Frequently Asked Questions: Emergency Medicine
Review Committee for Emergency Medicine
ACGME

Question	Answer
Introduction	
What should be included in the educational rationale for programs seeking a 48-month program format? *[Program Requirement: Int.C.1]*	The educational rationale for a 48-month program format should describe: 1. A more in-depth curriculum in areas related to emergency medicine, not just additional clinical rotations • Examples: Focused experiences in ultrasound (US), Emergency Medical Services (EMS), health administration, research, toxicology, critical care, etc. 2. The expected skillset/outcome residents will obtain by completing the additional 12 months of the program • Examples: US certification, global health, increased scholarly activity, including work toward a Master of Public Health or Master of Education degree, etc. 3. Graduated responsibilities for fourth-year residents • Example: Supervision of junior residents by fourth-year emergency medicine residents on critical care rotations
Oversight	
Should the Designated Institutional Official (DIO) from the institution *sending* learners to a site or from the institution *receiving* learners from another site sign the Program Letter of Agreement (PLA)? *[Program Requirement: I.B.2.a).(2)]*	Although the requirements do not specify that the PLA include the signature of the designated institutional official (DIO), institutions may find it prudent to include the signature of at least the DIO from the sending program's institution.
If a program uses a multi-hospital system that includes separate emergency departments located at separate sites, but references these separate sites under one hospital name, how should the program represent this configuration? *[Program Requirement: I.B.4.b]*	Each emergency department location is considered an additional participating site, and programs should list and describe each emergency department separately. Additionally, the annual patient volumes and critical care volumes at each site cannot be aggregated under one hospital name and should also be listed separately with their respective site.

Question	Answer
If a program wants to establish a rotation at a site that is not in close geographic proximity to the Sponsoring Institution, what accommodations should be made? *[Program Requirements: I.B.4.c) and I.B.4.c).(1).]*	If a program establishes an affiliation with a site which is geographically distant from the Sponsoring Institution due to special resources provided at the site: 1) The program should provide a rationale for why this site has been designated for the rotation over other potential sites that are closer in proximity. 2) The program should consider the social impacts of resident removal from family, life, and the day-to-day community of the residency program. The program should ensure that major burdens residents may experience in traveling to and from the site, including the financial impact are addressed. If the site is of such distance that daily travel between the site and the Sponsoring Institution is unfeasible or burdensome, the program may need to provide transportation options and/or housing arrangements for residents while on rotation there.
What is the Review Committee's expectation regarding the program's level of engagement in practices that focus on systematic recruitment and retention of a diverse and inclusive workforce? *[Program Requirement: I.C.]*	Rather than reiterating institutional polices or global statements of the importance of diversity, programs should implement at least two specific program-level strategies that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. Recommendations for programs to consider: • Research presentations and/or literature on DEI efforts from other institutions, departments, and programs that are doing this well • Strategies should be open and transparent • Processes and strategies should be objective and structured • Review ACGME's Equity Practice Toolkit
What other specialty programs should be present at the Sponsoring Institution to demonstrate the availability of educational resources that includes the presence of residents in other specialties? *[Program Requirement: I.D.1.a)]*	Residents' educational experience will be enhanced by exposure to other specialties and their academically-focused educational programs, particularly as related to faculty education and supervision, and through promotion of peer-to-peer collaboration and team building among specialties. The Review Committee does not require any specific specialty be present at the Sponsoring Institution.

Question	Answer
What should a written consultation protocol include? *[Program Requirement: I.D.1.e).(1)]*	Such a protocol should include written agreements for the transfer of patients to a designated hospital that provides the needed clinical services.
How can programs calculate their critical care numbers? *[Program Requirement: I.D.1.g).(1)]*	As programs determine their critical care patient volume at the primary site, resources can include: Emergency Department billing and coding numbers for critical care, admission data to step down unit, intensive care unit (ICU), operating room, or morgue.
Does every participating site need to have all resource amenities listed? *[Program Requirements: I.D.2.a-e)]*	The Review Committee expects most participating sites in ADS to demonstrate all site resources listed in the requirements to ensure healthy and safe learning and working environments that promote resident well-being. However, if the site is a non-clinical rotation outside of a university or hospital setting (i.e., high school, sports training facility, wilderness, firehouse, etc.) the Review Committee will not expect all areas delineated in the requirements to be static on-site (i.e. lactation facilities, refrigeration for human milk storage, sleep/rest facilities), but there should be a provision that accommodations will be made if/when needed.
Personnel	
What salary support is the institution/department expected to provide for the program director's non-clinical time for administration of the program? *[Program Requirements: II.A.2.a) and II.A.2.b)]*	The program director must receive no less than 35 percent support if their program is approved for 18-35 residents and no less than 50 percent support if their program is approved for 36 or more residents. This does not mean 50 percent of the **aggregate** support delineated in the support table in requirement (II.A.2.a), but rather a pure 0.5 FTE support or 0.35 FTE.

Question	Answer
How can a program identify and demonstrate adequate APD and program coordinator support for the number of residents in the program? *[Program Requirements: II.A.2.a) and II.C.2.a)]*	When reviewing a program, the Review Committee would expect to see the required FTE program coordinator and support personnel for the number of approved residents in the program as indicated under "Program Leadership" in ADS. If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see at least two program coordinator names listed in ADS. To add support personnel in ADS, click on "+ add personnel" in the "Program Profile, Program Leadership" section. To identify the required APD(s) for the program, add this title under "Program Specific Title" in their faculty profile to reflect it on the Faculty Roster.
What faculty and coordinator support is a new program applying for initial accreditation expected to have in place at the time of the application? *[Program Requirements: II.A.2.a), II.B.4.c), and II.C.2.a)]*	When the Review Committee reviews a new program application, it would expect to see a program director in place with the required protected support (a minimum of either 0.35 or 0.50 depending on program size), core faculty in a 1:3 ratio with the number of residents for at least the initial cohort of first year residents being requested, and the required FTE program coordinator for the number of approved resident positions in the program. If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see additional program coordinator names listed in ADS. Programs applying for initial accreditation may identify an interim program coordinator on the application, but the Review Committee will expect the program to fully meet the requirement by having a permanent program coordinator in place no later than 90 days prior to matriculation of the inaugural class on June 30th. Support personnel whose time is divided across several programs (such as emergency medical services, toxicology, and the core emergency medicine program) must have the time devoted to each program as described in each of the respective sets of Program Requirements. Example: If a Sponsoring Institution has an emergency medicine program approved for 24 residents, requiring a 1.0 FTE program coordinator, and also has a fellowship program in emergency medical services, requiring at least 0.2 FTE program coordinator time for the fellowship program, both programs must meet the requirements. Therefore, the EMS fellowship program cannot use the 1.0 FTE emergency medicine program coordinator to provide support to the fellowship.

Question	Answer
	Example: For a new EM program requesting 30 residents (10 per year for a three-year format), the program would be expected to have at least 10 core faculty (nine plus the PD) in place at the time of the application. The Review Committee would expect there to be one PD (minimum 0.35 FTE) and one APD (minimum 0.25 FTE) designated.
When a program requests a permanent increase in resident complement, what is the timeline for demonstrating a parallel increase in the required program resources to match the increased program size? *[Program Requirements: II.A.2.a-b), II.B.4.b), and II.C.2.a)]*	If a program requests a complement increase that will require an increase in program resources (i.e. program director support, number of APDs, program coordinator support, and the number of core faculty), the Review Committee would expect the program to outline a detailed plan for increasing the program's resources accordingly once the extra work of having the additional residents begins. Example: If a Sponsoring Institution has an emergency medicine program currently approved for 24 residents and requests to increase to 36 residents, the program will need to increase resources to add one additional APD, increase the PD support to at least 0.50 FTE, increase the number of core faculty from 8 to 12, and increase program coordinator support from 1.0 FTE to 1.30 FTE. The Review Committee will need to see a commitment and plan to increase the resources in the educational rationale.
Why must a program director have at least three years' experience as a core faculty member in an ACGME-accredited emergency medicine program? *[Program Requirement: II.A.3.a)]*	The administration of a program is so complex, that experience with and understanding of program operations are necessary for program director candidates. This is why the Review Committee believes that to ensure that programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents an optimal learning experience, the program director should have a minimum of three years' experience as a core faculty member in an ACGME-accredited emergency medicine program. The Committee will also accept core faculty experience in a former American Osteopathic Association (AOA)-approved program. It is desirable that the core faculty experience occurred within the most recent three-year period and in the program the program director will lead.

Question	Answer
When considering a new program director candidate, how does the Review Committee determine that an individual meets the qualification requirements? *[Program Requirements: II.A.3.a) - f)]*	The Review Committee will look for the following when evaluating new program director candidates submitted for approval: II.A.3.a) and II.A.3.e) Educational and administrative experience(s) acceptable to the Review Committee – While many types of leadership experience may be qualifying, the Review Committee expects this experience to be recently acquired and within the three years preceding a proposed appointment. In the case of a new program application, the Review Committee recommends this experience to have been acquired in the three years preceding the submission of the new 6application. The Review Committee will consider the following types of experiences as acceptable: • Experience as an assistant/associate program director, fellowship director or site director within EM or an EM subspecialty • Administrative program experience, such as serving on the program's Clinical Competency Committee (CCC), Program Evaluation Committee (PEC), or Graduate Medical Education Committee • Leadership role in the program, such as Chair of the department, Chair of the CCC, Research Director, etc. II.A.3.b) and b).(1) Board Certification – The Review Committee accepts only ABMS and AOA board certifications in Emergency Medicine. II.A.3.c) Ongoing clinical activity – The Committee expects the majority of the candidate's prior clinical activity to involve residents. The Committee will evaluate the amount of time the candidate will devote weekly to clinical supervision to determine whether the amount of time is sufficient to gain an independent understanding of any resident's clinical skills. II.A.3.e) Demonstrated leadership role - While many types of leadership experience may be qualifying, the Review Committee expects this experience to be recently acquired and within the three years preceding a proposed appointment. In the case of a new program application, the Review Committee expects the experience to have been acquired in the three years preceding the submission of the new application. II.A.3.f) Scholarly activity including peer-reviewed publications - The candidate must have peer-reviewed publications and acceptable scholarship within the five years preceding the proposed program director appointment. Peer-reviewed publications must have an associated PMID to be considered for this requirement.

Question	Answer
What faculty qualifications are acceptable to the Review Committee for faculty supervising EM residents in the ED? *[Program Requirement: II.B.2.g)]*	The Review Committee would accept faculty members' certification by the American Osteopathic Board of Emergency Medicine (AOBEM), or certification by a subspecialty board sponsored or co-sponsored by the American Board of Emergency Medicine (ABEM). It would also accept, for faculty appointment, recent residency or fellowship graduates (within the past three years) actively working toward certification by these boards.
Are there any other qualification requirements specific to faculty members providing supervision in an ED (either Adult or Pediatric ED)? *[Program Requirement: II.B.3.a).(1)]*	Faculty members providing supervision to emergency medicine residents on emergency medicine rotations must have appropriate qualifications relative to the patient population for which they are providing the supervision. For example, a faculty member certified in pediatrics and pediatric emergency medicine would be qualified to supervise emergency medicine residents on pediatric cases, but not adult cases. Emergency medicine residents rotating in a pediatric emergency department where there are also pediatric emergency medicine fellows in an ACGME-accredited program are subject to the pediatric emergency medicine requirements related to faculty qualifications and supervision. Faculty qualifications for supervision in an ACGME- accredited pediatric emergency medicine program include certification in pediatric emergency medicine, pediatrics, or emergency medicine. In all other instances, faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the Emergency Department.
Can non-ABEM-/non-AOBEM-certified faculty members see patients in the Emergency Department? *[Program Requirements: II.B.3.b).(1) and (2)]*	The presence of non-ABEM/non-AOBEM-certified faculty members in the Emergency Department is acceptable; however, they cannot directly supervise emergency medicine residents. They are allowed to see patients primarily or work with other provider groups, such as Advance Practice Providers (APPs).
Which physician faculty members are included in the required core faculty-to-resident ratio of 1-to-3? *[Program Requirement: II.B.4.b)]*	Only core faculty members certified by the ABEM or AOBEM, or certified in pediatric emergency medicine by the ABP or AOBP will be considered towards the required 1:3 faculty-to-resident ratio. The ADS system will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member towards the 1:3 ratio.

Resident Appointments

Question	Answer
Why does the Review Committee review resident attrition? *[Program Requirement: III.B.]*	Resident attrition may impact residents' work and learning environment, and may serve as an indicator for an unstable educational environment.
Why is the minimum number of approved resident positions in a training program 18? *[Program Requirement: III.B.1.]*	A minimum of 18 residents is needed to foster a sense of identity within the program and the department. Additionally,18 residents ensures a major impact in the Emergency Department to allow for meaningful attendance at emergency medicine conferences, to provide for progressive resident responsibility, and impact as resident teachers. The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year.
How can a new program meet the requirement for a minimum of 18 residents? *[Program Requirement: III.B.1.]*	The Review Committee understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by the end of the first graduating class, whether three or four years.
Can a program accept a resident transferring from another program? *[Program Requirements: III.C. and III.C.1.]*	Yes, the program can accept a transfer resident. For resident transfers, the Review Committee does not obtain verification of training or grant credit for prior training required for board eligibility. Programs should contact the ABEM and/or the AOBEM to verify previous experiences and determine what credit, if any, will be given for the resident's prior training.
Educational Program	
Can programs use the Emergency Medicine Milestones as goals and objectives or as a primary evaluation tool? *[Program Requirement: IV.A.2.]*	The required goals and objectives are **not** the Milestones. The Milestones are a competency assessment tool and should not be the only measure or primary evaluation tool used in conducting resident evaluations as the Milestones do not cover every aspect of training. The program's 360-degree evaluation tools are used by the program director and the Clinical Competency Committee to map the resident's longitudinal progress on the Milestones. Program evaluation tools can be Milestones-based, but the Milestones themselves do not meet the criteria for goals and objectives.

Question	Answer
How does the Review Committee define a major resuscitation? *[Program Requirement: IV.B.1.b).(2).(a).(v)]*	A major resuscitation is patient care for which prolonged physician attention is needed at the bedside, and interventions—such as defibrillation, cardiac pacing, treatment of shock, including emergent transfusion of blood products, intravenous use of drugs (e.g., thrombolytics, vasopressors, antiarrhythmics), or invasive procedures (e.g., central line insertion, tube thoracostomy, endotracheal intubations)—are necessary for stabilization and treatment. Each resident is provided the opportunity to make admission recommendations and direct resuscitations. Patients may experience a "major resuscitation" but may improve before disposition to a critical care area occurs. Programs are encouraged to measure the resident's resuscitation experience rather than focusing on the patient's disposition location.
What types of experiences *do not* qualify as didactic experiences? *[Program Requirement: IV.C.3.a)]*	Daily experiences, such as morning report or change of shift teaching, which are informal and at which not all residents are consistently present, do not meet the requirements for didactic experiences.
Can residents from my program attend the conferences at the site where their rotation is located or must they come back to our home institution for conferences? *[Program Requirement: IV.C.3.b)]*	The requirements for the didactic experiences allow for joint conferences co-sponsored with other disciplines, so if residents joined the participating site's conferences, this could count towards requirement: IV.C.3.a).(1). However, attendance at the participating site's conferences cannot count towards the five hours per week of planned didactic experiences since these must be developed by and supervised by the program's core faculty (IV.C.3.c) and IV.C.3.c).(2)). The program could also consider video conferencing while rotating at the participating site to allow those residents to participate in the home institution's conferences synchronously.

Question	Answer
How much individualized interactive instruction is acceptable and what qualifies? *[Program Requirement: IV.C.3.c).(1)]*	Programs may utilize individualized interactive instruction, such as web-based learning, for up to 20 percent of the planned educational experiences or didactics (i.e., on average, one hour out of the five hours per week of planned educational activity). The goal of individualized interactive instruction is to allow program directors to adjust curricular needs to the individual needs of each resident. It is important to note that simply reading or answering questions does not meet the requirements for planned educational activities. Watching pre-recorded conferences also does not count, given the activity is simply asynchronous, but not individualized for the learner. In order for an activity to qualify as individualized interactive instruction, the following four criteria should be met: 1. The program director must monitor resident participation and track attendance. 2. There must be an evaluation component. 3. There must be active faculty oversight and interaction. 4. The activity must be monitored for effectiveness. Examples of individualized interactive instruction include: • A resident prepares for and takes a quiz or test, and receives timely feedback about his or her performance from a faculty member. • A resident spends additional time in the simulation lab or cadaver/animal lab because he or she needs more practice with a certain procedure. • Residents who are doing poorly on quizzes/tests participate in board review study sessions with colleagues or faculty members. Attestation and completion pages are not acceptable to the Review Committee as evaluation. Use of audio, video, or podcasts alone constitutes passive learning and is not considered interactive learning unless an individualized study plan has been created with faculty, there is oversight, and there is an evaluative component. Proprietary systems that allow for real-time questions and answers qualify as active/interactive participation.
Why is there a requirement that each core faculty member attend, on average per year, at least 20 percent of planned didactic experiences? *[Program Requirement: IV.C.3.c).(3)]*	Core faculty members' attendance at conferences and other resident didactics gives residents the opportunity to benefit from their perspective, experience, and discussion. It also demonstrates their commitment to the educational program.

Question	Answer
What considerations are taken when calculating the 70 percent resident conference attendance? *[Program Requirements: IV.C.3.c) and IV.C.3.c).(5)]*	The expectation is that residents will attend at least 70 percent of the total planned didactic experiences per year. The program will determine the denominator for the number of "planned" didactic experiences per year. The denominator should include all conferences offered and not a reduced amount by the number of conferences missed due to vacation, off-service rotations, etc. as the lowered 70 percent attendance requirement already takes these absences into account. For example, if a program schedules five hours of weekly conference for 48 weeks, the total planned didactic experience per year is 240 hours. Each resident is expected to attend 168 hours of planned didactic experiences each academic year. The missed 72 hours can occur during vacation, illness, specific off-service rotation, or when work requirements preclude conference. Finally, residents can attend conference virtually, in an active, synchronous format using online platforms such as Zoom or Teams. Watching a recorded version of conference asynchronously does NOT count towards the 70 percent requirement.
How does the Review Committee verify resident attendance at 70 percent of the planned emergency medicine didactic experiences? *[Program Requirement: IV.C.3.c).(5)]*	Programs are to report the resident conference attendance in the Emergency Medicine Specialty Data section of the ADS. Verification should be crosschecked by reviewing an eight-week conference block and averaging resident attendance for that eight-week period.
In meeting the requirement for four months of critical care, can programs consider experiences in step-down units, Emergency Department critical care units, critical care transport teams or anesthesiology rotations? *[Program Requirement: IV.C.4.a)]*	No, experiences in step-down units, critical care/trauma units in the Emergency Department, critical care transport teams, and anesthesiology rotations do not count toward the critical care requirement. The intent of the requirement is for the resident to learn acute decision making and resuscitative skills outside the Emergency Department that can be applied in future Emergency Department patient care.
How can a program ensure their critical care experiences meet the requirement for "including the critical care of infants and children?" *[Program Requirement: IV.C.4.a)]*	The Review Committee expects there to be a minimum of four weeks or one block of time dedicated to the care of infants AND children. This can be met with either: • Four weeks or one block of PICU • At least two weeks or a half-block of PICU, plus two weeks or a half- block of NICU Given the lack of children in the NICU, time in the NICU alone does not satisfy this requirement.

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	Rotation on pediatric transport teams outside of the PICU/NICU also does not meet this requirement.
Can pediatric critical care months count toward the four months of required critical care? *[Program Requirements: IV.C.4.a) and IV.C.4.b)]*	Yes, months spent in the PICU or NICU setting count toward both the four-month critical care requirement and the five-month pediatric requirement.
Can residents take vacation time when assigned to Emergency Medicine, Critical Care, or Pediatric rotations? *[Program Requirements: IV.C.4.a); IV.C.4.b); and IV.C.4.d)]*	Yes, however, the expectation is that residents satisfy the minimum training time stipulated in the requirements for the designated experiences: • 60 percent time in the emergency department • Four months critical care • Five months pediatrics If vacation is taken during these rotations or if residents are pulled from these rotations to cover back-up call in the ED, it is up to the program director to ensure that the minimum time is met by the resident(s).
How are longitudinal pediatric experiences calculated? *[Program Requirement: IV.C.4.b)]*	To calculate longitudinal pediatric patient encounters, multiply the number of general Emergency Department months or four-week blocks by the percent of pediatric patients from the annual patient volume of the ED where the rotation is located. For example, if the annual patient volume of the ED includes 15 percent pediatric patients and the resident spends 20 months in the Emergency Department (i.e., 20 months x .15 = 3 or the equivalent of 3 months), the resident would need two additional months of dedicated pediatric experiences to meet the five-month minimum. This calculation should be completed for the primary site and all participating sites to which the residents rotate. Using this calculation assumes that pediatric patients are not periodically sequestered in a separate pediatric ED or pediatric treatment area. Programs that have a separate “pediatric ED” or area configured in or near the main ED must clearly describe what portion of the resident’s assignment to the ED is in this area. Programs that split ED rotations between emergency departments must clearly describe the assigned fraction to each ED on the block diagram to facilitate the calculation of the pediatric experience.

Question	Answer
Can a rotation assignment in an Observation Unit or non-ED based urgent care center satisfy the requirement that at least 60 percent of each resident's clinical experience must take place in the emergency department? *[Program Requirement: IV.C.4.d]*	No. Resident assignments to an Observation Unit or non-ED based urgent care center (i.e. for-profit locations such as Patient First) cannot be counted toward the requirement that 60 percent of the resident's clinical experience take place in the emergency department. Experiences that can be counted toward the 60 percent requirement require residents to: • Evaluate undifferentiated emergency department patients • Perform an appropriate history and physical examination • Order and interpret appropriate diagnostics tests • Assist in determining the patient's disposition While patients placed in Observation Units are often considered outpatients, not inpatients, and the Observation Unit may be under the control of the EM residency faculty, patients placed in observation status have already had a history and physical examination performed and sufficient diagnostic testing completed to determine that "observation status" is an appropriate disposition. Rotations in an Observation Unit should be represented on the Block Diagram as "Observation" and not as an emergency medicine rotation.
Can an ultrasound rotation be counted towards the 60 percent EM requirement? *[Program Requirement: IV.C.4.d]*	Yes, an ED- based ultrasound rotation can be counted towards the 60 percent EM requirement provided the rotation occurs in the ED and with ED patients. Rotations based in radiology would not satisfy this requirement.
What are examples of acceptable scholarly activity for faculty members? *[Program Requirements: IV.D.2) – IV.D.2.b).(2)]*	It is critical that faculty members participate in scholarly activity in order to appropriately mentor residents and enhance the educational program. Acceptable faculty scholarly activity includes: 1. Peer Review - This includes original contributions of knowledge published in journals indexed in PubMed or MEDLINE®. Submissions to peer-reviewed online venues and Med Ed PORTAL also count. This does not include abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process. 2. Non-Peer Review - This includes all submissions to journals or online venues that do not fulfill peer-review criteria. This also includes abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process. This category

Question	Answer
	also includes educational videos, social media posts, and podcasts. 3. Textbooks/Chapters - This includes submissions for which the faculty member served as editor, section editor, or chapter author. 4. Presentation at Local/Regional/National Organizations - This includes invited presentations, such as abstracts (posters), expert panel discussions, serving as a forum leader, grand rounds presentations, or interdisciplinary grand rounds presentations within the Sponsoring Institution. Grand rounds or other didactic presentations do not qualify unless presented at a department other than emergency medicine. The expectation is that this presentation is of original work. Instruction of, or participation in certification courses, such as Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support (ATLS), or Pediatric Advanced Life Support (PALS), do not qualify. 5. Committee Leadership - This includes elected or appointed positions in nationally recognized organizations. Membership alone does not qualify. 6. Editorial Services - This includes serving as an editor, editorial board member, reviewer, or content expert. Serving as an abstract reviewer or grant reviewer also qualifies. 7. Grants - The awarding of a grant or participation in grants for which the faculty had a leadership role such as the PI, Co-PI, or site director.
Are there any Review Committee considerations in meeting the faculty scholarly requirement? *[Program Requirements: IV.D.2) – IV.D.2.b).(2)]*	The Review Committee expects the program's core faculty members to lead the scholarly efforts by demonstrating significant contributions in the form of accomplishments in at least three of the domains listed in the program requirements, including peer-reviewed publications related to the specialty or subspecialty areas of emergency medicine. It is the Review Committee's expectation that this scholarly requirement be fulfilled by participation by multiple faculty members, specifically by at least half of the faculty (in particular the core faculty), and not by one or two prolific researchers/ authors with multiple publications, grants, etc. Faculty scholarly activity will be evaluated over a five-year interval.

Question	Answer
What are the Review Committee's expectations for resident scholarly activity? *[Program Requirement: IV.D.3.]*	The Review Committee expects all residents to participate in scholarly activity by the end of residency. Examples of acceptable resident scholarly activity include: 1. Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in journals indexed in PubMed, including original contributions of knowledge published in journals indexed in PubMed or MEDLINE®. Submissions to peer-reviewed online venues and Med Ed PORTAL also count. Submissions to online venues, abstracts, editorials, or letters to the editor do not qualify. 2. Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, letters to the editor of peer-reviewed journals, educational videos, social media, and podcasts. 3. Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author. 4. Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader. 5. Participation in Research – This refers to active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an Emergency Department quality improvement project.
Evaluation	
What does the Review Committee expect for multi-source resident evaluations? *[Program Requirement: V.A.1.c).(1)]*	The Review Committee expects ALL of the following evaluators to be used for multi-source evaluations: • faculty members • peers • patients • the residents themselves • other professional staff members (i.e.- RNs, Social Workers)

Question	Answer
How will resident advancement be affected if a resident needs remediation? *[Program Requirement: V.A.1.d).(3).(a)]*	Deficiencies in specific areas do not necessarily mean a resident should be held back in progressing to the next year or level of education; however, plans must be in place to support such residents in achieving the required competencies.
Is there specific language that must appear on the resident's final evaluation form? *[Program Requirement: V.A.2.a).(2).(b)]*	Yes, the form used to facilitate the final evaluation of the residents must include the verification language as stated in the requirements: "…the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice"
Can the program coordinator and/or residents be members of the Program Evaluation Committee (PEC) or the Clinical Competency Committee (CCC)? *[Program Requirements: V.A.3.a).(1) and V.C.1.a)]*	The Program Evaluation Committee (PEC) must include at least one resident and can include the program coordinator. The Clinical Competency Committee (CCC) may not allow residents (except post-grad Chief Residents) or program coordinators to serve as members, as the requirement is for those faculty members or other health professionals who have extensive contact with the residents.
How can a program demonstrate that resident evaluations of the faculty are anonymous? *[Program Requirement: V.B.1.b]*	The Review Committee recognizes that many programs use residency management systems to facilitate evaluations, and that the form may include a field for the evaluator name even when the settings are set to not show the evaluator name in certain instances. Should the evaluation form template not accurately represent that the form is anonymous, the program can either: • Print a copy and cross out the evaluator name to alert the committee that the program is aware of this requirement • Complete a dummy evaluation and print it as an example to the committee of how the template looks when viewed
The Learning and Working Environment	
Can residents be supervised by licensed independent practitioners? *[Program Requirement: VI.A.2.b).(1)]*	The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a physician faculty member during these situations is required.
Who can supervise EM residents in urgent care/fast track settings? *[Program Requirements: II.B.2.g) and VI.A.2.a).(2)]*	If an EM resident is assigned to an area of any ED where undifferentiated and less urgent patients are seen (i.e. fast track, quick care, urgent care) and the experience is counted toward the 60 percent required EM rotations, the EM resident must be supervised by EM certified physician faculty. If an EM resident is assigned to a freestanding facility geographically distinct from any

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	acute care hospital that treats undifferentiated "urgent care" patients and would not thus qualify as a full freestanding ED, the EM resident can be supervised by any credentialed provider in this site, but this experience cannot count toward the 60 percent required EM rotations.
Can residents from other specialties supervise emergency medicine residents? *[Program Requirement:* VI.A.2.b).(2)*]*	Residents from other specialties must not supervise emergency medicine residents on any rotation in the Emergency Department. Residents from other specialties can supervise emergency medicine residents on rotations in clinical areas related to their graduate medical education training and expertise, but the program director must monitor supervision on off-service rotations and ensure that the supervision is appropriate.
Under what circumstances can a first-year resident be supervised indirectly with direct supervision immediately available? *[Program Requirement: VI.A.2.c)]*	Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with direct supervision immediately available. Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with direct supervision immediately available while rotating in the Emergency Department, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as medical intensive care unit (MICU) or trauma surgery.
What types of circumstances and events should be included in the supervision policy to demonstrate when residents should communicate with the supervising faculty members? *[Program Requirement: VI.A.2.e)]*	For clarity, the supervision policy should include examples of circumstances and events for when residents should communicate with their supervising attending. Such examples could include: • Discussion of end-of-life/DNR decisions • Change in patient clinical status • Patients wishing to leave against medical advice
What does the Review Committee consider an optimal clinical workload? *[Program Requirement: VI.E.1.]*	A resident in the Emergency Department at the very beginning of the program should have a smaller workload than a resident at the same level in the same rotation at the end of that academic year. Each program must adhere to its graduated responsibility policy. This may vary by area of service, and is based upon each individual's level of achieved competence (knowledge, skills, and attitudes) and upon patient acuity. The Milestones must be used to assess each resident's competence. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of resident education.

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>How much time should a resident have off between emergency medicine shifts?

[Program Requirements: VI.E.1.a).(1)-VI.E.1.a).(1).(a)]</td><td>In emergency medicine, the scheduled clinical shift is the basis for the required time off and considers additional clinical time after the assigned shift is completed toward the total clinical and educational work hours each week (finishing documentation, transitions in care, etc.).

A resident must have at minimum a scheduled break equal to the scheduled length of the shift within the 24-hour period that includes the shift.

All time (clinical and educational) counts toward the total average time cap per week. Didactic and other educational experiences count toward weekly clinical and educational work hour limits but are not considered when calculating time off between clinical shifts.

Example:
If a resident works a 10-hour shift (9:00 p.m. to 7:00 a.m.) and then attends a conference until 11:00 a.m., he/she must have 10 hours off before returning to his/her next clinical shift (starting from the 11:00 a.m. end time of the conference, meaning that the resident should not return to clinical work until 9:00 p.m. If the resident chooses not to attend the conference, the 10-hour break begins at 7:00 a.m. when the clinical shift ends). Conference time is added in the calculation of clinical and educational work hours for the week when the resident is present.

<table>
<tr><th>Clinical Shift in the Emergency Department Tuesday</th><th>Break Wednesday</th><th>Conferences Wednesday</th><th>Clinical Shift in the Emergency Department Wednesday</th></tr>
<tr><td>4:00 p.m.-12:00 a.m.</td><td>(8 hours)</td><td>8:00 a.m.-12:00 p.m.</td><td>4:00 p.m.-12:00 a.m.</td></tr>
</table>
<table>
<tr><th>Clinical Shift in the Emergency Department Tuesday</th><th>Break Wednesday</th><th>Conferences Wednesday</th><th>Clinical Shift in the Emergency Department Wednesday</th></tr>
<tr><td>9:00 p.m.-7:00 a.m.</td><td>(10 hours)</td><td>7:00 -11:00 a.m.</td><td>9:00 p.m.-7:00 a.m.</td></tr>
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Question	Answer
	Example: If a resident works from 4:00 p.m. to midnight, has a conference from 8:00 a.m. to noon, and then works again at 4:00 p.m., this is compliant, since there is a scheduled eight-hour break in a 24-hour period. There is no expectation for an additional eight-hour break after the conference. The Review Committee does not have an expectation regarding time off between block didactic sessions followed by a clinical shift; however, programs must review the appropriateness of resident attendance at conferences following an evening or night shift based on the duration of the program's clinical shifts, didactic schedule, and resident fatigue. Residents should be provided the opportunity to adjust their individual attendance at didactic sessions scheduled between clinical shifts when necessary to mitigate excessive fatigue. The program should ensure the required time off between clinical shifts to allow adequate rest for each resident based on his/her individual schedule.
Are residents permitted to moonlight? *[Program Requirements: VI.E.1.a).(2),and VI.F.5.b) and c)]*	Emergency medicine residents may moonlight. However, the hours spent moonlighting in the Emergency Department count toward the 72 total hours per week on emergency medicine rotations. Hours spent moonlighting outside of the Emergency Department count toward the 80-hour weekly limit. PGY-1 residents are not permitted to moonlight.
Who should be included in interprofessional teams? *[Program Requirement: VI.E.2.a]*	Interprofessional team members must participate in the education of residents, and may include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.
When determining the one-day-off in seven, how should at-home call be considered? *[Program Requirement: VI.F.8.a)]*	At-home call, including sick call or back-up call, should not be assigned during the required one day free from clinical experience and education every week.
What are considered on-call hours and how should they be factored when determining clinical and educational work hours? *[Program Requirement: VI.F.8.a)-b)]*	On-call hours include scheduled sick call or back-up call. When determining clinical and educational work hours, only the hours spent in the hospital after being called in to provide patient care are considered. The clinical and educational work period begins at the time the resident reports for duty.

Question	Answer
Other	
Which faculty members should be included in the ADS Faculty Roster?	At a minimum, the program must list the following core faculty members: program director, associate/assistant program director(s) (if applicable), and all other core physician faculty members board certified in emergency medicine to demonstrate the 1:3 ratio of one core faculty member for every three resident positions (II.B.4.c).) The ADS system will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member towards the 1:3 ratio. Additional core faculty and non-core faculty may be added to the faculty roster at the discretion of the program. Note: The program will be required to report scholarly activity for all faculty on the roster, both core and non-core.
How must a request for a permanent change in resident complement be submitted?	A request for a change in resident complement must be submitted through ADS. The designated institutional official (DIO) of the Sponsoring Institution must sign off on the change in ADS before it can be processed and acted upon by the Review Committee. Additional data that must be submitted with the ADS request may be requested by the Review Committee staff and/or are outlined in the "Requests for Changes in Resident Complement" document posted on the Documents and Resources page of the Emergency Medicine section of the ACGME website.
How long does it take for the Review Committee to communicate its decisions regarding complement change requests?	Complement change requests are reviewed in an ad hoc fashion. Typically, the Committee is able to provide a response to a complement change request in approximately two to four weeks. Occasionally, responses to a request may take longer if it is determined that the request will need to be reviewed at the time of the Committee's next meeting. Complement increase requests will not be reviewed between the agenda closing date for an upcoming Committee meeting and the last date of that meeting. In order to be reviewed within two to four weeks of submission, all complement increase requests must be submitted through ADS, and approved by the DIO in ADS prior to the agenda closing dates posted on the bottom right-hand side of the Emergency Medicine webpage on the ACGME website.

Question	Answer
Are emergency medicine residents required to obtain or maintain life support certification(s)?	No, the Review Committee believes residency education in emergency medicine establishes expertise in acute cardiac life support beyond that which is taught in an Advanced Cardiac Life Support, Advanced Trauma Life Support, Basic Life Support, or Pediatric Advanced Life Support certification course.