Physical Medicine & Rehabilitation
Residency Program

COORDINATOR'S MANUAL

Spring 2024

FORWARD

(February 2024) – The role of the program coordinator is one that requires extensive knowledge of the workings of a residency / fellowship program, from national rules and regulations to hospital specific policies. In this role, professional community, sharing of experiences, and institutional knowledge are vital to program coordinator success. With the *Physical Medicine and Rehabilitation Residency Program - Coordinators' Manual*, we aim to provide a basic overview and reference tool for the new program coordinator, as well as a refresher / guide for the seasoned GME professional. Note that while this is periodically updated and reflects the most recent information at the time (CPRs effective 7/1/2023), changes in PM&R accreditation are frequent, and as such this should be used as a reference guide and not in place of your institution's policies, ACGME common program requirements, or the ABPMR rules and regulations. We hope this manual will serve as a valuable resource to you, and thank you!

Sincerely,

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TABLE OF CONTENTS

OVERVIEW

Across all specialties and sub-specialties, including Physical Medicine & Rehabilitation, the ACGME requires that each program have a dedicated program administrator (commonly referred to as a Program Coordinator). Although the program director is responsible for all aspects of the program, much of the work that is involved in administering a program is delegated to the program coordinator. In most cases, this role operates with a global view of all aspects of a program with regard to resident concerns, approaching deadlines, changes in ACGME and specialty board requirements, and upcoming changes in institutional policies. This essential position requires a highly skilled and experienced individual (or in some cases, individuals) that can serve as a member of the leadership team and must possess skills in leadership and personnel management. The program coordinator also serves as the primary contact for the program, where their administrative skills reflect the quality of the program and effectiveness of the program director. The program coordinator is expected to work independently within prescribed guidelines, engage in continuous professional development, suggesting initiatives to continuously improve the program while maintaining the quality and breadth of training. It is vitally important that the program director and program coordinator have a close and mutually respectful working relationship and a clear understanding of each other's role.

Program coordinators should engage in continuous professional development through ongoing training and participation in organized societies that support and enhance their profession. It is through these activities that a program coordinator becomes equipped with the skills needed to initiate actions that improve the efficiency of their work, reduce cost, and/or improve the quality of service to all they serve.

ACGME Common Program Requirements II.C.1 and 2:
> "There must be a program coordinator. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon it's size and configuration".

PM&R Program Requirement II.C.2.a:
> This table outlines the minimum FTE required for coordinator support based on program size within PM&R, with 0.5 FTE listed for a program of <7. This means at a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time.

Certification

The National Board of Certification for Training Administrators of Graduate Medical Education Programs (TAGME) was created in 2002 with the goal to establish standards for the profession, acknowledge the expertise needed to successfully manage graduate medical education programs, and to recognize administrators who have achieved competence in all fields related to their profession. Pursuing certification is voluntary but highly recommended. Program coordinators interested in certification must meet the established criteria of eligibility, then complete a general application and successful completion of the online assessment tool. Certificates are valid for five years at which time maintenance of certification is required. Further information can be found on the TAGME website: www.tagme.org.

GENERAL ROLES AND RESPONSIBILITIES OF PM&R COORDINATORS

The roles and responsibilities of a coordinator position vary greatly among PM&R programs, and are dependent on program size, number of administrators, hospital policies, etc. Some coordinators have combined jobs that require them to perform different functions outside of the realm of the coordinator's role, including department administrative functions, secretarial support, etc. Each training program is unique as it designs and implements a learning experience for residents and as such, program coordinators work closely with the program director to have an active role in the organization and management of day-to-day activities of the residency program. Below is an alphabetical list of the typical, general job responsibilities of the PM&R Coordinator.

Accreditation
1. Extensive knowledge and understanding of the ACGME (Accreditation Council for Graduate Medical Education) and ABPMR (American Board of Physical Medicine and Rehabilitation) requirements, as well as knowledge on how to reference these materials.
2. Organize and maintain information needed to complete the ACGME Annual Program Update through ADS.
3. Knowledge and understanding of the Clinical Learning Environment Review (CLER) program to know what is assessed during the visit.
4. Manage, prepare, and assist with self-study and site visits.

Administration
1. Manage the daily, monthly, and yearly operations of the PM&R residency program.
2. Coordinate specific activities and events related to the PM&R residency program (e.g., accreditation, credentialing, scheduling, recruitment, orientation, etc.), including timing, logistics, and participation.
3. Perform administrative duties such as updating resident policies, maintaining resident files, documenting conference attendance, monitoring resident work hours, tracking procedure logs, contracts, evaluations, and updating resident schedules and curriculum.
4. Act as liaison between department and graduate medical education office.

Budget
1. Manage and/or assist with the program's fiscal education budget.
2. Review monthly program financial reports.
3. Process invoices for program expenses.
4. Complete monthly Medicare tracking report for the institution for purposes of Medicare reimbursement.

Credentialing
1. Collect credentialing data and maintain credentialing records.

2. Schedule residents for credentialing courses (i.e., ACLS and BLS).
3. Distribute certificates to residents for program completion.
4. Manage graduate records and prepare verification and credentialing documents for program alumni.

Notary Public—Optional

1. Not required, but very helpful in this role.

Recruitment

1. Plan, develop, and coordinate resident recruitment activities.
2. Review applications and inquiries to identify appropriate candidates for the PM&R training program in accordance with the established criteria (i.e., credentials, licensures, visas, screening, etc.).
3. Participate in the ranking process for residency candidates.
4. Gain knowledge of ERAS and NRMP programs.
5. Represent program at conferences and recruitment fairs to recruit candidates for residency program.
6. Contribute to the evaluation of candidates.
7. Complete annual surveys such as the National GME Census Survey through GME Track.

Resident Support

1. Assist with orientation of new residents.
2. Recognize and support resident contributions.
3. Serve as a role model for positive character traits that should be exemplified by residents.
4. Practice and implement diversity, inclusivity, and engagement practices that limit bias, especially related to race, ethnicity, and culture; be an active listener; and be fair and nonjudgmental.
5. Demonstrate tact and diplomacy when dealing with others and relaying confidential information.
6. Advocate for resident wellbeing and overall wellness
7. Help build morale.

Scheduling

1. Schedule PM&R-related activities such as master schedule of rotations, conferences, electives, vacations, individualized rotations, didactics, committee meetings, recruitment, events (i.e., orientation, graduation), and ITE Examinations (ex: AAPMR SAE-R and AANEM EDX-SAE), etc.
2. Coordinate schedule for medical student elective in PM&R.
3. Prepare and/or distribute master rotation, call, and didactic schedules in cooperation with chief resident(s), with continuous related updates and communications.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)

The Accreditation Council for Graduate Medical Education (ACGME) accredits graduate medical education programs within the United States. The mission of the ACGME is to improve healthcare by assessing and advancing the quality of resident physicians' education through accreditation - a peer review process that is based upon established standards and guidelines outlined in three main requirement groups: the ACGME Program Requirements per specialty, ACGME Common Program Requirements, and Institutional Requirements. Completion of an accredited residency program is a prerequisite for primary board certification and for certification in the majority of subspecialty boards. Five organizations sponsor the ACGME—the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and the Council of Medical Specialty Societies (CMSS). For additional information on the ACGME, please visit www.acgme.org.

Program Coordinator's Role

1. Learn the ACGME's program requirements for physical medicine and rehabilitation, as well as the common and institutional requirements:
   a. PM&R Program Requirements (7/1/2023)
   b. Common Program Requirements (7/1/2023)
   c. Institutional Requirements (7/1/2022)
2. Graduate Medical Education is full of acronyms essential to a coordinators position. These can be reviewed on the ACGME website
   a. Glossary of Terms (*toggle between the common terms and common acronyms / abbreviations tabs*)
3. Assist the program director in making sure your residency program is complying with all ACGME guidelines and requirements. This is why you need to learn the requirements mentioned above.
4. Maintain your program's graduate medical education information through the ACGME Web Accreditation Data System (ADS).
   a. Accreditation Data System Login Page (*note: you will have your own unique login information as a coordinator for this system*).

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www.acgme.org

ACGME WEB ACCREDITATION DATA SYSTEM (ADS) and ADS ANNUAL PROGRAM UPDATE

The Accreditation Data System (ADS) is web-based software system through which the ACGME collects and organizes information for the purposes of accreditation and recognition and the advancement of graduate medical education. It also serves as a communication mechanism between the ACGME and accredited Sponsoring Institutions and programs. Internally, it assists the Review and Recognition Committees and ACGME Field Activities in conducting accreditation and recognition activities. ADS also facilitates annual data collection efforts, including for the Annual Update, Milestones, Case Logs, and applications for accreditation and recognition.

ACGME has provided each program and sponsoring institution with a User Identifier and Password to access the data system. The Designated Institutional Official (DIO's) will be contacted each year and will be asked to log on and verify their institutional data, as well as monitor the progress of their programs making annual updates. All specialties and subspecialties are required to update their data annually during the ADS window.

Program Coordinator's Role
Program Directors have the ability to grant and revoke program coordinator access to their ADS account. Ask your program director to grant you access by following these steps:
1. Login to ADS account
2. Click on the "Program" tab
3. Scroll to the bottom of the screen and locate the "Program Leadership" section
4. Next to the program coordinator's name, click the "Grant User" button
5. Program Coordinator will receive an email with a username and password

ADS Annual Program Update
As part of the accreditation process, each review committee (RC) performs an annual evaluation of every program. To do this, the RC reviews data entered by a program during the ADS window, which is typically July-September. Ongoing data collection and reporting of performance measures will ensure ongoing oversight that programs are meeting standards for high-quality education and a safe and effective learning environment.

The RC may use the following information to assess programs:
- ADS Annual Update
- Resident Survey
- Faculty Survey
- Milestone Data
- Certification examination performance
- Clinical Experience (Case Logs)

- Hospital Accreditation Data
- Scholarly Activity of Faculty & Residents
- Other
    - ACGME complaints
    - Verified public Information
    - Historical accreditation decisions/citations
    - Institutional/program quality and safety metrics

Program Coordinator's Role

You will receive notification from the ACGME when it is time for your program's annual update with a specified time frame to complete of approximately 8 weeks. Do not procrastinate! This takes a significant amount of time to complete.

The following is a list of the information in ADS that you will be asked to update:

Program Information

- Program profile information (review program leadership information for accuracy)
- Program's mission statement and program aims
- Describe how the program will achieve/ensure diversity in trainee recruitment, selection and retention as well as in individuals participating in the training program
- Participating Site Information (must have a primary teaching site)
- Clinical Experience and Educational Work
- Overall Evaluation Methods
- Common Program Requirement Questions
- Responses for current citations
- Major changes section
- Upload current block diagram (*in PDF format only*)

Resident Information

- Confirm all residents & update information
- Update scholarly activity for each resident
- Confirm certification status of graduated residents

Faculty Information

- Update Program Director information
- Update all faculty members' information
    - Program Specific Title
    - Valid email
    - National Provider ID
    - Primary Institution
    - Date first appointed faculty member
    - Year started teaching in PMR
    - Year started teaching in GME
- Enter Medical School Information and Graduation Year

ACGME WEB ACCREDITATON DATA SYSTEM (ADS) and ADS ANNUAL PROGRAM UPDATE 10

- Specialty, certificate type and certification status for each active faculty member
  - ABMS certification
    - This is imported from ABMS and is read only
    - Data is matched to each faculty using name, NPI, date of birth and medical school graduation year
      - If the information provided by the program is entered incorrectly, no ABMS match will occur of the match will be inaccurate
  - AOA certification
    - Imported from AOA
  - Specialty certification
    - Only complete this section if the faculty member has additional certifications, is board eligible, is not certified or ABMS/AOA data above is inaccurate or missing.
- Enter Faculty Hours (Clinical Supervision of Residents; Administration of the Program; Research/Scholarly Activity with Residents; Didactics/Teaching with Residents)
- Update scholarly activity for each physician faculty member
- Update Program Director's CV
- Enter CV information for Non-Physicians (required by your specialty)

The RC will confer an accreditation decision of **Continued Accreditation** based on satisfactory ongoing performance of the program. If a program's performance is deemed unsatisfactory, the RC may change the program's accreditation status or request a site visit and/or additional information prior to making a final decision.

PROGRAM ACCREDITATION
REVIEW COMMITTEE (RC)

A Review Committee (RC) is an ACGME committee that handles the accreditation activities for a specialty or sponsoring institution and functions according to ACGME policies and procedures. Each Review Committee is comprised of 7-20 volunteers and meets 2-4 times per year. Information on the Physical Medicine & Rehabilitation (PM&R) RC can be found here.

Accreditation is given once it has been determined that a program follows the standards and guidelines in the ACGME PM&R Program Requirements. To receive initial accreditation, or re-establish lost accreditation, the Program Director must initiate the application in ACGME Accreditation Data System (ADS). It typically takes six to 12 months to gather the necessary information and complete the program application. After the submission of the application, it may take four to 12 months for the RC to make an accreditation decision regarding the program's application. Click here for additional information about the application submission and review process for program accreditation applications.

Nearly all of the coordinator's activities in some way facilitate the program accreditation process. Becoming accredited by the ACGME and maintaining accreditation are extremely important events for every program. When a program is on probation because of noncompliance with ACGME program requirements, every potential resident applicant must be informed of the program's status during the initial application process. To comply, a program must not only function according to the requirements but must supply accurate information and statistical data about the program that document compliance.

To assess the compliance status of programs or sponsoring institutions, the ACGME uses accreditation site visits. Site visits may be announced or unannounced. There are several types of site visits. The definition and processes for these visits can be found in the ACGME Site Visit Overview here.

Once the Review Committee has met and reviewed your program, a detailed letter of notification will be posted to the ACGME Accreditation Data System (ADS) regarding the accreditation status of the program. Program Directors and Designated Institutional Officials (DIO's) are notified by email when a letter has been posted in ADS. The letter contains the results of the review committees decision and any additional information necessary for the program.

CLER (Clinical Learning Environment Review)
As a component of its next accreditation system (NAS), the ACGME has established the CLER program as a part of its Next Accreditation System (NAS). The CLER Program is designed to provide US teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited institutions with periodic feedback that addresses the following six Focus Areas: Patient Safety; Health Care Quality; Teaming; Supervision; Well-

Being; and Professionalism. CLER focuses on the responsibility of the sponsoring institution. A CLER site visit is for the GME office and institution, not individual programs.

The feedback provided by the CLER Program is designed to improve how clinical sites engage resident and fellow physicians in learning to provide safe, high quality patient care.

CLER assesses sponsoring institutions in the following six focus areas:

1. **Patient Safety** – including opportunities for residents to report adverse events, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.
2. **Health Care Quality** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
3. **Care Transitions** – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care and supporting high-performance teaming. The concept of teaming recognizes need for purposeful interactions in which team members coordinate safe and efficient care, collaborating and sharing accountability (formerly transitions of care)
4. **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
5. **Well-being** – including how the optimal clinical learning environment is engaged in systematic and institutional strategies and processes to cultivate and sustain the well-being of both its patients and clinical care team. The original focus area was called "Duty Hours, Fatigue Management, & Mitigation" but has evolved into "Well-Being," addressing four interrelated topics: work and life balance; fatigue; burnout; and support of those at risk or demonstrating self-harm. This new focus area recognizes the important role of clinical learning environments in designing and implementing systems that monitor and support physician well-being.
6. **Professionalism**— with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of Residents and faculty and respond to issues concerning: accurate reporting of program information; integrity in fulfilling educational and professional responsibilities; and veracity in scholarly pursuits.

More information on CLER, refer to the CLER Pathways to Excellence document here.

Self-Study / Self-Study Visit (SSV)
Effective October 2023, the ACGME has officially discontinued 10-Year Accreditation Site Visits for programs. While the program Self-Study is still required (Common Program Requirement V.C.2.), it will no longer be linked to or reviewed during a site visit. The ACGME is finalizing its plans for the program Self-Study and developing its process for conducting accreditation site visits for programs with a status of Continued Accreditation. The ACGME will provide updated information by spring 2024. Note: Sponsoring Institution Self-Studies and 10-Year Accreditation Site Visits will proceed according to the Institutional Review Committee's announced plan.

The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment, facilitated through the review of past annual program evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement.

The information collected should highlight strengths, areas where improvement has been achieved, and areas still in need of improvement. For areas for improvement, the focus should be on each year's action plans, records of progress on the previous year's action plans, and documentation in PEC meeting minutes that relate to the action plan. This information can be entered into a simple table or spreadsheet to create a longitudinal record of the improvements achieved. In addition to data from the Annual Program Evaluations, the Self-Study Committee may explore what other existing data (such as information collected by the sponsoring institution) may be of value to the Self-Study.

8 Steps for Conducting the ACGME Program Self-Study
1. Assemble the Self-Study Group
2. Engage Program Leader and Constituents in a Discussion of Program Aims
3. Aggregate and Analyze Data from Your Annual Program Evaluations and the Self-Study to Create a Longitudinal
4. Examine the Program's Environment for Opportunities and Threats
5. Obtain Stakeholder Input on Strengths, Areas for Improvement, Opportunities, and Threats to Prioritize Actions (SWOT Analysis)
6. Interpret the Data and Aggregate the Self-Study Findings
7. Discuss and Validate the Findings with Stakeholders
8. Develop a Succinct Self-Study Document for Use in Further Program Improvement
9. Approximately One Year after Completion of the Self-Study, Reassemble the Annual Program Evaluation/Self-Study Group to Review the Data in Areas for Improvement Identified in the Self-Study
10. Reassess Program Aims and Other Elements of the Program's Strategic Assessment (Strengths, Areas for Improvement, Opportunities, Threats)

For more information of the Self-Study and steps above, visit the ACGME Self-Study Overview here.

Elements of the Self-Study Document
1. **Introduction** - Provide a brief summary of how the Self-Study was conducted, and the participation of program leadership, residents, faculty, and any other stakeholders.

2. **Program Overview** – A brief description of your residency/fellowship program, as you would to an applicant or prospective faculty member. Discuss any notable information about the program.

3. **Program Aims** - Program aims are a new dimension for the Self-Study. They offer added context for a program's improvement efforts by focusing on program and institutional leaders' key expectations for the program, and are elicited through responses to the question, "What types of residents is the program educating; what are their future roles and practice settings?" Aims may focus on some or all of these dimensions: types of trainees accepted into the program, training for particular career options (clinical practice, academics, research, primary/generalist care), and added objectives, such as care for underserved patients, health policy or advocacy, population health, or generating new knowledge.

4. **Aggregated lists of Strengths and Areas for Improvement** for the period *since the last scheduled accreditation review.* The PEC (Program Evaluation Committee) is responsible for documenting the evaluation of the curriculum at least annually in the following areas:
   - o Resident performance
   - o Faculty development
   - o Graduate performance, including information the certification examination
   - o Program quality

5. **Common areas for improvement** related to the need to enhance the capabilities of vendor-provided residency management suites to generate useful data for Clinical Competency Committees, and faculty development needs, particularly needs related to faculty members' expanded role in making Milestone assessments. For example, an action plan would be to invest in a residency management software system such as MedHub, New Innovations, E-Value, etc. The program should follow up and see if the data collection has improved for the CCC after utilizing the software.

6. **Opportunities and Threats -** A new dimension of the Self-Study is the focus on opportunities and threats. Opportunities are factors beyond the immediate control of the program that, if acted upon, contribute to enhanced success, while threats are factors that could have a negative effect. Assessing the environment for opportunities and threats could be an ongoing activity, but at minimum, the Self-Study Committee and program leaders should examine these dimensions as part of the Self-Study.

   Exploring opportunities and threats is relevant to program sustainability by considering factors that may assist with, or detract from, the program succeeding and achieving its aims in the future. For example, the Self-Study test visits to several primary care programs revealed common threats for programs that depend on community settings for resident experiences. Added pressure for clinical productivity on community practitioners, and practices being assumed into delivery networks under the Affordable Care Act reduced community faculty ability and willingness to serve as preceptors for residents. A benefit of identifying potential threats is that it facilitates the development of contingency plans for dealing with them.

7. **Action Plans** for maintaining Strengths, addressing Areas for Improvement, capitalizing on Opportunities, and mitigating Threats.

Self-Study Timeline

The self-study timeline is a 12-18 month process. The first step is for the program to conduct the self-study. A few months later, the program is to upload the Self-Study Summary (8 questions) through ADS. 12 months after that, the program can upload any updates to the Summary through ADS. The self-study summary and timing process is now under the direction of the institution pending that the program is not undergoing a special review by ACGME.

Program Description and Aims

Question 1: Program Description

Provide a brief description of the residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about the program. (Maximum 250 words)

Question 2: Program Aims

Describe the program's aims. (Maximum 150 words)

Question 3: Program activities to advance the aims

Describe current activities that have been, or are being, initiated to promote or further these aims. (Maximum 250 words)

Environmental Context - Summarize the information on the program's environmental context that was gathered and discussed during the Self-Study.

Question 4: Opportunities for the program

Describe important opportunities for the program. (Maximum 250 words)

Question 5: Threats facing the program

Describe any real or potential significant threats facing the program. (Maximum 250 words)

Question 6a: Describe significant changes and improvements made in the program over the past five years. (Maximum 250 words)

Question 6b: Project your vision and plans for the program for the coming five years.

What will take this program to "the next level"? (Maximum 350 words) Note: In your response, discuss what the "next level" will look like, the envisioned steps and activities to achieve it, and the resources needed.

Question 7a: Describe elements of the Self-Study process for your program.

Provide information on your program's Self-Study, including who was involved, how data were collected and assessed, how conclusions were reached, and any other relevant information. (Maximum 300 words)

Who was involved in the Self-Study (by role/title)?

How were areas for improvement prioritized?

Question 7b: Describe the core program's role in the Self-Study(ies) of its dependent subspecialty program(s). (Maximum 150 words)

Note: If this is an individual core program without associated subspecialty programs or a dependent freestanding subspecialty program, skip to Question 8.

Question 8: Describe learning that occurred during the Self-Study.

This information will be used to identify potential best practices for dissemination. (Maximum 200 words)

References:

https://www.acgme.org/What-We-Do/Accreditation/Self-Study

https://www.acgme.org/acgmeweb/tabid/473/ProgramandInstitutionalAccreditation/Self-Study.aspx

https://www.acgme.org/acgmeweb/Portals/0/PDFs/SelfStudy/SelfStudyPilot.pdf

http://www.jgme.org/doi/pdf/10.4300/JGME-06-03-55

https://www.acgme.org/acgmeweb/Portals/0/PDFs/SelfStudy/SSSampleTimeline.pdf

Program Coordinator's Role
1. Review the steps to the Self-Study.
2. Ensure Annual Program Evaluation action plans are tracked from year-to-year.
3. Confirm action plans from the APE are noted in PEC minutes.
4. Ensure Self-Study Summary uploads through ADS are submitted in a timely manner.

Graduate Medical Education Oversight

The Graduate Medical Education Office used to be responsible for conducting internal reviews mid-way between a program's cycle length. With NAS implementation, the onus for accreditation oversight falls on the GME office. The GME office will require and analyze ongoing data from all programs to comply with the new institutional requirements.

There are three (3) processes:

- *AIR* – Annual Institution Review includes data collection from multiple sources such as the resident surveys, faculty surveys, and responses to RC accreditation citations. (I.B.5.).
- *APE and Oversight* – Annual Program Evaluation consists of collecting all required data from programs and the GME office oversees compliance.
- *Special Review Process* – this process is similar to an internal review for underperforming programs. Each GME office must establish performance indicators that determine which programs need to go through this process. (I.B.6. a).(1)). A report must

result that identifies the quality improvement goals, corrective actions, and process for monitoring outcomes. (I.B.6. a).(2)).

Program Coordinator's Role

1. You should be familiar with the ACGME program requirements. If you make certain changes in the program, notifying the ACGME may be required.
2. Collect data for the Annual Program Evaluation (APE). Review information at the APE meeting. Create an action plan for any areas of non-compliance. Continually review action plan at PEC meetings.
3. Establish CCC per requirements. Develop a policy to outline the responsibilities of the CCC. Conduct meetings semi-annually to review and assess milestones for each resident/fellow. Submit the milestones for each resident/fellow to the ACGME by the designated deadline.
4. Establish PEC per requirements. Develop a policy to outline the responsibilities of the PEC. Keep track of action plan improvements.
5. CLER Visit – Ensure faculty, residents, allied health professionals, staff, etc. are aware of policies pertinent to the flow of patient care (i.e. transitions of care).
6. Be familiar with your institutional GME requirements
7. Attend institutional coordinator meetings
8. GME Oversight – Comply with the GME office to provide any information needed to conduct processes mentioned above.

ACGME Resident/Fellow and Faculty Surveys

ACGME Resident/Fellow and Faculty surveys are an additional means of monitoring graduate medical clinical education. The survey contains questions about the clinical and educational experience within their training program as well as duty hours worked. As part of the accreditation process, all programs are required to participate each academic year between January and April. Program Directors and Education Coordinators will be notified at the beginning of their five-week reporting window. The notification from ACGME will include instructions on how to log into ADS to send the survey to both faculty and residents to take the survey.

Resident/Fellow Survey

Follow the instructions, notify your residents, and monitor their compliance (a 70% compliance rate is required for programs with 4 or more residents) to ensure they complete the survey by the required deadline. Residents will be asked questions in the following categories: Clinical Experience and Education, Faculty Teaching and Supervision, Evaluation, Educational Content, Diversity and Inclusion, Resources, Patient Safety and Teamwork, and Professionalism. It is the program's responsibility to have residents complete the survey by the due date.

For programs with less than 4 residents who meet the 70% compliance rate, reports will only be available on an aggregated basis after at least 3 years of survey reporting have taken place. Survey results will be available in ADS if your program meets the required compliance rate. The

aggregate report provides an anonymous and comparative look at how the program compares to national, institutional, and specialty averages.

Faculty Survey

Follow the instructions, notify your faculty, and monitor their compliance (a 70% compliance rate is required for programs with 4 or more faculty) to ensure they complete the survey by the required deadline. Faculty will be asked questions on the following areas: Faculty Teaching and Supervision, Educational Content, Diversity and Inclusion, Resources, Patient Safety and Teamwork, and Professionalism. They should base their response by their experience over the last academic year. Information will be available on the website for you to provide your faculty on how to access the survey. A 70% response rate is required. Programs with fewer than 4 faculty members participating in the survey should reach 100% response rate. It is the program's responsibility to monitor faculty's compliance and survey completion by the deadline.

More information can be found on ACGME Resident/Fellow and Faculty Surveys here.

Program Coordinator's Role
1. Program directors and coordinators will be notified when they are required to participate in the Resident & Faculty Surveys.
2. Follow the instructions from ACGME to log into the ADS system to notify/remind residents and faculty to complete the survey
3. Follow up to ensure a minimum of 70% of residents and 60% of faculty complete the survey by the deadline.
4. Review results at PEC meeting
5. Review resident and faculty rosters prior to the surveys and confirm all email addresses are correct.

Resident Case Log System

All ACGME accredited PMR programs must have their residents record procedures they are involved with in the Resident Case Log System in ADS. Coordinators need to enter their incoming residents into the ADS system. ACGME will then generate a welcome email to each resident with information to set up their Login username and password. It is imperative that residents keep their case logs up-to-date as this information is used as part of the assessment in the program accreditation process.

Program Coordinator's Role
- Each academic year, enter new residents into the ACGME Case Log System.
- Ensure residents are progressing to meet <u>minimum</u> numbers for required procedures.
  - EMG/NCS (Total performed and observed) 200
  - EMG/NCS (Performed) 150
  - Axial Epidural Injection (Total) 5
  - Axial: facet, SI joint, nerve block (Total) 5
  - Periph joint/intra-artic inj/tendon sheath/bursa inj (Total) 20

- o Periph joint/intra-artic inj/tendon sheath/bursa inj (Performed) 15
- o Botulinum toxin injection (Total) 20
- o Botulinum toxin injection (Performed) 15
- o Ultrasound (Total) 10
- At the end of the academic year and prior to the ACGME deadline of Aug. 1, ensure graduating residents have all their procedures recorded for the year end archiving process. Tip: Export raw data to excel before archive.

Scholarly Activity of Faculty and Residents

With NAS, ACGME is focusing on quantitative data collection. Programs are required to report scholarly activity on all faculty and residents during the Annual Program Update in ADS.

Program Coordinator's Role

Program coordinators will need to report the following scholarly activity each academic year:

Faculty Reporting:
- List up to 4 Pub Med ID's of articles published
- # of other publications
- # of conference presentations
- # of other presentations
- # of Chapters/Textbooks
- # of Grants with Leadership Role
- Y or N = Leadership or Peer-Review Role
- Y or N = Teaching Formal Courses
- Demonstrated accomplishments in the following domains: research, grants, quality, reviews, curricula, committees, innovations

Resident Reporting:
- List up to 3 Pub Med ID's of articles published
- # of other publications
- # of abstracts, posters, and presentations given at meetings
- # of Chapters/Textbooks
- Y or N = participation in funded/non-funded basic science or clinical outcomes research project
- Y or N = 30 minute lecture/presentation within program or institution

Milestones

The ACGME Outcomes Project that began in 1999 had difficulty in measuring resident performance and competency. As a result of restructuring the accreditation system, each specialty developed outcomes-based milestones to help assess resident/fellow performance within the six ACGME Core Competencies. The milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes and performance) that can be demonstrated progressively by residents/fellows from the beginning of their education through graduation.

Physical Medicine and Rehabilitation Milestones can be found here.

Milestones are designed to help all residencies and fellowships produce highly competent physicians to meet the healthcare needs of the public.

- For programs, the Milestones guide curriculum development, support better assessment methods, and enhance opportunities for early identification of struggling residents.

- For residents, the Milestones provide more explicit and transparent expectations for performance, support better self-directed assessment and learning, and facilitate better feedback for professional development.

- For accreditation, the Milestones allow for continuous monitoring of the programs and lengthening of site visit cycles and enhance public accountability.

Programs are required to report milestone information on each resident to the ACGME twice per year. For each reporting period, review and reporting will involve selecting the milestone level that best describes a resident's performance using evidence from multiple methods, such as direct observation, multi-source feedback, tests, and record reviews. Milestones are arranged into numbered levels. These levels do not correspond with post-graduate year of education. Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels. Selecting the box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

- Not yet assessable – indicates resident has not had an opportunity to learn and demonstrate the milestones
- Not Yet Completed Level 1– indicates the resident has not substantially demonstrated Level 1
- Level 1 (novice) – demonstrates milestones expected of an incoming resident.
- Level 2 (advanced beginner) – advancing but not performing at a mid-resident level.
- Level 3 (competent) – demonstrates the majority of milestones targeted for residency.
- Level 4 (proficient) – substantially demonstrates the milestones targeted for residency. This level is the graduation target but **does not** represent a graduation requirement.
- Level 5 (expert) – advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

At the completion of residency training, the final milestones provide meaningful data on the performance and competency that graduates must achieve prior to entering unsupervised practice.

The Review Committee examines milestone performance for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

Program Coordinator's Role
1. Plan and schedule semi-annual meetings.
2. Enter milestones into ACGME ADS twice per year.
3. Retrieve milestone reports from internship year for incoming residents.

Under eligibility requirements, residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. At the start of the academic year, coordinators should go into ADS and print off each of your incoming residents Milestones summary from their PGY-1 training.

<u>Prior to CCC Meeting</u>
- Schedule meeting and location / Notify attendees
- Aggregate data electronically or on paper
- Provide information to members before the meeting so they can prepare for meeting

<u>At the meeting</u>
- Provide any information needed by committee members
- Take minutes, documenting any necessary information to resident/fellow record
- Record recommendations on each resident by milestone

<u>Post-meeting</u>
- Communicate results to program director (if not present)
- Schedule meetings with resident and program director to review Milestone status
- Submit Milestone information on each resident to ACGME through ADS

References:
http://www.acgme.org/acgmeweb/tabid/430/ProgramandInstitutionalAccreditation/NextAccreditationSystem/Milestones.aspx
http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PMRMilestones.pdf
http://www.acgme.org/acgmeweb/Portals/0/MilestonesFAQ.pdf
http://www.acgme.org/acgmeweb/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf
http://www.acgme.org/acgmeweb/Portals/0/PDFs/NAS/NEJMfinal.pdf

EVALUATIONS

Evaluations are an essential tool for documenting the quality of programmatic learning, providing ongoing feedback regarding aspects of one's performance, knowledge, or understanding. In GME, evaluations must capture multiple perspectives of feedback to gain a holistic and rounded view of the resident experience and allow the learning experience to consistently evolve with the needs of healthcare. While some feedback should be continuously given (usually verbal and informal), evaluations serve as a formal capture of this information.

Types of Evaluations

There are several types of evaluations that are required to help capture the resident experience, depending on who is evaluating who:

- Faculty Evaluation of Resident
- Student Evaluation of Resident
- Staff Evaluation of Resident (360)
- Patient Evaluation of Resident (360)
- Resident Evaluation of Resident (360)
- Resident Evaluation of Faculty
- Resident Evaluation of Clinic
- Resident Evaluation of Program
- Final Evaluation of Resident

All of these evaluations provide a rounded view of the resident experience, and are defined in the Common Program Requirements under Evaluations (resident, faculty, and program).

Resident Evaluation [CPR V.A. – V.A.3.b).(3)]

First, resident evaluations can be divided into two categories - formative and summative evaluations:

- Formative evaluation: monitoring resident learning and providing ongoing feedback to improve their learning. It helps residents identify their strengths and weaknesses and areas they need to work on.
- Summative evaluation: evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program. It is used to make decisions on whether a resident can be promoted to the next level of training or completion of the program.

The program must have formal mechanisms for monitoring and documenting each resident's acquisition of fundamental knowledge, clinical skills, and his / her / their overall performance. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.

Evaluation(s) must be documented at the completion of the assignment. For block rotations greater than three months, evaluation must be documented at least every three months. Longitudinal experiences such as continuity clinic must be evaluated at least every three months and at completion.

The program must provide objective performance evaluation based on residents' competence in the six areas of competency: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The program must use all of the sources (types) mentioned above to capture a rounded view of information, and this all must be provided to the Clinical Competency Committee (CCC) for its synthesis of progressive resident performance and improvement toward unsupervised practice.

With input from the CCC, the program director must then meet with each resident to review their documented semi-annual evaluation of performance including progress along the specialty-specific Milestones and assist in developing individualized learning plans to capitalize on their strengths and identify areas for growth. For residents failing to progress, improvement plans must be developed following institutional policies and procedures.

Programs are required to keep permanent records of evaluations and the educational counseling process within the training program for each resident. Records must be available in the resident file and accessible to the resident and other authorized personnel.

At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program.

Final Evaluation [CPR V.A.2. – V.A.2.a).(2).(c)]

The final evaluation is a specific type of resident evaluation that provides a summary of all resident experiences and information that the resident is qualified for autonomous practice. It is the responsibility of the program director to provide this final evaluation upon completion of the residents training, and should use tools including specialty-specific milestones and case logs to support verification of training.

The final evaluation is required as 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. It must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice and consider recommendations from the Clinical Competency Committee. The final evaluation must be also shared with the resident upon completion of the program.

A final evaluation must also be submitted on the [ABPM&R website](#). The ABPMR *Booklet of Information* states that when a resident first applies for admissibility to the Part I Examination, the program director certifies that satisfactory completion of the required residency training is anticipated by August 31 of the year of examination and also provides a preliminary opinion regarding the candidate's qualifications to enter independent clinical practice in the specialty.

Faculty Evaluation [CPR V.B. – V.B.3.]

Faculty evaluations provide a review of a faculty member's ability to fulfill all required duties for resident education. These include: clinical teaching abilities; engagement; participation in faculty development related to their skills as an educator, quality improvement in patient safety; fostering their own and their residents' well-being; patient care based on their practice-based learning and improvement efforts; clinical performance; professionalism; and scholarly activities.

At least annually, the program director must evaluate faculty performance as it relates to the educational program that includes written, anonymous, and confidential evaluations by the residents. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

Program Evaluation and Improvement (CPR V.C. – V.C.1.e)

Program evaluations provide feedback that summarizes all aspects of a training program to identify its strengths and weaknesses, with the overall goal to continuously improve and provide the highest level of training and patient care. Program evaluations must document formal, systematic evaluation of the curriculum at least annually, monitoring and tracking each of the following areas: resident performance; faculty development; graduate performance, including performance of program graduates on the certification examination; and program quality. These must provide residents and faculty the opportunity to evaluate the program confidentially and in writing, which is conducted by ACGME in during the ACGME Survey (released and monitored via ADS).

Based upon the feedback provided from these formal surveys, the Program Evaluation Committee (PEC) is tasked with the development of two separate documents that provide formal review and revision of the program. The first document, titled the Annual Program Evaluation (APE), provides a detailed and comprehensive summary of the program based upon the program evaluations mentioned above. The second document, the Action Plan, takes the evaluation feedback of the program and develops tangible goals to improve in areas that were identified as weaknesses or in need of improvement. Both of these provide formal documentation and forward momentum for a program to practice continual development.

Evaluation of Resident Care Transitions [CPR VI.E.3. – VI.E.3.e)]

The ACGME assigns Sponsoring Institutions and individual programs the responsibility to ensure and monitor effective, structured, hand-off processes to facilitate continuity of care and patient safety. The ACGME also requires each program ensures trainees are compliant in

communicating with team members in the hand-off process. These requirements are explicitly stated in the ACGME Common Program Requirements (VI.E.3.) and are a focus of the ACGME Clinical Learning Environment Review (CLER). Each program should have an evaluation process for documenting faculty assessment of resident/fellow change of duty hand-offs and patient transfers between services and locations either through direct observation or simulation. Ideally programs should evaluate trainees on care transitions each year as resident's role in patient care advances.

Committees Related to Evaluations

As mentioned above, evaluations provide essential information for resident education but they alone cannot fulfill all the requirements associated with a program. To fully interpret and incorporate evaluation feedback, committees review the information and provide direction for a program's learning structure, resident progression, program changes, etc.

Clinical Competency Committee (CCC)

The Clinical Competency Committee (CCC) is a group that serves to determine each residents' progress on achievement of the specialty specific milestones, and meet at least semi-annually in tandem with the ADS reporting period via ACGME. The CCC must meet prior to the resident's semi-annual evaluations and advise the program director regarding each resident's progress.

The committee is composed of at least three members of the program faculty (at least one being core faculty), as well as other members who have experience and knowledge of the program and residents. These can include faculty from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents (residents including Chief residents, should not be on the CCC). The coordinator plays a major role in the CCC meeting; however, the coordinator cannot be an official voting member of the CCC. Instead, the coordinator serves to take minutes and record key aspects of the discussion, summarize the information for milestone reporting, and provide support to the program director in recording milestones and implementing improvement plans as needed.

Lastly, each program must develop a policy that outlines the responsibilities of the CCC, what information is used by the CCC to determine resident progress, formal quantitative measures for these assessments, etc. Based upon this policy and the discussions / decisions determined by the CCC, the committee then advises the program director regarding the resident's progress, including promotion, remediation, and dismissal.

Program Evaluation Committee (PEC)

The Program Evaluation Committee is a group that serves to review program evaluation feedback and provide both an APE and Action Plan for program development. The PEC is required to meet at least annually, and its duties include: acting as an advisor to the program director through program oversight; review of the program's self-determined goals and progress toward meeting them; guiding ongoing program improvement including development of new goals, based upon outcomes; and review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's missions and aims. The PEC must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident, of which are appointed by the program director.

The coordinator plays a major role in the PEC meeting, providing support to the program director and committee, recording the minutes, assisting in development of goals and overall programmatic changes, etc.

Lastly, each program must develop a policy that outlines the responsibilities of the PEC, what information is being used and where this information was obtained, what areas of information are monitored and developed, and outcomes that serve as the baseline for a program's success (board pass rates, graduate statistics, etc.). In completing all of the outlined duties, the annual review and action plan must be distributed to and discussed with the members of the teaching faculty and the residents and submitted to the DIO.

Program Coordinator's Role

While a program coordinator's role is discussed above related to committee involvement, a coordinator will also be responsible for the majority of evaluation specific duties within a program. As the educational support, the coordinator will be responsible for the following (can vary per program):

- Process monthly resident, faculty, rotation, multi-source (360), and patient hand-off evaluations.
    - Most residency programs use an electronic evaluation system (MedHub, E-Value, New Innovation, etc.) to complete evaluations. There are several different programs out there, and you will need to find the one that works best for your program. Your GME office may decide the evaluation program that is used across the institution.
- Track evaluations by
    - Monitoring the return of all evaluations
    - Providing residents, faculty, and program director access to evaluations while also maintaining confidentiality
    - Coordinate resident semiannual evaluations with the program director in conjunction with milestone reporting.
    - Coordinate and document annual program evaluation (APE) by the PEC, including written action plan for areas of improvement.
- Track action plan results of APE for improvement outcomes.
- Initiate the final evaluation by the program director of all G4 residents at the completion of their residency. Both program director and resident need to sign. A copy must be provided to the resident within 30 days of program completion.
- Send in *ABPM&R Final Evaluation* of PGY-4 residents. The residents cannot take their Boards if the ABPM&R does not receive the final evaluation by the deadline date.

ASSOCIATION OF ACADEMIC PHYSIATRISTS (AAP)

Established in 1967, the Association of Academic Physiatrists (AAP) is an organization for physiatrists interested in the academic aspects of Physical Medicine and Rehabilitation. The AAP strives to promote the advancement of higher education and research in PM&R and to encourage young physicians to pursue an academic career in physiatry. Membership is open to all physiatrists interested in education and research. Faculty, those in training (medical students to fellows), non-physiatrists interested in PM&R education and research, and non-physicians involved in academic PM&R (e.g., administrators and researchers) are eligible to join the AAP. The benefits of membership include subscriptions to the monthly publication, *American Journal of PM&R,* reduced rates for attending national meetings, and to the quarterly AAP newsletter.

The AAP maintains an extensive website that contains information about the field of PM&R, How to Find a Physiatrist, and information concerning education and research. A useful resource to training programs is the *PM&R Program Directory,* which contains not only a listing of every accredited training program, but also information on how to apply for a residency, resident demographics, etc.

Along with the standing committees, there are eight AAP councils that work to provide inclusive and consistent representation, bringing new ideas and relevant information to the community: Council of PM&R Chairs, Council of Residency & Fellowship Program Directors (RFPD), Council of Medical Students as Educators, Council of Residents and Fellows (RFC), Council of Program Coordinators, Council of Administrative Directors, Council of Veteran Affairs, and the Council of Junior Faculty (JFC). Additionally, there are a large number of sub-committees that have specific areas of interest, including Research and QI, Social Media, Wellbeing, and more.

The AAP holds an annual meeting with courses pertinent to academic physiatry in research, education, and administration. The conference also features scientific poster and paper presentations as well as committee / council meetings. Specific opportunities also exist that provide additional education, including the coordinator sessions and resident bootcamp.

Program Coordinator's Role
1. Read the relevant announcements, newsletters, and correspondence from AAP.
2. Process yearly memberships for residents (if your program pays for membership).
3. Join the AAP as a program coordinator and be an active participant. Membership and registration at the annual meeting are complimentary for academic partnerships.
4. Update program information in the *PM&R Program Directory* posted under the "News & Resources" tab of the AAP website.
5. Register residents, yourself, and program director for the AAP Annual Meeting.

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AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION (AAPM&R)

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is an organization founded in 1938 as an advocate for both the patient and the physiatrist. The Academy disseminates professional information regarding practice standards, quality assurance, and continuing medical education. Membership is open to any board-certified physiatrist. Membership is also available to residents at a reduced rate. Once a year, the AAPM&R holds an annual meeting. At the annual meeting, one of the activities is a job fair where available medical positions are advertised. The official journal of the AAPM&R is the *Archives of Physical Medicine and Rehabilitation,* and it comes with membership.

The Academy sponsors a self-assessment exam for residents (SAE-R). The SAE-R is an annual assessment designed by the AAPM&R to help residents-in-training objectively assess their professional knowledge in the field of Physical Medicine and Rehabilitation. It provides residents with successive measures of their individual progress in acquiring specialty knowledge and percentiles for comparison with scores of all residents. Residents in all programs take the online examination during a 7-day window at the end of January.

Program Coordinator's Role
1. Process yearly memberships for residents (if your program pays for membership).
2. Register residents who are attending the annual meeting.
3. Register for the Job Fair at the annual meeting to advertise for open faculty and fellowship positions.
4. Register for the Residency Fair at the annual meeting to introduce your program to medical students interested in the specialty.
5. Watch for the email to register your residents for the self-assessment exams (SAE-R's)
    a. If your program pays for resident memberships, there is an option to register the resident for the SAE-R at that time
    b. For proctoring the exam you can reserve a computer lab, laptops, or proctor remotely

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AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION (ABPM&R)

The American Board of Physical Medicine and Rehabilitation (ABPM&R) is the organization that establishes the criteria for certification of individuals in the field of Physical Medicine and Rehabilitation. Once the criteria are met, residents are eligible to take the Part I (written) and Part II (oral) Board examinations administered by the ABPM&R. The American Board of PM&R, in addition to the program director, maintains a record of the status of each resident throughout his or her residency program. A pamphlet, *Certification Booklet of Information,* which describes the criteria for certification, is available from the Board or on-line at www.abpmr.org.

Program Coordinator's Role

1. Provide incoming residents with instructions to the exam outline under Getting Certified, "Study Tips & Resources."
2. Submit to the ABPM&R the Registration of New Resident form by August 1. This is completed on-line at www.abpmr.org.
3. If there is a change in status of a resident (e.g., probation, withdrawal, leave of absence, etc.), a Change of Resident Status form must be completed and submitted to the Board.
4. PM&R training programs are sent an email from the ABPMR notifying them to go on-line and complete an Annual Evaluation form for each resident prior to the end of the academic year. Complete the forms by the date requested by the American Board of Physical Medicine and Rehabilitation.
5. The ABPMR sends the current Certification Booklet of Information to each resident after the Board office has processed registration forms. If your program is a 3-year program (PGY2-4), it may be helpful to forward to your newly matched people before they start their PGY-1, the ABPMR website so that they are made aware of the ABPMR requirements for their PGY-1 year. Make sure you keep a copy of the booklet on hand or bookmark the online version, so you can refer to it as needed.
6. Part I (Written Boards) usually occurs in August each year. Before the Part I examination, the Board will send Final Evaluation for the program to complete on the residents who are registered for the exam that year. In July, Verification of certification candidate photos for Part I Exam are sent to PD and Coordinators. You must complete by the deadline in order for the resident to take the examination. Residents taking Part I are required to have an expected date of completion on or before August 31 of the year that they are taking the exam. Most of the residents will have an anticipated date of completion on June 30 of the year they are taking Part I.
7. Part II (Oral Boards) usually occurs in May each year. Residents who successfully passed Part I are eligible to take Part II the following year. In April/May PD and Coordinators will be sent Verification of certification candidate photos for Part II Exam.
8. Keep track of each resident's days of absence from the program. A resident should not be absent from the residency training for more than six weeks (30 working days) annually, except in the case that a special leave period is granted. Regardless of institutional policies regarding absences, any leave time beyond six weeks would need to be made up

by arrangement with the program director and GME office (if applicable). Click here to view the ABPM&R Absence from Training Policy.

9. If a resident is placed on probation, a plan for remedial action must be submitted to the ABPMR.

10. To help with safeguarding exam security and raising awareness about ABPMR policies, each year new residents/fellows, program directors and coordinators need to sign the ABPMR Examination Irregularity Policy, Nondisclosure Policy, and Cooperation Agreement. You will receive an email from the ABPMR when it is time to sign the agreement. Signed agreements are due November 15th.

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NATIONAL GME CENSUS SURVEY

The National GME Census is an online survey completed by residency programs and institutional officials. The Census is comprised of two components: **The Resident Survey and the Program Survey**. Resident and program data are confirmed annually, but can be updated year-round. With the combination of the two surveys, the data collected in the Census are used by the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA).

The Program Survey collects detailed information about each residency program and is used to update FREIDA Online™, and the Graduate Medical Education Directory otherwise known as the Green Book. FREIDA Online™ contains extensive information on all the residency programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Residents and/or medical students can access this info by going to the website, https://login.ama-assn.org/account/login. FREIDA allows the user to search all accredited programs by such variables as specialty, state/region, program size, educational requirements, etc. By defining selection criteria, the resident can select different programs or focus on a specific program. You can obtain specific program information, such as size, salary, work schedule, policies, and resident-to-faculty ratio, using FREIDA.

The Resident Survey collects training status and biographical information on each resident and fellow, which is used for a variety of purposes including: monitoring career choices of medical school graduates; analyzing impact of market forces on GME; physician workforce studies; and specialty specific analyses.

Program Coordinator's Role
1. The Program Survey update usually begins the end of May and is due the beginning of July in order to participate in the Early FREIDA on-line listing or the end of September if you miss the early deadline. The Resident Survey begins the middle of July and is due the end of September. An email from gmetrack@aamc.org will be sent to the email listed for your program informing you of the dates and any other necessary information.
2. Keep record of your GME Track User ID and password.
3. When you receive the notice from gmetrack@aamc.org, complete the GME Census Survey through GME Track by updating information pertaining to your residency program annually before the given deadline. (If you do not receive the email notice by the second week of June, ask your program director or GME office if they received it.)
4. Print a copy of the survey for your records and to assist you the following year on how you answered the questions the previous year.
5. To assist you in completing the Resident Survey, collect your graduating residents' future plans. You will be asked specific information as to whether they are going into a fellowship (type of fellowship & accreditation status) or starting practice (academic/nonacademic, private/group practice, full-time/part-time) and also the location. Collecting this information ahead of time avoids the hassle of trying to track down your residents once they have left your program.

RECRUITMENT

Recruitment in graduate medical education is one of the largest and most important aspects of a training program, with the goal of successfully recruiting qualified medical students or interns to join a residency training program. The quality of a training program is directly dependent on the success and caliber of residents recruited and retained, and requires organized, detailed, and efficient work to be successful. For a coordinator, recruitment season (roughly Sept. – March of each academic year) is one of the biggest portions of the job, and while it can be time-consuming and high-stakes, it also can be highly rewarding. A coordinator serves as the main contact, support, and manager of a recruitment cycle.

Since recruitment is a national and regulated process, there are several online programs that are involved and required for participation.

Electronic Residency Application Service (ERAS)

ERAS is a centralized, online program that transmits the full application of a medical student to the programs they are interested in. These applications are all encompassing of their medical training, and include: letters of recommendation, medical student performance evaluations, medical school transcripts, USMLE transcripts, COMLEX transcripts, and other supporting credentials from applicants and their Designated Dean's Office (DDO). All ACGME accredited programs must use ERAS as their application service.

The five main components of ERAS include MyERAS, Dean's Office Workstation (DWS), Program Director's Workstation (PDWS), Letter of Recommendation Portal (LoRP), ERAS Post Office, and Thalamus (currently being incorporated for the 2024 season as part of the PDWS system). These areas of the program allow for seamless transmission of information between various involved parties while protecting the integrity and confidentiality associated with recruitment.

National Resident Matching Program (NRMP)

NRMP is a non-profit organization that serves to efficiently and fairly match medical students and programs in recruitment. This process, called The Match, hosts a sophisticated algorithm that takes rank lists from both medical students and programs and provides outcomes based on each parties preferences, while also outlining rules and regulations that are a legal binding contract for all those who enter into the program. These rules include specific guidelines that programs must follow, and a coordinator must enforce (along with program director support), including but not limited to confidential ranking, equitable opportunities for interview, transparency, etc. The details of The Match contracts can be found on NRMP's website under Match Participation Agreements. Once The Match has been completed, it is a binding contract of employment between the program and applicant, and cannot be altered except under extenuating circumstances.

Educational Commission for Foreign Medical Graduates (ECFMG)
The ECFMG is a group of non-profit organizations that review, process, and certify non-US medical graduates for training and practice in the United States. All foreign medical graduates must be ECGME certified to participate in The Match and train in ACGME accredited programs. To successfully achieve ECFMG certification, all international medical graduates (IMGs) must complete various credentialing including: medical school completion and confirmation, verification of credentials, completion of required examinations (including English language proficiency), etc. Programs, in partnership with their sponsoring institution, must develop policies for eligibility and selection for IMG candidates, with these policies clearly communicated and enforced prior to interview invitations.

Recruitment Schedule
As mentioned above, the recruitment season runs from Sept. – March of the academic year, and requires coordination at multiple levels. A program coordinator is responsible for the majority of these processes and will need to ensure the program is well equipped and prepared for the full process of recruitment.

Start Early: The program director should select a resident recruitment committee consisting of faculty who are willing to make the commitment of reviewing the ERAS files, interviewing applicants, and attending the recruitment meetings. Plan early by setting the interview dates, blocking faculty schedules that will be interviewing, and scheduling rooms for interviews.

Recruitment Meetings: The recruitment committee should meet at least twice during the recruitment season. The first meeting should be at the beginning of the recruitment season to discuss evaluating applications, interview schedules, and strategies for success. The second meeting should take place at the end of the season to determine the rank list and the order in which candidates will be ranked.

Interview Early: Medical students apply to internships and residency programs and set up interviews for both programs simultaneously. While the landscape of interviews changed with the onset of the COVID pandemic, many candidates interview and make their selections early in the season. As they near the end of their medical school training, their availability and time commitments will decrease. A program should plan to review ERAS applications and invite candidates for interviews early in the season to provide candidates time to organize interviews and explore their opportunities as well as final decisions on program rankings. Interviews that take place past December of each season have less success than those that take place in Oct – Dec.

Interview Process
The interview process has evolved over the past few years, with COVID and virtual opportunities becoming more widely available. While the overall recruitment process is universal, the details and design of each program's interview process can vary based on their preferences and requirements. The outline below is a generic summary of the interview process for a program that is doing virtual interviews (most common).

Inviting Applicants
- Check with the individual program, institution, NRMP, AAP, and AAMC to see what recommended guidelines are set for recruitment.
  - Ex: based on AAMC recommendations, the Univ. of Kentucky GME office required all programs to offer virtual interviews for the 2023 cycle.
- Using the program's preferred scheduler (ERAS, Thalamus, Interview Broker, etc.), prepare the scheduling platform with relevant interview and program information
  - This includes interview type (virtual, in-person, hybrid), location, times, and more.
  - Be sure to include information about the program, stipends, links to the website, or anything relevant to the candidate interview experience.
- Send interview invitations for all available slots, and provide a minimum of 48 hours for an applicant to respond / schedule.
- As declinations or cancellations from candidates are received, continue to send invitations from the waitlist to try and fill all interview slots.

Prior to Interview (upon candidate accepting / scheduling interview):
- Send out a confirmation email, letter, or create a program in the scheduling platform that includes details about the interview day, the schedule, program information, etc.
- Prepare an information packet for each interviewee – this can include various items including rotation schedules, information about the city and university, research opportunities, eligibility for the relevant specialty board exam (PR II.A.4.a).(9), Match commitment letter, information related to the applicant's terms and conditions of appointment and stipend and benefits, a summary of the program's policies and procedures, a sample contract, etc.
- Provide a clear explanation of expectations, required paperwork, contact information, and relevant information prior to the interview day.
- Schedule interviews with program leadership and additional faculty members – it is recommended that a program do 20-30 minutes for each interview.
- Ensure that all faculty / interviewers are aware of The Match rules, including avoiding questions that are illegal, avoiding match violations, or not following equitable interview practices.

Day of Interview:
- Ensure that faculty and candidates are aware of the schedule, including start / end times, breaks, lunch, etc.
- Ensure that all technology is working properly for all program participants, including providing private spaces if needed.
- Provide an opportunity to review program information with the Program Director and Program Coordinator, outlining important information that candidates will want / need to know.

- Ensure that clear communication is given to candidates (such as how they will be separated for interviews, time limits or time checks for interviews, and upcoming events in the schedule).

Additional Factors:

- Each program will have a unique interview experience that is determined by many factors, including restrictions and budget. While there are rules and guidelines to ensure equity for all candidates during recruitment interviews, there is no "correct" or "perfect" interview experience, and a program should run interviews as it best fits the program needs.
- If a program is doing in-person interviews, additional information such as hotel availability, airport information, directions, ordering food, or other related responsibilities may also be required for a successful interview day.

After Interview (optional):

- Prepare form letters to thank candidates for visiting your program, and provide contact information for their interviewers.
- Provide a summary of any information covered during the interview day that is not already available on the website / interview platform
- The form letters should be from the chair's office, program director's office and/or the chief resident.
- Do not be over-zealous by sending more than two letters to each person.

Eligibility and selection policies for selecting candidates are required as part of any program's recruitment policies and procedures. Each year, the process of filling open spots has become more and more competitive. At the end of the recruitment season, consider sending out a questionnaire, or "Post Match Survey" to all of the candidates who were ranked (above your last filled position) but did not match at your institution. In this questionnaire, candidates should be asked for suggestions or improvements to the program's interview process and what the program can do to attract more students.

Program Coordinator's Role

1. Register for ERAS between April and August.
2. Assist in forming recruitment committee of both faculty and residents.
3. Organize recruitment committee meetings.
4. Create schedule of interviewers, block their schedules, and reserve private spaces as needed.
5. Sign into the Web-based PDWS to review the resources and online tutorials to get started setting up your program.
6. Ensure that your website is updated and reflects the most up-to-date information about your program and the recruitment process.
7. Review ERAS files online for completeness and competitiveness—make sure you are meeting eligibility and selection policy criteria.
3. Know your state's licensing requirements and institutions visa requirements. If an applicant is not eligible, do not extend an interview.
4. Create schedule of applicants using your preferred scheduling software (ERAS, Thalamus, Interview Broker, etc.)
5. Formally invite applicants to schedule their interview (this can be done via email or your preferred scheduler).
6. Send confirmation emails or ERAS messages to applicants scheduled for an interview.
7. Organize interview day – the coordinator sets the tone of the day and helps to put candidates at ease by creating a welcoming atmosphere and well-organized interview.
8. Provide candidates with accurate information related to residency, including program information, stipends and benefits, geographic information, etc.
9. Send thank you letters.
10. Organize committee meeting to decide rank list (rank meeting)
11. If you need to change your quota (number of positions being offered), make sure you update your quota by the January 31 deadline through the NRMP website.
12. Submit rank list to the NRMP website by the deadline.
13. Announce the results of the Match to residents and faculty.
14. Send an email to those you matched with asking them for information not included in application (i.e. social security number, birthplace, etc. (you can unscreen their birth date in ERAS). This is also to keep updated information of any address and email changes, especially those who matched in advanced positions.
15. Send anonymous post-recruitment questionnaires.
16. At the end of the recruitment season, export the ERAS applicant data you wish to retain.
17. You should complete a statistical analysis of your applicant pool. Part of the program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce.

RESIDENT CONTRACTS

As with any employment opportunity, a written agreement, or contract, is needed to outline specific terms and conditions, benefits, and compensation. Sponsoring institutions are required to provide residents with an annual contract, outlining the terms and conditions of their appointment to an educational program, proposed salary, and agreement to comply with all institutional policies. Sponsoring institutions must monitor the implementation of these terms and conditions by the program directors in each residency / fellowship program, and ensure that residents adhere to established practices, procedures, and policies of the institution. These contracts are renewed annually by the institution, and are directly related to promotions and milestones determined by a program's CCC.

Agreement of Appointment / Contract [IR IV.C. – IV.D.1.b]
The ACGME specifies that the contract must directly contain, or reference, the following items:

a) Resident/Fellow responsibilities
b) Duration of appointment
c) Financial support for residents/fellows
d) Conditions for reappointment and promotion to a subsequent PGY level
e) Grievance and due process
f) Professional liability insurance including a summary of pertinent information regarding coverage
g) Hospital and health insurance benefits for residents/fellows and their eligible dependents
h) Disability insurance for residents/fellows
i) Vacation, parental, sick, and other leave(s) for residents/fellows, compliant with applicable laws
j) Timely notice of the effect of leave(s) on the ability of residents/fellows to satisfy requirements for program completion
k) Information related to eligibility for specialty board examinations
l) Institutional policies and procedures regarding resident/fellow clinical and educational work hours and moonlighting

Of note, before accepting a resident who is transferring from another program, the program director must obtain verification of previous educational experiences and a summative competency-based performance evaluation and Milestones evaluations upon matriculation (this includes residents matched in advance positions coming from their preliminary year).

It is important to include in the appointment letter any contingencies the program may have prior to the commencement of their training. Requirements vary by institutions but may include the following contingencies:

1. A copy of official transcripts from all post-secondary educational institutions attended, (i.e., medical school [showing degree granted and date conferred], undergraduate college or university, and graduate school [if applicable]).
2. A copy of medical school diploma.
3. A copy of all licensure and/or examination scores (sent by appropriate test administrators) for each time exams (e.g., USMLE, LMCC, or COMLEX) were taken. In order to meet licensure requirements, it is important to get scores for each time a candidate attempted these exams, as certain states require tests be passed within a certain number of attempts. Note that licensure requirements vary from state to state.
4. Proof of legal right to work, as defined by the 1986 Immigration Reform and Control Act, by bringing documents that establish identity and employment eligibility
5. PGY-1 mid-point evaluation from the program director.
6. Those starting as PGY-2s have to bring a copy of their PGY-1 certificate.
7. Submit to a health review and pass a urine drug screen.

Program Coordinator's Role

1. Provide a copy or sample contract to recruitment candidates that reflects the information mentioned above.
2. The Graduate Medical Education Office (GME) of each institution should provide an ACGME compliant contract format as well as copies of the appropriate institutional policies.
3. The program coordinator may be required to personalize the contracts and distribute and/or mail them to each resident for signature.
4. Monitor the return of contracts, and contact those residents who have not returned their copy.
5. File a signed copy of the returned contract in the appropriate resident's personnel file (or in the electronic records system such as MedHub).
6. If your GME office doesn't collect the required documentation needed to meet the terms and conditions of the appointment, you will need to do so.

ORIENTATION

The goal of orientation is to provide information to a resident for a successful transition to their residency training program. Even though you should spread orientation lectures throughout the first month, there should be a specific day or week scheduled for orientation. The structure of the orientation will depend on institution and department needs. If possible, schedule orientation prior to the first day of training. If you do schedule orientation on the starting date, it is advisable to have the residents from the previous month's service remain on that service an additional day and start new rotations on the following day.

You must assign a faculty mentor/advisor to each new resident. We also recommend that you assign a senior resident mentor to each new resident, for guidance through the first few strenuous months.

Orientation Schedule

Graduate Medical Education (GME) Orientation: At some institutions, the GME office meets with the residents/fellows from all disciplines, introduces the staff, and provides information on the possible following subjects:

1. Safety and security
2. Health Care Financing Administration (HFCA) documentation requirement
3. Substance abuse
4. Resident mental health program
5. Medical library information and contacts
6. Residents' organization/association
7. Risk management/professional liability
8. Infection control
9. Caring for culturally diverse populations
10. Information technology
11. EMR & other computer training
12. Professionalism
13. Conflict of interest
14. Integrity & compliance
15. Medication safety
16. Advanced directives & medical ethics

Departmental Orientation:

1. Meeting with the Chair
2. Meeting with Program Director
3. Meeting with Program Coordinator to review program specific policies and guidelines
4. Meeting with Chief Residents—explanation of *Orientation Manual (online or written)*
5. Orientation to the inpatient services
6. Tour of the department

Processing:
1. ID badge
2. Pager
3. Keys
4. Employee's health/registration
5. Lab coats/scrubs
6. Benefits
7. Parking permits

Welcome Lunch or Picnic: Held with all residents, attending staff, and clinic staff

Orientation Manual

Prepare an *Orientation Manual* that provides information on the following areas and give it to the residents on, or before, orientation day (some choose to have this available on-line only).

- Introduction
- Schedules
  - o Yearly schedule of events
  - o Lecture schedules
  - o Resident rotation schedule
  - o Faculty staffing schedule
  - o Continuity clinic schedules
  - o Call schedule
- Telephone and/or paging list
  - o Faculty/resident paging list and cell phone numbers
  - o List of commonly used phone numbers
  - o PT/OT/Speech-Language Path, etc. paging list
- Dictation
  - o Dictation system instructions
  - o Dictation guidelines and examples
  - o Discharge summaries
  - o Team meeting
- On-call duties
  - o Sign-out policy and checkout sample
  - o Call guidelines and policies
- Vacation/absence policy
- Rotation specific information/handouts
- Goals and objectives on each rotation
- Rotation specific books
- Maps
- Miscellaneous (laminated cards for reference, etc.)

ORIENTATION   **41**

Orientation Lectures
1. Explanation of school policies (leave, sick leave, etc.) and resident contract
2. Introduction to PT
3. Introduction to OT
4. Introduction to Speech Language Pathology
5. Introduction to Rehab Engineering
6. What to expect when on-call
7. Baclofen pump in-service
8. American Spinal Injury Association (ASIA) exam for spinal cord injuries
9. History of PM&R

Program Coordinator's Role
1. Review orientation contact list
2. Send out welcome email/letter to newly matched residents (include all pertinent information, i.e. contract, USMLE Step 3 policy, names and emails of chiefs).
   a. For Advanced Programs whose residents start at the PGY-2 level or for programs taking in transfer residents be sure to get PGY-1 information (i.e. certificate, milestones evaluations, previous educational experience, and a summative competency-based performance evaluation).
3. Send new resident names and general demographic information to GME
4. Send out orientation instructions and attachments to matched applicants
5. New resident documentation checklist
6. Order items for residents (i.e., pagers, books, keys, ID badge, lab coats, scrubs, parking)
7. Order food and A/V for welcome breakfast/lunch orientation sessions
8. Email all orientation dates (GME, institution (if applicable), department)
9. Coordinate orientation schedules and lectures (email and confirm participants)
10. Schedule trainings (ACLS, BLS, Dragon, eRecord, Library, etc.)
11. Update the orientation/policies and procedures manual
12. Update department website/Sharepoint site
13. Update orientation overview assignments
14. Update powerPoint (if applicable)
15. IMS (Identity Management Systems) Activations (i.e., Network, Email, Cerner)
16. Orientation follow up / follow through
17. Send updated lists and documentation to internal and external rotation contacts
18. Organize welcome picnic/lunch/dinner

New Resident Data Entry
❖ ACGME ADS
❖ ACGME Caselogs
❖ ABPMR Registrations

❖ Update lists (Resident files, pager lists, contact information, attendance sheets, birthday club, etc)
❖ Update composite photo
❖ Online evaluation system (EValue, New Innovations, MedHub, etc)
❖ Specialty society membership applications (AAP, AAPMR, etc.)
❖ Website/Sharepoint (if resident specific information included)

SCHEDULES

As with any educational program, an outline of the educational opportunities and experiences is necessary to ensure that a full curriculum is being met. In medical education, there are a variety of schedules that provide details on when / where / what a resident will be doing during their time.

Master Schedule

The master schedule provides a resident's rotation for the year, broken down into monthly and "block" (multiple consecutive months) rotations. The program design and/or structure must be approved by the Review Committee (RC) for Physical Medicine & Rehabilitation as part of the regular review process, and must reference all forms of requirements through ACGME (CPR, PM&R, and IR).

Residents applying for certification examination must have satisfactorily completed 48 months of training in a PMR residency accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC). Keeping this in mind, when making the schedule the following requirements should be followed.

- 12 of the 48 months must consist of a coordinated program of experience in fundamental clinical skills such as an accredited transitional year, or include six months or more in accredited training in family practice, internal medicine, pediatrics, or surgery, or any combination of these patient care experiences. The remaining months of this year may include any combination of accredited specialties or subspecialties.
- The program must include 36 months of PM&R in a training program accredited by ACGME or the RCPSC.
- Of the 36 months of PM&R training, no more than 6 months can be elective.
- No more than one of month of this elective time may be taken in a non-ACGME or non-RCPSC-accredited program, unless prior approval is given by the RC.
- The training program must include at least 12 months with direct responsibility for complete management of hospitalized patients on the physical medicine and rehabilitation service.
- Residents must spend at least 12 months of their training in the care of outpatients, including a significant experience in the care of musculoskeletal problems.
- Competence in electrodiagnostic studies. Residents are expected to be involved in a minimum of 200 electrodiagnostic evaluations from separate patient encounters.
- Competence in performance of therapeutic and diagnostic injections. Review minimum number of physical medicine and rehabilitation procedures on the ACMGE PM&R Documents site (click here).

Call Schedule

Physicians must have a keen sense of personal responsibility for continuing patient care and be able to recognize that their obligations to patients are not automatically discharged at any given time of the day or any particular day of the week. Work hours and weekend call for residents

reflect the concept of responsibility for patients and provide for adequate patient care. It is the responsibility of the program director, however, to ensure and monitor assignment of reasonable inpatient and outpatient work hours for care to ensure that the resident is not subjected regularly to excessively difficult or unduly prolonged duties. The ACGME Common Program Requirements outline several conditions that all resident schedules (regardless of PGY level) should adhere to: [CPR VI.F.1 – VI.F.8.a).(1)]

- Clinical / educational work hours must be limited to no more than 80 hours per week (averaged over 28 days)
  - This includes all in-house clinical and educational activities, home call, and moonlighting.
- At least 8 hours off between scheduled clinical and education periods
- At least 14 hours free of clinical work and education after 24 hours of in-house call.
- Schedules a minimum of one day off in seven free of clinical work and education (averaged over 28 day)
- Clinical / educational work periods must not exceed 24 hours of continuous assignments
- Must be scheduled for in-house call no more frequently than every third night (averaged over 28 days)
- Note that exceptions can be made and are further specified in the Common Program Requirements.

In addition to the limitations for clinical activities, residents must also be provided with adequate support, such as sleeping and food facilities, during work hours as well as safe transportation options for residents who may be too fatigued to safely return home. Supervision levels and clinical responsibilities should also be appropriately considered and assigned when the schedule is being generated. [CPR VI.A.2.b and VI.E.1.]

Other Schedules

There are several types of faculty schedules including inpatient, outpatient, sub-specialty clinic, and after hours call schedule. These schedules should highlight the times, the dates, and the areas to which each faculty member has been assigned.

Suggested Material to Add

1. Resident Master Yearly Schedule
2. Call Schedule
3. Sub-Specialty Schedules
4. Other schedules may include:
   - Ancillary or Off-Service Rotation Schedules

- Continuity Clinic Schedule
- Conference Schedule
- Didactic Schedule
- Journal Club Schedule
- Vacation Schedule
- Holiday Schedule

Program Coordinator's Role

1. Determine who is responsible for developing the schedule. In some programs the coordinator develops the schedules, while in others the chief residents are responsible.

2. Find out the type of scheduling system used by your institution. Some institutions use computerized programs to develop the schedules while others use the traditional method of pencil and paper.

3. Maintain and/or distribute schedules for faculty, residents, and staff. (If possible, emailing the schedules saves time and copying). Don't forget to distribute schedules to support staff responsible for maintaining the physician's calendars.

THE LEARNING AND WORKING ENVIRONMENT

According to the Common and Institutional Requirements, programs and sponsoring institutions must have oversight of the clinical experience and education of residents. They must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities as well as reasonable opportunities for rest and personal activities. Their training must be carefully planned and balanced to ensure optimal patient care and safety, which requires a diligent commitment to resident well-being. Each program must ensure that the learning objectives of the program are not dependent on residents/fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of resident/fellows' time and energies. Clinical assignments must respect that faculty and residents/fellows collectively have responsibility for the safety and welfare of patients.

According to Program Requirement VI.A.1.a, residency education must occur in the context of learning and working environment that emphasizes the following principles:
- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members and all members of the health care team

Patient Safety, Quality Improvement, Supervision and Accountability (PR VI.A.)

Patient Safety (PR VI.A.1.a)
Programs must create a culture of safety that includes education on patient safety, continuous identification of vulnerabilities, reporting, investigating and following up on patient safety events, and education and experience in disclosure of adverse events.

      Program Coordinator's Role
1. Review ACGME website for formal mechanisms and information related to Patient Safety.
2. Document that residents are receiving didactics on patient safety related goals, tools, and techniques.
3. Document that residents know how to report a medical error, adverse event, close calls and near misses, inefficiencies in care, unsafe conditions.
4. Document that residents are provided with training on how to break bad news.
5. Document what the program does to ensure your institution prioritizes maintaining a culture of safety.

Quality Metrics (PR VI.A.1.a).

The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. Programs should have a process in place for engaging residents in quality improvement projects with the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.

Education in Quality Improvement

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.

Quality Metrics

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

Engagement in Quality Improvement Activities

Residents must have the opportunity to participate in interprofessional quality improvement activities. This should include activities aimed at reducing health care disparities.

Bank-a-PIP through the ABPMR

After becoming board certified, graduates will be required to complete a quality improvement (QI) activity, also called a practice improvement project (PIP), for the ABPMR every five years. Residents and fellows can 'bank' a project they completed during training with the ABPMR to count toward future requirements.

- Instructions on how to "bank-a-PIP" can be found at:
  https://www.abpmr.org/MOC/PartIV/SelfDirected

Program Coordinator's Role

1. Coordinate quality improvement curriculum for residents
2. Track residents' progress on their quality improvement project
3. Review ACGME website for information related to Quality Improvement.
4. To obtain quality metrics data, contact your FIM (Functional Independence Measurement), PPS (Prospective Payment System) Coordinator, or UDS (Uniform Data System) or Rehab Specialist for Rehab Outcomes data. Provide the residents with the information on units where they rotate. Both inpatient and outpatient services.
5. Document what the program does regarding quality improvement projects and activities, including activities aimed at reducing health care disparities.
6. Send an email to the graduating residents about banking their QI project to meet the MOC PIP requirement.

Supervision and Accountability (PR VI.A.2)

Programs must define, widely communicate, and monitor a structured chain of responsibility as it relates to supervision of all patient care. The program must demonstrate that the appropriate level of supervision is in place for all residents based on each resident's level of training and ability as well as patient complexity and acuity.

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.

Program Coordinator's Role

1. Review ACGME website for information related to Supervision and Accountability.
2. Ensure there is a global communication avenue for residents, faculty members, other members of the health care team, and patients can receive or access.
3. A policy must be in place that describes the graded authority and responsibility is in place as well as detail indirect and direct supervision. That specific language should be used in the policy.
4. Document what the program does to ensure supervision and hold faculty and resident accountable.

Professionalism (PR VI.B.)

Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

Residents and Faculty must demonstrate an understanding of their personal role and responsibility to the provision of patient and family-centered care, safety and welfare of patients, fitness for work including, time management and impairment recognition, commitment to lifelong learning, monitoring patient care improvement indicators and accurately reporting work hours, patient outcomes, and clinical experience data.

Program Coordinator's Role
1. Review ACGME website for information related to Professionalism.
2. Document didactics, seminars, webinars, articles, etc. related to patient safety, time management, fitness for work including recognition of impairment, illness, fatigue, substance abuse in themselves, others, or other members of the health care team.

Well-Being (PR VI.C.)

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

The ACGME is committed to addressing physician well-being for individuals and as it relates to the clinical learning environment. The creation of a learning environment with a culture of respect and accountability for physician well-being is crucial to the ability of those working in it to deliver the safest, best possible care to patients. The ACGME is focusing on five key areas to support its ongoing commitment to physician well-being: Resources, Education, Influence, Research, and Collaboration.

AWARE Well-Being Resources

A new suite of resources designed to promote well-being among residents, fellows, faculty members, and others in the GME community is now available on demand. This initial set of AWARE resources focuses on individual strategies for cognitive skill building, and includes a video workshop, podcasts, and the ACGME AWARE app. Institution and program leaders, as well as faculty members, residents, and fellows, are encouraged to download these educational resources for use or integration into local curricula to mitigate the effects of stress, prevent burnout, and foster well-being among members of the GME community.

Program Coordinator's Role
1. Review ACGME website for information related to well-being.
2. Contact the GME office for a list of activities and initiatives that may be available.
3. Coordinate well-being committee comprised of residents, fellows, and faculty to ensure all groups are covered.
4. Document what the program does to ensure physician well-being.
5. Familiarize yourself, trainees, and Faculty with the AWARE Well-Being Resources.
6. Know your institutional resources for mental health and well-being including crisis hotlines.

Fatigue Mitigation (PR VI.D.)

Programs must:
1. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation

2. Educate all faculty members and residents in alertness management and fatigue mitigation processes

3. Encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

Clinical Responsibilities, Teamwork, and Transitions of Care (PR VI.E.)

Clinical Responsibility

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

Teamwork

Residents must care for patients in an environment that maximizes 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 and larger health system.

Transitions of Care

Programs must identify how trainees and faculty members are educated on the process and content, where and how schedules are available and posted, how trainees are assessed for competency on the process, how trainees are monitored, and that the exchange of patient information is HIPAA compliant.

Program Coordinator's Role
1. Review ACGME website for information related to Transitions of Care.
2. Ensure policy is in place.
3. Document how transitions of care activities are monitored and evaluated.

Clinical Experience and Education (formerly known as duty hours) (PR VI.F.)

Programs must design an effective program structure that is configured in a way that provides residents with educational and clinical experiences as well as reasonable opportunities for rest and personal activities.

1. Clinical and educational work hours must be limited to 80 hours per week and are averaged over a four-week period, inclusive of all in-house clinical and educational activities, all moonlighting, and clinical work done from home. This average should be based on trainee rotations not a "rolling average".

2. Residents should have eight hours off between scheduled clinical work and education periods.

3. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call

4. Residents must be scheduled for a minimum of 1 day in 7 free of clinical work and required education (averaged over 4 weeks). At-home call cannot be assigned on these free days.

THE LEARNING AND WORKING ENVIRONMENT   **51**

5. Clinical and education work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
   - Up to 4 hours of additional time may be used for activities related to patient safety such as providing effective transitions of care and/or resident education.

Moonlighting

Moonlighting is defined as any outside activity for which compensation is received, especially when not related to the training program. Because residency/fellowship education is a full-time endeavor, the program director must approve and monitor all moonlighting to ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.
2. Moonlighting (both internal and external) must be counted toward the 80-hour maximum weekly limit.
3. Moonlighting hours must be entered in the system your program uses for tracking.
4. PGY1 residents are not permitted to moonlight.

On-Call Activities

The objective of on-call activities is to provide residents/fellows with continuity of patient care experiences throughout a 24-hour period. **In-house call** is defined as those duty hours beyond the normal workday when residents/fellows are required to be immediately available in the assigned institution. **At-home call** is defined as call taken from outside the assigned site.

1. Averaged over a four-week period, in-house call must occur no more frequently than every third night.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents/Fellows may be allowed to remain on-site for activities related to patient safety, such as to accomplish effective transfers and/or education; however, this period of time must be no longer than an additional four hours.
3. Night float must occur within the context of the 80-hour maximum and 1 day off in 7.
4. Night float cannot exceed more than 18 nights total per year.
5. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident/fellow. Residents/Fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
   - When residents/fellows are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit beginning from the time the resident/fellow arrives at the hospital (excludes travel time).
   - Time getting called back to the hospital to provide direct patient care does not restart the clock for time off between scheduled clinical periods.

Program Coordinator's Role

1. Make sure your program has a process in place for tracking resident clinical and educational work hours.
2. Monitor residents' reported hours for compliance with work hour requirements.
3. Review schedules including call schedules to avoid work hour violations.
4. Make sure your residents and faculty participate in annual training to recognize the signs of fatigue and sleep deprivation and alertness management and fatigue mitigation processes.
5. Encourage residents/faculty members to alert the program director/program coordinator when they are concerned that another resident, fellow or faculty member may be unfit for work (i.e. Displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential violence).
6. Provide residents the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
7. Make sure your program has a policy and process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
8. Learn the "Clinical Experience and Education" Section in the ACGME Program Requirements for GME in PMR (VI.F.).

DIDACTIC CURRICULUM

Didactics in medical education are a type of learning program that provide foundational education in the various sciences and disciplines that are vital for a rounded educational experience. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas through oversight of the quality of didactic and clinical education in all sites that participate in the program. The program director will use various types of conferences and/or lectures, held on a regularly scheduled basis, to teach the various subjects in the curriculum and ensure that the educational time is protected for residents. Active participation by faculty in the didactic program is also required. There are various types of didactics that can fulfill these criteria:

Case Management – Either a resident or faculty member presents a unique case to share ideas or opinions on the symptoms, diagnosis, specific treatment, and other related topics.

Didactic Lectures – Most programs have a specified block of time(s) each week protected for resident didactics. The didactics must include instruction in basic sciences relevant to physical medicine and rehabilitation such as anatomy, pathology, pathophysiology, and physiology of the neuromusculoskeletal systems; biomechanics; electrodiagnostic medicine; functional anatomy; kinesiology; effective teaching methods; medical administration, including risk management and cost-effectiveness; and use and interpretation of psychometric and vocational evaluations and test instruments in the common practice of rehabilitation medicine. There should be an alternative means for residents to experience missed lectures. Options include taping lectures, having slides available on website, and repeating lectures.

Grand Rounds – Either a faculty member, resident, or visiting professional gives a more formalized lecture. Typically held weekly, Grand Rounds participants receive CME credits if applied for and approved by the Accreditation Council for Continuing Medical Education

Journal Club – Participants discuss and evaluate articles from peer-reviewed journals at these regularly scheduled conferences.

Morbidity and Mortality – Participants discuss cases with emphasis being on quality improvement. The session usually evaluates cases with a systems or management learning objective or questionable outcome.

Program Coordinator's Role
1. The RC requires that you take attendance at these conferences. The chief resident may do this, but you need to keep copies for the site visitor.
2. With guidance of your program director or chief resident, you may be responsible for setting up the monthly schedule, obtaining room reservations, equipment requests, etc.
3. You may need to send out announcements regarding invited speakers.
4. The program coordinator must collect and maintain the evaluations by the participants of the didactic lectures and Grand Rounds for review by the site visitor.

RESIDENT SCHOLARLY ACTIVITY/SCHOLARSHIP (IV.D.)

ACGME Program Requirement states 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. Residents should participate in scholarly activity. The sponsoring institution and program should allocate adequate additional resources to facilitate resident involvement in scholarly activities.

Each PMR program should have a structured research course for their residents to advance their knowledge in research including statistics, literature review, manuscript writing, different types of research, and IRB submission. Residents should investigate one topic in depth. Outcomes of this research/investigation could include: a chapter or review article; a local, regional, or national presentation; a case report/series presented as a poster or platform presentation at a national meeting; preparation or submission of a manuscript for publication; or a research project.

- The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims.
- The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.
- The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.

Program Coordinator's Role
1. Scholarly activity will need to be reported for both core faculty and residents during the Annual Program Update in ADS so keep an ongoing list of resident and faculty publications and presentations.
2. Some programs have a formal "Research Day" to have senior residents present their research project they've worked on throughout residency to all the faculty and residents.
3. Try to incorporate a literature review presentation and a case presentation by residents so they are involved in scholarly activity throughout their training.

RESIDENT COMMITTEES

All PM&R programs are required to have regular, documented Program Evaluation Committee (PEC) meetings (*refer to the Evaluations section*). At least one resident representative should participate on the PEC; however, we suggest that you have resident representation from each PGY level on the committee.

Other institutional committees with resident representation may include the Graduate Medical Education Committee, Undergraduate Medical Education Committee, and Resident Recruitment Committee.

Programs should encourage "resident-only" meetings to foster social and professional relationships as well as provide support for each other.

Program Coordinator's Role
1. Participate as a member of the PEC.
2. Schedule PEC meetings, notify members of the meeting times and locations, prepare the agenda and materials, and take minutes.
3. Initiate and facilitate selection of resident representation for the committee.
4. Implement changes or new policies established by the committee.
5. Communicate changes and/or new policies to affected individuals.
6. Keep a record of each resident's involvement on committees.
7. Coordinate peer-nominated positions to GMEC.

RESIDENT TRAVEL

Rules for resident travel vary per institution; in addition, institutions must abide to rules mandated by certain states. Consult your institution's policies and procedures manual to learn more about travel requirements.

When residents are traveling abroad for programmatic experience, they must meet certain conditions. Resident must inform the program director of the goals and objectives, who will supervise the resident, and the source of the funding. In addition, the experience must comply with the ACGME and RC requirements. Some programs may provide funding for residents to attend national meetings. Registration forms, hotel reservations, and plane arrangements may be required.

Program Coordinator's Role
1. Ensure all funding (if needed) is approved and the proper paperwork (e.g., rotation, malpractice insurance, licensing, program director's approval, institutional agreement, etc.) is processed accordingly, to allow resident to complete the proposed travel.
2. Assist resident in registration and travel arrangements for meetings, according to your program's policies and procedures.
3. Submit appropriate paperwork and receipts for reimbursement for travel expenses.

GRADUATION

Graduation is a time to celebrate and recognize the accomplishments of Physical Medicine and Rehabilitation trainees (i.e., residency, research or clinical fellowships, and Orthotic, Prosthetic, or Rehabilitation Engineering internships, etc.). Every program may want to establish its own graduation traditions. Listed below are a few suggestions for awards, receptions, and dinner celebrations. The size of your program, as well as your budget, should determine how elaborate an event to hold and what type of awards to present.

Graduation Reception

Plan a reception to honor the department's graduates. This celebration with department personnel such as physical therapists, occupational therapists, rehab engineers, orthotists, prosthetists, nurses, and support staff provides the opportunity to congratulate the graduates and bid them farewell. The reception should be on-site, at the end of a working day, and at the end of an academic year, before the graduates leave for their prospective jobs. A garden, lobby, or courtyard is the perfect setting for punch, hot and cold hors d'oeuvres, and desserts, making it easy to mingle. The department may present a gift (e.g., desk clock, pen sets, etc.) with the graduate's name, department, and year engraved on the gift to each graduate. The graduate's program director, or mentor, could present the gift and give a brief description of the graduate's accomplishments and future endeavors. The emphasis of the reception should be on recognition and celebration—not on elegance and expense.

Attendees may receive the following awards during the graduation reception:
1. Gifts for graduates
1. Certificate of completion
2. Teaching Award—presented to a faculty member
3. Peer Teaching Award—presented to a resident for resident-to-resident teaching
4. Clinician Teaching Award—presented to an allied health professional working with residents
5. Lecture Attendance Award—presented to a resident for superb attendance at lectures
6. Research Award – presented to a resident with the best research project
7. Excellence Award – presented to the resident who exemplified outstanding qualities

Note that the above items can also be given at other events like graduation, and each program handles these differently.

Graduation Dinner

The institution honors the MD/DO graduates with a formal evening celebration at a restaurant or reception hall. Invite the residency coordinator, attending physicians, resident physicians, and their guests to attend the graduation dinner. Smaller programs may also want to include Ph.D. staff. The guest list will depend on your program's budget. The coordinator is responsible for a smooth setup and the after-dinner program. The program coordinator can provide guidelines in making this event as elaborate as the budget allows.

Resident Appreciation Day (Optional)

Residents may also be rewarded an appreciation day. Residents would be required to round on patients, write notes, and do last-minute admits or discharges. Residents on outpatient assignments should assist their fellow residents on inpatient services. The residents leave at noon and gather at a park for lunch then go canoeing, bowling, or another recreational activity. At 5 p.m., the residents return to their services, if necessary, and the on-call residents resume their responsibilities. The appreciation day is the final event for graduates to socialize with their fellow residents. If a resident is not interested in the activities of the appreciation day, they should continue their work assignment. This event must receive approval from the chair and program director(s).

Program Coordinator's Role

1. Order certificates from the Graduate Medical Education Office well in advance of graduation dinner. Double check spelling of graduate's name. Get the required signatures on the certificates. Once you have all signatures, make a photocopy of the certificate to keep in the resident's file. You may choose to present the certificates at one of the celebrations or hold them until the last day of their residency.
2. Send out graduation invitations and announcements.
3. Establish the location and make reservations.
4. Decide on the menu for dinner and reception.
5. Make place cards or name badges.
6. Distribute, collect, and tally the ballots for award nominations.
7. Purchase the awards and gifts, and arrange for the engraving, if necessary.
8. Coordinate individual graduate and group photos.
9. Obtain speakers for program.
10. Arrange for entertainment.
11. Prepare program agenda.
12. Organize "Appreciation Day."
13. Schedule exit interviews of graduating residents with the program director
14. Provide residents with a copy of their procedure list
15. Collect resident pagers, parking tags, institution badges, new address, etc.

Physical Medicine and Rehabilitation Coordinator
Calendar of Events

While duties may vary between programs and institutions, below are some outlines of what a program coordinator commonly handles in an academic year:

MONTHLY

- ☐ Work Hour Reports (averaged over 28 days)
- ☐ Call Schedule
- ☐ Clinic Schedule
- ☐ Didactic Schedule
- ☐ Parking
- ☐ Provide goals and objectives for upcoming rotations
- ☐ Directions and onboarding for visiting / rotating learners
- ☐ Birthday Club
- ☐ Update Research / QI List
- ☐ Update Electives List
- ☐ Track Mid / End of Rotation Evaluations
- ☐ Send Upcoming Residency Events List
- ☐ Conference Attendance Tracking
- ☐ Review and manage program committees (DEI, Wellness, Education, etc.)

WEEKLY

- ☐ Work Hours Review
- ☐ Management of emails and resident needs

ONGOING

- ☐ Verifications
- ☐ Loan Deferments
- ☐ Time Off Request
- ☐ Poster Deadlines
- ☐ Corporate compliance (TB, ACLS, BLS, Safety modules)
- ☐ Special Conferences/Workshops
- ☐ Website and other promotional item updates and maintenance

July

Accreditation
- Accreditation Database Systems (ADS) Updates Prep
  - Get CV's and scholarly activity information from residents / faculty
- ACGME Case Log Data Window (July and August)
- ACGME Case Log Archive deadline (August 1)

Events
- GME / Institution Orientation
- Department Orientation
  - Complete all required onboarding paperwork for your institution and rotation sites
- Set dates for any retreats or program specific events

Meetings
- Annual Program Evaluation (APE) Meeting
  - Review previous year's Action Plan
  - Review ACGME Resident / Faculty / Wellness survey results
  - Set goals for upcoming academic year

Program Updates / General Maintenance
- Schedule various yearly meeting and events (CCC, mentor meetings, mid-year PEC, etc.)
- AAPMR
  - Membership registration for residents and faculty
  - Registration for SAE Exam
    - Reserve location for exam / send "save-the-date" for event
  - Registration for AAPMR Annual Conference (if applicable)
- ABPMR
  - Online ABPMR Registration Forms for new residents / fellows (due August 1)
  - ABPMR Continuing Resident Evaluations (due August 1)
- AAP
  - Membership registration for Academic Partnership, faculty, residents, and program coordinator(s)
- New Resident Data Entry
  - Update online evaluation system (New Innovations, MedHub, etc)
  - Specialty Board Database
  - Update all program rosters, schedule templates, and program profiles
- Complete Medicare and Medicaid enrollment for residents
- Complete DEA / KASPER registration for residents
- Begin moonlighting approval forms for eligible residents
- Provide policy and procedure manual / resident handbook with updated policies
- Update committee members for academic year

Recruitment
- NRMP and ERAS open for Fellowships (July 15th)
- Choose recruitment dates for residency

August

Accreditation
- Accreditation Database Systems (ADS) Updates
  - Enter and update requested information in the database
- ACGME Case Log Data Window (July and August)

Program Updates / General Maintenance
- Set up Billing and Coding modules

Recruitment
- Meet with recruitment committee to plan various aspects of recruitment day:
  - Conduct a meeting to review recruitment logistics
  - Email interview days to faculty and chiefs/residents to solicit availability to participate
  - Review/Update Eligibility and Selection criteria
  - Check "give-a-way" inventory and reorder if necessary
- Update all templates used for recruitment (rosters, emails, invitations, presentations, etc.) and recruitment packets
- Place orders for SWAG and materials (folders, boxes, software, etc.)
- Review NRMP Schedule of Dates – (click here)
- Install ERAS Workstation – erashelp@aamc.org or 202-828-0413

September

Accreditation
- Accreditation Database Systems (ADS) Updates Prep
  - Finalize all information and submit to DIO

Meetings
- Mentor Meetings (CCC)
  - Schedule and complete paperwork related to mentor meetings (semi-annual forms)

Program Updates / General Maintenance
- Schedule photo day for faculty and residents
- Faculty appointment renewal documentation / promotional materials

Recruitment
- NRMP and ERAS open for Residency (September 15th)
- PD and PC begin review of applications
- Recruitment committee finalizes all related decisions
  - Both faculty and resident rank meetings scheduled

October

Accreditation
- Annual Program Evaluation (APE) Documentation completed

Events
- Program Retreat (if applicable)

Meetings
- Mentor meetings (CCC) continue
  - Collect paperwork, feedback, and data for CCC meeting

Recruitment
- October 1st – Dean's Letters (MSPE-Medical School Performance Evaluation) are released in ERAS.
- Send invitations and schedule recruitment interviews

November

Accreditation
- Annual Program Evaluation (APE)
  - Send out survey and collect mid-year data

Events
- AAPMR Annual Conference

Meetings
- Clinical Competency Committee (CCC) Meeting (Nov. or Dec.)
- ACGME Mid-Year Milestone Reporting opens

Program Updates / General Maintenance
- ABPMR Examination Irregularity Policy, Nondisclosure Policy, and Cooperation Agreement (Due November 15th)
- AAP Conference Registration
  - Look for registration codes for those who are academic partners
  - Book hotel and flights
- ACGME Conference Registration
  - Book hotel and flights

Recruitment
- Interviews are being conducted

December

Events
- Holiday Party

Meetings
- Clinical Competency Committee (CCC) Meeting (Nov. or Dec.)
  - Issue of committee decision (via letter or formal evaluation)
- Semi-Annual Meetings with the PD
  - Documentation of CCC final decision and any deficiencies
  - Completion of the semi-annual evaluations
- ACGME Mid-Year Milestone Reporting
- PD enters milestones after CCC meeting
- Annual Program Evaluation (APE)
  - Conduct mid-year meeting to review action items and mid-year survey data for improvements (Dec. or Jan.)

Program Updates / General Maintenance
- Flu / other required vaccination documentation
- Holiday schedule
- AANEM
  - Registration for EDX-SAE Exam
    - Reserve location for exam
    - Send "save-the-date" for event
- SAE Exam materials / passwords should arrive from AANEM

Recruitment
- Interviews are being conducted

January

Accreditation
- Schedule CCC meetings for the end of the academic year

Events
- SAE Exam
  - Proctor exam and ensure that all applicable residents take the exam

Meetings
- Annual Program Evaluation (APE)
  - Conduct mid-year meeting to review action items and mid-year survey data for improvements (Dec. or Jan.)

Program Updates / General Maintenance
- PGY-4 Completion of Training Prep
  - Complete GME verifications and certificate forms
  - Reminder to submit ABPMR applications (January 31st)
  - Reminder to start thinking of terminal vacations and last working days
- Nominations / Opt Outs for chief resident position(s) for the next academic year
- Follow up on outstanding USMLE and COMLEX Step 3
- Start planning any "Thank a Resident Day" activities
- Planning for departments Graduation event
  - Work with department to determine date and venue
  - Book venue and confirm date
  - Finalize contracts and deposits

Recruitment
- Conclude interview season and prepare for rank meeting
- NRMP Quota change deadline January 31
- Resident and Faculty rank meetings (Jan. or Feb.)
- Schedule second looks (if applicable) prior to rank list deadlines

February

Accreditation
- ACGME Resident and Faculty Surveys become available to send out to program participants in ADS

Events
- Program Retreat (if applicable)
- AAP Annual Conference
- ACGME Annual Conference
- Thank a Resident Day Festivities (usually the last Friday in Feb.)

Program Updates / General Maintenance
- Send out survey / poll for chief resident votes
- Planning for departments Mock Oral Boards event
- Planning for departments Graduation event
    - Send "save-the-date" to all attendees
    - Order graduation certificates and ensure correct graduate information

Recruitment
- Resident and Faculty rank meetings (Jan. or Feb.)
- PD to finalize rank list in NRMP
- Work on creating a post-match survey
- ERAS Registration (may be handled by GME office)
- NRMP Rank Order Deadline: 4th Wednesday of February by 9:00 PM EST

March

Accreditation
- ACGME Resident and Faculty Survey

Events
- Match Day Party

Program Updates / General Maintenance
- License Renewal Forms
- Contract Addendum Forms (Re-appointment agreements)
- GME Appointment Forms (change PGY level and salary)
- Start working on next AY master schedule and rotation paperwork
  - Send requests to off-services for non-PMR rotations
  - Being working on off-site paperwork renewals
- Announce new chief resident(s)
- Planning for departments Graduation event
  - Send "save-the-date" to new incoming residents
  - Order graduation materials and gifts
  - Work on food and drink options
- Send graduates information on requirements to graduate the program and what has / has not been completed

Recruitment
- Match Week
  - See if your program filled all available positions
    - If not: SOAP Begins
  - Learn which individuals matched
  - Save electronic copy of Confidential Roster report
  - Complete all required paperwork for GME onboarding
  - For Advanced Programs whose residents start at the PGY-2 level or for programs taking in transfer residents
- Send Post-Match Survey
- NRMP Match Results: 3rd Week in March

April

Accreditation
- Annual DIO Report
- Send post-graduation survey to graduates 1 year and 5 years out of residency.

Events
- Mock Oral Boards

Meetings
- Mentor Meetings (CCC)
  - Schedule and complete paperwork related to mentor meetings (semi-annual forms)

Program Updates / General Maintenance
- Start on End of Year / Academic Year Transitions
  - Graduates:
    - Confirm all requirements for graduates have been met, and notify if not
    - Schedule exit interviews with PD
    - Get exit information (last working day, terminal vacation, post residency plans, etc.)
  - New academic year setup
    - Schedule and start planning orientation dates
    - Confirm and compile all master schedule rotation items (off-service agreements, Master Affiliation Agreements (MAA), Program Letter of Agreements (PLA), etc.)
    - Get vacation requests from incoming and continuing residents
    - Review evaluation setup and format and revise as needed
  - Chief resident transitions and overlap for training
  - Incoming and continuing setup
    - Order items for residents per PGY level (ID badge, lab coats, scrubs, educational materials, etc.)
- Schedule new AY PEC meeting
- Planning for departments Graduation event (con't)

May

Accreditation
- GME Track for Program Information
- Update program policies
    - Resident Handbook
    - Policy and Procedure Manual
    - PEC and CCC policies
    - Goals & Objectives

Events
- EDX SAE Exam
    - Proctor exam and ensure that all applicable residents take the exam

Meetings
- Mentor meetings (CCC) continue
    - Collect paperwork, feedback, and data for CCC meeting
- Clinical Competency Committee (CCC) Meeting (May or June)

Program Updates / General Maintenance
- Continue New Year Setup
- Send survey / poll to vote for program representatives for various committees (both dept. and GME level)
- Graduates
    - Schedule exit meetings with PD
    - Finalize all graduate data and plans
    - Confirm all requirements for graduates have been met
- Planning for departments Graduation event
    - Send formal invitation with all relevant info and request RSVPs
    - Create program agenda
    - Finalize all menu and event selections
    - Make final payments
    - Order award and related certificates
- Planning for departments Orientation event
    - Coordinate orientation schedules
    - Schedule trainings (EPIC, ACE-IT, ACLS, etc.)
    - Update presentation materials and handouts

Recruitment
- Schedule Interview Days for Fellowships

June

Accreditation
- ABPMR
  - PGY-4 and Fellow Completion Evaluations (due July 1)
  - Annual Survey
- GME Track for Resident Information

Events
- Graduation
  - Ensure setup for event is properly done
  - Ensure that all food, drinks, and presentation go off without issue
  - Present awards, certificates, and gifts to graduates and other residents

Meetings
- Clinical Competency Committee (CCC) Meeting (May or June)
  - Issue of committee decision (via letter or formal evaluation)
- Semi-Annual Meetings with the PD
  - Documentation of CCC final decision and any deficiencies
  - Completion of the semi-annual evaluations
- ACGME Mid-Year Milestone Reporting
- PD enters milestones after CCC meeting

Program Updates / General Maintenance
- Plan Annual Program Evaluation (APE) meeting
  - ACGME Resident and Faculty Survey results published on ACGME website
- Summary evaluations for all graduating residents for file/verifications
- Finalize the master rotation schedule
  - Ensure PGY-1 residents' schedules meet ACGME requirements, i.e. 1-month PMR
  - Ensure PGY-4 residents' schedules meet ACGME requirements, i.e. 12 months inpatient, 12 months outpatient, etc.
- Finalize Orientation event planning

SPECIAL EVENTS

Special events take place throughout the residency year. They are crucial to the overall effectiveness of the physical medicine and rehabilitation program. Special events promote team building, contribute to high morale, and demonstrate that the overall well-being of residents is important to the program. You can hold special events on location and/or other venues.

Special events can encompass a broad spectrum of activities. The number of yearly events varies among programs depending on availability and funding. Special events can include a dance, football games, family picnics, happy hours, etc. The following is a list of sample activities you may wish to plan:

JULY	JANUARY
Orientation Welcome Cookout Picnics Pool Party Lunches River Excursion Intern Dinner Fish Fry	Mid-Year Party
AUGUST Retreat Resident Breakfast Meeting Get Together Dinner	**FEBRUARY** AAP Annual Meeting Mardi Gras Party Valentine's Day Potluck Luncheon Resident Breakfast Meeting FUNuary *(competitions between faculty and residents)*
SEPTEMBER Retreat (with families)	**MARCH** Post-Match Party AAP Annual Meeting
OCTOBER Retreat Resident Breakfast Meeting Get Together Dinner	**APRIL** Softball Game
NOVEMBER Thanksgiving Breakfast AAPM&R Academy Meeting	**MAY** Resident Jeopardy Game Canoe Party Senior Dinner for Faculty
DECEMBER Holiday Party Holiday Potluck Luncheon Holiday Dinner— Resident & Spouse	**JUNE** Graduation Party Reception for Family Night Cookout for Senior Class Country Club Day Pager Exchange Ceremony

ANNUAL PROGRAM EVALUATION (APE) CHECKLIST

Note that not all the items listed below are required, but helpful for generating an action plan and annual program evaluation.

- ☐ ABPMR Board Results – Part 1
- ☐ ABPMR Board Results – Part 2
- ☐ ACGME Survey – Faculty and Residents
- ☐ APOR (Annual Program Oversight Review)
- ☐ Aims and Mission Statements
- ☐ Career Placement
- ☐ CCC Comments
- ☐ Common Program Requirements
- ☐ Conference Attendance
- ☐ Didactic Evaluations
- ☐ Faculty Development
- ☐ Faculty Performance Evaluations
- ☐ Major Changes
- ☐ Milestones Evaluations
- ☐ Multi Source Evaluations (Patient, Peer, Nurse, PT, OT, Speech, Staff)
- ☐ NRMP Match
- ☐ PLA's (Program Letter of Agreement)
- ☐ PMR Mock Orals
- ☐ Policies
- ☐ Post-Graduation Survey
- ☐ Post-Match Survey
- ☐ Procedure Logs
- ☐ Program Evaluations/SWOT – Faculty and Residents/Fellows
- ☐ Program Requirements Review
- ☐ Quality Improvement / Patient Safety Projects
- ☐ Recruitment (include Diversity statistics)
- ☐ Research Project
- ☐ Resident/Fellow Performance Evaluations
- ☐ Resident Retreat Report
- ☐ ROCA
- ☐ Rotation Evaluations
- ☐ RRC LON (Letter of Notification) Review
- ☐ SAE EMG Results
- ☐ SAE PMR Results
- ☐ Scholarly Activity – Faculty and Residents
- ☐ Transitions of Care
- ☐ Well-Being
- ☐ Work Hours