FORWARD

(July 2002) - Based on our experiences, we put together the Physical Medicine and Rehabilitation Residency Program—Coordinators’ Manual with the new program coordinator in mind. We, as “veterans,” hope that this will be a useful reference tool. You must realize that PM&R accreditation rules and regulations change from year to year and that program coordinator roles vary from institution to institution. With this in mind, please use this manual as a guide based on our experiences and NOT in place of your school’s policies or the PM&R program and institutional requirements of the ACGME.

Sincerely,

PM&R Program Coordinators Steering Committee:
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Barb Cook, Rush-Presbyterian-St.Luke’s Medical Center
Cindy Grogg, Mayo Clinic
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Cherie Packard, Medical College of Ohio

ACKNOWLEDGEMENT

The members of the Program Coordinators Council of the Association of Academic Physiatrists (AAP) who compiled the original manual would like to give a BIG thank you to the Handbook Committee of the Association of Pediatric Program Directors. We used their Pediatric Residency Program Coordinators Handbook as a guide. Because of their foresight in realizing that residency coordinators needed a manual, we saved many hours in the preparation. In the writing of the PM&R manual, it was interesting to see that many of our duties as coordinators were the same or very similar. In these instances, we used their information in our manual, and we are so grateful to them for allowing us to do so.

Finally, we would like to thank the Association of Academic Physiatrists for their support and encouragement. We, as coordinators, feel honored to be a part of this national organization!

(September 2008) – Second Edition
The second edition of the PMR Program Coordinator’s Manual was edited by Cindy Grogg with contributions from Miki DeJean, Cheri Packard, and Stacey Snead-Peterson. This edition refers to the program requirements that were effective July 2007.

(February 2015) – Third Edition
This is the third edition of the PMR Program Coordinator’s Manual. This edition was edited by Cindy Grogg and Stacey Snead-Peterson and refers to the program requirements that were effective July 2014.

(Updated February 2016 – referring to the program requirements effective 7/1/15)
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(Updated March 2020 – referring to the program requirements effective 7/1/2019)
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OVERVIEW

The ACGME does require that a program have a dedicated program coordinator. Although the program director is responsible for all aspects of the program, much of the work that is involved in administering a program is delegated to the program coordinator. The program coordinator, in most programs, is the person with the most global view of the program with regard to resident concerns, approaching deadlines, changes in ACGME requirements and specialty board requirements that need to be implemented, and upcoming changes in institutional policies. A highly skilled and experienced program coordinator is valuable to the program. He or she is a member of the leadership team and must possess skills in leadership and personnel management. The program coordinator is often the first person someone contacts with questions about the residency program. His or her professional and administrative skills are a reflection of the quality of the program and effectiveness of the program director. The program coordinator needs to work independently within prescribed guidelines, engage in continuous professional development, and suggest initiatives to improve the quality of the program. It is vitally important that the program director and program coordinator have a close and mutually respectful working relationship and a clear understanding of each other’s role.

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

PMR Program Requirement II.C.2.: At a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time.

Reference

Certification
The National Board of Certification for Training Administrators of Graduate Medical Education Programs (TAGME) has been created to establish standards for the profession, to acknowledge the expertise needed to successfully manage graduate medical education programs and to recognize those training program administrators who have achieved competence in all fields related to their profession. Pursuing certification is voluntary. Program coordinators interested in certification must meet the established criteria to be eligible for certification. Criteria for certification can be found at www.tagme.org. The process of certification includes the completion of an application and successful completion of the online assessment tool. Certificates are valid for five years at which time you would need to complete the process for maintenance of certification. Further information can be found on the TAGME website: www.tagme.org.
GENERAL ROLES AND RESPONSIBILITIES OF PM&R COORDINATORS

The roles and responsibilities vary greatly among PM&R programs. Some coordinators have combined jobs that require they perform duties outside the realm of the coordinator’s role in graduate medical education, including department administrative functions, secretarial support, etc. Each training program is unique as it designs and implements a learning experience for residents. Program coordinators work closely with the program director and have an active role in the administration and management of the day-to-day operations of the residency program. Below is an alphabetical list of the typical, general job responsibilities of a PM&R Coordinator.

Accreditation
1. Familiarize yourself with current ACGME (Accreditation Council for Graduate Medical Education) and ABPMR (American Board of Physical Medicine and Rehabilitation) requirements, and know where to find them.
2. Organize and maintain information needed to complete the ACGME Annual Program Update through ADS.
3. Familiarize yourself with the Clinical Learning Environment Review (CLER) program to know what is assessed during the visit.
4. Manage, prepare, and assist with self-study and site visits.

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

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

Credentialing
1. Collect credentialing data and maintain credentialing records.
2. Schedule residents for credentialing courses (i.e., ACLS and BLS).
3. Distribute certificates to residents for program completion.
4. Manage graduate records and prepare verification and credentialing documents for program alumni.
Scheduling
1. Schedule PM&R-related activities such as master schedule of rotations, conferences, electives, vacations, individualized rotations, didactics, committee meetings, recruitment, events (i.e., orientation, graduation, AAPMR SAE-R and AANEM TPSAE and NMSAE examinations), etc.
2. Coordinate schedule for medical student elective in PM&R.
3. Prepare and/or distribute master rotation, call, and didactic schedules in cooperation with chief resident(s).

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

Resident Support
1. Assist with orientation of new residents.
2. Recognize and support resident contributions.
3. Serve as a role model for positive character traits that should be exemplified by residents.
4. The coordinator must be sensitive to race, ethnicity, and culture; be an active listener; and be fair and nonjudgmental.
5. Demonstrate tact and diplomacy when dealing with others and relaying confidential information.
6. The coordinator should be seen as an advocate to the residents.

Notary Public—Optional
1. Not required, but very helpful in this role.
ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)

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

Program Coordinator’s Role
1. Learn the ACGME’s program requirements for physical medicine and rehabilitation, and the common and institutional requirements (located on the ACGME website).
2. Graduate Medical Education is full of acronyms. Print off the “ACGME Glossary of Terms” to help you learn the terms at the following website: https://www.acgme.org/Designated-Institutional-Officials/Institutional-Review-Committee/Documents-and-Resources
3. Assist the program director in making sure your residency program is complying with all ACGME guidelines and requirements. This is why you need to learn the requirements mentioned in #1 above.
4. Maintain your program’s graduate medical education information through the ACGME Web Accreditation Data System (ADS).

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ACGME WEB ACCREDITATION DATA SYSTEM (ADS)

The ACGME 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 accredited 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). Programs will receive an email from the ACGME informing program personnel of the timeframe the ADS update needs to occur as well as the Resident and Faculty surveys.

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 (DIO’s) will be contacted each year and will be asked to log on and verify their institutional data, as well as monitor the progress of their programs making annual updates. All specialties and subspecialties are required to update their data annually.

Program Coordinator’s Role
Program Directors have the ability to grant and revoke program coordinator access to their ADS account. Ask your program director to grant you access by following these steps:

1. Login to ADS account
2. Click on the “Program” tab
3. Scroll to the bottom of the screen and locate the “Program Leadership” section
4. Next to the program coordinator’s name, click the “Grant User” button
5. Program Coordinator will receive an email with a username and password
PROGRAM ACCREDITATION REVIEW COMMITTEE (RC)

The Review Committee (RC) is a section of the ACGME that is responsible for the accreditation of a particular specialty or subspecialty and its member programs. Accreditation is given once it has been determined that a program is in compliance with the standards and guidelines set up in the ACGME Physical Medicine and Rehabilitation Program Requirements.

To receive initial accreditation, or re-establish lost accreditation, the program director needs to send a letter of application to the executive director of the Review Committee. It may take 8-12 months from the beginning of the application process to the conclusion of the accreditation process. The Review Committee only meets twice a year, so notification of the committee’s decision depends on when the site visit takes place in relation to when the RC convenes.

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

To assess the compliance status of programs or sponsoring institutions, the ACGME uses accreditation site visits. Site visits may be announced or unannounced. There are three types of site visits: Focused Site Visit, Full Site Visit and Site Visit for Alleged Egregious Violations. The definition and processes for these visits can be found in the ACGME Policies and Procedures. A full site visit must be scheduled at the end of the initial accreditation period for newly accredited programs and up to the end of a 10 year accredited period for programs with Continued Accreditation status.

Once the Review Committee has met and reviewed your program, a detailed letter of notification will be posted to the ACGME Accreditation Data System (ADS) regarding the accreditation status of the program. Program directors and designated institutional officials (DIO’s) are notified by email when a letter has been posted in ADS. Listed in this letter are the deficiencies along with the approximate time of the next site visit. The program director needs to address these deficiencies in a letter of response to the RC only if the letter specifically asks you to do so.

Next Accreditation System (NAS)
The aims of the NAS are to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century (maintenance of certification, ongoing quality improvement), to accelerate the ACGME’s movement toward accreditation on the basis of educational outcomes (demonstrated program improvement), and to reduce the burden associated with the current structure and process-based approach (elimination of PIFs and traditional site visits).
The NAS moves the ACGME from an episodic “biopsy” model (in which compliance is assessed every 4 to 5 years for most programs) to annual data collection. Each RC (Review Committee) performs an annual evaluation of trends in key performance measurements and extends the period between scheduled accreditation visits to 10 years. In addition to the milestones, other data elements for annual surveillance include the ACGME resident and faculty surveys and operative and case-log data. The NAS eliminates the program information form, which previously was prepared before a site visit to describe compliance with the requirements. Programs will conduct a self-study before the 10-year site visit, similar to what is done by other educational accreditors. It is envisioned that these self-studies will go beyond a fixed description of a program by offering opportunities for meaningful discussion of what is important to stakeholders and showcasing of achievements in key program elements and learning outcomes.

Ongoing data collection and trend analysis will base accreditation in part on the educational outcomes of programs while enhancing ongoing oversight to ensure that programs meet standards for high-quality education and a safe and effective learning environment. Programs that demonstrate high-quality outcomes will be allowed to innovate by relaxing detailed process standards that specify elements of residents' formal learning experiences (e.g., hours of lectures and bedside teaching), leaving them free to innovate in these areas while continuing to offer guidance to new programs and those that do not achieve good educational outcomes.


**CLER (Clinical Learning Environment Review)**

As a component of its next accreditation system (NAS), the ACGME has established the CLER program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites. CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care. In essence, CLER is a traditional site visit of GME and the institution, not individual programs.

The feedback provided by the CLER Program is designed to encourage clinical sites to improve engagement of resident and fellow physicians in learning to provide safe, high quality patient care. The CLER visit is built on a model of continuous quality improvement with its purpose being to evaluate, encourage, and promote improvements to the clinical learning environment.

**CLER assesses sponsoring institutions in the following six focus areas:**

1. **Patient Safety** – including opportunities for residents to report adverse events, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.
2. **Health Care Quality** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
3. **Care Transitions** – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.
4. **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
5. **Well-being**—including how sponsoring institutions promote well-being across the clinical care team to ensure safe and high quality patient care. This includes building awareness and educating the clinical care team on the risks, signs, symptoms, and recognition of both fatigue and burnout in the context of patient care specific to the clinical site.

6. **Professionalism**—with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of residents and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

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**Self-Study / Self-Study Visit (SSV)**

The Self-Study constitutes an in-depth assessment of the program that examines longitudinal data from all annual evaluations since the program's last scheduled accreditation review. Depending on the timing of the Self-Study, it may also incorporate the Annual Program Evaluation for the current year.

The information collected should highlight strengths, areas where improvement has been achieved, and areas still in need of improvement. For areas for improvement, the focus should be on each year's action plans (V.C.3 (Core)), records of progress on the previous year's action plans (V.C.2.e (Core)), and documentation in PEC meeting minutes that relate to the action plans (V.C.3.a (Detail)). This information can be entered into a simple table or spreadsheet to create a longitudinal record of the improvements achieved.

In addition to data from the Annual Program Evaluations, the Self-Study Committee may explore what other existing data (such as information collected by the sponsoring institution) may be of value to the Self-Study.

**8 Steps for Conducting The ACGME Program Self-Study**

1. Assemble the Self-Study Group
2. Engage Program Leader and Constituents in a Discussion of Program Aims
3. Aggregate and Analyze Data from Your Annual Program Evaluations and the Self-Study to Create a Longitudinal Assessment of Program Strengths and Areas for Improvement
4. Examine the Program’s Environment for Opportunities and Threats
5. Obtain Stakeholder Input on Strengths, Areas for Improvement, Opportunities, and Threats to Prioritize Actions (SWOT Analysis)
6. Interpret the Data and Aggregate the Self-Study Findings
7. Discuss and Validate the Findings with Stakeholders
8. Develop a Succinct Self-Study Document for Use in Further Program Improvement as Documentation for the Program’s 10-Year Site Visit

**Elements of the Self-Study Document**

1. **Introduction** - Provide a brief summary of how the Self-Study was conducted, and the participation of program leadership, residents, faculty, and any other stakeholders.
2. **Program Overview** – A brief description of your residency/fellowship program, as you would to an applicant or prospective faculty member. Discuss any notable information about the program.

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

4. **Aggregated lists of Strengths and Areas for Improvement** for the period since the last scheduled accreditation review. The PEC (Program Evaluation Committee) is responsible for documenting the evaluation of the curriculum at least annually in the following areas:

   - Resident performance, V.C.2.a) (Core)
   - Faculty development, V.C.2.b) (Core)
   - Graduate performance, including performance of program graduates on the certification examination, V.C.2.c) (Core)
   - Program quality, V.C.2.d) (Core)

Programs should have an aggregated list of all action plans including follow-up or results of each action plan for every APE for 10 years at the time of the self-study visit.

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

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

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

6. **Action Plans** for maintaining Strengths, addressing Areas for Improvement, capitalizing on Opportunities, and mitigating Threats. Programs are required to keep ongoing track of action plans from year-to-year for the 10-year self-study visit (SSV).

**Self-Study Timeline**

The self-study timeline is a 12-18 month process. The first step is for the program to conduct the self-study. A few months later, the program is to upload the Self-Study Summary (8 questions) through ADS. 12 months after that, the program can upload any updates to the Summary through ADS. A month or so after that 2 field representatives will come to your institution to review your program. Within the same time period, the field representatives will upload their report from the visit into ADS. The final part of the process is the Review Committee will make an accreditation decision including an assessment of the effectiveness of the self-study.

**Self-Study Summary**

The Self-Study Summary is what gets uploaded into ADS to initiate the Self-Study. The program has until the end of the month listed on the Program’s ADS to complete and upload (i.e., if August 1, 2021 is listed on ADS, the deadline to upload is August 31, 2021). Completion of the Self-Study Summary involves answering the following 8 questions. Actual documents are not required, only descriptions and processes. The document is limited to 2500 words (approximately 7 pages of single spaced narrative). The program will have an opportunity to update the Summary and post the final version 10 days before the SSV (Self-Study Visit).

**Program Description and Aims**

**Question 1: Program Description**

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

**Question 2: Program Aims**

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

**Question 3: Program activities to advance the aims**

Describe current activities that have been, or are being, initiated to promote or further these aims. (Maximum 250 words)
Environmental Context - Summarize the information on the program’s environmental context that was gathered and discussed during the Self-Study.

Question 4: Opportunities for the program
Describe important opportunities for the program. (Maximum 250 words)

Question 5: Threats facing the program
Describe any real or potential significant threats facing the program. (Maximum 250 words)

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

Question 6b: Project your vision and plans for the program for the coming five years.
What will take this program to “the next level”? (Maximum 350 words) Note: In your response, discuss what the “next level” will look like, the envisioned steps and activities to achieve it, and the resources needed.

Question 7a: Describe elements of the Self-Study process for your program.
Provide information on your program’s Self-Study, including who was involved, how data were collected and assessed, how conclusions were reached, and any other relevant information. (Maximum 300 words)
Who was involved in the Self-Study (by role/title)?
How were areas for improvement prioritized?

Question 7b: Describe the core program’s role in the Self-Study(ies) of its dependent subspecialty program(s). (Maximum 150 words)
Note: If this is an individual core program without associated subspecialty programs or a dependent freestanding subspecialty program, skip to Question 8.

Question 8: Describe learning that occurred during the Self-Study.
This information will be used to identify potential best practices for dissemination. (Maximum 200 words)

References:
https://www.acgme.org/What-We-Do/Accreditation/Self-Study
https://www.acgme.org/acgmeweb/tabid/473/ProgramandInstitutionalAccreditation/Self-Study.aspx
https://www.acgme.org/acgmeweb/Portals/0/PDFs/SelfStudy/SelfStudyPilot.pdf
https://www.acgme.org/acgmeweb/Portals/0/PDFs/SelfStudy/SSSampleTimeline.pdf

Program Coordinator’s Role
1. Review the 8-steps to the Self-Study.
2. Ensure Annual Program Evaluation action plans are tracked from year-to-year.
3. Confirm action plans from the APE are noted in PEC minutes.
4. Ensure Self-Study Summary uploads through ADS are submitted in a timely manner.
Clinical Competence Committee (CCC)
Each program must appoint a CCC to evaluate each resident’s milestones semi-annually. Milestones must be reported semi-annually to the ACGME via ADS.

The committee should be composed of three members of the core faculty. Other members can include faculty from other programs and non-physicians of the health care team (residents including Chief residents, should not be on the CCC).

Each program must develop a policy that outlines the responsibilities of the CCC. The CCC is to advise the program director regarding the resident’s progress, including promotion, remediation, and dismissal.

In the Annual WebADS update, the Overall Evaluation Methods section, CCC members and their role in the program is required to be listed. Also, the Program is asked to briefly describe the process used by the Clinical Competency Committee to accomplish semiannual and summative evaluations.


Program Evaluation Committee (PEC)
The PEC must be composed of at least two program faculty members and at least one resident. Each program must develop a policy that outlines the responsibilities of the PEC.

Members of the PEC should participate actively to plan, develop, implement and evaluate educational activities of the program; review and make recommendations for revision of competency-based curriculum goals and objectives; address non-compliant ACGME standards; review the program through multiple evaluations and document it at least annually [Annual Program Evaluation (APE)].

In the Annual WebADS update, the Overall Evaluation Methods section, PEC members and their role in the program is required to be listed. Also, the Program is asked to briefly describe the process used by the Program Evaluation Committee to conduct the annual program review, develop and review the annual action plan, and guide ongoing program improvement.

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

There are three (3) processes:

AIR – Annual Institution Review includes data collection from multiple sources such as the resident surveys, faculty surveys, and responses to RC accreditation citations. (I.B.5.).
APE and Oversight – Annual Program Evaluation consists of collecting all required data from programs and the GME office oversees compliance.

Special Review Process – this process is similar to an internal review for underperforming programs. Each GME office must establish performance indicators that determine which programs need to go through this process. (I.B.6. a).(1)). A report must result that identifies the quality improvement goals, corrective actions, and process for monitoring outcomes. (I.B.6. a).(2)).

You can find information on the ACGME website at www.acgme.org.

Program Coordinator’s Role
1. You should be familiar with the ACGME program requirements. If you make certain changes in the program, notifying the ACGME may be required.
3. Establish CCC per requirements. Develop a policy to outline the responsibilities of the CCC. Conduct meetings semi-annually to review and assess milestones for each resident/fellow. Submit the milestones for each resident/fellow to the ACGME by the designated deadline.
4. Establish PEC per requirements. Develop a policy to outline the responsibilities of the PEC. Keep track of action plan improvements in preparation for 10-year self-study visit.
5. CLER Visit – Ensure faculty, residents, allied health professionals, staff, etc. are aware of policies pertinent to the flow of patient care (i.e. transitions of care).
6. GME Oversight – Comply with the GME office to provide any information needed to conduct processes mentioned above.
ACGME ADS ANNUAL PROGRAM UPDATE

As part of the accreditation process, each review committee (RC) will perform an annual evaluation of programs. This will extend the period between scheduled accreditation visits to 10 years. Ongoing data collection and reporting of performance measures will ensure ongoing oversight that programs are meeting standards for high-quality education and a safe and effective learning environment.

The RC may use the following information to assess programs:

- ADS Annual Update
- Resident Survey
- Faculty Survey
- Milestone Data
- Certification examination performance
- Clinical Experience (Case Logs)
- Hospital Accreditation Data
- Scholarly Activity of Faculty & Residents
- Other
  - ACGME complaints
  - Verified public Information
  - Historical accreditation decisions/citations
  - Institutional/program quality and safety metrics

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

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

Program Information

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

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

Faculty Information

- Update Program Director information
- Update all faculty members’ information
  - Program Specific Title
  - Valid email
  - National Provider ID
  - Primary Institution
  - Date first appointed faculty member
  - Year started teaching in PMR
  - Year started teaching in GME
- Enter Medical School Information and Graduation Year
- Enter a specialty, certificate type and certification status for each active faculty member
- Enter Faculty Hours (Clinical Supervision of Residents; Administration of the Program; Research/Scholarly Activity with Residents; Didactics/Teaching with Residents)
- Update scholarly activity for each physician faculty member
- Update Program Director’s CV
- Enter CV information for Non-Physicians (required by your specialty)

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

ACGME Resident/Fellow and Faculty Surveys

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

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

For programs with less than 4 residents who meet the 70% compliance rate, reports will only be available on an aggregated basis after at least 3 years of survey reporting have taken place. Survey results will be available in ADS if your program meets the required compliance rate. The aggregate report provides an anonymous and comparative look at how the program compares to national, institutional, and specialty averages.

Faculty Survey

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

More information can be found on the ACGME website - ACGME Faculty Survey FAQ’s.

Program Coordinator’s Role

1. Program directors and coordinators will be notified when they are required to participate in the Resident & Faculty Surveys.
2. Follow the instructions from ACGME to log into the ADS system to notify/remind residents and faculty to complete the survey
3. Follow up to ensure a minimum of 70% of residents and 70% of faculty complete the survey by the deadline.
4. Review results of the survey at your PEC meeting.

Resident Case Log System

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

**Program Coordinator’s Role**

- Each academic year, enter new residents into the ACGME Case Log System.
- Ensure residents are progressing to meet minimum numbers for required procedures.
  - 200 EMG’s (no more than 25% (50) should be observed)
  - Axial Epidural Injections = 5 total
  - Axial facet, SI joint, nerve block = 5 total
  - Peripheral joint/intra-articular injection/tendon sheath/bursa injection = 20 total (15 performed)
  - Botulinum toxin injection = 20 total (15 performed)
  - Ultrasound = 10 total
- At the end of the academic year and prior to the ACGME deadline of Aug. 1, ensure graduating residents have all their procedures recorded for the year end archiving process. *Tip: Export raw data to excel before archive.

**Scholarly Activity of Faculty and Residents**

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

**Program Coordinator’s Role**

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

**Faculty Reporting:**

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

**Resident Reporting:**

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

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

Physical Medicine and Rehabilitation Milestones can be found at the following site: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PMRMilestones.pdf

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

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

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

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

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

- Has not Achieved Level 1 – indicates the resident has not substantially demonstrated Level 1 or has not had an opportunity to learn and demonstrate the milestones.
- Level 1 (novice) – demonstrates milestones expected of an incoming resident.
- Level 2 (advanced beginner) – advancing but not performing at a mid-resident level.
- Level 3 (competent) – demonstrates the majority of milestones targeted for residency.
- Level 4 (proficient) – substantially demonstrates the milestones targeted for residency. This level is the graduation target but does not represent a graduation requirement.
- Level 5 (expert) – advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.
At the completion of residency training, the final milestones provide meaningful data on the performance and competency that graduates must achieve prior to entering unsupervised practice.

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

**Program Coordinator’s Role**

The Program Director should review the results of the Milestone determinations with the resident soon after the CCC meeting has occurred. As the reporting of the Milestones is at the midpoint and end of an academic year, semi-annual evaluations with the Program Director should be set up at this time.

Under eligibility requirements (refer to CPR III.A.2.a), residency programs must receive verification of each resident’s level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. At the start of the academic year, coordinators should go into ADS and print off each of your incoming residents Milestones summary from their PGY-1 training.

**Pre-meeting**
- Schedule meeting and location
- Notify attendees
- Aggregate data electronically or on paper
- Provide information to members before the meeting so they can prepare for meeting
- Summarize data

**At the meeting**
- Provide any information needed by committee members
- Take minutes
- Document any necessary information to resident/fellow record
- Record recommendations on each resident by milestone

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

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

Evaluations are an essential tool for documenting the quality of rotations, the residents’ experiences, and the faculty’s observations. Feedback is ongoing information provided regarding aspects of one’s performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent and need not always be formally documented.

Clinical Competence Committee (CCC)
The program director must appoint a Clinical Competency Committee to determine each resident’s progress on achievement of the specialty specific Milestones at least semi-annually. Milestones must be reported semi-annually to the ACGME via ADS. The CCC must meet prior to the resident’s semi-annual evaluations and advise the program director regarding each resident’s progress.

The committee should be composed of at least three members of the program faculty, one of whom is a core faculty member. Other members can include faculty from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s residents (residents including Chief residents, should not be on the CCC). The coordinator plays a major role in the CCC meeting; however, the coordinator cannot be an official voting member of the CCC. The coordinator should take minutes and record key aspects of the discussion. The coordinator should enter the Milestone information for each resident into ADS following the CCC meeting.

Each program must develop a policy that outlines the responsibilities of the CCC. The CCC is to advise the program director regarding the resident’s progress, including promotion, remediation, and dismissal.

Resident Evaluation [CPR V.A. – V.A.1.f)]

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

The program must have formal mechanisms for monitoring and documenting each resident’s acquisition of fundamental knowledge, clinical skills, and his or her overall performance. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
Evaluation must be documented at the completion of the assignment. For block rotations greater than three months, evaluation must be documented at least every three months. Longitudinal experiences such as continuity clinic must be evaluated at least every three months and at completion.

The program must provide objective performance evaluation based on residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The program must use multiple evaluators such as faculty, peers, patients, self, and other professional staff. The information must be provided to the Clinical Competency Committee (CCC) for its synthesis of progressive resident performance and improvement toward unsupervised practice.

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

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

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

**Final Evaluation [CPR V.A.2. – V.A2.a).(2).(d)]**

The program director must provide a final evaluation for each resident upon completion of the program.

The specialty-specific milestones and Case Logs must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. The final evaluation must become part of the resident’s permanent record maintained by the institution and must be accessible for review by the resident in accordance with institutional policy. It must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice and consider recommendations from the Clinical Competency Committee. The final evaluation must be shared with the resident upon completion of the program.

The ABPMR *Booklet of Information* states, when a resident first applies for admissibility to the Part I Examination, the program director certifies that satisfactory completion of the required residency training is anticipated by August 31 of the year of examination and also provides a preliminary opinion regarding the candidate’s qualifications to enter independent clinical practice in the specialty.
Evaluation of Resident Care Transitions [CPR VI.E.3. – VI.E.3.e)]
The ACGME assigns Sponsoring Institutions and each program the responsibility to ensure and monitor effective, structured, hand-off processes to facilitate continuity of care and patient safety. The ACGME also requires each program ensures trainees are compliant in communicating with team members in the hand-off process. These requirements are explicitly stated in the ACGME Common Program Requirements (VI.E.3.) and are a focus of the ACGME Clinical Learning Environment Review (CLER). Each program should have an evaluation process for documenting faculty assessment of resident/fellow change of duty hand-offs and patient transfers between services and locations either through direct observation or simulation. Ideally programs should evaluate trainees on care transitions each year as resident’s role in patient care advances.

Evaluation of Faculty [CPR V.B. – V.B.3.]
At least annually, the program director must evaluate faculty performance as it relates to the educational program. Faculty evaluations should include a review of the faculty’s clinical teaching abilities; engagement with the educational program; participation in faculty development related to their skills as an educator, quality improvement in patient safety, in fostering their own and their residents’ well-being, and in patient care based on their practice-based learning and improvement efforts; clinical performance; professionalism; and scholarly activities. This evaluation must include written, anonymous, and confidential evaluations by the residents. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

Evaluation of Program [CPR V.C.]
The program, through the Program Evaluation Committee (PEC), must document formal, systematic evaluation of the curriculum at least annually and is responsible for rendering a written Annual Program Evaluation (APE). The program must monitor and track each of the following areas: resident performance; faculty development; graduate performance, including performance of program graduates on the certification examination; and program quality. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually. The program must use the results of all assessments to improve the program. Progress of the previous year’s action plan must be reviewed and documented.

Program Evaluation Committee (PEC)
The program director must appoint the Program Evaluation Committee (PEC). The PEC must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. Each program must develop a policy that outlines the responsibilities of the PEC.

Program Evaluation Committee responsibilities include: acting as an advisor to the program director through program oversight; review of the program’s self-determined goals and progress toward meeting them; guiding ongoing program improvement including development of new goals, based upon outcomes; and review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program’s missions and aims. The PEC should consider the following elements as part of their annual assessment of the program:
• Curriculum
• Outcomes from prior annual program evaluation (APE)
• ACGME letters of notification, including citations & areas for improvement
• Quality and safety of patient care
• Aggregate resident and faculty
  o well-being
  o recruitment and retention
  o workforce diversity
  o engagement in quality improvement and patient safety
  o scholarly activity
  o ACGME Resident and Faculty Surveys
  o written evaluations of the program
• Aggregate resident
  o achievement of the Milestones
  o in-training examinations
  o board pass and certification rates
  o graduate performance
• Aggregate faculty
  o evaluation
  o professional development

The PEC must evaluate the program’s mission and aims, strengths, areas for improvement, and threats. The annual review including the action plan must be distributed to and discussed with the members of the teaching faculty and the residents and submitted to the DIO.

**Program Coordinator’s Role**

1. Process monthly resident, faculty, rotation, multi-source, and patient hand-off evaluations. Most residency programs use an electronic evaluation system (MedHub, E-Value, New Innovation, etc.). There are several different programs out there, and you will need to find the one that works best for your program. Your GME office may decide the evaluation program that is used across the institution.

2. Track evaluations by
   o Monitoring the return of all evaluations
   o Providing residents, faculty, and program director access to evaluations while also maintaining confidentiality

3. Coordinate resident semiannual evaluations with the program director in conjunction with milestone reporting.

4. Coordinate and document annual program evaluation (APE) by the PEC, including written action plan for areas of improvement.

5. Track action plan results of APE for improvement outcomes.

6. Initiate the final evaluation by the program director of all G4 residents at the completion of their residency. Both program director and resident need to sign. A copy must be provided to the resident within 30 days of program completion.

7. Send in *ABPM&R Final Evaluation* of PGY-4 residents. The residents cannot take their Boards if the ABPM&R does not receive the final evaluation by the deadline date.
ASSOCIATION OF ACADEMIC PHYSIATRISTS (AAP)

Established in 1967, the Association of Academic Physiatrists (AAP) is an organization for physiatrists interested in the academic aspects of Physical Medicine and Rehabilitation. The AAP strives to promote the advancement of higher education and research in PM&R and to encourage young physicians to pursue an academic career in physiatry.

Membership is open to all physiatrists interested in education and research. Faculty, those in training (medical students to fellows), non-physiatrists interested in PM&R education and research, and non-physicians involved in academic PM&R (e.g., administrators and researchers) are eligible to join the AAP. The benefits of membership include subscriptions to the monthly publication, American Journal of PM&R, and to the quarterly AAP newsletter.

The AAP maintains an extensive website that contains information about the field of PM&R, How to Find a Physiatrist, and information concerning education and research. A useful resource to training programs is the PM&R Program Directory that lists every accredited training program, information on how to apply for a residency, resident demographics, etc.

Along with the standing committees, there are eight AAP councils—Council of PM&R Chairs, Council of Residency & Fellowship Program Directors, Council of Residents and Fellows, Council of Medical Student Educators, Council of Program Coordinators, Council of Administrative Directors, Council of Medical Students, and Council of Veteran Affairs.

The AAP holds an annual meeting with courses focusing on issues pertinent to academic physiatry in research, education, and administration. The conference also features scientific poster and paper presentations as well as committee and council meetings. A good way for residents to become involved in the AAP is through the Council of Residents and Fellows. This council has a separate program each year at the annual meeting. There is also a one-day leadership workshop for residents, which offers an excellent opportunity to learn and network.

Program Coordinator’s Role
1. Read “The Coordinators’ Corner” in the quarterly newsletter to stay abreast of pertinent information.
2. Process yearly memberships for residents (if your program pays for membership).
3. Join the association as a residency program coordinator and be an active participant. If your institution joins as an academic partner, your membership and registration at the annual meeting is complimentary.
4. Update program information in the PM&R Program Directory posted under the “News & Resources” tab of the AAP website.
5. Register residents, yourself, and program director for the AAP Annual Meeting.

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

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

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

Program Coordinator’s Role

1. Process yearly memberships for residents (if your program pays for membership).
2. Register residents who are attending the annual meeting.
3. Register for the Job Fair at the annual meeting to advertise for open faculty and fellowship positions.
4. Register for the Residency Fair at the annual meeting to introduce your program to medical students interested in the specialty.
5. Watch for the email to register your residents for the self-assessment exams (SAE-R’s) by the November 1 deadline, reserve a computer room for administration of the exam, and serve as proctor.

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

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

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

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

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

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NATIONAL GME CENSUS SURVEY

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

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

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

**Program Coordinator’s Role**

1. Keep in mind that the Program Survey update usually begins the end of May and is due the beginning of July in order to participate in the Early FREIDA on-line listing or the end of September if you miss the early deadline. The Resident Survey begins the middle of July and is due the end of September. An email from gmetrack@aamc.org will be sent to the email listed for your program informing you of the dates and any other necessary information.

2. Keep record of your GME Track User ID and password.

3. When you receive the notice from gmetrack@aamc.org, complete the GME Census Survey through GME Track by updating information pertaining to your residency program annually before the given deadline. (If you do not receive the email notice by the second week of June, ask your program director or GME office if they received it.)

4. Print a copy of the survey for your records and to assist you the following year on how you answered the questions the previous year.

5. To assist you in completing the Resident Survey, collect your graduating residents’ future plans. You will be asked specific information as to whether they are going into a fellowship (type of fellowship & accreditation status) or starting practice (academic/nonacademic, private/group practice, full-time/part-time) and also the location. Collecting this information ahead of time avoids the hassle of trying to track down your residents once they have left your program.
RECRUITMENT

Recruitment is one of the most time-consuming and important roles of a coordinator. It will consume the majority of your time from September through March. The goal is the successful recruitment of qualified medical students or interns to join your residency training program. The quality of the training program is dependent upon successful recruitment of residents. Eligibility and selection policies for selecting candidates are required as part of your recruitment policies and procedures. Each year, the process of filling open spots has become more and more competitive. At the end of the recruitment season, consider sending out a questionnaire to all of the candidates who were ranked (above your last filled position) but did not match at your institution. In this questionnaire, you should ask the candidates what suggestions they have to improve your interview process and what the program can do to attract more students.

Electronic Residency Application Service (ERAS): [www.aamc.org/services/eras/programs/] ERAS is a service that transmits letters of recommendation, medical student performance evaluations, medical school transcripts, USMLE transcripts, COMLEX transcripts, and other supporting credentials from applicants and their Designated Dean’s Office (DDO) to program directors. The four main components of ERAS include MyERAS, Dean’s Office Workstation (DWS), Program Director’s Workstation (PDWS), Letter of Recommendation Portal (LoRP) and ERAS PostOffice.

All ACGME accredited programs must use ERAS as their application service. Programs can start reviewing applications through ERAS on September 15.

National Resident Matching Program (NRMP): [www.nrmp.org] – Know the rules of the “Match,” and be prepared to answer questions from students and faculty. Remember, you cannot comment on how a candidate will be ranked with your program, nor can you ask the candidate how they will rank your program before the Match. When matching with an applicant, you are offering employment in your program contingent upon the applicant meeting your eligibility requirements. At the beginning of the recruitment season, go to the NRMP website and print off the list of NRMP dates so you know the deadlines. The Rank Order List (ROL) deadline is VERY important.

Educational Commission for Foreign Medical Graduates (ECFMG): [www.ecfmg.org] – Obtain the information booklet from the ECFMG. In order for your state to license International Medical Graduates, they must first obtain an ECFMG certificate. Before you invite a candidate to an interview, make sure that they understand and meet the requirements of your eligibility and selection policy.

Recruitment Schedule
Start Early: The program director should select a resident recruitment committee consisting of faculty who are willing to make the commitment of reviewing the ERAS files, interviewing applicants, and attending the recruitment meetings. Plan early by setting your interview dates, blocking faculty schedules that will be interviewing, and scheduling rooms for interviews.
Recruitment Meetings: Your recruitment committee should meet at least twice. The first
meeting should be at the beginning of the recruitment season to discuss evaluating applications,
interview schedules, and strategies. The second meeting should take place at the end of the
season to determine the Match list.

Interview Early: Medical students apply to internships and residency programs and set up
interviews for both programs simultaneously. They start out fresh but soon run out of time,
money, and enthusiasm. Review ERAS applications and invite candidates for interviews early in
the season to provide candidates time to organize interviews in neighboring programs. Many
applicants cancel January interviews, especially in the snow regions where weather is a factor.

Interview Process
Before Interview:
- Send out a confirmation email or letter (this can be done through ERAS)—include
  information about time and location of the interview, hotels, airport shuttles, maps and a
  schedule for the interview day.
- Work with hotels to obtain a discounted rate and transportation to interview.
- Prepare an electronic information packet for each interviewee—including rotation
  schedules and information about your city and university, research opportunities,
  eligibility for the relevant specialty board exam (PR II.A.4.a)(9), Match commitment
  letter, information related to the applicant’s terms and conditions of appointment and
  stipend and benefits, and a summary of your program’s policies and procedures.

Day of Interview:
- Set a start and end time and try to stay on schedule.
- Schedule interview on lecture days—a lecture is a great way to start an interview day and
  to meet faculty and residents.
- Schedule a tour of department and off-site facilities with one of your current residents.
- Schedule interviews (not more than four) with the Chair or Associate Chair, Program
  Director or Associate Director, and two faculty members—20-30 minutes for each
  interview. If able, use the same faculty for all interviews for a fair comparison.
- Lunch with a few residents—the residents should be from different PGY levels.
- Exit interview with the Program Director.
- Dinner with residents (optional, and if budget permits).

Note: You cannot always fit in all the above on an interview day. Some programs provide
breakfast or dinner with residents. Your program director and administrator will provide you
with a budget to accommodate the interview season. The goal is to give medical students as
much information as possible without completely overwhelming him or her. Have your residents
involved in the recruitment process to answer applicant questions, give tours, and take
candidate(s) to lunch/dinner.

After Interview (optional):
- Prepare form letters to thank candidates for visiting your program.
- The form letters should be from the program director and/or chief resident.
- Do not be over-zealous by sending more than two letters to each person.
Program Coordinator’s Role

1. What to email to register for ERAS in April.
2. Assist in forming recruitment committee of both faculty and residents.
3. Organize recruitment committee meetings.
4. Create schedule of interviewers, block their schedules, and reserve rooms.
5. In August sign into the Web-based PDWS to review the resources and online tutorials to get started setting up your program.
6. Starting September 15, review applications regularly from the ERAS Post Office.
7. Review ERAS files online for completeness and competitiveness—make sure you are meeting eligibility and selection policy criteria.
8. Know your state’s licensing requirements. If an applicant is not eligible, do not extend an interview that will waste the applicant’s time and money.
9. Set up rank meeting.
10. Create schedule of applicants or use the Scheduler in ERAS.
11. Send decline emails to applicants who will not be extended an interview (this will save you time in replying to messages from applicants about the status of their application).
12. Send ERAS messages or e-mails to applicants inviting them for interviews.
13. Organize interview day—the coordinator sets the tone of the day and helps to put candidates at ease by creating a welcoming atmosphere and well-organized interview.
14. Create name tags, order lunch, and make reservations at a local restaurant if you provide dinner the day of the interview or the evening prior.
15. Provide candidates with accurate information about salary, benefits, rotations, etc.
16. Send thank you letters.
17. Organize committee meeting to decide rank list.
18. If you need to change your quota (number of positions being offered), make sure you update your quota by the January 31 deadline through the NRMP website.
19. Submit rank list to the NRMP website by the deadline.
20. Announce the results of the Match to residents and faculty.
21. Send an email to those you matched with asking them for information not included in application (i.e. social security number, birthplace, etc. (you can unscreen their birthdate in ERAS) to keep you informed of any address and email changes, especially those who matched in advanced positions.
22. Send anonymous post-recruitment questionnaires.
23. At the end of the recruitment season, export the ERAS applicant data you wish to retain.
24. You should complete a statistical analysis of your applicant pool. Part of the program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce.
RESIDENT CONTRACTS

Sponsoring institutions must provide residents with a written agreement, or contract, outlining the terms and conditions of their appointment to an educational program, and institutions must monitor the implementation of these terms and conditions by the program directors. Institutions must ensure that residents adhere to established practices, procedures, and policies of the institution. Residents cannot participate in their residency program if they do not have a contract. The contract is an agreement letter in which residents accept the responsibilities of their position along with the proposed salary and comply with all institutional policies.

Institutional Requirement IV.B.2.

The ACGME specifies that the contract must directly contain, or reference, the following items:

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

You can find additional information regarding contract requirements on the ACGME website, www.acgme.org. The written policies can be included as attachments to the contract or as a handbook.

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

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

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

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

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

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

Orientation Schedule

Graduate Medical Education (GME) Orientation: At some institutions, the GME office meets with the residents/fellows from all disciplines, introduces the staff, and provides information on the possible following subjects:
  1. Safety and security
  2. Health Care Financing Administration (HFCA) documentation requirement
  3. Substance abuse
  4. Resident mental health program
  5. Medical library information and contacts
  6. Residents’ organization/association
  7. Risk management/professional liability
  8. Infection control
  9. Caring for culturally diverse populations
  10. Information technology
  11. EMR & other computer training
  12. Professionalism
  13. Conflict of interest
  14. Integrity & compliance
  15. Medication safety
  16. Advanced directives & medical ethics

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

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

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

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

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

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

1. Review Orientation Contact List
2. Send out welcome email/letter to newly matched residents (include all pertinent information, i.e. Contract, USMLE Step 3 policy, names and emails of Chiefs).
   a. For Advanced Programs whose residents start at the PGY-2 level or for programs taking in transfer residents be sure to get PGY-1 information (i.e. certificate, Milestones evaluations, previous educational experience, and a summative competency-based performance evaluation).
3. Send new resident names and general demographic information to GME
4. Send out Orientation Instructions and attachments to Matched Applicants
5. New Resident Documentation Checklist
6. Order items for residents (i.e., pagers, books, keys, ID badge, lab coats, scrubs, parking)
7. Order Food and A/V for Welcome Breakfast/Lunch, Orientation sessions
8. Email all Orientation dates (GME, Institution (if applicable), Department)
9. Coordinate orientation schedules and lectures (email and confirm participants)
10. Schedule trainings (ACLS, BLS, Dragon, eRecord, Library, etc.)
12. Update Department Website/Sharepoint site
13. Update Orientation Overview Assignments
14. Update PowerPoint (if applicable)
15. IMS (Identity Management Systems) Activations (i.e., Network, Email, Cerner)
16. Orientation Follow up / Follow Through
17. Send updated lists and documentation to internal and external rotation contacts
18. Organize Welcome Picnic/Lunch/Dinner

New Resident Data Entry

- ACGME ADS
- ACGME Caselogs
- ABPMR Registrations
- Update Lists (Resident files, pager lists, contact information, attendance sheets, birthday club, etc)
- Update composite photo
- Online evaluation system (EValue, New Innovations, MedHub, etc)
- Specialty Society Membership Applications (AAP, AAPMR, etc.)
- Website/Sharepoint (if resident specific information included)
SCHEDULES

Master Schedule

The master schedule shows in block form the resident’s rotation for the year. The program design and/or structure must be approved by the Review Committee (RC) for Physical Medicine and Rehabilitation as part of the regular review process. Program requirements for Physical Medicine and Rehabilitation are available on the ACGME web site (www.acgme.org). It is important to read the institutional requirements as well.

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

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

Call Schedule

Physicians must have a keen sense of personal responsibility for continuing patient care and must recognize that their obligations to patients are not automatically discharged at any given time of the day or any particular day of the week. Work hours and weekend call for residents reflect the concept of responsibility for patients and provide for adequate patient care. It is the responsibility of the program director, however, to ensure and monitor assignment of reasonable inpatient and outpatient work hours for care to ensure that the resident is not subjected regularly to excessive difficult or unduly prolonged duties. Residents at all levels, on average, should have the opportunity to spend 1 full day out of 7 free of inpatient and outpatient care responsibilities.
and, on average, should be on night call no more than every third night. The resident must be provided with adequate support, such as sleeping and food facilities, during work hours as well as safe transportation options for residents who may be too fatigued to safely return home.

On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty.

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

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

Suggested Material to Add
1. Resident Master Yearly Schedule
2. Call Schedule
3. Sub-Specialty Schedules
4. Other schedules may include:
   - Ancillary or Off-Service Rotation Schedules
   - Continuity Clinic Schedule
   - Conference Schedule
   - Didactic Schedule
   - Journal Club Schedule
   - Vacation Schedule
   - Holiday Schedule

Program Coordinator’s Role
1. Determine who is responsible for developing the schedule. In some programs the coordinator develops the schedules, while in others the chief residents are responsible.
2. Find out the type of scheduling system used by your institution. Some institutions use computerized programs to develop the schedules while others use the traditional method of pencil and paper.
3. Maintain and/or distribute schedules for faculty, residents, and staff. (If possible, emailing the schedules saves time and copying). Don’t forget to distribute schedules to support staff responsible for maintaining the physician’s calendars.
THE LEARNING AND WORKING ENVIRONMENT

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

According to Program Requirement VI., residency education must occur in the context of learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members and all members of the health care team

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

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

**Program Coordinator’s Role**
1. Review ACGME website for formal mechanisms and information related to Patient Safety.
2. Document that residents are receiving didactics on patient safety related goals, tools, and techniques.
3. Document that residents know how to report a medical error, adverse event, close calls and near misses, inefficiencies in care, unsafe conditions.
4. Document that residents are provided with training on how to break bad news.
5. Document what the program does to ensure your institution prioritizes maintaining a culture of safety.
Quality Improvement (PR VI.A.1.b)
The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. Programs should have a process in place for engaging residents in quality improvement projects with the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.

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

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

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

Bank-a-PIP through the ABPMR
After becoming board certified, graduates will be required to complete a quality improvement (QI) activity, also called a practice improvement project (PIP), for the ABPMR every five years. Residents and fellows can ‘bank’ a project they completed during training with the ABPMR to count toward future requirements.
- Instructions on how to “bank-a-PIP” can be found at: https://www.abpmr.org/MOC/PartIV/SelfDirected

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

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

Direct Supervision:
- the supervising physician is physically present with the resident and patient.

Indirect Supervision:
- with Direct Supervision immediately available—the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
- with Direct Supervision available—the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision.

Oversight:
- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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

Professionalism (PR VI.B.)

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

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

Program Coordinator’s Role
1. Review ACGME website for information related to Professionalism.
THE LEARNING AND WORKING ENVIRONMENT

2. Document didactics, seminars, webinars, articles, etc. related to patient safety, time management, fitness for work including recognition of impairment, illness, fatigue, substance abuse in themselves, others, or other members of the health care team.

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

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

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

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

Fatigue Mitigation (PR VI.D.)

Programs must:
1. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation
2. Educate all faculty members and residents in alertness management and fatigue mitigation processes
3. Encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
Clinical Responsibilities, Teamwork, and Transitions of Care (PR VI.E.)

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

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

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

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

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

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

1. Clinical and educational work hours must be limited to 80 hours per week and are averaged over a four-week period, inclusive of all in-house clinical and educational activities, all moonlighting, and clinical work done from home. This average should be based on trainee rotations not a “rolling average”.
2. Residents should have eight hours off between scheduled clinical work and education periods.
3. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call
4. Residents must be scheduled for a minimum of 1 day in 7 free of clinical work and required education (averaged over 4 weeks). At-home call cannot be assigned on these free days.
5. Clinical and education work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
   - Up to 4 hours of additional time may be used for activities related to patient safety such as providing effective transitions of care and/or resident education.
Moonlighting

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

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

On-Call Activities

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

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

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

The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must oversee and ensure the quality of didactic and clinical education in all sites that participate in the program. The program director will use various types of conferences and/or lectures, held on a regularly scheduled basis, to teach the various subjects in the curriculum. Active participation by faculty in the didactic program is required.

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

Didactic Lectures – Most programs have a 3-4 hour block of time each week protected for resident didactics. The didactics must include instruction in basic sciences relevant to physical medicine and rehabilitation such as anatomy, pathology, pathophysiology, and physiology of the neuromusculoskeletal systems; biomechanics; electrodiagnostic medicine; functional anatomy; kinesiology; effective teaching methods; medical administration, including risk management and cost-effectiveness; and use and interpretation of psychometric and vocational evaluations and test instruments in the common practice of rehabilitation medicine.

There should be an alternative means for residents to experience missed lectures. Options include taping lectures, having slides available on website, and repeating lectures.

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

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

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

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

ACGME Program Requirement states the curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. Residents should participate in scholarly activity. The sponsoring institution and program should allocate adequate additional resources to facilitate resident involvement in scholarly activities.

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

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

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

All physical medicine and rehabilitation programs are required to have regular, documented Program Evaluation Committee (PEC) meetings to review program goals and objectives and to assess the program’s effectiveness in achieving these goals and objectives. At least one resident representative should participate on the PEC; however, we suggest that you have resident representation from each PGY level on the committee.

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

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

Program Coordinator’s Role

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

RESIDENT TRAVEL

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

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

Program Coordinator’s Role

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

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

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

Attendees may receive the following awards during the graduation reception:
1. Gifts for graduates
2. Certificates—residents may opt to receive their certificates at the formal dinner
3. Other awards and honors

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

Attendees may receive the following awards during the graduation dinner:
1. Certificate of completion
2. Teaching Award—presented to a faculty member
3. Peer Teaching Award—presented to a resident for resident-to-resident teaching
4. Clinician Teaching Award—presented to an allied health professional working with residents
5. Lecture Attendance Award—presented to a resident for superb attendance at lectures
6. Research Award – presented to a resident with the best research project
7. Excellence Award – presented to the resident who exemplified outstanding qualities
Resident Appreciation Day (Optional)
Residents may also be rewarded an appreciation day. Residents would be required to round on patients, write notes, and do last-minute admits or discharges. Residents on outpatient assignments should assist their fellow residents on inpatient services. The residents leave at noon and gather at a park for lunch then go canoeing, bowling, or another recreational activity. At 5 p.m., the residents return to their services, if necessary, and the on-call residents resume their responsibilities. The appreciation day is the final event for graduates to socialize with their fellow residents. If a resident is not interested in the activities of the appreciation day, they should continue their work assignment. This event must receive approval from the chair and program director(s).

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

Calendar of Events

MONTHLY

☐ Work Hour Reports (averaged over 28 days)
☐ Call Schedule
☐ Clinic Schedule
☐ Didactic Schedule
☐ Parking
☐ Send Goals and Objectives Email
☐ Birthday Club
☐ Update Research List
☐ Update Electives List
☐ Update QI Project List
☐ Track End of Rotation Evaluations
☐ Send Upcoming Residency Events List
☐ Medical Student Schedules
☐ Conference Attendance Tracking

WEEKLY

☐ Work Hours Review

ONGOING

☐ Verifications
☐ Loan Deferments
☐ Time Off Request
☐ Poster Deadlines
☐ Corporate compliance (TB, ACLS, BLS, Safety modules)
☐ Special Conferences/Workshops
PEC Meeting Agenda

- Welcome New Chiefs (update sign-in sheet)
- Recruitment Data for the season
- Culture of Patient Safety Updates
- Faculty Development

- Mid-Year Evaluation meetings
- Harass PGY-4s about submitting their ABPMR application by January 31
- Schedule meeting for Chair and PDs to review Resident/Faculty survey questions
- Register residents for AANEM SAE exam in May (early bird deadline in March)
- Send email to incoming PGY-2 programs about their current status
- Send email incoming PGY-2 Residents (Welcome Part 2 includes Step 3 info)
- Send email to new Chiefs with incoming PGY-2 information
- Follow up on outstanding USMLE and COMLEX Step 3
- AAPMR SAE exam (ensure room reserved, food ordered and residents and faculty notified)
- Conclude interview season and prepare for rank meeting
- Send graduates email asking how they want their name spelled on their completion certificate and where they are going next year
- Schedule CCC meetings for the end of the academic year
- NRMP Quota change deadline January 31.
- Update the Upcoming Residency Events List (schedule APE meeting, PMR Mock Orals, end-of-year eval meetings, Resident Retreat, CCC Meetings, PD and Chair meetings with Faculty,
  
  - Data Collection for APE Meeting (Review APE Checklist)
  - Review Graduation Checklist

FEBRUARY

- Rank meeting
- Anatomy Lab Paperwork
- Complete GME verifications and certificate forms
- ERAS Registration (may be handled by GME office)
- Send out Graduation email (to residents and fellows) documenting what needs done before graduation.
  
  - Data Collection for APE Meeting (Review APE Checklist)
  - Review Graduation Checklist
PEC Meeting Agenda
✓ Match Results
✓ Awards Nominations for Graduation
✓ Print out promotion forms for faculty in attendance to sign
✓ Culture of Patient Safety Updates
✓ Faculty Development

☐ ACGME Resident and Faculty Survey
☐ New Resident/Fellow lists detailing photos, name, address, email, phone, med school/residency info.
☐ License Renewal Forms
☐ Contract Addendum Forms (Re-appointment agreements)
☐ GME Appointment Forms (change PGY level and salary)
☐ Send Post-Match Survey

❖ Data Collection for APE Meeting (Review APE Checklist)
❖ Review Orientation Checklist
❖ Review Graduation Checklist

APRIL

☐ Send post-graduation survey to graduates 1 year and 5 years out of residency.
☐ Annual DIO Report
☐ Mentor Meetings
☐ Resident Retreat
☐ Mid-Year Evaluation Data Collection

❖ Data Collection for APE Meeting (Review APE Checklist)
❖ Review Orientation Checklist
❖ Review Graduation Checklist
PEC Meeting Agenda
✓ Faculty Mentor Assignments
✓ Review Master Rotation Schedule
✓ Graduation Awards
✓ Review Goals and Objectives
✓ Review Policies and Procedures
✓ Culture of Patient Safety Updates
✓ Faculty Development: Teaching Faculty Policy Review; Alertness Management and Fatigue Management

☐ AANEM SAE Exam
☐ PMR Mock Orals
☐ Schedule Interview Days for Fellowships
☐ GME Track for Program Information
☐ Year End Evaluation Meetings
☐ Enter new rotation schedule in MedHub
☐ Update expiring Master Affiliation Agreements (MAA) Program Letter of Agreements (PLA)

❖ Data Collection for APE Meeting (Review APE Checklist)
❖ Review Orientation Checklist
❖ Review Graduation Checklist

JUNE

☐ Update Resident Procedures on Institution website
☐ ABPMR PGY-4 and Fellow Completion Evaluations (due July 1)
☐ ABPMR Continuing Resident Evals (Based on Year End Eval. Meeting) (due August 1)
☐ ABPMR Annual Survey
☐ ACGME Case Log Archive deadline (August 1) – download and transfer to Excel document and save first!
☐ GME Track for Resident Information
☐ Year End Evaluation Meetings
☐ Summary evaluations for all graduating residents for file/verifications
☐ Rotation Breakdown (ensure PGY-4 residents’ schedules meets ACGME requirements, i.e. 12 months inpatient, 12 months outpatient, etc.)
☐ ACGME Resident and Faculty Survey results published on ACGME website
☐ Graduation Ceremony

❖ Data Collection for APE Meeting (Review APE Checklist)
❖ Review Orientation Checklist
❖ Review Graduation Checklist
**JULY**

**APE Meeting**
- APE Review
  - ABPMR Part 2 Board Results
- New Residents/Fellows
- Recruitment Interview Days
- ACGME Resident/Faculty Survey Results

☐ ABPMR Registration Forms to complete online for new residents and fellows (due August 1)
☐ ABPMR Continuing Resident Evaluations (due August 1)
☐ ACGME Case Log Archive deadline (August 1)
☐ Update the Upcoming Residency Events List (schedule mid-year eval meetings, mentor meetings, CCC Meetings for the end of the academic year)
☐ Follow Up on PGY-1 information for Advanced Residents
☐ July 15th - AAPMR Registration opens for PMR SAE exam in January (early bird deadline in September)
  - Send Residents and Faculty Save the Date email for AAPMR SAE exam.
  - Reserve room and order food
☐ July 15th – ERAS opens for Fellowships

❖ Review Orientation Checklist
❖ Review Recruitment Checklist

**AUGUST**

☐ Website Review
☐ WebADS Annual Update
☐ Set up Billing and Coding modules

❖ Review Recruitment Checklist

**SEPTEMBER**

**PEC Meeting Agenda**
✓ APE Minutes Approval
✓ APE and Resident and Faculty Survey Action Plan Update
✓ ABPMR Part 1 Board Results
✓ Recruitment Update
✓ Culture of Patient Safety Updates
✓ Faculty Development
CALENDAR OF EVENTS

PM&R Residency Program—Coordinators Manual

☐ WebADS Annual Update due
☐ Mentor Meetings
☐ Photo Day for All Residents
☐ Faculty Appointment Renewal Documentation
☐ Renew AAP Academic Partnership
☐ ABPMR Irregularity Policy Agreements sent for completion from new residents, PD, and Coordinator (due November 1)
☐ September 15th – ERAS Opens for Programs

❖ Review Recruitment Checklist

OCTOBER

☐ Schedule mid-year evaluation meetings for residency and fellowships
☐ October 1st – Dean’s Letters (MSPE-Medical School Performance Evaluation) are released in ERAS.

❖ Review Recruitment Checklist

NOVEMBER

PEC Meeting Agenda
✓ APE and Resident Survey Action Plan Update
✓ Chief Resident Vote
✓ Culture of Patient Safety Updates
✓ Faculty Development

☐ Mid-Year Evaluation Data Collection
☐ ABPMR Examination Irregularity Policy, Nondisclosure Policy, and Cooperation Agreement (Due November 15th)

❖ Review Recruitment Checklist

DECEMBER

☐ Holiday Party
☐ Mid-Year Evaluation Meetings (if applicable)

❖ Review Recruitment Checklist

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SPECIAL EVENTS

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

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

<table>
<thead>
<tr>
<th>JULY</th>
<th>JANUARY</th>
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<tbody>
<tr>
<td>Orientation</td>
<td>Mid-Year Party</td>
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<tr>
<td>Welcome Cookout</td>
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<tr>
<td>Picnics</td>
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<td>Pool Party</td>
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<td>Lunches</td>
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<td>River Excursion</td>
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<td>Intern Dinner</td>
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<td>Fish Fry</td>
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<tr>
<td>AUGUST</td>
<td>FEBRUARY</td>
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<tr>
<td>Retreat</td>
<td>AAP Annual Meeting</td>
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<tr>
<td>Resident Breakfast Meeting</td>
<td>Mardi Gras Party</td>
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<tr>
<td>Get Together Dinner</td>
<td>Valentine’s Day Potluck Luncheon</td>
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<tr>
<td>SEPTEMBER</td>
<td>MARCH</td>
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<tr>
<td>Retreat (with families)</td>
<td>Post-Match Party</td>
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<td>OCTOBER</td>
<td>APRIL</td>
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<tr>
<td>Retreat</td>
<td>Softball Game</td>
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<tr>
<td>Resident Breakfast Meeting</td>
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<tr>
<td>Get Together Dinner</td>
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<tr>
<td>NOVEMBER</td>
<td>MAY</td>
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<tr>
<td>Thanksgiving Breakfast</td>
<td>Resident Jeopardy Game</td>
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<tr>
<td>AAPM&amp;R Academy Meeting</td>
<td>Canoe Party</td>
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<td>DECEMBER</td>
<td>JUNE</td>
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<tr>
<td>Holiday Party</td>
<td>Graduation Party</td>
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<tr>
<td>Holiday Potluck Luncheon</td>
<td>Reception for Family Night</td>
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<tr>
<td>Holiday Dinner—</td>
<td>Cookout for Senior Class</td>
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<tr>
<td>Resident &amp; Spouse</td>
<td>Country Club Day</td>
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<td></td>
<td>Pager Exchange Ceremony</td>
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</tbody>
</table>
# ORIENTATION CHECKLIST

## March
- Review Orientation Contact List
- Send out welcome email/letter to newly matched residents (include all pertinent information, i.e. Contract, USMLE Step 3 policy, names and emails of Chiefs)
- For Advanced Programs whose residents start at the PGY-2 level or for programs taking in transfer residents
- Send post-match survey
- Send new resident names and general demographic information to GME
- Send out Orientation Instructions and attachments to Matched Applicants

## April – June
- New Resident Document Checklist
- Order items for residents (i.e., books, keys, ID badge, lab coats, scrubs, parking)
- Order Food and A/V for Welcome Breakfast/Lunch, Orientation sessions
- Email all Orientation dates (GME, Institution (if applicable), Department)
- Coordinate orientation schedules and lectures (email and confirm participants)
- Schedule trainings (ACLS, eRecord, Library, etc.)
- Update the Orientation/Policies and Procedures Manual
- Update Department Website/Sharepoint site
- Update Orientation Overview / PowerPoint (if applicable)
- IMS (Identity Management Systems) Activations (i.e., Network, Email, Cerner, Mars, etc)

## June-July
- Orientation Follow up / Follow Through
- Send updated lists and documentation to internal and external rotation contacts

## New Resident Data Entry
- Update Lists (Resident files, pager lists, Resident Contact, sign-in sheets, birthday club, etc)
- Update composite photo
- Online evaluation system (EValue, New Innovations, MedHub, etc)
- ACGME WebADS
- Specialty Board Database
- Specialty Society Membership Applications
- Website/Sharepoint (if resident specific information included)

## July –August
- Orientation Follow up / Follow Through
RECRUITMENT CHECKLIST

July – August
- Update the information on your program’s website
- Conduct a meeting to review recruitment logistics
- Email interview days to faculty and chiefs/residents to solicit availability to participate
- Review/Update Eligibility and Selection criteria
- Check “give-a-way” inventory and reorder if necessary
- Install ERAS Workstation – erashelp@aamc.org or 202-828-0413

September – October
- ERAS Opens September 15.
- Dean’s Letter (MSPEs (Medical Student Performance Evaluation) available October 1.
- Schedule conference rooms, interview rooms, AV, Food
- Update Email templates (invite, confirmation, re-confirm, thank you)
- NRMP Match History Check
- Prepare Recruitment Packets
- Update Recruitment Presentations

November – January
- Conduct Interviews
  - Send emails a week in advance to re-confirm interview.
  - Prepare schedules for the day
  - Packets for applicants
  - Packets for interviewers
  - Send thank you email
- Quota Change Deadline: January 31st

February
- Conduct Rank Meeting
  - NRMP Rank Order Deadline: 4th Wednesday of February by 9:00 PM EST

March
- NRMP Match Results: 3rd Week in March
- Send an interview day survey to ranked applicants.
- Begin Orientation process...
**GRADUATION CHECKLIST**

**January - February**
- Secure Date (check with all graduates, PD, Chair), Facility, Start Time, Format, and Entertainment
- Send “Save the Date” email
- Order graduation certificates (check with how each graduate wants their name spelled)

**March – April**
- Send email to graduates letting them know everything that needs to be completed before graduation (i.e., medical records sign off, email inactive date, benefits continuation date, release form, etc.)
- Send official invitations (at least 6 weeks before date)
- Order graduation gifts, favors, cakes
- Decide on menu selections
- Program agenda

**May**
- Complete Awards Ballots
- Get Awards made
- Graduate Bios
- Collect RSVPs
- Finalize RSVP List, create name badges, and place cards
- Print Programs
- Wrap graduation gifts and awards

**June**
- Get to venue early to set up and ensure everything is in order (AV, podium, general room set up)
- Reserve venue for next year.
ANNUAL PROGRAM EVALUATION (APE) CHECKLIST

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

Action Plan based on results of the above should be created and then reviewed and updated at all PEC meetings. More often as applicable.