Program Coordinator’s Organization

University of Arkansas for Medical Sciences
Little Rock, Arkansas
Program Coordinator Manual
Program Coordinator’s Manual

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SECTION 1

INTRODUCTION
This Program Coordinator’s Manual is a compilation of ideas from experienced coordinators to new coordinators. The knowledge and expertise, on these pages, present a guide to help you become an experienced coordinator also. Teamwork is a key to the success of the Program Coordinator’s Organization, and that teamwork and effort is what has developed this Handbook for you. Use it with pride in knowing you are part of the Program Coordinator’s Team. Thank you to everyone who placed their knowledge into this Manual. It is a job well done and will be appreciated and used for years to come.

THE PROGRAM COORDINATOR’S ORGANIZATION (PCO)

MISSION
The mission of the Program Coordinator’s Organization is to provide sources of information to all program coordinators, to aid new coordinators in learning their responsibilities, to serve as mentors to new coordinators, and to provide and develop tools to build professional skills as coordinators.

OBJECTIVES
1. Formulate innovative ideas for program coordination.
2. Learn helpful tips to facilitate coordination.
3. Gain insight on how to develop program materials.
4. Enhance and/or fine tune personal and professional skills.
5. Increase job satisfaction.
6. Recognize the marketable skills of a coordinator.
7. Determine skill growth opportunities.

PROGRAM COORDINATOR’S ROLE AND RESPONSIBILITIES¹
OVERVIEW (Suggested possibilities – as directed by Program Director)
Also see Section 5.2 Sample Job Description of the Residency Program Administrator

A. Accreditation
1. Be familiar with current Accreditation and Residency Boards requirements, through the Accreditation Council for Graduate Medical Education (ACGME) and know where to find them.
2. Organization and maintenance of information needed to complete the Program Information Form (PIF) provided by the ACGME.
3. Preparation of PIF for Resident Review Committee (RRC) site visit.
4. Manage, prepare, and assist with site visits.

B. Budget
1. Manage and/or assist with the program’s educational fiscal budget.
2. Review financial program reports.
3. Process invoicing for program expenses.

C. Credentialing
1. Collect credentialing data and maintain credentialing records, i.e. rotations, documents required by rotation sites, etc.
2. Schedule residents/fellows for credentialing courses, i.e. ACLS, etc.
3. Prepare requested program surveys.

D. Scheduling
1. Scheduling program related activities: conferences, electives, vacations, rotations, teaching courses, committee meetings, recruitment, events (retreats, orientation, graduation), etc.
E. Recruitment
1. Plan, develop, and maintain recruitment activities for House Staff.
2. Review letters, applications, and inquiries to identify appropriate candidate for the training program in accordance with the established criteria (credentials, licensures visas, screening, etc.).
3. Participate in the ranking process for residency candidates.
4. Represent the hospital at conferences and recruitment fairs to recruit candidates for residency program.
5. Contribute to the evaluation of candidates.
6. Annual update of FREIDA survey.

F. Coordination – Administrative
1. Manage the daily, monthly and annual operations of the residency program.
2. Coordinate specific activities related to the program, i.e. (accreditation, credentialing, scheduling, recruitment, etc.) including timing, logistics, and participants.
3. Perform administrative duties, i.e. maintain resident files, document conference attendance, update resident and teaching schedules, etc.

OTHER RESPONSIBILITIES
The Program Coordinator’s role varied among residency/fellowship programs. Program coordinators may have combined jobs and may be required to perform different functions outside the realm of the Program Coordinator’s role. For example…

G. Resident Support/Morale Building
1. Recognize and acknowledge resident’s contributions.
2. Contribute to a positive residency environment.
3. Serve as a sounding board.
4. Be available at all times for residents.

H. Management
1. Implement the hospital and department policies, procedures, and objectives within the Department.
2. Provide supervision of support personnel including interviewing, mentoring, and evaluation.

Optional: Insert your job description in this section.
This is an area you can refer to whenever necessary.

¹ (Reprinted with permission of the Association of Pediatric Program Directors (APPD) Administrator’s Executive Committee)
WORKSHOPS AND PROGRAMS

Accreditation Council for Graduate Medical Education (ACGME)
Annual Educational Conference held in March of each year.
Registration available online at http://www.acgme.org.
Workshops include sessions for Program Coordinators (Administrators)
Good for new and experienced coordinators.

National Center for Evaluation of Residency Programs (NCERP)
Annual Workshops and Conferences – Specialty Specific
Registration and information available online at http://www.ncerp.com/workshop.htm
Questions or comments can be sent to Dr. Don Bosshart at dbosshart@ncerp.com
Workshops include sessions exclusively for Program Coordinators (Administrators)
Especially good for new coordinators and a chance to share for experienced coordinators.

Program Coordinator’s Organization
Meets once a month on the first Tuesday, unless otherwise noted.
No reservation required.
Meetings include sharing sessions, information on New Innovations, updates from the GME Office, special speakers, and presentations to help the new and experienced coordinator.
Good for all program coordinators/administrators.

Check Other Possibilities
Check out the American Medical Association and the Subspecialty workshops that are offered through Societies, and American Academies.
Be sure to get your name on the List-Serv of these organizations so that you will receive information on these workshops and updated news and notes. A List-Serv disseminates information through email and will safely include your address on notices, as they come out.
SECTION 2.1
GME Track/FREIDA, WebCT

The UAMS College of Medicine conducts a survey of all of its residents and fellows through the Graduate Medical Education (GME) Annual Survey. This survey helps to monitor and improve the quality of education throughout the individual residency/fellowship programs, and the hospitals through which residents rotate (ACH, CAVHS, ASH, UAMS, and UH). The GME Committee, composed of Residency/Fellowship Program Directors, Program Coordinators, Residents, and Fellows, review the ratings residents and fellows provide in the Annual Survey. These ratings are then used as an impetus for improvements.

The Office of Educational Development (OED) at UAMS is responsible for creating the survey according to the standards set by the administration. The OED then posts the survey on WebCT, troubleshoots and maintains the survey, and collects the data when the survey has been completed, by all eligible residents and fellows. Once the data has been collected and statistically analyzed, the results are sent to the GME committee. The data is finally passed to program directors and department chairs, to target areas for improvement. The individual programs can work out a plan to make changes if needed.

Each year, the Annual Survey is opened in WebCT around March 15, and continues until May 31. Residents/Fellows are required to complete it in order to receive their annual pay raise or receive their certificate of program completion. Residents go to http://distance-ed.uams.edu and log in to take the survey. The survey takes about 45 minutes to complete and can be accessed from any computer with Internet service, including home computers. The next page includes the instructions for the WebCT data entry.
2.1a Annual GME Survey – Using WebCT

As part of the yearly registration process and a requirement for continued accreditation of the residency/fellowship programs, residents and fellows must complete a confidential questionnaire about their educational program. All residents and fellows must participate except those who began their current residency/fellowship program on or after November 1 of this academic year (i.e. if you started on November 1, 2004, you do not complete the survey in 2005).

Your input is essential and is used by the Graduate Medical Education Committee to improve the educational environment. The committee has acted on results of last year’s survey at the institutional and program levels. The survey has easy to follow instructions and takes about 45 minutes to complete. The survey is only available through the UAMS WebCT web site at http://distance-ed.uams.edu

It must be completed between March 15 and May 31.

You may access it at any of the following locations:

1. Any PC on campus with access to the UAMS homepage, including PCs in the Learning Resource Center.
2. Any PC in the College of Medicine Housestaff Office, located in the Dean's Office, 1st floor of University Hospital, room M 1/1021
3. Your own PC at home with Internet access.

Access:

1. From Internet Explorer go to http://distance-ed.uams.edu
2. Choose Login to WebCT
3. Type in your WebCT ID and password
   - WebCT ID is last name followed by first name; your middle initial may or may not be included (based on previous use of WebCT). For example: John E. Doe’s WebCT ID might be doejohn or doejohne, try both
   - Password is all nine digits of your social security number with no dashes For example: social security number 123-45-6789 would be 123456789
4. This takes you to the “My WebCT” page
5. Select the Annual GME Survey in the upper left-hand section
6. Read the general information and the instructions for completing the survey
7. Select the Annual GME Survey button to access the survey
8. Select the Annual GME Survey link
9. Select the gray “Begin Survey” button
10. A new screen will appear, you may now begin the survey

Key Points:

- You must select “Save Answer” for each question to save your answer
- After completing the entire survey, you must select “Finish” to submit the survey
- Immediately following selecting the final “Finish” button, you will see a message from Dr. Jim Clardy to confirm that you have correctly submitted the survey.
- Note: A few residents/fellows who have similar names will be assigned and notified of special usernames that must be used to access the Annual GME Survey and all web-based courses.
- If you have problems accessing or completing the survey, contact Office of Educational Development, Janet Whitten (686-5720) whittenjanett@uams.edu or Cindy Mercado (603-1634) mercadocynthiac@uams.edu

Remember: You must complete this by May 31. Thank You
SECTION 2.2
Web Accreditation Data System (ADS)

Background
Accreditation of GME programs is accomplished through a peer review process, and is based upon established standards and guidelines. Currently, ACGME accreditation activities depend, to a great extent, on a site visit and the Program Information Form (PIF). The site visit serves to clarify and verify information, and measures the extent to which the PIF reflects reality. The ACGME operational support, for data analysis and other support activities related to accreditation, continues to move toward ongoing data collection and analysis, rather than data collection just occurring at the time of the site visit. All programs will be profiled annually, and concise reports will be provided to the Residency Review Committees (RRCs) for interpretation. This shift will offer many efficiencies; for the program director, the sponsoring institution, and the Residency Review Committee (RRC).

The first phase of the transition, from dependency on the PIF form and site visit to ongoing communication, with all accredited residency programs and the sponsoring institutions, involves moving a portion of the paper-based PIF to a user-friendly web-based system. The data elements, critical for accreditation and common to all disciplines, have been defined, and these elements generally constitute the 'institutional and program demographic' section of the PIF.

Specifically, the Web Accreditation Data System (ADS) is an Internet based data collection system that contains the current data on file with ACGME for all sponsoring institutions and programs. Sponsors and accredited programs are required to verify and update general information annually, in a secured environment. In addition, programs will be required to verify the accredited training of all residents, and to communicate organizational changes as they occur (https://www.acgme.org/ADS).

Over time, the PIFs for all specialties will be rewritten to exclude these common elements collected annually. Prior to a site visit, the program will print the web information and attach it to the specialty specific portion of the PIF. At this time, the PIFs for several specialties have been re-organized and now follow the Part 1 and Part 2 format. They are available in the Program Information Form Section of the ACGME website (www.acgme.org). The specialties with the converted PIF can use the ADS system to generate Part 1 of the PIF. Contact WebADS@acgme.org to obtain the updated list of specialties with new PIFs. Over the next several years, more specialty specific information from the PIF will be made available over the web.

Other site visit related items are moved to the web for collection. Specifically, any program site visited after July 2002 must complete the Competencies and Assessment Form.

Data Collaboration with Other Professional GME Organizations
There are an increasing number of entrepreneurial GME data collection systems available. Some of these are tailored for a single discipline and others are quite broad. Because licensing data from an existing system would require post-collection primary source verification and due to the fact that many existing systems exceed the data needed for accreditation and may offer the data commercially, the ACGME will continue to collect and own the data needed for accreditation decisions.

You may be asked by several other organizations to provide program and resident data similar to the information provide in ADS. Therefore, the ACGME has created a new feature in ADS that allows programs to request their completed information in file format for internal use or for submission to other organizations of your choice (Download My Data).

List of All Accredited Programs
To view basic information on ACGME-accredited programs, select the Accredited Programs and Sponsors link from the ACGME homepage (www.acgme.org). This information, on all programs, is available to everyone, including potential residents, other programs, and the general public. This section has been revised to reflect data maintained and updated from the Accreditation Data System (ADS).

**Access to the Application** The Accreditation Council for Graduate Medical Education (ACGME) has provided each program and sponsoring institution with a User Identifier and Password to access the data system. The Designated Institutional Officials (DIOs) 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.

Access to the system is available through most commonly used Internet Browsers and providers. No specific software is required and no software will be sent or needs to be downloaded to operate the web accreditation data system.

**Security** The accreditation data may be entered from any PC connected to the World Wide Web, and the site is secured by a 128 bit SSL encryption certificate obtained through the Verisign Corporation. The data you provide will be used by ACGME for accreditation, will be maintained confidentially, and will not be distributed for commercial use.

**Help-Contact ACGME** As you use this application, do not hesitate to call your assigned ADS Representative or email WebADS@acgme.org. Additionally, you may contact the ACGME support center (312-755-7464) and someone will direct you to the proper ADS staff. The Center is staffed from 8:00 a.m. to 5:00 p.m. Central Time Monday through Friday. Voicemail is used when staff is busy on other calls.

From [http://www.acgme.org/acWebsite/ads/ads_intro.asp](http://www.acgme.org/acWebsite/ads/ads_intro.asp)
SECTION 2.3
Maintaining the Educational Records of Residents/Fellows
Guidelines for Program Directors and Program Coordinators

There are two types of records maintained for residents/fellows who are currently in, or have completed ACGME-accredited residency/fellowship programs sponsored by the College of Medicine.

1. **Dean’s Office Personnel File:** The Director of House Staff Records (DHR) maintains a file on each resident/Fellow which includes:
   - Biographical data sheet
   - VISA information and ECFMG certification
   - Signed letter of appointment (contract)
   - Other employment information.

   When the resident/fellow graduates or leaves the program, this record is converted to a microfilm document. The DHR maintains a record of training dates for each resident/fellow, which is to verify information requested by licensing bodies or hospitals and the home address and/or business address at the time they clear UAMS. The DHR verifies only the dates the trainee was in a program in the COM, by does not verify successful completion or credit for training. Information about successful completion or credit for training is maintained by the training program director.

2. **Department File:** The training Program Director maintains the permanent educational record for each resident/fellow. Most of the documents described below should be kept for minimum of five (5) years, but most programs maintain the files indefinitely. The file should include, but is not limited to:
   - **Documents** considered directly related to the academic and professional development of the resident; examples include in-service examinations, surgical procedure/log books, results of skills tests, results of assessments of the general competencies;
   - **Written evaluations by faculty and others** – these may be monthly, quarterly, rotational, every six months, annually, end of training. Such evaluations stipulate the degree to which the resident/fellow has mastered each component of clinical competence and skills identified in the program’s curriculum. These should be reviewed periodically with the resident/fellow, and the resident/fellow should acknowledge (usually by signature) that the review has been provided;
   - **Program Director’s final written evaluation** for each resident/fellow who completes the program. This evaluation must include a review of the resident/fellow’s performance during the final period of training and should verify that the resident/fellow has demonstrated sufficient professional ability to practice competently and independently and should verify successful completion or credit for training. This final evaluation should be part of the resident/fellow’s permanent record maintained by the Program Director;
   - **Documentation of disciplinary or remediation actions** – when a training Program Director counsel a resident/fellow about a particular academic or behavioral issue, the training Program Director should record the discussion in written format. Documentation that reflects the legitimate professional development and skills of the resident/fellow should remain a part of the permanent record. However, if a resident/fellow had one episode of difficulty and then improved to the expected level, the Program Director would have the discretion to remove this documentation from the permanent file. Training
Program Directors may seek advice from legal counsel about documents and records in cases of disciplinary actions. Documents about formal grievance proceedings should be kept separate from the resident's educational file;

- **Documents about medical conditions** should be kept separate from the resident's educational or personnel file;

- **Optional documentation** – documentation primarily to assist the Program Director in remembering the facts can be placed in a separate file maintained by the Program Director.

Residents/fellows must have access to their educational record and can review their record (while being observed). Upon request by the resident/fellow, a copy of all contents of their record must be provided to them. All patient identification included in these records should be redacted.

I:\GME\GME\POLICY\Guidelines for Educational Records.doc
SECTION 2.4  
Board Information Tracks

Each Residency/Fellowship Program answers to a Board (i.e. American Board of Internal Medicine). The program must process resident/fellowship information to these boards each academic year. These individual Boards usually contact the program to update their data and enter the Clinical Competence Reports for each individual Resident and/or Fellow. The Board uses this information to verify satisfactory completion of training. When a Resident or Fellow completes their training satisfactorily, they are reviewed by the Board to sit for their subsequent exam.

Individual Board information can be placed after this page.
SECTION 3.1
The ACGME: Information from http://www.acgme.org

What is the Accreditation Council for Graduate Medical Education?  The ACGME is a private, non-profit organization that accredits about 8,000 residency programs in 119 specialties and subspecialties affecting nearly 100,000 residents. Its mission is to improve the quality of patient care through improving and maintaining the quality of graduate medical education for physicians in training in the United States.

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits medical residency programs in the United States.

The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education for physicians in training.

The ACGME's member organizations are the American Board of Medical Specialties, American Hospital Assn., American Medical Assn., Association of American Medical Colleges, and the Council of Medical Specialty Societies.


Why was the ACGME established?  The ACGME was established in 1981 out of a consensus need in the medical community for an independent accrediting organization for graduate medical education programs. Its forerunner was the Liaison Committee for Graduate Medical Education.

How is the ACGME governed?  The members of the ACGME Board of Directors are appointed in equal number by the American Assn. of Medical Colleges, American Board of Medical Specialties, American Hospital Assn., American Medical Assn. and Council of Medical Specialty Societies. The Board also includes two resident members, three public members and a federal representative appointed by the Dept. of Health and Human Services.  The ACGME governance structure also includes an RRC Council, consisting of the chairs of the 27 residency review committees, and an RRC Resident Council, comprising resident members of the RRCs.

What is a residency program?  A residency program is a period of education and training that physicians undergo after they graduate from medical school in order to learn how to care for patients in their chosen specialty. Most residency programs last from three to seven years, during which residents care for patients under the supervision of physician faculty and participate in educational and research activities. When physicians graduate from a residency program, they are eligible to take their board certification examinations and begin practicing independently.  Residency programs are sponsored by teaching hospitals, academic medical centers, health care systems and other institutions.
How does the accreditation process work? The work of reviewing specific programs and making accreditation decisions is carried out by 27 residency review committees one for each major specialty, as well as one for transitional year programs. RRC members are volunteer physicians appointed by the appropriate medical specialty organization, medical specialty board and the AMA Council on Medical Education.

ACGME field staff representatives conduct one-day site visits to programs once every two to five years, depending on the strength of the program. About one-third of the programs are visited each year. The field staff representatives write objective narrative reports about the programs they visit based on lengthy interviews with the program directors, faculty and residents, as well as a review of supporting documents. The RRCs, which meet three times a year, review the site visitors’ reports, along with data provided by the programs. The RRC members then vote on the appropriate accreditation action for each program on the agenda for that meeting. New programs are given provisional accreditation, while continuing programs are given full accreditation if they substantially comply with the ACGME common and specialty-specific requirements. Programs that have deficiencies may be given accreditation with warning or probationary accreditation. Programs that fail to demonstrate that they have corrected their deficiencies and are in substantial compliance with ACGME requirements may have their accreditation withdrawn. Programs can appeal adverse accreditation actions to an appeals panel composed of volunteer physicians in the appropriate specialty. Although withdrawal of accreditation is usually preceded by probationary accreditation, programs which have egregious violations of program standards have experienced a catastrophic loss of resources or become inactive may have their accreditation administratively or summarily withdrawn.

Is accreditation voluntary or mandatory? Accreditation is voluntary. However, programs must be ACGME-accredited in order to receive graduate medical education funds from the federal Center for Medicare and Medicaid Services. Residents must graduate from ACGME-accredited programs to be eligible to take their board certification examinations. In addition, many states require completion of an ACGME-accredited residency program for physician licensure.

For more information, contact Julie A. Jacob, Communications Manager, (312) 755-7133, juliej@acgme.org.
SECTION 3.2
Residency/Fellowship Activities with ACGME/RRCs that Require Approval by the GME Committee (Associate Dean for GMEC) Prior to Submission

The GME Committee must review and approve, prior to submission to the ACGME:

1. changes in resident compliment
2. additions and deletions of participating institutions used in a program
3. appointments of new program directors
4. progress reports requested by any review committee
5. responses of all proposed adverse actions
6. requests for increases or any change in resident duty hours
7. all applications for ACGME accreditation of new program and subspecialties
8. requests for “inactive status” or to reactivate a program
9. voluntarily withdrawals of ACGME-accredited programs
10. request for appeal of adverse actions
11. written appeal presentations to the ACGME.
SECTION 3.3

Internal Review of Residency Programs

From http://www.uams.edu/gme/internal.htm

Internal Review Protocol
Graduate Medical Education Committee
University of Arkansas for Medical Sciences College of Medicine

All accredited graduate medical education programs (residency and fellowship) sponsored by the University of Arkansas for Medical Sciences College of Medicine undergo a periodic internal review as described in the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME). The review is conducted under the guidance of the Graduate Medical Education Committee (GMEC), which reviews the final report of each internal review, and makes recommendations as indicated. The internal review is usually conducted at approximately the mid-point between the ACGME surveys (accreditation site visit) of each program.

Internal Review Panel
The GMEC Chair selects the Internal Review Panel for each program. The panel includes: a Program Director (from a program not under review), a faculty member of the GMEC or its subcommittees, a resident member of the Resident Council, and an administrator (either the Associate Dean for GME or GMEC Chair). The Associate Dean for GME or GMEC Chair chairs the panel. Other members may be appointed at the discretion of the Chair. The responsibilities of the panel are to review the Internal Review Packet (described below), to conduct interviews with the Program Director, the residents, the program coordinator and other faculty and staff members of the department and to provide a final report to the GMEC.

Questionnaires/Interviews
The Program Self-Study Questionnaire includes questions about the educational program, general competencies, evaluation, supervision, scholarship and research and policies. This self-study is sent to the Program Director approximately four months prior to the internal review along with guidelines for the upcoming internal review. The self-study, completed by the Program Director and key teaching faculty, is due one month prior to the internal review so that it can be distributed to the Internal Review Panel.

The Resident Questionnaire includes questions about educational and curricular components, duty hours, supervision, conferences and evaluations, support services, previous citations. The resident member of the Internal Review meets with a group of residents in the program (representing each PGY year) and completes the Resident Questionnaire. This meeting occurs about one month prior to the internal review meeting so that all materials may be assembled for the Internal Review Panel. The program coordinator of the program under review assists in scheduling the resident meeting.

Prior to the internal review, a faculty member of the Internal Review Panel meets with key teaching faculty and staff of the program under review to discuss goals and objectives of the program, research opportunities, clinical and didactic teaching, evaluation and feedback, duty hour issues and recommendations for improving the program. The faculty member prepares a summary of the faculty interview. The program coordinator of the program under review assists in scheduling the faculty meeting.
**Internal Review**

The Internal Review Packet is distributed to all internal reviewers approximately two weeks prior to the internal review meeting. It includes:

1. The Summary from the last Internal Review; all correspondence/progress reports to the GMEC
2. The most current Program Requirements (Essentials- green book)
3. Any correspondence with the ACGME including questions, citations, or progress reports
4. The Program Self-Study Questionnaire
5. The Resident Questionnaire
6. Summary of Faculty Interview
7. The current Institutional Requirements and Common Program Requirements
8. Results of the last Annual GME Survey
9. Work Plan to Correct Annual GME Survey Ratings (if applicable)

The Internal Review Panel reviews the packet and formulates an Internal Review Checklist, then meets with the program director, key teaching faculty and staff to discuss its findings and innovations of the program, changes that have been made based on the RRC recommendations, problems with meeting the Program, Common and Institutional Requirements, and plans for improvement. They review information from the Program Self-Study Questionnaire, the Resident Questionnaire, the faculty interview and the Annual GME Survey.

The Internal Review Panel reviews letters of educational agreement with institutions through which residents rotate, the written goals and objectives, the program’s curriculum (to include the six general competencies), the resident manual which includes pertinent policies and procedures, representative residents’ files including written evaluations, measures to assess competence, moonlighting permission information. The internal review:

1. Assess the program’s compliance with the program and institutional requirements
2. Appraises the educational objectives of the program
3. Appraises the adequacy of available educational and financial resources to meet these objectives
4. Determines the effectiveness of each program in meeting its objectives
5. Assures that the program has defined, in accordance with the relative program requirements, the specific knowledge, skills and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice
6. Obtains documentation that the program uses evaluation tools to ensure that the residents demonstrate competence in each of the six areas
7. Appraises the development and use of dependable outcome measures by the program for each of the general competencies
8. Appraises the effectiveness of the program in implementing the process that links educational outcomes with program improvement
9. Determines the effectiveness of the program in addressing the previous ACGME citations and/or previous GMEC concerns

Following the meeting, the Chair of the Internal Review Panel prepares a Summary of Internal Review, which follows a standard template, which includes topics 1-9 above, commendations and recommendations for improvement.

**Internal Review Report**

The Internal Review Subcommittee of the GMEC discusses the Summary of Internal Review and makes recommendations to the GMEC at its meeting following the internal review. Following approval by the GMEC, the Summary of Internal Review is sent to the Program Director and Department Chair who must acknowledge receipt of the summary and can offer
corrections or clarification. A final report with recommendations and response from the Program Director becomes part of the record. Depending on the type and extent of the recommendations, the GMEC may require a progress report from the Program Director in about 6 months.

Follow up
1. In preparation for the ACGME survey visit, the faculty members of the Internal Review Panel (same members as above) review and critique the Program Information Form (PIF) at least one month prior to the external site visit.
2. Following the ACGME survey visit, the Program Director submits the final PIF to the Associate Dean for GME and completes a Satisfaction Survey about the Internal Review process. This is reviewed by the Internal Review Subcommittee and reported to GMEC.
3. Approximately 6 months after the ACGME site visit, the Program Director and the Associate Dean for GME receive a response letter from the ACGME which may include citations/concerns. If applicable, the Program Director submits a work plan to correct the citations to the GMEC. After review of the work plan, the GMEC assists with addressing citations and, if indicated, sets a date for a focused internal review or progress report to the GMEC. The original internal review panel assists with subsequent responses or interim reviews.
4. If the ACGME requires a response, work plan, or progress report, the GMEC reviews and approves these materials prior to submission to the ACGME. The GMEC Chair or, in his/her absence the Associate Dean for GME, signs the letter to the ACGME indicating approval of the response.
5. After receiving the final accreditation letter from the ACGME, including the tentative date for the next external site visit, the Associate Dean for GME makes a final report to the GMEC, including citations/commendations, and sets a tentative date for the next internal review (approximately midpoint between ACGME external reviews).

(Developed 1988; major revision April 1997, last revision August 2003 based on ACGME Institutional and Common Program Requirements of July, 2003)
EXAMPLE
(Check the requirements in the Program PIF)

Date

Ann Norwood
4301 W. Markham, Slot #837
Little Rock, AR  72205

Dear Ms. Norwood:

Please find enclosed all of the attachments listed below that were requested from me for the Internal Review of the Department of ________________________.

Attachment 1: Letter of Agreement
Attachment 2a: Written statement outlining the educational goals of the program
Attachment 2b: Dept. of Ophthalmology Goals & Objectives for each level of training
Attachment 3a: Evaluations of the residents (each type used including final evaluation)
Attachment 3b: Residents’ evaluation of faculty
Attachment 3c: Residents’ evaluation of the program
Attachment 3d: Program Improvement Plan
Attachment 4a: Guidelines for selection
Attachment 4b: Process for evaluation and promotion
Attachment 4c: Procedure which residents can use to raise concerns
Attachment 4d: Description of supervision for the care of patients
Attachment 4e: Policy on duty hours
Attachment 4f: Procedure for moonlighting
Attachment 4g: Approval form for moonlighting
Attachment 5: Summary of results of the program’s duty hour monitoring
Attachment 6: Evaluation form used for interviewing applicants
Attachment 7: Contents of Programs Web Page (brochure has same info. And is sent only when specifically requested, after providing applicant with web address)
Attachment 8: Resident Manual

Thank you so much for all of your assistance and if I can be of any further information, please do not hesitate to contact me.

Sincerely,

Name
Program Coordinator
SECTION 3.4
THE SITE VISIT

A SCENARIO
Odd or Bizarre Site Visitor Behavior:

You have a site visitor and they are nice, but very different. Questions were not appropriate, the demands were complex, and the overall visit with the residents was quite nerve wracking.

If the site visitor asks odd, strange, or inappropriate questions, make a note of the questions and the responses that were made. If the site visitor acts in any way that is unusual, note this also: inappropriate statements to the residents concerning the RRC rules, strange or bizarre comments, arriving a day early for the site visit, and lack of familiarity with the RRC requirements, have all happened. If you suspect that the site visitor is unstable or erratic during the site visit, you may have a legitimate concern that the same lack of stability may manifest itself in the site visit report when it is written. The best defense is to document the events and take action.

Prepare detailed notes about what was said to whom and what responses were made. Signed and dated statements by witnesses may be helpful. Assemble the information and share it, first with your designated institutional official and then communicate it to the ACGME. Comments about the site visitor that are submitted after the notification of an adverse action by the RRC are seen quite differently from those that are submitted within a day or two of the site visit.

PREPARING FOR THE SITE VISIT

Note: This information was adapted from a handout distributed by the ACGME. The information is current as of 9/01/02. Communicate changes to: D. Bosshart, The National Center for Evaluation of Residency Programs, 315 Elmwood Drive, Kent, OH 44240 Ph: 330-678-2011.

I. START EARLY!!!
EVERYONE SHOULD KNOW THE APPROXIMATE DATE OF THEIR NEXT SITE VISIT. START AT LEAST ONE YEAR IN ADVANCE. THE LETTER NOTIFYING YOUR PROGRAM OF AN IMPENDING SITE VISIT SHOULD NOT BE A SURPRISE.

A. Review your program's history of problems noted by the ACGME. Site visitors have access to both your program's and your institution's accreditation history back to 1987 and will look to see if the issues or citations previously noted in the history have been resolved:
1. Concerns cited in your program's last two (or more) ACGME Accreditation Letters.
2. Concerns cited in your institution's last two Letters of Report (report sent by ACGME after each of the last two institutional reviews).

Review all correspondence with the ACGME about compliance and any status reports sent to the ACGME. It may be helpful to examine your last Program Information Form (PIF).

B. Review your program's last two internal reviews. Pay particular attention to the summary of the review and the issues that your sponsoring institution felt should be addressed. The site visitor will not ask to see the summary of your last internal review. They usually ask the program director and key faculty what problems were identified
and what was done to address them. Have all the problems or issues been addressed so that you are in compliance with the institutional and program requirements? Develop a time-line to address any issues. How can you document that each concern has been successfully addressed?

C. Maintain a problem list for your program so that each problem will be resolved and that you will have documentation. Review your program's "problem list." Are you addressing all the problems that place you out of compliance with the RRC rules? Do you have a positive track record of addressing residents' concerns or issues? Repetitive patterns of non-compliance are not tolerated.

D. Make several copies of the PIF that you can download (in MS Word or WordPerfect 6.1) and print out from the ACGME home page (WWW.ACGME.ORG). This contains the questions that you must answer. For Internal Medicine this is the CAAR. Be sure to print out the addendum to the PIF that address the competencies (outcomes).

E. Read and reread Program and Institutional Requirements to understand the relationship between the questions on the (PIF) and both of these requirements. The program and institutional requirements contain the correct answers to the questions in the PIF (similar to an open book test). The trick is that your answers must reflect how the program actually operates.

F. Review the Program Information Forms from your last review and any interim correspondence you have had with the RRC office. Have all problems been addressed? Are you now in compliance?

G. Review the information you prepared for your last internal review and the problems and recommendations that came from this review. Internal reviews should take place midway between the last site visit and the next one (see letter of accreditation). If your sponsoring institution has not completed an internal review that conforms to the current Institutional Requirements, the program director should request that the Graduate Medical Education Committee complete a review ASAP!

H. Ask yourself tough questions. What is the state of the program's compliance? Is your institution striving for excellence or does it just get by? Can the problems be fixed in time? Do you know how to fix them? Do you need a consultant?

I. If it is less than three months from the site visit, notify all needed officials that a site visit is pending and give them the dates of the visit.

II. ASSEMBLE A TEAM!!!

A. Get the key players in your department involved early on in the preparation process. Include a senior resident as your reality checker. Conduct your own review of the program. As a team, analyze the program's strengths and weaknesses. Start lists of things to be done. Make subcommittee assignments. Choose your SD leaders carefully; you can't afford someone who doesn't follow through! The program director must maintain management control over preparations. Review the curriculum and the rotations. Review past resident evaluations of the rotations and program. Review yearly faculty reviews of the program and issues that were identified. See your program requirements. Have residents' issues been addressed? Develop a time-line including tasks and deadlines. Get resident feedback. If your program hasn't changed at all since the last review of the program, something is wrong with it!
B. To avoid "procrastination," suggest that the task be broken into parts and have a few individuals write or rewrite different sections. When asking them to write sections, clarify that the program director may have to re-work what they have written so that the entire document "fits together" and reads as if it was written by one individual. This saves "hard feelings" when the material that is submitted undergoes a major re-working, which it often does, and the program director circulates the final application to key members of the education team. Remind everyone that the application is written in present tense and that there is generally no need to use the future tense.

III. MAKE A SCHEDULE!!!

A. Start with the actual or theoretical date of the site visit and work backward. (You will be notified of the date of the site visit three months in advance). Do not wait until you are notified to get started!!!! Start early. Site visits are scheduled three months in advance and your specific site visitor will contact you four to six weeks (45 days) prior to the site visit. You can call Ingred Philibert at 312-464-4948 to determine the approximate date of your next visit.

Note: Your files will be inspected during the site visit. The Program Director and Coordinator should review the files and make sure that they are complete (i.e., a written summary evaluation of each resident at least two times a year, rotation evaluations, evaluations by residents of the program, appropriate minutes of the clinical competence committee and/or education committee). Documentation that faculty with teaching problems have gone through remediation should be available. Do you have an evaluation plan and evaluation data related to the competencies? Do your records show resident improvements and/or changes in the program that are a result of the assessment and evaluation process? If information is not in the files have the necessary items submitted ASAP. DO NOT back date evaluations, signatures, or letters. Be honest!

B. The site visitor will most likely be a member of the ACGME field staff (98%), but may be a Medical Specialist (2%) in your discipline who has been trained to make site visits (This is rare and, depending on the discipline, may indicate that your program has had a problem). Specialist site visitors may be selected by their RRCs. Site visitors are the eyes and ears of the RRC and they are sent to check on the accuracy of the PIF. They check to see if you are following the program and institutional requirements and that faculty and residents answer the questions the way the PIF was answered. (This is one good reason to have your PIF reviewed by a few residents and faculty.) However, site visitors are not members of the RRC, do not make an overall judgment or recommendation concerning what your accreditation status should be, and they are not consultants concerning the RRC and ACGME policies and procedures. The site visitors do file a written report describing errors or oversights with the PIF as well as what they were told and saw when they visited.

C. As soon as you know the name of the site visitor. Make a tentative schedule for the day well in advance. What would be the best times to get the key players to the meetings? We strongly recommend that the program director speak directly with the site visitor concerning the agenda for the day. (The coordinator can get the site visitor on the telephone and may also participate in the conversation.) It is usually a good idea to try to reach the site visitor on a Friday since they are frequently on the road on Monday, Tuesday, Wednesday and Thursday. The site visitor will usually want to meet with the program director, chairperson, faculty in the department, residents in the program, and perhaps the designated institutional official (see institutional requirements). Some site visitors speak with the program director or chairperson of other programs in your
institution where there is an RRC requirement that the program supports your program. The site visitor will meet with all 10 residents (if there are 10 or less) and will meet with 10 or so peer-selected residents if there are 10 or more residents. "Peer-selected" means that the residents meet as a group and select who will meet with the site visitor. Program directors and coordinators should not be involved in selecting residents. Some site visitors pick the residents themselves. The site visitor will tell you what he/she wants to see and who she/he wants to meet.

D. Your completed PIF will have to be mailed to arrive at the site visitor's office (home) at least 10 working days prior to the visit. The site visitor may want it early because of his or her schedule. Be ready for that! Remember that it may take additional time to get the required signatures. Late PIFs make a very negative first impression. Follow the site visitor's instructions about how to send the materials.

E. Use an analysis of a program's weaknesses to set a schedule for getting the problems fixed. If the problems can't be fixed in time for the site visit, be sure to have a plan in place, including a timetable, for fixing them. Be able to show documentation that the plan is being implemented. In general, the RRC wants to see substantial compliance with requirements, not plans for reaching requirements.

F. Make another schedule for when each aspect of the application will be completed in draft and in final form. Assign responsibility for each section to someone. Be sure to schedule enough time for final editing and checking for internal consistency so that it will appear as though it was written by a single individual. The document should be well written.

G. If possible, build in time for a mock site visit with sufficient time to permit revision of the PIF based on how the mock visit goes.

H. Build in time for someone who is familiar with your specialty, but not a member of the program, to read the application and raise questions and make suggestions.

I. At least one month prior to the time that you must send the RRC Application to the site visitor (i.e. six weeks prior to the actual site visit), you should begin the process of sending the application out for critical reviews. Reviewers should include individuals who will be meeting with the site visitor since they should have read the document prior to their meeting with the site visitor. If you ask them to review it prior to submission to the site visitor, they will be more likely to read it (as opposed to just prior to the meeting with the visitor). BY READING IT IN ADVANCE THEY CAN NOTICE ERRORS OR SUGGEST ADDITIONS THAT WILL IMPROVE THE IMPRESSION THAT THE PROGRAM GIVES. They will be forced to take some responsibility for any adverse actions that may be an outcome of the accreditation process. As a minimum, the chair, the director of graduate medical education, the chief resident, the associate program director, and the outpatient clinic director should be given copies to read. Give each person who reviews the document the instructions, all parts of the application, and a copy of the Institutional and Program Requirements. Their task is to check for ACCURACY and CLARITY of communication and compliance with the requirements. Give them fairly rapid turn-around time — two to four days. Make it clear that, if due to unforeseen problems they are going to have difficulty meeting the deadline, you will get them a copy of a future draft. Take their changes, make corrections, and then send it to the next reviewer. Schedule times for the program director to review the feedback and incorporate changes. It is a waste of time for five people to review the same document and make the same corrections. Stagger the process and start early.
IV. WRITING THE APPLICATION (PIF)

A. Know the Program Information Forms including the Competency Addendum if this is required by your Program Requirements. Read the entire application prior to starting. Make sure you are writing about the issue precisely where it is asked for. A little redundancy, to make sure you cover your bases, won’t hurt as opposed to just cross referencing. For example, there’s a section on progressive responsibility, as well as a portion pertaining to the resident experience in trauma management.

B. In answering the PIF questions, write with clarity and brevity! Be comprehensive, succinct, accurate and clear. This application must be totally understandable to a tired, overworked physician who has 10 applications to read. Avoid puffery, and don’t let a public relation’s office write it. Remember that the correct "answers" to the "questions" are in the Program and Institutional Requirements. They are looking for the "correct" answers to the questions so you can repeat words or phrases from the SD requirements when necessary. You must, of course, be doing or teaching these things in the program! Be honest!

Watch your vocabulary. Use the language of the program requirements where appropriate to demonstrate your compliance. Note definitions given in the PIFs, especially for resuscitation. Be careful with abbreviations. Define them when you first use them. Make a table of abbreviations if you use many. Remember that if the program requirements indicate that you must do something, do it! If it says "should," then you should give an explanation of how you meet the general intent of the requirement, but perhaps not the specific mandate concerning how. We recommend that all requirements be considered to be a "must," regardless of if it says "should," or "desirable." Our experience is that "should" becomes "must." Someone must have considered it important, otherwise they would not have written it down. Be consistent in tone and style.

Be positive and assertive, yet modest. Programs that act like they wrote the book in their field are not impressive.

DO NOT INCLUDE ANYTHING IN THE APPLICATION THAT IS NOT REQUIRED.
DO NOT INCLUDE OVERSIZED OR REPRINTED MATERIALS, SUCH AS A RESIDENT HANDBOOK, BROCHURES ON THE HOSPITAL, ETC.
ABSOLUTELY EVERYTHING MUST BE 8 1/2" x 11"!
Any extras will be discarded and the committee will miss the point you were trying to make.
DO NOT SEND YOUR APPLICATION IN A THREE-RING BINDER, BOUND WITH PICTURES ON THE COVER, OR IN ANY PLAIN OR FANCY FOLDERS. THESE WILL BE DISCARDED.
HEAVY DUTY RUBBER BANDS DO THE JOB OF HOLDING THE APPLICATION TOGETHER VERY NICELY AND ARE MUCH CHEAPER! (We use Plymouth size 117).
Make one-sided duplicates of your application.

Make sure the document is accurate. This is where resident participation can be crucial. You may know the experiences you think the residents are supposed to have, but the residents know what experiences they actually have. The site visitor is looking to verify these actual experiences. If you have made changes to the program shortly before the survey such that not all residents will have had the experience yet, be sure residents and faculty know about the change and the schedule for its implementation and why it is being made so they don’t give the site visitor blank stares or worse deny it when the site visitor asks them about it. Use the PIF application templates on
computer disk that are supplied by the ACGME or can be obtained by downloading from the Internet and the WebADS system (if implemented for your specialty).

Make sure the pagination remains the same! (Some specialties have implemented a computerized PIF that you must use. If so, submit the data, the diskette and/or paper documents as directed). If you alter the application form, the trouble could be very serious. If you must add pages they should be numbered a, b, c (10a, 10b, 10c, etc). Use the same font throughout the document. Serif fonts are easiest to read. Don't go below 11 point font. The ACGME specifically states not to go below 10 characters per inch, but remember that the person reading the PIF on the RRC will probably be older and may need all the help you can give them! Generally your answers should fit in the space provided. Be concise.

NO BLANKS!!! If you are completing the PIF form for a new program and the question is, "How many residents do you have," the answer should be, "Not Applicable." "Not Available" is not an acceptable answer. If you are an existing program and you do not have residents in a combined program, type "Not Applicable" on those sections of the forms.

Use the most current year or academic year data. If for some reason you use data other than that which is current, specify the time period you are using. If you are using estimates or projections (this should be avoided if at all possible), be sure to include the basis or formulas used in the estimates or projections. The information should be verifiable against actual records. Call the RRC if you have questions about what to use.

Identify all the data that will be needed and where you will be able to obtain the data. In most cases, you may need to seek such information from the hospital's administration to obtain certain statistics that are needed. The medical records department, the accounting department, the outpatient department, and the GME office may be involved. It is extremely helpful in many institutions for the program director, director of graduate medical education (DME), and the coordinator to meet to discuss the information that will be needed. The Central Graduate Medical Education Office will know who to contact and how they should be contacted in order to obtain the information, since all programs face the same basic "information needs."

N. Make sure your affiliation agreements are current and available for inspection by the site visitor and that they meet the institutional and program requirements. If you have added new institutions to the program since the last review, you must include these affiliation agreements in your Program Information Forms (Note that all changes in affiliation for the program are supposed to be communicated to the ACGME and should be approved by the DIO). Agreements that were signed by individuals who are no longer at the institution are no longer considered "current".

O. Develop a cover letter that reviews previous RRC citations or RRC concerns and provides a summary of the actions that have been taken to resolve these concerns. Reread and rework the letter when you are finished with the PIF.

V. REVIEWING THE APPLICATION

A. Once the application is complete, review the entire document for the big picture and the little picture. The document should stand as a comprehensive description of your program in the context of the program requirements. Read it as though you were the site visitor looking for something that seems wrong or doesn’t make sense. Read each question in the PIF, then the response, and then the corresponding section of the program requirements (or institutional requirements). Is your answer to each question...
complete? Review the document against the RRC checklist if available. (Some RRCs use a checklist of requirements that can be helpful.)

B. Check the use of abbreviations. Are they necessary? Make sure they are defined and included in a list.

C. Make sure the document is internally consistent. You can’t have more autopsies than deaths or more pediatric resuscitations per resident than you have pediatric patients. Cross check the numbers, narrative, lists and I, block diagrams to make sure they are consistent.
   - # of residents in the program with the list of names of residents in the lists.
   - # of months of full-time teaching faculty activity that is reported with the number of months on the block diagram.
   - # of months residents spend in a specific rotation with the # of months on the block diagram.
   - # of patients per resident in the clinic with the overall volume of the clinic.
   - # of beds available with patient census (be careful with the # of discharges from the NICU because it may be different than the number of admissions since patients may be transferred).

Frequency of performance evaluations and frequency of performance reviews.
Institutions referenced in the block diagram or narrative but not noted elsewhere.
Faculty lists and CVs (a CV for everyone on the list).
Notations about faculty credentials in the narrative and actual faculty CVs.
Amount of time spent teaching with rotation assignments and C.V.

D. Send the application to individuals on your list. Get someone familiar with the institution, but not within your department, to read the application. Be sure to have at least one resident read it for accuracy.

E. Be sure to complete a spell check, but don’t always trust the system. Search for the word "will." The RRC generally doesn’t care what "will" happen. They care about what has happened or what is happening now! Excessive use of the word "will," may be a red flag to the reviewer. Academic physicians sit on the RRC and they expect the proper use of the English language. Have someone edit the PIF so that it is easy to read and locate hidden errors.

F. Time permitting, hold a mock site visit.

G. When you send your PIF application in, we recommend that you write a cover letter. If you are making any special requests, such as an increase in the resident complement or adding or changing a hospital, clearly specify this in the cover letter. Review the cover letter in order to make sure you have addressed prior problems. If you had numerous serious citations at the last review, the cover letter should specify what you have done to correct them. Include the date when the issue was resolved and a reference to the data used to document this. What you say in the letter should match what’s inside the application, but should be a concise summary.

VI. ORIENTATION FOR ALL ABOUT THE SITE VISIT

A. Have the program director orient the faculty and residents to the accreditation process and the fact that the site visitor will be verifying the RRC application and assessing compliance with the Institutional and Program Requirements. It is helpful to give everyone copies of the Program and Institutional Requirements. Be sure to tell them that there is a time and a place to express their frustrations about the program, and
that during the site visit is not the most appropriate time. Explain how the accreditation process works, and tell the residents that, although they may be able to finish the program, most graduates of programs become distressed when their program is closed.

Everyone knows about the closing, and this reflects on the quality of all the graduates and the institution as a whole. We have seen personal vendettas worked out by faculty, residents and administrators against the program director (or department or hospital) during site visits. The sponsoring institution must take responsibility for the quality of the program and for insuring that the program meets all the requirements. When the RRC site visitor (or the RRC directly) is informed about the lack of compliance, or about major problems, then the program, the program director, and the sponsoring institution look bad. All faculty members who will be meeting the site visitor should be honest with the site visitor. Everyone who will be meeting with the site visitor should be given a copy of the PIE and asked to read it prior to meeting with the site visitor. Some programs give all or part of the completed PIE to all residents.

B. Many programs give the residents the Institutional and Program Requirements each year and indicate to the residents that they should notify the program director if the program is not in compliance with the requirements. This helps to avoid problems and, over time, residents become very familiar with the requirements and the language that is used.

C. The following are sample questions asked of residents during the resident interview process.
   Have you seen and did you receive a copy of the program's educational goals and objectives?
   What were the reasons you chose this program?
   Do you evaluate the faculty, your rotations and the educational program? How?
   How and how often are you evaluated?
   How are you supervised? Please describe. Is this too much, too little, just right?
      If you or a colleague had stress or other difficulties, how would you get assistance? Would it be confidential?
   Please explain the call system.
      If you had to use the due process procedure, where would you find it and whom would you contact?
   How did you get selected to meet with me? Were you selected by your peers?
   Other questions are derived from the Institutional and Program Requirements. Prior institutional and program citations from the last two visits are frequently explored. Questions about how the competencies are being taught and evaluated are now being asked. Changes in resident performance and changes to the program will be a focal point of some questions. All site visitors ask residents for the strengths of the program and for problems or challenges faced by the program.

D. Cancel all patient care responsibilities and committee responsibilities for the program director for the day of the site visit. The coordinator and any support staff should be available all day since the site visitor may ask for information that is not available and may have to be assembled — if so, you can make a good impression by producing it with speed.

E. Attend to details for the site visitor. Send a good map and written directions, hotel and restaurant recommendations; ask if there are any dietary restrictions so that a special lunch can be ordered. Arrange for VIP parking space; notify security guards. Offer to meet him/her at the front desk if the department is difficult to find; reserve a conference room that can be used all day. Prepare an agenda indicating times of meetings, names
of participants and their titles (relationship to the program if not clear in their title). Do not offer to take the site visitor out to dinner since this is not considered appropriate.

F. Send a reminder to all individuals who will be meeting with the site visitor, as well as to key laboratory personnel and the directors of key facilities such as the library, operating rooms, clinics, etc. that will be visited by the site visitor. Confirm room reservations and catering for lunch. Notify housekeeping to check the on-call rooms on the day of the site visit to ensure that they are clean.

G. Review the program history that is on file with the ACGME (e.g., citations from the site visits from the last 10 years, correspondence and reports sent to the RRC, the all Letters of Report for your sponsoring institution for the last 10 years and summaries from internal reviews for the last 5 to 10 years). Know about corrective action that has taken place concerning the citations. Review the summaries of the internal reviews conducted on the program and the details of the last internal review (especially if there is a new program director).

VII. THE SITE VISIT

A. Make sure the individuals on the schedule are there!

B. Try to keep the site visit running on time. Offer to meet the site visitor at the hotel and bring him/her to the hospital if appropriate. You should provide transportation between hospitals if more than one site must be inspected. If the site visitor has a rental car, make sure he/she has a parking space close to the hospital.

C. Do not wine and dine your visitor. You can provide a working lunch unless the visitor specifically indicated that this would be unnecessary. Ask about dietary restrictions. The site visit is business; you should keep it that way.

D. The site visitor will always want to talk to the program director and the chief of the department if they are not the same person, as well as key program faculty and residents. If the director of the service(s) is a third individual, she or he will be interviewed as well. The site visitor will usually want to meet with the "Designated Institutional Official" who may be the Dean or CEO of the hospital and/or his or her high-level designee, such as the Director of Medical Education, Associate Dean for GME, or the Chair of the Committee on Graduate Medical Education. The site visitor will also usually wish to interview the chiefs of the other services that interact closely with your specialty. The site visitor will give you specific directions on what specific residents he/she wishes to meet or will direct you about how they should be selected (i.e. peer nominated).

E. A private room should be available for the use of the site visitor to conduct all interviews. It is ideal if this is located within the department

F. When the Program Director meets with the Site Visitor, it is appropriate for the program director to ask the program coordinator to participate in the meeting. However it is a good idea to ask the site visitor's permission. It is not a good idea for the coordinator to be alone with the site visitor since some site visitors have been known to ask probing questions that should be more appropriately asked of the director. Some site visitors are quite clever in extracting information from the coordinator. It is the director's job to make sure the program is accredited. For the director to be unavailable, not understand how the program operates, or to not be involved in the programs operation, says something about his/her commitment to the educational process.
G. Have supporting documentation available for all aspects of the Program Information Forms. (For example, the site visitor may wish to see a copy of faculty development plans, or your resident and faculty evaluations.) You should have the following items ready to show the site visitor if asked:

1. The written curriculum and written goals and objectives for the program, including goals for each rotation. Site visitors may ask for documentation that faculty and residents have received them. The curriculum may include rotation schedules, resources to be used in reaching the goals, descriptions of learning activities such as lecture, conferences, reading assignments, educational materials, and methods used to evaluate the curriculum and residents.

2. Evaluations: examples of evaluation forms, written documentation of bi-annual evaluations by the program director, evaluations by faculty of residents at the end of rotations and evaluations of the faculty, residents, and program (end of year). Summary evaluations of each resident who graduated from the program (these should have been sent to the sponsoring institution).

3. An evaluation plan that spells out how and what is being done to evaluate the competencies. Information about evaluation results and subsequent changes in the program as well as changes in resident performance.

4. Methods for keeping track of attendance, methods for documenting resident clinical experiences and how the program director knows they are accurate.

5. Program committee minutes and faculty meeting minutes depending on the specialty (Clinical Competence Committee, documentation of faculty meetings reviewing the program, program committee minutes). Are residents present at meetings?

6. Written policies and procedures for the program and institution, including written guidelines for supervision of residents. Do you have a program specific policy for recruitment and selection of residents? Do you have documentation that the program "establishes and implements formal written criteria and processes for the selection, evaluation, promotion, and dismissal of residents in compliance with both the Institutional and relevant Program Requirements?"

7. Affiliation agreements that meet the Institutional Requirements and Program Requirements.

8. Resident files.

H. The site visitor will probably ask about the following:

1. Previous citations. You may be asked to provide a written status report in advance. We recommend that the written cover letter addresses what you have done to correct prior citations. The site visitor will check to see if the problems have been solved by asking residents and faculty.

2. Changes in the program (i.e., leadership, curriculum, faculty, facilities, mergers, etc.).

3. Questions about the different institutions involved. Who is the sponsoring institution and how does the program relate to the sponsor (see Institutional Requirements)? Who controls the training sites and are the affiliation agreements functional? Does the program director visit the training sites or meet regularly with key administrators responsible for the sites? What policies are followed at each site (see Institutional Requirements)? How does the director exercise oversight responsibility over external rotations?

4. What other training programs support your program (see Program Requirement for the list for your discipline)? How could the relationship with the program be characterized? How are problems resolved? How are residents treated when on rotations in these departments? Are they given adequate responsibility for their level of training?
5. When was the last internal review, who conducted it, what were the findings, and how have they been addressed? Site Visitors may not ask to see the internal review document or summary.

6. Credentials of the Program Director.

7. Is there a Program Committee or Education Committee? How does it function and are resident representatives involved in this and other education and patient care committees?

8. How effective is the program administration? Does the program director have sufficient authority and responsibility? Are the chief residents functioning effectively? Can residents raise concerns about the program without intimidation and fear of reprisals?

9. Faculty credentials.

10. Faculty involvement with the program and dedication to education. Do faculty members evaluate the residents and participate in the clinical competence committee and other evaluation processes? Do core faculty members spend the required amount of time in teaching (see individual Program Requirements)? Is there evidence that faculty, who have difficulty as teachers, are given remediation and, if necessary, removed from teaching duties?

11. Are the faculty involved with research and scholarly activity? Do they support resident research? Do they attend Journal Club and lectures?

12. The written curriculum and written goals and objectives for the program, including goals for each rotation will be reviewed. When were they written and last revised? When are they distributed to faculty and residents? What is the structured curriculum including rotation schedules; resources to be used in reaching the goals; descriptions of learning activities such as lecture, conferences, reading assignments, educational A materials, and methods and procedures used to make sure that residents have achieved the objectives? Do the evaluation systems document that residents have met the objectives? How often are conferences canceled and/or re-scheduled? Can you describe what was planned and what actually took place?

13. Each RRC has specific curriculum and/or patient care requirements and the site visitor may check to see if these are being addressed. Statistics reported in the PIF will be verified with source documents.

14. How are residents selected for the program and does the program follow its own written policies? Are there sufficient applicants to select individuals that meet the basic requirements? Are the residents of sufficient quality?

15. How are the residents evaluated and does the system work? Are evaluations done at the end of rotations? The program director must meet with each resident at least twice a year to review her/his performance. This meeting must be documented. (Larger programs can have an associate director perform this task, but it must be done!). Do residents evaluate the program in a confidential manner at least once a year? Residents must have access to their evaluations in their files!! There are no confidential resident files.

16. Are there problems with the board performance of the program graduates? For example do at least 50% pass on their first attempt? Has there been significant attrition in the program? If so, why and is this a problem with the educational program. Is there adequate documentation for the dismissal or non-renewal of residents? Are contract renewals made 4 months prior to the start of the contract year?

17. The PIF will be verified for accuracy-what are the sources of data. They may be checked!

I. Be honest, but put the best face on things.
J. Have the coordinator/secretary standing by to make immediate changes in the application. If you make mistake or want to clarify what was written in the PIF. You are permitted to send changes within a few days of the site visit. Talk to your site visitor and/or RRC Executive Director.

K. If you agree to send in additional materials, send them right away. If the site visitor makes a friendly hint, suggestion (for example, that you notify the executive secretary that the program director has changed or that you added XYZ Hospital four years ago), you are being given important advice that should be heeded.

L. Do not ask the site visitor what he/she thinks of your program or how you did. Do not ask him/her what he or she thinks the decision will be. Do not ask the site visitor for advice on how to fix problems. Do not ask the site visitor what he/she thinks the RRC thinks on various topics. These are simply inappropriate questions. You can ask if there were any inconsistencies between what the PIF stated and what was detected through the site visit. Indicate that you are interested in correcting or clarifying information in the PIF.

M. Although it may seem obvious, it bears repeating that this is also not a good time to tell the site visitor that you think the Institutional or Program Requirements stink and that the RRC employs a bunch of jerks.

N. Use the site visit to your advantage. Within the limits, the RRC will help you get things that you need if they believe that you need them. This should only be done after consulting the Chair and DIO and repeated efforts to work through the GMEC. For example, if the program director believes the residency suffers because the conference room is too small, it may be appropriate to mention it to the site visitor. Don’t be surprised if you get this citation.

O. If you are assigned a specialist site visitor or field staff member who you believe has a conflict of interest in surveying your program, call the executive secretary immediately. The situation will be evaluated and, if appropriate, a change in the site visitor will be made. If you have a problem with the site visitor at the time of the site visit itself, either field staff or specialist, complain immediately, BEFORE the committee meets, and be specific about what was said. Complaints received after the Committee has made its decision tend to be dismissed. If the site visitor is terrible (asks bizarre questions, is abrupt and rude) and, as a result is not told key information or has significant difficulty understanding the program and you feel this will create a negative report, call Ingrid Philibert, Director of Field Staff Activity. Prior to calling, write out a description of what happened and who said what so that you can give a good description. Complaints are not transmitted to the RRC reviewers. It does little good to complain about this site visitor after you receive a poor RRC report! Complaints received before the Committee meets are carefully reviewed independently of the Committee’s review.

VIII. AFTER THE SITE VISIT

A. Convene your staff for a post-mortem. Identify areas where you think the program may not have come off as strongly as it should have or items that were not available that should have been (e.g., records of resident evaluations of faculty). Take notes on what was said, when and by whom. One could ask a resident or two an open-ended question about the meeting with the site visitor, but do not interrogate them to determine who said what. (This would be intimidation.)
B. Take corrective action if you discover that you are not meeting the requirements. If it can be totally fixed right away, do so. Call the Executive Director to see if the RRC should be notified.

C. Immediately forward to the site visitor or to the RRC Office any additional materials you have agreed to send.

D. Shortly before the Residency Review Committee meets, mentally review your program and any changes you’ve made since the site visit. If you have made changes that have a significant impact on the program (e.g., hired new faculty, permanently replaced the chairman, added another rotation), call the Executive Director to discuss whether you should notify the Committee and the time frame for getting the additional information to the RRC office.

E. When the RRC meets, they judge the program based on the completed Program Information Evaluation (PIE), the site visit report. Also considered is the Board performance data, supplied by the Board, and supplemental data such as operative logs, CAAR survey results, the accreditation history of the program, information from institutional reviews, and correspondence between the program and the RRC.

IX THE RRC LETTER

A. You may call the RRC Executive Director three or four days after the RRC meeting to get a preliminary I verbal report. By giving the report, they are doing you a favor, so do not argue with them or ask for details. The written report will be sent out in several weeks.

B. If there is notification of proposed adverse action, re-read your PIE to see if you were not clear. Reconsideration may be indicated. Get guidance about what to do from your Associate Dean for GME. Spend considerable time and effort on your request for reconsideration. If you don’t, this may make your situation worse if you need to file an appeal.

C. If there is no adverse action, but you feel your program received citations that were not justified, consider addressing these in writing with the RRC. Remember, for your next internal review and site visit, you will need to show that you addressed the "problem." It is difficult to address a problem that does not exist!

D. When you learn about your positive RRC results, celebrate your success. Have a party, invite all who contributed, and thank them all.

X TIPS FOR THE COORDINATOR

All the RRCs work to be "fair." Your program director must take the job of preparing for the site visit very seriously and must be involved. There is little that you can do if they are unwilling or unable to do their part in the process.

A. Keep to the time-line in order to complete the various parts of the PIF by the targeted dates. You should not have to work 18-hour days because your director and faculty did not do their jobs in a timely manner.

B. The PIF is your program director’s job. He/she can delegate a portion of the job to you. While it may be flattering to you to be given the job of preparing the PIF, very few coordinators have knowledge of the clinical discipline and the requirements to write the PIF alone. We recommend that program directors use a team approach. No
coordinator should attempt to write the PIF alone. Make sure the program director has read the document that is being submitted. The best preparation for the site visit is to operate your program in compliance with the Program and Institutional Requirements. Ongoing documentation and complete records should be maintained on an ongoing basis. Remember:

1. Don’t procrastinate
2. Don’t panic
3. Don’t be paranoid
4. Be businesslike
5. Make the review process a positive experience
6. Organize: team, goals, deadlines
7. Use the constructive criticism and feedback
8. Make the review process an ongoing one
Requests for Reconsideration, Appeals of RRC and IRC Actions

It is best if you avoid the reconsideration and appeals process by following the ACGME institutional requirements and the relevant program requirements, preparing an accurate, clearly written PIF and orchestrating your site visit. Each program should have a file containing the accreditation history for the last 10 years. This should include all correspondence from the RRC, all correspondence to the RRC, and copies of all internal reviews, action plans and the dates by which prior citations were resolved. Copies of all program information forms should also be in this file. It is bad news to learn about damaging correspondence with the RRC after developing a request for reconsideration or an appeal. Prior to all site visits, orient all faculty, staff, residents and institutional representatives. In meetings with the residents, do not say anything that could be interpreted as not contributing to an "environment in which residents may raise and resolve issues without fear of intimidation or retaliation." If the site visitor assesses the climate of the program as one where the program leadership uses fear and intimidation, such a report is difficult to defend. The RRC will be suspicious regarding all resident comments and about the accuracy of the information provided in the PIF.

Ask the site visitor during the exit interview if there are any corrections or clarifications that should be made to the PIF. If any are mentioned, offer to make the changes.

Immediately After All Site Visits:

Make a record of what happened during the site visit. Debrief faculty, staff, and residents (use caution here) to determine what actually transpired during the different meetings. Make notes regarding who was present in each meeting with the site visitor and the approximate duration of the meetings. If you become aware of faculty and/or resident disagreements that were articulated to the site visitor within the meetings with the faculty and residents, make notes about what was said by whom. What did the PIF say about the topic? Make a note of which resident files and/or faculty files were reviewed and any documents that were requested and supplied to the site visitor. (It is best if the site visitor is not aware that you are doing this.)

Arrival of the Accreditation Letter or Letter of Report:

Read all accreditation letters carefully. If the letter indicates any area of non-compliance, perform a self-assessment to determine if the citation is accurate. If justified, develop a work plan to address it. Set a deadline by which time it will be resolved and reported to In the GMEC. (Remember that the GMEC is informed of citations, will review action plans and should be notified when citations have been corrected.)

If no adverse accreditation action is taken, and there are one or two citations that are groundless, we feel the best course of action it to correspond with the RRC in order to correct their misunderstanding or error in judgment. The ACGME philosophy emphasizes the accreditation history. It requires the GMEC of the sponsoring institution to monitor the citations and actions that have been taken to resolve them. As a consequence, it is to your advantage to communicate information that refutes each unjustified citation. Generally the RRC Executive Director does not forward the information to the entire RRC arid they do not take action to remove incorrect citations form your accreditation history. The advantage is that you have put forward your point of view in writing to the individuals that issued the citation and to all other concerned individuals: the current RRC, the current GMEC; the future internal review committee (who will ask to see what has been done to correct the citation); the future members of your GMEC; the site visitor for your next site visit (who will want to know what actions have take place to resolve the citation); and members of your faculty who will meet each subsequent year to review your program. It can be helpful if a subcommittee of your GMEC examines the citation, reviews relevant data, and takes action stating that there is not evidence to support the citation. Formal action by the GME may be helpful in the future. The data that is assembled to refute the citation is the most important.
If Adverse Action is Recommended, Take the Following Action
1. Seek advice and council regarding what you say and do. Have at least one other person read all letters that are sent to the RRC.
2. Carefully read the list of areas of non-compliance. (They are usually arranged in order of importance with the most important first.)
3. Re-read the program requirements that were in effect at the time of the site visit (if new requirements have been proposed or have not yet gone into effect, look to see if the RRC "jumped the gun" by enforcing the requirements prior to the scheduled date that they are to go into effect).
4. Re-read the relevant sections of the Program Information Forms.
   Review your notes from the site visit to determine how the site visitor may have formed any negative impressions about the program.
   The next step is to read the site visitors report. Re-read the information again to determine how the site visitor or the RRC may have reached their conclusions. If the citation does not seem justified, then consult the central GME office to determine if your perception of the data is accurate. This is the time to take an honest look at the program and the data. The RRC may be correct and it is best to move forward by accepting the adverse action and take steps to correct the problem.

Preparing a Request for Reconsideration
The site visitor's report may provide important information about how the RRC made their decision. As with any report, it is not only the words and phrases, but also the tone of the report that can make a significant difference. RRC members read between the lines as well as the actual words. Attempt to determine the origin of each citation. The accreditation letter will reference the pages or section of the PIF and pages of the site visitor's report. Frequently both the site visitor's report and the PIF are the source of citations.

In developing the request for reconsideration, you must provide evidence that you have met the criteria. Assertions do not count. There must be supporting evidence. Since the site visitor has already visited your program, no one can check the accuracy of your assertions. You must send lecture schedules, patient logs, attendance sheets, list of publications, procedure logs, statistical reports from the clinic or hospital, survey results, revised bio-sketch forms, or anything that will document that you have met the requirements.

If the site visitor report was a problem (not just the PIF) refute each and every statement that the site visitor made that is related to each of the citations. Do not assume that the RRC will understand that other aspects of the site visitor's report are in error as well. Unfortunately they will assume that if you do not refute the statements, they must be true. You are setting forth a request for reconsideration and you want the RRC to reconsider their decision after they discount all the incorrect information in the site visitor's report. Depending on nature of the site visitor's report, it can be helpful to discredit the site visitor by refuting his/her other inaccurate assertions that were not translated into citations by the RRC. During the reconsideration process, the RRC does not add new citations that they may have previously overlooked.

Honesty and accuracy is critical. While mistakes may have been made on the PIF, your request for reconsideration MUST be accurate and complete. To make one error is forgivable, but to make a second error in your request for reconsideration calls into question your ability to provide any accurate data. Think about how the appeal will be received if you indicate that you made a mistake on the PIF and made a mistake on your request for re-consideration. Your credibility will be low. If the RRC citations are correct do not attempt to refute them. Take steps
to correct the problems. What data can be provided to demonstrate that the problem has been addressed? Focus your time and energy during reconsideration on citations that are inaccurate. All RRCs use private standards to determine if a program is in compliance. These are based on the member’s experience with numerous programs over years of experience. As the PIFs are computerized and other data is collected by the RRC about other programs, the data may be private to the RRC, and not available to you. If you can provide data that your program is similar to many other programs throughout the country and that the RRC is applying a new standard to your program, you may be able to eliminate a citation. Check the medical education literature, ask others in the field, and ask the RRC executive director if summary comparative statistics are available that may help you make your point. Remember that the RRC is supposed to set standards that will improve graduate medical education and it may not be sufficient to be an "average program."

During reconsideration do not argue about the validity of the RRC rules. If you do not like an RRC regulation you can request an experimental program (an exception to the rule...you will need to evaluate your approach and provide data to the RRC). This is done prior to any site visit. Prior to finalizing the request for reconsideration, it is very helpful to read the ACGME Procedures for Appeal of Adverse Action. It is important to note that “the program may not amend the statistical or narrative description on which the RRC decision was based.” It is imperative that the Request for Reconsideration be as complete and detailed as possible.
SECTION 3.5
RESIDENCY REVIEW COMMITTEE (RRC)

Overview

The Residency Review Committee (RRC) operates under the auspices of the ACGME and is responsible for determining whether a training program conforms to established educational standards. Accreditation represents a professional judgment about the quality of an educational program. Every specialty that has a certifying board approved by the ABMS has a residency review committee for its training programs. There are 26 such boards and therefore 26 RRCs. The RRC for pediatrics includes three (3) representatives appointed by the AMA, three by the American Academy of Pediatrics (AAP), and three by the American Board of Pediatrics (ABP), as well as a resident member nominated by the Resident Section of the AAP.

The RRC establishes special requirements for pediatric training programs including the responsibilities of the program director, number and diversity of faculty, ratio of faculty to residents, diversity of pediatric patient population seen by residents, and minimum requirements for the educational curriculum, including scheduled rotations and continuity clinic experience. The RRC also requires the sponsoring hospital(s) to meet certain standards for hospital accreditation and quality assurance such as resident supervision, salaries, benefits, working conditions and ancillary support services such as laboratory facilities, expertise in pediatric surgery, radiology and pathology.

The RRC performs accreditation reviews of residency programs at intervals ranging from one to five years, depending on the degree to which a program is found in compliance with established guidelines. Failure to meet institutional or special requirements of the RRC can result in the loss of accreditation. Since residents who complete training in non-accredited programs may not be eligible for specialty certification in pediatrics, accreditation is critical for the residency program and individual residents. Programs are notified in writing approximately three months in advance of their scheduled site visit. Information regarding program requirements, site visits, and program information forms can be found at the ACGME website: www.acgme.org. To obtain a Program Information Form (PIF), click here.

Suggested Materials to Add
1. RRC Site Visit Notification Letter
2. Accreditation Letter
3. Institutional ACGME Accreditation Letter
4. Internal Review Letter
5. ACCGME and RRC Contact List

Program Coordinator's Role

Before the scheduled site visit for your program, you and your program director will need to work together to gather and report all of the information requested in the Program Information Form (PIF). This form is available to download from the ACGME website. The program coordinator's role in this process will most likely involve assisting the Program Director in gathering information to be included in the form as well as putting together the site visit schedule. The field representative will contact the Program Director or Coordinator approximately one month in advance of the scheduled site visit to obtain the schedule of meetings for the day. The preparation for the RRC visit is a lengthy and involved process. It is suggested you start preparing for the site visit one year prior to the visit and familiarize yourself with the PIF form. Other responsibilities can include:
1. Design a system to monitor changes in requirements.
2. Devise a system to accumulate needed information for the Program Information Form (PIF).
3. Help prepare the PIF.
4. Prepare and facilitate the site visit.
   o conference rooms
   o participants
   o prepare faculty and residents for the visit

Please Note: The APPD sponsors a fall meeting each year, which devotes a large portion of the program to "Preparation for a Successful RRC site visit."

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SECTION 4.1
Applications

*Your application(s) to be inserted into this section*
SECTION 4.2
Recruitment & Appointment

Policy of the Graduate Medical Education Committee
Section: Institutional Responsibilities
Subject: Recruitment and Appointment
Number: 1.200
Date Developed: 1/89
Last Review/Revision: 2/04
Replaces: policy same name, dated 5/03
ACGME Requirements: Institutional IIIA; Common IIA

Purpose
To define the requirements and procedures for the application, eligibility, selection, and appointment of residents to residency programs (includes fellows and fellowship programs) sponsored by the University of Arkansas for Medical Sciences College of Medicine (UAMS-COM).

Policy
The recruitment and appointment of residents to training programs sponsored by the UAMS-COM is based on and is in compliance with the institutional, common and specific program requirements of the Accreditation Council for Graduate Medical Education (ACGME). The process of application, eligibility, selection and appointment of residents to a program is the responsibility of the Departmental Chairperson, the Program Director, and/or departmental faculty. The program must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status. Each program must establish and implement written criteria and procedures for the selection of residents which includes a description of the application process and the criteria for eligibility and selection according to the following guidelines:

I. Application Process
The program’s written procedure for selection shall include a description of the application process. All accredited core programs must participate in the NRMP except for those specialty programs who either participate in a separate matching program or for which there is no established match process. It is the responsibility of the Program Director to inform all applicants (i.e., person invited for an interview), either through written or electronic means, of the terms, conditions and benefits of appointment (and employment). This information is available in the UAMS-COM Resident Handbook at http://www.uams.edu/gme/toc.htm.

The application process should include the following:
   A. How and to whom an application must be submitted,
   B. Deadlines, if any, for application submission,
   C. Contents of a completed application,
   D. The process of notification in the event an applicant is selected for interview, and
   E. The method by which each applicant is informed of the terms, conditions and benefits of appointment (and employment).

II. Eligibility
The program’s written procedure shall include eligibility criteria. The Program Director is responsible for verifying that an applicant is eligible for appointment and meets the following eligibility requirements:
   A. An applicant must be able to carry out the duties as required of the residency program.
   B. An applicant must demonstrate the following English language proficiency to the satisfaction of the Program Director:
      1. Proficiency in reading printed and cursive English,
      2. Proficiency in writing (printing) English text,
3. Proficiency in understanding spoken English on conversational and medical topics, and
4. Proficiency in speaking English on conversational and medical topics.

C. An applicant must meet one of the following qualifications as established by the ACGME:
1. a graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME).
2. a graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA).
3. a graduate of a medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
4. a graduate who holds a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
5. a graduate of a medical school outside the United States or Canada with one of the following qualifications:
   a. A currently valid certificate from the Education Committee for Foreign Medical Graduates (ECFMG), or
   b. A full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

D. An applicant is eligible for appointment only after a negative result on a pre employment drug test as administered by the UAMS Drug Testing Program (UAMS Policy 3.1.14).

E. An applicant must meet all program-specific eligibility requirements. These may include, but are not limited to, the following:
1. Application only submitted through the Electronic Resident Application System (ERAS), if available and participation in the National Resident Matching Program (NRMP) or other matching process.
2. A minimum standard of performance on the USMLE board examinations.
3. Documentation of successful completion of a minimum amount of clinical work in a supervised setting in the U.S. medical system.
4. A maximum length of time elapsed since completion of medical school training.
5. A maximum length of time elapsed since the practice of medicine as a physician.
6. A commitment to complete the entire training program.

III. Selection
The program’s written procedure will include the criteria and procedure used by the program to select residents and the length of time the program keeps the applications on file. The selection process should include, at a minimum, a review of eligible applicants by a program selection committee, individual interviews, and/or written interview evaluations. Criteria used for selection may include, but are not be limited to, the following:
A. Review and confirmation of eligibility requirements
B. Performance on standardized medical knowledge tests
C. Overall academic performance in medical school
D. Recent clinical training or experience
E. Demonstrated ability to choose goals and to complete the tasks necessary to achieve those goals
F. Maturity and emotional stability
G. Honesty, integrity, and reliability
H. Lack of history of drug or alcohol abuse
I. Motivation to pursue a career in the selected specialty
J. Prior research and publication experience
K. Verbal and written communication skills (personal statement and interviews)
L. Letters of recommendation from faculty
M. Dean’s letter
N. Medical school transcript
O. The ability to reside continuously in the U.S. for the length of training
P. A commitment to complete the entire training program

IV. Appointment/Registration
Upon verification by the Program Director that an applicant has met eligibility requirements, completed the application process, and been selected according to established criteria, he/she will begin the process of appointment and registration with the UAMS-COM Director of Housestaff Records. An applicant is considered fully appointed and registered in the College and entered into the payroll system in order to receive a stipend only after all the following information has been submitted to the Director of Housestaff Records:

A. Documentation of a negative drug test (UAMS Policy 3.1.14),
B. Verification of successful graduation if previously anticipated. For graduates of US or Canadian medical schools this includes a final official transcript, or letter from the Registrar, or a notarized copy of the diploma. For graduates of medical schools outside the US and Canada, this includes a currently valid ECFMG certificate,
C. All of the following forms (with valid signature):
   1. Resident Agreement of Appointment (contract),
   2. Medical Records Agreement,
   3. Attestation acknowledging receipt of GMEC policies and procedures and Terms and Conditions of Appointment
   4. Confidential Practitioner Health Questionnaire,
   5. Employee Drug Free Awareness Statement,
   6. Housestaff Medical Screening Form,
   7. Postdoctoral Medical Education Biographical Data Form,
   8. Long Term Disability Form,
   9. Acknowledgement of Benefits Policies,
   10. I9, State & Federal Tax Forms,
D. Copy of a valid VISA (if applicable).
E. Incoming residents/fellows are expected to attend Orientation/Registration in mid-June.

Procedure
A program’s compliance with the terms of this policy is monitored according to the following procedure:

A. Each June the Program Director and/or Program Coordinator submits to the Director of Housestaff Records a verification that all incoming residents of the program meet the eligibility requirements described in II.C and IV.B above.
B. Any resident found to be in violation of the English proficiency eligibility requirement (section II.B.) will be referred, at the expense of the program, for appropriate remediation.
C. The GMEC verifies the presence of a program’s written procedure for selection and monitors compliance with this policy and a program’s applicant pool and demographics characteristics as part of the internal review process.
SECTION 4.3
SUGGESTIONS
– Interviews and what to include for interview day and or application packet.

SUGGESTIONS for free handouts - I usually save these until Interview Day because postage is expensive if you start sending too much in the application packets.

Many free magazines/handouts are available outside of the Main Hospital Library that include real estate information, apartment guides, the Arkansas Times, Visitor's Guide to Greater Little Rock, Arkansas Health & Living, ARJobs and Little Rock Family. You can always pick these up to provide to your incoming (or interviewing) residents. Little Rock Fast Facts, which contains information about schools, colleges, hospitals, motor vehicle registration and other community information can be obtained thru the Little Rock Regional Chamber of Commerce by contacting them at 374-2001 or chamber@littlerockchamber.com. They also have a website at www.littlerockchamber.com.

The Arkansas Parks and Tourism department can provide you with the Little Rock Visitor Guides, Arkansas Adventure Guides and State Parks guides for free. You can contact them at 682-1191. The Little Rock Convention Bureau can also provide area information, maps, pencils, litter bags (which are great on interview dates to distribute brochures in) and their phone number is 376-4781.

INTERVIEWS
Airline Arrival
   Obtain airline arrival time from applicant
Make Hotel Reservation – If made by Department
   Contact applicant with Confirmation #
   Inform them about Transportation to hotel and then to hospital/interview site
Packet for Applicant/Interviewee:
   Little Rock Information
   Apartment Guides
   Arkansas Packet
   Arkansas Times Paper

PLAN OUT ITINERARY
Packet for Interviewers:
   Itinerary for the Day
   Evaluation Form
   Copy of the Application
Packet for Program Director:
   Itinerary for the Day
   Evaluation Form
   Copy of the Application
   Eligibility and Selection Requirements Letter
SAMPLE
Invitation Letter

DEPT. LETTERHEAD

Date

Dear Applicant:

Thank you for your application for residency and the supporting documents. We are pleased that you are interested in our training program and wish to invite you to visit and meet members of the faculty and house staff of the Department of _____________. A visit an interview may be scheduled for one of the following days:

(List of possible interview days, dates, etc.)

(The following paragraphs will need to be adjusted according to your Dept. procedures.)
You should plan to arrive in Little Rock by 5:00 p.m. on the day preceding the interview. We will provide one night’s lodging for you at the (hotel name, address, and phone number). A reservation will be made there in your name. Members of our house staff will take you and your spouse or guest, if someone accompanies you and perhaps one or two other applicants to dinner at a local restaurant that evening so that you may get an introduction to our program in a congenial, relaxed atmosphere before the formal visit and interview. A packet containing specific plans for the evening and the following day will await you when you register at the hotel.

Briefly stated, your visit will begin at 7:45 a.m. with a meeting in _________________, which will include a continental breakfast, welcoming remarks and a get-acquainted session. During the day, you will attend morning report, have an interview with a faculty member, tour the facilities at the University Hospital and adjoining Veteran’s Administration Hospital, have lunch with members of the house staff, and have a concluding interview to answer any questions.

To arrange an interview date, please email at __________________________ or call ____________________________.

Thank you again for your interest. We look forward to meeting you soon.

Sincerely yours,
Etc., etc., etc.
SAMPLE
No Invite Letter

DEPT. LETTERHEAD

Date

Dear Applicant:

Thank you for completing your application file for post-graduate training in ________________ at the University of Arkansas for Medical Sciences. We have reviewed all of the components of your file carefully.

Unfortunately, we will not be able to offer you an invitation to visit since we do not have the facilities or resources to invite all candidates to interview.

We wish you success in the forthcoming matching program and throughout your medical career.

Sincerely yours,
Etc., etc., etc.
SECTION 4.4
AREA INFORMATION – Little Rock and Surrounding Areas

Each of you probably already have a welcome letter that you use but if you need a template for this, please contact Linda Higdon at higdonlindal@uams.edu and she will be happy to share hers.

Glenda Cooper, director of faculty affairs office (contact # 661-7965) creates an "Absolutely Unofficial Faculty Handbook" which is used for recruitment purposes but is also handed out to residents during orientation. This provides the residents with a lot of area information that may help them if they are moving from another state or country. They are hoping to eventually have this information available on the internet and I will try to get you the web address as soon as this available. There is also additional information currently available on the web for foreign faculty and residents, specific to their needs at: http://www.uams.edu/cmefa/FacultyAffairs/InternationalFacultyResources.asp
If you have residents that enter your program after July 1, you may wish to contact Glenda for a copy of the "Absolutely Unofficial Fill in the Gaps Faculty Handbook" (or FIGS Survival Guide) for those residents.

You may also contact Susan Marlowe, the relocation specialist at the Janet Jones Company. She does a wonderful job of helping new residents/fellows learn more about the community by taking them on tours, and preparing great packets of information. The phone number is 224-3201 and Susan's email address is susanm@cei.net. They also have a website - www.janetjones.com. Another real estate agent that I have used who will provide tours of the local areas and provide area information along with assisting someone to buy a home is Lois Wallis, with Rector, Phillips, Morse and she can be contacted at 907-4413.

For financial services, you may give out the name of Ashley Carper, VP at Arvest Bank. Her number is 379-7940 and her email is acarper@arvest.com. Glenda has worked with her for several years and has found her to be very helpful and a delight to work with. The real estate agents listed above can provide information about area daycares but you may want to tell the residents that they can call ACH for information about the daycare they provide. They would need to call the Hospital main number at 364-1100 and ask to speak with Sue Mackey in the Child Enrichment Center or you can email her at MackeySA@archildrens.org and she can provide you with a brochure that includes fees and other information. Baptist Hospital also has a daycare and they can be reached at 202-1945.

Apartment Hunters is a great resource to use for helping residents/fellows to find an apartment. They have a form on line that you can fill out where you indicate how much you are able to spend on rent for a month, what you would like available and the areas you are interested in and then they do the hunting and show you what is available that fits in the guidelines you provided. They can be contacted at 1-800-644-2787 and their web address is www.lrapartments.com.
I always provide our incoming residents with a calendar and inside I will put many web addresses, passwords and user names that they may need during their residency. I am not sure of the cost of the calendars but it is minimal and they can be purchased by contacting Sue Reed with Zebra Marketing at 834-4766.

Many free magazines/handouts are available outside of the Main Hospital Library that include real estate information, apartment guides, the Arkansas Times, Visitor's Guide to Greater Little Rock, Arkansas Health & Living, ARJobs and Little Rock Family. You can always pick these up to provide to your incoming (or interviewing) residents. Little Rock Fast Facts, which contains information about schools, colleges, hospitals, motor vehicle registration and other community information can be obtained thru the Little Rock Regional Chamber of Commerce by contacting
them at 374-2001 or chamber@littlerockchamber.com. They also have a website at www.littlerockchamber.com.

The Arkansas Parks and Tourism department can provide you with the Little Rock Visitor Guides, Arkansas Adventure Guides and State Parks guides for free. You can contact them at 682-1191. The Little Rock Convention Bureau can also provide area information, maps, pencils, litter bags (which are great on interview dates to distribute brochures in) and their phone number is 376-4781.
SECTION 4.5
The Match

The National Resident Matching Program provides a system for the confidential ranking and selection of applicants to residency positions. Teaching hospitals that enroll their programs in the NRMP agree to select senior students of US Allopathic medical schools only through the Matching Program in accordance with the policies established by the NRMP. Positions may be offered to physician graduates of medical schools in the United States and elsewhere who meet the eligibility requirements set forth by the NRMP. All participants are bound to abide by the policies of the NRMP. See http://www.aamc.org/students/eras/start.htm

The purpose of the Matching Program is to provide a uniform time for both applicants and programs to make their selections without pressure. Matches between applicants and programs constitute a firm commitment between the two parties.
SECTION 4.6
VISAS

Contact the Immigration Office at UAMS, 686-7073 for help or instructions.

General Eligibility & Requirements

Foreign national physicians seeking J-1 sponsorship to enroll in programs of graduate medical education (GME) or training in the United States must fulfill a number of general requirements, which are detailed in the application materials. At a minimum, applicants must:

• Have passed Step 1 and Step 2 Clinical Knowledge (CK) of the United States Medical Licensing Examination™ (USMLE™) [and/or an acceptable combination of components of the former Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), the National Board of Medical Examiners® (NBME®) Part sequence, or the Visa Qualifying Examination (VQE)];
• Hold a valid Standard ECFMG Certificate at commencement of training;
• Hold a contract or an official letter of offer for a position in a program of graduate medical education or training that is affiliated with a medical school;
• Provide a Statement of Need from the Ministry of Health of the country of most recent legal permanent residence, regardless of country of citizenship. This statement provides written assurance that the country needs physicians trained in the proposed specialty and/or subspecialty. It also serves to confirm the applicant physician’s commitment to return to that country upon completion of training in the United States, as required by Section 212(e) of the Immigration and Nationality Act, as amended.

Exchange visitor physicians must maintain J-1 status by applying to ECFMG for renewed visa sponsorship, typically on an annual basis. Through this process ECFMG reevaluates the physician’s continued eligibility to participate in the J-1 Exchange Visitor Program.

To ensure that approved training begins and continues as scheduled, physicians and host institutions should allow adequate time for the processing of required immigration and GME authorizations. This processing time, which begins with the foreign national physician’s application for sponsorship, varies widely and may range from several weeks to months. Additionally, the U.S. Government continues to review its visa procedures, which may affect processing time.

Sponsorship Process

ECFMG facilitates J-1 visa sponsorship through the coordinated efforts of training institutions and foreign national physician applicants. ECFMG verifies that the foreign national physicians meet J-1 eligibility requirements. The host institution is responsible for providing the J-1 physician with the approved clinical training. Each host institution designates a Training Program Liaison (TPL) who serves as the official representative to communicate with ECFMG (usually the coordinator). This communication ensures regulatory compliance, and provides the required administrative oversight for J-1 physicians. Communication regarding all aspects of J-1 sponsorship must be conducted through the TPL.

Immediately after obtaining a training contract, the foreign national physician should initiate the sponsorship process by contacting the TPL at the host institution. Effective January 30, 2003, the U.S. Government implemented the Student and Exchange Visitor Information System (SEVIS). SEVIS is a national, web-based tracking system designed to assist educational institutions and government agencies in managing foreign national student and exchange visitor data. As a designated visa sponsor, ECFMG is required to process J-1 visa sponsorship through SEVIS. Upon establishing an applicant’s eligibility, ECFMG issues Form DS-2019, Certificate of Eligibility for Exchange Visitor (J-1) Status. The physician may also request Form DS-2019 to enable dependents (spouse and unmarried, minor children) to apply for J-2 dependent status. Issuance of Forms DS-2019
indicates that the physician and dependents are eligible to apply for the J visa. Agencies of
the U.S. Government make decisions regarding the issuance of visas. The DS-2019 is one
of many factors considered by the U.S. Government in determining whether to issue the
visa. Policies and procedures of the U.S. Government vary and are subject to change. J-1
physicians and J-2 dependents are responsible for complying with all U.S. laws and
regulations pertaining to foreign nationals. A summary of selected regulations follows.

Duration of Participation
The duration of participation for J-1 physicians in graduate medical education is the “time
typically required” to complete the program. This generally refers to the minimum number of
training years required by an American Board of Medical Specialties (ABMS) member
board for specialty or subspecialty certification and/or the accredited length of training as
defined by the Accreditation Council for Graduate Medical Education (ACGME). Duration is
further limited to seven years, provided that the J-1 physician is advancing in an approved
program of graduate medical education or training. The J-1 visa, however, does not entitle
J-1 physicians to seven years of sponsorship. J-1 physicians are encouraged to consult
with ECFMG regarding proposed educational pathways and sponsorship eligibility.

Renewals
J-1 renewals have to be done each year. Allow at least three to four months to process the
paperwork. It is best to begin the July renewals in January or February (before the Match
process). Once the Match occurs, the new visas take priority over renewals. Keep track of
renewals because most of the residents do not.

Paperwork for renewals is on the ECFMG website – it will be the Continuing paperwork.
A booklet of information is available for this paperwork also.

H-1B Processing
Have proof of the resident’s Step 3 score and then begin processing through the UAMS
Immigration Office. Work directly with them for the entire processing procedure. They will
send two separate forms -- one to be filled out by the program and one to be sent to the
resident. Examples of the program form are in resident’s files check one of these to use as
a guide. The resident’s portion of the form should be sent through UPS or FedEx.

After the Chairman signs the program paperwork, make a copy of it for the personnel file
and then take the original to the UAMS Immigration Office. Their office will handle the visa
paperwork.

Resources
ECFMG Exchange Visitor Sponsorship Program — Visit ECFMG’s website at
http://www.ecfmg.org/evsp for access to: Exchange Visitor Sponsorship Program

Reference Guide
Application materials Important updates ECFMG Certification — http://www.ecfmg.org
U.S. Department of State Exchange Visitor Program (DOS-EVP) —
http://www.exchanges.state.gov/education/jexchanges
U.S. Embassies and Consulates — http://travel.state.gov/visa/questions_embassy.html
American Board of Medical Specialties (ABMS) — http://www.abms.org
Accreditation Council for Graduate Medical Education (ACGME) — http://www.acgme.org
Additional Information
ECFMG-EVSP representatives are available to answer your questions by phone at 215-823-2121 from 9:00 am to 5:00 pm, Eastern Time in the USA, Monday through Friday; fax at 215-386-9766; or mail at 3624 Market Street, Philadelphia, PA 19104-2685, USA.

OTHER HINTS & TIPS:
New Residents
Immediately after the Match in March of each year, begin to process the visas for International Medical Graduates (IMG’s) who need to have a visa. If the new resident does not have the USMLE Step 3 score in their hand, there is not enough time to wait for results, no matter if it’s two or three weeks until the results come. Time is of the essence and waiting will only result in a late start (proven fact). In this case, a resident will have to apply for the J-1 visa not the H-1B.

J-1 Processing
Have the new resident sign onto ECFMG website and print off the Initial Application for the J-1 Visa. You may want to print off the booklet of information also.

The resident will fill out all the parts that they need to fill out, mail it by UPS or FedEx to the residency office for portions of it to be completed and signed by the Chairman (Program Directors). Then send it back to the resident, by UPS or FedEx, so that they can include their check, the letter from their home country, and any other information that needs to be included. Double check with the resident a week after mailing it back to them to make sure they have not forgotten to send it UPS or FedEx to ECFMG for processing.

When ECFMG sends the IAP-66 back to the Program (it will come to the Chairman’s office), take off the goldenrod copy for the resident’s file, make a copy of the white cover sheet for the resident’s file, and mail the packet to the resident by UPS or FedEx. Email them letting it know that it has arrived and is on the way to them. It is a good idea to call or email them to make sure of where they are so that it can be mailed to a correct address. If the resident has to go to their home country to have the Duration of Status (D/S) stamped on their visa, they must have at least three to four weeks to do so before the June Orientation.
CERTIFICATION FACTSHEET
Medical schools outside the United States and Canada vary in educational standards, curriculum, and evaluation methods. The Educational Commission for Foreign Medical Graduates (ECFMG), through its program of certification, assesses whether physicians graduating from these schools are ready to enter programs of graduate medical education in the United States.

This Fact Sheet is intended to provide international medical school students and graduates (IMGs) interested in graduate medical education in the United States with basic information on ECFMG Certification, as well as next steps and additional resources for those who are ready to begin the certification process.

The definitive resource on ECFMG Certification is the ECFMG Information Booklet. The definitive resource on the United States Medical Licensing Examination™ (USMLE™) is the USMLE Bulletin of Information. Before applying for examination and certification, you must read the appropriate editions of these publications. In the event that information in this Fact Sheet differs from the corresponding information in the ECFMG Information Booklet / USMLE Bulletin of Information, the latter publications will contain the most current and accurate information.

ECFMG Certification
The purpose of ECFMG Certification is to assess the readiness of IMGs to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). If you wish to enter such a program, you must be certified by ECFMG before you can start the program. ECFMG Certification is also required before applying to take Step 3 of the United States Medical Licensing Examination (USMLE). In the United States, to obtain a license to practice medicine, physicians must apply directly to the jurisdiction where they plan to practice medicine. Licensing jurisdictions in the United States require that IMGs applying for unrestricted licensure be certified by ECFMG. To be certified by ECFMG, you must satisfy ECFMG’s medical education credential requirements. You must also pass a series of exams. Applicants who satisfy all requirements are issued ECFMG’s Standard ECFMG Certificate.

Eligibility & Requirements
To apply for ECFMG Certification, you must be an international medical student or graduate. This means that your medical school is located outside the United States and Canada. U.S. citizens who graduate from such schools are considered IMGs and are eligible to apply for ECFMG Certification. Non-U.S. citizens who graduate from schools in the United States and Canada are not considered IMGs and are not eligible for ECFMG Certification. Additionally, your medical school must be listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER®). If you are a medical school graduate, your graduation year must be included in your school’s IMED listing. If you are a student, the “Graduation Years” in IMED for your medical school must be listed as “Current.” You can access IMED on the ECFMG website at www.ecfmg.org.
To be eligible for certification, you must graduate from a medical school that meets the requirements described above, and fulfill the following additional medical education credential requirements:

- You must have had at least four credit years (academic years for which credit have been given toward completion of the medical curriculum) at a medical school listed in IMED.
- You must supply ECFMG with copies of your medical education credentials. These medical education credentials are listed in ECFMG’s Reference Guide for Medical Education Credentials, available in the ECFMG Information Booklet on the ECFMG website. ECFMG sends medical education credentials to the medical school that issued them and must receive verification of these documents directly from the medical school. Applicants for ECFMG Certification must also satisfy the following examination requirements:
- Medical Science Examination. USMLE Step 1 and Step 2 Clinical Knowledge (Step 2 CK) are the exams currently administered that satisfy this requirement. Applicants register for these exams with ECFMG and take these exams worldwide at test centers of Prometric; a division of Thomson Learning, Inc. ECFMG also accepts certain former medical science exams to fulfill this requirement. Refer to the ECFMG Information Booklet for more information.
- Clinical Skills Requirement. USMLE Step 2 Clinical Skills (Step 2 CS) is the exam currently administered that satisfies this requirement. Applicants register for Step 2 CS with ECFMG and take the exam at one of several regional Clinical Skills Evaluation Centers in the United States. Applicants who have both passed the former ECFMG Clinical Skills Assessment (CSA®) and achieved a score acceptable to ECFMG on an English language proficiency test (such as the Test of English as a Foreign Language™ [TOEFL®] or the former ECFMG English test) can use these passing performances to fulfill this requirement. Refer to the ECFMG Information Booklet for more information. Step 1, Step 2 CK, and Step 2 CS are the same exams taken by graduates of U.S. and Canadian medical schools. Detailed information on the USMLE is available on the USMLE website at www.usmle.org. Refer to the ECFMG website at www.ecfmg.org for information on exam eligibility, fees, application, scheduling, test centers, preparation, and sample test materials.

Applying for ECFMG Certification
The certification process begins when you send your first exam application to ECFMG. Before applying for examination, you must read the appropriate editions of the ECFMG Information Booklet and the USMLE Bulletin of Information. Both publications are available on the ECFMG website at www.ecfmg.org. You can apply for the exams online, or you can download paper application materials from the ECFMG website. Detailed instructions accompany each application. Both medical school students and graduates can begin the certification process. You can apply for the required exams as soon as you meet the exam eligibility requirements. All of the required exams are offered continuously throughout the year.
However, since one of the requirements for ECFMG Certification is verification of your medical education credentials with your medical school, you cannot complete the process until you graduate and obtain these documents.

There is no time limit for completing the certification process. However, there are specific time requirements for completing the exams for ECFMG Certification and medical licensure. These requirements are described in the ECFMG Information Booklet and USMLE Bulletin of Information, respectively. The academic year for U.S. graduate medical education programs typically begins in July. You must be certified by ECFMG before your program’s start date, although you can apply to programs before becoming certified. In planning the timing of your exam application and scheduling, you should also consider deadlines imposed by the programs.
to which you plan to apply and the National Resident Matching Program. See Applying to Graduate Medical Education Programs.

Applying to Graduate Medical Education Programs
The **Graduate Medical Education Directory**, published by the American Medical Association (AMA), is recognized as the official list of ACGME-accredited graduate medical education programs. For each medical specialty, the **Directory** provides general and special requirements and specific information on each program in that specialty. You can order the **Directory** on the AMA website at www.ama-assn.org. Application deadlines vary among programs. You should contact programs directly for information on their deadlines.

Most programs require applicants to submit their applications using the **Electronic Residency Application Service (ERAS®)**. ERAS was developed by the Association of American Medical Colleges (AAMC) to transmit residency applications via the Internet. ECFMG coordinates the ERAS application process for IMGs. ERAS information for IMGs is available at www.ecfmg.org/eras. Programs that do not participate in ERAS require applicants to use paper application materials. You should contact programs directly for their requirements.

The National Resident Matching Program (NRMP), also known as “the Match,” matches applicants with available residency positions in the programs to which they have applied. If you wish to participate, you must register with the NRMP. Refer to the NRMP website at www.nrmp.org for requirements and deadlines, as well as information on the numbers of IMGs who have obtained residency positions through the Match in recent years.

Obtaining a Visa
IMGs who are neither citizens nor lawful permanent residents of the United States must obtain an appropriate visa to participate in U.S. graduate medical education programs. The most common visa employed for this purpose is the J-1 visa.

Resources
ECFMG Certification
Visit the ECFMG website at www.ecfmg.org for access to important updates, application materials, and publications, including:

- **ECFMG Information Booklet**, including the **Reference Guide for Medical Education Credentials**
- **USMLE Bulletin of Information**
- **International Medical Education Directory**
- **The ECFMG Reporter** – ECFMG’s free e-mail newsletter for IMGs interested in ECFMG Certification. Subscribe at www.ecfmg.org/reporter.

Applying to Graduate Medical Education Programs
- **Graduate Medical Education Directory** – www.ama-assn.org
- AAMC ERAS website – www.aamc.org/eras
- ERAS for IMGs – www.ecfmg.org/eras
- **ECFMG-ERAS News** – ECFMG’s free e-mail newsletter for IMGs participating in ERAS. Subscribe at www.ecfmg.org/eras.
- National Resident Matching Program – www.nrmp.org
Visas

• ECFMG Exchange Visitor Sponsorship Program – www.ecfmg.org/evsp
• ECFMG® J-1 Visa Sponsorship Fact Sheet
• U.S. Department of State Exchange Visitor Program – http://exchanges.state.gov/education/jexchanges
• Bureau of Citizenship and Immigration Services – www.immigration.gov

Additional Information ECFMG representatives are available to answer your questions by
• e-mail at info@ecfmg.org, or
• phone at (215) 386-5900 from 9:00 am to 5:00 pm, Eastern Time in the United States, Monday through Friday.

ECFMG

ECFMG is a private, non-profit organization committed to promoting excellence in international medical education. ECFMG’s aims and missions include providing information to IMGs regarding entry into graduate medical education and health care systems in the United States, evaluating the qualifications of IMGs, and providing international access to testing and evaluation programs.

ECFMG’s organizational members are:
American Board of Medical Specialties
American Medical Association
Association of American Medical Colleges
Association for Hospital Medical Education
Federation of State Medical Boards of the United States, Inc.
National Medical Association

ECFMG CERTIFICATION FACT SHEET

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Educational Commission for Foreign Medical Graduates www.ecfmg.org
SECTION 5
PROGRAM ADMINISTRATOR/COORDINATOR TASKS (by topic, alphabetically)
(The following are guides and are not necessarily the rule. Please use this as a resource, with additional information from your Program Director.)

Administrative Support for Training Program
Serves as a primary liaison between Residency Director(s), the Department Chairman, the Review Boards, various national and educational societies, and area hospitals. Processes loan deferrals, letters of recommendation, and verifications of training. Other support, as assigned or approved by Program Director.

Alumni
One of the requirements of the ACGME is to keep up with the Program’s Alumni. Many distinguished graduates come from the UAMS programs and it is the program’s duty to keep up with where they are and what they are doing. This is a way to accumulate a history for the department. Keeping track of alumni can be challenging, but there are creative ways to keep in touch with them. Some suggested ways to keep in touch is through gatherings, receptions at annual meetings, CME programs, Departmental publications, or a program Newsletter. These newsletters can feature alumni’s accomplishments, changes in procedures within the specialty, news from the Department, especially the coming and going within the residency program. Features on special events within the residency program can also be placed in a newsletter. By sending these out on a regular basis, a program can keep track of alumni as they move around. Alumni are an important part of a program’s history. You won’t want them to slip away from the memories of the program.

Verification of Residency or Fellowship Training can be done through the alumni list. Maintain a database of alumni with Social Security Numbers, beginning and ending dates, explanation if there is an interruption in training, and data that pertains to their training. This data will also help with the Site Visit preparation.

Send out Alumni surveys about every two to three years to keep track of where they are, what they are doing, and their further goal and objectives.

Awards and Nominations
Oversees the nomination and election of the chief residents each year and the vote for such. Also oversees other special recognitions (i.e. resident of the year, faculty of the year, etc.). Orders plaques/awards for special residency and/or faculty recognition, as directed by the Program Director or as assigned in the departmental job description. Makes sure that these plaques/awards are ready for the reception or graduation ceremony. Also recognize the residents/fellows for their achievements at national and local meetings/conferences, and any committees that they served on during their training.

Budget
Sits in with the Program Director when the Residency Budget is planned. Knows how many positions are available on each level and how many can be filled. Completes and submits Housestaff payroll within the budget. Approves and oversees the resident book fund requests and prepares report for distribution of Housestaff book fund monies (if available). Manages the travel funds (varies with department) and dues for national and local groups (per department’s requirements). Also oversees speaker, grant, and/or miscellaneous funds, as requested by the individual department.

Communication with Society and Organizations
General inquiry communications to Societies and Organizations are usually accomplished through email, unless the inquiry is required to be a formal document. In this case, a letter
has to be written on Departmental letterhead with the Program Director’s signature. Phone call inquiries can also be made, but document your call with date, time, and the information that you received. Always keep a copy of your correspondence, whether email or formal, so that you can account for the information you received and/or sent.

All communication to the ACGME and/or the RRC, regarding a Site Visit, should be on Departmental letterhead, signed by the Program Director, and signed by the GME Office.

Coordination of Resident Functions
Throughout each year, special functions take place within the program, including invited lecturers, formal presentations by the residents (Resident’s Day), subspecialty presentations, etc. They are very important for the morale of the residents and the overall Residency Program. The coordination of these events is usually headed by the program coordinator, sometimes with the help of other office staff or personnel. These functions can be held on campus, in off-campus facilities, or homes.

Some programs have several functions during an academic year, while others may only have one or two functions, which include all the residents and faculty members. These could be a welcome for new residents, a graduation party, a “thank you the exams are over” party, retreats, or holiday gatherings. No matter what type of celebration or function occurs, the camaraderie is the important factor. Even family picnics, game nights, sporting events, or playing some type of sport, as a team, are good for morale.

Special functions, within the program, should be casual unless it is dictated to be a formal affair, and then only adults should be in attendance. Speak with another coordinator if you are not sure about a particular type of function you will be coordinating.

Distribution of Schedules and Information
Assists in or prepares the rotation and call schedules for the residents and maintains both after the start of the academic year. Prepares appropriate responses to communication and passes on appropriate information to the residents. Receives and screens visitors and telephone calls, and notifies appropriate personnel. Assists in or schedules educational conferences, outreach programs, meetings, and seminars for the residents.

End of Year Activity²
A graduation ceremony or completion party can differ between programs. The best thing to do is to speak with your Program Director to see if they want it done like prior years, or to plan something different. Be sure to get the approval of your Program Director before proceeding with changed plans. Surprises are usually not welcome on the evening of an event.

These activities usually take place the later part or May of sometime in June, but all have the same theme – “We’ve finished a long and grueling training and we’re ready to get on with our lives.” All residents, faculty, families and friends should be welcomed to this type of celebration. The goal is to make it a special and memorable event for everyone.

One checklist has the following:

1. Save-the-date Graduation/Party announcement
2. Guest List – Invitations
3. Location Reservations (may have to be made several months to a year in advance)
4. Award Nominations (teaching, humanistic, etc.)
5. Awards and Gifts
6. Graduation Certificates or copies of actual certificates (unsigned)
7. Graduation Program Handout
8. Menu selections (watch for special diet requirements for international residents)
9. Speakers
10. Entertainment (if needed)
11. Schedule exit interviews for graduates
12. Help graduating resident with information regarding the next phase of their career (license applications, credentialing request, and letters of recommendation).
13. Prepare a packet of information to give to each departing resident which can include a notarized copy of their diploma, USMLE Step 1, 2, 3 scores, copies of licenses, ACLS, PALS, NRP cards, a signed copy of the credentialing log, etc.)
14. Other documents could be a graduation program handout, graduation invitation, graduation announcement, awards and gifts list, and a signed proof of exit interview with Program Director, etc.

² (Reprinted with permission of the Association of Pediatric Program Directors (APPD) Administrator’s Executive Committee)

Evaluation Process
Evaluation processes vary somewhat with each program. The basic requirements are that evaluations be processed at least quarterly, a bi-annual evaluation, and an evaluation summary at the end of the training. End of rotation evaluations should be completed by attending faculty members, and anyone the resident worked with during the rotation. The 360° should be completed at least once a year by faculty, staff, nurses, patients, peers, and others, where applicable. The Program must also be evaluated, by the residents, once a year, along with the residents evaluating the rotation and faculty members.

Some program required evaluations are mid-rotation evaluation by faculty, in an electronic or paper form; Resident teaching evaluation by students at the end of their rotation, in a paper form; end of rotation evaluation by faculty, in an electronic or paper form; an oral examination by faculty, and the end of rotation in an electronic or paper form. Some programs use all paper or electronic forms, and some both. It varies within the programs. No matter the process, be sure to document these evaluations and get at least 90% return but try for 100%. The return on these evaluations is especially critical within small programs.

Journal Clubs/Conferences
Coordinate and arrange for Departmental Journal Clubs and Conferences. Post those that are applicable to the Resident’s/Fellows training.

List-Serv
You will want to get your name on the List-Serv of organizations so that you will receive information on workshops and updated news and notes. A List-Serv disseminates information through email and will safely include your address on notices, as they come out. You can create a List-Serv for your residents so that, if you want to mail out a notice for all the PGY-1’s you can send just to them, or the PGY-1’s & 2’s. You can select and send to only the residents. A true List-Serv allows the mailer to contact everyone on a list or just one person on the list. Contact your IT person, within UAMS, to check if this can be done for your program.

Organizations
ACGME – Accreditation Council of Graduate Medical Education
http://www.acgme.org

AMA – American Medical Association
http://www.ama-assn.org

ABMS – Arkansas Board of Medical Specialties
http://www.abms.org
Each program has its own medical boards and societies. Be sure to look them up and add them to your list of organizations to keep close at hand. You will want these websites and numbers available for easy access.

Orientation³
Departmental orientations vary with each program, but the following are suggestions to help get things ready and organized for your own orientation. Items may need to be added or deleted according to common practice for your program. Be sure to keep a list of things to do and/or gather before and after the orientation. Take notes during the orientation if you think of things to do or not do the next year.
Send a letter to your new residents/fellows as soon as they match or are accepted into your program. Provide the Housestaff Office with the names and addresses of new residents / fellows. Also provide the Housestaff Office with photos of the newly matched interns – these can be from ERAS or from their personnel files.

Packet – The following is a suggested list which can be added to or taken away from.
- Office/Room Key (if applicable)
- Cell Phone (if applicable)
- Office Supplies
- Biosketches
- Curriculum / Resident’s Manual
- Membership Forms (Societies, etc.)
- Procedure log books
- Pagers & Pager numbers
- Maps of campus
- List of mentor/advisor assignments
- Emergency contact form
- ID’s and passwords
- Schedules
- Dictation medical forms/dictation codes
- Faculty and Support Staff List
- Birthday list
- Consent release forms
- Clinical Evaluation Book
- Continuity Clinic Assignments
- Manuals
- Vacation forms
And the list goes on according to what your program needs to offer.

Orientation Presentation – This list is also a suggested list.
- Chair/Program Director welcome
  (If these are different people, have them both come in and welcome them briefly)
- Chief Resident and Program Administrator welcome
- Subspecially faculty presentations
- Specialized lectures – from different faculty members
- Sponsored lunch with mentors/advisors, staff, administrative personnel, other residents
- Computer training sessions
- Document training sessions
- Tour of facilities
Nuts & bolts session with Chief Residents
If they don’t already have them, distribute nametags, beepers, lab coats, etc.
Retreat or dinner with interns, coordinator(s), Chairman, Program Director, support
staff, clinic personnel, etc.

³ (Reprinted with permission of the Association of Pediatric Program Directors (APPD) Administrator’s
Executive Committee)

Payroll – Stipend Schedule
At the beginning of each academic year, develop a Stipend Schedule, using the rotation
schedule for the division of sites. Use a past stipend schedule as a guide, making additions
and deletions on the residents. Verify the stipend schedule, as rotation changes are made,
so that the payroll will agree with the site. Email the new and changed stipend schedule to
Dwana McKay and change it on the Intranet, after Dwana McKay enters the July starts.
After the initial data is entered, you only have to change it on the Intranet if the work site,
vacation, or sick changes. Around the 5th of each month, verify your stipend schedule and
the Intranet billing to make sure that they are the same.
If your Department has a 13 Block rotation schedule, payroll has to be figured on the
following basis:
VA payroll is figured at 8 hours per day unless the resident is there the entire month
and then they are given the straight 176 hours.
Ex: 15 days (first part of rotation) x 8 = 120
16 days (second part of rotation) x 8 = 128
Vacation is only counted off at the VA hospital. Subtract 40 hours for each week on
vacation or 8 hours a day.
All other payroll (ACH, UAMS, BMC, and SVI) is figured at 176 hours divided by the
number of days in the month. Then multiply the number of days in the first part of the
rotation and subtract that from the 176 to give the total for the remainder of the rotation.
Ex: 176/31 = 5.67x15=85 hrs. for the first part of the rotation.
176-85 = 91hrs. for the second part of the rotation.
(See addendum #1 and #2 for Examples).
Presentations/Programs
May aid in preparation of resident/fellow presentation, as a proofreader, editor, and ability to critique the presentation. Presentations should always have the final approval of the Program Director for content, accuracy, and application of topic.

Reports / Surveys / WebADS
AMA-ASSN – Frieda Online Data
http://www.ama-assn.org/ama/pub/category/2997.html
To track your program information to let applicants know what is available for them to apply.

AAMC – Association of American Medical Colleges (GME Track)
https://services.aamc.org/gme/admin/login/index.cfm?fuseaction=login
To track training for Graduate Medical Education with the Association of American Medical Colleges

WEBADS – ACGME
http://www.acgme.org/acWebsite/ads/ads_intro.asp
WebADS can be used as an instrument to prepare for your RRC Site Visit, especially the first portion of your PIF. Your program will receive a letter, from the ACGME, stating your timeframe to place the information onto the website. The login ID and password are available to the director and the coordinator so that both can enter data.

Resident Travel
The rules and guidelines for resident travel vary from each department. Some coordinators plan the resident’s travel and complete all the paperwork, while others have to depend on other office personnel to carry out the actual travel plans and reservations. Consult your department’s policies and procedures to learn about what you should do for residents/fellows who travel for meetings and presentations. The coordinator’s role is to make sure that the proper paperwork for the travel is completed the educational leave is approved by the Program Director, the resident has contacted or you have contacted the rotation attending that they will be gone and for what period of time.
Addendum #1
Payroll – Stipend Schedule Example:

Straight monthly stipend

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Split monthly stipend

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Sample Job Description
Residency Program Administrator/Coordinator
(The following list is an example, not a factual list. No two job descriptions are the same within UAMS Departments. The idea behind this list and the Tasks list is to jog your mind as to what you actually do as a Program Administrator/Coordinator. You should develop your own job description, based on these principles and what works within your department. Save that job description, refer to it often, and keep it current, just in case you have to leave your position.)

Introduction
The Association of Program Directors in Internal Medicine (APDIM) recognizes and affirms the need for a professional manager or program administrator in the internal medicine training office. APDIM recognizes and supports the program administrator position as one of professional stature and one whose compensation should be commensurate with the responsibilities outlined.

The APDIM Council has prepared the following list of suggested qualifications and duties with the help of program administrators from residency programs of various sizes and affiliations. The list also includes a variety of ways that the program director’s administrative burden may be delegated, allowing more time for teaching, interaction with residents, and improvement of the program. It is hoped that this job description will prompt the establishment of a program administrator position in many programs where such duties are currently the responsibility of a secretary, chief resident, or the program director.

Job Summary
The program administrator is responsible for the day-to-day administration of the residency training program and should be directly responsible to the program director or department chair. The program administrator functions as a liaison between the program director and the hospital administrator or director of medical education as well as other departments, divisions, residents, and students. In addition, the program administrator is responsible for supervising staff members working in the office of the program director.

Desired Qualifications Of A Program Administrator/Coordinator
Training:
* Bachelor’s degree (such as, management or social science) and three years of office management experience.
or
* Equivalent experience in administration and office management in an academic health care setting.

Professional Skills:
With the increasing scope and complexity of program requirements and documentation, the program administrator must have superior organizational skills. The ability to prioritize work independently and to meet important deadlines is critical.

The program administrator/coordinate should demonstrate superior skills in:
- Communication (written and verbal).
- Problem-solving and decision-making.
- Administration and organization.
- Supervision.
- Prioritization.
- Goal-setting.
- Collegiality.
- Timeliness.

The program administrator/coordinator should have a broad knowledge of the following:
- Internal medicine residency program annual calendar.
- Recruitment.
- International medical graduates.
- Accreditation.
- Regulatory issues.
- Faculty.
- Professional issues.
- Legal and risk management issues.
- Information technology.
- Finance.
- Medical student curriculum and annual cycle.
- Continuing medical education.

Typical Duties of the Program Administrator/Coordinator
The APDIM Program Administrator Job Description indicates that the program administrator or one of the staff supervised by the program administrator is responsible for the following duties in more than 85 percent of the nation’s programs.

Program Responsibilities:
- Oversees day-to-day operations of the program.
- Provides office support for faculty and residents.
- Counsels housestaff on program policies and procedures.
- Drafts recommendation letters.
- Evaluates housestaff morale and responds to concerns.
- Assists in housestaff remediation.
- Conducts exit interviews.
- Coordinates residency retreats, conferences, and attendance.
- Tracks and verifies procedures.
- Maintains documentation for board eligibility.
- Maintains residency database and hard copy files of current and alumni housestaff.
- Produces and distributes housestaff manual, annual rotation schedule, and monthly changes.
- Plans and produces orientation program.
- Ensures completion of housestaff and faculty evaluations.
- Coordinates feedback process to division directors on faculty and rotation evaluations.
- Coordinates In-Training Examination administration.
- Recruitment:
  - Partners with the program director to establish recruitment policy.
  - Attends and coordinates information for recruitment fairs.
  - Manages Electronic Residency Application Service (ERAS) interaction (many program administrators are solely responsible for screening and inviting candidates).
  - Writes, edits, and revises recruitment letters, brochures, and recruitment information on program website.
  - Coordinates interview process, ranking process, and post-match activities.
• Submits National Resident Matching Program (NRMP) list via internet.

Accreditation:
• Knowledgeable of Accreditation Council for Graduate Medical Education (ACGME) requirements for institutional, core, and program requirements.
• Advises program director of requirement interpretation.
• Coordinates completion of Program Information Form (PIF) for ACGME site review.
• Prepares department, faculty, and Housestaff for site visit.
• Serves as key participant in site visit.
• Organizes Internal Review with institution’s graduate medical education (GME) office.

Information Technology:
• Uses internet for ACGME WebADS, ERAS, NRMP, surveys, and national reports.
• Implements and maintains residency program management software.
• Develops and maintains database on Housestaff and alumni.
• Develops informational sites for faculty and Housestaff.
• Creates and maintains recruiting and Housestaff web pages.

Supervising Staff:
• Hires, trains, counsels, and contracts for office staff.
• Directs office workload.

Regulatory:
• Maintains current knowledge of state licensure requirements; processes licenses.
• Ensures Health Insurance Portability and Accountability Act (PL 104-191) compliance.
• Monitors resident work hours.
• Documents all conference attendance.

Legal and risk management issues:
• Assists with due process for Housestaff probation and termination.
• Consults with legal counsel on hiring issues.

Other Responsibilities of the Program Administrator

Finance:
• Oversees budget for residency program.
• Gathers internship and residency information site data for time distribution and Intern Resident Information System (IRIS) reporting.
• Monitors residency payroll.
• Estimates direct medical education and indirect medical education resident count.
• Develops fund raising activities.
• Develops financial/disbursement arrangements between sponsoring and participating institutions.

Conference Credits/Attendance:
• Coordinates CME activities for faculty, attendance, and budget (i.e. Resident's Day, Special Lectures/Seminars).
• Ensures accreditation compliance.
• Documents commercial support agreements.
• Documents resident’s attendance at all conferences applicable to program.

**Medical Students:**
• Arranges student electives and rotations.
• Ensures completion of student evaluations.
• Advises clerkship director on student morale and feedback.
• Advises students on application process.

**International Medical Graduates:**
• Serves as training program liaison to Educational Commission for Foreign Medical Graduates (ECFMG).
• Supervises visa preparation.
• Verifies ECFMG information.

**Faculty:**
• Active in faculty development sessions.
• Responsible for faculty credentialing.
• Maintains faculty activity reports.

**Professional Development:**
• Attends local, state, and national GME and APDIM conferences.
• Apprises program director of trends in GME.
• Presents at GME/APDIM conferences.

**Other Responsibilities:**
• Acts as liaison on various education committees and implements committee decisions.
• Completes annual American Board of Internal Medicine tracking forms.
• Acts as liaison between residents and attending staff.
• Coordinates resident assignments to various core and elective rotations.
• Arranges coverage for vacation, illness, or leave of absence.
• Integrates residents from other departments into schedule.
• Prepares annual program agreements with participating institutions and private offices.
• Prepares monthly call schedule.
• Develops clinic schedule.
• Arranges basic and advanced life support classes.
• Develops faculty advisor program for career planning and research mentoring.
• Coordinates semi-annual resident reviews.
• Coordinates malpractice insurance, on-call facilities, parking, lab coats, pagers, maternity/ paternity leave, keys, name tags, mail, and on-call meals.
• Counsels residents on loan deferment opportunities.
• Publishes Housestaff newsletter.
• Creates fellowship and job opportunity file.
• Analyzes long-range planning needs.
• Reviews teaching programs, peer review, and quality assurance activities.
• Organizes new resident reception, annual awards banquet, and various social activities for Housestaff.
• Coordinates selected fellowship matches.
• Maintains statistics for the Joint Commission for Accreditation of Healthcare Organizations and the Association of American Medical Colleges surveys and ACGME directory of residency programs.
• Maintains database of graduates and statistics on residents’ fellowship experiences and practice locations.
• Surveys alumni periodically.

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Acknowledgement
This chapter was adapted from the 2002 APDIM Program Manual chapter “Internal Medicine Residency Program Administrator” by Cathleen C. Rook and Henry J. Schultz, MD.
**SECTION 6**

**House Staff Requirements**

**Timeline of Coordinator Duties Requested by the Housestaff Office**

<table>
<thead>
<tr>
<th>January</th>
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<tbody>
<tr>
<td>Mail out Letters of Intent for visa and ECFMG renewals</td>
</tr>
<tr>
<td>Submit to Housestaff your list of terminations (names of residents and fellows that are for sure completing program by June 30)</td>
</tr>
<tr>
<td>Submit to Housestaff names of chief residents for next academic year</td>
</tr>
<tr>
<td>Submit to Housestaff Certificate Request forms on all residents and fellows that will be receiving a certificate</td>
</tr>
<tr>
<td>Pick up W-2's from Housestaff Office and distribute</td>
</tr>
<tr>
<td>January bills are harder because of change over date - verify change over date with HS Office</td>
</tr>
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<table>
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<tr>
<th>February</th>
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<tbody>
<tr>
<td>Give names of early Match results to HS Office</td>
</tr>
<tr>
<td>Housestaff Office will mail out reminder of new Housestaff stipends</td>
</tr>
<tr>
<td>Start typing new contracts for existing residents and fellows (make sure you use the newest version of the contract &amp; new stipends)</td>
</tr>
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<tr>
<th>March</th>
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<tbody>
<tr>
<td>Distribute existing Housestaff packets to residents and fellows for completion</td>
</tr>
<tr>
<td>Verify terminations and names of the new Chief Residents - second time to the HS Office</td>
</tr>
<tr>
<td>Submit names of residents &amp; fellows that will be changing to another program (example-surgery to NS) to HS Office</td>
</tr>
<tr>
<td>NRMP Match - submit to the HS Office new resident &amp; fellow names, addresses, SSN's, DOB's &amp; pay levels ASAP</td>
</tr>
<tr>
<td>Submit new contracts with Program Director signatures on them to HS Office to mail out with packets</td>
</tr>
<tr>
<td>Receive credential request paperwork from HS Office - start verifying</td>
</tr>
<tr>
<td>Receive malpractice paperwork from HS Office - start verifying</td>
</tr>
<tr>
<td>Residents and Fellows start completing GME survey</td>
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<tr>
<th>April</th>
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<tbody>
<tr>
<td>Terminations &amp; promotions on residents &amp; fellows verified to HS Office - HS Office enters in Budget System for Payroll</td>
</tr>
<tr>
<td>Verify Changing Roster to HS Office</td>
</tr>
<tr>
<td>Start resident/fellow schedules - don’t put internationals on VAH services in July unless they are complete (SS#, ECFMG &amp; visa)</td>
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<tr>
<th>May</th>
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</thead>
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<tr>
<td>Verify terminations to HS Office - last chance - will be entered in SAP (remember indicate if staying on as faculty)</td>
</tr>
<tr>
<td>Keep track of residents and fellows - must complete mandatory GME Survey</td>
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</table>

**Submit Visas (J-1’s, H-1’s, Permanent Resident Cards, etc.) to HS Office immediately upon receipt**

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<thead>
<tr>
<th>June</th>
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<tbody>
<tr>
<td>Housestaff Orientation - three days and falls in the third week of June</td>
</tr>
<tr>
<td>Deadline of Existing and New HS paperwork to HS Office</td>
</tr>
<tr>
<td>Remind residents and fellows to renew their TB skin test</td>
</tr>
<tr>
<td>Existing residents &amp; fellows must have valid visas, ECFMG’s et. &amp; be verified by HS Office or they cannot start July 1</td>
</tr>
<tr>
<td>Remind residents and fellows to renew their parking decals (UAMS Police will be on campus during Orientation - HS Office will notify the exact times)</td>
</tr>
<tr>
<td>Credential and malpractice paperwork due to Housestaff Office (must have on all Housestaff or they cannot start)</td>
</tr>
<tr>
<td>Housestaff begin clearing out - Clearance Forms located in Housestaff Office</td>
</tr>
<tr>
<td>Inform HS Office names of residents &amp; fellows that can receive certificates or the names that are flagged</td>
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<tr>
<th>July</th>
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<tbody>
<tr>
<td>Housestaff Billing - Web schedules are updated</td>
</tr>
<tr>
<td>Verify all residents ACLS that attend the VAH, SVI and BMC.</td>
</tr>
<tr>
<td>Month</td>
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<tr>
<td>August</td>
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<td>September</td>
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<td>October</td>
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<td>November</td>
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<tr>
<td>December</td>
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## Section 7
### Education

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Residency or Fellowship Program Coordinators should have core knowledge or awareness of the following:

- **Program Requirements**
  - ACGME
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  - Program-specific
  - Certifying Boards (ABP, ABIM, etc.)
  - Institution (GME required online courses)

- **Commonly-accepted Educational Theories**
  - How people learn
  - Learning modalities
  - Learning Domains
  - Adult learning theory
  - Dreyfus model of skill acquisition
  - Bloom’s taxonomy
  - Personality / Learning styles
  - Organizational / Conflict resolution styles

- **Educational Management**
  - ACGME Core Professional Competencies
  - Curriculum development
  - Kern model
  - Program’s curriculum plan – 3/5-year block diagram
  - Writing effective educational goals and objectives
  - Assessments/evaluations
  - Documentation (of any activity in which the resident participates)
  - Educational technology
  - Program’s educational curriculum

- **Program Improvement Models**
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  - Astin’s IEO

- **Professional Development Resources**
  - LearnKey
  - Office of Educational Development

- **Glossary of Educational Terms**

- **References**
PROGRAM REQUIREMENTS

All GME (residency and sub-specialty residency) programs are governed on several different levels. Each level has a different set of requirements. Program coordinators should be aware that these different levels exist and should be familiar with the requirements.

- **ACGME** – see [www.acgme.org](http://www.acgme.org); go to “residency review committees” on the left menu bar.
- **Certifying Boards** (ABP, ABIM, etc.)
- **Institution - GME policies and procedures** [www.uams.edu/gme](http://www.uams.edu/gme)
- **Common Program** – see [www.acgme.org](http://www.acgme.org); go to “residency review committees” on the left menu bar.
- **Program-specific** – see [www.acgme.org](http://www.acgme.org); go to “residency review committees” on the left menu bar.

Program coordinators should be aware of the GME required online courses that residents must complete during their residency.

- Institutional Required Courses ([http://distance-ed.uams.edu](http://distance-ed.uams.edu))
  - Patient Safety / Systems-based Practice
  - Ethics
  - Medical/Legal

Other institution-required online courses

- HIPAA
- FPG physician compliance
COMMONLY-ACCEPTED EDUCATIONAL THEORIES

In order for Program Coordinators to be effective administrators for their programs and support the program director in his/her efforts, they should know their own personal preferences, tendencies, and abilities. “Knowing thyself” can make a person more effective in developing all aspects of the education process.

How people learn
Evolving brain research has yielded key finding of learning:
- Students come to the “classroom” with preconceived notions of how the world works. If their initial understanding is not engaged:
  - 1) They may fail to grasp the new concepts and information taught:
  - 2) They may learn them for the purposes of a test but revert to preconceptions outside of the classroom
- To Develop Competence in an Area, Students Must:
  - 1) Have a deep foundation of factual knowledge;
  - 2) Understand facts and ideas in the context of a Conceptual Framework;
  - 3) Organize information in ways that facilitate retrieval and application.
- A “Metacognitive” approach to instruction can help students:
  - 1) Learn to take control of their own learning
  - 2) Takes the form of an “internal conversation

Source: PowerPoint presentation by Carol Thrush Teaching Scholars Workshop January 2005.

Learning Modalities
Auditory
People with auditory strength or preference
- like verbal instructions & learn by listening
- enjoy dialogues, discussions, and plays
- often remember names but forget faces
- easily distracted by noise and work better where it is relatively quiet
People who are not auditory
- often sit in a lecture and do not really grasp what is being said
- find it difficult to concentrate or listen for long periods of lecture
- will often tune out what is being said or find it hard to stay with the speaker

Visual
People with visual strength or preference
- learn through descriptions & like demonstrations
- often use lists to organize thoughts
- remember faces but forget names
- easily distracted by movement or action but tend to be unaware of noise
People who are not visual
- often read a page and then realize they don't know what they have read
- find it difficult to concentrate on reading assignments or overhead notes
Tactile
People with tactual strength or preference
- often do best when taking notes during a lecture or when reading something new or difficult
- draw or doodle to remember
- do well with hands-on projects, demonstrations, or labs

People who are not tactual
- rarely take notes or only for things that cannot be remembered easily such as numerical data
- often do not do well with hands-on and find it hard to concentrate during lab activities

Kinesthetic
People with kinesthetic strength or preference
- often do best when involved or active
- have trouble concentrating when sitting still
- often have high energy levels
- prefer to do rather than watch or listen

People who are not kinesthetic
- rarely get involved action-oriented activities
- prefer not to participate but would rather watch

According to the noted educator Sandra Rief, students retain
- 10% of what they read
- 20% of what they hear
- 30% of what they see
- 50% of what they see and hear
- 70% of what they say
- 90% of what they say and do.

Commentary: That would depend on what learning modality fits your learning preference!
(Source: http://www.geocities.com/CollegePark/Union/2106/4mod.html [accessed 9/29/05])

Domains of learning:
- Knowledge/cognitive
- Attitudes/affective
- Skills/psychomotor

Adult Learning Theory – Characteristics first described by Malcolm Knowles
- Adults are autonomous and self-directed
- Adults have accumulated a foundation of life experiences and knowledge
- Adults are goal oriented
- Adults are relevancy oriented
- Adults are practical

**Bloom’s taxonomy** is a classification system of behavior important to cognitive learning. It is useful for writing effective educational goals, and developing a variety of good test questions. Hierarchy from less to more complex.

“Taxonomy” means “classification”.

**Levels in the Cognitive Domain:**

**Knowledge**: Recall data or information. Defined as remembering previously learned information. Key Words: define, describe, identified, label, list, matched, outline.

**Comprehension**: Understand the meaning, translation, interpolation, and interpretation of instructions and problems. State a problem in one’s own words. Key Words: distinguish, estimate, explain, gives examples, interpret, paraphrase.

**Application**: Use a concept in a new situation or unprompted use of an abstraction. Applies what was learned in the classroom into novel situations in the work place. The use of previously learned information in new and concrete situations to solve problems that have single or best answers. Key Words: change, compute, construct, demonstrate, produce, relate, use.

**Analysis**: Separates material or concepts into component parts so that its organizational structure may be understood. Key Words: breaks down, compares, contrasts, diagrams, differentiates, separates.

**Synthesis**: Builds a structure or pattern from diverse elements. Put parts together to form a whole, with emphasis on creating a new meaning or structure. Creatively or divergently applying prior knowledge and skills to produce a new or original. Key Words: combine, compile, compose, design, plan, reconstruct, summarize.

**Evaluation**: Make judgments about the value of ideas or materials. Example: Explain or justify new curriculum or educational intervention. Key Words: appraise, critiques, defends, justifies, supports.

**Other domains** of educational objectives

- Affective Domain (emphasizing feeling and emotion)
- Psychomotor Domain (concerned with motor skills)

Source: [http://faculty.washington.edu/krumme/guides/bloom1.html](http://faculty.washington.edu/krumme/guides/bloom1.html)
**Dreyfus Model of Skill Acquisition**
The Dreyfus model is a general model of skill acquisition originally developed through observation of thousands of nurses performing their work. H. Dreyfus and S. Dreyfus describe the phenomenology of skill acquisition in their book, *Mind Over Machine*, published in 1982.

**Summary of Characteristics**

**Level 1: Beginner**
- Little or no previous experience
- Doesn’t want to learn: wants to accomplish a goal
- No discretionary judgment
- Rigid adherence to rules

**Level 2: Advanced Beginner**
- Starts trying tasks on their own
- Has difficulty troubleshooting
- Wants information fast
- Can place some advice in context required
- Uses guidelines, but without holistic understanding

**Level 3: Competent**
- Develops conceptual models
- Troubleshoots on their own
- Seeks out expert advice
- Sees actions at least partially in terms of long-term plans and goals

**Level 4: Proficient**
- Guided by maxims applied to the current situation
- Sees situations holistically
- Will self-correct based on previous performance
- Learns from the experience of others
- Frustrated by oversimplified information

**Level 5: Expert**
- No longer relies on rules, guidelines, or maxims
- Works primarily from intuition
- Analytic approaches only used in novel situations or when problems occur
- When forced to follow set rules, performance is degraded

**Level 6: Master** (suggested by the ACGME at the Educational Conference, March 2001)
- Goes beyond characteristics of Expert

**Personality Styles** and how they affect learning and education

**MBTI** – Myers Briggs Type Indicator – personality styles – see chart insert.

A note about introversion/extroversion in the temperament styles – two distinguishing characteristics are energy and information processing.

<table>
<thead>
<tr>
<th>Extroversion</th>
<th>Introversion</th>
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<tbody>
<tr>
<td>Gains energy being in a crowd</td>
<td>Gains energy being alone</td>
</tr>
<tr>
<td>Expends energy being alone</td>
<td>Expends energy being in a crowd</td>
</tr>
<tr>
<td>Formulate thoughts as they talk</td>
<td>Think first then speak</td>
</tr>
</tbody>
</table>


**Gregorc Style Delineator Organizational Style**

**Perceiving Abilities**

Concrete –
Uses 5 senses: sight, smell, touch, taste, and hearing. Not looking for hidden meanings, or making relationships between ideas or concepts.

Abstract –
allows you to visualize, to conceive ideas, to understand or believe that which you cannot actually see.

**Ordering abilities**

Sequential – organize information in a linear, step-by-step manner, following a logical train of thought. Prefer to have a plan and to follow it, rather than relying on impulse.

Random – organize information by chunks, and in no particular order. Prefer your life to be more impulsive, or spur of the moment, than planned.

**Gregorc’s Learning Styles**

| Concrete-Sequential Learning is linear and sequential. |
| Concrete-Random Learning is concrete and intuitive; person thrives on problem-solving. |
| Abstract-Sequential Learning is abstract and analytical; person thrives on mental challenge but in an ordered learning environment. |
| Abstract-Random Person is emotional and imaginative, prefers an active, interesting, and informal learning environment. |

**Thomas-Kilmann Conflict Resolution Styles**

- **Avoid** – One party completely withdraws from the conflict, as if it doesn’t exist. Typical response: “Silence” (I lose – you lose)
- **Compete** – One party forces the point until the other party gives up. An authoritarian approach to problems in which only one side gets their say. Typical response: “Just do it this way!” (I win – you lose)
- **Accommodate** – One party puts aside his/her goals in order to satisfy the other party’s goals. Typical Response: “I give up; we’ll do it your way.” (I lose – you win)
- **Compromise** – Often involves some give-and-take, sacrificing some personal goals in order to gain others. Typical response: “Let’s meet half way.” (We both give up something)
- **Collaborate** – Problems are solved in ways that meet the needs of all parties. Typical response: “Let’s work this out so we can both get what we want.” (I win – you win)

Source: [http://www.nus.edu.sg/uhwc/counselling/selfhelp/conflicts02.html](http://www.nus.edu.sg/uhwc/counselling/selfhelp/conflicts02.html)

Conflict Resolution Style Questionnaire: [http://academic.engr.arizona.edu/vjohnson/ConflictManagementQuestionnaire/ConflictManagementQuestionnaire.asp](http://academic.engr.arizona.edu/vjohnson/ConflictManagementQuestionnaire/ConflictManagementQuestionnaire.asp)
EDUCATIONAL MANAGEMENT

Program Coordinators should be aware of elements of the educational progress, specifically elements used in graduate medical education.

ACGME Outcome Project, “enhancing residency education through outcomes assessment”, includes the implementation of core professional competencies (www.acgme.org/outcome). These competencies form the framework for developing educational goals and instructional objectives for rotations.

Core Professional Competencies:

- **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value


Curriculum Development

Kern’ 6-Step Model offers a comprehensive approach to curriculum development. Each step influences or is influenced by the others either directly in a sequential order or indirectly by way of another step. The steps may be reviewed and revised at any stage of the process. Elements of curriculum development include:

- Step 1: Problem Identification & General Needs Assessment
- Step 2: Needs Assessment of Targeted Learners
- Step 3: Goals and Objectives
- Step 4: Educational Strategies
- Step 5: Implementation
- Step 6: Evaluation and Feedback
Program’s Educational Curriculum
Program Coordinators should at least be aware of the overall educational structure of their specific program. Depending on the program, coordinators may be responsible for scheduling, monitoring, or making sure evaluations are completed.

- Program Information Form – completion required for periodic external site reviews.
- Block Diagram – depicts program’s
- Required Rotations – core elements in a program
- Elective Rotations – special interest tailored to resident’s needs
- Standing Conference Schedule – core lectures or

Writing Effective Educational Goals and Objectives
Robert Mager and Norman Gronlund provide a foundation for developing effective instructional objectives. The goal in writing instructional objectives is to make clear statements about the product, or outcome, you wish the learner to achieve.

“An instructional objective is a collection of words and/or pictures and diagrams intended to let others know what you intend for your students to achieve.” (Mager, 1997, p.3)

It is related to intended outcomes, rather than the process for achieving those outcomes.

It is specific and measurable, rather than broad and intangible.

It is concerned with students, not teachers.

Specifically: “Given any objective in a subject area with which you are familiar, be able to identify (label) correctly the performance, the conditions, and the criteria of acceptable performance when those characteristics are present.” (Mager, 1997, p.4)

Elements of Instructional Objectives:
- Who…?
- Will do…?
- How much…?
- Of what…?
- By when…?

Example of competency-based objectives: At the completion of the PG-1 year, the resident will be able to diagnose and manage common ambulatory medical disorders, i.e., hypertension, diabetes, angina, COPD with minimal supervision. (ACGME Outcomes Project)

Outcomes vs. Process
An objective is related to an intended outcome of instruction, rather than the process of instruction. For example, “when a chef adds seasoning to soup, that is part of the
process of cooking. But it isn’t the result of the cooking. The soup itself is the outcome, or result, of the cooking.” (Mager, 1997, p. 5) The ACGME is now concerned with resident performance outcomes (the soup) rather than the program components (the seasoning). Therefore, educational goals and instructional objectives should be written to reflect learning outcomes.

For more information on writing effective goals and objectives: OED Resources http://www.uams.edu/oed/resources/resources.asp

Documentation Tools/Methods and Forms
Any activity in which a resident participates should be documented with either attendance or some form of assessment measure. Common educational activities of which a program coordinator should be aware include:
  Procedure logs (Specialty-specific procedures as specified by the RRC)
  Journal clubs
  Educational Conferences
  Continuity Clinic Conferences
  Morbidity and Mortality (M & M)
  Senior project: prospectus/strategic plan, mid-cycle report, final report
  Grand Rounds or other presentations
  Board reviews
  Certification courses:
    Basic Life Support,
    Advanced Life Support,
    Advanced Cardiac Life Support
    Others?
  Other activities?

Assessments/Evaluations
Program coordinators should have be aware of different areas from which assessment data are collected. Data from various assessments may be used for resident / faculty promotion or graduation. Common areas of assessment include:
  In-service exam
  Resident – by students & faculty
  Faculty – by residents
  Rotation/program – independent of faculty involvement
  Didactic conferences
  Annual Program Evaluation
  Resident End-of-Program Summary Evaluation – copy kept in resident’s permanent file; must contain the “magic statement” written in competency language.
  ACGME-suggested assessment tools may be obtained on the ACGME website at http://www.acgme.org/outcome/assess/assHome.asp

Writing Well-structured Test Questions
Susan Case and David Swanson, in association with the National Board of Medical Examiners have a course and publication for writing well-structured test questions. To be a well-structured question, it “must satisfy two criteria: 1) question must address important content; 2) question must avoid flaws that benefit the test wise examinee and avoid irrelevant difficulty.” (Case & Swanson, 2002, p. 13)

Although writing test questions is beyond the scope of the program coordinator’s responsibilities, at times they may be called upon to review or critique tests developed by faculty members in their department. If comprehensive test construction is undertaken, please contact the Office of Educational Development for someone with this particular expertise.
PROGRAM IMPROVEMENT MODELS

PDSA Model
Referred to as the Deming PDSA Cycle (Plan Do Study Act) or the Shewhart PDCA Cycle (Plan Do Check Act) was developed by Walter A. Shewhart in 1939 for quality control, but Deming encouraged a systematic approach to problem solving and promoted the now widely recognized four step process for continual improvement.

The model can be used for the ongoing improvement of almost anything and it contains the following continuous four steps:
- Plan: Develop a plan for improving quality of a process
- Do: Execute the plan, first on a small scale
- Study: Evaluate feedback to confirm or to adjust the plan
- Act: Make the plan permanent or study the adjustments

The Deming Wheel or the Shewhart Cycle

Source: [http://www.saferpak.com/pdsa.htm](http://www.saferpak.com/pdsa.htm) [accessed 4/24/06].

Astin’s IEO Model

The Input-Environment-Outcome (I-E-O) model was developed by Alexander W. Astin (1993) as a guiding framework for assessments in higher education. The premise of this model is that educational assessments are not complete unless the evaluation includes information on student inputs (I), the educational environment (E), and student outcomes (O) (Astin, 1993).

Inputs - personal qualities the student brings initially to the education program, including the student's initial level of developed talent at the time of entry, e.g., demographic information, educational background, political orientation, behavior pattern, degree aspiration, reason for selecting an institution, financial status, disability
status, career choice, major field of study, life goals, and reason for attending college. Personal qualities may have influences on the environment. These input data could include gender, age, ethnic background, ability, and socioeconomic level.

**Environment** - "refers to the student’s actual experiences during the educational program" (Astin, 1993, p. 18). The environment includes everything and anything that happens during the program course that might impact the student, and therefore the outcomes measured. Environmental items can includes those things such as educational experiences, practices, programs, or interventions.

**Outputs** - "the ‘talents’ we are trying to develop in our educational program" (Astin, 1993, p. 18), may include posttests, consequences, or end results. In education, outcome measures include indicators such as grade point average, exam scores, course performance, degree completion, and overall course satisfaction.

PROFESSIONAL DEVELOPMENT

Educational Technology & Data Management
UAMS offers a variety of technological support from web-based courseware to data management programs. Selected programs supported by UAMS include:

1. WebCT – distance education; “online classroom” web-based course management/testing feature
   accessed through http://distance-ed.uams.edu
   Contact: Robin Smith, PhD, Program Facilitator
2. Question Mark Perception – online survey tool;
   Accessed through http://www.library.uams.edu/lrc
   Contact: Jan Hart, Ed.D., or Heather Smith
3. New Innovation resident data management system resident data management/evaluations
   Accessed through http://www.new-innov.com
4. UAMS Library – a wealth of literature online databases
   Accessed through http://www.library.uams.edu
5. World Wide Web

Online Tutorials (sponsored by UAMS library) - CBT online tutorials for just about anything you want to learn. Go to http://www.uams-it.onlineexpert.com

The LearnKey Computer Based Library of tutorials. Log onto it at http://www.uams-it.onlineexpert.com and then log into the student section. The current default for LearnKey is that you are registered for one course at a time. You must complete it before beginning another. However, if you call or email Terry (TJ) Johnson, he can set you up to have access to all learning programs. Not only does this allow you to work in two courses at a time, it also lets you jump in and out of programs to just review or learn a particular topic in the program. Terry assures us that the default will ultimately be that you have access to all programs at all times. If you have any questions or problems forward them to TJ at tj@uams.edu.

Office of Educational Development (OED) www.uams.edu/oed
   Faculty/Staff
   Diane Heestand, Ed.D., Director
   Mike Petty, Ph.D.
   Carol Thrush, M.Ed.
   Anna Moses, M.Ed.
   Elizabeth Hicks

GME Office www.uams.edu/gme
   Staff
   Jim Clardy, M.D., Associate Dean for GME and DIO
   Ann Norwood, GME compliance
   Sally Marus, Dr. Clardy’s executive assistant
GLOSSARY OF EDUCATIONAL TERMS

- Accreditation Council for Graduate Medical Education (ACGME) Outcome Project – is a long-term initiative to increase emphasis on educational outcomes in the accreditation of residency training programs; www.acgme.org/outcome
- Residency Review Committee (RRC) – specialty-specific groups who provide oversight of residency programs.
- CBT – computer-based teaching
- PBL – problem-based learning
- TBL- team-based learning
- CBL – case-based learning
- Certifying boards -
- Assessment – data collected as a result of a learning experience
- Evaluation – the value placed on the data
- Goal – a desired purpose; an objective; a directive that is not measurable
- Objective – something worked toward or striven for, a goal
- Educational Goal – what you want to know or be able to do
- Educational Objectives – experiences designed to meet educational goals
- Curriculum – “a planned educational experience…encompassing a breadth of educational experiences, from one or more sessions on a specific subject, to a clinical rotation or clerkship, to an entire training program” (Kern, Thomas, Howard, & Bass, 1998)
- WebCT – Web-based online learning system
  - For more definitions, go to the ACGME’s website at http://www.acgme.org/outcome/project/proHome.asp and click on Glossary.
REFERENCES

Accreditation Council for Graduate Medical Education (ACGME) www.acgme.org.


Mager, Robert F. (1997). Preparing Instructional Objectives: A critical tool in the development of effective instruction. 3rd Ed. The Center for Effective Performance; Atlanta, GA.


Schwenk, Thomas L. & Whitman, Neal. (1993). Residents as teachers: A guide to educational practice. 2nd Ed. University of Utah School of Medicine; Salt Lake City, UT.


SECTION 8.1
ONE PAGE SUMMARY OF ABBREVIATIONS

American Association of Medical Colleges (AAMC), Washington, DC
• ERAS – Electronic Residency Application Service
• NRMP – National Resident Matching Program
• ROLIC (web ROLIC) – Rank Order List Interactive Confirmation

American Board of Medical Specialties (ABMS): An umbrella organization that represents the medical specialties

Accreditation Council for Graduate Medical Education (ACGME), Chicago, IL
• Green Book – Directory of Graduate Medical Education Programs (Now on line)
• RRC – Residency Review Committee: Produces Program Requirements and Standards that Programs must meet to be accredited
• PIF – Program Information Form (Different for each Specialty and changed from time to time.)
• Institutional Review (Review of the Institution by ACGME): Gives a satisfactory rating or results in LOR (Letter of Report) that indicates areas where the Institution does not comply with Institutional Requirements of the ACGME.

American Medical Association (AMA), Chicago, IL
• FREIDA Fellowship and Residency Education Interactive Database Access
• Survey of Residents
• Complete tracking database on all graduates of medical schools

Doctor of Medicine (M.D.) – Accepted by all residency programs after completion of an accredited Medical School.

Doctor of Osteopathic Medicine (D.O.) – Accepted by most programs just as a Medical Doctor (MD).

Educational Commission for Foreign Medical Graduates (ECFMG)
• CSA – Clinical Skills Assessment: Now required for ECFMG certification
• Visa – ECFMG aids in the processing of J-1 and H-1B Visas for Foreign Medical Graduates (FMG’s). See section on Visas in this manual.

National Board of Medical Examiners NBME
• USMLE – United States Medical Licensing Exam
• Administers the USMLE Steps 1, 2, 3 (replaced Part I, II, II of NBME EXAM)
• Provides focused subject exams or "shelf copies" of old NBME/USMLE exams
• CBX – computer based exam method to be used for testing

Test of English as a Foreign Language (TOFEL) – Given by the ECFMG.

World Health Organization (WHO) – List of foreign medical schools
SECTION 8.2
TERMINOLOGY

These are taken from http://www.acgme.org/acwebsite/gme_info/gme_glossary.asp, with additions from the Program Coordinators Organization members.

Glossary - Selected Terms Used in GME Accreditation

Accreditation: A voluntary process of evaluation and review performed by a nongovernmental agency of peers.

Applicant: A MD or DO invited to interview with a GME program.

At-Home Call (see also Pager Call): A call taken from outside the assigned institution.

Categorical Resident (also see also “Graduate Year 1”): A resident who enters a program with the objective of completing the entire program.

Certification: A process to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality care in that specialty.

Chief Resident: A position in the final year of the residency (e.g. surgery) or in the year after the residency is completed (e.g. internal medicine and pediatrics).

Clinical Supervision: A required faculty activity involving the oversight and direction of patient care activities that are provided by residents.

Combined Specialty Programs: Programs recognized by two or more separate specialty boards to provide GME in a particular combined specialty. Each combined specialty program is made up of two or three programs, accredited separately by the ACGME at the same institution.

Competencies: Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs.

Consortium: An association of two or more organizations or institutions that have come together to pursue common objectives (e.g., GME).

Designated Institutional Official (DIO): The individual in a sponsoring institution who has the authority and responsibility for the graduate medical education programs.

Didactic: A kind of systematic instruction by means of planned learning experiences, such as conferences, grand rounds, etc.

Duty Hours: All clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic assignments such as conferences. (See Common Program Requirements)
**ECFMG Number:** The identification number assigned by the Educational Commission for Foreign Medical Graduates (ECFMG) to each international medical graduate physician who receives a certification from ECFMG.

**Elective:** An educational experience approved for inclusion in the program curriculum and selected by the resident in consultation with the program director.

**Essential:** (See "Must")

**Faculty:** Any individuals who have received a formal assignment to teach resident physicians. In some institutions appointment to the medical staff of the hospital constitutes appointment to the faculty.

**Fellow:** A physician in a program of graduate medical education accredited by the ACGME who has completed the requirements for eligibility for first board certification in the specialty. Such physicians are also termed subspecialty residents. Other uses of the term "fellow" require modifiers for precision and clarity (e.g., research fellow).

**Fifth Pathway:** One of several ways that individuals who obtain their undergraduate medical education abroad can enter GME in the United States. The fifth pathway is a period of supervised clinical training for students who obtained their premedical education in the United States, received undergraduate medical education abroad, and passed Step 1 of the United States Medical Licensing Examination. After these students successfully complete a year of clinical training sponsored by an LCME-accredited US medical school and pass USMLE Step 2, they become eligible for an ACGME-accredited residency as an international medical graduate.

**Graduate Medical Education:** The period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education, and which prepares physicians for the independent practice of medicine, also referred to as residency education.

**Graduate Year Level:** Refers to a resident's current year of accredited GME. This designation may or may not correspond to the resident's particular year in a program. For example, a resident in pediatric cardiology could be in the first program year of the pediatric cardiology program but in his/her fourth graduate year of GME (including the 3 prior years of pediatrics).

**House Staff:** The term given to students, residents, and fellows who are in a training program and report to the House Staff office of the University of Arkansas for Medical Sciences. All initial paperwork, orientation sessions, and payroll is processed through the House Staff office for the trainees. The trainee's records are also maintained in this office, during and after the completion of their training.

**In-House Call:** Duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution. (See Common Program Requirements)

**Institution:** An organization having the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).
Sponsoring Institution: The institution (or entity) that assumes the ultimate financial and academic responsibility for a GME program.

Major Participating Institution: An RRC-approved participating institution to which the residents rotate for a required educational experience. Generally, to be designated as a major participating institution, in a 1-year program, residents must spend at least 2 months in a required rotation; in a 2-year program, the rotation must be 4 months; and in a program of 3 years or longer, the rotation must be at least 6 months. RRCs retain the right to grant exceptions to this formula. (See individual program requirements)

Other participating institutions: Those institutions to which residents rotate for a specific educational experience for at least one month, but which do not require prior RRC approval. (See specific program requirements) Subsections of institutions, such as departments, clinics, or units in a hospital, do not qualify as participating institutions.

Institutional Review: The process undertaken by the ACGME to determine whether a sponsoring institution offering GME programs is in substantial compliance with the Institutional Requirements.

Integrated: An institution may be considered integrated when the program director; a) appoints the members of the faculty and is involved in the appointment of the chief of service at the integrated institution, b) determines all rotations and assignments of residents, and c) is responsible for the overall conduct of the educational program in the integrated institution. There must be a written agreement between the sponsoring institution and the integrated institution stating that these provisions are in effect. This definition does not apply to all specialties. (See specific Program Requirements)

Intern: Historically, a designation for individuals in the first year of GME, which is no longer used by the ACGME.

Internal Review: A self-evaluation process undertaken by sponsoring institutions to judge whether its ACGME-accredited programs are in substantial compliance with accreditation requirements.

International Medical Graduate (IMG): A graduate from a medical school outside the United States and Canada (and not accredited by the Liaison Committee on Medical Education (LCME)).IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who were admitted to the United States by US Immigration authorities. All IMGs should undertake residency education in the United States before they can obtain a license to practice medicine in the United States even if they were fully educated, licensed, and practicing in another country.

In-Training Examination: Formative examinations developed to evaluate resident progress in meeting the educational objectives of a residency program. These examinations may be offered by certification boards or specialty societies.

JCAHO: Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an organization focused on improving the safety and quality of care provided to the public. It accomplishes this goal by accrediting healthcare organizations and offering healthcare improvement services.
**LCME:** Liaison Committee on Medical Education, an agency cosponsored by the American Medical Association and Association of American Medical Colleges, with participation from the Canadian Medical Association for schools in Canada, that accredits educational programs in allopathic schools of medicine in the United States and Canada. Allopathic schools of medicine grant a doctor of medicine (MD) degree.

**Medical School Affiliation** A formal relationship between a medical school and a sponsoring institution.

**Months of Rotation:** Refers to the total number of months a typical resident spends at an institution.

**Must:** A term used to identify a requirement which is mandatory or done without fail. This term indicates an absolute requirement.

**National Resident Matching Program (NRMP):** A private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME) in the United States. Five organizations sponsor the NRMP: American Board of Medical Specialties (ABMS), American Medical Association (AMA), Association of American Medical Colleges (AAMC), American Hospital Association (AHA), and Council of Medical Specialty Societies (CMSS).

**New Innovations:** is a tool that assists in the area of medical education, department administration, and schedule automation to unify data into a centralized data warehouse and to complete tasks, historically performed using multiple, incompatible methods, through one common interface. Training and updates are maintained through the Office of Educational Development (OED).

**New Patient:** A new patient is defined as any patient for whom the resident has not previously provided care. An individual RRC may further define new patient. (See Program Requirements)

**One Day Off:** One (1) continuous 24-hour period free from all administrative, clinical and educational activities.

**Ownership Type of Institution:** Refers to the governance, control, or type of ownership of the institution. (See Common Program Requirements)

**Pager Call:** A call taken from outside the assigned institution.

**Preliminary Positions:**

*Designated Positions:* Positions for residents, who have already been accepted into another specialty, but are completing prerequisites for that specialty. (See General Surgery Program Requirements)

*Non-Designated Positions:* Positions for residents, who at the time of admission to a program have not been accepted into any specialty. (See General Surgery Program Requirements)

**Primary Teaching Institution:** If the sponsoring institution is a hospital, it is by definition the principal or primary teaching hospital for the residency program. If the sponsoring institution is a
medical school, university, or consortium of hospitals, the hospital that is used most commonly in the residency program is recognized as the primary teaching institution.

**Program:** A structured educational experience in graduate medical education designed to conform to the program requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.

**Program Coordinator (PC):** The person answerable to the Program Director and is designated to oversee the Residency/Fellowship Program in accreditation, budget, credentialing, scheduling, recruitment, and administrative duties, as required by the Program Director.

**Program Director (PD):** The one physician designated to oversee and organize the activities for an educational program. The Program Director is responsible for the implementation of the Program Requirements for a specific specialty. (See specific Program Requirements for Program Director responsibilities and qualifications.)

**Program Information Form (PIF):** The PIF is the specialty-specific document completed by the program director in preparation for a site visit. The document is a compilation of requested information that reflects the current status of the educational program. Part 1 of the PIF is electronically generated through the Accreditation Data System.

**Program Letters of Agreement:** See Common Program Requirements.

**Program Merger:** Two or more programs that combine to create a single program. One program may maintain continued accreditation while accreditation is voluntarily withdrawn from the other program or programs. Alternatively, both programs may be withdrawn and a new program may be established.

**Program Year:** Refers to the current year of education within a specific program; this designation may or may not correspond to the resident’s graduate year level.

**Required:** Educational experiences within a residency program designated for completion by all residents.

**Resident:** A physician in an accredited graduate medical education program.

**Rotation:** An educational experience of planned activities in selected settings developed to meet the goals and objectives of the program.

**Scholarly Activity:** An opportunity for residents and faculty to participate in research and the scholarship of discovery, dissemination, application and active participation in clinical discussions and conferences. (See Common Program Requirements)

**Shall:** (See must)

**Should:** A term used to designate requirements so important that their absence must be justified.

**Site Review/Survey/Visit:** The term given to the
Specialty program: (See definition of Program)

Subspecialty program: A structured educational experience following completion of a prerequisite specialty program in graduate medical education designed to conform to the Program Requirements of a particular subspecialty.

**Dependent Subspecialty Program:** A program that is required to function in conjunction with an accredited specialty program, usually reviewed conjointly with the specialty program, usually sponsored by the same sponsoring institution, and geographically proximate. The continued accreditation of the subspecialty program is dependent on the specialty program maintaining its accreditation.

**Independent Subspecialty Programs:** A program that is not directly related to, or dependent upon, the accreditation status of a specialty program.

Suggested: A term along with its companion “strongly suggested,” used to indicate that something is distinctly urged rather than required. An institution or program will not be cited for failing to do something that is suggested or strongly suggested.

Transitional Year Program: A one-year educational experience in GME, which is structured to provide a program of multiple clinical disciplines; its design to facilitate the choice of and/or preparation for a specialty. The transitional year is not a complete graduate education program in preparation for the practice of medicine.

VISA: International medical graduates who are neither U.S. citizens nor lawful permanent residents must obtain an appropriate visa for themselves and their dependents, if any, to participate in programs of graduate medical education or training in the United States. The most common visa employed for this purpose is the J visa (See Manual Section on Visas for types and descriptions).
SECTION 8.3
Web Site Addresses

• http://www.aamc.org
  Association of American Medical Colleges Contains a list of
  academic societies and their web sites.

• http://www.AAMC.org/about/progemp/ERAS/start.htm
  ERAS home page

• http://www.aamc.org/nrmp
  NRMP information

• http://www.vsu.com/
  Vital Signs Unlimited for ACLS course.

• http://www.acgme.org
  Accreditation Council for Graduate Medical Education

• http://www.ama-assn.org/cgi-bin/freida.cgi
  American Medical Association (FREIDA)

• http://www.amsa.org
  American Medical Student Association Foundation

• http://www.ecfmg.org
  Education Commission for Foreign Medical Graduates

• http://www.ncerp.com
  The National Center for Evaluation of Residency Programs

• http://ahme.med.edu
  Association for Hospital Medical Education

• http://www.aafp.org
  American Academy of Family Physicians

• http://gasnet.med.yale.edu/vl
  (then click on "Academic Sites") List of Academic Web Sites (Including
  Residency Programs in anesthesiology)

• http://www.NBME.org
  National Board of Medical Examiners

• http://www.toefl.org
  Describes the TOEFL exam required for all IMGs 4/99

• http://www.ABIM.org/announce/passrate.htm
  Location showing % of residents who pass the ABIM exam over a 3-yt period
• http://www.eyenet.org
  This is the AAO

• http://www.usmle.org
  United States Medical Licensing Exam information

ACGME Glossaries
• http://www.acgme.org/acWebsite/about/ab_ACGMEglossary07_05.pdf

• http://www.acgme.org/outcome/project/glossary.asp