tied to the competencies.  
    If not compliant explain

12) **Competency-Based Goals and Objectives** (for Overall program, by PGY level, and for each major assignment).  
    The program is compliant with this requirement(s).  If not, explain.  
    The program is compliant with reviewing and distributing the goals and objectives to the residents/fellows and faculty at least annually.  
    If not, explain

13) **Educational and financial resources** – the program appears to have sufficient resources and is compliant with this requirement.

B. **Specialty/Subspecialty Program Requirements**
   Clinical Curriculum (including procedures)  
   Didactic Curriculum (including conference schedule)  
   Scholarly Activity / Research - Required, Yes or No – Protected time and indicated on block rotation diagram?

III. **Effectiveness of educational outcomes in ACGME general competencies:** (unless specifically noted below the program is in substantial compliance with relevant institutional requirement).

1. **Patient Care** – Patient/Case logs, evaluations, direct observation by attendings
2. **Medical Knowledge** –  
   o In Service Exam Scores with pass/fail threshold percentile and remediation plan for fellows who do not pass
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- Clinical Skills Assessment
- Board Preparation/Mock Boards

3. Practice-based Learning and Improvement – self assessment, individualized learning plans
4. Professionalism – Multisource evaluations
5. Interpersonal and Communication Skills – patient/family surveys, teaching evaluations
6. System-based Practice – quality improvement activities

IV. ACGME Resident Survey: The program has an action plan for all areas of non-compliance. N/A no survey less than 4 F/R 100% Compliant Yes has action – if No explain

V. Annual program improvement efforts in (1) resident performance using aggregated resident data, (2) faculty development, (3) graduate performance including performance of program graduates on the certification exam and (4) program quality (as relating to opportunities for residents and faculty to at least annually evaluate the program in a confidential manner and use of program evaluation results to improve the program).

Program Strengths:

Opportunities for Improvement:

SPECIFIC RECOMMENDATIONS

<table>
<thead>
<tr>
<th>GMEC ACTION</th>
<th>DATE</th>
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<tbody>
<tr>
<td>The Internal Review Report was reviewed and approved by the GMEC on:</td>
<td></td>
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<tr>
<td>A Progress Report addressing the recommendations is due to the GME Office no later than:</td>
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<tr>
<td>The Progress report will be reviewed by the GMEC on:</td>
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<tr>
<td>Other GMEC Action</td>
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### Competencies-Based Learning Objectives and Assessment Methods

**Program Name:**

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<tr>
<th>PGY Level: (insert answer)</th>
<th>Rotation: (insert answer)</th>
<th>Location: (insert answer)</th>
</tr>
</thead>
</table>

### How Topic or Skill is Taught

**Examples:**

1. Didactic
2. Case conference
3. Continuity clinic
4. Work rounds
5. Inpatient attending rounds
6. Procedure room/OR
7. Simulation
8. Journal Club

### Assessment Method(s) or Evaluation Tool

| (C) | Clinical records review |
| (D) | Direct observation |
| (E) | Evaluation by non-faculty |
| (G) | Global faculty evaluation |
| (L) | Case log review |
| (P) | Portfolio review |
| (PTS) | Patient survey |
| (PES) | Peer survey |
| (S) | Skills checklist |
| (SA) | Self-assessment form |
| (T) | In-training exam |
| (O) | Other (specify) |

### What Constitutes Acceptable Performance Rating

**Examples:**

1. Specific score on in-training exam
2. Completing steps in proper sequence
3. Specified Likert scale rating
4. Listing specific possibilities in a differential diagnosis
5. Graded presentation

### Rotation Objectives:

1. **Medical Knowledge (topics to be covered – must cover and assess)**
   a. (begin list here)

2. **Patient Care Skills (including technical skills to be learned and demonstrated – must cover and assess)**
   a. (begin list here)

3. **Interpersonal and Communication Skills**
   a. (begin list here)

4. **Professionalism**
   a. (begin list here)

5. **Systems-Based Practice**
   a. (begin list here)

6. **Practice-Based Learning and Improvement**
   a. (begin list here)

(Insert answers here. Complete for each competency)

(Insert answers here. Complete for each competency)

(Insert answers here. List or provide information about the criteria that must be met in order to demonstrate competence for each of the 6 areas)
About Rotation Objectives

Listing objectives provides a tool to discern between knowledge and skills existing in a resident at the beginning of a rotation with those demonstrated at the end of the period.

The questions to ask when developing objectives are:

1. What are the specific areas (topics, disease conditions, management options) of knowledge the resident should be able to demonstrate at the end of this rotation, above and beyond what was known initially?

2. What are the specific skills (exams, specific procedures) that the resident should be able to demonstrate at the end of this rotation, above and beyond what was known initially?

3. What tools or techniques will be used to measure or verify that (1) the knowledge has been obtained, demonstrated and applied and (2) the stated level of performance for skills demonstration has been achieved?

4. What criteria will be used to assess whether the resident has demonstrated adequate performance? The program should identify objective performance benchmarks to complement the global faculty evaluation form that often employs a Likert scale.

In addressing the knowledge component it may be helpful to think about the specific conditions in terms of pathophysiology, patient presentation, symptoms, options for management, tests to order or exams to perform.

For the skills component, it may be helpful to think about the specific steps (and order of steps) included in performing an exam or procedure, along with accepted levels of complications.

It is important to map your program’s ACGME RRC requirements to your curriculum, goals and objectives, etc., and to also use exact wording as listed in the requirements throughout your program documentation as appropriate.
o General Information
o Yearly Updates
  o General
  o Annual Resident Survey
o Online PIF
o Resident Case Log

“An Unfailing Success Plan: At each day’s end write down the six most important things to do tomorrow; number them in order of importance, and then do them.”
Anonymous
This is your 10-digit ACGME Program ID number.
Once logged in to WebAds, click on Tools/Reference and then on ADS tutorials. There are a number of video tutorials to assist you as you navigate through the system.
Please note there are minor variations in some tutorial screens. The PIF examples you will see in these tutorials may not pertain to your program.

Additional tutorials coming soon.

**ADS Video Tutorials**
*(please make sure audio is turned up/on)*

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<thead>
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<th>Tutorial Name</th>
<th>Flash Version</th>
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<td>Using the Quick Update Tool</td>
<td>Flash Version</td>
<td>Windows Media Player Version</td>
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<td>Changing ADS Password</td>
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<td><strong>PIF Preparation</strong></td>
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<td>Navigating the New Faculty Roster</td>
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<tr>
<td>Navigating the Preview/Edit PIF</td>
<td>[3:36]</td>
<td>[3:36]</td>
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<tr>
<td>Sorting Participating Sites within the PIF</td>
<td>[3:19]</td>
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<tr>
<td>Troubleshooting Missing Primary Site on PIF</td>
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<td>Troubleshooting Participating Site Not Appearing in PIF</td>
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<td>Printing the HTML PIF - Setting Page Numbers &amp; Margins</td>
<td>[6:11]</td>
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<tr>
<td>Generating the PIF Table of Contents (for Anesthesiology, Internal Medicine subspecialties, Obstetrics and Gynecology, Ophthalmology, Diagnostic Radiology, Radiation Oncology and Pain Medicine only)</td>
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**Resident Survey**

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<tr>
<td>Troubleshooting Aggregate Report Difficulties</td>
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**Resident Case Logs**

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<tr>
<td>Case Log System Overview</td>
<td>[3:35]</td>
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</tbody>
</table>

For more Resident Case Log System tutorials, click here.

Please note there are minor variations in some tutorial screens.  
The PIF examples you will see in these tutorials may not pertain to your program.

Additional tutorials coming soon.
Resident/Fellow Survey

What do programs need to do?

In preparation for the Resident Survey, ALL PROGRAMS should comply with #1 below.

1. Check the listing of your residents in the Accreditation Data System (ADS). Please make sure:
   - all are listed in ADS.
   - all are listed with their correct statuses (active full time, etc.) - no unconfirmed residents
   - all their birthdates and first and last names are entered correctly.

When your program is required to complete the survey, the ACGME will notify you directly. Your notification will include detailed instructions, including how residents and fellows should log in to the survey and a completion date deadline. To comply with this requirement, please do the following.

2. Inform your residents about the survey. Please tell them:
   - they will need to login to the ACGME Survey using these specific instructions below:
     - Close all running applications
     - Open a new internet connection with a browser like Internet Explorer, or Mozilla Firefox.
     - In the internet address bar, type https://www.acgme.org/surveys and press Enter.
     - their initial password will be their DOB, plus the last 2 characters of their last name. For example, the password for Dr. Mary Jones, born 03/14/1979, would be: 03141979es.
     - surveys need to be completed by the completion date given in your notification.
     - they may make changes (additions or corrections) to the survey anytime prior to the completion date. After this due date, access to the survey will be denied.
   - all responses will remain confidential. No individual data will ever be shared with the program.
   - in order to protect their data, residents will be required to change their initial user id and password.

3. Monitor your residents’ compliance with the survey.
   - Check the percentage of your residents that have completed the survey. This number will be listed near the top of your ADS Main Page. A 70% response rate is required for programs with 4 or more residents/fellows; programs with fewer than 4 residents should obtain a 100% response.
   - You may access a list of those who have not yet completed the survey. Select “Residents not completing survey” located under the RESIDENT/FELLOW SURVEY heading from the left side menu.

   An Aggregate Report is available to view in ADS once your deadline date has passed.

4. Review your Resident Survey Aggregate Report
   - You may access the Aggregate Report and Aggregate Report Guide under the RESIDENT/FELLOW SURVEY heading from the left hand menu.
   - Summary data will be available if at least 70% of residents in programs with 4 or more residents/fellows complete the survey.
   - Programs with fewer than 4 residents will not see aggregate reports in order to maintain the anonymity of the residents.

Please note that programs are NOT required to send the Resident Survey report to site.
All information you provide about your current program will be saved anonymously. No individual responses will be given to your program, your program director, your faculty, your institution, or the Residency Review Committee. The summarized data will be a part of the information considered by the accreditation site visitor and RRC for the accreditation of the program and sponsoring institution. Summary data from this survey may be used to inform ACGME policy decisions at the national level. Summary data and other information about programs, institutions, resident physicians or resident physician education which is not identifiable by person or organization may be published in a manner appropriate to further the quality of GME and consistent with ACGME policies and with law.

1. The following are the ACGME requirements regarding duty hours.
   Read each requirement carefully and give your honest evaluation.
   Answer each question in this survey about your experiences since the beginning of the current academic year.

   How often did you break the rule that duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

2. How often did you break the rule that residents/fellows must be scheduled for a minimum of 1 day in 7 free from all residency related duties, averaged over a 4-week period?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

3. Since the beginning of the current academic year, have you ever taken in-house call?
   - Yes
   - No

4. How often did you break the rule that in-house call must occur no more frequently than every third night, averaged over a four-week period?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often
5. How often did you break the rule that there should be a 10-hour time period provided between all daily duty periods and after in-house call?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

6. How often did you break the rule that continuous on-site duty, including in-house call, may be scheduled to a maximum of 24 consecutive hours with up to 6 additional hours on duty to allow for continuity or transition of care, scheduled didactic activities, or outpatient clinics?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

7. Since the beginning of the current academic year, have you ever taken at-home call?
   - Yes
   - No

8. How often did you break the rule that at-home call must not be so frequent as to preclude rest and reasonable personal time for you?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

9. When you take at-home call and are called into the hospital, the hours you spend in-house should be counted in the 80-hour limit. How often did you count these hours towards the 80-hour limit?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often
   - Not applicable: You were not called into the hospital from home

10. Which of the following explain why you reported breaking one or more of the duty hour rules:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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c. Because you wanted to work additional hours for the educational experience?  

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d. Because you had to cover someone else’s work or patient load?  

<p>| | |</p>
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e. Because of a night-float system?  

<p>| | |</p>
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f. Because of a schedule conflict, such as educational conferences scheduled during your free time?  

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<tbody>
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</tbody>
</table>
g. Any other reasons? (open-ended text box)  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</tbody>
</table>

Remember, answer each of these survey questions based on your experiences since the beginning of the current academic year.

11. How sufficient is the supervision you receive from faculty and staff in your program:

- Not at all sufficient
- Slightly sufficient
- Somewhat sufficient
- Very sufficient
- Extremely sufficient

12. How often do your faculty and staff provide an appropriate level of supervision for residents when the residents care for patients?

- Extremely often
- Very often
- Sometimes
- Rarely
- Never

13. Although the type of instruction residents receive varies based on their specialty, instruction can occur while rounding and caring for patients, and during conferences and lectures.

How sufficient is the instruction you receive from faculty and staff in your program:

- Not at all sufficient
- Slightly sufficient
- Somewhat sufficient
- Very sufficient
- Extremely sufficient

14. Thinking about the faculty and staff in your program overall, how interested are they in your residency education?

- Extremely interested
- Very interested
- Somewhat interested
- Slightly interested
- Not at all interested

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15. Thinking about the faculty and staff in your program overall, how effective are they in creating an environment of scholarship and inquiry?

- Extremely effective
- Very effective
- Somewhat effective
- Slightly effective
- Not at all effective

The next questions are about the ways residents/fellows evaluate their program.

16. Do you have the opportunity to evaluate your faculty members at least once a year?

- Yes
- No

17. How satisfied are you that your program treats your evaluations of faculty members confidentially?

- Not at all satisfied
- Slightly satisfied
- Somewhat satisfied
- Very satisfied
- Extremely satisfied

18. Do you have the opportunity to evaluate your overall program at least once a year?

- Yes
- No

19. How satisfied are you that your program treats your evaluations of the program confidentially?

- Not at all satisfied
- Slightly satisfied
- Somewhat satisfied
- Very satisfied
- Extremely satisfied

20. How satisfied are you with the way your program uses the evaluations that residents/fellows provide to improve the program?

- Not at all satisfied
- Slightly satisfied
- Somewhat satisfied
- Very satisfied
- Extremely satisfied

21. Has your program provided you with its general goals and objectives in either a hard copy or electronic form?

- Yes
- No
22. Has your program provided you with goals and objectives for each rotation and major assignment in either a hard copy or electronic form?
   - Yes
   - No

23. Overall, how satisfied are you with the written or electronic feedback you receive after you complete a rotation or major assignment?
   - Not at all satisfied
   - Slightly satisfied
   - Somewhat satisfied
   - Very satisfied
   - Extremely satisfied

24. If you want to review feedback on your performance, are you able to access your evaluations?
   - Yes
   - No

The next questions are about other aspects of your program.

25. Has your program adequately instructed you on how to manage the negative effects of fatigue and sleep deprivation on patient care?
   - Yes
   - No

26. How satisfied are you with the opportunities your program provides for you to participate in research or scholarly activities?
   - Not at all satisfied
   - Slightly satisfied
   - Somewhat satisfied
   - Very satisfied
   - Extremely satisfied

27. Interdisciplinary teams may include residents, fellows, faculty, and other clinical support personnel such as nurses, pharmacists, case workers, and dieticians.

   How often do you work in interdisciplinary teams to care for patients?
   - Extremely often
   - Very often
   - Sometimes
   - Rarely
   - Never

28. When you need reference materials for your specialty, do you have ready access to printed or electronic materials?
   - Yes
   - No
29. To what extent does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?
   - Not at all
   - A little
   - Somewhat
   - Quite a bit
   - A great deal

30. How satisfied are you with your program’s process to deal confidentially with problems or concerns residents/fellows might have?
   - Extremely satisfied
   - Very satisfied
   - Somewhat satisfied
   - Slightly satisfied
   - Not at all satisfied

31. In your opinion, how often do your rotations and other major assignments provide an appropriate balance between your residency education and other clinical demands?
   - Extremely often
   - Very often
   - Sometimes
   - Rarely
   - Never

32. How often has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspecialty fellows, PhD students, or nurse practitioners?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

33. How often has your clinical education been compromised by excessive service obligations?
   - Never
   - Rarely
   - Sometimes
   - Very often
   - Extremely often

34. Which of the following best summarizes your opinion of your residency program?
   - The best possible experience – if I had to select residency programs again, I’d pick this one.
   - A good experience – if I had to select residency programs again, I would probably choose this one.
   - A neutral experience – if I had to select residency programs again, I might or might not choose this one.
   - A negative experience – if I had to select residency program again, I would probably not choose this one.
   - A very negative experience – if I had to select residency programs again, I would definitely not pick this one.
THE RESIDENCY REVIEW COMMITTEE FOR INTERNAL MEDICINE

This part of the survey collects information about specific aspects of your Internal Medicine program. Not all questions below may apply to you. If you have not had experience in a particular area, or if your experience to date does not allow you to answer accurately, please enter N/A (not applicable) for “Don’t Know/NA.”

What year are you in the program?  YR1 ☐  YR2 ☐  YR3 ☐

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know / NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities</td>
<td>Do you use an electronic health record at the site(s) where the majority of your training occurs?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Do you provide care for patients with acute coronary syndromes before and after interventional cardiology procedures?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are you satisfied with your on-call (sleeping room) facilities in terms of ALL the following: privacy, convenient location, safety, security, cleanliness, quiet, shower/bath? (NOTE: If you are unsatisfied with ANY aspect of your on-call facilities, please mark No for this question.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Is there a safe place at the hospital for you to store your books, medical equipment and other possessions?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Do residents have 24-hour access to a lounge (i.e., a place to relax with fellow residents)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Do residents have 24-hour access to food facilities (either from a cafeteria or vending area)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are the following facilities and services adequate for patient care and teaching in the following settings?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>Nursing Services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>Clerical and Clinical Support Services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>9</td>
<td>Translators</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10</td>
<td>Social Workers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11</td>
<td>Dieticians</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12</td>
<td>Patient Exam Rooms</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13</td>
<td>Space for Teaching Rounds</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14</td>
<td>Conference / Teaching Facilities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15</td>
<td>Computer Access</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16</td>
<td>Medical Records</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>17</td>
<td>Laboratory Data Retrieval</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18</td>
<td>Radiographic Studies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
19 Radiology Film and Report Retrieval

Faculty

20 Do the faculty promote an environment of inquiry and scholarship in the residency program?  
Yes  No  Don't Know / NA

21 Please rate the interest of your faculty members in resident education  
Poor  1  2  3  4  Outstanding  5

Are the following consultation services adequate to meet your educational and patient care needs?  

22 Internal Medicine Subspecialties

23 General Surgery

24 Medical Ophthalmology

25 Office Gynecology

26 Otorhinolaryngology

27 Orthopedics

28 Psychiatry

29 Dermatology

30 Neurology

31 Physical Therapy and/or Rehabilitation Medicine

Inpatient Setting

32 Are first-year residents ever responsible for more than 5 new admissions and 2 transfers or night float admissions per admitting day?  
Yes  No  Don't Know / NA

33 Do first-year residents ever have primary responsibility for the on-going care of more than 10 patients (excluding cross-coverage)?  

34 Do first-year residents ever admit more than 5 new patients in 48 hours?  

35 Do supervising residents ever admit more than 16 new patients in 48 hours? (except during night float rotations)  

36 Do supervising residents ever admit more than 16 patients in 48 hours? (except during night float rotations)  

37 Does the supervising resident with one R1 ever have responsibility for the care of more than 14 patients? (excluding cross coverage)  

38 Does the supervising resident with two R1s ever have responsibility for the ongoing care of more than 20 patients?  

39 Are there rotations or assignments where you do history and physicals or provide care for patients who are not admitted to a resident team? (Not including emergency or consulting services)  

40 Do you routinely provide care for patients on the non-teaching service?  

41 Do residents write all of the orders for patients on the teaching service?  

42 Are all patient consultations from other services supervised by a qualified attending?
<p>| | | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>43</strong></td>
<td>Do your teaching attendings conduct rounds with a frequency and duration sufficient to ensure a meaningful teaching relationship?</td>
<td></td>
</tr>
<tr>
<td><strong>44</strong></td>
<td>Does the number of attending physicians-of-record on inpatient rotations interfere with your educational experience or ability to accomplish your daily tasks of patient care, including work rounds?</td>
<td></td>
</tr>
<tr>
<td><strong>45</strong></td>
<td>Do you receive adequate education in performing safe transitions of care (handoffs)?</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td><strong>46</strong></td>
<td>Do you have first-contact responsibility for a sufficient number of unselected patients when you are assigned to emergency medicine?</td>
</tr>
<tr>
<td><strong>47</strong></td>
<td>On your emergency medicine rotation, do you spend more than 12 hours of continuous duty (including sign-out)?</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity Clinic</strong></td>
<td><strong>48</strong></td>
<td>Does your continuity clinic experience allow you to follow the same panel of patients throughout all 3 years of the training program?</td>
</tr>
<tr>
<td><strong>49</strong></td>
<td>Do you have adequate supervision and teaching during your longitudinal continuity clinic experience?</td>
<td></td>
</tr>
<tr>
<td><strong>50</strong></td>
<td>Are you able to obtain appropriate and timely consultations for your continuity patients?</td>
<td></td>
</tr>
<tr>
<td><strong>51</strong></td>
<td>Do you have adequate opportunity to participate in the management of your continuity panel of patients between outpatient visits?</td>
<td></td>
</tr>
<tr>
<td><strong>52</strong></td>
<td>Has your program implemented models and/or schedules that minimize conflicts between inpatient and outpatient responsibilities?</td>
<td></td>
</tr>
<tr>
<td><strong>Conferences</strong></td>
<td><strong>53</strong></td>
<td>Do you have an adequate opportunity to attend your program's teaching conferences?</td>
</tr>
<tr>
<td><strong>54</strong></td>
<td>Are the teaching conferences educationally valuable?</td>
<td></td>
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<tr>
<td><strong>Evaluation</strong></td>
<td><strong>55</strong></td>
<td>Does the program train residents by using simulation (examples: simulation of: codes; medical emergencies; medical procedures; simulated patients)?</td>
</tr>
<tr>
<td><strong>56</strong></td>
<td>Do faculty routinely evaluate your interview and physical examination techniques?</td>
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<tr>
<td><strong>57</strong></td>
<td>Do all your supervising faculty review your performance with you at the end of each rotation?</td>
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<tr>
<td><strong>58</strong></td>
<td>Do you receive feedback on your performance from patients (peers) and non-physician team members?</td>
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<tr>
<td><strong>59</strong></td>
<td>Does your program offer an effective resident advising program?</td>
<td></td>
</tr>
<tr>
<td><strong>60</strong></td>
<td>Does the program director consider the opinion of the residents when making changes to the program?</td>
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<tr>
<td><strong>61</strong></td>
<td>Are your ideas to improve patient care sought and used constructively by hospital and/or clinic leaders?</td>
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</tbody>
</table>

**Continue**
### Duty Hours

<table>
<thead>
<tr>
<th>Rule</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Very often</th>
<th>Extremely often</th>
<th>NA</th>
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<tr>
<td>How often did you break the rule that duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities?</td>
<td>60.0%</td>
<td>10.0%</td>
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### Which of the following explain why you reported breaking one or more of the duty hour rules:

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<tr>
<td>Because you wanted to work additional hours for the educational experience?</td>
<td>0.0%</td>
</tr>
<tr>
<td>Because you had to cover someone else's work or patient load?</td>
<td>0.0%</td>
</tr>
<tr>
<td>Because of a night-float system?</td>
<td>0.0%</td>
</tr>
<tr>
<td>Because of a schedule conflict, such as educational conferences scheduled during your free time?</td>
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</tr>
<tr>
<td>Any other reasons?</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

### Faculty

<table>
<thead>
<tr>
<th>Question</th>
<th>Extremely</th>
<th>Very</th>
<th>Somewhat / Sometimes</th>
<th>Slightly / Rarely</th>
<th>Not at all / Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How sufficient is the supervision you receive from faculty and staff in your program?</td>
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<td>10.0%</td>
<td>10.0%</td>
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</tr>
<tr>
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<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
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<td>10.0%</td>
<td>10.0%</td>
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</tbody>
</table>

### Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you want to review feedback on your performance, are you able to access your evaluations?</td>
<td>10.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>How satisfied are you that your program treats your evaluations of faculty members confidentially?</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>How satisfied are you that your program treats your evaluations of the program confidentially?</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>How satisfied are you with the way your program uses the evaluations that residents/fellows provide to improve the program?</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Overall, how satisfied are you with the written or electronic feedback you receive after you complete a rotation or major assignment?</td>
<td>60.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

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Educational Content

Has your program provided you with its general goals and objectives in either a hard copy or electronic form?  
- No: 10.0%  
- Yes: 90.0%

Has your program provided you with goals and objectives for each rotation and major assignment in either a hard copy or electronic form?  
- No: 10.0%  
- Yes: 90.0%

Has your program adequately instructed you on how to manage the negative effects of fatigue and sleep deprivation on patient care?  
- No: 10.0%  
- Yes: 90.0%

How satisfied are you with the opportunities your program provides for you to participate in research or scholarly activities?  
- Extremely: 60.0%  
- Very: 10.0%  
- Somewhat/Sometimes: 10.0%  
- Slighty/Rarely: 10.0%  
- Not at all/Never: 10.0%

In your opinion, how often do your rotations and other major assignments provide an appropriate balance between your residency education and other clinical demands?  
- No: 10.0%  
- Yes: 90.0%

How often has your clinical education been compromised by excessive service obligations?  
- No: 10.0%  
- Yes: 90.0%

Resources

When you need reference materials for your specialty, do you have ready access to printed or electronic materials?  
- No: 10.0%  
- Yes: 90.0%

How often do you work in interdisciplinary teams to care for patients?  
- No: 60.0%  
- Yes: 10.0%

How satisfied are you with your program's process to deal confidentially with problems or concerns residents/fellows might have?  
- No: 60.0%  
- Yes: 10.0%

How often has your ability to learn been compromised by the presence of trainees who are not part of your program, such as residents from other specialties, subspeciality fellows, PhD students, or nurse practitioners?  
- No: 10.0%  
- Yes: 60.0%  
- A great deal: 64.2%

To what extent does your program provide an environment where residents/fellows can raise problems or concerns without fear of intimidation or fear of retaliation?  
- A great deal: 60.0%  
- Quite a bit: 10.0%  
- Somewhat: 10.0%  
- A little: 10.0%  
- Not at all: 10.0%

Overall Experience

Which of the following best summarizes your opinion of your residency program?  
- A great experience - if I had to select residency programs again, I would definitely choose this one.  
- A good experience - if I had to select residency programs again, I would probably choose this one.  
- A neutral experience - if I had to select residency programs again, I might or might not choose this one.  
- A negative experience - if I had to select residency programs again, I would probably not choose this one.  
- A very negative experience - if I had to select residency programs again, I would definitely not choose this one.
What activities are included in "duty hours"?
Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical cases (both inpatient and outpatient care), administrative duties related to clinical cases, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences, journal club, and grand rounds. Also included in duty hours are all hours spent on activities required by the accreditation standards such as memberships on hospital committees, or any activities that are an accepted practice in residency programs, such as participating in interviewing residency candidates.
Duty hours do not include reading, studying, and preparation time spent away from the hospital or ambulatory site. For call from home, only the hours spent in the hospital after being called in count toward duty hours.

What does “averaged over a four-week period” mean?
This means that the average should be working hours within, and not across, rotations. It is not appropriate to combine rotations having in-house call with those that do not include call to obtain a lower average. Similarly, it is inappropriate to average a vacation week (with 0 hours worked) with regular duty weeks to obtain a lower average.

Does the “1 day in 7 free” mean that I must have 1 day per week off?
It is common in smaller surgical residency programs to have residents on duty one weekend (Friday and Sunday for instance), so they can be off the next weekend. As long as duty hours requirements are met within the specified averages, this type of every other weekend schedule is acceptable.

How does the ACGME define "adequate time for rest" between duty shifts?
This is generally defined as 10 hours, however programs may provide somewhat shorter rest periods when appropriately educationally justified. Allowing additional time for didactic lectures of high importance, or for surgical experience in rare cases or cases with particular educational value, are examples most Review Committees would consider appropriate.

If I’m on call from home, but I have to go to the hospital, is that in-house call?
For call taken from home, any time spent in the hospital after being called in is counted toward duty hours. Call from home that does not result in travel to the hospital or clinical site is NOT to be included in duty hours.

If call from home isn’t included in duty hours, is it permissible for me to take call from home or night float for extended periods, such as a month?
No. The requirement that 1 day in 7 be free of patient care responsibilities would prohibit being assigned home call for an entire month. Assignment of a partial month (more than six days but less than 24 days) is possible. However, keep in mind that call from home is appropriate if the service intensity and frequency of being called is low. The ACGME requires that programs monitor the intensity and workload resulting from home call, through periodic assessment of workload and intensity of the in-house activities.

Do I include my research project in duty hours worked?
Research time is included if it is a program-required activity. If the research is pursued on the resident or fellow’s own time (without program requirement), it is not included in on-duty time.

What does “didactics” mean?
The word didactic refers to systematic instruction by means of planned learning experiences such as class room lectures, conferences, and grand rounds. It is often used in contrast with “clinical” education.

How should I interpret the Resident Survey duty hour response options?
Extremely often - every time; continuously; with the highest frequency
Very often - frequently; many times
Sometimes - on some occasions; at times
Rarely – infrequently
Never - at no time; not ever

Other information about the ACGME duty hour standards may be found here:
http://www.acgme.org/acWebsite/dutyhours/dh_index.asp
Glossary of Terms Related to Resident Duty Hours
September 29, 2010

Attending Physician: An appropriately credentialed and privileged member of the medical staff who accepts full responsibility for a specific patient’s medical/surgical care.

Clinical Responsibility/Workload Limits: Reasonable maximum levels of assigned work for residents/fellows consistent with ensuring a quality educational experience. Such work, and its level of intensity, varies by specialty and should be studied by all RRCs before a decision is made to incorporate specifics into the program requirements.

Conditional independence: Graded, progressive responsibility for patient care with defined oversight.

Continuity clinic: Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients.

Duty Hours: Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Faculty: Any individuals who have received a formal assignment to teach resident/fellow physicians. At some sites appointment to the medical staff of the hospital constitutes appointment to the faculty.

Fatigue management: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.

Fitness for duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

Supervising Physician: A physician, either faculty member or more senior resident, designated by the program director as the supervisor of a junior resident. Such designation must be based on the demonstrated medical and supervisory capabilities of the physician.

Transitions of care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.
Frequently Asked Questions about the ACGME Common Duty Hour Standards
Effective July 1, 2011

**Question:** How should the averaging of the duty hour standards (e.g., 80-hour weekly limit, one-day-off-in-seven, and call every third night) be handled? For example, what should be done if a resident takes a vacation week?

**Answer:** Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period; or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident takes vacation or other leave, the ACGME requires that vacation or leave days be taken out of the numerator and the denominator for calculating duty hours, call frequency or days off (i.e., if a resident is on vacation for one week, the hours for that rotation should be averaged over the remaining three weeks). The standards do not permit a “rolling” average, because this may mask compliance problems by averaging across high and low duty hour rotations. The rotation with the greatest hours and frequency of call must comply with the common duty hour standards.

Program directors should check with the specific Review Committee to determine if further guidelines or requirements apply to this regulation. For example, the Program Requirements for Internal Medicine do not permit averaging of the interval between in-house call. It is useful to remember that the ACGME expects that duty hours during the rotation with the greatest hours and frequency of call comply with the common standards.

**VI.A.4.b): Professionalism, Personal Responsibility, and Patient Safety**

“The learning objectives of the program must...not be compromised by excessive reliance on residents to fulfill non-physician service obligations.”

**Question:** What is meant by “non-physician service obligations”?

**Answer:** Non-physician service obligations are those duties which in most institutions are performed by technologists, aides, transporters, nurses, or other categories of health care workers. Examples include transport of patients from the wards or units for procedures elsewhere in the hospital, routine blood drawing for laboratory tests, routine monitoring of patients when off the ward and awaiting or undergoing procedures, etc.

**VI.A.5.: Professionalism, Personal Responsibility, and Patient Safety**

**Question:** How will compliance with the new standards be determined?

**Answer:** These requirements will be assessed by the Site Visitor’s report of resident and faculty interviews, and the anonymous resident survey. Additional data will come from faculty participation in maintenance of certification and involvement in CME and scholarly activity. The program director is expected to constantly work with faculty members and residents to establish a milieu of professional behavior and personal responsibility, and a high regard for patient safety in the department.
The program director cannot be accountable for faculty and resident activity during time off. However the program director must be sensitive to signs of lack of professionalism as indicated by lack of fitness for duty (as defined in the ACGME glossary).

VI.B.: Transitions of Care

**Question:** Please define the ACGME’s expectations regarding transitions of care. How should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

**Answer:** Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming teams/individuals responsible for that specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. This can be accomplished in many different ways. For example, the program or institution can review and document on a regular basis a sample of a transition, to include review of a sample patient’s chart and interview of the incoming responsible individual and/or team to ensure key elements in the patient care continuum for that patient have been transmitted and are clearly understood. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible attending physician. Scheduling of on-call shifts should be optimized to ensure a minimum number of transitions, and there should be documentation of the process involved in arriving at the final schedule. The specifics of these schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident education.

VI.C.3.: Alertness Management

**Question:** Please clarify the definition of adequate sleep facilities. Do call rooms meet this need?

**Answer:** “Adequate sleep facilities” are defined as an environment in which residents may sleep or rest for periods of time, ranging from minutes to hours. While traditional call rooms may meet this need, other technologies/areas may be useful as well. This is an area of rapid development, and thus this definition is necessarily broad.

VI.D.: Supervision of Residents

**Question:** Who can be a supervising physician?

**Answer:** A physician, a member of the medical staff, or a more senior resident designated by the program director can supervise a junior resident. Such designation must be based on demonstrated competency in medical expertise and supervisory capability.

In rare instances, a Review Committee may allow non-physician, licensed, independent practitioners designated by the program director to supervise residents.

**Question:** What is meant by “progressive authority and responsibility, conditional independence, and a supervisory role in patient care” for residents?

Duty Hour FAQs 2
Residents enter residency programs as novices and are expected to graduate as accomplished physicians capable of functioning competently and without supervision. Depending on the specialty, this transition may take from three to seven or more years. The development and adoption of specialty-specific “milestones” (objective curricular criteria to be mastered during a given year of residency) that will govern residents’ advancement from one year of education to the next will provide one tool for guiding the authority and responsibility granted to residents. These milestones will help program directors and faculty members determine the levels of responsibility assigned to each individual resident. Until those are in place, documented criteria for such assignments need to be included in the make-up of the program. Great care must be taken in determining the level of involvement each resident will have in direct patient care so as to ensure patient safety. Another level of advancement lies in the granting of supervisory authority to resident over a more junior resident. This will require not only documentation of a medical knowledge and procedural competency skill sets, but also a documented ability to effectively teach and oversee the work of others. At any level of assignment, the initial few days or weeks should be carefully monitored to ensure that the individual resident is capable of functioning in his/her assigned role. If not, then remediation will be necessary before the assignment can continue.

VI.G.1.: Maximum Hours of Work Per Week

**Question:** What is included in the definition of duty hours under the standard “duty hours must be limited to 80 hours per week.”?

**Answer:** Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care. For call from home, only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit. Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in residency programs, such as residents’ participation in interviewing residency candidates, must be included in the count of duty hours. It is not acceptable to expect residents to participate in these activities on their own hours; nor should residents be prohibited from taking part in them.

Duty hours do not include reading, studying, and academic preparation time, such as time spent away from the patient care unit preparing for presentations or journal club.

**Question:** Which tasks that can be completed at home (completion of medical records and office tasks; orders submitted and lab tests reviewed; verbal orders that can be signed at home; preparing conferences; and time spent on research) would count toward the 80 hours?

**Answer:** Any tasks related to performance of duties, even if performed at home, count toward the 80 hours.

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

“A Review Committee may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale.”

**Question:** Can duty hours for surgical chief residents be extended to 88 hours per week?
Answer: Programs interested in extending the duty hours for their chief residents can use the “88-hour exception” to request an increase up to 10% in duty hours on a program-by-program basis, with endorsement of the sponsoring institution’s graduate medical education committee (GMEC) and the approval of the Review Committee. Requests for an exception must be based on a sound educational justification. Some Review Committees categorically do not permit programs to use the 10% exception.

Question: What is meant by “sound educational justification” for a request to increase the weekly limit on duty hours by up to 10 percent?

Answer: The ACGME’s position is that an increase in duty hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents’ educational experience. This requires that all hours in the extended work week contribute to resident education. An example is that a surgical program needs to demonstrate that residents do not attain the required case experiences in some categories, unless resident hours are extended beyond the weekly limit, and that all reasonable efforts to limit activities that do not contribute to enhancing their surgical skills have already been made.

Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and for a subgroup of the residents/fellows in the program (e.g., the chief resident year) or for individual rotations or experiences.

VI.G.3.: Mandatory Time Free of Duty
“Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.”

Question: The common duty hour standards state that residents must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period. How should programs interpret this standard if the “day off” occurs after a resident’s on-call day?

Answer: The common duty hour standards call for a 24-hour day off. Many Review Committees have recommended that this day off should ideally be a “calendar day,” e.g., the resident wakes up in his or her home and has a whole day available. Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident’s post-call day, but understand that in smaller programs it may occasionally be necessary to have the day off fall on the post-call day. Note that in this case, a resident would need to leave the hospital post-call early enough to allow for 24 hours off of duty. For example, if the resident is expected to return to the hospital at 7:00 a.m. the following day, he/she would need to leave the hospital at 7:00 a.m. on the on-call session day. Because call from home does not require a rest period, the day after a pager call may be used as a day off.

Question: If a program only has a few residents and the residents prefer to be on call for two days during one weekend so that they can have another weekend completely free of duties, does this comply with the duty hour standards?

Answer: In some programs residents take call for an entire weekend (Friday and Sunday for instance), to allow them to take the next weekend off. This practice is acceptable so long as total duty hours, one-day-off-in–seven, and frequency of call are within the limits specified by the relevant requirements. For example, this would not be permissible in Internal Medicine,
because the Program Requirements for Internal Medicine do not permit averaging of in-house call assignments.

Note that for in-house call, residents must be accorded adequate rest time (usually 10 hours) between the two weekend duty periods. There are no exceptions to this rule. Thus, in-house call on two consecutive nights (e.g., Friday and Saturday) must include adequate rest (usually 10 hours) between the two duty shifts.

VI.G.4.: Maximum Duty Hour Period Length

**Question:** Are first-year residents allowed to remain on-site for an additional four hours after their sixteen hour shifts for didactics, patient follow-up, and care transition?

**Answer:** PGY-1 residents may not remain on-site after their 16-hour shifts. Periods of duty for first-year residents must not exceed 16 hours in duration.

**Question:** Please clearly define “duty hour period”. Does it only include scheduled work hours or hours directly working with patients, or does it include hours doing any patient-related activities?

**Answer:** Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

VI.G.4.b): Maximum Duty Period Length

**Question:** How should naps for residents be scheduled? What if a resident chooses not to nap?

**Answer:** Strategic napping is strongly suggested in the Program Requirements, especially between the hours of 10:00 p.m. and 8:00 a.m. Naps should not be scheduled, but rather should occur based upon patient needs and resident fatigue.

VI.G.4.b).(2):

**Question:** What activities are permitted during the four hours allowed for transitions?

**Answer:** Residents who have completed a 24-hour duty period may spend up to an additional four hours to ensure an appropriate, effective, and safe transition of care.

Residents must not be permitted to participate in the care of new patients in any patient care setting during this four-hour period.

Residents must not be assigned to outpatient clinics, including continuity clinics, during this four-hour period.

Residents must not be assigned to participate in a new procedure, such as an elective scheduled surgery, during this four-hour period.

Residents who have satisfactorily completed the transition of care may, at their discretion, attend an educational conference that occurs during the four hours.
**Question:** Can a resident attend continuity clinic during the four hours after a 24-hour period of continuous duty?

**Answer:** Residents must not be assigned any additional clinical responsibilities after a 24-hour period of continuous in-house duty, which includes attending continuity clinic. The additional four-hour period following a 24-hour shift is to ensure that effective transitions in care occur.

**Question:** How is the 24-hour limit on in-house call duty applied?

**Answer:** The activity that drives the 24-hour limit is “continuous duty”. If a resident spends 12 hours in the hospital caring for patients, performing surgery, or attending conferences, followed by 12 hours on-call, he/she has spent 24 hours of “continuous duty” time, and is limited to up to four additional hours during which their activities are limited to participation in didactic activities, transfer of patient care, and maintaining continuity of medical and surgical care.

**Question:** What is the ACGME’s interpretation of the use of the added period of up to four hours at the end of a 24-hour duty and on-call shift?

**Answer:** The goal of the added hours at the end of the on-call period is to promote didactic learning and continuity of care. Clarifying language for activities that are permitted during the up-to-four-hour period after the end of the 24-hour continuous duty period for each specialty can be found by clicking on the Duty Hour menu item from the homepage of the ACGME website.

**VI.G.5.: Minimum Time Off Between Scheduled Duty Periods**

**Question:** Please explain the rule regarding time off between scheduled duty periods. What is meant by “should be 10 hours, must be eight hours”?

**Answer:** “Should” is used when a requirement is so important that an appropriate educational justification must be offered for its absence. It is important to remember that when an abbreviated rest period is offered either regularly or under special circumstances, the program director and faculty must monitor residents for signs of sleep deprivation.

A typical resident work schedule specifies the number and length of nights on call, but does not always outline the length of each work day. Scheduled or expected duty periods should be separated by 10 hours.

There are however, inevitable and unpredictable circumstances in which resident duty periods will be prolonged. In these instances, residents must still have a minimum of eight hours free of duty before the next scheduled duty period begins. This standard applies to PGY-1 and intermediate-level residents (as defined by the individual Review Committees).

**Question:** Under what circumstances would eight hours between shifts be acceptable?

**Answer:** Scheduled or expected duty hour periods should be separated by 10 hours. If there are inevitable and unpredictable circumstances that occur in which a resident’s duty hours are prolonged, they must still have a minimum of eight hours free from duty before the next scheduled duty period begins.

**VI.G.7.: Maximum In-House On-Call Frequency**
“PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night, (when averaged over a four-week period).”

**Question:** What is the definition of “on-call duty”?

**Answer:** On-call duty is defined as a continuous duty period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home, but home call is appropriate only if the service intensity and frequency of being called is low. Scheduled duty shifts (generally eight, 10 or 12 hours in length), such as those worked in the ICU, on emergency medicine rotations, or on “night float”, are exempt from the requirement that call be scheduled no more frequently than every third night.

**Question:** How many times in a row can a resident take call every other night?

**Answer:** The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month.

Residents can be assigned to a maximum of four call nights in any seven-day period. This can only be done one week per month. Residents must not take night call for two consecutive nights.

**Question:** Is it permissible for a resident to be on call every other night for two weeks straight and then be off for two weeks?

**Answer:** No.

VI.G.8.: At-Home Call
“The frequency of at-home call is not subject to the every-third-night limitation…”

**Question:** Which standards apply to time in the hospital after being called in from home call?

**Answer:** For call taken from home (pager call), the time the resident spends in the hospital after being called in is counted toward the weekly duty hour limit. The only other numeric duty hour standard that applies is that one-day-in-seven that must be free of all patient care responsibilities, which includes at-home call. The ACGME also requires that programs monitor the intensity and workload resulting from at-home call, through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

**Question:** Does the minimum of eight hours between shifts apply to at-home call?

**Answer:** Although it must count toward the 80-hour weekly maximum, when residents assigned to at-home call return to the hospital to care for patients a new off-duty period is not initiated, and therefore is not subject to the requirement of eight hours between shifts. However, the frequency and duration of time returning to the hospital must not preclude rest or reasonable personal time for residents.

**Question:** Can PGY-1 residents take at-home call, and if so what are the work-hour restrictions for this?
**Answer:** PGY-1 residents are limited to a 16-hour shift and are not allowed to take at-home call.

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

**Clarification:** The Review Committees recognize that at-home call may, on occasion, be demanding. This may include frequent phone consultations or a return to the hospital to provide emergency care or consultation. However, if at-home call predictably prevents a resident from obtaining adequate rest, or if it is associated with extensive returns to provide hospital service, the Review Committee may cite the program under this standard.

**Duty Hours Limits and Research and Other Non-Patient Care Activities**

**Question:** How do the ACGME common duty hour standards apply to research activities?

**Answer:** The ACGME duty hour standards pertain to all required hours in the residency program (the only exceptions are reading and self-learning, and time on call from home during which the resident is not required to be in the hospital). Research of up to six months scheduled during one or more of the accredited years of the program is required in many specialties and may also contain a clinical element. When research is a formal part of the residency and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent duty hour standards.

There are only two situations when the ACGME duty hour standards do not apply to research. One is when programs offer an additional research year that is not part of the accredited years. In this case the ACGME standards do not apply to that year. The other case is when residents conduct research on their own time, which makes these hours identical to other personal pursuits. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident when he or she participates in patient care.

**Question:** How are the standards applied to rotations that combine research and clinical activities?

**Answer:** Some programs have added clinical activities to “pure” research rotations, such as having research residents covering “night float”. This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments. This suggests limits on clinical assignments during research rotations, both to ensure safe patient care, resident learning, and resident well-being, and to promote the goals of the research rotation.

**Question:** If a journal club is held in the evening for two hours, outside of the hospital, and is not held during the regularly scheduled duty hours, and attendance is strongly encouraged but not mandatory, would those hours count toward the 80-hour weekly total?
Answer: If attendance is “strongly encouraged,” the hours should be included because duty hours apply to all required hours in the program, and it is difficult to distinguish between “strongly encouraged” and required. Another way to look at it is that such a journal club, if held weekly, would add two hours to the residents’ weekly time. A program in which two added hours result in a problem with compliance with the duty hour standards likely has a duty hour problem.

Question: If some of a program’s residents attend a conference that requires travel, how should the hours for duty hour compliance?

Answer: If attendance at the conference is required by the program, or the resident is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be recorded just as they would for an “on-site” conference hosted by the program or its sponsoring institution. This means that the hours during which the resident is actively attending the conference should be recorded as duty hours. Travel time and non-conference hours while away do not meet the definition of “duty hours” in the ACGME standards.

Institutional Monitoring and Oversight of Duty Hours

Question: The ACGME states that it rigorously monitors duty hours in accredited programs, and that the sponsoring institution has the oversight for duty hour. Does this mean that our sponsoring institution must do electronic, “real-time” monitoring of duty hours in all accredited programs?

Answer: The ACGME requires that programs and their sponsoring institutions monitor resident duty hours to ensure they comply with the standards, but does not specify how monitoring and tracking of duty hours should be handled. The only ACGME requirement related to monitoring is that all programs complete the six-question duty hour survey on the ACGME’s Accreditation Data System (ADS) and that this information be reviewed and endorsed by each program’s designated institutional official (DIO).

A number of approaches exist for monitoring resident hours, from resident self-reporting to swipe cards and other electronic measures. All of these have some advantages and some drawbacks, with none clearly being superior in every way and in all settings. The ACGME does not mandate a specific monitoring approach, since the ideal approach should be tailored to the program and the sponsoring institution, and the approach best suited for neurological surgery will be different from the one most appropriate for preventive medicine, dermatology, or pediatrics, etc. Programs and institutions may benefit from hearing what has worked in settings similar to theirs.

Question: If the results of a program’s completed ACGME Resident Survey show that a number of residents exceeded several of the duty hour limits, what will the ACGME do?

Answer: The survey has several objectives, but its most important functions are to serve as a focusing tool for the ACGME site visit. If such a program is scheduled for a site visit soon, the site visitor will ask detailed questions about duty hour compliance to verify and clarify the information from the resident survey through on-site interviews and review of documents such as rotation and on-call schedules. This may highlight that residents misunderstood the question, or it may reveal problems with duty hour compliance. If such a program is not scheduled for a site visit in the near future, resident survey results that suggest non-compliance with the duty hours may result in the Review Committee’s following up to request data on duty hours and, if indicated, a corrective action plan. The Review Committees recognize that in many programs a
few residents occasionally work beyond the limits, and limit follow-up to programs where the
data suggest a potential program-level compliance problem.

**Best Practice:** Programs should note that the results of the ACGME Resident Survey
are available to them and their sponsoring institutions in ADS. Programs can use this
information to determine if compliance problems suggested by the data are confirmed by
the residents, and to pinpoint compliance problems and address them before their next
ACGME site visit.

**Other Frequently Asked Questions**

**Question:** Can we “relax” the duty hour standards over holidays or during other times when the
hospital is “short-staffed,” during periods when some residents are ill or on leave, or when there
is an unusually large patient census or demand for care?

**Answer:** The ACGME expects that duty hours in any given four-week period comply with all
applicable standards. This includes months with holidays, during which institutions may have
fewer staff members on duty. During the holiday period, residents not on vacation may be
scheduled more frequently, but the scheduling for the rotation (generally four weeks of a month)
must comply with the common and Review Committee-specific duty hour standards. Further,
the schedule during the holidays themselves may not violate common duty hour standards
(such as the requirement for adequate rest between duty periods), or Review Committee-
specific standards.
### Specialties Using Case Logs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Required July 1</th>
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<tbody>
<tr>
<td>Allergy &amp; Immunology</td>
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</tr>
<tr>
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<tr>
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<tr>
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<tr>
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<tr>
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<td>Physical Medicine and Rehabilitation</td>
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<td>Hand</td>
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<td>Radiation Oncology</td>
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<td>Pediatrics</td>
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<td>Vascular</td>
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<td>Vascular Surgery (Integrated)</td>
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<td>Critical Care</td>
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<td>Urology</td>
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</tr>
<tr>
<td>Pediatric</td>
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</table>
Welcome to the Resident Case Log System

Notice: ACGME will be performing server maintenance on Tuesday, April 20th, 2010; the case log system will be unavailable from 5:00PM till 6:00PM CDT on Tuesday, April 20th.

User ID: [blank]

Password: [blank]  □ Change Password

Login  Clear

Forgot your User ID or Password?

Summary data and other information about programs, institutions, resident physicians or resident physician education which is not identifiable by person or organization may be published in a manner appropriate to further the quality of GME and consistent with ACGME policies and the law. The CPT five-digit codes and/or nomenclature are copyright 1994 American Medical Association (or such other date of publication of the work as defined in the federal copyright laws). All Rights Reserved.

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Electronic Evaluation Systems

Evaluation documents that should be available during a Site Visit for programs that use electronic resident evaluation systems

A growing number of programs/institutions use electronic evaluation systems or data management “suites” for collection, aggregation and presentation of a variety of data related to the administration of residency programs. The ACGME and the Council of Review Committee Chairs have clarified the expectation for information that should be available during the site visit, with the goal of allowing site visitors to verify the existence of a functioning evaluation process, including discussion of the evaluations with the residents. Evidence of this can be offered either via traditional paper-based evaluation forms or print-outs of electronic evaluations, and evidence these evaluations were reviewed with the resident, such as the residents’ signatures. If the program uses an electronic system, it should always maintain a paper record of the final evaluation at completion of training. For residents with academic or other performance problems, there should be additional hard-copy records, because the electronic evaluation parameters may not be appropriate or sufficient in cases where remediation, probation, non-renewal or dismissal needs to be documented.
UCDSOM
Office of Graduate Medical Education (GME)

What GME Does for You
  Accreditation
  Benefits
  Payroll
  Verification
  New Innovations

GMEC
GME Manual
March Madness
Policies and Procedures

“Every worthwhile accomplishment, big or little, has its stages of drudgery and triumph; a beginning, a struggle and a victory.” Ghandi
What GME Does For You

- Contact Us
  - GME Staff
- Annual Requests
- Meetings
- New Innovations
- Payroll and Benefits

“The bad news is time flies. The good news is you’re the pilot.”
Michael Altshuler
Login Instructions for the GME Intranet:

All Program Directors and Program Coordinators should have access to the GME intranet. If you are unsure as to whether you are included in the GME intranet user group, please contact Ashley Walter, 303-724-6030, ashley.walter@ucdenver.edu, to verify your access.

Access requires an SOM e-mail username and password. If you do not have an SOM e-mail account, follow these steps to become a GME sponsored user:
1. Go to [http://passport.ucdenver.edu](http://passport.ucdenver.edu)
2. Select the "Sponsored User Registration" link.
3. Click "Proceed with Requesting an Account."
4. Complete the form and include the organization name of sponsoring department: Anschutz Campus - Sch of Med - Graduate Medical Education.
5. This form requires you to create a password. Please make a note of the password as it will be necessary to login to the GME intranet.
6. Your form will be sent automatically to Gail Silber for approval.
7. Once the account is approved and created, GME will forward your UCD SOM e-mail account information.

Once you have received your UCD SOM e-mail account information from GME, use the following steps to login to the GME intranet.

1. Click on a secure links on the GME website. Most commonly used links are the Program Letters of Agreement located at [www.medschool.ucdenver.edu/gme/pla](http://www.medschool.ucdenver.edu/gme/pla).
2. Once you click the link, a pop-up will appear requesting authentication.

   ![](Authentication.png)

   **Enter the following into the authentication pop-up:**
   
   **User Name:** University\E-mail username  
   **Password:** E-mail password  
   Click **OK**

3. Another pop-up will appear defaulting to **OPEN** the file.

   ![](Opening.png)

   **Leave the default selection as OPEN**
   Click **OK**

4. A third pop may appear which instructs you to authenticate again. This pop-up will only occur if you are attempting to open a Microsoft document.

   ![](Authentication.png)

   **You can bypass this pop-up by clicking Cancel**

If all steps are followed the document should now open. Please contact Ashley Walter, 303-724-6030, ashley.walter@ucdenver.edu, with any questions regarding the GME intranet.
**Annual Requests Made by the Office of Graduate Medical Education**

**Fall**

**Confirmation of Funding:** Each fall, a report detailing the funding status of each resident is sent to the program director from Julie Chavez. It should be reviewed and signed; then returned to the GME Office. The funding should accurately reflect the number and level of residents being sent to each hospital, so it is important to note if you see an error.

**Educational Funds:** Each year, the residents are allotted funds to be used for education. Each GMEC approved program, per the policy on the Distribution of Educational Funds, must have written policy on the allocation of the funds. The GME office will distribute the funds via a journal entry or check by December of each year, and will require an accounting of the funds by May of each year. Templates are included (Attachment A) and emails will go out with exact deadlines for the return of these documents.

**Tax time:** Each fall, residents and fellows will be asked to verify the addresses we have on file in PeopleSoft to ensure that their W2s are sent to the right place. Instructions verifying the information we have on file are as follows:

Go to MyCU portal: From the University website, [http://www.ucdenver.edu](http://www.ucdenver.edu) click on Faculty and Staff. In the upper right hand corner there is a link to MyCU above the search field. Choose Denver as the campus name, and use the login/password used to access the University computers. Once logged in, they may view the information on file for accuracy. This is also the location from which they can view/print their pay advices. If they need assistance logging on to the system, they should call the IT Help Desk at 303-724-4357.

Should there be an error in the information on file, the resident must complete a change of address form and submit it to Nancy McKay so the necessary updates can be made. The change of address form may be found on our website under Residents and Fellows: Payroll and Update Personal Information.

**Winter**

**Didactic Form:** Semi annually (usually January and June), Gail Silber will send a request on behalf of Ann LaFond, for the documentation of time residents are away from the hospital for didactic or scholarly activities. A full description of what should be included is on the top of the form (Attachment B). This requirement is due to the Centers for Medicare & Medicaid Services (CMS) clarifying its policy that hospitals cannot be reimbursed for time that residents spend in activities unrelated to the care and treatment of patients.

**Spring**

**Pagers:** Each spring you will need to submit to Nancy McKay, a list of residents/fellows needing pagers. An email request for this information typically goes out in April and the coordinators will be notified when they can pick up their pagers in the GME office.

**NCE Lists:** The New, Continuing and Exiting spreadsheet (Attachments A through H) is designed to gather information on your residents, and will be emailed to all coordinators after the March meetings. The information is used to input the residents into PeopleSoft and New Innovations and is then returned to the coordinator with the residents CU ID and Pharm numbers. The residents CU ID and pharm numbers are necessary on some of the IS forms from different hospitals.
Resident Charge Sheets (RCS): A simple explanation of a resident charge sheet is that it explains where the money comes from to pay a resident or fellow. If they are not 100% hospital funded, then you must complete one of these. An example is included for reference but these forms are updated yearly to account for the changes to the cost of benefits (health and life/disability), malpractice insurance, parking and pagers. New templates with instructions and deadlines are emailed yearly. These forms are important! If they are not returned, you run the risk of the resident not receiving a check!

PPD Campaign: The campaign runs from early May through early July and is a requirement for all residents. To fulfill this obligation, they must submit one of the following pieces of documentation: annual PPD test, a positive PPD questionnaire or a PPD waiver request. Residents may access the positive PPD questionnaire, the waiver request and the result card on the GME website. Information on where to submit this documentation, along with a schedule of dates and locations where they can have a PPD placed, is sent out in early May. Please note that if a resident has not submitted this documentation by the specified deadline, they will be pulled from the clinical service until documentation is received by the appropriate parties.

Immunization Screening: Residents new to CUGME must have an immunization screening to be conducted in late June/early July. Instructions for scheduling this screening are given out during the March coordinators meeting and should be scheduled early to ensure the residents complete this important requirement.

Annual Enrollment in CUGME Benefits: Each year, all residents must fill out an annual enrollment form for the CUGME Benefit plan. For new residents, the form is included in the packets handed out at the March coordinators meeting. Coordinators will be notified approximately mid April to pick up the continuing resident paperwork. All forms must be completed and returned to the GME office by the specified deadline.

Various Times:

In Service exams: The GME Office will pay for residents to take yearly in-service exams. To take advantage of this, contact Julie Chavez prior to registering your residents to determine the best method for payment.

Leaves of Absence: Coordinators are encouraged to contact the GME office as soon as they are made aware of any resident taking a leave of absence. A leave letter must be signed and on file in your resident’s file. Some key points which must be covered in the letter are: Reason for leave (for example Family Medical Leave), start and end date, number of weeks, paid vs. unpaid, amount of time which must be made up (if applicable), and plan for covering the cost of the insurance premium while on leave. As each case is unique, it is best to speak with either Dee Fetter or Gail Silber before composing the letter.

Travel Awards: GME will provide funds to offset costs for program directors and program coordinators who travel to ACGME workshops and meetings. Forms and instructions for requesting these funds may be found on the GME website under Program Directors/Coordinators: Forms and Templates.
Policy: **Distribution of Educational Funds**

Effective date: July 1, 2008

GMEC Approval / Revision Date: June 11, 2008

Pages: 1

**Purpose:**

To ensure that residents are provided with educational funds.

Note: ACGME makes no distinction between interns, residents and fellows. All levels are referred to as “residents”.

**Policy:**

All University of Colorado School of Medicine GMEC approved training programs must have a written policy by November, 2008 as to how the educational funds received from the GME office are distributed each academic year.

**Program plans must contain the following:**

1. Decision-making process as to how the funds will be allocated. There must be resident participation in this decision.

2. Explanation of allocation of funds, i.e. directly to the residents, for program-wide expenses, etc.

By December of every year, the GME office will transfer via a journal entry/check the amount of funds allocated to the program. Every program will distribute/use these funds according to its written policy and the UC Denver Fiscal Policies and Procedures. In May of every year, the GME office will request from every program an accounting as to how the funds were distributed/used along with a copy of the written policy.
Based on Individual Program Plan, complete either Section 1 or Section 2. Complete Section 3 if your Program will be carrying forward any funds.

### Section 1: Individual Reimbursement to Residents

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Amount</th>
<th>Date</th>
<th>Description of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(insert rows as needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: 0.00

Budget: (Please enter your Program's Budget)

Current Balance: 0.00

### Section 2: Program purchased items for use by entire Program

a) Description of use:

### Section 3: Program will be carrying forward funds

a) Amount of carry forward:

$ ________

b) Reason:

c) Program's Plan for using the funds:

Completed by:

Print Name

Signature

Date
CMS (Centers for Medicare & Medicaid Services) has clarified its policy that time spent by residents in activities that do not involve the care and treatment of particular patients, such as didactic or scholarly activities, is not allowable for GME and IME reimbursement in a non-hospital setting, and not allowable for IME reimbursement when in a hospital setting. A "one workday" threshold will be used to document this time, and subtract it from allowable FTEs.

**One Workday Threshold** - If a resident's or fellow's workday consists entirely of scheduled non patient care activities and no scheduled patient care activities, please list below. This does not apply to time spent on vacation, sick leave, orientation, grand rounds or research activities. **If the resident had patient care activity for any part of the day, the didactic conference need not be included on this form.**

* Indicate with a "x" if taken away from or in a hospital facility. If in a hospital, please identify by name.

<table>
<thead>
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<th>&lt;-----Dates------&gt;</th>
<th>Name &amp; Location of Conference/Didactic Activity</th>
<th>Away From Hospital</th>
<th>In a Hospital</th>
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</tr>
<tr>
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<td>Two</td>
<td>F.</td>
<td>VI</td>
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<tr>
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<td>F.</td>
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Transferring Out of My Program Into Another UCD SOM GME Program: 2011 - 2012

<table>
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<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
<th>Current PGY Level</th>
<th>Funding Source</th>
<th>End Date</th>
<th>Name of UCD SOM GME Program Transferring to:</th>
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<tbody>
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<td>One</td>
<td>P.</td>
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Transferring Into My Program From Another UCD SOM GME Program: 2011 - 2012

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<th>End Date of My Program</th>
<th>2011/2012 PGY Level</th>
<th>Funding</th>
<th>Name of UCD SOM GME Program Transferring From:</th>
<th>End Date of Current Program</th>
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<td>III</td>
<td>Hosp.</td>
<td>Internal Medicine</td>
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<td>CU ID &amp; Pharm #</td>
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## Exiting Residents (Leaving UCD SOM GME) 2011 - 2012

program:

program coordinator:

campus box:

**Exiting Residents**

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<th>First Name</th>
<th>Middle Initial</th>
<th>PGY Level</th>
<th>End Date</th>
<th>Comments</th>
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<td>(xxx) xxx-xxxx</td>
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</tbody>
</table>

**Exiting Residents Being Hired As Faculty At UCD SOM**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>PGY Level</th>
<th>End Date</th>
<th>Comments</th>
<th>Hiring Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>One</td>
<td>S.</td>
<td>V</td>
<td>7/10/2011</td>
<td>Off-cycle</td>
<td>Anesthesiology</td>
</tr>
</tbody>
</table>
Requires For Hazardous Materials Handling or Exposure.

Program: 
Program Coordinator: 
Campus Box: 
Contact Phone #: 

INSTRUCTIONS TO PROGRAM COORDINATOR: In order to meet regulatory requirements, it is necessary for UCD SOM GME to identify positions for Hazardous Materials or Exposure reporting. This will also assist University Environmental Safety offices in identifying positions on the campuses that require training in the use of such hazardous Materials.

Please fill out the information below for all residents new to UCD SOM GME, or residents that have been out of a UCD SOM GME program for greater than one year.

**SECTION 1:** Information is the same for all residents in the Program.

<table>
<thead>
<tr>
<th>Hazardous Chemicals</th>
<th>Radioactive Materials/Ionizing Radiation</th>
<th>Infectious Matls/Human Blood or Bodily Matls/Recombinant DNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**SECTION 2:** If the information is different for each resident, please provide the following information:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
<th>Hazardous Chemicals</th>
<th>Radioactive Materials/Ionizing Radiation</th>
<th>Infectious Matls/Human Blood or Bodily Matls/Recombinant DNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>One</td>
<td>H.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>
Hospitals Rotating to During Academic Year 2011 - 2012

Please fill out the information below for all residents new to UCD SOM GME.

Section 1: Information is the same for all residents in this program.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
<th>The Children's Hospital</th>
<th>Denver Health</th>
<th>University Hospital</th>
<th>Rose Medical Center</th>
<th>PSL</th>
<th>Swedish Medical Center</th>
<th>VA</th>
<th>National Jewish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example One</td>
<td>Q.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Example Two</td>
<td>D.</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Section 2: IF the information is different for each resident, please provide the following information:
SECTION I: MONTHLY STIPEND OF $__________ SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):
IF MORE THAN ONE ACCOUNT (OR DEPARTMENT/DIVISION) WILL PROVIDE FUNDING, INCLUDE ALL INFORMATION & AUTHORIZED SIGNATURES.

<table>
<thead>
<tr>
<th>Training Grant *</th>
<th>Speedtype or Hospital</th>
<th>Program or Project</th>
<th>Monthly Amount</th>
<th>Monthly % of Total Monthly Salary</th>
<th>Start &amp; end dates (mm/dd/yy)</th>
<th>Authorized Signature(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES/NO</td>
<td></td>
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</table>

* INDICATE YES IF FUNDING SOURCE IS A TRAINING GRANT. GME MUST OBTAIN APPROVAL FROM GRANTS AND CONTRACTS.

SECTION II: ANNUAL GME HEALTH ($8,892.00) + DENTAL ($901.00) BENEFITS = $9,793.00 SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):

<table>
<thead>
<tr>
<th>Training Grant *</th>
<th>Speedtype or Hospital</th>
<th>Program or Project</th>
<th>Yearly Amount</th>
<th>% of Total (Should match above)</th>
<th>Start &amp; end dates (mm/dd/yy)</th>
<th>Authorized Signature(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES/NO</td>
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</tbody>
</table>

SECTION III: LIFE & DISABILITY = $303.00 SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):
LIFE & DISABILITY CANNOT BE PUT ON NIH TRAINING GRANTS.

<table>
<thead>
<tr>
<th>Speed Type</th>
<th>Program or Project #</th>
<th>Amount</th>
<th>Authorized Signature(s)</th>
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<tbody>
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</table>

SECTION IV: ANNUAL MALPRACTICE SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):
MALPRACTICE WILL NOT BE CHARGED FOR THOSE RESIDENTS PAID FROM RESEARCH TRAINING GRANTS.

<table>
<thead>
<tr>
<th>Speed Type</th>
<th>Program or Project #</th>
<th>Amount</th>
<th>Authorized Signature(s)</th>
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</table>

SECTION V: ANNUAL PARKING $684.00 CHARGE SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):

<table>
<thead>
<tr>
<th>Speed Type</th>
<th>Program or Project #</th>
<th>Amount</th>
<th>Authorized Signature(s)</th>
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<tbody>
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</table>

SECTION VI: ANNUAL PAGER $120.00 SHOULD BE CHARGED TO THE FOLLOWING ACCOUNT(S):

<table>
<thead>
<tr>
<th>Speed Type</th>
<th>Program or Project #</th>
<th>Amount</th>
<th>Authorized Signature(s)</th>
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<tbody>
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</tbody>
</table>

SECTION VI: TO BE COMPLETED BY GME:

<table>
<thead>
<tr>
<th>PeopleSoft #</th>
<th>Position #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date entered into PS:</th>
<th>Date entered into GME Admin:</th>
</tr>
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<tbody>
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<thead>
<tr>
<th>TCH Approval</th>
<th>Grants Approval:</th>
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<tbody>
<tr>
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</tbody>
</table>
Meetings Which Take Place throughout the Year
*Check the GME website for details*

What: Graduate Medical Education Committee (GMEC) Meetings
When: 2nd Wednesday of the month
Who: Program Directors

What: Program Coordinator Meetings
When: 3rd Thursday of each month
Who: Program Coordinators and GME

What: GME Program Coordinator Workshops
When: Schedule is posted on the website under Program Directors/Coordinators; Meetings
Who: Any coordinator interested in ongoing professional development

What: New Coordinator Orientation
When: As needed; coordinators will be invited to an orientation shortly after they start.
Who: Director of Accreditation and Compliance (DAC) and Gail Silber/ New Program Coordinators

What: Program Coordinator Council
When: Monthly; please refer to the schedule on the GME website
Who: Program Coordinators
New Innovations Training and Support

The GME Office has in-house support for New Innovations, provided by Ashley Walter. She provides training, both classroom style and one on one, for all coordinators to ensure they are comfortable with using the modules we require as well as any module the program wishes to incorporate. In addition, Ashley frequently holds open labs for coordinators where they receive help with issues specific to their program. As the resident New Innovations expert, Ashley is available for questions and is always happy to help. She may be contacted via email at Ashley.Walter@ucdenver.edu or phone at 303-724-6030.

Inputting Resident Information

The GME Office is responsible for inputting residents into New Innovations each year, however, it is the coordinators responsibility to review this information for accuracy. Additionally, coordinators must input the following information for each resident. Included are instructions for inputting each of the required items.

GME Instructions on Entering New Resident Personnel Data into New Innovations

**Entering State Medical Licenses and DEAs**

1. Go to Main > Personnel Data.
2. Hover over the name of the first demographics record and wait the down arrow to appear to the right of the name.
3. Select desired Resident from the personnel data drop down.
4. To filter the demographics for Residents only, click the Filter List tab, select the work role of Resident, and click Update List.
5. For each Resident’s demographics, select the Licenses link located at the bottom of page among the “Other” heading.
6. To edit existing license (or to add dates), click Edit.
7. To add a new State License or DEA, click New. For State Licenses, enter the license number into the description field. Use TL-xxxx for Training License and DR-xxxx for Full License. Leave the number field blank.
8. Enter Start and End Dates into the Dates field.
9. It is optional to upload a scanned image (file size cannot exceed 12 megabytes) of the license/certificate/permit. Scan the license and save it to your computer, click Browse to select desired file.
10. Click Save and Return or Apply Changes depending on desired function.

**Entering Pager Numbers**

1. Go to Main > Personnel Data.
2. Hover over the name of the first demographics record and wait the down arrow to appear to the right of the name. Select desired Resident from the personnel data drop down.
3. To filter the demographics for Residents only, click the Filter List tab, select the work role of Resident, and click Update List.
4. For each Resident’s demographics, select the Phone/Pager link under the “Contact” heading.
5. Click New to enter a new pager number, or Edit to edit an existing pager number.
6. Select Pager from the Location/Type down list.
7. Enter 10-digit number using (xxx) xxxxxxx as the format.
8. Click Save and Return or Apply Changes depending on desired function.

Created By Ashley Walter 06/03/2010
**Setting Up Text Paging Feature**

1. Go to **Main > Personnel Data**.
2. Hover over the name of the first demographics record and wait the down arrow to appear to the right of the name. Select desired Resident from the personnel data drop down.
3. To filter the demographics for Residents only, click the **Filter List** tab, select the work role of **Resident**, and click **Update List**.
4. For each Resident, scroll the demographics page, select **Phone/Pager** link.
5. Click **Edit** to edit an existing pager number. If adding a new pager number, see instructions in previous section for entering new Pager Numbers.
6. Enter the **Last 4 digits of the Pager Number** in the **Extension Field**.
7. Select the **Pager Template** from the drop down. Example: 303266####@page.metrocall.com.
8. Click **Save and Return**.
9. Go to **Main > Lists**.
10. In **Information Listing and Group E-mails/Paging > Open in New Window**.
11. To filter, select desired **Dept/Division** and **Work Status > Display**.
12. Select desired individuals to receive text pages by selecting the radio button next to their name. Note that only personnel with a hyperlinked pager # (underlined in blue) will be able to receive a text page. The hyperlinked pager number indicates that the pager is properly set up in the Personnel Data.
13. Scroll down and select the **Send Text Page** radio button.
14. Type the **Message** into the text box.
15. Click **Send**.

**Enter E-Mail Address**

1. Go to **Main > Personnel Data**.
2. Hover over the name of the first demographics record and wait the down arrow to appear to the right of the name. Select desired Resident from the personnel data drop down.
3. To filter the demographics for Residents only, click the **Filter List** tab, select the work role of **Resident**, and click **Update List**.
4. For each Resident’s demographics, select the **E-mail Address** link under the “Contact” heading.
5. Click **New** to enter a new e-mail address, or **Edit** to edit an existing e-mail address.
6. Enter the institution based **e-mail address** into the Primary E-mail Address field.
7. Click **Save and Return** or **Apply Changes** depending on desired function.

**Entering NPI Numbers**

1. Go to **Main > Personnel Data**.
2. Click the **Basic Information** link under the “Personal” heading.
3. Enter the **10-digit NPI number** into National Provider Identifier field.
4. Click **Save and Return** or **Apply Changes** depending on desired function.

**Enable Automatic E-mail Notifications for Expiring Licenses**

1. Go to **Main > Administration**.
2. In **Local Set Up > E-mail Notifications**.
3. Enter your e-mail address in the **Department Administrator’s E-mail Address**.
4. Click on **State Licenses** or **DEA** from left side-bar depending on the desired function.
5. Under **Work Roles to Notify for State License** select **Resident**. If you plan to enter Faculty licenses, select **Faculty** as well.
6. Enter number of days to send e-mail notifications prior to the expiration of a license (preferably 60 or more).
7. Enter number of days for expiration reminder e-mails to be sent (maybe every 7 days).
8. Click **Save This Tab**.

### Enter the Resident's Semi-Annual Review Dates

1. Go to Main > Personnel Data.
2. Hover over the name of the first demographics record and wait the down arrow to appear to the right of the name.
3. Select desired Resident from the personnel data drop down.
4. Click the Custom Data link (located among the personal information or first quadrant).
5. Enter dates into the following fields in the custom data for each Resident:

   - **Semi-Annual Review - 1st - 2010-11** (Enter the date of the first semi-annual review for 2010-11)
   - **Semi-Annual Review - 2nd - 2010-11** (Enter the date of the second semi-annual review for 2010-11)
   - **Final "Summative" Letter** (Enter the date on the final "summative" letter when the Resident is completing training)
Additional Pay Form (previously One Time Pay Form)

PBS and Campus HR have updated the Additional Pay Form which replaced the One Time Pay Form. This form is used to authorize and process additional payments which are not a part of the resident’s regular stipend. To receive additional pay, the resident must have an active appointment for the time period in which the services were performed.

This form is to be used for all GME residents.

This form may be found on the GME website under Program Directors/Coordinators, Forms and Templates, Additional Pay Form.

Please fill in the following spaces and then send to Nancy McKay at Campus Box C293, Fax 303-724-6034, or email as an attachment to Nancy McKay at Nancy.McKay@ucdenver.edu.

- Total Additional Pay Amount
- Employee (Resident) Name
- Earnings Code: should always be ADP
- Amount
- Speedtype
- Reason/Justification for payment/dates of service for this payment/rate of pay.
- Employee (Resident) Signature and date
- Initiating Department/Supervisor authorizing work signature and date
- Initiating Department Contact
- Phone #

The Additional Pay Form must arrive in the GME office no later than the 5th of the month to ensure that it is added to that month’s pay.

As of August 1, 2009 the new Additional Pay Form must be used for all additional pay.
Submit this completed and signed Additional Pay form to PBS for processing. DO NOT enter payment information into HRMS Time Collection.

PAY WILL BE DIRECT DEPOSITED.

The exception will be an award to be presented during a ceremony, which can be distributed to the appropriate campus. Please select your campus Bursar's Office.

PLEASE NOTE: All boxes must be completed or form may be returned to the initiating department.

<table>
<thead>
<tr>
<th>Pay Period End Date</th>
<th>Batch ID</th>
<th>Total Additional Pay Amt.</th>
<th>GROSS (before taxes/deductions)</th>
<th>NET (after taxes/deductions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee ID #</td>
<td>Employee Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job Code:</td>
<td>Job Code Description:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department #:</td>
<td>Department Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is employee's permanent appointment full or part time?</td>
<td>Full Time</td>
<td>Part Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Group:</td>
<td>Monthly</td>
<td>Bi-Weekly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Earnings Code | Amount | Speedtype | Position # | Job Record #

Reason/Justification for payment/dates of service for payment/rate of pay:
Reminder - This form is not to be used for retroactive payment to an employee, or to pay additional salary amounts. HRMS appointment must be active during stated period of service (pay period end date) for the payment to be processed.

EMPLOYEE SIGNATURE (Required for APF/ADP to certify that additional work has been completed.)

Initiating Department/Supervisor authorizing work: Required authorization signature:

Initiating Department Contact: Email: Phone No.:

Approvals:
 PRINT Approving Dean, Director or designee name: Required Signature: Phone No.: Date:
 PRINT Approving Chancellor/Vice Chan. or designee: Required Signature: Phone No.: Date:
 PRINT Approving HR or Finance Authority: Required Signature: Phone No.: Date:
 PRINT Grants/Contracts Approval (Res. FOPPs Only): Signature: Phone No.: Date:
 PRINT Home department/campus contact name*: Signature: Phone No.: Date:
 PRINT Home depart. supervisor/appointing authority*: Signature: Phone No.: Date:
Items Requiring GMEC Action

Templates
- Annual Program Evaluation and Action Plan
- Application for New Program
- Request for Increase in Complement
- Program Letters of Agreement

“That which we obtain too easily, we esteem too lightly.”
Thomas Paine
University of Colorado Denver School of Medicine
Graduate Medical Education Committee

Requirements for GMEC approved programs

All programs (ACGME and GMEC sponsored programs) must follow the requirements below:

1. Resident/Fellow complete the GME Training Agreement
2. Residents/Fellows attend GME Orientation in the last week of June (Interns) or July 1st.
3. Follow all GMEC policies
4. All program changes (change in complement, program requirements, program director, rotation sites) must be presented and approved by GMEC
5. Complete an Annual Program Evaluation and Action Plan and submit to the GME Office in August
6. Evaluate all residents/fellows semi-annually, year end, and final summative letter at end of fellowship program.
Items Requiring GMEC Approval

Based on the ACGME Institutional Requirements, the GMEC must approve

1. (III. B.10) Oversight of program changes: Review of the following for approval, prior to submission to the ACGME by program directors:
   
   a) All applications for ACGME accreditation of new programs;
   b) Changes in resident complement;
   c) Major changes in program structure or length of training;
   d) Additions and deletions of participating sites;
   e) Appointments of new program directors;
   f) Progress reports requested by any Review Committee;
   g) Responses to all proposed adverse actions;
   h) Requests for exceptions of resident duty hours;
   i) Voluntary withdrawal of program accreditation;
   j) Requests for an appeal of an adverse action; and,
   k) Appeal presentations to a Board of Appeal or the ACGME.

2. Internal Reviews (IV.A)
   
   a) Internal reviews must be in process and documented in the GMEC minutes by approximately the midpoint of the accreditation cycle.
   b) Program responses to actions recommended in the internal review process.
University of Colorado School of Medicine
Graduate Medical Education

**Instructions for Requesting Approval for New Training Program**

1. Parties interested in obtaining approval and recognition in GME for new training program must complete the form below and submit it to the Office of GME for presentation to the GMEC. The GMEC meets on the second Wednesday each month. To be considered for presentation the Program Director must notify Dr. Rumack and the Director of Compliance (DAC) of the intent to request approval for a new program and submit the final proposal at least 10 days before the desired GMEC meeting.

2. Once the form has been submitted, the Program Director must come to a GMEC Meeting to present the request to establish a new training program. The GMEC will make a decision to approve the request based on educational merit. Approval of a program means that the individuals entering the program will fall under the administrative management of the GME Office. This includes benefits, stipend and liability coverage.

3. If the program will be accredited by the ACGME, the Program Director must review the respective requirements to ensure the program meets the standards. The Request for GMEC Sponsorship of New Training Program and only the signature page of the ACGME PIF must be presented at the GMEC. The Program Information Form (PIF) must be completed and submitted to the GME Office. It is expected that the program will apply for ACGME accreditation if available.

4. The ACGME initial application fee is the responsibility of the program. In addition, it will be the responsibility of the program to pay the annual ACGME fee each year that no slots are filled.

   If the program will not be ACGME-accredited, the Program Director is advised that periodic reporting of certain information to the GME Office will be required.
## Request for GMEC Sponsorship of New Training Program

### Part I: General Information

#### Requesting Academic Department/Division:

Program Name: __________________________________________

Are there ACGME requirements available for this program?  
Yes ☐  No ☐

Are you applying for ACGME accreditation?  
Yes ☐  No ☐

Entire Program Length: _______________________

Number of Trainees per year of training: ______________________

PGY starting level:  
PGY 1 ☐  PGY 2 ☐  PGY 3 ☐  PGY 4 ☐  PGY 5 ☐  PGY 6 ☐  PGY 7 ☐

Proposed Program Start Date: ______________________

Will completion of this program make trainees eligible for Boards or a CAQ?  
Yes ☐  No ☐

Indicate the total number of faculty available for teaching: ______________________

### Funding Source (check as appropriate):

- Hospital  ☐  Name of hospital ______________________
- Grant  ☐  PI's Name ______________________
- Department  ☐  Name of department ______________________
- Other  ☐  Describe ______________________

Will resident salaries differ from those set by the GMEC for each PGY level?  
*Yes ☐  No ☐

*If answer is yes include an explanation as Item X in Part II

A guaranteed source of funding is required prior to offering a training agreement. Please attach a copy of letter of funding commitment from Hospital(s), Departments and/or notice of awards that verify funding source and its duration. Approval and signature and signature below acknowledges that the Department Chair guarantees funding of all filled training positions if hospital or other funding sources are not obtained. In addition, the program/dept agrees to pay the initial accreditation fee and the annual ACGME fees each year no slots are filled.

### Submitted by:

Name of program director ______________________  Signature: ______________________  Date: __________

### Approval Required:

Division Chief: Name ______________________  Signature: ______________________  Date: __________

Department Chair: Name ______________________  Signature: ______________________  Date: __________

### Program Contact Information:

**Program Director**

Phone: ______________________  Pager: ______________________  Email: ______________________

**Associate Program Director**

Phone: ______________________  Pager: ______________________  Email: ______________________

**Program Coordinator**

Phone: ______________________  Fax: ______________________  Email: ______________________
REQUEST FOR GMEC SPONSORSHIP OF NEW TRAINING PROGRAM

Part II: Narrative: Program Summary/Curriculum Outline

1) Program Description
Provide the following information:
- Length of program (in years)
- Number of trainees per year
- Pre-requisites for admission (Before entering the program what should the person have completed or know?)

II. Program Administration
Provide the following information:
- Program Director
- Section/Division chief
- Key faculty members
- Administrative support staff

III. Facilities and Resources
Describe the facilities and resources available to residents including:
- Training (rotation) sites, e.g., hospitals
- Availability and diversity of patient population
- Library facilities
- On-call rooms
- Laboratories
- Offices, computers, etc.

IV. Educational Program
Describe the following:
1) Overall Program Goals-
   - Describe the overall body of knowledge to be acquired by the end of the program.
   - What Board certification, Certificate of Added Qualification or other formal recognition will trainees be eligible to apply for at the successful completion of training?

2) List learning objectives for each year of training-
   - What are the specific knowledge topics to be learned?
   - What are the specific skills to be acquired?

3) List the major rotation(s) and provide-
   - Learning objectives for each major rotation, including knowledge topics and skills to be acquired.

4) Supervisory Guidelines: Describe how supervision will be provided during clinical component.

5) Didactic Education: List the name(s) of conferences and rounds with usual frequency of occurrence.

6) As applicable, describe requirements for completion of research/scholarly activities. Include the process for selection of topic(s) and mentor(s). Indicate what deliverables, if any, are required to successfully complete the program.
7) Rotation Schedule: Complete a block rotation diagram for the typical trainee’s schedule per year of training. See Example Below.

<table>
<thead>
<tr>
<th>Year-1</th>
<th>Month</th>
<th>3 months</th>
<th>3 months</th>
<th>3 months</th>
<th>3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Experience</td>
<td>In-patient Service- Red Team</td>
<td>ER</td>
<td>Consults</td>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>Name Institution</td>
<td>UCH / DH</td>
<td>DH</td>
<td>UCH / DH</td>
<td>UCH</td>
<td></td>
</tr>
</tbody>
</table>

½ day Continuity Clinic (UCH)

V. Evaluation
Describe the evaluation method for the following:
1) Resident evaluation by faculty
2) Faculty evaluation by residents
3) Program evaluation by residents and faculty

VI. Duty Hours/Moonlighting Compliance
(Please review the institutional policies on duty hours and moonlighting before answering the following.)
1) Describe the process by which duty hours will be monitored.
2) Describe the process by which moonlighting will be approved and monitored.
3) Describe the process by which fatigue will be monitored.

VII. Describe the impact if any, this new program may have on other residency or fellowship training programs residents’ experience
(How will this program enhance or diminish the educational experience of other specialty programs provided by the department/division/section? Describe the impact of this new program on the availability of patients or other resources necessary for other programs to provide education.)

VIII. Describe the impact if this request is not approved by the GMEC.

IX. (If applicable) Explain the reason for deviating from the current GMEC stipend structure for residents.
Instructions for Requesting an Increase in Resident Complement

Programs interested in increasing the resident complement must complete the attached form and submit it to the Office of GME for presentation to the GMEC. The GMEC meets on a monthly basis. To be considered for presentation the Program Director must submit it at least one week before the scheduled GMEC meeting.

The e-mail version of the form is in Microsoft Word and can be completed using word and by using the tab key to move to the next blank.

The Program Director must come to the GMEC Meeting to present the request for an increase in resident complement.

The GMEC will make a decision to approve the request based on educational merit.

The GMEC will prioritize all requests approved by the GMEC at the September GMEC meeting for the following academic year.
   a. Funding from the department or a grant require no further GME action.
   b. Funding requested from a hospital will be reviewed by the GME Affiliated Hospital Steering Committee.

The GME Affiliated Hospital Steering Committee, at their September meeting, will review all requests for increased complements that require hospital funding based on the prioritized list approved by the GMEC.

For all increases that require ACGME approval, the program must enter the request (temporary or permanent) into webADS after the GMEC has approved the increase. The requests to the RRC should include:
   a. A summary of the proposed increase request, the number of trainees, the level of training, the effective date for the increase, and schedule and manner in which the increase would be phased-in.
   b. An explanation of how the increase will improve the educational experience of all the residents.
   c. The current block diagram of all resident rotations.
   d. The new block diagram of resident assignments if the increase were approved.
   e. Funding support available to support the increase.

The program will not be able to fill the increased positions if funding is not available even if the program receives RRC approval.
# Request to Increase Resident Complement

**Part I: General Information**

Requesting Academic Department/Division:  

Name of Program: ____________________________ Residency ☐ Fellowship ☐  

Duration of program: __________________________ Number of months which are: Clinical ______ Research ______  

Total # of residents currently in the program: __________________________  

Total # residents per year of training: __________________________  

Maximum number of: ACGME positions ______ Non ACGME positions ______  

Total number of new positions being requested: __________________________  

Indicate whether positions are temporary or permanent:  

Effective Start Date: __________________________ End Date: __________________________  

Starting level for the new position(s):  

PGY 1 ☐ PGY 2 ☐ PGY 3 ☐ PGY 4 ☐ PGY 5 ☐ PGY 6 ☐ PGY 7 ☐ Other: ______  

**Funding Source (check as appropriate):**  

☐ Hospital __________________________ ☐ Department ☐ Grant __________________________  

Please attach copy of letter of funding commitment from Hospital(s), Department and/or notice of awards that verify funding source and its duration.  

If a funding source will not be billed indicate whether the position(s) will be filled by:  

☐ Military __________________________ ☐ Foreign Country __________________________  

Submitted by: __________________________ Signature: __________________________ Date: ____________  

Approval Required:  

Division Chief: __________________________ Signature: __________________________ Date: ____________  

Department Chair: __________________________ Signature: __________________________ Date: ____________  

**Program Contact Information:**  

Program Director  

Phone: __________________________ Pager: __________________________ Email: __________________________  

Associate Program Director  

Phone: __________________________ Pager: __________________________ Email: __________________________  

Program Coordinator  

Phone: __________________________ Fax: __________________________ Email: __________________________
Part II: Narrative
Please answer the following questions and submit with your request.

1. Describe the educational justification for the increase in the resident complement including an explanation of how the increase will improve the educational experience of all the residents.

2. Describe the availability of educational resources for training. Please be sure to address the following:
   A. Faculty:
      What would be the new faculty to resident ratio: _____ Faculty: _____ Resident:
      Would this increase require the hiring of additional faculty: Yes No
      Additional Information: _____
   B. Patient Load, Mix and Procedures
      Please describe the availability of the patients, mix and number of cases available for resident education. Include any data that shows patient load increase. _____
   C. Space, Equipment and Support Services
      Please describe the availability of both clinical space and facilities and personal space and equipment (computers, work area, place to keep belongings, library, etc) for residents.
      Please describe the availability of patient support services such as transport, phlebotomy services to support residents while providing patient care.
      Describe any other resources available to the program: _____

3. Describe how this additional position would strengthen the training program? (e.g. If this additional position would help resolve any ACGME citations/concerns, describe the citation and how it would help alleviate it, including how this may help meet the new duty hour requirements).

4. Describe the impact, if any, this additional position may have on other residency training programs and/or residents.

5. Describe how the change will be implemented or phased-in

6. If this request is not approved by the GMEC, briefly describe the consequences.

7. On a separate document, please make and submit a current and proposed block diagram for the rotations or educational experience per year of training as you would for your particular RRC. If the RRC does not require a particular format please make a rotation schedule following the sample below.
On a separate document, please make a rotation schedule based on this example. Please note that this is just a sample and the scheduled cannot be completed on the tables below.

Program Name: ________________________________

Year 1

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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<tbody>
<tr>
<td>Rotation Name</td>
<td>ICU</td>
<td>ER</td>
<td>General Med</td>
<td></td>
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<tr>
<td>Institution/Hospital Name</td>
<td>UCH</td>
<td>DH</td>
<td>UCH</td>
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<td>Total # FTE/Rotation</td>
<td>2</td>
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</table>

Year 2

<table>
<thead>
<tr>
<th>Month</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>Rotation Name</td>
<td>NICU</td>
<td>ER</td>
<td>General Med</td>
<td>Geriatrics</td>
<td>Research</td>
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</tr>
<tr>
<td>Institution/Hospital Name</td>
<td>UCH</td>
<td>DH</td>
<td>UCH</td>
<td>VA</td>
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</tr>
<tr>
<td>Total # FTE/Rotation</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
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University of Colorado Denver School of Medicine  
Graduate Medical Education Committee

Annual Program Evaluation and Action Plan  
Academic Year 2010-2011

Program Name: ________________________________

Date of Program Evaluation Meeting: ________________________________

Number of Residents/Fellows in Program: ________________________________

Number of Key Clinical Faculty listed on the PIF ____________

Key Clinical Faculty (KCF) members are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program.

Program Director Signature: ________________________________

ACGME Common Program Requirements (V.C.) requires a formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas: 1. Resident performance; 2. Faculty development; 3. Graduate performance, including performance of program graduates on the certification examination; and 4. Program quality.

Please complete this form and return to the GME Office by May 6, 2011, including all attachments. The program review can be part of the annual faculty meeting, the department education committee, or faculty education meeting. All faculty and resident must have the opportunity to evaluate the program confidentially and in writing at least annually.

The following key teaching faculty members participated in the meeting:

The following residents/fellows participated in the meeting:

A. Educational Component

| 1. Program goals/objectives are distributed to faculty and residents annually | Yes_________ No________ |
| 2. Each assignment/rotation has competency based goals & objectives | Yes_________ No________ |
| 3. Program Letter’s of Agreement for all required and elective sites current | Yes_________ No________ |
| (Agreements must have current PD, current Site Director, and rotation length by PGY levels and goals/objectives by competency) | |
| a) Please identify any new sites or sites no longer used below | |

| 4. Conferences | |
| a) Is attendance taken at required conferences for faculty and residents? | Yes_________ No________ |
| b) Average attendance of residents at required conferences as listed on the PIF | ____________ % |

| 5. Transition of Care (CPR VI.B.): |
| Does the program monitor an effective and structured hand-over process? | Yes_________ No________ |
6. Clinical Quality Improvement/Patient Safety Program
Describe at least one quality improvement activity or project in which residents participated, including the outcome and how it improved patient outcomes. (If you need more space, please attach the QI project description including the outcome).

B. Resident Participation in Scholarly, Educational and Professional Activities
1. Scholarly Activities
   1. Number of articles authored/coauthored by residents for 2010-2011
   2. Number of presentations at professional meetings by residents for 2010-2011

2. Committee Participation
   List all committees with resident participation (For example, Patient Safety, Education/Curriculum, QI, etc.)

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Resident Name(s)</th>
<th>PGY Level(s)</th>
<th>Program/Dept/Hospital/Other</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

3. Do all residents participate in interdisciplinary teams? Yes________ No________

C. Evaluation
1. Residents are evaluated on their performance following each learning experience. Yes_______ No________

2. Residents are evaluated semi-annually and evaluation is in the residents file. Yes_______ No________

3. Evaluations are in New Innovations. Yes_______ No________

4. Multisource evaluations are used. (Ex. Nurses, Allied Health, Peer, Patients) Yes_______ No________

5. Final summative evaluation verifies that the resident has “demonstrated sufficient competence to enter practice without direct supervision”. Yes_______ No________

6. Faculty and residents have the opportunity to evaluate the program confidentially and in writing at least annually Yes_______ No________

D. Duty Hour Monitoring and Supervision
1. How does the program monitor compliance with duty hours? (Please attach a copy of your program duty hour policy including the monitoring process).

2. How does the faculty provide appropriate supervision of residents in patient care activities? (Please attach a copy of your program Supervision Policy ensuring oversight and graded authority and responsibility CPR VI.D.3).
E. ACGME Citation Responses
1. Attach your program’s current updated responses for all citations from the last RC review or describe below.

2. Responses to citations have been updated in webADS as of __________________________ Date

F. ACGME Resident Survey
Respond to all areas (duty hours, faculty, evaluation, educational content, and resources) that have unfavorable or non-compliant responses on the 2011 ACGME Resident Survey. Non-compliance includes questions with greater than 20% or 3 or more responding in the unfavorable area. Describe the improvement efforts undertaken to address potential issues identified by the most recent ACGME Resident Survey.

G. Overall Program
1. Board Pass Rates for residents graduating during last three academic years. Please provide national comparison if available.

<table>
<thead>
<tr>
<th>Academic Year ending</th>
<th>Number of residents completing the program</th>
<th>Number of residents taking 1st stage of Board exam for 1st time</th>
<th>Number of 1st time takers who passed 1st stage of Board exam</th>
<th>National 1st time pass rate</th>
<th>Number of residents taking 2nd stage of Board exam for 1st time</th>
<th>Number of 1st time takers who passed 2nd stage of Board exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 30, 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>June 30, 2010</td>
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</tr>
<tr>
<td>June 30, 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. In-Training Exams
   a) Results of ITE (Shelf, PRITE, etc.) by PGY level if applicable

PGY 1 _______  PGY 4 _______  PGY 7 _______
PGY 2 _______  PGY 5 _______  PGY 8 _______
PGY 3 _______  PGY 6 _______

   b) How is this information used to improve the program?

H. Faculty Professional Development
1. Key Clinical Faculty* CV’s, for this academic year, are current in webADS Yes _______ No _______
2. Number of Key Clinical Faculty who participated in faculty development programs? # ___________
3. What program activities are in place to support faculty teaching effectiveness?

*Per ACGME – Key Clinical Faculty (KCF) members are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program.
I. Program Strengths and Opportunities for Improvement
What are the resident educational and professional development strengths and opportunities for improvement of your program?

J. Program Action Plan for Improvement
Attach your program’s plan for improvement or describe below. Please include improvement goals for conferences, rotations/assignments, curriculum, etc. Identify your timeline for the actions and how you will measure improvement.

K. Program Changes/Resources Needed
Please identify any changes in complement or change in participating sites.

Required Attachments:
1. Program specific duty hour monitoring process
2. Program specific supervision policy
Instructions: Program Letter of Agreement Templates

The Program Letter of Agreement (PLA) provides details on faculty, supervision, evaluation, educational content, length of assignment and policy and procedures for each required/elective assignment* that occurs at any location no matter the length. These documents are intended to protect the residents by ensuring an appropriate educational experience under adequate supervision and are required of all GMEC approved programs.

What Template to Use

For Required Rotation- all residents/fellows must successfully complete this rotation at some point during their training and are:

1. Doing so at a facility with an existing Master Affiliation Agreement (MAA). Use hospital specific template:
   **Standard 5 Year (MAA).** These facilities are:
   - University of Colorado Hospital
   - The Children’s Hospital
   - Denver Health and Hospital Authority
   - Veteran’s Affairs Medical Center
   - National Jewish Health
   - Rose Medical Center
   - Swedish Medical Center
   - Presbyterian St. Luke’s
   - St. Anthony Central
   - Craig Hospital

2. Doing so at a facility not mentioned above. Use template: **Non Standard 5 Year (No MAA)**

For Elective Rotation, Recurring Use template: **Non Standard 5 Year (No MAA)** or **Standard 5 Year (MAA)**
Open and available for all residents/fellows to incorporate into their training. This PLA will be active for 5 years.

For Elective Rotation, One-time/Person Specific - Use template: **Non Standard Elective (No MAA)**
An individual resident/fellow chooses to incorporate this new rotation into their training. At this time, the program does not wish to make it available to all residents/fellows but may do so at a later date. This PLA will begin and end with the rotation itself.

What to Do

1. Submit the PLA with goals and objectives attached to Gail Silber in the GME office no later than 2 months prior to the rotation start date or the current PLA expiration date. Goals and objectives must be competency-based.
2. All parties must sign prior to sending to GME for Dr. Rumack’s approval.
3. Fill the forms out completely. **Tips** on completing the forms are below:
   a. The name of the GMEC approved program must be identified at the top of the page under University of Colorado Denver School of Medicine and again, in the body of the first paragraph after “Sponsoring Institution”.
   b. List the academic title (also called faculty appointment) and the academic department of the Site Director.
   c. Include a detailed description of how the resident will be evaluated. This includes who will complete the evaluations, when they will be completed and in what format (electronic, printed and completed, etc) *Sample text: Evaluations will be completed by Dr. X electronically in New Innovations at the end of each rotation or Evaluations will be sent via email to Dr. X for completion at the end of each rotation.*
   d. Include the hours or days or weeks per month (rotation).
4. Attach information sheet, which appears as page 1 of each PLA template.

Out of State or International Rotations

The above templates do not apply for any out of state or international rotations. To begin the application process for one of these rotations you must contact Gail Silber, 303-724-6025 or Gail.Silber@ucdenver.edu

There are always unique and uncommon situations that arise. If you have questions not covered by the above information or questions about PLAs in general, please do not hesitate to contact the GME Office at 303-724-6031.

*New PLAs must be completed if there are changes to any of these details and are at most only valid for 5 years.
I am submitting this **new** PLA because:

- [ ] Current PLA will expire on: _______________________
- [ ] Change in Program Director
- [ ] Change in Site Director
- [ ] Change in names on signature page
- [ ] Change in Rotation status (required vs. elective)
- [ ] None of the above; this is a new rotation

**Do you have a site visit or internal review scheduled? If so, what is the date? (Month/Year):**

Name of Program:

Name of Person Completing this form:

Phone number of Person completing this form:

Return this form with NEW PLA to Gail Silber in the GME Office.

GME Guidelines:
Return this form with NEW PLA to Gail Silber in the GME Office.

1. The Site Director must have a UCD SOM faculty appointment.
2. Goals and Objectives, by competency and PGY level, must accompany the PLA.
3. All parties are required to sign the PLA prior to submission to the GME Office for the DIO (Carol M. Rumack, MD) signature.
University of Colorado Denver
School of Medicine

Name of Program

Program Letter of Agreement

This Program Letter of Agreement is between the Regents of the University of Colorado, a body corporate, for and on behalf of the University of Colorado Denver School of Medicine (UCDSOM – “Sponsoring Institution”) Name of Program and Denver VA Medical Center (DVAMC - “Participating Site”).

This Agreement is effective beginning Date and expires on this date five years hence unless there is a change in the named Program Director, Participating Site Director, or this Agreement is terminated by either party upon 90 days notice or other conditions described in the Agreement or upon termination of the Master Affiliation Agreement.

The parties are currently subject to a UCDSOM Graduate Medical Education (GME) Master Affiliation Agreement, which set forth the duties and obligations of the parties with respect to the establishment, maintenance, and provision of an Accreditation Council for Graduate Medical Education ("ACGME") accredited sponsoring institution and graduate medical education training program. The purpose of this Program Letter of Agreement is to further clarify the learning objectives of the training program, the mechanism for evaluating resident performance, and requirements for participating residents regarding licensing, insurance, immunization, OSHA and HIPAA training, and background checks.

The following conditions apply:

1. Persons Responsible for Education and Supervision

   At UCDSOM

   Name of Program Director, Credentials
   Program Director
   Name of Program

   At DVAMC

   Name of Site Director, Credentials
   Academic Title
   Academic Department
   Participating Site Director

2. Responsibility for Education, Supervision and Evaluation of Residents/Fellows

   The teaching faculty at DVAMC must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The teaching faculty must evaluate resident performance in a manner consistent with ACGME Common Program Requirements and conditions set forth in Residency Review Committee Program Requirements for individual specialties and subspecialties. The teaching faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. Evaluations are to be completed by both the Participating Site Teaching Faculty and the rotating residents/fellows at the end of each rotation and sent to the UCDSOM Program Director. Specific information as to how evaluations will be performed, eg when, by whom and what type of format.
3. **Educational Goals and Objectives**

Educational goals and objectives to be obtained by the residents/fellows while on rotation at the Participating Site have been developed jointly by the UCDSOM Program Director and Teaching Faculty and the Participating Site Director and Teaching Faculty. They are either attached or outlined in Appendix A and are in the program manual for review.

4. **Resident Level(s) and Period of Assignment**

This agreement covers the following ☐ **required** educational experiences for Number of resident(s) at PGY level(s) **All levels applicable**. Goals and Objectives have been distributed by the program to the program director, site director and resident(s).

To assure that the educational goals and objectives are obtained by the residents, the recommended period of assignment will be for a period of Number of either hours or days or weeks per month per year.

And/or

This agreement covers the following ☐ **elective** educational experiences for Number of resident(s) at PGY level(s) **All levels applicable**. Goals and Objectives have been distributed by the program to the program director, site director and resident(s).

To assure that the educational goals and objectives are obtained by the residents, the recommended period of assignment will be for a period of Number of either hours/days/weeks per month per year.

5. **Policies and Procedures that Govern Resident Education.**

While at the Participating Site the residents/fellows shall comply with all the Participating Site’s applicable rules, regulations, polices, and other provisions addressing patient care activities, education experiences, research and other scholarly activities, and use of institution facilities. However, all UCDSOM Graduate Medical Education Committee (GMEC) Policies and Procedures, in particular those related to benefits, disciplinary actions, grievance procedures and requirements to comply with ACGME and GMEC duty hour standards, shall govern the resident(s) while at the Participating Site.

UCDSOM has performed and all residents/fellows have completed training on OSHA Universal Precautions (including blood-borne pathogens), as defined by the Center for Disease Control and Prevention.

UCDSOM has performed and all residents/fellows have passed a criminal background check.

UCDSOM has performed and all residents/fellows have completed training on HIPAA and patient privacy standards.

Designated provider for UCDSOM has on file each resident's/fellow’s infectious disease and immunization summary and follow-up information, which covers Rubella, Mumps, Measles, Diphtheria, Hepatitis B, and Tetanus and TB and includes annual PPD documentation.
All residents/fellows are licensed to practice medicine or have a physician training license in the State of Colorado.

All residents/fellows receive a stipend and benefits through UCDSOM.

UCDSOM warrants and represents that it self-insures for professional liability insurance for itself and for its public employees who provide health care services pursuant to the Colorado Governmental Immunity Act (C.R.S. §§24-10-101 through 24-10-120) and that its self-insurance program will provide coverage for residents in accordance with the limits of the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act provides that the maximum amount that may be recovered against a public entity or public employee will be (a) $150,000 for any injury to one person in a single occurrence, and (b) $600,000 for any injury to two or more persons in any single occurrence (except that no person may recover in excess of $150,000). The UCDSOM does not provide liability insurance for rotations outside of the United States.

UCDSOM will be responsible for providing workers’ compensation and liability coverage for all residents/fellows and that residents are subject to the provisions of §8-40-101 C.R.S. et seq. (the Colorado Workers’ Compensation Act).

Upon request from Participating Site, the Graduate Medical Education Office at UCDSOM agrees to provide documentation of a resident’s/fellow’s immunization summary, OSHA training, background check, and HIPAA privacy training.

The Participating Site has the right to immediately remove any resident/fellow who has failed to follow Participating Site’s policies and procedures, exhibits unprofessional or disruptive behavior, presents a threat to patient safety or welfare, or whose performance is otherwise unsatisfactory.

IN WITNESS WHEREOF, the parties here subscribe and agree as of the date first written above.

University of Colorado Denver School of Medicine  Denver VA Medical Center

Name of Program Director, Credentials  Name of Site Director, Credentials
Program Director  Participating Site Director
Name of Program

______________________________  _____________________
Name of Program Director      Participating Site Director
Date ______  Date _____

______________________________  _____________________
Carol M. Rumack, M.D.        Thomas J. Meyer, M.D.
Associate Dean for GME    Associate Chief of Staff/Academic Affiliations
ACGME Designated Institutional Official  VA Eastern Colorado Healthcare System

Sample
APPENDIX A

Educational Goals and Objectives

Name of Rotation
Rotation(s) between
UCDSOM and DVAMC

☐ Goals and Objectives by competency and PGY level are attached or

☐ Goals and Objectives by competency and PGY level are:

Enter Goals and Objectives
University of Colorado Denver
Graduate Medical Education

Program Letter of Agreement (PLA) Information Sheet

I am submitting this new PLA because:       For GME Office use only

☐ Current PLA will expire on:    _________________
☐ Change in Program Director
☐ Change in Site Director
☐ Change in names on signature page
☐ Change in Rotation status (required vs. elective)
☐ None of the above; this is a new rotation

**Do you have a site visit or internal review scheduled? If so, what is the date?**
(Month/Year):

Name of Program:
Name of Person Completing this form:
Phone number of Person completing this form:

GME Guidelines:
Return this form with NEW PLA to Tammy Samuels in the GME Office.

1. The Site Director must have a UCD SOM faculty appointment.
2. Goals and Objectives, by competency and PGY level, must accompany the PLA.
3. All parties are required to sign the PLA prior to submission to the GME Office for the DIO (Carol M. Rumack, MD) signature.
University of Colorado Denver School of Medicine

Insert Name of Program

Program Agreement Letter

This Program Agreement Letter is between the Regents of the University of Colorado, a body corporate, for and on behalf of the University of Colorado Denver School of Medicine (“UCDSOM”) Name of program, and the following Participating Institution (“Participating Site):

Name/address of participating site

This Agreement is effective beginning Rotation start date and expires on this date five years hence unless there is a change in the named Program Director, Participating Site Director, or this Agreement is terminated by either party, for any reason, upon 90 days notice or other conditions described in the Agreement. Should notice of termination be given, residents/fellows then scheduled to Participating Site will be permitted to complete any previously scheduled rotation at Participating Site.

The purpose of this Program Agreement Letter is to guide and direct the parties respecting their relationship, clarify the learning objectives of the training program, the mechanism for evaluating resident/fellow performance, and requirements for participating residents/fellows regarding licensing, insurance, immunization, OSHA and HIPAA training, and background checks.

It is understood and agreed that neither party intends for this Agreement to alter in any way its respective legal rights or its legal obligations to the other party, the residents/fellows assigned to the Training Program, or any third party.

The following conditions apply:

1. Persons Responsible for Education and Supervision

   At UCDSOM
   Program Director Name, Credentials
   Program Director
   Name of program

   At PARTICIPATING SITE
   Site Director Name, Credentials
   Faculty Appointment
   Academic Department
   Participating Site Director
2. **Resident Level(s) and Period of Assignment**

This agreement covers recurring elective educational experiences and covers Number of residents at PGY level(s) PGY levels

To assure that the educational goals and objectives are obtained by the residents/fellows, the recommended period of assignment will be for a period of Length of Rotation.

Or

This agreement covers required educational experiences and covers Number of residents at PGY level(s) PGY Levels

To assure that the educational goals and objectives are obtained by the residents/fellows, the recommended period of assignment will be for a period of Length of Rotation.

3. **Educational goals and objectives applicable to this rotation or experience**

Educational goals and objectives to be obtained by the residents/fellows while on rotation at the Participating Site have been developed jointly by the UCDSOM Program Director and Teaching Faculty and the Participating Site Director and Teaching Faculty. They are either attached or outlined in Appendix A and are in the program manual for review.

4. **Participating Site Responsibility for Education, Supervision, and Evaluation of Residents/Fellows**

The teaching faculty at Participating Site must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The teaching faculty must evaluate resident/fellow performance in a manner consistent with ACGME Common Program Requirements and conditions set forth in Residency Review Committee Program Requirements for individual specialties and subspecialties. The teaching faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. Evaluations are to be completed by both the Participating Site Teaching Faculty and the rotating residents/fellows at the end of each rotation and sent to the UCDSOM Program Director, fill in how evaluations will be done, i.e. via New Innovations, hard copy, etc.

The Participating Site will retain full responsibility for care of the patients and will maintain administrative and professional supervision of residents/fellows insofar as their presence and program assignments affect the operation of the Participating Site and its care, direct and indirect, of patients.
The Participating Site agrees to provide sufficient orientation relative to its rules and regulations so that the residents/fellows may be informed of these rules and regulations for adherence to them.

The Participating Site will permit, on reasonable request, the inspection of clinical and related facilities by agencies charged with the responsibility for accreditation of the UCDSOM’s graduate medical education program(s) as well as by the UCDSOM’s Office of Graduate Medical Education.

Upon request, the Participating Site will provide proof of liability insurance in an amount that is customary in the community. The Participating Site will provide written notification to UCDSOM promptly if a claim arises involving a resident/fellow.

Participating Site shall maintain accreditation from the Joint Commission.

5. Policies and Procedures that Govern Resident Education.

In consultation with the Participating Site, UCDSOM will select residents/fellows for participation in the rotation at Participating Site in a manner consistent ACGME specific program requirements and in accordance with rules and regulations adopted by the Graduate Medical Education Committee.

UCDSOM has an equal opportunity/affirmative action program and does not discriminate on the basis of race, sex, creed, color, age, national origin, sexual orientation, or individual handicap in any aspect of employment or training. The institution’s educational programs, activities, and services offered to students, residents/fellows, faculty, and/or employees are administered on a nondiscriminatory basis subject to the provisions of Title VI and VII of the Civil Rights Act of 1964, Titles VII and VIII of the Public Health Services Act, the Rehabilitation Act of 1973 (Section 504), the Equal Pay Act of 1963 as amended, Title IX of the Educational Amendments of 1972, the Vietnam Era Veteran’s Readjustment Assistance Act of 1974, and the nondiscrimination laws of the State of Colorado.

While at the Participating Institution the residents/fellows shall comply with all the Participating Institution’s applicable rules, regulations, polices, and other provisions addressing patient care activities, education experiences, research and other scholarly activities, and use of institution facilities, including, without limitation, Participating Site’s policies with regard to credentialing, privileging, orientation and training. However, all UCDSOM Graduate Medical Education Committee (“GMEC”) Policies and Procedures, in particular those related to benefits, disciplinary actions, grievance procedures and requirements to comply with ACGME and GMEC duty hour standards, shall govern the residents/fellows while at the Participating Institution.

UCDSOM has performed and all residents/fellows have completed training on OSHA Universal Precautions (including blood-borne pathogens), as defined by the Center for Disease Control and Prevention.
UCDSOM has performed and all residents/fellows have passed a criminal background check.

UCDSOM has performed and all residents/fellows have completed training on HIPAA and patient privacy standards. UCDSOM will instruct all residents/fellows assigned to the Participating Institution that the confidentiality requirements survive the termination or expiration of this Agreement.

Designated provider for UCDSOM has on file each residents/fellows infectious disease and immunization summary and follow-up information, which covers Rubella, Mumps, Measles, Diphtheria, Hepatitis B, and Tetanus and TB and includes annual PPD documentation.

All residents/fellows are licensed to practice medicine or have a physician training license in the State of Colorado.

All residents/fellows receive a stipend and benefits through UCDSOM. UCDSOM will require all participating residents/fellows to provide proof of health insurance. In the event of an emergency, the Participating Institution will provide such emergency care as is provided its employees. The residents/fellows will be responsible for any charges thus generated if the charges are not covered under the Colorado Workers’ Compensation Act.

UCDSOM warrants and represents that it self-insures for professional liability insurance for itself and for its public employees who provide health care services pursuant to the Colorado Governmental Immunity Act (C.R.S. §§24-10-101 through 24-10-120) and that its self-insurance program will provide coverage for residents in accordance with the limits of the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act provides that the maximum amount that may be recovered against a public entity or public employee will be (a) $150,000 for any injury to one person in a single occurrence, and (b) $600,000 for any injury to two or more persons in any single occurrence (except that no person may recover in excess of $150,000). The UCDSOM does not provide liability insurance for rotations outside of the United States.

UCDSOM will be responsible for providing workers’ compensation and liability coverage for all residents/fellows and that residents/fellows are subject to the provisions of §8-40-101 C.R.S. et seq. (the Colorado Workers’ Compensation Act).

Upon request from Participating Institution, UCDSOM agrees to provide documentation of a resident/fellow’s immunization summary, OSHA training, background check, and HIPAA privacy training.

The Participating Site has the right to immediately remove any resident/fellow who has failed to follow Participating Site’s policies and procedures, exhibits unprofessional or
disruptive behavior, presents a threat to patient safety or welfare, or whose performance is otherwise unsatisfactory.

All patient information, financial information, information concerning any matter relating to the business of the other party, records and data collected or obtained by Participating Site (or its employees) or exchanged among Participating Site and UCDSOM will be treated in a confidential manner and in compliance with applicable state and federal law. Neither party shall disclose any information acquired from the other party during the course of this Agreement to any third party unless required by law or authorized, in writing, by the other party. This section does not apply to information: (1) required by law to be disclosed or to be provided to government agencies and organizations; (2) required by the Joint Commission or other accreditation organization(s); (3) disclosed in legal or government administrative proceedings, when ordered to do so by court of competent jurisdiction; (4) disclosed through no fault of the party with the obligation not to disclose; or (5) which is or becomes part of the public domain through no fault of either party hereto.

6. Governing Law

The laws of the State of Colorado and rules and regulations issued pursuant thereto will be applied in the interpretation, execution, and enforcement of this Agreement. Any provisions of this Agreement, whether or not incorporated herein by reference, that provide for arbitration by any extra-judicial body or person or that are otherwise in conflict with said laws, rules, and regulations will be considered null and void. Nothing contained in any provision incorporated herein by reference which purports to negate this provision in whole or in part will be valid or enforceable or available in any action at law whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision will not invalidate the remainder of this Agreement to the extent that the Agreement is capable of execution.

7. Employment Disclaimer

The residents/fellows participating in the program will not be considered employees or agents of the Participating Site for any purpose. Residents/fellows will not be entitled to receive any compensation from Participating Site or any benefits of employment from Participating Site, including but not limited to, health care or workers’ compensation benefits, vacation, sick time, or any other benefit of employment, direct or indirect. Participating Site will not be required to purchase any form of insurance for the benefit or protection of any resident/fellow of UCDSOM.

8. Assignment
This Agreement will not be assigned by either party without the prior written consent of the other.

9. Governmental Immunity

It is specifically understood and agreed that nothing contained in this paragraph or elsewhere in this Agreement will be construed as: an express or implied waiver by UCDSOM of its governmental immunity or of the governmental immunity of the State of Colorado; an express or implied acceptance by the UCDSOM of liabilities arising as a result of actions which lie in tort or could lie in tort in excess of the liabilities allowable under the Colorado Governmental Immunity Act, C.R.S. §§ 24-10-101 through 24-10-120; a pledge of the full faith and credit of a debtor contract; or, as the assumption by the UCDSOM of a debt, contract, or liability of the Participating Site in violation of Article XI, Section 1 of the Constitution of Colorado.

10. Notices

All notices provided by either party to the other will be in writing, and will be deemed to have been duly given when delivered personally or when deposited in the United States mail, First Class, postage prepaid, addressed as follows:

For the Participating Site: For UCDSOM:

Site Director Name, Credentials Program Director Name, Credentials
Address Line 1 Address Line 1
Address Line 2 Address Line 2
City, State, Zip Code City State, Zip Code
Fax Number Fax Number

11. Responsibilities for Injuries

The Participating Site will be responsible for any claim or cause of action based upon the negligence of its employees and agents involved in providing services related to this agreement.

Pursuant to the Colorado Governmental Immunity Act, UCDSOM agrees to be responsible for injuries sustained solely from an act or omission of its public employee occurring during the employee’s duties and within the scope of his/her employment, unless the act or omission is willful and wanton or where sovereign immunity bars the action against the UCDSOM.

Notwithstanding the foregoing, in no event shall either party be liable hereunder (whether in an action in negligence, contract or tort or based on a warranty or otherwise) for any indirect, incidental, special or consequential damages incurred by the other party or any third party, even if the party has been advised of the possibility of such damages, except
that this limitation shall not apply to damage to tangible property or injuries to persons, including death.

12. Severability

The invalidity of any provision of this Agreement will not affect the validity of any other provisions.

13. Entire Agreement

This Agreement contains the entire Agreement of the parties and may be modified only by a written instrument executed by both parties.
Required or Elective Rotation

In WITNESS WHEREOF, the parties hereto have caused this AGREEMENT to be executed effective as of the date first written above.

The Regents of the University of Colorado, a body corporate, for and on behalf of the University of Colorado Denver School of Medicine

E. Kim Huber
Interim Associate Vice Chancellor for Finance and Administration

Program Director Name, Credentials
Program Director
Program Name

Carol M. Rumack, MD
Associate Dean for GME
ACGME Designated Institutional Official
University of Colorado Denver School of Medicine
APPENDIX A

Educational Goals and Objectives

Name of Rotation
Rotation(s) between UCDSOM and
Name of participating site

☐ Goals and Objectives by competency and PGY level are attached or

☐ Goals and Objectives by competency and PGY level are:

Enter goals and objectives
University of Colorado Denver
Graduate Medical Education

Program Letter of Agreement (PLA) Information Sheet

I am submitting this new PLA because: For GME Office use only
☐ Current PLA will expire on: _________________
☐ Change in Program Director
☐ Change in Site Director
☐ Change in names on signature page
☐ Change in Rotation status (required vs. elective)
☐ None of the above; this is a new rotation

**Do you have a site visit or internal review scheduled? If so, what is the date? (Month/Year):**

Name of Program:
Name of Person Completing this form:
Phone number of Person completing this form:

GME Guidelines:
Return this form with NEW PLA to Tammy Samuels in the GME Office.

1. The Site Director must have a UCD SOM faculty appointment.
2. Goals and Objectives, by competency and PGY level, must accompany the PLA.
3. All parties are required to sign the PLA prior to submission to the GME Office for the DIO (Carol M. Rumack, MD) signature.
University of Colorado Denver School of Medicine

Insert Name of Program

Program Agreement Letter

This Program Agreement Letter is between the Regents of the University of Colorado, a body corporate, for and on behalf of the University of Colorado Denver School of Medicine (“UCDSOM”) Name of program, and the following Participating Institution (“Participating Site):

Name/address of participating site

This Agreement is effective beginning Rotation start date and expires Rotation end date unless there is a change in the named Program Director, Participating Site Director, or this Agreement is terminated by either party, for any reason, upon 90 days notice or other conditions described in the Agreement. Should notice of termination be given, residents/fellows then scheduled to Participating Site will be permitted to complete any previously scheduled rotation at Participating Site.

The purpose of this Program Agreement Letter is to guide and direct the parties respecting their relationship, clarify the learning objectives of the training program, the mechanism for evaluating resident/fellow performance, and requirements for participating residents/fellows regarding licensing, insurance, immunization, OSHA and HIPAA training, and background checks.

It is understood and agreed that neither party intends for this Agreement to alter in any way its respective legal rights or its legal obligations to the other party, the residents/fellows assigned to the Training Program, or any third party.

The following conditions apply:

1. Persons Responsible for Education and Supervision

   At UCDSOM
   Program Director Name, Credentials
   Program Director
   Name of program

   At PARTICIPATING SITE
   Site Director Name, Credentials
   Faculty Appointment
   Academic Department
   Participating Site Director

Page 2 of 9
2. **Resident Level(s) and Period of Assignment**

This agreement covers a **one time/person specific elective** educational experiences.

Name and PGY Level of Resident: Name of Resident/PGY Level

To assure that the educational goals and objectives are obtained by the residents/fellows, the recommended period of assignment will be for a period of **Duration of Rotation**.

3. **Educational goals and objectives applicable to this rotation or experience**

Educational goals and objectives to be obtained by the residents/fellows while on rotation at the Participating Site have been developed jointly by the UCDSOM Program Director and Teaching Faculty and the Participating Site Director and Teaching Faculty. They are either attached or outlined in **Appendix A** and are in the program manual for review.

4. **Participating Site Responsibility for Education, Supervision, and Evaluation of Residents/Fellows**

The teaching faculty at Participating Site must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The teaching faculty must evaluate resident/fellow performance in a manner consistent with ACGME Common Program Requirements and conditions set forth in Residency Review Committee Program Requirements for individual specialties and subspecialties. The teaching faculty must evaluate resident/fellow performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. Evaluations are to be completed by both the Participating Site Teaching Faculty and the rotating residents/fellows at the end of each rotation and sent to the UCDSOM Program Director, **fill in how evaluations will be done, i.e. via New Innovations, hard copy, etc.**

The Participating Site will retain full responsibility for care of the patients and will maintain administrative and professional supervision of residents/fellows insofar as their presence and program assignments affect the operation of the Participating Site and its care, direct and indirect, of patients.

The Participating Site agrees to provide sufficient orientation relative to its rules and regulations so that the residents/fellows may be informed of these rules and regulations for adherence to them.

The Participating Site will permit, on reasonable request, the inspection of clinical and related facilities by agencies charged with the responsibility for accreditation of the UCDSOM’s graduate medical education program(s) as well as by the UCDSOM’s Office of Graduate Medical Education.
Upon request, the Participating Site will provide proof of liability insurance in an amount that is customary in the community. The Participating Site will provide written notification to UCDSOM promptly if a claim arises involving a resident/fellow.

Participating Site shall maintain accreditation from the Joint Commission.

5. **Policies and Procedures that Govern Resident Education.**

In consultation with the Participating Site, UCDSOM will select residents/fellows for participation in the rotation at Participating Site in a manner consistent ACGME specific program requirements and in accordance with rules and regulations adopted by the Graduate Medical Education Committee.

UCDSOM has an equal opportunity/affirmative action program and does not discriminate on the basis of race, sex, creed, color, age, national origin, sexual orientation, or individual handicap in any aspect of employment or training. The institution’s educational programs, activities, and services offered to students, residents/fellows, faculty, and/or employees are administered on a nondiscriminatory basis subject to the provisions of Title VI and VII of the Civil Rights Act of 1964, Titles VII and VIII of the Public Health Services Act, the Rehabilitation Act of 1973 (Section 504), the Equal Pay Act of 1963 as amended, Title IX of the Educational Amendments of 1972, the Vietnam Era Veteran’s Readjustment Assistance Act of 1974, and the nondiscrimination laws of the State of Colorado.

While at the Participating Institution the residents/fellows shall comply with all the Participating Institution’s applicable rules, regulations, polices, and other provisions addressing patient care activities, education experiences, research and other scholarly activities, and use of institution facilities, including, without limitation, Participating Site’s policies with regard to credentialing, privileging, orientation and training. However, all UCDSOM Graduate Medical Education Committee (“GMEC”) Policies and Procedures, in particular those related to benefits, disciplinary actions, grievance procedures and requirements to comply with ACGME and GMEC duty hour standards, shall govern the residents/fellows while at the Participating Institution.

UCDSOM has performed and all residents/fellows have completed training on OSHA Universal Precautions (including blood-borne pathogens), as defined by the Center for Disease Control and Prevention.

UCDSOM has performed and all residents/fellows have passed a criminal background check.

UCDSOM has performed and all residents/fellows have completed training on HIPAA and patient privacy standards. UCDSOM will instruct all residents/fellows assigned to the Participating Institution that the confidentiality requirements survive the termination or expiration of this Agreement.
Designated provider for UCDSOM has on file each resident/fellow’s infectious disease and immunization summary and follow-up information, which covers Rubella, Mumps, Measles, Diphtheria, Hepatitis B, and Tetanus and TB and includes annual PPD documentation.

All residents/fellows are licensed to practice medicine or have a physician training license in the State of Colorado.

All residents/fellows receive a stipend and benefits through UCDSOM. UCDSOM will require all participating residents/fellows to provide proof of health insurance. In the event of an emergency, the Participating Institution will provide such emergency care as is provided its employees. The residents/fellows will be responsible for any charges thus generated if the charges are not covered under the Colorado Workers’ Compensation Act.

UCDSOM warrants and represents that it self-insures for professional liability insurance for itself and for its public employees who provide health care services pursuant to the Colorado Governmental Immunity Act (C.R.S. §§24-10-101 through 24-10-120) and that its self-insurance program will provide coverage for residents in accordance with the limits of the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act provides that the maximum amount that may be recovered against a public entity or public employee will be (a) $150,000 for any injury to one person in a single occurrence, and (b) $600,000 for any injury to two or more persons in any single occurrence (except that no person may recover in excess of $150,000). The UCDSOM does not provide liability insurance for rotations outside of the United States.

UCDSOM will be responsible for providing workers’ compensation and liability coverage for all residents/fellows and that residents/fellows are subject to the provisions of §8-40-101 C.R.S. et seq. (the Colorado Workers’ Compensation Act).

Upon request from Participating Institution, UCDSOM agrees to provide documentation of a resident’s immunization summary, OSHA training, background check, and HIPAA privacy training.

The Participating Site has the right to immediately remove any resident/fellow who has failed to follow Participating Site’s policies and procedures, exhibits unprofessional or disruptive behavior, presents a threat to patient safety or welfare, or whose performance is otherwise unsatisfactory.

All patient information, financial information, information concerning any matter relating to the business of the other party, records and data collected or obtained by Participating Site (or its employees) or exchanged among Participating Site and UCDSOM will be treated in a confidential manner and in compliance with applicable state and federal law. Neither party shall disclose any information acquired from the other party during the course of this Agreement to any third party unless required by law or authorized, in writing, by the other party. This section does not apply to information: (1) required by
law to be disclosed or to be provided to government agencies and organizations; (2) required by the Joint Commission or other accreditation organization(s); (3) disclosed in legal or government administrative proceedings, when ordered to do so by court of competent jurisdiction; (4) disclosed through no fault of the party with the obligation not to disclose; or (5) which is or becomes part of the public domain through no fault of either party hereto.

6. Governing Law

The laws of the State of Colorado and rules and regulations issued pursuant thereto will be applied in the interpretation, execution, and enforcement of this Agreement. Any provisions of this Agreement, whether or not incorporated herein by reference, that provide for arbitration by any extra-judicial body or person or that are otherwise in conflict with said laws, rules, and regulations will be considered null and void. Nothing contained in any provision incorporated herein by reference which purports to negate this provision in whole or in part will be valid or enforceable or available in any action at law whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision will not invalidate the remainder of this Agreement to the extent that the Agreement is capable of execution.

7. Employment Disclaimer

The residents/fellows participating in the program will not be considered employees or agents of the Participating Site for any purpose. Residents/fellows will not be entitled to receive any compensation from Participating Site or any benefits of employment from Participating Site, including but not limited to, health care or workers’ compensation benefits, vacation, sick time, or any other benefit of employment, direct or indirect. Participating Site will not be required to purchase any form of insurance for the benefit or protection of any resident/fellow of UCDSOM.

8. Assignment

This Agreement will not be assigned by either party without the prior written consent of the other.

9. Governmental Immunity

It is specifically understood and agreed that nothing contained in this paragraph or elsewhere in this Agreement will be construed as: an express or implied waiver by UCDSOM of its governmental immunity or of the governmental immunity of the State of Colorado; an express or implied acceptance by the UCDSOM of liabilities arising as a result of actions which lie in tort or could lie in tort in excess of the liabilities allowable under the Colorado Governmental Immunity Act, C.R.S. §§ 24-10-101 through 24-10-120; a pledge of the full faith and credit of a debtor contract; or, as the assumption by the
UCDSOM of a debt, contract, or liability of the Participating Site in violation of Article XI, Section 1 of the Constitution of Colorado.

10. Notices

All notices provided by either party to the other will be in writing, and will be deemed to have been duly given when delivered personally or when deposited in the United States mail, First Class, postage prepaid, addressed as follows:

For the Participating Site:  
Site Director Name, Credentials  
Address Line 1  
Address Line 2  
City, State, Zip Code  
Fax Number

For UCDSOM:  
Program Director Name, Credentials  
Address Line 1  
Address Line 2  
City State, Zip Code  
Fax Number

11. Responsibilities for Injuries

The Participating Site will be responsible for any claim or cause of action based upon the negligence of its employees and agents involved in providing services related to this agreement.

Pursuant to the Colorado Governmental Immunity Act, UCDSOM agrees to be responsible for injuries sustained solely from an act or omission of its public employee occurring during the employee’s duties and within the scope of his/her employment, unless the act or omission is willful and wanton or where sovereign immunity bars the action against the UCDSOM.

Notwithstanding the foregoing, in no event shall either party be liable hereunder (whether in an action in negligence, contract or tort or based on a warranty or otherwise) for any indirect, incidental, special or consequential damages incurred by the other party or any third party, even if the party has been advised of the possibility of such damages, except that this limitation shall not apply to damage to tangible property or injuries to persons, including death.

12. Severability

The invalidity of any provision of this Agreement will not affect the validity of any other provisions.

13. Entire Agreement

This Agreement contains the entire Agreement of the parties and may be modified only by a written instrument executed by both parties.
One Time Person Specific

In WITNESS WHEREOF, the parties hereto have caused this AGREEMENT to be executed effective as of the date first written above.

The Regents of the University of Colorado, a body corporate, for and on behalf of the University of Colorado Denver School of Medicine

Date

E. Kim Huber
Interim Associate Vice Chancellor for Finance and Administration

Date

Program Director Name, Credentials
Program Director
Program Name

Date

Participating Site Director Name, Credentials
Participating Site Director

Date

Carol M. Rumack, MD
Associate Dean for GME
ACGME Designated Institutional Official
University of Colorado Denver School of Medicine
Educational Goals and Objectives

Name of Rotation
Rotation(s) between UCDSOM and
Name of participating site

☐ Goals and Objectives by competency and PGY level are attached or

☐ Goals and Objectives by competency and PGY level are:

Enter goals and objectives
University of Colorado Denver
School of Medicine
Graduate Medical Education
Out-of-State Elective Program Director Request Form

Date of Request:_____

1. Name of GME Program:_____
2. Name of Program Director:_____
3. Is this program accredited by ACGME? □ yes □ no

4. How is this resident's slot funded? □ Hospital □ Depart/UPI □ Grant □ Other
   On a daily basis, will fewer residents be on the hospital service when this resident is away? If so, which hospital?_____
   Does Program/Dept have funds to pay for stipend while resident is on elective? □ yes □ no

5. Name of Resident going on Out-of-State Elective:_____
6. PGY level of resident:_____
7. Dates of Elective:_____
8. Location of Elective: This information will be used if resident must be contacted for emergency purposes
   Participating Institution Name:_____
   Site of rotation at that institution:_____
   Street address:_____
   State:_____
   Country:_____
   Zip:_____
   Phone:_____
   FAX:_____
   E-mail address:_____

9. Site Description - Please provide details of the setting, size, patient population, accreditation status, clinics, facilities available (lab, x-ray, etc):_____

10. Site Director (supervisor of resident) - Please provide CV of Site Director
    Name:_____
    Credentials:_____
    Faculty Appointment (Must be at UC Denver or other academic institution):_____

12. Justification for Out-of-State Elective:
    Does it fulfill an RRC requirement? □ yes □ no
    If yes, which one?_____
    Will the resident get credit with the certifying board? □ yes □ no
    Will this elective extend the length of training? □ yes □ no
    Explain using the Core Competencies why this requirement cannot be fulfilled at any of our UCDenver Participating Institutions:
        What patient demographics are included which are different than our sites?_____
        What procedures or types of diseases will the resident take care of that do not occur here or are not sufficient for their ACGME competency in procedures or types of disease? Please be specific about what is missing here._____
        What new techniques or clinical care models will they work in that do not occur here?_____
        Will the resident be able to practice medicine or just observe?_____

13. Does this elective involve research and/or data collection requiring COMRIB approval? □ yes □ no

Approved:

__________________________
Carol M. Rumack, MD
Associate Dean for GME
ACGME DIO
Please answer all the above questions and submit this completed request form with:
1. Program Letter of Agreement signed by Program Director
2. Any signed documents you already have in place with this site

Send all the above to Gail Silber, Administrator, GME at C-293 or gail.silber@uchsc.edu.
“Knowledge comes, but wisdom lingers.”
Alfred Lord Tennyson
The GME Manual is published annually and is housed electronically on the GME website at http://www.medschool.ucdenver.edu/gme. Should changes occur throughout the year, they will be reflected on the web. Each year, GME orders enough manuals for every new resident and for each program to receive one hard copy. You will find on this page an example of the table of contents for the GME Manual.

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Licensure

Section IV: Policies and Procedures
Complaint Procedure
Disability Accommodation Policy

Disaster Policy
Disciplinary Action Policy
Duty Hours Policy
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Medical Records Policy
Moonlighting Policy
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Program Size and Closure Policy
Sexual Harassment Procedure
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Section V: Resources
Campus Support Services
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Section VI: Risk Management
Malpractice Insurance
The National Practitioner Data Bank
Peer Review Organization (PRO) Points
Risk Management Guide
The Blue Notebook

Overview

“We are what we repeatedly do.
Excellence then, is not an act, but a
habit.” Aristotle
March Madness....

Every March we begin preparing for the influx of new residents and fellows as well as preparing for those people finishing their training at UCDSOM. As there is so much involved with this process, the GME office began using a notebook system to relay all the information to the coordinators. Each January, we begin the process of updating the information for “The Blue Notebook” to be distributed at the March Coordinators meeting (we schedule the same meeting twice in March to allow for scheduling conflicts). As there is so much information contained in this notebook alone, and as each coordinator receives a blue notebook, we have opted not to include it in this handbook. Instead, below you will find an overview of the information contained in the blue notebook.

As there are many items which are not common to all programs and therefore not included here, it is suggested that coordinators find a way to incorporate their own program procedures into the notebook.

The Blue Notebook is divided into three sections:

**GME documents the Program Coordinator must insert into the new resident packet**
- Training agreement- sample, list of department names and stipend amounts
- State licensure application instructions
- VA Resident Forms: all forms related only to the VAMC
- Hospital Information Security (IS) forms: DHHA, UCH and all HealthOne facilities
- Parking forms: UCD monthly parking agreement sample, DHHA forms

**GME documents already contained in the new resident packet**
- Cover letter, tips and checklist
- W4
- CU Payroll direct deposit form
- GME Trainee Information Form
- GME Background Check consent form
- Instructions for completing NPDB and HIPDB Self Query
- Infectious Disease & Immunization Summary & Screening Forms
- CU GME Health/Dental Benefits Plan Enrollment Change Form
- Symetra Life insurance Enrollment Form
- Optional Vision Care Plan Information & Enrollment Form
- Immunization Screening & TB Mask Fit instructions
- CU GME Benefits
- CU GME Health Plan Required Notices
- Loan Deferment and Forbearance Information sheet
- Housestaff Association Membership form

**GME documents for Program Coordinator use only**
- New, Continuing, Exiting (NCE) list
- Packet Checklist
- UCD ID Access Control Badge Form and instructions for scheduling appointments
- UCH ID Badge form and instructions for scheduling appointments
- UCH Lab Coat Order Form
- Information on scheduling Immunization Screening & TB Respiratory Mask Fit

Refer to the Blue Notebook for details.
Don’t forget your NCE lists, Educational Funds, Certificate Orders, Resident Charge Sheets to name a few!

- Information on scheduling Hospital-specific orientation times
- Information sheet on required information to enter into New Innovations
- Sample UCD New User login information email notice
- Blank Approval for Moonlighting Form
- Instructions on how to verify employment documents: I-9, Affirmation of Legal Work Status, and Affidavit- Restrictions on Public Benefits
Policies and Procedures

- Disability Accommodation
- Disaster
- Disciplinary Action
- Duty Hours
- Education Committee
- Eligibility and Selection
- Evaluation and Promotion
- Graduate Medical Education Committee
  Membership
- Grievance
- Leave
- Medical Records
- Moonlighting
- Non-Compete
- Physician Impairment and Health
- Prescription Writing
- Program Director Appointment and Approval
- Program Size, Closure and Changes
- Smoke Free and Tobacco Free Environment
- Stipend
- Supervision
- USMLE (and COMLEX) Examinations
- Work Environment
- Workers Compensation

The best preparation for good work tomorrow is to do good work today.
Elbert Hubbard
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Introduction

The Americans with Disabilities Act (ADA) applies to university of Colorado Denver and provides that individuals who are otherwise qualified for jobs or educational programs will not be denied access simply because they have a disability. Its goal is to guarantee that individuals with disabilities are not discriminated against or denied equal access to the same programs, services and facilities available to others. The ADA prohibits employers, including University of Colorado Denver, from discriminating against applicants and workers with disabilities in all aspects of employment. The Act also prohibits the University from discriminating on the basis of disability in access to its programs and services.

Accommodation

The ADA requires that the University of Colorado Denver provide reasonable accommodations to qualified individuals with disabilities who are employees or applicants for employment, and for persons who participate in or apply for participation in the University’s programs and activities. Exceptions to the obligation for providing accommodation may be made if doing so would cause undue financial or administrative burdens, fundamental alteration to a program or activity, or significant risk to health or safety to self and/or others. Additional information regarding the ADA may be obtained online from the ADA Home Page: http://www.usdoj.gov/crt/ada/adahom1.htm.

If you are a member of the faculty or staff (including residents in the SOM) at the University of Colorado Denver and need to make application for accommodations or need information regarding the ADA, contact the University of Colorado Denver ADA Coordinator at: (303) 315-2700; TTY (303) 556-6204; mailing address P.O. Box 173364, Campus Box 130, Denver, CO 80217-3364; or email to becka.hill@ucdenver.edu.

Reporting Discrimination

Article 10 of the Laws of the University of Colorado Board of Regents prohibits discrimination on the basis of disability (or on the basis of membership in other protected classes) in admission and access to, and treatment and employment in, University of Colorado educational programs and activities. To report discrimination or to obtain additional information, contact the University of Colorado Denver ADA Coordinator. Complaints of discrimination based upon disability will be processed according to the provisions of University of Colorado Denver Nondiscrimination Procedures Guideline.

Web Reference

In this document, “resident” refers to both specialty residents and subspecialty fellows.

Policy

The purpose of the policy is to describe the Graduate Medical Education guidelines to address any disciplinary action. The program director, department chair or division head and the resident should attempt to resolve problems with a resident’s performance and/or behavior on an informal basis prior to invoking the procedure set forth below.

Definitions for Administrative and Academic Disciplinary Actions:

Probation:

a. Probation is used when ongoing and/or significant deficiencies in a resident’s performance or behavior are noted.
b. Probation allows the resident to continue active participation in the program while addressing the concerns and deficiencies identified in the written notice of probation.
c. Residents will be issued a remediation plan to strengthen the resident’s performance deficiencies that may cause disruption to a resident’s progression or continuation within the program.
d. Probation is the period of critical evaluation of remediation designated by the faculty during which substandard performance may be cause for immediate dismissal from the program.
e. Time spent on probation may or may not be used for credit toward the completion of the training program at the Program Director’s discretion. The period of probation shall be specified and normally should be a period of time appropriate to achieve the necessary performance or behavioral improvements. However, there may be instances where it is appropriate for the period to be as long as 12 months.

Immediate Suspension from Clinical Responsibilities:

a. Immediate suspension from clinical responsibilities involves removal from clinical responsibilities for an indefinite period of time, usually not to exceed 30 days, without prior notice or the probationary/remedial period described above due to significant performance deficiencies related to patient safety.
b. Immediate Suspension from Clinical Responsibilities may be imposed at the discretion of the program director, department chair or Associate Dean for GME.
c. Short-term paid administrative leave can be granted by the Associate Dean for GME during preliminary verification of the allegation(s).
d. During the period of immediate suspension from clinical responsibilities, the program director, department chair and Associate Dean for GME must determine whether the resident should be reinstated to clinical service.

e. Immediate Suspension from Clinical Responsibilities is not grievable.

Suspension from the Program:

a. Suspension from the program involves removal from the program for an indefinite period of time without prior notice due to serious deficiencies in knowledge, performance, or behavior.

b. The decision to suspend a resident from the program may be made at the discretion of the program director and the department chair with the prior approval of the Associate Dean for GME.

c. During the period of suspension from the program, usually not to exceed 30 days, the program director, department chair and Associate Dean for GME must determine whether the resident should be reinstated to the Program or dismissed.

d. Suspension from the Program is grievable under the Grievance Policy and Procedure.

Renewal without Promotion:

a. Renewal without promotion means the resident will not be promoted to the subsequent PGY-year at the completion of their current year of training.

b. Renewal without promotion should be used when a resident has not been able to clearly demonstrate the knowledge, skills, or behaviors required to advance to the next level of training and responsibility.

c. Renewal without promotion is grievable under the Grievance Policy and Procedure.

Non-renewal:

a. Non-renewal means the training program has decided not to offer a contract to the resident for the next academic year or training period.

b. The resident will receive credit for successfully completing training as determined by the program director.

c. Non-renewal is grievable under the Grievance Policy and Procedure.

Dismissal:

a. Dismissal involves immediate and permanent removal of the resident from the educational program for failing to maintain academic and/or other professional standards required to progress in or complete the program, by the program director, department chair and the Associate Dean for GME.

b. Dismissal is typically preceded by sufficient notice to the resident that there are significant deficiencies in the knowledge, performance, or behaviors and potentially by previous disciplinary actions.

c. Dismissal can occur at any point other than the end of the academic year or end of the stated contract period, at which time it is defined as non-renewal.

d. However, there is no requirement that there be any preceding disciplinary action prior to a resident being terminated.

e. Dismissal from the program is not grievable if the action directly related to suspension from the program and the resident invoked the grievance procedure for the suspension action.
f. Dismissal from the program for other actions is grievable under the Grievance Policy and Procedure.

**Disciplinary Procedure:**

1. Program Directors have the primary responsibility to monitor resident’s progress and take appropriate academic and administrative disciplinary actions based on the resident’s performance in accordance with all ACGME core competencies.

2. The program director, after consultation with the Associate Dean for Graduate Medical Education may proceed under this policy to address deficiencies in resident performance.

3. In instances where a training agreement will not be renewed, or when a resident will not be promoted to the next level of training, the program director must provide the resident(s) with a written notice of intent no later than four months (typically March 1st) prior to the end of the resident’s current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the program must provide the resident(s) with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the current agreement.

4. It is expected that appropriate probationary and remedial periods as described in this policy will have occurred prior to non-renewal and/or renewal without promotion. However, there may be instances where immediate suspension without probation or remediation will occur.

5. The resident will be placed on probation for a specified period of time. The probationary and remedial period together should not be less than 30 days in length and may last as long as 12 months if appropriate (such as in the case of academic probation for yearly board exams, etc.). For ethical misconduct or substance abuse, a resident may be placed on probation indefinitely, through the remainder of the training program. The mentor and program director shall meet with the resident regularly during the probationary period to formally review the resident’s progress. (Meetings may be held more frequently if deemed necessary.)

6. While on probation, all moonlighting privileges and out-of-town electives for the resident will be suspended.

7. During and at the end of the probationary period, the program director will review the resident’s progress and determine whether satisfactory improvement has been made based on information obtained from various sources and results relating to terms of remediation outlined in the Letter of Probation, which may be solicited from faculty, staff and peers of the resident. If improvement has been unsatisfactory during the probation period, the resident may be (1) continued on probation for a specific period of time not to exceed an additional six months or (2) dismissed. Any resident who is placed on probation for a third time for any reason may be continued on probation indefinitely, through the remainder of the training program, or dismissed without further notice.
8. There are limited circumstances where the period of probation may be indefinite and could be imposed for the remainder of the program. These circumstances include, but are not limited to, substance abuse and ethical misconduct. Examples of ethical misconduct include, but are not limited to, sexual harassment, patient abandonment, abuse of prescribing privileges and unlawful discrimination. Certain programs may have stricter standards regarding substance abuse which supersede this policy. Any substance abuse or ethical misconduct will result in mandatory referral of the resident to the Colorado Physicians Health Program (CPHP). As a condition of probation, the resident must allow exchange of information between CPHP and the training program/UCDSOM GME office. The resident shall sign a release of information from the CPHP as a condition of probation.

9. In the case of a resident who has been placed on probation for substance abuse or ethical misconduct, if the resident demonstrates a recurrence of unsatisfactory performance due to substance abuse during his/her training program, additional disciplinary actions may occur. He/she may be re-referred to CPHP, or he/she may be dismissed without any additional remedial period. If the resident’s behavior is considered potentially dangerous to patients, himself, herself or other individuals, immediate suspension of clinical responsibilities may be imposed at the discretion of the program director and department chair without a probationary period.

10. If the resident’s deficiencies are not satisfactorily corrected or if other deficiencies arise during the remedial/probationary period, the program director and department chair will notify the Associate Dean for GME of the intent to dismiss the resident from the residency training program. The Associate Dean for GME will review the department’s intended action prior to any notification being sent to the resident. After such a review, the program director, department chair and Associate Dean for GME must notify the resident in writing of the decision to dismiss the resident. (If mailed, certified mail is required.) The letter must identify the deficiencies that have not been adequately corrected.

Notification of State Boards

1. Reporting required for residents dismissed, suspended from the program, or required to repeat year: Pursuant to the Medical Practice Act, the University is required to report to the Colorado Board of Medical Examiners (BME) any violation of the Medical Practice Act Physician Training License Statute, or for licensed physicians, any violation of the Medical Practice Act. The University will promptly report to the Board of Medical Examiners (BME) any physician training licensee or licensed physician who has not progressed satisfactorily in the program. The phrase “not progressed satisfactorily in the program” means any individual who has been dismissed, suspended from the program or who has been placed on probation for violating the Unprofessional Conduct Statute, Colorado Revised Statute Sec. 12-36-117. The University shall report the dismissal or resignation of an intern, resident or fellow to the Board of Medical Examiners no later than thirty (30) calendar days following the action. In addition to the obligation of the University to report to the BME, individuals associated with the decision to suspend, dismiss or non-renew the resident may also have an individual obligation to report to the BME. Prior to making such a report to the BME, those individuals should notify the Associate Dean for Graduate Medical Education.
2. Probation: Probation is a remedial mechanism utilized by the University in a variety of circumstances. It is designed to improve the academic performance of a resident. In most instances, residents placed on probation continue to progress satisfactorily in a program. Reporting of residents placed on probation to the BME is not required of the University except as set forth above.

3. Referral to Colorado Physicians Health Program (CPHP): As a term of probation a resident may be referred to CPHP for a variety of reasons. As a condition of probation, the resident must allow exchange of information between CPHP and the training program/UCDSOM GME office. If as a condition of probation a resident is required to be evaluated and or treated by CPHP for a mental disability or habitual intemperance or excessive use of any habit-forming drug, it will be left to the discretion of CPHP whether or not that person needs to be reported to the BME. In the event the resident fails to comply with this condition of probation, the resident either will be suspended or dismissed, which would result in a report to the BME by the University. CPHP also has discretion regarding reporting to BME those residents who have been referred to CPHP through mechanisms other than probation. Residents are encouraged to voluntarily self-refer to the Colorado Physician Health Program for any health condition or concern about a potential health condition. Residents may self-refer at any time, without or prior to any workplace intervention. This service is confidential. Residents and fellows who self-report and utilize CPHP services for treatment of a mental disability, or drug or alcohol abuse do not have to disclose their health conditions when applying for a Colorado license or renewing a license, with the exception of legal charges.

4. Licensed physicians are obligated under CRS 12-36-118(3)(a) to report unprofessional conduct of other licensed physicians to the Colorado Board of Medical Examiners (http://www.dora.state.co.us/medical/Statute.pdf). As defined by the statute, “unprofessional conduct” includes “habitual intemperance or excessive use of any habit-forming drug or any controlled substance…” and “such physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient.” This obligation to report to BME does not apply to situations where the licensed physician has referred the resident to CPHP for treatment as part of the probationary process.
University of Colorado Denver School of Medicine
Graduate Medical Education

Policy: Duty Hours


In this document, “resident” refers to both specialty residents and subspecialty fellows.

Policy

The University of Colorado Denver School of Medicine policy on duty hours for residents follows the intent and language found in the Accreditation Council for Graduate Medical Education (ACGME) guidelines addressing this topic. All ACGME and non-ACGME programs must follow the following principles:

1. Be committed to and be responsible for promoting patient safety and resident well-being and provide a supportive educational environment.
2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
3. Clinical education must have priority in the allotment of residents’ time and energy.
4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Fatigue Mitigation

Programs must educate all faculty and residents to recognize the signs of fatigue and sleep deprivation; provide education in alertness management and fatigue mitigation processes; and must adopt and apply policies to prevent and counteract the potential negative effects on patient care and learning such as back-up call schedules and naps. All residents and fellows are required to complete the online educational fatigue and sleep deprivation module. The module is available on the GME website for faculty. Programs may provide additional training and must identify and document faculty training methods.

Duty Hour Requirements

Duty hours are defined as all clinical and academic activities related to the program, i.e., patient care (inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Averaging must occur by rotation – 4 week period, 1 month period, or the period of a rotation if less than 4 weeks. Vacation and leave must be excluded when calculating duty hours, call frequency or days off.

When resident and fellows are assigned to a rotation outside their program, the specialty-specific Program Requirements regarding duty hours, as well as the receiving program’s duty hour policy apply.
University of Colorado Denver School of Medicine
Graduate Medical Education

1. **Maximum Hours of Work Per Week – 80 hour rule:**
Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities, and internal and external moonlighting.

2. **Mandatory Time Free of Duty – 1-in-7 off rule:**
A. Residents must be scheduled for a minimum of 1 day free of duty every week (when averaged over a 4-week period). At-home call cannot be assigned on these free days.
B. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.

3. **Maximum Duty Period Length:**
A. **PGY 1** Residents may not work over 16 hours, may not take at home call, and may not moonlight.
B. **PGY 2** and above have a 24 hour maximum
   1) (24+4) - The additional 4 hours for transitions of care, no additional clinical responsibilities after 24 hours of continuous in-house duty.
   2) Strategic napping, especially after 16 hours of continuous duty and between 10:00 pm and 8:00 AM, is strongly suggested.
   3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
      i. Under those circumstances the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
      ii. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

4. **Minimum Time off Between Scheduled Duty Periods – 10 hour rule:**
A. Residents should have 10 hours and must have 8 hours free of duty between scheduled duty periods.
B. Intermediate-level residents (as defined by the Review Committee) must have at least 14 hours free of duty after 24 hours of in-house duty.
C. Residents in the final years of education and under certain circumstances (as defined by the Review Committee), may need to stay on duty to care for their patients or return to duty less than 8 hours in preparation of entering unsupervised practice of medicine and care for patients over irregular or extended periods.
   1) These instances must be monitored by the program director and there must continue to be compliance with the 80 hour, 1-in-7 off, and maximum duty period length requirements.

**On-Call Activities**
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the
normal work day when residents are required to be immediately available in the assigned institution.

5. **Maximum Frequency of In-House Night Float**: Residents must not be scheduled for more than six consecutive nights of night float. This may be further specified by the Review Committee.

6. **Maximum In-House On-Call Frequency**: PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

*Internal Medicine and subspecialty programs may not schedule in-house call more frequently than every third night. Averaging of the interval between in-house call is not permitted.*

7. **At-Home Call**: At-home call (pager call) is defined as call taken from outside the assigned institution. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit.

   A. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident/fellow.

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

**Institutional Oversight and Monitoring**

Website address for the GME Duty Hour compliance procedure and processes:

[http://www.medschool.ucdenver.edu/gme/policiesprocedures](http://www.medschool.ucdenver.edu/gme/policiesprocedures)
Policy: ACGME Program Education Committee

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For the purposes of this policy, “resident” means all interns, residents, and fellows in GME training programs.

Procedure:

1. Each Department must have an “Education Committee” or equivalent committee or committees that oversee all ACGME programs.

2. Committee membership. The committee should include at least the following individuals:
   a. The Program Director.
   b. At least three faculty members involved in education who are full-time university faculty members.
   c. At least one resident from the program.
   d. The Division Director or Department Chair should serve as an ex-officio member of the committee.
   e. It is recommended that at least one faculty member from each major participating institution for the program be included on the committee.

3. Committee logistics.
   a. Committee meeting minutes must be available at the time of the program internal review and site review. Programs may use the Annual Program Evaluation and Action Plan template for the meeting minutes.

4. Committee responsibilities.
      1) Based on the program’s annual self-assessment, the program director will develop a written improvement action plan. The approval of this plan should be recorded in the committee minutes.
      2) The program improvement action plan must be forwarded to the GME office by August 1st of each year as part of the Annual Program Evaluation & Action Plan template.
Policy: Eligibility and Selection

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In this document, “resident” refers to both specialty residents and subspecialty fellows.

Purpose

To establish a formal institutional policy addressing eligibility and selection criteria for applicants to ACGME-accredited training programs.

Policy

Applicants eligible for appointment must meet the following qualifications to maintain compliance with the Institutional Requirements published by the ACGME:

1. Graduation from a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME); or
2. Graduation from any college of Osteopathic Medicine accredited by the American Osteopathic Association (AOA); or
3. Graduation from medical school outside of the United States or Canada and possessing a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, have a full and unrestricted license to practice medicine in Colorado; or
4. Graduation from medical schools outside the United States and completion of a Fifth Pathway Program provided by an LCME-accredited medical school.
5. Individuals applying for Fellowship programs must document completion of an appropriate residency program, including an ACGME-accredited residency, or meet requirements as outlined in ACGME program requirements.
6. Programs may establish additional selection criteria. For example, determine specific passing scores for the USMLE. Specific criteria must be published for applicants to review as part of the required program-level policy on Eligibility and Selection.
7. Residents in our program must be a U.S. citizen, lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow resident to legally train at the University of Colorado Denver School of Medicine.
8. Applicants must be eligible for either a training certificate or a permanent medical license as granted by the Colorado Board of Medical Examiners (CBME).

Selection from among eligible applicants is based on residency program-related criteria such as:

1. Ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty.
2. To determine the appropriate level of education for individuals wishing to transfer from another training program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to acceptance into the program.

3. Programs will review and select applicants in a manner consistent with provisions of equal opportunity employment and must not discriminate with regard to sex, race, age, religion, color, national origin, disability or any other applicable legally protected status.

Programs are encouraged to participate in an organized matching program, where available, such as the National Resident Matching Program (NRMP).
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Policy:

All programs sponsored by the GME Committee, including those not accredited by ACGME, are required to load evaluation forms pertaining to performance by trainees and faculty into the New Innovations software program. As part of the Common Program Requirements (V.A.B.C.), supervising faculty must evaluate the resident’s performance in a timely manner during each rotation or similar educational assignment, and document the evaluation at the completion of the assignment. The resident’s evaluation should include an assessment of competence using ACGME competencies, evaluations by multiple evaluators, and documented progressive resident performance improvement appropriate to educational level. The program must provide each resident with documented evaluations at regular intervals not less than semi-annually, and in compliance with RC requirements. The faculty evaluation must include at least annual written confidential evaluations by the residents. The residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.

Procedure:

1. Programs must use New Innovations or the ACGME Residency Competency Evaluation System for the following evaluation types:

   Residents:
   - Faculty evaluation of Residents - should be immediately available for review by the resident after completion by the faculty. Resident notification of completed evaluations can be generated in New Innovations by requiring that the residents sign off on the evaluation.
   - Multiple evaluators (i.e., peers, patients, self, other ancillary professional staff, and/or medical students)
   - Program Director semi-annual evaluations of Residents

   Faculty:
   - Resident evaluation of Faculty – all programs must withhold resident evaluations of the faculty until the end of the academic year, at which time an anonymous, aggregate summary of their evaluations may be released to them. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.
   - Program Director review of Resident evaluation of Faculty should occur regularly. Program Directors must be notified of low (below average) evaluation scores through notices setup in New Innovations.
   - Division Chiefs and/or Department Chairs should be notified by the program director when faculty receive low evaluation scores. Resident evaluations of Faculty must be reviewed and discussed during the annual faculty evaluation review process.
Program:

- Faculty and Residents must complete a written confidential evaluation of the program annually.

2. In order to maintain confidentiality of Fellow evaluation of the Faculty, small programs with four or less fellows, may use one of the following:
   a. Aggregate the faculty evaluations for the subspecialty and core residency program.
   b. Forward evaluations to the DIO/GME office
   c. For residents on the same service, combine the faculty evaluations from fellows with the residents, thus increasing anonymity

The GME Office will monitor completion rates for various evaluation forms and work with those programs deemed deficient in securing appropriate numbers of completed forms.

Promotion:
Reappointment to a post-MD position/promotion for a subsequent year is not automatic. Reappointment and promotion are contingent on mutual agreement, and an annual review of satisfactory or better performance. Residents may be reappointed for a period of not more than one (1) year. A residents’ advancement to a position of higher responsibility will be made only on the basis of an evaluation of their readiness for advancement.
Policy: Graduate Medical Education Committee Membership

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In this document, “resident” refers to both specialty residents and subspecialty fellows.

**Purpose**

The Graduate Medical Education Committee (GMEC) exists to oversee all aspects of residency education and reports to the Dean of the School of Medicine.

The GMEC is responsible to establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs. The policies and procedures must include the following:

1. Make annual recommendations to the Dean of the School of Medicine on resident stipends, benefits and funding for resident positions.

2. Develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common and specialty/subspecialty-specific Program Requirements.

3. Ensure communication mechanisms exist between the GMEC and all program directors, and ensure program directors maintain effective communication with site directors.

4. Maintain oversight of activities occurring in participating hospitals and other training sites.

5. Conduct Internal Reviews of programs and monitor progress by programs in addressing concerns.

6. Monitor and assure adequate and timely supervision of residents.

7. Assure that all programs provide a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies.

8. Establish policies for resident eligibility, selection, promotion, evaluation, discipline and/or dismissal.

9. Review program accreditation letters and monitor action plans for correction of citations and areas of noncompliance.

10. Review and provide oversight for all program changes prior to submission to the ACGME by program directors.
    a. Comply with all requirements stated in Section III of the ACGME Institutional Requirements.
The Associate Dean for GME shall serve as Chair of the GMEC. GMEC membership shall include representation from training program faculty, residents and hospital training sites. Appointments are made by the Chair of the GMEC and are reviewed annually.

Voting membership on the committee includes:

**Designated Institutional Official**

**GME Director of Education and Accreditation**

**One Program Director or designated faculty member representing each of the following ACGME Residency programs:**

- Anesthesiology
- Dermatology
- Family Medicine
- OB/GYN
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Psychiatry
- Internal Medicine
- Neurological Surgery
- Neurology
- Radiation Oncology
- Radiology
- PM & R
- Surgery
- Thoracic Surgery
- Urology

**One representative from the following Departments:**

- Internal Medicine Fellowship program – Program Director
- Pediatrics Fellowship program - Program Director
- Emergency Medicine designated faculty

**Resident Representatives** (selected by the Housestaff Association):

- Association Co-Chairs (2)
- Additional Resident or Fellow (1)

The Housestaff Association may designate an alternate member for each appointee described above.

**Hospital Liaisons:**

GME Hospital liaison or his/her designee (MD or medical education management level) from each of the following:

- University of Colorado Hospital
- Denver Health Medical Center
- The Children’s Hospital
- Veterans Affairs Medical Center

The complement of voting members present at a meeting of the GMEC shall constitute a quorum.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Grievance Policy:

If a resident believes s/he has been wrongfully suspended from the program, dismissed, not renewed or renewed without promotion the grievance procedure described below can be invoked. The process is intended to protect the rights of the resident and the training program and to ensure fair treatment for both parties. Grievances are limited to allegations of wrongful dismissal, wrongful suspension, wrongful nonrenewal or wrongful renewal without promotion of the annual Resident Training Agreement. Being placed on probation and immediate suspension from clinical responsibilities are not grievable.

The decision to suspend from the program, dismiss, not renew or renew without promotion a resident is an academic responsibility and is the decision of the University of Colorado Denver School of Medicine Graduate Medical Education programs.

In all cases of suspension from the program, dismissal, nonrenewal or renewal without promotion of a contract, it is expected that the appropriate probationary and remedial periods will have occurred as prescribed in this manual. However, as discussed in this document there may be instances where immediate suspension without probation or remediation will occur.

All “written notification” associated with the formal grievance process shall be by certified mail.

Academic actions, including non-promotion, non-renewal or termination as a consequence of failure to meet performance requirements in the USMLE policy are not grievable under terms of the GME Disciplinary Action policy.

Grievance Procedure:

1. Notification of intent to appeal: Any resident who is suspended from the program, dismissed or whose Resident Training Agreement is not renewed or renewed without promotion shall be informed of the decision in person and/or by certified mail. The resident who receives said notice may appeal the dismissal, suspension, nonrenewal or renewal without promotion. Any appeal by the resident must be received by the program director within ten (10) calendar days of the resident’s receipt of the certified notice, or personal notice, whichever occurs first. The appeal notice period shall begin to run based on the date the certified notice is received by the resident or the date the resident personally receives the notice, whichever occurs first. However, in the event the resident refuses to accept the notice or otherwise does not receive the certified notice, the University will presume that the certified notice is received within three (3) business days following dispatch from the University. In that case, the resident will have ten business days, plus three business days for a total of thirteen (13) days from the date of dispatch to file an
appeal. A dated return receipt from the United States Postal Service shall be conclusive proof of an “attempt to deliver the notice.”

2. Assembly of review committee: Upon receipt of an appeal, the Hearing Officer (or designee) will convene an ad hoc committee to review the resident’s case. The committee shall seek advice from University counsel who shall be present for the hearing to advise the committee. The review committee may also seek advice from outside experts in the field of the resident’s specialty if deemed necessary. The review committee will include the Hearing Officer (or designee), one full-time faculty member from a different training program and one representative from the Housestaff Association who is in a different clinical training program. The Hearing Officer will chair the review committee. The resident may object to a member of the review committee for cause. The Hearing Officer has sole discretion to replace a member if deemed warranted.

3. Hearing: The review committee will assess the merits of the decision at issue and hear evidence and arguments by the resident and the program director, department chair or division head. Since the hearing is an academic proceeding, the rules of evidence shall not apply.

The program director and department chair or division head are obligated to present to the review committee the reasons for and substantiating evidence in support of the decision at issue. The resident and program director may present documents or letters of support and call the testimony of witnesses. The resident may question witnesses who testify on behalf of the program director, department chair or division head. Witnesses called by the resident may be questioned by the program director, department chair or division head.

The review committee shall tape record the hearing proceedings, but not its deliberations. Either party may, at its own expense, have a verbatim transcript made of the proceedings by a court reporter. Both parties may request a copy of the tape recording that was made by the committee.

The resident may be represented by an attorney in an advisory capacity, but the attorney may not function as a spokesperson for the resident during this grievance process.

4. Final Determination: The review committee will not overturn or modify the academic decision at issue unless, by majority vote, it concludes that the resident has established by a preponderance of the evidence that the decision at issue was arbitrary or capricious. The review committee will make its determination within thirty (30) calendar days from the close of the hearing. The review committee will notify the resident and department chair, or program director and the associate dean (in writing) of its decision. The decision of the committee is final. Should the resident be reinstated, the review committee may impose an additional period of probation as a condition of continuation.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

This policy and procedural steps relate to Family and Medical Leave of Absence, military leave, sick leave, vacation and other leaves of absences. Any leave time that impacts the resident’s ability to satisfy requirements necessary to complete the program is addressed under Leave Documentation on page 2.

**Family and Medical Leave of Absence**

It is the policy of the University of Colorado Denver School of Medicine Graduate Medical Education Committee to allow leave for maternity, paternity, adoption, illness of a close relative that requires the trainee’s care, or illness of the resident. Residents may be granted up to 12 calendar weeks of leave during a 12-month period for certain family and medical reasons with the program holding the resident position.

Leaves are granted at the discretion of the Program Director and with the prompt notification of the Associate Dean for Graduate Medical Education, provided that the time away does not cause any undue hardship for the program as defined by the Program Director. The Program Director will determine how much of the time will need to be made up in order to fulfill the specialty Board certification and RRC requirements.

If leave is granted, the resident must first use the current year’s vacation and/or educational leave as part of the leave thereby continuing to receive stipend. If the paid leave is not desired for the first 4 weeks, but instead at a later time during the leave, OR any/all of the leave is to be unpaid, the Program Director must state in the Leave Documentation (see below) this exception has been made. Vacation and/or education leave cannot be used to extend the length of the leave beyond the 12 weeks. The only paid leave available to residents is the 3-week vacation and/or 1-week educational leave (PGY II and above) per contract year. Once that is exhausted, the resident must go on unpaid leave.

**Benefits during a Family and Medical Leave of Absence:**

During the 12-week period of Family and Medical Leave of Absence, a funding source must be identified to pay the cost of maintaining the resident’s benefit package (health, dental, disability and life insurance) through GME.

**Benefits for leaves that exceed, or are not eligible for, the 12-week period of Family and**
Medical Leave:

Health and Dental: During this leave, the resident must self-pay entire premium(s) to maintain coverage. If the resident is eligible and decides to continue benefits through the COBRA continuation of the CU GME Health Benefits Plan, the resident must follow the enrollment procedures detailed in the Plan Document posted at www.medschool.ucdenver.edu/gme/healthdental to obtain coverage.

Long-Term Disability: Premiums for long-term disability coverage are paid by the funding source during the first 90 days of an approved Family and Medical Leave. Self-payment of the premium is not allowed. A resident on Family and Medical Leave that involves personal (not family) disability should contact the GME office as soon as it is realized that the leave may exceed 90 days. The resident will be given information on how to file a long-term disability claim. Disability benefits may be available beginning the 91st day of a disability. The decision of whether or not long-term disability coverage can be reinstated and the terms of reinstatement when the resident returns from leave will be subject to the provisions of the disability insurance policy.

Life Insurance: During an approved leave period when the department is not required to pay the life insurance premium, the resident may elect to continue life insurance coverage through GME by payment of the monthly premium. If the resident chooses to not pay the life insurance premium, coverage will be canceled until the resident’s return.

Other Leave of Absence

Requests to take a leave of absence other than Family and Medical Leave or to extend a leave beyond the 12-week period of Family and Medical Leave must be made through the Program Director and with the notification of the Associate Dean for Graduate Medical Education. Such requests will be handled on a case-by-case basis, with the program determining whether an unpaid leave will be granted (with the program holding the resident’s position) or if the resident would be required to resign in order to take such leave.

Benefits during this leave are the same as those above for leaves that exceed, or are not eligible for, the 12-week period of Family and Medical Leave. The resident must be made aware that it is the resident's responsibility to arrange for insurance coverage during this time, and be given information on how to contact the GME office with inquiries.

Leave Documentation

Any time a leave of absence is granted; the resident must receive a letter from the Program Director, co-sign the letter in acknowledgment, and return the letter to the Program Director who must promptly forward a copy to the Associate Dean for Graduate Medical Education. The letter should state the following:

1) reason(s) for the leave
2) beginning and anticipated ending date of the leave
3) time period of paid leave and time period of unpaid leave
4) period of time the department is required to cover benefits during any unpaid portion for up to 12 weeks of Family and Medical Leave
5) period of time the resident is responsible for insurance coverage and information on
how the resident may contact the GME office with questions.
6) plan for any time and/or rotations that the resident will be required to make up in order to complete the program (consistent with the rules of the RRC) and/or to be eligible to sit for Boards, with a clear indication of whether the make-up time will be paid or unpaid. (If paid, the letter must state the monthly stipend amount. If the leave is made up in the next academic year, the make-up time will be at the salary rate in effect at the time the leave is made up.)

Educational Leave

PGY IIs and above may receive up to seven calendar days per year for paid educational leave at the discretion of the Program Director. This leave should be primarily to attend major conferences and meetings. Educational leave generally cannot be accumulated from year to year.

Military Leave

Military leave will be considered the same as an approved (NON medical) leave of absence and requires the same leave documentation as stated above, with the exception of 5). In the case of a Military leave, the Resident must contact the GME office regarding benefits while on Military Leave prior to the start of the leave. The Military Leave portion of this policy will adapt to comply with USERRA regulations.

Sick Leave

Residents do not accrue an annual sick leave allotment. However, leaves of absence are granted as needed when approved by the Program Director. Residents are encouraged to seek medical attention as necessary so that they may best serve their patients and attend to assigned duties. Sick leave may not be used in lieu of vacation, and such substitution is strictly prohibited.

Vacation

Residents are granted 21 calendar days* for paid vacation. Vacation leave generally cannot be accumulated from year to year. Residents are expected to use vacation leave for interviews. Many programs require that all leaves be scheduled at the beginning of the academic year or far enough in advance to maintain compliance with duty hours.

Before starting leave, a resident must have completed all patient medical records in the hospitals.

*Seven days represents a calendar week. A calendar week is defined as consecutive weekdays and one attached weekend that a resident is on vacation.
**Policy: Medical Records**

| Original Approval: December 12, 2001 | Effective date: | Revision Date: November 19, 2003 April 21, 2010 |

**In this document, “resident” refers to both specialty residents and subspecialty fellows.**

**Purpose**

This policy will provide residents the rules for addressing the timely completion of medical records.

**Policy**

Accurate and timely completion of medical records is essential to provide good medical care. This policy will apply to all UC Denver SOM residents at each of the participating hospital/institutions.

1. All residents must comply with the applicable hospital policies where they rotate.

2. If a resident rotates away from a hospital they are still responsible for completion of charts left at the hospital.

3. As part of the annual Training Agreement, residents are expected to keep charts, records and/or reports up to date and signed at all times.

4. The formal semi-annual evaluation of a resident’s performance must include an element under the competency of Interpersonal and Communication, an assessment of timely completion of all medical records.

5. All medical record documentation must be current and completed prior to completion of the training program and exiting the UC Denver SOM.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

**Purpose**

To ensure that professional activities falling outside the course and scope of an approved training program are consistent with policies and guidelines set forth by the Accrediting Council for Graduate Medical Education (ACGME).

**Definitions:**

External Moonlighting – Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Internal Moonlighting – Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the resident is in training or at any of its related participating sites.

**Policy**

The Graduate Medical Education Committee (GMEC) recognizes that moonlighting is not an activity associated with part of the formal educational experience. Residents must not be required to participate in moonlighting activities. Moonlighting includes both internal and external moonlighting (as defined in the ACGME Glossary of Terms).

Moonlighting is allowed for those residents providing satisfactory performance in duties relating to the formal academic program (as determined by the program director) and who meet the following requirements:

1. The individual wishing to moonlight must obtain annually, prior written approval from the Program Director. (Complete the “Approval for Resident Moonlighting” form and return to the GME office).

2. The individual seeking permission to moonlight must possess a valid license to practice medicine in the State of Colorado. A “Physician Training License” does not meet this requirement. For additional information see Colorado Revised Statutes Article 36, also known as the Medical Practice Act.

3. The individual seeking permission to moonlight must secure professional liability (malpractice) insurance coverage apart from that provided to residents as part of the formal academic training program. Coverage provided residents as referred to in the residency contract do not include activities occurring as part of a moonlighting experience.
4. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour maximum weekly hour limit.
5. Programs operating under an exception to the 80-hour weekly duty limit endorsed by the GMEC and approved by the appropriate RRC may not allow residents to moonlight while serving on rotations with a duty hour exception.
6. PGY-1 residents are not permitted to moonlight.
7. Individuals possessing a J-1 visa are not eligible to moonlight.
8. Residents with prior permission to moonlight will have that permission revoked by the program director if academic performance is determined to no longer be at a satisfactory level, e.g., probation, or other major concerns arise.
9. Residents continuing to moonlight following revocation of permission can be dismissed from the program. This notice must be contained in documentation placing the resident on probation.
10. The obligation to notify an outside employer is the responsibility of the resident who established that employment relationship, not the responsibility of the University or training program.

Procedure

1. Residents seeking approval to moonlight should obtain the required written approval by completing the appropriate request form. The program director must provide written approval prior to engaging in moonlighting activities. A copy of the completed approval form must be supplied upon request to the GME Office.
2. Programs must maintain a copy of the completed form in the individual’s permanent file.
3. Programs must maintain an ongoing record of all moonlighting approvals for all residents and this record may be reviewed at the time of the Internal Review by the GMEC.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Policy:

ACGME institutional requirements state that ACGME-accredited residencies must not require residents/fellows to sign a non-competition guarantee in return for fulfilling their educational obligations.

In addition, the GMEC of the University of Colorado Denver School of Medicine established a policy opposing non-compete clauses for any UCD trainees, either in ACGME accredited programs or non-ACGME accredited programs.
Policy: Physician Impairment and Health

In this document, “resident” refers to both specialty residents and subspecialty fellows.

Purpose

Physician health is essential to quality patient care. University of Colorado Denver School of Medicine (UCDSOM) GME strives to create an environment to assist residents in maintaining wellness and in proactively addressing any health condition that could potentially affect their health, well-being, and performance. Most health conditions do not affect workplace performance or impair the practice of medicine. For the purposes of this policy and procedure, a health condition is defined as including (but not limited to) any physical health, mental health, substance use/abuse, or behavioral condition that has the potential to adversely affect the practice of medicine and/or impair the resident’s performance in the program.

Colorado Physician Health Program

Residents are encouraged to voluntarily self-refer to the Colorado Physician Health Program for any health condition or concern about a potential health condition. Residents may self-refer at any time, without or prior to any workplace intervention. This service is confidential. Residents and fellows who self-report and utilize CPHP services do not have to disclose their health conditions when applying for a Colorado license or renewing a license, with the exception of legal charges. For more information about CPHP, visit www.CPHP.org or call at 303-860-0122. Request for paid leave or unpaid time off in order to participate in CPHP confidential evaluations and monitoring will be considered under Family Medical Leave (FML) if applicable or on a case by case basis.

University of Colorado Alcohol and Drug Policy

The University of Colorado Alcohol and Drug Policy in compliance with the federal Drug-Free School and Communities Act prohibits the unlawful manufacture, possession, use, or distribution of a controlled substance (illicit drugs and alcohol) of any kind and of any amount. These prohibitions cover any individual’s actions which are part of any University activities, including those occurring while on University property or in the conduct of University business away from the campus (http://www.colorado.edu/humres/policies/ad.html).

Residents violating this policy will be subject to appropriate University disciplinary procedures, which may include probation and/or termination of the training agreement. Residents violating the University of Colorado Drug-free Workplace Policy may also be asked or required to participate in the Colorado Physician Health Program, including any monitoring and/or treatment recommendations.
Program Director Responsibilities

Program directors are required under Accreditation Council for Graduate Medical Education guidelines to “monitor stress, including mental or emotional conditions inhibiting performance or learning, and drug-or alcohol-related dysfunction.” When health conditions that affect the resident’s ability to practice medicine safely are known or suspected, the program director should make appropriate and timely referrals to the Colorado Physician Health Program to assist with necessary assessment, treatment referral and monitoring.

When the known or suspected health condition is related to substance use/abuse, the following additional steps must be taken by the program director:

1. Review the situation with the Associate Dean for Graduate Medical Education/Designated Institutional Official, including written documentation outlining resident performance deficiencies, before discussing with the resident.

2. Discuss the potential job performance deficiencies and/or policy non-compliance issues with the resident. Make clear that a change in performance, including compliance with this policy, is expected, or appropriate disciplinary action will result. Remind the resident that he/she is required to report the use of any drug/medication that may adversely affect ability to perform to their program director. Make the resident aware of options to seek help for any health condition. Do not make a clinical diagnosis of substance use/abuse or accuse the resident of using substances.

Some training programs may have stricter standards regarding health conditions that may affect the ability to practice medicine safely, calling for additional steps or actions beyond the above. In such cases, the program must have a written policy, and a copy must be placed in the program manual and provided to the GME Office.

Resident Performance and Disciplinary Action Policy

The GME disciplinary action policy states that “for ethical misconduct or substance abuse, a resident may be placed on probation indefinitely, through the remainder of the training program” Any substance abuse or ethical misconduct will result in mandatory referral of the resident to the Colorado Physician Health Program (CPHP).” As a condition of probation, the resident must allow exchange of information between CPHP and the training program/UCDSOM GME office. If CPHP requires “screening for cause,” the resident is responsible for payment; however, expenses may be reimbursable through CU GME health plan and GME office.

If a resident demonstrates a recurrence of unsatisfactory performance due to substance abuse during his/her training program, additional disciplinary actions may occur, he/she may be re-referred to CPHP, or he/she may be dismissed without any additional remedial period.

If a resident’s behavior is considered potentially dangerous to patients himself, herself or other individuals, immediate suspension of clinical responsibilities may be imposed at the discretion of the program director and department chair without a probationary period.
Colorado Board of Medical Examiners Reporting Requirements

Licensed physicians are obligated under CRS 12-36-118(3)(a) to report unprofessional conduct of other licensed physicians to the Colorado Board of Medical Examiners (http://www.dora.state.co.us/medical/Statute.pdf). As defined by the statute, “unprofessional conduct” includes “habitual intemperance or excessive use of any habit-forming drug or any controlled substance…” and “such physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient.”
Policy: Program Director New Appointment and Approval Process

Original Approval: January 13, 2010
Effective date: January 13, 2010
Revision Date:

All Program Directors for ACGME and non-ACGME should meet the following:

A. Program Director Qualifications:
   1. Must have the specialty expertise and educational and administrative experience acceptable to the Review Committee and GMEC,
   2. Hold current ABMS board certification in the specialty area they will be directing, or be certified in a core when no ABMS certification is available in the subspecialty, or
   3. Hold other specialty qualifications must be acceptable to the Review Committee prior to submission to GMEC for approval,
   4. Hold current medical licensure,
   5. Hold the appropriate medical staff appointment,
   6. Hold an academic appointment for a minimum of three years, or specialty RRC requirements,
   7. Demonstrate proof of scholarly activities within the last 5 years.

B. Process for Approval:
   1. Notify the GME Office for new appointments in order to be added to the GMEC agenda,
   2. Submit a letter of support from the Department Chair and/or core residency program director to the Associate Dean for Graduate Medical Education and Chair of the GMEC,
   3. Submit a current electronic copy of the CV,
   4. Final approval for the appointment must be voted by the GMEC,
   5. Formal notification if an ACGME program, in webADS will be done by GME.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Training Programs Closure

The University of Colorado Denver School of Medicine is committed to supporting residents in the completion of their training. However, occasionally circumstances arise which may require a program to close. Program Directors shall consult with the Dean, DIO, GMEC and the Chair, Division Chief and Service Chief of the Department or Section of the affected program, if reduction in size of the program or program closure is being considered. Residents will be notified as early as possible of plans involving closure of a training program. If a training program is to close either voluntarily or involuntarily, residents in the program will complete their training but no new residents will be admitted. However, if the program will not continue long enough for currently enrolled residents to complete training, the UC Denver School of Medicine will assist displaced residents with finding a position in a different ACGME-accredited training program. While the UC Denver School of Medicine will make its best effort to assist displaced residents, it cannot guarantee that residents will find a position in a different training program.

Hospital Closure Policy

In the event an affiliated hospital terminates or suspends operations for whatever reason, efforts to find alternate locations which will provide the necessary clinical and educational resources for residents to complete their training shall be made by the program(s) involved. Should it not be possible to relocate the affected residents, the department will assist displaced residents to find a position in a different ACGME-accredited training program. While the UC Denver School of Medicine will make its best effort to assist displaced residents, it cannot guarantee that residents will find a position in a different training program.

Program Change in Complement

Changes in complement may include any of the following actions: temporary to extend training year due to leaves or other program issues, temporary when an additional resident joins the program for a year or more, or permanent increases. All program changes in complement must follow the following procedure:

1. Requests must be made to the GMEC office and include if request is temporary or permanent, justification for the change in complement, funding support for additional time and/or resident, and effective time period for increase.
2. Requests must be approved by GMEC for ACGME accredited programs
3. All requests (temporary and permanent) for ACGME accredited programs must be entered in webADS, subject to specialty RRC guidelines (ex. temporary increases extending).
Policy: **Smoke-Free and Tobacco-Free Environment**

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**Introduction**

In accordance with our mission, which commits in part to improving the health and well-being of Colorado and the world, the University of Colorado Denver will ensure a smoke-free and tobacco-free environment to protect the health of its faculty, staff, students and visitors at the Anschutz Medical Campus.

**Purpose**

In order to promote health and wellness within the University community, it is the policy of University of Colorado Denver that smoking or tobacco use of any kind is prohibited on any property or in any facilities at the Anschutz Medical Campus. This policy is consistent with policies already in place for neighboring affiliates at the campus, including University of Colorado Hospital and The Children’s Hospital. All persons on the Anschutz Medical Campus are prohibited from smoking products including, but not limited to, cigars, cigarettes, pipes or any device or material which is lighted and inhaled. Smokeless tobacco products such as chewing tobacco or snuff are also prohibited. *Smoke-Free and Tobacco-Free Environment*

**Implementation**

This policy will be distributed to the University community, made available on its website, presented during new student, faculty and staff orientation programs, and promoted using signage on the campus. Individuals observed smoking or using tobacco products on the campus will be informed of the policy and asked to stop. Continued violation of the policy may result in disciplinary action, according to processes specific to faculty, staff and students. As part of the implementation, Human Resources will provide program and benefits resource information to assist with smoking cessation. During the initial implementation of the policy, a limited number of smoking areas away from public activity may be identified to allow faculty, staff and students the opportunity to participate in smoking cessation. For information or assistance with smoking cessation resources or implementation of this policy, please call Human Resources at 303-315-2700.

Smoke-Free and Tobacco-Free Environment  
University of Colorado Denver Administrative Policy  
Effective Date: April 6, 2009
In this document, “resident” refers to both specialty residents and subspecialty fellows.

**Purpose:**

To provide each resident in a Graduate Medical Education Committee (GMEC) approved training program with an annual stipend deemed fair and reasonable by the University of Colorado Denver School of Medicine as the sponsoring institution for medical training programs.

**Policy and Procedure:**

All contracts will follow the GME academic year calendar – June 23rd for Interns and July 1 for PGY II and above. Stipends will reflect the stipend level in effect for that academic year.

A. **Change in the stipend level**

1. All residents and fellows, in a GMEC approved medical training program will receive a stipend based on the annually approved schedule for up to seven levels of graduate medical education and for chief resident positions in Internal Medicine, Pediatrics, Psychiatry and Surgery.

2. Stipends are standardized for all GMEC-approved programs.

3. All exceptions to the established stipend rates must be justified by the Program Director in writing to the DIO. The Program Director must request and obtain approval from the GMEC before making an offer to a resident for a stipend that is greater or lower than the established approved stipend level.

4. If the resident is funded from a NIH training grant rate, the program can pay just the NIH rate if it is more than the stipend rate for the appropriate PGY level minus the taxes.

B. **Change in the PGY level**

5. The PGY level of appointment is determined by the requirements for entering and successfully completing a particular residency or fellowship program leading towards eligibility for Board certification. All exceptions to starting a resident at a level higher or lower level must be justified by the Program Director in writing to the DIO.
Policy: **Supervision**

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In this document, “resident” refers to both specialty residents and subspecialty fellows.

**Purpose**

To ensure that residents are provided adequate and appropriate levels of supervision at all times during the course of the educational training experience and to ensure that patient care is delivered in a safe manner.

**Policy**

All residents working in clinical settings must be supervised by a licensed physician. Within the State of Colorado, the supervising physician must hold a regular faculty or clinical faculty appointment from the University of Colorado School of Medicine. For clinical rotations occurring outside of Colorado the supervising physician must be approved by the training program director.

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the ACGME classification of supervision (CPR Vi.D.3):

**Direct Supervision:**

- The supervising physician is physically present with the resident and patient.

**Indirect Supervision:**

- With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

- With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

**Oversight:**

- The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

Each program must specify in writing the type and level of supervision required for each level of the program. Levels of supervision must be consistent with Joint Commission regulations for
supervision of trainees, “graduated job responsibilities/job descriptions”. The required type and level of supervision for residents performing invasive procedures must be clearly delineated.

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

**Process**

Each program will maintain current call schedules with accurate information enabling residents, at all times, to obtain timely access and support from a supervising faculty member. Verification of required levels of supervision for invasive procedures will be accomplished as part of the Internal Review process. Programs must advise the Associate Dean for GME, in writing, of proposed changes in previously approved levels of supervision for invasive procedures. The GMEC Committee must approve requests for significant changes in levels of supervision.

The Program Director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on Supervision must be included in the official Program Manual and provided to each resident upon matriculation into the program.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

**Purpose:**

To ensure that residents enrolled in training programs meet eligibility requirements to obtain medical licensure in Colorado beyond the level of the Physician Training License.

**Policy:**

All residents in GMEC approved programs are required to successfully complete the USMLE Step 2 (CS and CK) or COMLEX Level 2 (CE and PE) examination, as evidenced by obtaining a passing grade for that examination, prior to the mid-point in the first post-graduate year (PGY1). Failure to demonstrate passage within the stated timeline may result in termination from the training program at the end of the academic year.

All residents in GMEC approved programs are required to successfully complete the USMLE Step 3 examination or COMLEX Level 3 examination, as evidenced by obtaining a passing grade for that examination, prior to the mid-point of the second post-graduate year (PGY2). Failure to demonstrate passage within the stated timeline may result in termination from the training program at the end of the academic year.

All fellows entering GMEC approved programs must have successfully completed the USMLE Step 3 examination or COMLEX Level 3, as evidenced by obtaining a passing grade for that examination, prior to starting a fellowship.

Individual training programs reserve the right to establish written criteria requiring prior completion of USMLE Steps 2 and 3 or COMLEX Levels 2 or 3 as an element of eligibility for applicants to be selected for appointment to a training program.

Academic actions, including non-renewal or dismissal as a consequence of failure to meet requirements in this policy are not grievable under the terms of the GME Disciplinary Action Policy.
Policy: Work Environment

<table>
<thead>
<tr>
<th>Original Approval:</th>
<th>Effective date:</th>
<th>Revision Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>May 3, 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>November 24, 2010</td>
</tr>
</tbody>
</table>

In this document, “resident” refers to both specialty residents and subspecialty fellows.

Purpose and Policy

To ensure that residents have a healthy and safe work environment that provides for:

1. Food Service - access to appropriate food services 24 hours a day while on duty in all institutions. If the cafeteria is not open, adequate and appropriate food items must be available for on-call residents.

2. Call rooms – participating hospitals shall provide adequate and appropriate sleeping quarters that are safe and quiet, for residents’ assigned in-house overnight call, for naps as needed for potential negative effects of fatigue or sleep deprivation, or if the resident is too fatigued to safely return home. Call areas shall include convenient and adequate toilet and shower facilities (cleaned daily); clean linens; security including door locks; an adequate number of lockers for storage of personal belongings; and telephone access.

3. Security/safety – appropriate security and personal safety measures at all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related facilities. Safe transportation options must be available for residents who may be too fatigued to safely return home.

Procedure

If a resident is not provided with the above, the resident should contact hospital appropriate departments, program director, Housestaff Association and/or UCD SOM GME office at 303-724-6031.
In this document, “resident” refers to both specialty residents and subspecialty fellows.

Work-Related Injuries, Needle-sticks, or Exposures (Workers' Compensation Claim Procedures)

Medical Treatment:
Residents who experience a needle-stick or bodily fluid exposure (BFE) should seek immediate medical attention in the Emergency Room of the hospital where the work-related injury occurs.

Exceptions are:
University of Colorado Hospital - Go to the Infectious Disease Clinic at Anschutz Outpatient Pavilion, 1637 Aurora Court, 7th floor, 8:00 a.m. – 4:00 p.m. Monday through Friday. Go to the Emergency Department, Anschutz Inpatient Pavilion at all other times.

Denver Health Medical Center (DHMC) - The Occupational Health and Safety Center (corner of Sixth Avenue and Bannock, 4th Floor) is available 8:00 a.m. - 3:30 p.m. Monday through Friday. Go to the Emergency Room at all other times.

If working in clinics or in laboratories off campus, go to the nearest emergency room or facility that can perform a blood draw.

For follow up care as instructed by the above provider and/or for follow up on all work-related injuries, needle-sticks or exposures, you must go to one of the Designated Medical Providers listed on the University Risk Management website, [www.cu.edu/content/workerscompensation](http://www.cu.edu/content/workerscompensation).

Please direct any workers’ compensation questions to University Risk Management (303) 860-5682, (888) 812-9601 or University of Colorado Denver Risk Management (303) 724-1269.

Claim
You must file an online worker’s compensation claim form within 4 days of the injury or exposure. Go to the University Risk Management website, [www.cu.edu/content/workerscompensation](http://www.cu.edu/content/workerscompensation), to complete and submit the claim form. Failure to file this form timely may result in penalties to you, including financial responsibility for treatment.

University Risk Management, not your health insurance, is responsible for payment of services related to a work-related injury or exposure. Report work-related injuries to University Risk Management, and follow Risk Management protocol. Workers' compensation coverage pays for reasonable and necessary medical expenses from designated providers with no co-pays or

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### Procedure: Workers’ Compensation Claim

| Original Approval: | Effective date: March 15, 2010 | Revision Date: August 11, 2010 |
deductibles, and preserves the resident's rights in the event the injury requires recovery time off work, future treatment, etc.

Send bills from authorized medical providers for a work-related occurrence to:

University Risk Management
1800 Grant St., Suite 700
Denver, CO 80203
Phone: 303-860-5682
Fax: 303-860-5680
Residents

Recruitment and Selection
ERAS
NRMP
Interview Tips and Suggestions
Resident/Fellow Requirements

“Obstacles are those frightful things you see when you take your eyes off your goals.” Anonymous
Recruitment and Selection

- ERAS
- NRMP
- Interview Tips and Suggestions

“Everyone who got to where he is has had to begin where he was.”
Robert Louis Stevenson
ERAS for Residency Applicants

About ERAS
What is ERAS?; Components of ERAS; How does ERAS work?

ERAS Policies
Description of ERAS Data Policy; ERAS Integrity Promotion Program; and ERAS Investigations Policy

Participating Specialties and Programs
Verify if the specialties and programs you are interested in are participating in ERAS

Timeline and Deadlines
Timeline for residency and osteopathic applicants; Information on program application deadlines

Application Process Guideline
A guideline of the ERAS application process

Using MyERAS
Overview and Minimum Requirements for Using MyERAS

Resources to Download
A center to download all documentation from ERAS; such as Applicant Information Sheet; MyERAS Application Worksheet; LoR Cover Sheet; ECFMG Policy on Original Documents; MSPE Guide; MyERAS Manual; etc.

Fees and Billing
ERAS Fees; Other Fees; Refund Policy; Payment Method; Consequences of Nonpayment of ERAS Fees; ERAS Use During the Scramble Period
**About ERAS**

Electronic Residency Application Service (ERAS) is a service that transmits applications, letters of recommendation (LoRs), Medical Student Performance Evaluations (MSPEs), medical school transcripts, USMLE transcripts, COMLEX transcripts, and other supporting credentials from applicants and their designated dean's office to program directors. ERAS consists of MyERAS, Dean's Office Workstation (DWS), Program Director's Workstation (PDWS), and ERAS PostOffice.

**Components of ERAS**

ERAS is comprised of four (4) main components:

- **MyERAS** is the Web site where applicants complete their MyERAS Application, select programs to apply to, and assign documents to be received by programs.
- **DWS** is the software used by the designated dean's office. From this software, medical school staff create the ERAS electronic token that applicants use to access MyERAS. They also use this system to scan and attach supporting documents to the application, such as photographs, medical school transcripts, MSPE, and LoRs. These documents are then transmitted to the ERAS PostOffice.
- **PDWS** is the ERAS software used by program staff to receive, sort, review, evaluate, and rank applications.
- **ERAS PostOffice** is the central bank of computers that transfer the application materials from applicants and their designated dean's office to residency programs.

**How does ERAS work?**

Applicants receive an electronic token from their designated dean's office and use it to register with MyERAS.

Applicants complete their MyERAS application, select programs, assign supporting documents, and transmit their application to programs.

Schools receive notification of the completed application, and start transmitting supporting documents: transcripts, LoRs, photographs, MSPE.

Examining boards receive and process requests for score reports.

Programs contact the ERAS PostOffice on a regular basis to download application materials.
ERAS for Program Staff
General information and software resources for residency and fellowship program staff using ERAS to manage and streamline the recruitment process.

2012 Registration Open
Programs need to register to ensure all ERAS software and communications will be received throughout the season.

- Fellowship registration open February 14
- ACGME residency registration open March 1
- Osteopathic residency registration open March 8

Program registration closes March 31

More About Registration

ERAS PDWS Training
Each year ERAS offers Instructor-based and Web-based training sessions for the Program Director's Workstation (PDWS), beginning in July. ERAS Instructor-based training is a hands-on, step-by-step, half-day training session designed for all residency and fellowship program staff responsible for operating the PDWS. ERAS Web-based training allows users to attend an hour and a half session designed for either Seasoned or New Users using Microsoft® Live Meetings® software remotely at their desktop.

More About ERAS PDWS Training

Residency Timeline
- September Application Cycle
  - AOA Match results are available.

More About the Residency Timeline

Fellowship Timeline
- July Application Cycle
  - ERAS PostOffice will close to prepare for ERAS 2012.
- December Application Cycle
  - ERAS PostOffice closes to prepare for ERAS 2012.

More About the Fellowship Timeline

Getting Started with ERAS
Programs interested in joining ERAS will find information regarding fees, getting their specialty prepared, as well as submitting their written requests to participate.

More About Getting Started with ERAS
ERAS 2012 Participating Specialties & Programs

ERAS provides comprehensive listings of the specialties currently participating in ERAS. You may view the list of programs in a specific specialty by clicking the specialty name.

**Fellowship Programs**

- Adolescent Medicine (Pediatrics)  **New!** (July Cycle)
- Allergy and Immunology  (Dec. Cycle)
- Cardiovascular Disease (Internal Medicine)  (Dec. Cycle)
- Colon and Rectal Surgery  (July Cycle)
- Critical Care Medicine (Internal Medicine)  (Dec. Cycle)
- Endocrinology, Diabetes, and Metabolism (Internal Medicine)  (Dec. Cycle)
- Female Pelvic Medicine and Reconstructive Surgery  (Dec. Cycle)
- Gastroenterology (Internal Medicine)  (Dec. Cycle)
- Geriatric Medicine (Family Practice)  (July Cycle)
- Geriatric Medicine (Internal Medicine)  (July Cycle)
- Gynecologic Oncology  (Dec. Cycle)
- Hematology (Internal Medicine)  (Dec. Cycle)
- Hematology and Oncology (Internal Medicine)  (Dec. Cycle)
- Hospice and Palliative Medicine  (Dec. Cycle)
- Infectious Disease (Internal Medicine)  (Dec. Cycle)
- Interventional Cardiology (Internal Medicine)  (Dec. Cycle)
- Maternal-Fetal Medicine  (Dec. Cycle)
- Medical Genetics  (July Cycle)

**Osteopathic Residency Programs (July Application Cycle)**

**39 specialties, 2 new for ERAS 2012**

- Nephrology (Internal Medicine)  (Dec. Cycle)
- Oncology (Internal Medicine)  (Dec. Cycle)
- Pediatric Cardiology (Pediatrics)  (Dec. Cycle)
- Pediatric Critical Care Medicine (Pediatrics)  (July Cycle)
- Pediatric Emergency Medicine (Emergency Medicine)  (July Cycle)
- Pediatric Emergency Medicine (Pediatrics)  (July Cycle)
- Pediatric Endocrinology (Pediatrics)  (Dec. Cycle)
- Pediatric Gastroenterology (Pediatrics)  (Dec. Cycle)
- Pediatric Hematology/Oncology (Pediatrics)  (Dec. Cycle)
- Pediatric Infectious Diseases (Pediatrics)  (Dec. Cycle)
- Pediatric Nephrology (Pediatrics)  (Dec. Cycle)
- Pediatric Pulmonology (Pediatrics)  (Dec. Cycle)
- Pediatric Rheumatology (Pediatrics)  (July Cycle)
- Pediatric Surgery (General Surgery)  (Dec. Cycle)
- Pulmonary Disease (Internal Medicine)  (Dec. Cycle)
- Pulmonary Disease and Critical Care Medicine (Internal Medicine)  (Dec. Cycle)
- Rheumatology (Internal Medicine)  (Dec. Cycle)
- Sleep Medicine  **New!** (July Cycle)
- Thoracic Surgery  (Dec. Cycle)
- Vascular Surgery (General Surgery)  (Dec. Cycle)

**26 specialties, 0 new for ERAS 2012**
Residency Programs (All are September Cycle) 43 specialties, 0 new for ERAS 2012

- Anesthesiology
- Child Neurology (Neurology)
- Dermatology
- Emergency Medicine
- Emergency Medicine/Family Medicine
- Family Medicine
- Internal Medicine
- Internal Medicine/Dermatology
- Internal Medicine/Emergency Medicine
- Internal Medicine/Family Practice
- Internal Medicine/Medical Genetics
- Internal Medicine/Neurology
- Internal Medicine/Pediatrics
- Internal Medicine/Physical Medicine and Rehabilitation
- Internal Medicine/Preventive Medicine
- Internal Medicine/Psychiatry
- Neurological Surgery
- Neurology
- Nuclear Medicine
- Obstetrics and Gynecology
- Orthopaedic Surgery
- Otolaryngology
- Pathology-Anatomic and Clinical
- Pediatrics
- Pediatrics/Dermatology
- Pediatrics/Emergency Medicine
- Pediatrics/Medical Genetics
- Pediatrics/Physical Medicine and Rehabilitation
- Pediatrics/Psychiatry/Child and Adolescent Psychiatry
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Plastic Surgery-Integrated
- Preventive Medicine (Public Health, General, Occupational and Aerospace)
- Psychiatry
- Psychiatry/Family Practice
- Psychiatry/Neurology
- Radiation Oncology
- Radiology-Diagnostic
- Surgery-General
- Thoracic Surgery-Integrated
- Transitional Year
- Urology
- Vascular Surgery-Integrated

* Indicates specialties that participate with the National Resident Matching Program (NRMP)
+ Represents specialties that offer OGME-2 training
2012 Main Match Schedule

September 1, 2011
Registration opens at 12:00 noon eastern time for applicants, institutional officials, program directors, and medical school officials.

November 30, 2011
Applicant early registration deadline
Note: Applicants may register for $50 until 11:59 p.m. eastern time. Applicants who register after November 30 must pay an additional $50 late registration fee ($100 total fee) until February 22, 2012, when registration closes.

January 15, 2012
Rank order list entry begins
Applicants and programs may start entering their rank order lists at 12:00 noon eastern time.

January 31, 2012
Quota change deadline
Programs must submit final information on quotas and withdrawals by 11:59 p.m. eastern time.

February 22, 2012
Deadline for registration and ROL certification
Rank order list certification deadline
Applicants and programs must certify their rank order lists before 9:00 p.m. eastern time. Staff will be available to answer your questions during the final deadline hours.

CERTIFIED applicant and program rank order lists and any other information pertinent to the Match must be entered in the R3 System by this date and time.

Withdraw deadline
Independent applicants who have accepted a position through another national matching plan or by agreement outside the Matching Program must withdraw before 9:00 p.m. eastern time.

March 12, 2012
Applicant matched and unmatched information posted to the Web site at 12:00 noon eastern time.

Filled and unfilled results for individual programs posted to the Web site at 12:00 noon eastern time.

Locations of all unfilled positions are released at 12:00 noon eastern time only to participants eligible for the Supplemental Offer and Acceptance Program (SOAP).
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 13, 2012</td>
<td>Programs with unfilled positions may start entering their SOAP preference lists at 11:30 a.m. eastern time.</td>
</tr>
<tr>
<td>March 14, 2012</td>
<td>Programs with unfilled positions must finalize their first-round SOAP preference lists by 11:30 a.m. eastern time. Supplemental Offer and Acceptance Program (SOAP) offer rounds begin at 12:00 noon eastern time.</td>
</tr>
<tr>
<td>March 16, 2012</td>
<td>Match Day! Match results for applicants are posted to Web site at 1:00 p.m. eastern time. Supplemental Offer and Acceptance Program (SOAP) concludes at 5:00 p.m. eastern time.</td>
</tr>
<tr>
<td>March 17, 2012</td>
<td>Hospitals begin sending letters of appointment to matched applicants after this date.</td>
</tr>
</tbody>
</table>

**Note:** SOAP-eligible unmatched applicants shall initiate contact with the directors of unfilled programs only through ERAS. Other individuals or entities shall not initiate contact on behalf of any SOAP-eligible unmatched applicant prior to contact from directors of unfilled programs. Such contact is a violation of the Match Participation Agreement. Contact between programs and matched applicants prior to the general announcement of 2012 Match results at 1:00 p.m. eastern time Friday, March 16, 2012 also is a violation of the Match Participation Agreement.

Updated 07/01/2011
## Specialties Matching Service

### General Schedule of Dates

<table>
<thead>
<tr>
<th>Specialty &amp; Appointment Year</th>
<th>Match Begins</th>
<th>Rank Order List Opens</th>
<th>Quota Change Deadline</th>
<th>Rank Order List Closes*</th>
<th>Match Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Transplant Surgery 2013</td>
<td>01/11/12</td>
<td>04/11/12</td>
<td>05/22/12</td>
<td>06/06/12</td>
<td>06/20/12</td>
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<tr>
<td>Allergy/Immunology 2013</td>
<td>08/01/12</td>
<td>10/10/12</td>
<td>11/07/12</td>
<td>11/14/12</td>
<td>12/05/12</td>
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<tr>
<td>Child &amp; Adolescent Psychiatry 2012</td>
<td>08/31/11</td>
<td>11/02/11</td>
<td>11/30/11</td>
<td>12/14/11</td>
<td>01/04/12</td>
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<tr>
<td>Colon &amp; Rectal Surgery 2012</td>
<td>07/27/11</td>
<td>09/21/11</td>
<td>10/19/11</td>
<td>11/02/11</td>
<td>11/16/11</td>
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<tr>
<td>Combined Musculoskeletal (Hand Surgery) 2013</td>
<td>01/11/12</td>
<td>03/21/12</td>
<td>04/18/12</td>
<td>05/02/12</td>
<td>05/16/12</td>
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<tr>
<td>Female Pelvic Medicine &amp; Reconstructive</td>
<td>04/06/11</td>
<td>06/08/11</td>
<td>07/06/11</td>
<td>07/20/11</td>
<td>08/03/11</td>
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<td>Specialty</td>
<td>Dates</td>
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<tr>
<td>Surgery</td>
<td>09/28/11 12/14/11 01/04/12 01/18/12 02/01/12</td>
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<tr>
<td>Laryngology</td>
<td>07/27/11 10/05/11 11/02/11 11/16/11 11/30/11</td>
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<tr>
<td>Medical Genetics</td>
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<tr>
<td>Medical Specialties** (MSMP)</td>
<td>05/11/11 07/13/11 08/31/11 09/14/11 09/28/11</td>
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<tr>
<td>Neonatal-Perinatal Medicine</td>
<td>06/01/11 08/10/11 09/14/11 09/28/11 10/12/11</td>
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<tr>
<td>Obstetrics &amp; Gynecology*** (OB/GYN)</td>
<td>03/02/11 05/11/11 05/25/11 06/08/11 06/22/11</td>
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<tr>
<td>Pediatric Anesthesiology</td>
<td>11/16/11 03/21/12 04/04/12 04/18/12 05/02/12</td>
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<tr>
<td>Pediatric Hematology / Oncology</td>
<td>08/10/11 10/05/11 11/02/11 11/16/11 11/30/11</td>
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<tr>
<td>Specialty</td>
<td>Start Dates</td>
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<td>Pediatric Specialties Spring Match (PSSM) 2012</td>
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<td>Pediatric Surgery 2013</td>
<td>11/16/11, 03/21/12, 04/04/12, 04/18/12, 05/02/12</td>
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<td>Primary Care Sports Medicine 2012</td>
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<td>Radiology 2013</td>
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<tr>
<td>Thoracic Surgery 2013</td>
<td>01/04/12, 04/04/12, 05/09/12, 05/23/12, 06/06/12</td>
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<tr>
<td>Vascular Surgery 2013</td>
<td>12/07/11, 03/28/12, 04/18/12, 05/02/12, 05/16/12</td>
<td></td>
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</tr>
</tbody>
</table>

* The rank order list deadline is 9:00 p.m. eastern time for all fellowship matches. Applicants who have accepted a position through another national matching plan or by agreement outside the Matching Program must withdraw by 9:00 p.m. eastern time.

**MSMP**

- Cardiovascular Disease
- Endocrinology
- Gastroenterology
- Hematology
- Hematology/Oncology
- Infectious Disease
- Interventional Pulmonology
- Nephrology
- Oncology
- Pulmonary Disease
- Pulmonary Disease and Critical Care Medicine
- Rheumatology

**OB/GYN***

- Gynecologic Oncology
- Maternal-Fetal Medicine
- Reproductive Endocrinology

**PSFM****

- Developmental-Behavioral Pediatrics
- Pediatric Critical Care Medicine
- Pediatric Emergency Medicine
- Pediatric Rheumatology

**PSSM*****

- Pediatric Cardiology
- Pediatric Gastroenterology
- Pediatric Nephrology
- Pediatric Pulmonology

**RADIOLOGY******

- Vascular / Interventional Radiology
- Neuroradiology

Updated 09/22/2011
About the NRMP

The National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME). It is governed by its Board of Directors. Five medical/medical education organizations, one program director organization, and three medical student organizations nominate candidates for election to the Board: the American Board of Medical Specialties (ABMS), the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), the Council of Medical Specialty Societies (CMSS), the Organization of Program Director Associations (OPDA), the AAMC Organization of Student Representatives, the American Medical Student Association (AMSA), and the AMA Medical Student Section. The Board also selects one program director, three resident physicians, and one public member from at-large nominations. Each year, the NRMP conducts a Main Residency Match that is designed to optimize the rank-ordered choices of applicants and program directors. In the third week of March, the results of the Match are announced.

The NRMP is not an application processing service; rather, it provides an impartial venue for matching applicants’ and programs’ preferences for each other consistently. Each year, approximately 16,000 U.S. medical school students participate in the Main Residency Match. In addition, another 20,000 “independent” applicants compete for the approximately 25,000 available residency positions. Independent applicants include former graduates of U.S. medical schools, U.S. osteopathic students and graduates, Canadian students and graduates, and students and graduates of international medical schools.

In 2010, the NRMP enrolled 4,176 programs in the Match, which altogether offered 25,520 positions. A total of 37,556 applicants participated in the Match. Of those, 16,427 were 2010 graduates of accredited U.S. medical schools and 21,129 were independent applicants.

Specialties Matching Service

The NRMP also conducts matches for fellowship positions in 38 subspecialties through its Specialties Matching Service. Those positions involve further training after completion of the initial residency program and lead to certification in a subspecialty (i.e., cardiology).

The fellowship matches are conducted throughout the year. Please verify each fellowship’s respective Schedule of Dates.

Please contact the NRMP at (202) 862-6077 or 1-866-617-5834 if you have questions about fellowship matches.

Updated 09/09/2010
<table>
<thead>
<tr>
<th>Hotel Name</th>
<th>Phone Number</th>
<th>UCD Rate</th>
<th>Amenities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cambria Suites</strong></td>
<td>303-574-9600</td>
<td>$89/jr. suite</td>
<td>- Courtesy Shuttle to &amp; from airport and Anschutz Medical Campus</td>
</tr>
<tr>
<td><strong>Denver Airport Marriott @Gateway Park</strong></td>
<td>303-371-4333</td>
<td></td>
<td>- 16455 E. 40th Circle</td>
</tr>
<tr>
<td><strong>Doubletree Hotel</strong></td>
<td>303-337-2800</td>
<td>$89/std. room</td>
<td>- Courtesy shuttle to &amp; from airport as well as Anschutz Medical Campus</td>
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<td>- Full Restaurant /cocktail lounge</td>
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<td><strong>Drury Inn –Denver East</strong></td>
<td>303-373-1983</td>
<td>$69/ $89</td>
<td>- $89 rate for transportation to &amp; from airport and Anschutz Medical Campus</td>
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<td>- Complimentary quick start hot breakfast</td>
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<td>- Wireless Internet –no charge</td>
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<td>- 1 hour of long distance free in evening</td>
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<tr>
<td><strong>Hilton Garden Inn Hotel</strong></td>
<td>303-371-9393</td>
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<td>- Complimentary shuttle to &amp; from airport as well as Anschutz Medical Campus</td>
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<td>- Complimentary Buffet Breakfast –full breakfast</td>
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<tr>
<td><strong>Staybridge Suites</strong></td>
<td>303-574-0888</td>
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<td>303-272-1444</td>
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<td>- Complimentary Hors D’Oeuvres Reception 5pm-7pm</td>
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</table>
Hotels: Near Stapleton Redevelopment – About 7 miles from Anschutz Medical Campus & 16 from DIA

**Doubletree Hotel – Denver**
- Phone: 303-321-3333
- UCD Rate: $89/std. rm.
- 3203 Quebec St.
- Denver, CO
- • Courtesy shuttle to & from airport

**Embassy Suites**
- Phone: 303-375-0400
- UCD Rate: $109
- 4444 North Havana St.
- Denver, CO 80207
- • Courtesy shuttle to & from airport as well as Anschutz Medical Campus

**Red Lion Hotel**
- Phone: 303-321-6666
- 4040 Quebec St.
- Denver, CO
- • Complimentary shuttle from airport & hotel as well as Anschutz Medical Campus

**Radisson Hotel**
- Phone: 303-321-3500
- UCD “Residency Interview” Rate: $79

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Hotels: Downtown Denver – About 14 miles from Anschutz Medical Campus and 20 miles from DIA

**Brown Palace Hotel**
- Phone: 303-297-3111
- UCD Rate: $169
- 321 17th Avenue
- Denver, CO
- • Denver’s oldest operational hotel. Guests include former presidents and rock stars

**Crown Plaza Denver**
- Phone: 303-573-1450
- UCD Rate: $99
- 15th & Glenarm Place
- Denver, CO

**Grand Hyatt Denver**
- Phone: 303-295-1234
- UCD Rate: $129
- 1750 Welton St.
- Denver, CO

**Warwick Hotel**
- Phone: 303-861-2000
- UCD Rate: $119
- 1776 Grant St.
- Denver, CO
FELLOW APPLICANTS

Fellow Application Packets
- Cardiology Teaching faculty pubs list (3yrs)
- Email directory for fellows and UCD Cardiology Faculty according to practice sites
- Sample contract
- Stipends package (last years)
- Name badge
- Itinerary for day’s visit
- Denver Magazine
- Campus Map
- Background check (to be signed & returned that day)

Advance email to confirmed applicant interviewees:
- Confirmation letter
- Campus map
- Hotel list
Coordinator’s Informational Packets for Residents/Fellows Invited for Interviews

Courtesy of the GME Program Coordinator Council

Information included prior to the interview:
- AMC campus map that includes buildings and parking identified.
- Denver regional map and specific map from DIA to AMC campus
- Confirmation letter with date of interview that also includes overview of day’s activities and interview process that includes start and end time. If a pre-evening social get-together is included, details and contact information for that event are also included.
- List of hotels with UCD special rates and notations of inclusions such as free breakfast and/or evening cocktail HorsD’Oeuvres. Complimentary shuttle service to and from DIA as well as to and from our AMC campus.
- GME website address as well as Division / Department website address
- Coordinator’s contact information including “emergency only” cell phone contact
- Request sheet for specific areas of long term career interests that involve additional appointments with specific faculty (Example: In Cardiology perhaps Electrophysiology)
- Special dietary requests for box lunches.

Information provided the day of interview to applicant:
(Materials are presented in notebook binders or in pocket folders. Pocket folders with CU logo are available at our campus bookstore or through ProForma Single Source 303-791-8738 extension 5 for Mary) Bookstore-$1.85 ea no minimum; ProForma=$1.47 for 500 or $1.85 for 250 minimum)
- Teaching faculty publications list for past three to five years
- Sample training agreement. Benefits package. Stipends page from GME. Background check form that you ask applicant to complete and turn in prior to end of day so you have this on file if applicant is selected to program.
- The Denver Magazine (obtained free from Denver Visitors Bureau contact Kathy Reynolds @ 303-571-9448 or kreyolds@visitdenver.com Lead time 2-3 weeks)
- A 40 minute power point presentation on a CD of Division overview by Program Director and Division Head or consider hardcopy handout of academic and clinical program.
- Individual agenda for each applicant in packet
- Email lists for faculty and residents/fellows in your program. Business card for Program Director and Coordinator
- List of ten top reasons to come to our program.
- Sample monthly educational calendar for your program with description of curriculum.
- Survey for completion “How you heard about our program?”
- Pen. Note pad for taking notes
- Sample rotation and call schedule
- Name tag for applicant to wear.

Miscellaneous

Created by Elaine Farrell – April 2010
• Interviews are handled differently in each program. Some do one on one while other programs do small groups with applicants and faculty panelists. Another method is where applicants rotate among five faculty panel in twenty-five minute sessions of individual meetings. Faculty complete forms that are then later reviewed and discussed in the selection process.

• Tours are provided in a variety of ways. Some programs provide walking tours led by existing residents/fellows of specific areas of hospital(s) relevant to the program. Some provide a long tour of campus that includes the library and other broad areas of the AMC campus. Some provide the walking tour campus maps and have applicants conduct self-tours. If programs provide shuttled tours to other key practice sites, many coach services are available in the phone book as well as our own campus. All are expensive.
“You can finish school, and even make it easy—but you never finish your education, and it’s seldom easy.” Zig Ziglar
Requirements for GME Residents and Fellows are as follows:

- Licensure
- Training Agreement
- USMLE/COMLEX
- Modules
- Surveys (ACGME Resident Survey, GME Surveys, Housestaff Association Survey)
- Duty Hours
- ACLS and/or BLS
- Stamper
Helpful Information

Schedules
Resources and Toolkits

“Begin with the end in mind.” Stephen Covey
Schedules

- GME meeting schedules
- ACGME meeting schedules
- Holiday schedules
- Internal Reviews and Site Visits
- Information on yearly updates

“Confidence is the companion of success.” Anonymous
A Year in the Life
The below is an overview of what goes on in the life of a program coordinator in any given year. Listed under each month are activities that generally occur at that time each year. Dates and deadlines for items for the GME Office will be disseminated via email, web or program coordinator meetings. You may find additional information on the below in this handbook or via the web.

July
Beginning of new academic year
GME Orientation for new residents and fellows- July 1 (PGY 2s and above)
Annual ACGME WebADS and GMETrack updates begin- programs are notified directly to complete these updates and deadlines are given at that time.
Prepare for the academic year in New Innovations: Evaluations and rotation schedules
Begin tracking/monitoring duty hours (GMEOne or New Innovations)
Train new residents/fellows on the use of New Innovations
Assist residents/fellows with the transition into the program

August
Annual Program Evaluation and Action Plan due in GME Office (Refer to GMEC section under GME)
ERAS opens for residency programs

September
NRMP Residency Program registration opens
Prepare recruitment material
Applications begin to arrive for upcoming interview season- download from ERAS each day.
Set up process with program director for screening and/or sorting applications
Update and/or prepare all materials for interview season
Select interview dates- schedule rooms and block time on calendars where applicable
GME Track updates (National GME Census) – end of September deadline
Confirmation of funding- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section
Educational Funds- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook

October
Finalize details for the upcoming interview season: recruitment packets/activities, etc
Many programs have an October or November deadline for applications
Begin sending invitations
Finalize itineraries
Registration for in-training exams
Address update for residents- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook

November
Medical student performance evaluations are released (formerly known as Dean’s letters)
Field calls regarding application status
Interviews begin
Annual resident survey sent to residents via GME.

December
Interviews continue
Letters of regret for those not interviewed
Resident semi-annual evaluations with program directors (ACGME Requirement)
Didactic Form- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook

January
Finish with interviews
Second look at candidates
Committee should finalize rank list
NRMP Residency Match Quota deadline
NRMP Residency match rank list opens
Send follow-up correspondence to candidates- thank you, survey, etc
ACGME Resident Survey (Jan-Jun, residents will be notified by the ACGME. Further information under ACGME section of this notebook)

February
GME request for certificates of completion lists emailed to coordinators (if not hospital funded must include an IN)
NRMP rank order certification deadline
Submit notification to trainees of any contract non-renewal, if applicable
Coordinate match list; enter into NRMP website
Plan for annual program evaluation meeting
Submit orders for certificates for graduating residents/fellows
Pager orders for incoming residents- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook
NCE Lists- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook
Resident Charge Sheets (RCS)- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook

March
Match day
GME “March Madness”: Attend one of two March coordinators meetings at which you will be given updates for your blue notebook and new resident packets
Return to GME Office: NCE lists, certificate lists, pager lists
Send out packets to new residents/fellows
Register for ERAS for following year
Execute new training agreements for all residents/fellows
Schedule immunization screenings for new residents
ACGME Annual Education meeting (1st week in March)
Check visa requirements for any international medical graduates (contact Julie Chavez when you have a foreign medical graduate)
Review checklists for exiting and incoming residents
Many in-training exams happen during this time
April
Return resident packets to GME Office
Receive NCE list from GME Office with CU ID and Pharm numbers
Begin schedules for next academic year
Plan for graduation party
Schedule semi-annual evaluations- this will be the last one for those graduating
Update program documents
Open enrollment for continuing residents begins- obtain packets from GME Office
Continue to send, receive, and process information from incoming residents

May
Annual PPD campaign begins
GME Exit Survey for graduating residents
Housestaff Association Annual Survey
Return continuing packets to GME office- Open enrollment ends this month
Submit pager order to GME office
Return resident charge sheets to GME
Plan department/program orientation for new residents/fellows
Training modules for new and continuing residents/fellows available on Blackboard
PPD Campaign- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook
Immunization Screening- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook
Annual Enrollment in CUGME Benefits- for a full description please refer to “Annual Requests Made by the Office of Graduate Medical Education” in the GME Section of this notebook
ERAS Post Office closes May 31st

June
GME Orientation for Interns- Late June, TBD by the GME Office (PGY 1)
Pick up pagers from the GME office
Pick up GME Resident manuals from GME office
Verify all new residents/fellows have Colorado medical licenses (Training or Full)- put copy in file
Verify all new residents/fellows have NPI number- put copy in file
Obtain future contact information for graduating residents and forward to the GME office for PeopleSoft update
Complete final program letter of completion for graduates
Finalize program documents
Distribute schedules for next academic year
Graduation ceremony
Completion of modules for residents/fellows beginning June 23 or July 1
The Basics of Accreditation for New Program Coordinators

*Must have less than 2 years total experience as a program coordinator

ACGME Headquarters
515 N. State St. Suite 2000
Chicago, IL 60654

Dates of 2011 Workshops

July 25th  Internal Medicine & Subspecialties
August 8th  Anesthesiology, Nuclear Medicine, Obstetrics & Gynecology, Orthopaedic Surgery, Physical Medicine & Rehabilitation, Preventive Medicine, Diagnostic Radiology
August 22nd  Colon & Rectal Surgery, Pediatrics & Subspecialties, Neurology, Urology
October 10th  Allergy & Immunology, Dermatology, Ophthalmology, Otolaryngology, Pathology, Radiation Oncology, Transitional Year
October 24th  Emergency Medicine, Family Medicine
November 7th  Institutional/GME Office
November 14th  Neurosurgery, Medical Genetics, Plastic Surgery, Psychiatry, Thoracic Surgery, Surgery

Subspecialty/fellowship coordinators should select the date scheduled for the core specialty for their subspecialty.

Questions about the workshop can be submitted to the ACGME by email at the following address: coordinatorworkshops@acgme.org

**Goal:** This one-day intensive workshop will help new program coordinators understand the basics concerning ACGME accreditation of residency training programs in the specialties listed above.

**Who Should Attend:** This interactive workshop is designed for individuals who assist the program director in the administration of the residency/fellowship program and are new to the accreditation process. The information given in this workshop is very introductory; it is not designed for seasoned coordinators. **Participants must have less than two years of experience in the position of program coordinator to attend.** The ACGME reserves the right to cancel your registration if you have more than two years of experience in the role of a program coordinator.
GENERAL WORKSHOP INFORMATION

The workshops are scheduled from 8:00 a.m. – 4:00 p.m. and held at the ACGME headquarters, 515 N. State St, Suite 2000, Chicago, IL 60654. Each workshop will be limited to 60 registrants. The agenda will include basic information concerning the ACGME, RCs, and the accreditation process, and also a choice of two breakout sessions. Attendees will have the chance to meet their RC team during the specialty specific sessions. Faculty will include ACGME senior staff, administrative staff from the specific RCs, ACGME staff representatives from the departments of data collection, education and field activities, as well as a guest coordinator. All participants will have a laptop available for use during the workshop. Questions about the workshop can be submitted to the ACGME by e-mail (coordinatorworkshops@acgme.org).

REGISTRATION

Online registration will be available at www.acgme.org starting May 13th.

Registration is limited to coordinators who are NEW to their positions (under 2 years) and who wish to learn the fundamentals of the accreditation process. This workshop is not meant for program directors, associate program directors, DIO’s or experienced coordinators. The ACGME reserves the right to cancel your registration if you have more than two years of experience in the role of a program coordinator.

The registration fee is $250 and includes all activities, materials, continental breakfast, break refreshments and a box lunch.

Registration will be limited to 60 individuals per workshop. Registration must be completed online; faxed or mailed in registrations are not accepted. Confirmation of workshop acceptance will be sent via e-mail immediately after registration has been submitted. Please do not make plane or hotel reservations until you receive a confirmation of acceptance.

All meeting cancellations and requests for refunds must be received two weeks prior to the workshop and are subject to a $25.00 administrative fee.

HOTEL ACCOMMODATIONS

Hotel accommodations should be made after you receive confirmation of acceptance to the workshop. ACGME headquarters are located in the River North neighborhood of Chicago. There are a number of hotels, restaurants, theaters, museums, shopping, and other major entertainment and cultural attractions within walking distance of Embassy Suites and the ACGME.

ACGME has reserved a block of rooms at Embassy Suites for the night prior to the workshop; these rooms are on a first-come, first-served basis, and you must identify yourself as an ACGME workshop participant to receive the workshop rate. Reservations must be made four weeks prior to the workshop to receive the discounted rate, after this time rooms will be available at standard hotel rates.

Room Rates: All cancellations require 48-hour notice.

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<th>July 24, August 7, August 21, October 9, October 23, November 6</th>
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<tr>
<td>single/double</td>
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Embassy Suites
600 N. State St.
Chicago, IL 60654
(312) 943-3800
The Workshops will be held at ACGME Headquarters at 515 N. State St. Suite 2000; Embassy Suites is located one block north on State Street.
The Basics of Accreditation for New Program Coordinators
Workshop Agenda

7:30 a.m. Continental Breakfast

8:00 a.m. Welcome and Introductions
Debra Dooley

8:30 a.m. Introduction to the ACGME
John Nylen, MBA

8:45 a.m. Navigating the ACGME Website
Karla Wheeler, MA

9:00 a.m. Specialty Specific Sessions - Review of Program Requirements and PIF
RC Team

10:00 a.m. Break

10:15 a.m. Continue Specialty Specific Sessions - Review of Program Requirements and PIF

11:45 a.m. How Does It All Fit Together?
Debra Dooley

12:00 p.m. Lunch and Networking Session

12:30 p.m. Preparing for the Site Visit
Jane Shapiro, MA Ed

1:30 p.m. What Happens after the Site Visit?
RC Administrator

1:45 p.m. Break

2:00 p.m. Breakout Session #1
ADS Technology Session
ADS Staff

Breakout Session #2
Building a Team-Oriented Approach to the PIF
Debra Dooley

3:00 p.m. A Year in the Life of a Coordinator

4:00 p.m. Workshop Ends
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<td>General Surgery</td>
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<td>October 28, 2010</td>
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<td>Cytopathology</td>
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<td>April 28, 2011</td>
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2011-2012
Meeting Schedule
4:00-5:30 pm

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, July 13, 2011</td>
<td>4:00</td>
<td>Anschutz Campus Academic Office Building 1-7th Floor Boardroom (AO1-7th Floor Boardroom)</td>
</tr>
<tr>
<td>Wednesday, August 10, 2011</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, September 14, 2011</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, October 12, 2011</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, November 9, 2011</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, December 14, 2011</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, January 11, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, February 8, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, March 14, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, April 11, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, May 9, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
<tr>
<td>Wednesday, June 13, 2012</td>
<td>4:00</td>
<td>AO1-7th Floor Boardroom</td>
</tr>
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Revised: February 7, 2011
Holiday Schedule
Fiscal Year 2011-12

Common Holidays
The following holidays will be observed at both campuses. Offices not designated as essential services will be closed.

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Day</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Day</td>
<td>Monday</td>
<td>July 4, 2011</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Monday</td>
<td>September 5, 2011</td>
</tr>
<tr>
<td>Thanksgiving</td>
<td>Thursday</td>
<td>November 24, 2011</td>
</tr>
<tr>
<td>Christmas</td>
<td>Monday</td>
<td>December 26, 2011</td>
</tr>
<tr>
<td>Alternate Holiday</td>
<td>Tuesday</td>
<td>December 27, 2011</td>
</tr>
<tr>
<td>New Years Day</td>
<td>Monday</td>
<td>January 2, 2012</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Monday</td>
<td>May 28, 2012</td>
</tr>
</tbody>
</table>

Campus-Specific Holidays

Denver Campus
Units specifically serving the Denver Campus and its colleges and schools will observe the following holidays:

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday</td>
<td>December 28, 2011</td>
</tr>
<tr>
<td>Thursday</td>
<td>December 29, 2011</td>
</tr>
<tr>
<td>Friday</td>
<td>December 30, 2011</td>
</tr>
</tbody>
</table>

Anschutz Medical Campus
Units specifically serving the Anschutz Medical Campus and its colleges and schools will observe the following holidays:

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday</td>
<td>November 25, 2011</td>
</tr>
<tr>
<td>Monday</td>
<td>January 16, 2012</td>
</tr>
<tr>
<td>Monday</td>
<td>February 20, 2012</td>
</tr>
</tbody>
</table>

Consolidated Units
Consolidated units serving both campuses will remain open on the campus-specific holidays and each employee will request either the Denver Campus or Anschutz Medical Campus schedule for the fiscal year.

Holiday Policy
For more information and guidance on administering holiday leave, please see the Holiday Policy: http://administration.ucdenver.edu/admin/policies/hr/HolidayPolicy.pdf
Resources and Toolkits

- Alphabet Soup
- Campus Maps
- Coordinator Council Information
- Useful Websites

“We aim above the mark to hit the mark.” Ralph Waldo Emerson
## Professional Associations

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>FULL NAME</th>
<th>PURPOSE</th>
<th>FUNCTION</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAIM</td>
<td>Alliance for Academic Internal Medicine</td>
<td>Professional/Education</td>
<td>The Alliance for Academic Internal Medicine is the consortium of five academically focused specialty organizations representing departments of internal medicine at medical schools and teaching hospitals in the United States and Canada. AAIM consists of the Association of Professors of Medicine, the Association of Program Directors in Internal Medicine, the Association of Specialty Professors, the Clerkship Directors in Internal Medicine, and the Administrators of Internal Medicine. Representing departments of internal medicine at 143 medical schools and 263 teaching hospitals in the United States and Canada, AAIM represents department chairs and chiefs; clerkship, residency, and fellowship program directors; division chiefs; and academic and business administrators as well as other faculty and staff in departments of internal medicine and their divisions.</td>
<td><a href="http://www.im.org/aaim/">http://www.im.org/aaim/</a></td>
</tr>
<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
<td>Professional/Education</td>
<td>Improvement of the nation’s health through the strengthening the quality of medical education and training, to enhance the search for biomedical knowledge, to advance research in health sciences and to integrate education into the provision of effective health care.</td>
<td><a href="http://www.aamc.org/">http://www.aamc.org/</a></td>
</tr>
<tr>
<td>ABMS</td>
<td>American Board of Medical Specialties</td>
<td>Certifying/Professional</td>
<td>An organization of 24 approved medical specialty boards. ABMS coordinates the activities of its members boards and provides information to others concerning issues about specialization and certification of medical specialists.</td>
<td><a href="http://www.abms.org/">http://www.abms.org/</a></td>
</tr>
<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
<td>Accrediting</td>
<td>Responsible for the accreditation of post MD medical training programs within the US, through a peer-review process and based upon established standards and guidelines.</td>
<td><a href="http://www.acgme.org">http://www.acgme.org</a></td>
</tr>
<tr>
<td>ACP</td>
<td>American College of Physicians</td>
<td>Professional/Education</td>
<td>The American College of Physicians is a national organization of internists — physicians who specialize in the prevention, detection and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 124,000 includes internists, internal medicine subspecialists, and medical students, residents, and fellows.</td>
<td><a href="http://www.acponline.org">http://www.acponline.org</a></td>
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<tr>
<td>AHA</td>
<td>American Hospital Association</td>
<td>Professional</td>
<td>The American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Close to 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members come together to form the AHA.</td>
<td><a href="http://www.aha.org/aha/about/index.html">http://www.aha.org/aha/about/index.html</a></td>
</tr>
<tr>
<td>APDIM</td>
<td>Association of Program Directors in Internal Medicine</td>
<td>Professional/Educational</td>
<td>Is the international organization of accredited internal medicine residency programs. APDIM is a professional and educational organization dedicated to the promotion of excellence in internal medicine training. APDIM has a membership of over 1,800 individuals from approximately 400 institutions. APDIMs’ members represent 95 percent of the accredited internal medicine residency programs within the United States, Puerto Rico, and Canada.</td>
<td><a href="http://www.im.org/APDIM/">http://www.im.org/APDIM/</a></td>
</tr>
<tr>
<td>CMSS</td>
<td>Council for Medical Specialty Societies</td>
<td>Professional</td>
<td>Not for profit organization established to foster, promote, support, augment, develop and encourage improved quality and delivery of care and systems of medical education and communication among professional organizations. Represents specialty societies on ACGME, ACCME, ABMS, CMFA, NBME, NRMP. Council consists of members from specialty societies having Boards recognized by ABMS.</td>
<td><a href="http://www.cmss.org">http://www.cmss.org</a></td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
<td>Regulatory Government Agency</td>
<td>Federal agency responsible for administering the Medicare, Medicaid, SCHIP (State Children's Health Insurance), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs.</td>
<td><a href="http://www.cms.hhs.gov/medicaid/default.asp">http://www.cms.hhs.gov/medicaid/default.asp</a></td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Administration</td>
<td>Licensure</td>
<td>Governmental agency responsible for providing licensure/certification to physicians for dispensing all controlled substances.</td>
<td><a href="http://www.usdoj.gov/dea/">http://www.usdoj.gov/dea/</a></td>
</tr>
<tr>
<td>ECFMG</td>
<td>Educational Commission for Foreign Medical Graduates</td>
<td>Certifying</td>
<td>Assesses the readiness of international medical graduates to enter residency or fellowship programs in the US that are accredited by the ACGME.</td>
<td><a href="http://www.ecfmg.org/">http://www.ecfmg.org/</a></td>
</tr>
<tr>
<td>ERAS</td>
<td>Electronic Residency Application Service</td>
<td>Service</td>
<td>On line application service used by medical graduates or medical students in their final year of medical school to apply for specialized graduate training in residency programs in the US.</td>
<td><a href="http://www.aamc.org/students/eras/start.htm">http://www.aamc.org/students/eras/start.htm</a></td>
</tr>
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<tr>
<td>FCVS</td>
<td>Federation Credentials Verification Service</td>
<td>Service</td>
<td>Collects, verifies and maintains information and copies of documents and records that can be provided to professional licensing boards, hospitals and other entities when applying for licensure, staff membership, employment or other privileges.</td>
<td><a href="http://www.fsmb.org/forcvs_program/cvrhome.htm">http://www.fsmb.org/forcvs_program/cvrhome.htm</a></td>
</tr>
<tr>
<td>FREIDA or AMA FREIDA</td>
<td>Fellowship and Residency Electronic Interactive Database</td>
<td>Information</td>
<td>Database with over 7,800 graduate medical education programs accredited by the ACGME, containing information about residency and fellowship training programs, affiliated teaching institutions, training statistics and graduates career plans statistics.</td>
<td><a href="http://www.ama-assn.org/ama/pub/category/2997.html">http://www.ama-assn.org/ama/pub/category/2997.html</a></td>
</tr>
<tr>
<td>FSMB</td>
<td>Federation of State Medical Boards</td>
<td>Professional</td>
<td>A national not-for-profit organization representing the 70 medical boards of the United States and its territories, including 14 state boards of osteopathic medicine whose mission is to provide continual improvement in the quality, safety and integrity of health care through the development and promotion of high standards for physician licensure and practice.</td>
<td><a href="http://www.fsmb.org/">http://www.fsmb.org/</a></td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
<td>Accreditation</td>
<td>Independent non for profit organization that evaluates the quality and safety of care for more than 16,000 health care organizations. Evaluates the organization’s performance in areas that affect care. On-site visits are done at least once every three years. Sets the standards by which health care quality is measured.</td>
<td><a href="http://www.jcaho.org/">http://www.jcaho.org/</a></td>
</tr>
<tr>
<td>LCME</td>
<td>Liaison Committee on Medical Education</td>
<td>Accrediting</td>
<td>Nationally recognized authority for medical education programs leading to the M.D. degree in US and Canadian medical schools.</td>
<td><a href="http://www.lcme.org/">http://www.lcme.org/</a></td>
</tr>
<tr>
<td>NBME</td>
<td>National Board of Medical Examiners</td>
<td>Certifying</td>
<td>Independent, not-for-profit organization that provides high quality examinations for the health professions – accepted by medical licensing authorities as the standard to judge candidates for medical licensure</td>
<td><a href="http://www.nbme.org/">http://www.nbme.org/</a></td>
</tr>
<tr>
<td>NBOME</td>
<td>National Board of Osteopathic Medicine Examiners</td>
<td>Certifying</td>
<td>The NBOME is the National Board of Osteopathic Medical Examiners. It's a nonprofit corporation dedicated to serving the public and state licensing agencies by administering examinations testing the medical knowledge of osteopathic medical students and interns.</td>
<td><a href="http://www.nbome.org">http://www.nbome.org</a></td>
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<tr>
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<tr>
<td>NRMP</td>
<td>National Resident Matching Program</td>
<td>Service</td>
<td>Private, non-for-profit corporation established to provide a uniform date of appointment to positions in graduate medical education in the US. All US medical school graduates must register through NRMP for post graduate training.</td>
<td><a href="http://www.nrmp.org/">http://www.nrmp.org/</a></td>
</tr>
<tr>
<td>OPDA</td>
<td>Organization of Program Director Associations</td>
<td>Professional/Education</td>
<td>Established to allow review and collaboration between disciplines on various GME topics.</td>
<td><a href="http://www.cmss.org/index.cfm?p=display&amp;detail=Organization%20of%20Program%20Directors">http://www.cmss.org/index.cfm?p=display&amp;detail=Organization%20of%20Program%20Directors</a></td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
<td>Oversight</td>
<td>Governmental agency with mission to save lives, prevent injuries and protect the health of America's workers, by establishing protective standards, enforcing standards and providing technical assistance and consultations to employers and employees.</td>
<td><a href="http://www.osha.gov/">http://www.osha.gov/</a></td>
</tr>
<tr>
<td>RRC</td>
<td>Residency Review Committee</td>
<td>Accreditation</td>
<td>Under the policies and procedures of the ACGME, the RRC reviews residency programs to determine whether they are in substantial compliance with the Essentials of Accredited Residencies.</td>
<td><a href="http://www.acgme.org">http://www.acgme.org</a></td>
</tr>
<tr>
<td>TAGME</td>
<td>Training Administrators of Graduate Medical Education</td>
<td>Certifying/Education Professional</td>
<td>To assure a comprehensive level of services, training, knowledge and leadership through certification for the administration of graduate medical education programs for physicians-in-training</td>
<td><a href="http://www.tagme.org">http://www.tagme.org</a></td>
</tr>
<tr>
<td>USMLE</td>
<td>United States Medical Licensing Examination</td>
<td>Certifying</td>
<td>Three step examination that assesses a physician's ability to apply knowledge, concepts and principles that are important in health and disease, and that constitute the basis of safe and effective patient care. Used by medical licensing authorities in the US for granting initial license to practice medicine.</td>
<td><a href="http://www.usmle.org">http://www.usmle.org</a></td>
</tr>
<tr>
<td>VA</td>
<td>Department of Veteran's Association</td>
<td>Education</td>
<td>Supports over 8,600 resident FTE- about 10% of eligible specialty residents.</td>
<td><a href="http://www.va.gov/">http://www.va.gov/</a> (national site - each program should have a local site/connection)</td>
</tr>
<tr>
<td>ACRONYM</td>
<td>FULL NAME</td>
<td>PURPOSE</td>
<td>DEFINITION/FUNCTION</td>
<td>URL – if applicable</td>
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<tr>
<td>AOA</td>
<td>Alpha Omega Alpha</td>
<td>Honorary</td>
<td>National medical honor society.</td>
<td><a href="http://www.alphaomegaalpha.org">http://www.alphaomegaalpha.org</a></td>
</tr>
<tr>
<td>CAAR</td>
<td>Computer Assisted Accreditation Review</td>
<td>Honorary</td>
<td>CAAR stands for the Computer Assisted Accreditation Reporting system. The system collects and stores information about your internal medicine and subspecialty residency education programs. The purpose of this software application is to gather information about the program as part of the accreditation process.</td>
<td></td>
</tr>
<tr>
<td>COMLEX</td>
<td>Comprehensive Osteopathic Medical Licensing Examination</td>
<td>Certifying</td>
<td>In order to more accurately measure the knowledge required by today's physicians, the NBOME initiated the three-level Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) to replace the former three-part NBOME examination series. The COMLEX is a three part exam. Each exam is administered over a two day period, and employs an osteopathic primary care approach to patient care fully integrated throughout the examination.</td>
<td><a href="http://www.nbome.org/">http://www.nbome.org/</a></td>
</tr>
<tr>
<td>DIO</td>
<td>Designated Institutional Official</td>
<td>Oversight</td>
<td>Individual who has the authority and responsibility for the oversight and administration of the GME programs.</td>
<td><a href="http://www.acgme.org">http://www.acgme.org</a></td>
</tr>
<tr>
<td>GME</td>
<td>Graduate Medical Education</td>
<td>Training</td>
<td>Specialized training for physicians after medical school graduation.</td>
<td>(use your hospitals GME website)</td>
</tr>
<tr>
<td>GMED</td>
<td>Graduate Medical Education Directory</td>
<td>Resource Guide</td>
<td>Director of graduate medical education programs. Published by the AMA. (The “Green Book.”)</td>
<td><a href="http://www.ama-assn.org/">http://www.ama-assn.org/</a> Can be purchased from the AMA website, under the “Bookstore” link, or major booksellers such as Amazon or Barnes and Noble.</td>
</tr>
<tr>
<td>IMG</td>
<td>International Medical Graduate</td>
<td></td>
<td>A graduate from a medical school outside the United States and Canada (and not accredited by the Liaison Committee on Medical Education). IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who are admitted to the United States by US Immigration authorities.</td>
<td></td>
</tr>
<tr>
<td>IT Exam</td>
<td>In Training Exam</td>
<td>Education/ Training</td>
<td>Formative examinations developed to evaluate resident/fellow progress in meeting the educational objectives of a residency/fellowship program. These examinations may be offered by certification boards or specialty societies.</td>
<td></td>
</tr>
<tr>
<td>JC</td>
<td>Joint Commission</td>
<td>Hospital Accreditation</td>
<td>Formally known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO, which evaluates and accredits health care organizations in the United States.</td>
<td></td>
</tr>
<tr>
<td>LON</td>
<td>Letter of Notification</td>
<td></td>
<td>The official communication from a Review Committee that states the action taken by the Review Committee.</td>
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</tr>
<tr>
<td>ACRONYM</td>
<td>FULL NAME</td>
<td>PURPOSE</td>
<td>FUNCTION</td>
<td>URL is applicable</td>
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<tr>
<td>NF</td>
<td>Night Float</td>
<td>Resident Rotation</td>
<td>Rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus.</td>
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<tr>
<td>PD</td>
<td>Program Director</td>
<td></td>
<td>The one physician designated with authority and accountability for the operation of the residency/fellowship program.</td>
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<tr>
<td>PGY</td>
<td>PGY: Graduate Year</td>
<td></td>
<td>Refers to a resident's current year of accredited GME. This designation may or may not correspond to the resident's particular year in a program. For example, a resident in pediatric cardiology could be in the first program year of the pediatric cardiology program but in his/her fourth graduate year of GME (including the 3 prior years of pediatrics).</td>
<td></td>
</tr>
<tr>
<td>PIF</td>
<td>Program Information Form</td>
<td>Site Visit/ Accreditation</td>
<td>The PIF is the document completed by the program director in preparation for a site-visit. The document is a compilation of requested information that reflects the current status of the educational program. The PIF is organized in two parts: the Common PIF, which addresses the program’s compliance with the Common Program Requirements, and the specialty or subspecialty specific PIF, which addresses compliance with the specialty or subspecialty specific program requirements. The Common PIF is electronically generated through the Accreditation Data System.</td>
<td></td>
</tr>
<tr>
<td>FLA</td>
<td>Program Letter of Agreement</td>
<td></td>
<td>A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education.</td>
<td></td>
</tr>
<tr>
<td>USMLE</td>
<td>USMLE Step 3 Examination</td>
<td>Certifying</td>
<td>Step 1 assesses whether you understand and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. Step 1 ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning. Step 1 is constructed according to an integrated content outline that organizes basic science material along two dimensions: system and process.</td>
<td><a href="http://www.usmle.org">http://www.usmle.org</a></td>
</tr>
<tr>
<td>ACRONYM</td>
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<tr>
<td>USMLE Step 2</td>
<td>USMILE Step 2 Examination</td>
<td>Certifying</td>
<td>Step 2 assesses whether you can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision and includes emphasis on health promotion and disease prevention. Step 2 ensures that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. Step 2 is constructed according to an integrated content outline that organizes clinical science material along two dimensions: physician task and disease category. Step 2 CS uses standardized patients, i.e., people trained to portray real patients. The cases cover common and important situations that a physician is likely to encounter in clinics, doctors’ offices, emergency departments, and hospital settings in the United States.</td>
<td><a href="http://www.usmle.org">http://www.usmle.org</a></td>
</tr>
<tr>
<td>CS CK</td>
<td>Clinical Skills Clinical Knowledge – (are part of this examination)</td>
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<tr>
<td>USMLE Step 3</td>
<td>USMILE Step 3 Examination</td>
<td>Certifying</td>
<td>Step 3 assesses whether you can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step 3 provides a final assessment of physicians assuming independent responsibility for delivering general medical care. Step 3 is organized along two principal dimensions: clinical encounter frame and physician task. Step 3 content reflects a data-based model of generalist medical practice in the United States.</td>
<td><a href="http://www.usmle.org">http://www.usmle.org</a></td>
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Please Note:
UC Denver Patients and Visitors are advised to enter the Anschutz Medical Campus via Montview Blvd. to easily access visitor parking areas. Barbara Davis Center Visitors should enter on Aurora Court.
Program Coordinator Council

Program Coordinator Council Mission Statement

The mission of the University of Colorado Denver School of Medicine Program Coordinator Council is to provide coordinators a platform to exchange ideas while fostering communication between Program Coordinators, Program Directors, and the Office of Graduate Medical Education. As a council, we are dedicated to:

• Creating an atmosphere of camaraderie and support among Program Coordinators.
• Developing and encouraging opportunities for professional growth.
• Educating the campus community on the vital role of the Program Coordinator.

Through collaborative efforts, we aspire to ensure the success of residency and fellowship training programs.

Program Coordinator Council Members:

Sheilah Redmond- Chair
Michele Bialkowski
Elaine Farrell
Kim Mondragon
Beth Musser
Kristine Smith
Pam Sullivan
GME Representatives:
Gail Silber
Ashley Walter
## GME Program Coordinator Mentors

As of 10/03/11

<table>
<thead>
<tr>
<th>E-mail address</th>
<th>Phone Number</th>
<th>New Innovations</th>
<th>Internal Reviews, PIFs, Site Visits</th>
<th>Recruitment</th>
<th>NRMP</th>
<th>ERAS</th>
<th>GMEOne</th>
<th>Program Orientation</th>
<th>Duty Hour Monitoring</th>
<th>Policies, Manuals, Training Files</th>
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<tr>
<td>Sherry Berka (Internal Med)</td>
<td><a href="mailto:sherry.berka@ucdenver.edu">sherry.berka@ucdenver.edu</a></td>
<td>303-724-1788</td>
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<td>Christine Raffaelli (OB/GYN)</td>
<td><a href="mailto:christine.raffaelli@ucdenver.edu">christine.raffaelli@ucdenver.edu</a></td>
<td>303-724-2052</td>
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<td>Matt Gomboc (Psych)</td>
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<td>303-724-6019</td>
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<td>Alicia Gore (ENT)</td>
<td><a href="mailto:alicia.gore@ucdenver.edu">alicia.gore@ucdenver.edu</a></td>
<td>303-724-1957</td>
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<td>Beth Musser (Urology)</td>
<td><a href="mailto:beth.musser@ucdenver.edu">beth.musser@ucdenver.edu</a></td>
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<td>Elizabeth Pae (Neurology)</td>
<td><a href="mailto:elizabeth.pae@ucdenver.edu">elizabeth.pae@ucdenver.edu</a></td>
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<td>Pam Sullivan (Fam Med)</td>
<td><a href="mailto:pam.sullivan@ffnh.com">pam.sullivan@ffnh.com</a></td>
<td>303-584-7913</td>
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<td>Claire Tavis (Surgery)</td>
<td><a href="mailto:claire.travis@ucdenver.edu">claire.travis@ucdenver.edu</a></td>
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<td>Tina Kutsuama (Radiology)</td>
<td><a href="mailto:tina.kutsuama@ucdenver.edu">tina.kutsuama@ucdenver.edu</a></td>
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<td>Brenda Battle (Hem/Onc)</td>
<td><a href="mailto:brenda.battle@ucdenver.edu">brenda.battle@ucdenver.edu</a></td>
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<td>Holly Smith (Endocrinology)</td>
<td><a href="mailto:holly.2.smith@ucdenver.edu">holly.2.smith@ucdenver.edu</a></td>
<td>303-724-3927</td>
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<td>Melissa Jordan (Pulmonary)</td>
<td><a href="mailto:melissa.jordan@ucdenver.edu">melissa.jordan@ucdenver.edu</a></td>
<td>303-724-6043</td>
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<td>Jennifer Sabell (PEDS ID)</td>
<td><a href="mailto:jennifer.sabell@childrenscolorado.org">jennifer.sabell@childrenscolorado.org</a></td>
<td>720-777-2858</td>
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<td>Michele Blaikowski (PEDS Critical Care)</td>
<td><a href="mailto:michele.blaikowski@childrenscolorado.org">michele.blaikowski@childrenscolorado.org</a></td>
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<tr>
<td>Eric Sommers</td>
<td><a href="mailto:eric.somers@childrenscolorado.org">eric.somers@childrenscolorado.org</a></td>
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As Manager of GME at TCH, Eric is a resource for any Pediatric Program Coordinator who needs help with any/all of the above.
Annual Surveys

Monthly

**GMEOne Duty Hour Tracking**
9 programs currently log duty hours in GMEOne and report to GME

**GME New Innovations Duty Hour Tracking**
GME Office distributes via New Innovations a monthly duty hour survey. Data is monitored and reported monthly at the GMEC meetings.

Training Program New Innovations Surveys Faculty/Resident/Rotation Evaluations

November

**GME Annual Survey**
- Duty hour questions by site
- ACGME Resident Survey questions
- UC Hospital survey questions – selected satisfaction questions

January – June

**ACGME Resident Survey** – must have 70% response rate
The ACGME’s Resident/Fellow survey is an additional method to monitor graduate medical clinical education and to provide early warning of potential non compliance with ACGME accreditation standards. Currently, all core specialty programs (regardless of size) and subspecialty programs (with 4 or more fellows) are surveyed every year between January and June. Aggregate reports will be made available to programs with 4 or more residents if a 70% response rate is reached.

May

**GME Exit Survey**
Data required for the Dean, and all Annual Reports
- Satisfaction with training
- Professionalism
- Graduates future plans
- Demographics
- Debt

May

**Housestaff Association Survey**
The purpose is to communicate resident feedback on their educational and work environment. Data is collated by the Housestaff Association by program and site, and is shared with the Program Directors.

May-June

**Program Annual Program Evaluation**
ACGME requirement V.C. The program must document formal, systematic evaluation of the curriculum at least annually and must monitor and tract the following: resident performance; faculty development, graduation performance, and program quality. The GME Office has a template.
GME Useful websites

GME Office [www.medschool.ucdenver.edu/gme](http://www.medschool.ucdenver.edu/gme)
Under Directors and Coordinators you will find toolkit resources, GME policies, Forms, Request for an Increase in Resident Complement, and Request for New Training Programs.

The Group on Resident Affairs [http://www.aamc.org/members/gra/](http://www.aamc.org/members/gra/) provides information, networking, and professional development programs to help members meet their responsibilities as Graduate Medical Education (GME) leaders in AAMC-member medical school, hospitals, and academic societies. GRA also serves as a forum on GME issues such as institutional accreditation, GME costs and financing, resident recruitment and orientation, GME office organization, and GME core curriculum. It provides members the opportunity to contribute to AAMC policy development and advocacy on Graduate Medical Education.

ACGME [http://www.acgme.org/acWebsite/home/home.asp](http://www.acgme.org/acWebsite/home/home.asp)

International medical graduates wishing to enter a U.S. ACGME accredited residency or fellowship training program must be certified by the ECFMG prior to entering the program. International medical graduates wishing to take Step 3 of the three step United States Medical Licensing Examination (USMLE, [www.usmle.org](http://www.usmle.org)) also must be certified by the ECFMG. In addition, ECFMG Certification is required to obtain an unrestricted license to practice medicine in any U.S. licensing jurisdiction.

ERAS [https://services.aamc.org/eras/erasstats/par](https://services.aamc.org/eras/erasstats/par)
ERAS is a service that transmits applications, letters of recommendation (LoRs), Medical Student Performance Evaluations (MSPEs), medical school transcripts, USMLE transcripts, COMLEX transcripts, and other supporting credentials to program directors using the Internet. ERAS consists of MyERAS (the Web site where the application is created), the Dean's Office Workstation (DWS), the Program Director's Workstation (PDWS), and the ERAS PostOffice. ERAS is used by 36 residency and 29 fellowship programs.

GME Track [http://www.aamc.org/programs/gmetrack/start.htm](http://www.aamc.org/programs/gmetrack/start.htm)
GME Track is a resident database and tracking system to assist GME administrators and program directors in the collection and management of GME data. GME Track contains the National GME Census, a yearly survey that allows users to update information on their residents and fellows. The National GME Census is also used to update information relating to the characteristics of the program. The program survey deadline for the October FREIDA Online update is September. The deadline for the resident survey is also September and is required.

NRMP [www.nrmp.org](http://www.nrmp.org)
The National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME) in the United States. Registration for the NRMP opens on August 15 of each year and continues until the rank order list deadline, although an additional late registration fee applies after December 1.
## Specialty Boards

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<td>Allergy and Immunology</td>
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