ACGME Institutional Requirements

Summary and Impact of Major Requirement Revisions

Overview

In this major revision, the Institutional Review Committee (IRC) has developed ACGME Institutional Requirements that represent the continuing evolution of the Sponsoring Institution, its programs, and its relationships to clinical learning environments for resident and fellow education. To develop durable requirements through 2035 and beyond, the IRC has participated in an intensive period of discovery, collaboration, and reflection to simplify and build upon its minimum standards for Sponsoring Institutions, and welcomes additional feedback from all individuals and organizations that wish to provide comments.

History

Institutional sponsorship of residency and fellowship programs was introduced to ACGME requirements in the early 1980s. Those early requirements envisioned hospitals or other health care facilities as institutional sponsors, and outlined sponsors' responsibilities for providing resources, policies, and procedures to support the essential functions of graduate medical education (GME). While compliance was initially evaluated by specialty Review Committees, these first requirements for GME sponsors formed the basis for the development of ACGME institutional accreditation in the decades to follow.

Since this foundational period for GME accreditation, the ACGME has advanced Institutional Requirements and institutional accreditation in a health care system characterized by rapid organizational change, including a continuous overall increase in operational scale and complexity. Adapting to these conditions, the concept of the Sponsoring Institution in ACGME requirements became centralized so that there is a single structure for guaranteeing oversight, adequate educational resources, safe clinical learning environments, and sufficient policies and procedures across participating sites for ACGME-accredited programs. In the mid-1990s, the designated institutional official (DIO) and the Graduate Medical Education Committee (GMEC) were assigned responsibility for overseeing and administering GME on behalf of the Sponsoring Institution across programs and health care settings. By partnering with participating sites, Sponsoring Institutions, which may or may not be health care organizations, have been able to fulfill required responsibilities with modest expectations for specifying the nature of institutional GME leaders' relationships with participating site leaders.

Centralization of essential elements of GME authority and responsibility permitted various types of organizations to serve as Sponsoring Institutions, and permitted Sponsoring Institutions to have any number of participating sites that are needed to provide education and clinical experience for residents and fellows. Types of Sponsoring Institutions have included, and have not been limited to, health systems, medical schools, other educational organizations, hospitals, medical centers, community health centers, clinics, consortia, and medical examiners' offices. In addition, during the transition to a single GME accreditation system from 2015 to 2020, approximately 90 organizations of various types, including osteopathic postgraduate training institutions (OPTIs) that served as educational support structures for GME, became ACGME-accredited Sponsoring Institutions. This adaptation of the Sponsoring Institution structure has often led to educational administration being located outside of the clinical learning environments in which residents and fellows gain their clinical

experience. The separation of many Sponsoring Institutions from clinical learning environments has highlighted the increasing importance of understanding the clinical learning environment in the context of institutional accreditation, and has indicated the need to introduce standards for Sponsoring Institutions' partnerships with clinical learning environments.

Proposed Updates to the Current Requirements

Among requirements currently in effect, the IRC identified several for elimination, consolidation, or recategorization in this major revision. Some current institutional requirements were determined to be in need of revision, out of date, redundant with other ACGME requirements, or associated with other unnecessary administrative burden. Existing requirements that have been proposed for elimination include those describing:

- a statement of GME mission (I.A.7.a))
- for Sponsoring Institutions with one program, inclusion in the GMEC of a voting member other than the DIO or the quality improvement or patient safety member who is actively involved in GME and outside the program (I.B.1.b).(6))
- GMEC subcommittee structure, function, and documentation (I.B.2., I.B.2.a), I.B.4.b).(2))
- dedicated GMEC oversight of:
  - programs' measurement of achievement of educational outcomes
  - implementation of institutional policies for vacation and leaves of absence
  - provision of summary patient safety report information to residents, fellows, faculty members, and other clinical staff members (I.B.4.a).(3,5,7))
- GMEC review and approval of:
  - responses to Clinical Learning Environment Review (CLER) reports
  - requests for exceptions to clinical and educational work hour requirements
  - appeal presentations to an ACGME Appeals Panel
  - exceptionally qualified candidates for resident/fellow appointments who do not meet eligibility conditions (I.B.4.b).(10,11,14,15))
- a list of necessary support services and systems for minimizing resident/fellow work extraneous to their education (II.F.1.a))
- medical records for patient care and resident/fellow education (II.F.1.b))
- institutional processes for ensuring the availability of resources to support residents'/fellows' well-being and education by minimizing impact to clinical assignments resulting from leaves of absence (II.F.1.c))
- resident/fellow access to data to improve systems of care, reduce health care disparities, and improve patient outcomes (III.B.2.a))
- oversight and monitoring of structured patient hand-over processes at participating sites (III.B.3.b))
- an educational program for residents/fellows and faculty members in fatigue mitigation (III.B.5.a).(3))
- systems for education in and monitoring of:
  - residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits
  - accurate completion of required documentation by residents/fellows (III.B.6.c), III.B.6.c).(1-2))
- resident/fellow eligibility specifications (IV.B.2., IV.B.2.a-c), IV.B.2.c).(1-2))
- resident/fellow appointment contract references to:

- timely notice of the effect of leave(s) of absence on the ability of residents/fellows to satisfy requirements for program completion (IV.C.2.j))
- information related to eligibility for specialty board examinations (IV.C.2.k))

Some requirements were updated, clarified, consolidated, or moved. Some examples of key changes include:

- simplifying institutional review documentation by changing certain GMEC expectations for review and approval to become expectations for oversight;
- modernizing the resident/fellow forum by removing an expectation for in-person meetings; and
- concentrating requirements for resident communication and reporting within a new subsection.

The requirement for the Sponsoring Institution to complete a Self-Study prior to its 10-Year Accreditation Site Visit is unchanged in this major revision. However, as part of the transition to new Institutional Requirements, the IRC plans to revise its guidance to introduce more flexibility for Sponsoring Institutions in the timing, process, and documentation of institutional Self-Studies.

Proposed New Requirements

The 2025 Institutional Requirements streamline the essential, centralized oversight functions of the Sponsoring Institution in relation to ACGME-accredited programs and participating sites, while (1) reintroducing foundational responsibilities for health care organizations that partner with Sponsoring Institutions to serve as primary clinical learning environments (PCLEs) for GME, and (2) setting the expectations for DIOs and others involved in leadership, oversight, and administration of institutional GME. To facilitate integration between Sponsoring Institutions and health care organizations participating in resident/fellow education, it was necessary to specify that every Sponsoring Institution will identify at least one organization to serve as a PCLE, and the DIO will be appointed as an executive PCLE leader. The Sponsoring Institution's and DIO's formalized partnership with a PCLE provides a starting point for establishing institutional accountability, authority, and responsibility for aspects of GME that are integrated with the clinical operations of participating sites.

In preparation for adding new standards, the Department of Sponsoring Institutions and Clinical Learning Environment Programs partnered with the IRC to consider strategically important aspects of GME and health systems, which are reflected in proposed new requirements.

Prior to drafting new requirements, the IRC worked with a 19-member multistakeholder advisory group—which included expertise from clinical and interprofessional health system leadership, DIOs, other GME leaders, residents, and the public—to analyze and prioritize information and input from the following ACGME programs and initiatives: (1) the CLER Program; (2) Sponsoring Institution 2025; and (3) the Pursuing Excellence Initiative. IRC members also engaged in an organizational professionalism symposium hosted by the ACGME in June 2024, when the IRC had begun drafting new requirements.

For many years, the CLER Program has served as a catalyst to inform accreditation, while striving for excellence in patient safety and health care quality through continuous

improvement. In 2022, the CLER Evaluation Committee provided the IRC with inputs corresponding with its synthesis of aggregated, actionable information from the CLER Program. Multiple sources informed the CLER inputs to the IRC for the major revision, including: 1) CLER findings, including data in published reports as well as other data and analyses that are publicly available; 2) important urgent or emergent gaps for which one or more Sponsoring Institutions have implemented solutions; and, 3) urgent gaps or adverse trends for which expedited efforts to identify solutions are needed. Inputs from CLER were provided to the IRC in a manner that ensures complete protection of identifiable information obtained in CLER site visits from use in institutional accreditation processes.

Almost a decade ago, the ACGME began the multi-year Sponsoring Institution 2025 project with a task force that developed a future vision for accredited institutional sponsors of GME programs. The report of the task force and recommendations of a Sponsoring Institution 2025 work group indicated further development of Institutional Requirements in specified domains for strategic and future-oriented development in Sponsoring Institutions and clinical learning environments.

Pursuing Excellence was a four-year initiative involving the partnership of organizations undertaking transformative improvements in clinical learning environments. The ACGME convened representatives from Sponsoring Institutions to engage in collaborative learning activities based on their participants' substantial local efforts to enhance patient care and learner experience.

Participants in the organizational professionalism symposium engaged 75 thought leaders, including subject matter experts, health care executives, public representatives, institutional leaders, residents, and fellows, in a national conversation advancing organizational professionalism and its relationship to high-quality health care and education within Sponsoring Institutions and participating sites.

When working with the multistakeholder advisory group and creating the proposed 2025 Institutional Requirements, the IRC utilized these sources to specify necessary structures for Sponsoring Institutions and GME leaders in relation to clinical participating sites and clinical leaders, as well as aspects of clinical integration that will improve quality, safety, and other aspects of environments in which resident/fellow education occurs. Most of the new requirements are found in Section I: Structure for Educational Oversight and a new Section V: GME and Clinical Learning Environment Integration. Section I describes an updated institutional structure, including the personnel and teams that support compliance with Sponsoring Institution accreditation. This includes new requirements that support the emerging role of DIOs as executive GME leaders collaborating with the interprofessional leadership of the PCLE in GME and clinical learning environment integration. Section V specifies minimum requirements for GME and clinical learning environment integration, recognizing the role played by health care organizations serving as PCLEs in institutional oversight, support, and operations.

Background and Intent statements have been added to describe the context for new proposed requirements. In recognition of the planning and resource needs of Sponsoring Institutions and participating sites, the IRC is proposing a schedule for implementation in which requirements would phase in over a four-year period:

- July 1, 2025: Institutional Requirements effective

- July 1, 2026: IRC begins citing first phase of newly added Institutional Requirements
- July 1, 2027: IRC begins citing second phase of newly added Institutional Requirements
- July 1, 2028: IRC begins citing third phase of newly added Institutional Requirements

The impact statement below includes specific information about the proposed phases of implementation of each new requirement and denotes the categorization of Detail requirements, which can only be cited in an institutional review when a Sponsoring Institution has a pre-review accreditation status other than Continued Accreditation.

Proposed Requirements: **I.A.3., I.A.3.a)**
Existing Requirements: **I.A.7., I.A.7.a-b)**

Requirement Revision (significant change only):

I.A.3. A written statement of commitment~~,~~ must be reviewed, dated, and signed at least once every ~~five~~ three years by the designated institutional official (DIO), a representative of ~~the executive leadership team from each primary clinical learning environment (PCLE) of~~ the Sponsoring Institution's senior administration, and a representative of the Sponsoring Institution's governing body~~,~~ (Core).

I.A.3.a) The statement of commitment must document the Sponsoring Institution's~~: GME mission; and,~~ commitment to GME by ensuring the provision of the necessary administrative, educational, financial, human, and clinical resources, and by adhering to Sponsoring Institution GME policies and procedures. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The requirement for a statement of GME mission is eliminated to reduce administrative burden. A shortened, three-year renewal period in committing resources and adhering to GME policies and Procedures ensures more regular review by institutional leadership and governance.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The revision provides more regular review for commitment of resources needed for safe and high-quality patient care by Sponsoring Institution leadership and governance.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will provide assurance of the Sponsoring Institution's commitment of resources and adherence to policies in support of continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   No additional resources will be required to fulfill this requirement. The IRC will continue issuing citations on this requirement in 2025, with citations on new elements of the requirement (i.e., three-year renewal, a statement of adherence to institutional GME policies and procedures) in 2026.

5. How will the proposed revision impact accredited programs?
   The commitment to GME will be strengthened for all accredited programs.

Proposed Requirement: **I.B.2-3.**
Existing Requirements: **I.A.9., I.A.9.a), I.A.9.a).(1-2), I.A.10., I.A.11.**

Requirement Revision (significant change only):

I.B.2. Any ~~Sponsoring Institution or~~ clinical participating site of a Sponsoring Institution ~~that is a hospital~~ must ~~maintain accreditation~~ be approved to provide patient care by accreditation and regulatory authority(ies) for the type(s) of clinical services available at the location of the clinical participating site.~~(Core)~~ (Outcome)

I.B.2.a) For clinical participating sites that are hospitals, ~~(Core)~~ ~~A~~accreditation for patient care must be provided by~~:~~ an entity ~~granted "deeming authority" for participation in Medicare under federal regulations; or, (Core) an entity~~ certified as complying with the conditions of participation in Medicare under federal regulations. ~~(Core)~~ (Outcome)

I.B.3. When a ~~Sponsoring Institution or major~~ clinical participating site ~~that is a hospital~~ loses ~~its accreditation for~~ approval to provide patient care as identified in I.B.2 above; ~~the Sponsoring Institution must notify and provide a plan for its response to the Institutional Review Committee within 30 days of such loss. Based on the particular circumstances, the ACGME may invoke its procedures related to alleged egregious and/or catastrophic events. (Core) When a Sponsoring Institution's~~ or when a clinical participating site's license is denied, suspended, or revoked~~,~~; or when a Sponsoring Institution or a participating site is required to curtail ~~activities~~ operations, or is otherwise restricted, the Sponsoring Institution must notify and provide a written plan for its response to the Institutional Review Committee within 30 days of such loss or restriction. (Outcome) ~~Based on the particular circumstances, the ACGME may invoke its procedures related to alleged egregious and/or catastrophic events. (Core)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   The requirement expands the need for approval to provide patient care from hospitals to all clinical facilities, and eliminates statements that are redundant, or are not requirements.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Maintaining current information regarding health care regulatory approval will ensure that resident/fellow education is occurring only at participating sites deemed to provide safe patient care.

3. How will the proposed requirement or revision impact continuity of patient care?

While there is no direct impact, patient care approval processes include standards and measurements related to the continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The intent of the requirement is unchanged and it is anticipated that additional resources will not be required to fulfill this requirement. The IRC will continue issuing citations on this requirement in 2025.

5. How will the proposed revision impact accredited programs?
   Programs benefit from utilizing only those clinical participating sites that have approval to provide patient care.

Proposed Requirements: **I.B.4., I.B.4.a-d), I.B.4.d).(1-4)**
Existing Requirement: **None**

Requirement Revision (significant change only):
Background and Intent: Educational experiences for residents and fellows occur at participating sites, and the number of participating sites per Sponsoring Institution ranges from one to more than one hundred, depending upon the scale and complexity of GME operations. A Sponsoring Institution has responsibility for overseeing compliance with ACGME requirements at every participating site for its programs.

Decades of changes to market and government involvement in the US health care system have influenced the structure and function of Sponsoring Institutions, including their relationships with participating sites. In a first acknowledgment of the growing complexity of health care delivery and GME financing, the Institutional Requirements from the 1990s to the mid-2000s described the oversight relationships needed to ensure educational quality across a Sponsoring Institution's programs. Increasingly, health care services and facilities have consolidated under the operations of large health systems spanning multiple locations. In 2007, a major revision of the Institutional Requirements further specified expectations for the Sponsoring Institution's centralized oversight of GME across participating sites. Since the early 2010s, the ACGME's Clinical Learning Environment Review (CLER) Program has informed Sponsoring Institutions' and participating sites' efforts to ensure safety while improving health care and population health in clinical learning environments for GME. The 2013 major revision of the Institutional Requirements included new standards for institutional oversight of all participating sites, or clinical learning environments, corresponding with the CLER Focus Areas.

More recent findings from the CLER Program and the ACGME's Sponsoring Institution 2025 initiative indicate the need for greater integration of GME and clinical learning environments to advance safety and improvement in health care organizations as they are being reshaped by the forces of health system transformation. The 2025 Institutional Requirements account for this necessary transition by recognizing the need for a Sponsoring Institution to identify at least one primary clinical learning environment from among its programs' participating sites. A primary clinical learning environment (PCLE) is a participating site for programs that is substantially integrated with a Sponsoring Institution to collaborate in oversight and

responsibility for GME. Sponsoring Institutions may have multiple PCLEs, and a PCLE may be integrated with more than one Sponsoring Institution.

Section V of the Institutional Requirements specifies the integrative responsibilities of Sponsoring Institutions and PCLEs. Some new requirements apply only to PCLEs and not to all participating sites. The selection of one or more PCLE enables the focused introduction of GME and clinical learning environment integration to a smaller number of locations. It is anticipated that future requirement revisions will include enhanced expectations for the integration of GME and all clinical participating sites.

In a PCLE, the DIO or other GME leader is expected to be part of the executive leadership team. Responsibility for implementing the Institutional Requirements is shared across clinical care teams, and therefore an interprofessional working group is needed. This working group provides organizational structure that brings together representatives from the health system and GME to fulfill required responsibilities, address challenges, and pursue opportunities in partnership. The interprofessional working group has responsibility for overseeing compliance with Institutional Requirements for integration of GME and the clinical learning environment, and fulfills defined functions related to safety, interprofessional safety engagement, quality, well-being, supervision, health systems management, strategy, and education. The interprofessional work group can be managed either within an existing structure such as an executive team, or as a newly developed work group with dedicated support.

I.B.4. The Sponsoring Institution must identify at least one PCLE that has: (Core)

I.B.4.a) an executive leadership team with responsibility for the PCLE's GME strategy, vision, and programmatic changes; (Core)

I.B.4.b) a chief executive officer or equivalent who provides an addendum to the Statement of Commitment affirming the PCLE's support of GME; (Detail)

I.B.4.c) opportunities for GME leaders to regularly interact with executive leaders with authority and responsibility for patient care in that PCLE; (Core) and,

I.B.4.d) a designated, interprofessional working group reporting to the chief executive officer of that PCLE, and including interprofessional leadership with authority and responsibility for patient care in that PCLE.(Core) Membership of the working group must include:

I.B.4.d).(1). the quality and safety leader(s); (Core)

I.B.4.d).(2). the chief nursing officer or designee, or other leader of patient care services; (Core)

I.B.4.d).(3). the chief medical officer or equivalent or designee; (Core) and,

I.B.4.d).(4). the DIO or designee. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:

The full rationale is provided above as Background and Intent. To support integration of GME and the PCLE and the introduction of new Section V requirements, decisions regarding GME will need to be made in a structure for that brings together leaders of the Sponsoring Institution and the PCLE.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The proposed requirements recognize the important roles of interprofessional executive leadership in the PCLE's patient safety and quality improvement efforts in a manner that integrates GME. This addition will promote further alignment between GME and patient safety and quality improvement within health care organizations.

3. How will the proposed requirement or revision impact continuity of patient care?
   Sponsoring Institutions and PCLEs have responsibilities for transitions of patient care that are described in Section V of the proposed Requirements.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   No. Sponsoring Institutions should identify PCLEs from among existing participating sites. The leadership should be identified from among existing leaders of the Sponsoring Institution and the PCLE. The IRC will begin citations for this requirement in 2026. The IRC will begin to cite specific functions of the PCLE specified in Section V of the proposed Requirements in three annual phases from 2026 to 2028.

5. How will the proposed revision impact accredited programs?
   To fulfill the institutional functions described in Section V, the Sponsoring Institution and the PCLE will partner with ACGME-accredited programs involved in resident/fellow education at that PCLE.

Proposed Requirements: **I.C., I.C.1-2., I.C.2.a-d), I.C.3.**
Existing Requirements: **I.A.5., I.A.5.a-b), I.A.5.b).(1-3)**

Requirement Revision (significant change only):

Background and Intent: Within a Sponsoring Institution's organizational structure, a DIO collaborates with other executive leaders of a PCLE to ensure a safe and appropriate environment for resident and fellow education that is aligned with health system goals. The position of the DIO within the executive team of a PCLE reflects the ongoing professional evolution of GME leaders within the US health system, and recognizes their necessary contributions to strategy, vision, and patient care services in health care organizations. The DIO serves in an executive leadership position in at least one PCLE. The DIO has the ability to identify a designee as a GME leader who serves as an associate DIO when there is more than one PCLE. Designated GME leaders who will serve as an associate DIO at a PCLE will need to have appropriate executive appointments (i.e., chief, chair, or equivalent). The DIO or designee will be included in regular meetings, communications, and planning activities with other executive leaders of the PCLE.

I.C. Designated Institutional Official

I.F.1.	The Sponsoring Institution must identify one DIO who, in collaboration with a Graduate Medical Education Committee (GMEC), has authority and responsibility for the oversight and administration of each of the Sponsoring Institution's programs, as well as for ensuring compliance with the Institutional, Common, and specialty-/subspecialty-specific Program Requirements, and Recognition Requirements, as applicable. (Core) [Edited and combined I.A.5 and I.A.5.a)]
I.C.2.	The DIO must:
I.C.2.a)	engage in professional development applicable to responsibilities as an educational leader in health care; (Core)
I.C.2.b)	with GMEC approval of participating site addition(s), approve program letters of agreement (PLAs) that govern relationships between each program and each participating site providing a required assignment for residents/fellows in the program; (Core) [Edited and moved from I.A.5.b).(1)]
I.C.2.c)	oversee submissions of the Accreditation Data System (ADS) Annual Update for the Sponsoring Institution and each of its programs to the ACGME; (Core) [Edited and moved from I.A.5.b).(2)]
I.C.2.d)	after GMEC approval, oversee the submission of applications for ACGME accreditation and recognition, requests for voluntary withdrawal of accreditation and recognition, and requests for changes in residency and fellowship program complements; and, (Core) [Edited and moved from I.A.5.b).(3)]
I.C.2.e)	submit each annual report of the Annual Institutional Review (AIR) to the Sponsoring Institution's governing body and the chief executive officer(s) of the PCLE(s). (Core)
I.C.3.	At a PCLE, the DIO or designee must have an executive leadership appointment with a title of chief, chair, or equivalent that enables collaboration with other executive leaders related to the PCLE's strategy, vision, and patient care services. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided as Background and Intent. The proposed requirement clarifies the role of the DIO and recognizes the DIO's GME executive leadership function within PCLEs. If there is only one PCLE, the DIO has an executive leadership appointment at that PCLE and may not identify a designee. If more than one PCLE is identified, the DIO may identify a designee to fulfill this role at the additional PCLE(s). An existing requirement for DIO professional development (II.A., II.A.2) has been moved into this requirement, with further specification that professional development should be relevant to the DIO's educational leadership role in the context of health care.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement intends to strengthen the connections between Sponsoring Institutions and clinical learning environments by recognizing the integrated leadership role of the DIO that must be fulfilled in partnership with other health care organizational leaders. This will advance patient safety and quality by ensuring the DIO's or designee's coordination and partnership within the health system.

3. How will the proposed requirement or revision impact continuity of patient care?
   The DIO or designee, with the PCLE's interprofessional working group, has responsibilities for transitions of patient care that are described in Section V of the proposed Requirements.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The need for additional resources will vary across Sponsoring Institutions, depending on the current status of the DIO's appointment within a participating site that will serve as the PCLE. In some Sponsoring Institutions, the DIO does not currently have an executive leadership appointment, and the DIO will need to be integrated appropriately into the organizational leadership structure of the PCLE. The IRC will begin citations for this requirement in 2026.

5. How will the proposed revision impact accredited programs?
   Accredited programs providing resident/fellow education at a PCLE will benefit from the assurance of executive GME leadership collaborating with interprofessional health care leadership to improve the learning and working environment for GME.

Proposed Requirements: **I.D.1-2.**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: In order to fulfill requirements for oversight and administration of the Sponsoring Institution and its programs, the DIO delegates some responsibilities to administrative personnel, including an institutional administrator. When delegating some institutional responsibilities, the DIO retains authority and ultimate responsibility for institutional oversight and administration throughout the Sponsoring Institution, and an executive leadership role in at least one PCLE.

I.D.1. The DIO must identify an institutional administrator to whom the DIO delegates responsibility for supporting the GME oversight and administrative functions of the Sponsoring Institution and the GMEC. (Core)

I.D.2. In addition to the institutional administrator, the DIO must identify administrative personnel, as needed, to support the oversight and administrative functions of the Sponsoring Institution, the GMEC, and the PCLE(s). (Core)

1. Describe the Institutional Review Committee's rationale for this revision:

The full rationale is provided above as Background and Intent. The proposed requirement recognizes the need across all types of Sponsoring Institutions for an institutional administrator with delegated responsibility for GME. Depending on the scale and complexity of GME in the Sponsoring Institution and other factors, other individuals may participate in institutional oversight and administration.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   A structure that includes personnel who support institutional oversight and administration is needed for high-quality resident/fellow education.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no direct impact on continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   In many Sponsoring Institutions, this change formalizes a structure that already exists. In such cases, no additional resources will be required. Sponsoring Institutions that have not assigned administrative GME roles will identify an institutional administrator and other personnel, as needed. Institutional administrators and other institutional GME personnel may also have roles or responsibilities outside of GME, which may limit the need for additional resources. Recognizing that this requirement represents a substantial change for some Sponsoring Institutions, the IRC will begin issuing citations based on this requirement in 2027.

5. How will the proposed revision impact accredited programs?
   Accredited programs will benefit from an appropriate institutional structure for oversight and administration that includes an institutional administrator and other GME personnel, as needed.

Proposed Requirements: **I.E.1.**, **I.E.1.a-c)**
Existing Requirements: **I.B.1.a), I.B.1.a).(1-4), I.B.1.b), I.B.1.b).(1-6), I.B.2., I.B.2.a)**

Requirement Revision (significant change only):

I.E.1. ~~A~~ Sponsoring Institution<u>s</u> ~~with multiple ACGME-accredited programs~~ must have a GMEC that includes at least the following voting members: ~~(Core)~~

I.E.1.a) the DIO; (Core)

I.E.1.b) ~~a representative sample of~~ <u>at least two</u> program directors ~~(minimum of two)~~ from its ~~ACGME-accredited~~ program<u>s, or the only program director, if applicable</u>; (Core)

I.E.1.c) a minimum of two peer-selected residents/fellows from ~~among~~ its ~~ACGME-accredited~~ program<u>(s), or the only resident or fellow, if applicable</u>; and, (Core)

I.E.1.d)	for each PCLE, a member of the executive leadership who is responsible for monitoring quality and ~~improvement or~~ patient safety, ~~officer~~ or a designee. (Core) ~~A Sponsoring Institution with one program must have a GMEC that includes at least the following voting members: the DIO; (Core) the program director when the program director is not the DIO; (Core) one of the program's core faculty members other than the program director, if the program includes core faculty members other than the program director; (Core) a minimum of two peer-selected residents/fellows from its ACGME-accredited program or the only resident/fellow if the program includes only one resident/fellow; (Core) the individual or designee responsible for monitoring quality improvement or patient safety if this individual is not the DIO or program director; and, (Core) one or more individuals who are actively involved in GME, are outside the program, and are not the DIO or the quality improvement or patient safety member. (Core) Additional GMEC members and subcommittees: In order to carry out portions of the GMEC's responsibilities, additional GMEC membership may include others as determined by the GMEC. (Detail) Subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow. (Detail)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   Requirements for membership of the GMEC and subcommittees have been reduced and simplified to address administrative burden of Sponsoring Institutions, including those Sponsoring Institutions with only one program.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The revision clarifies that the quality and safety representation in the GMEC should be that of the PCLE leadership. This integration will ultimately enhance integration of safety and quality between GME and learning environments.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact to continuity of care other than the benefit to GME and clinical learning environment integration described above.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The requirement reduces the administrative resources needed for compliance.

5. How will the proposed revision impact accredited programs?
   There is no impact to accredited programs.

Proposed Requirement: **I.E.5.**
Existing Requirement: **None**

Requirement Revision (significant change only):

I.F.1.	The GMEC must not receive or discuss identifiable information about the assessment of individual residents or fellows. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:

This requirement protects the confidentiality of resident- and fellow-specific information and strengthens an existing Institutional Requirement FAQ.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   There is no impact on patient safety or quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact on continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Formative assessment functions, such as those of the Clinical Competency Committee, should be separated from the business of the GMEC. Sponsoring Institutions should ensure that there are administrative resources to protect information about the formative assessment of individuals from use in GMEC and other institutional processes. The IRC will continue issuing comments based on this issue until 2026, when it will begin issuing citations related to the new requirement.

5. How will the proposed revision impact accredited programs?
   Information from residents' and fellows' educational files will be protected from use in institutional processes.

Proposed Requirements **I.E.6., I.E.6.a-b), I.E.6.b).(1-2), I.E.6.c), I.E.6.c).(1-2), I.E.6.d-e), I.E.6.e).(1-2), I.E.6.f-g)**
Existing Requirement: **I.B.4.a), I.B.4.a).(1-7)**

Requirement Revision (significant change only):

Background and Intent: The Sponsoring Institution annual report provides institutions a framework for reflection on their progress toward institutional goals and an opportunity to develop strategic plans for ongoing improvement. Within the context of the integration of continuing medical education and GME, the Sponsoring Institution will need to include aggregated findings pertaining to professionalism at the organizational level as identified by the PCLE's interprofessional working group. These findings will be included in the annual report of the AIR provided to the Sponsoring Institution's governing body and the chief executive officer(s) of the PCLE(s).

I.E.6. ~~Responsibilities:~~ The GMEC ~~responsibilities~~ must ~~include: Oversight of~~ oversee:

I.E.6.a) ~~ACGME-accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs; (Outcome)~~ the quality of the GME learning and working environment ~~within the Sponsoring Institution,~~ for each ~~of its ACGME-accredited~~ program~~s,~~ and ~~its~~ each participating site~~s~~; (Outcome)

I.E.6.b) ~~the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-~~

	~~specific Program Requirements; (Outcome)~~ institutional accreditation, including an AIR summarized in an annual report that documents: (Outcome)
I.E.6.b).(1)	institutional performance on indicators to include, at a minimum, the accreditation and recognition statuses and citations of the Sponsoring Institution and each accredited/recognized program, and the aggregated results of most recent ACGME Resident/Fellow and Faculty Surveys; and, (Outcome)
I.E.6.b).(2)	action plans and performance monitoring procedures resulting from the AIR. (Outcome)
I.E.6.c)	program accreditation and recognition, including: (Core)
I.E.6.c).(1)	~~the ACGME-accredited program(s)'~~ annual program evaluation~~(s)~~ ~~and Self-Study(ies)~~ of all programs; (Core)
I.E.6.c).(2)	a special review process for addressing underperforming programs which adheres to a written protocol that establishes criteria for identifying underperformance, including, at a minimum, all warning and adverse accreditation and recognition statuses as described by the ACGME Policies and Procedures; and which results in a timely report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes, including timelines for each. (Core)
I.E.6.d)	annual recommendations to the administration of the Sponsoring Institution and its PCLE(s) regarding resident and fellow salary and benefits; (Core)
I.E.6.e)	institutional and program-level compliance with ACGME clinical and educational work hour requirements, including institutional procedures for monitoring resident and fellow clinical and educational work hours that:
I.E.6.e).(1)	address non-compliance with ACGME requirements in a timely manner; and, (Core)
I.E.6.e).(2)	do not depend only on reports from program directors and coordinators. (Core)
I.E.6.f)	information regarding the financial performance of the PCLE(s), including the impact of organizational financial status on the administrative, educational, financial, human, and clinical resources needed for GME; (Core) and,
I.E.6.g)	~~ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually; (Core)~~ all processes related to reductions in the resident/fellow complement of programs, and

closures of ~~individual ACGME-accredited~~ programs, ~~major~~ participating sites, and the Sponsoring Institution. ~~; and, (Core) the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided. (Detail)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   This requirement revises the GMEC's oversight responsibility to reduce unnecessary administrative burden by eliminating requirements, and by consolidating and clarifying various expectations for GMEC oversight of the AIR, special reviews, recommendations regarding resident/fellow salaries and benefits, and clinical and educational work hours requirements (I.B.4.b), I.B.4.).(3), I.B.5., I.B.5.a), I.B.5.a).(1-3), I.B.5.b), I.B.5.b).(1-2), I.B.6., I.B.6.a), I.B.6.a).(1-2), III.B.5.a), III.B.5.a).(1) in the Requirements currently in effect). A new requirement strengthens an existing Institutional Requirement FAQ stating that institutional oversight of resident/fellow work hours must be independent of program-level monitoring efforts. An additional requirement for the GMEC to oversee information about the PCLE's financial status will assist in institutional oversight of health care organizations' commitment to GME.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Streamlined and integrated GMEC oversight will benefit patient safety and quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   Streamlined and integrated GMEC oversight will benefit continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   No additional institutional resources are needed. The IRC will issue citations on revised and consolidated portions of the requirement beginning in 2025. The IRC will continue issuing comments based on the issue of independent work hours oversight until 2026, when it will begin issuing citations related to the new requirement. The IRC will begin issuing citations related to oversight of PCLE financial performance information in 2027.

5. How will the proposed revision impact accredited programs?
   This revised requirement enhances oversight of accredited programs.

Proposed Requirements: **I.E.7., I.E.7.a-g)**
Existing Requirements: **I.B.4., I.B.4.b), I.B.4.b).(1-15)**

Requirement Revision (significant change only):

I.E.7. ~~Responsibilities:~~ The GMEC ~~responsibilities~~ must ~~include:~~ review and approve~~al of~~:

I.E.7.a) new and revised Sponsoring ~~i~~Institution~~al~~ GME policies and procedures; (Core)

I.E.7.b) ~~GMEC subcommittee actions that address required GMEC responsibilities; (Core) annual recommendations to the Sponsoring Institution's administration~~

~~regarding resident/fellow stipends and benefits; (Core)~~ applications for ACGME accreditation and recognition of new programs, and requests for voluntary withdrawal of ACGME program accreditation and recognition; (Core)

I.E.7.c) major changes in the structure or duration of education in any program, including any change in the designation of a program's primary clinical site, and additions and deletions of any of a program's participating sites; (Core)

I.E.7.d) requests for permanent ~~changes in~~ resident/fellow complement changes; (Core) ~~major changes in each of its ACGME-accredited programs' structure or duration of education, including any change in the designation of a program's primary clinical site; (Core) additions and deletions of each of its ACGME-accredited programs' participating sites; (Core)~~

I.E.7.e) appointment~~s~~ of new program directors; (Core)

I.E.7.f) progress reports requested by a Review Committee; (Core) ~~responses to Clinical Learning Environment Review (CLER) reports; (Core) requests for exceptions to clinical and educational work hour requirements; (Core) voluntary withdrawal of ACGME program accreditation or recognition; (Core)~~

I.E.7.g) requests for appeal of an adverse action by a Review Committee~~; and, (Core) appeal presentations to an ACGME Appeals Panel; and, (Core) exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements~~. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   This requirement revises the GMEC's review and approval responsibility to reduce unnecessary administrative burden by eliminating requirements, and by consolidating, reordering, and clarifying various expectations for GMEC review and approval.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   There is no impact on patient safety or quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact on continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Additional resources are not needed for this requirement, which reduces administrative burden. The IRC will issue citations based on this requirement in 2025, as it is a revision of existing requirements.

5. How will the proposed revision impact accredited programs?
   This requirement reduces administrative burden associated with review and approval of actions related to programs.

Proposed Requirements: **I.F., I.F.1-3., I.F.3.a-c)**
Existing Requirements: **III.A., II.C., II.C.1-3., III.B.1., III.B.1.a), III.B.4.a).(2)**

Requirement Revision (significant change only):

I.F. Residents, Fellows, and Faculty Members

I.F.1. The Sponsoring Institution and each of its programs must ensure a learning and working environment in which residents/fellows and faculty members have opportunities to raise concerns and provide feedback without intimidation or retaliation, and in a confidential manner, as appropriate. (Core) [Edited and moved from IV.A.]

Background and Intent: A Sponsoring Institution has flexibility to develop a format for its Resident/Fellow Forum that is well suited for the organizational structure and residents'/fellows' preferences. There are various structures that could support a compliant Resident/Fellow Forum, including in-person meetings, electronic communication mechanisms, and organized asynchronous or hybrid engagements that are inclusive of all residents/fellows. Regardless of the structure of the forum, it is to be provided in a manner that enables the participation of all residents/fellows as well as timeliness in communication, exchange of information, and presentation of concerns.

I.F.2. Resident/Fellow Forum: Sponsoring Institutions must provide all residents/fellows from within and across the Sponsoring Institution's programs with a structure for open communication and exchange of information with all other residents/fellows relevant to any aspect of GME and their learning and working environment, including an option to communicate and exchange information without the DIO, faculty members, or other administrators present, and an option to present concerns to the DIO and GMEC. (Core) [Edited and moved from II.C.1-3.]

I.F.3. The Sponsoring Institution must ensure that residents/fellows and faculty members have access to systems for reporting, in a protected manner that is free from reprisal: (Core)

I.F.3.a) patient care errors, adverse events, unsafe conditions, and near misses; (Core)

I.F.3.b) inadequate supervision and patient care accountability; and, (Core)

I.F.3.c) unprofessional behavior, including discrimination, sexual and other forms of harassment, mistreatment, abuse, and/or coercion of residents/fellows, other learners, faculty members, and staff members. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   This new section reorganizes existing requirements to recognize the importance of residents, fellows, and faculty members in the structure for institutional oversight, and to create a reader-friendly list of some required institutional resources for communication and reporting. The obligation of Sponsoring Institutions to have systems for reporting unprofessional behavior is derived from a broader existing requirement (III.B.6.d).(1));

obligations for Sponsoring Institutions to investigate, monitor, and address unprofessional behavior were retained as proposed requirement IV.F.2.a) in this revision.

The rationale for the update to the Resident/Fellow Forum is described in Background and Intent. The forum can provide a structure for communication and exchange of information that occurs asynchronously and without in-person meetings, depending on operational circumstances of the Sponsoring Institution and its programs, and on the preferences of residents and fellows.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This revision provides transparency of standards for resident/fellow and faculty member communication, exchange of information, and reporting.

3. How will the proposed requirement or revision impact continuity of patient care?
   These reorganized standards facilitate resident/fellow and faculty member awareness of mechanisms for reporting issues that may affect continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   As with other current requirements that have been retained in the major revision, the IRC will begin issuing citations based on this requirement in 2025. The IRC will not cite any Sponsoring Institutions with only one program for their Resident/Fellow Forums until 2026, recognizing that these Sponsoring Institutions have previously been exempted from this portion of the requirement.

5. How will the proposed revision impact accredited programs?
   Resident, fellow, and faculty member communication in accredited programs will be enhanced by the proposed revision.

Proposed Requirements: **II.A., II.A.1-3.**
Existing Requirements: **II.A., II.A.1-3.**

Requirement Revision (significant change only):

Background and Intent: Due to differences in the scale and structure of GME operations, there is variability in the amount of salary support and resources needed to provide effective institutional GME administration. Individuals who are designated as institutional administrators and other administrative personnel may have professional titles that include, but are not limited to, assistant or associate DIO, GME director, accreditation specialist, or data analyst. When institutional administrators and other administrative personnel are assigned responsibilities outside institutional GME, the support and time dedicated to institutional GME administration responsibilities is to be clearly specified.

II.A. ~~Institutional GME Infrastructure and Operations:~~ The Sponsoring Institution must ensure that sufficient salary support and resources are provided for effective institutional GME administration~~:~~. (Core)

II.A.1.	~~t~~The DIO ~~has~~ must be provided with sufficient support and dedicated time to effectively carry out educational, administrative, and leadership responsibilities~~;~~. (Core)
II.A.2.	~~t~~The institutional administrator must be provided with sufficient support and dedicated time to fulfill the responsibilities for supporting institutional GME oversight and administration. ~~DIO engages in professional development applicable to responsibilities as an educational leader; and,~~ (Core)
II.A.3.	Administrative personnel supporting GME oversight or administrative functions of the Sponsoring Institution, the GMEC, and the PCLE(s) must be provided with sufficient support and dedicated time~~sufficient salary support and resources are provided for effective GME administration~~. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided above as Background and Intent. The proposed requirement recognizes the need across all types of Sponsoring Institutions to ensure appropriate salary support and dedicated time to support institutional GME administration. Depending on the scale and complexity of GME in the Sponsoring Institution and other factors, support and dedicated time may be needed for individuals other than the DIO and the institutional administrator. The proposed requirement recognizes that institutional GME support and dedicated time are needed for GME administration in a PCLE.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Effective institutional GME administration is needed for high-quality resident/fellow education.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no direct impact on continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   In some Sponsoring Institutions, the proposed Requirement formalizes an expectation for support and dedicated time that is already being provided. In such cases, no additional resources will be required. In other Sponsoring Institutions, additional administrative resources in the form of salary support and dedicated time will be needed to ensure effective GME administration in the Sponsoring Institution and the PCLE. In 2025, the IRC will issue citations based on already-existing elements of the revised requirement. Recognizing that new resources may need to be identified in some Sponsoring Institutions and PCLEs, the IRC will begin issuing citations related to institutional administrator support and institutional GME administrative support in the PCLE in 2027.

5. How will the proposed revision impact accredited programs?
   Providing appropriate resources for institutional GME administration will ensure that personnel are able to support accredited programs, faculty members, residents, and fellows.

Proposed Requirements: **II.G., II.G.1-9.**
Existing Requirements: **II.F., II.F.1., II.F.1.a-c), III.B.7.c).(2-3), III.B.7.d), III.B.7.d).(1-6)**

Requirement Revision (significant change only):

Support Services and Systems

II.G. The Sponsoring Institution, in partnership with its program(s) and participating sites, must ~~provide~~ ensure:

II.G.1 support services ~~and develop health care delivery systems~~ to minimize residents'/fellows' work that is extraneous to their ~~ACGME-accredited~~ program(s)' educational goals and objectives, and to ensure that residents'/fellows' educational experience is not compromised by excessive reliance on residents/fellows to fulfill non-physician service obligations~~. These support services and systems must include: (Core) peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care; (Core) medical records available at all participating sites to support high quality and safe patient care, residents'/fellows' education, quality improvement and scholarly activities; and, (Core) institutional processes for ensuring the availability of resources to support residents'/fellows' well-being and education by minimizing impact to clinical assignments resulting from leaves of absence.~~; (Core)

II.G.2. ~~provide~~ resident/fellow access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

II.G.3 ~~provide~~ resident/fellow and faculty member access to appropriate tools for self screening; and, (Core)

II.G.4. ~~The Sponsoring Institution must ensure a healthy and safe clinical and educational environment that provides for: (Core)~~ access to food during clinical and educational assignments; (Core)

II.G.5. sleep/rest facilities that are safe, quiet, clean, and private, and that must be available and accessible for residents/fellows, with proximity appropriate for safe patient care; (Core)

II.G.6. safe transportation options for residents/fellows who may be too fatigued to safely return home on their own; (Core)

II.G.7. clean and private facilities for lactation with proximity appropriate for safe patient care, and clean and safe refrigeration resources for the storage of ~~breast~~ human milk; (Core)

II.G.8. safety and security measures appropriate to the ~~clinical learning environment~~ participating site; and, (Core)

II.G.9.	accommodations for residents/fellows with disabilities, consistent with policy(ies) of the Sponsoring Institution~~'s policy~~ and participating sites and applicable laws. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The proposed requirement reduces burden by eliminating several elements and consolidating a list of some required services and systems that support a safe learning and working environment for GME.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Support services and systems are needed to support residents/fellows and faculty members in providing safe patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
   Support services and systems are needed to support continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This revised requirement reduces administrative burden through elimination and consolidation of standards**.** There are no new elements, and therefore the IRC will begin issuing citations based on the requirement in 2025.

5. How will the proposed revision impact accredited programs?
   The requirement clarifies expectations for support services and systems available to residents, fellows, and faculty members in accredited programs.

Proposed Requirements: **III.A., III.A.1-2.**
Existing Requirement: **IV.A.**

Requirement Revision (significant change only):

III.A. The Sponsoring Institution must:

III.A.1.	demonstrate adherence to all institutional graduate medical education policies and procedures~~.~~; and, (Core)
III.A.2.	ensure that all Sponsoring Institution GME policies and procedures are available for review by all residents and fellows at all times. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   Institutional GME policies and procedures should be transparent to residents and fellows.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Resident/fellow access to information supports high-quality education and patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no direct impact on continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Existing institutional resources can be used to meet the requirement. The IRC will cite existing elements of the requirement starting in 2025, and will begin issuing citations for availability of policies and procedures to residents/fellows in 2026.

5. How will the proposed revision impact accredited programs?
   Residents/fellows will have guaranteed access to institutional GME policies and procedures.

Proposed Requirements: **III.D.10., III.D.10.a-g), III.D.11., III.D.11.a-c)**
Existing Requirements: **IV.N., IV.N.1., IV.O., IV.O.1-2.**

Requirement Revision (significant change only):

Background and Intent: Occasionally, disruptions in patient care or education result in extraordinary circumstances for GME in Sponsoring Institutions, programs, and participating sites. There are multiple potential causes for these extraordinary circumstances, or circumstances that significantly alter the ability of a Sponsoring Institution, its programs, and its participating sites to support GME. The ACGME developed policies and procedures for addressing extraordinary circumstances in the mid-2000s after the impact of Hurricane Katrina disrupted GME in New Orleans, leading to the temporary and permanent transfer of many residents and fellows who were able to continue their education in other ACGME-accredited programs. Since that time, ACGME extraordinary circumstances policies have been invoked if a participating site for GME abruptly closes, such as when bankruptcy caused the displacement of more than 500 Hahnemann University Hospital residents and fellows in 2019. The ACGME implemented policies and procedures for extraordinary circumstances at a national scale in 2020 when the COVID-19 pandemic disrupted GME across the US.

The proactive inclusion of the DIO and other institutional leaders in organizational responses to substantial disruptions protects patients and residents. Robust institutional policies and procedures are needed to ensure appropriate planning, oversight, support, and communication in the event of a substantial disruption in patient care or education in a Sponsoring Institution or any of its programs or participating sites. The 2025 Institutional Requirements describe the essential components of an institutional GME policy that is compatible with the ACGME Policies and Procedures, and establishes a commitment to assist residents and fellows while protecting them from negative effects on their education in ACGME-accredited programs. This institutional policy will focus on addressing substantial disruptions that affect an organization's ability to continue GME operations on a temporary or permanent basis, which may or may not be associated with invocation of ACGME policies and procedures regarding extraordinary circumstances.

[III.D. The Sponsoring Institution must have written policies that:]

III.D.10. address substantial disruptions in patient care or education, including: (Core)

III.D.10.a)	the authority of the DIO or designee to activate the substantial disruptions in patient care or education policy (Core)
III.D.10.b)	notification to the DIO within 30 days of any decision to close a participating site; (Core)
III.D.10.c)	support for each of its programs and residents/fellows in the event of a disaster or other substantial disruption in patient care or education, consistent with the ACGME Policies and Procedures; (Core)
III.D.10.d)	support for resident/fellow well-being during a substantial disruption; (Core)
III.D.10.e)	information about assistance for continuation of salary, benefits, professional liability coverage, and resident/fellow assignments; (Core)
III.D.10.f)	assurance of regular and direct communication and engagement between the DIO and other organizational leaders during the response to the substantial disruption in patient care or education; (Core) and,
III.D.10.g)	information about assistance for transfer of residents/fellows, including financial assistance provided by the Sponsoring Institution or participating sites. (Core)

III.D.11. address reductions in size or closure of any of its programs, or closure of the Sponsoring Institution, including:

III.D.11.a) notification of residents/fellows as soon as possible when there is a decision to reduce the size of or close one or more programs, or when it is decided to close the Sponsoring Institution; (Core)

III.D.11.b) allowance of residents/fellows already in an affected program(s) to complete their education at the Sponsoring Institution, or assistance for residents/fellows in enrolling in other program(s) in which they can continue their education; and, (Core)

III.D.11.c) GMEC oversight of the process. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The committee recognizes the need for the Sponsoring Institution to consider the impact of disruption of resident/fellow education (whether by natural disaster, loss of institutional resources, closures, or other causes) and the need to establish policies and procedures for when resident/fellow education is disrupted. This new requirement outlines fundamental considerations for a Sponsoring Institution when establishing a substantial disruptions policy and provides the DIO a set of oversight functions.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This requirement is intended to protect residents/fellows and patients.

3. How will the proposed requirement or revision impact continuity of patient care?
   Institutional oversight in circumstances of disruption or closure should support continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Implementation of this requirement should not require additional institutional resources. Existing elements of the requirement can be cited by the IRC starting in 2025. The IRC will begin citing components III.D.10.a,b,d,g) and III.D.11.c) in 2026, and III.D.10.f) in 2027.

5. How will the proposed revision impact accredited programs?
   Institutional oversight will assist accredited programs that are substantially disrupted and/or closing.

Proposed Requirement: **IV.B.**
Existing Requirements: **III.B.2., III.B.2.a-b)**

Requirement Revision (significant change only):

IV.B. Health Care Quality ~~Improvement~~: The Sponsoring Institution must ensure that residents/fellows have~~: access to data to improve systems of care, reduce health care disparities, and improve patient outcomes; and,~~ ~~(Core)~~ opportunities to participate in quality improvement initiatives. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The IRC eliminated a portion of this requirement to narrow its focus on the foundational need for residents to participate in quality improvement initiatives. As seen in CLER reports, this foundational learning experience is not being met. By narrowing the focus to seeking assurance of opportunities to participate in quality improvement initiatives, the IRC believes it can send a clearer message of its expectation that this needs to be achieved for all residents and fellows.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Is its anticipated that this shorter, more focused requirement will send a clear signal to the GME community of the importance of residents and fellows having learning experiences in quality improvement.

3. How will the proposed requirement or revision impact continuity of patient care?
   This change is aimed at improvement in patient care**.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   None.

5. How will the proposed revision impact accredited programs?
   There is no anticipated impact.

Proposed Requirement: **IV.C.**
Existing Requirements: **III.B.3., III.B.3.a-b)**

Requirement Revision (significant change only):

IV.C. ~~Transitions of Care~~ Teaming: The Sponsoring Institution must ensure that there are structured learning activities for residents, fellows, and faculty members incorporating interprofessional, team-based care~~: facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, (Core) in partnership with its ACGME-accredited program(s), ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites~~. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   Requirements for transitions of care were updated to a more foundational requirement emphasizing the essential need for residents and fellows to participate in learning activities seeking to improve interprofessional, team-based care at all participating sites for GME.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The existing requirement has been difficult to understand and implement for Sponsoring Institutions. This emphasis on the basic need for learning around interprofessional engagement is intended to improve education and patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement is intended to improve patient care. The updated requirement provides flexibility for Sponsoring Institutions to plan learning activities that improve interprofessional relationships, communications, and workforce well-being, all in the service of better continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Sponsoring Institutions, in partnership with their participating sites, will determine the resources that will be needed to develop structured learning activities that integrate GME and interprofessional, team-based care. The IRC will begin issuing citations based on this requirement in 2026.

5. How will the proposed revision impact accredited programs?
   Recognizing that there may be specialized patient care needs in different clinical service areas, Sponsoring Institutions should work with accredited programs and participating sites to develop appropriate learning activities.

Proposed Requirement: **None**
Existing Requirements: **III.B.5., III.B.5.a), III.B.5.a).(1-3)**

Requirement Revision (significant change only):

~~Clinical Experience and Education~~

~~The Sponsoring Institution must oversee:~~

~~resident/fellow clinical and educational work hours, consistent with the Common and specialty-/subspecialty-specific Program Requirements across all programs, addressing areas of non-compliance in a timely manner; (Core)~~

~~systems of care and learning and working environments that facilitate fatigue mitigation for residents/fellows; and, (Core)~~

~~an educational program for residents/fellows and faculty members in fatigue mitigation. (Core)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   The requirement for overseeing resident/fellow clinical and educational work hours has been moved to a GMEC oversight requirement. The requirement for overseeing systems and environments facilitating fatigue mitigation has been moved to a well-being requirement. The requirement for educational programs in fatigue mitigation has been removed to reduce administrative burden. Publicly available information and education about fatigue mitigation are widely accessible for use by Sponsoring Institutions and programs.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   There is no change in these areas.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no change in these areas.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The elimination of this requirement reduces institutional resources needed for compliance.

5. How will the proposed revision impact accredited programs?
   There is no impact.

Proposed Requirement: **None**
Existing Requirements: **III.B.6., III.B.6.a-b)**

Requirement Revision (significant change only):

~~The Sponsoring Institution must provide systems for education in and monitoring of:~~

~~residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits; and, (Core)~~

~~accurate completion of required documentation by residents/fellows. (Core)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   This requirement has been eliminated to reduce administrative burden.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The existing requirement has been difficult to understand and implement for Sponsoring Institutions. Removal of the requirement will enhance resident/fellow education by reducing administrative burden.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The elimination of this requirement reduces institutional resources needed for compliance.

5. How will the proposed revision impact accredited programs?
   There is no impact.

Proposed Requirement: **None**
Existing Requirements: **IV.B.1-2., IV.B.2.a-c), IV.B.2.c).(1-2)**

Requirement Revision (significant change only):

~~The Sponsoring Institution must have written policies and procedures for resident/fellow recruitment, selection, eligibility, and appointment consistent with ACGME Institutional and Common Program Requirements, and Recognition Requirements (if applicable), and must monitor each of its ACGME-accredited programs for compliance. (Core) An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or, (Core) graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association (AOA); or, (Core) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core) holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or, (Core) holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty-/subspecialty program. (Core)~~

1. Describe the Institutional Review Committee's rationale for this revision:
   Requirements for resident/fellow eligibility are included in the ACGME Common Program Requirements.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   There is no impact.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   No.

5. How will the proposed revision impact accredited programs?
   Programs and Sponsoring Institutions should work together to ensure compliance with eligibility requirements for appointment to ACGME-accredited programs.

Proposed Requirement: **V.A.1.**
Existing Requirement: **None**

Requirement Revision (significant change only):

V.A.1 <u>At least annually, staff members of each PCLE with responsibility for patient safety and quality must solicit input regarding patient safety concerns from the GMEC. (Core)</u>

1. Describe the Institutional Review Committee's rationale for this revision:
   The CLER National Reports of Findings have demonstrated the need for a heighted focus on how the clinical learning environment and GME leadership need to regularly interact on the specific issues around patient safety concerns. This requirement will inform the PCLE regarding GMEC concerns related to patient safety and will support the PCLE patient safety leadership's engagement with program directors, faculty members, and residents/fellows.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement will improve resident/fellow education and patient safety by identification of potential gaps in resident/fellow patient safety education, engagement of residents/fellows in patient safety programs at the PCLE, and other patient safety concerns.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement ensures that the GMEC can provide insight to the PCLE(s) regarding continuity of care concerns, if applicable.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   No additional resources will be required to implement the requirement. The GMEC and the quality and safety leadership of the PCLE(s) should collaborate to develop an annual process for soliciting input. The IRC will begin issuing citations related to this requirement in 2026.

5. How will the proposed revision impact accredited programs?

The GMEC will provide patient safety insights from programs to the quality and safety leadership of the PCLE(s) through this process.

Proposed Requirements: **V.A.2., V.A.2.a-d)**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: It has been 25 years since the National Academy of Medicine (then the Institute of Medicine) issued its report *To Err Is Human* (Institute of Medicine (US) Committee on Quality of Health Care in America. 2000. *To Err is Human: Building a Safer Health System*. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. National Academies Press. PMID: 25077248). The report was a definitive statement of patient safety concerns in US health care with clear recommendations for engaging the health care workforce in patient safety processes to improve patient care.

With early input from the CLER Program, the first Institutional Requirements related to patient safety were introduced in the early 2010s. Those requirements recognized the importance of experiential learning as residents/fellows learn to participate in implementing sustainable interprofessional solutions to patient safety issues that arise in everyday clinical care.

More recent findings from the CLER Program have indicated that while there has been progress in engaging residents and fellows in patient safety reporting, these changes have been insufficient to provide physicians with experiential learning that addresses educational and patient care needs.

The ACGME Pursuing Excellence Initiative conducted a learning collaborative in patient safety. It had several key observations. First, the goal of resident engagement in patient safety is not to increase resident reporting of patient safety events; rather, residents and fellows are much more interested in resolving the underlying causes for the safety event. The collaborative identified many opportunities for engaging residents in patient safety events if they examined low-harm and near-miss events. The collaborative also found that engagement needed to be one of active experiential learning in an interprofessional small group setting. Finally, engaging residents early in their program was both feasible and useful for getting residents actively engaged.

This requirement was developed to close the gap in resident engagement with patient safety and to enhance patient care. A PCLE that integrates GME provides robust experiential learning in patient safety for residents. Many health care organizations have existing activities, such as morbidity and mortality conferences, that may provide early learners with basic knowledge and initial exposure to patient safety concepts. For first-year residents, this exposure may provide introductory education prior to their participation in a real patient safety event investigation in the form of online modules, lectures, simulations, or morbidity and mortality conferences directed toward understanding patient safety. These pedagogical methods are not equivalent to residents' engagement in real-time, actual patient safety event analyses done in a timely fashion after an event and with a small enough interprofessional group to fully engage all participants in the discovery, analysis, action plan development, and monitoring of action plan implementation.

While all residents and fellows are expected to have opportunities to participate in risk reduction processes at every participating site, the Sponsoring Institution and PCLE(s) are responsible for ensuring that each first-year resident in the PCLE(s) is engaged in meaningful activities supporting patient safety. Authentic analyses need not be limited to serious safety events. The analysis of near misses, close calls, and safety events that did not cause harm to patients may optimize the participation of first-year residents, reserving participation in analysis of events in which patients were harmed for more senior residents and fellows.

V.A.2. Each PCLE must ensure that each resident who is new to that PCLE participates in a non-simulated interprofessional process addressing a real patient safety event. (Core) This must occur within the resident's first year of engagement in patient care at that PCLE, and include:

V.A.2.a) analysis; (Core)

V.A.2.b) action planning; (Core)

V.A.2.c) implementation of improvement; (Core) and,

V.A.2.d) evaluation of clinical care outcomes of implementing improvement. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:

The full rationale is provided in Background and Intent. The Pursuing Excellence collaborative studied the feasibility of the approach defined in the requirement. The Pursuing Excellence summary report identified that residents tend to think about patient safety events only as those events with a serious outcome, such as harm to a patient. This requirement intends to expand organizational and resident learning that is primarily based on non-harm events and recognizes systems-based patient safety events, such as failed connection points in the health care system that contribute to challenges in patient care. Providing residents with experiential learning opportunities will advance their understanding beyond didactic patient safety curricula and traditional mortality and morbidity conferences, and will prepare them to respond to systems-based issues and evaluate outcomes in the context of an interprofessional team.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This requirement improves resident education by strengthening active participation in patient safety event investigations. Health care organizations that have adopted this model have not only improved resident competence in patient safety, but they have also increased resident reporting of patient safety events and broadened the types of patient safety events that are reported within the clinical learning environment.

3. How will the proposed requirement or revision impact continuity of patient care?

This requirement can be used to engage residents in analyzing patient safety events in which continuity of patient care is a factor.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

The Sponsoring Institution and PCLE will need to commit the necessary administrative and educational resources to implement this requirement. The Sponsoring Institution, in collaboration with its programs and PCLE(s), will need to develop processes to ensure that all new residents participate in the analysis of actual patient safety events. Residents of the Sponsoring Institution will require time to participate in interprofessional event analysis teams during their first year of engagement in patient care at that PCLE. Sponsoring Institutions and PCLEs should identify personnel and processes that ensure resident participation in interprofessional patient safety event analysis. The IRC recognizes that implementation of this requirement will potentially require the GME office to coordinate with programs about resident engagement, in close collaboration with the PCLE's patient safety program. Respecting the complexity of this requirement, it is anticipated that full implementation will require more time than other, less complex new requirements. In 2027, the IRC will begin issuing citations if less than 50 percent of new residents are participating in patient safety event analysis; starting in 2028, citations will be issued for less than 90 percent participation.

5. How will the proposed revision impact accredited programs?
   This requirement will enhance experiential patient safety and quality education for residents.

Proposed Requirements: **V.A.3., V.A.3.a-b), V.A.4.**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: This new requirement is responsive to the US President's Council of Advisors on Science and Technology report to the President: A Transformational Effort on Patient Safety, issued September 2023**.** The report's recommendation 2.B identifies the need to create a learning ecosystem and shared accountability system to ensure that evidence-based practices are implemented and goals for reduced harms and risks of harm for every American are realized.

The CLER Program has indicated that participating sites for GME provide residents and fellows with experiential training opportunities in communicating and resolving patient safety events with patients and families; and these opportunities may ensure that residents and fellows are involved with faculty members in such disclosures relating to patients to whom they have provided care. In recent years, health care organizations have widened their focus by creating programs that address physicians' communication and resolution of issues in care with patients, families, and caregivers, irrespective of whether harm has occurred. There are examples of nationally recognized communication and resolution programs that have been well studied.

PCLEs need to engage clinical care team members, including residents and fellows, in programs that provide emotional support after safety events in which a patient is harmed by their health care. General well-being or employee assistance programs may not be specially designed to manage the complex needs of care practitioners after a patient is harmed.

Additionally, CLER visits have identified many participating sites with safety cultures that are challenged by the interactions between clinical patient safety and risk management programs.

In some participating sites, these two different important functions are consolidated in a single program even though clinical patient safety and risk management have differing primary functions. To make further progress in creating cultures of safety, PCLEs and other participating sites will need to clarify and balance the respective functions of patient safety and risk management. Programs responding to care events will establish roles for both patient safety and risk management that are transparent to residents, fellows, and faculty members, and enable them to engage appropriately with patients, families, and caregivers while contributing to health care improvement.

V.A.3. At each PCLE, there must be a program for responding to harm events that includes the residents, fellows, and faculty members. (Core) The program must include residents/fellows and faculty members in:

V.A.3.a) communicating and seeking resolution with patients and families following a harm event; (Core) and,

V.A.3.b) support provided to clinicians following a harm event. (Core)

V.A.4. At each PCLE, there must be policies and procedures outlining actions taken after the occurrence of a patient safety event, with or without harm, and distinguishing the role of the clinical patient safety program from the role of risk management. Residents, fellows, and faculty members must be provided with education on these policies and procedures. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. It is essential that residents, fellows, and faculty members are able to communicate and seek resolution with patients, families, and caregivers after events in which patients are harmed by their health care.

   To follow up after such events, a clinician support structure is needed to support the well-being of the care team, including residents, fellows, and faculty members, and to provide an avenue for professional and psychological support. The support structure should engage experienced individuals that may include faculty members who are experienced in the emotional support around the complex issues of patient harm events. This support program is distinct from other well-being resources as it requires a specific skill set to support the impact of patient safety events experienced by physicians. This structure should be activated for all patient harm events and should not rely on individuals to self-report a need for support.

   Additionally, it is becoming apparent from CLER Program findings that organizations do not often clearly describe distinct and necessary responsibilities and procedures of clinical patient safety and organizational risk management to members of the GME community. Lack of clarity and understanding of these two distinct health care functions creates challenges for residents and fellows who are expected to participate in patient safety event analysis. This requirement emphasizes the need for clearer delineation of these functions and greater awareness among care team members of the respective roles of the clinical patient safety processes and those of risk management in addressing patient safety events.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This requirement will enhance experiential learning in residents'/fellows' and faculty members' communication with patients and their families following harm events. Transparent communication and attempts at resolution after patient safety events will benefit patient safety and lead to improvements in quality of care. The availability of support services will protect the well-being of residents, fellows, and faculty members after harm events.

Delineation of clinical patient safety and risk management programs' roles will allow for better resident and fellow contributions to the patient safety programs and clinical improvements that come from analyzing patient safety events.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will impact continuity of patient care as an aspect of patient safety.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The Sponsoring Institution and PCLE will need to dedicate administrative, educational, and human resources to support a program that complies with the requirement. Administrative resources will be required to ensure appropriate policies concerning actions taken after a patient safety event. In recognition of the developmental time and resources that may be required to accomplish this requirement in some Sponsoring Institutions and PCLEs, the IRC will begin issuing citations related to this requirement in 2027.

5. How will the proposed revision impact accredited programs?
   This will be a primary responsibility of the PCLE. The Sponsoring Institution will need to work with its programs to regularly ensure that this information is communicated to the residents and fellows.

Proposed Requirements: **V.B.1., V.B.1.a-f)**
Existing Requirement: **None**

Requirement Revision (significant change only):

V.B.1 Each PCLE must have a patient safety and quality plan that integrates GME. (Core) The plan must:

V.B.1.a) describe the roles of residents and fellows, and their participation in the plan; (Core)

V.B.1.b) establish accountability and oversight; (Core)

V.B.1.c) include a timeline and monitoring procedures for implementing the plan and evaluating progress toward goals; (Core)

V.B.1.d) provide residents and fellows with opportunities to participate in any existing surveys of the culture of patient safety in the PCLE; (Core)

V.B.1.e)	include the goals of integrating GME and patient safety and quality programs; and, (Core)
V.B.1.f)	specify how the PCLE will work with the Sponsoring Institution to provide data for quality performance and ensure interpretation of the data in the context of the PCLE. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   Residents and fellows play a key role in patient care and have unique insights regarding patient safety and improvement opportunities. Because of this, the IRC recognized that the integration of residents and fellows into patient safety and quality improvement activities of health systems is critical to success. The CLER Program has demonstrated that each clinical learning environment that has been site visited has a quality and safety plan. This requirement is designed to ensure that the patient safety and quality improvement plans of the PCLE integrate GME with clearly defined resident and fellow roles and participation expectations, including the assessment of residents'/fellows' perspective of the culture of patient safety in the PCLE. In addition, the plan should allow for transparency in the patient safety and quality improvement processes, including establishment of accountability and oversight, monitoring progress toward goals, and collaboration with the Sponsoring Institution in evaluating data related to resident and fellow engagement in patient safety and quality improvement activities at the PCLE.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement will improve organizational understanding of residents'/fellows' roles in improving patient safety and quality in the PCLE. This requirement seeks to improve patient safety and care quality by ensuring that residents/fellows are engaged in activities that assess and improve these processes at the PCLE.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will impact continuity of patient care as an aspect of health care quality.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Minimal resources will be needed to fulfill this requirement. Some time may be necessary to revise, review, and approve the plan. The IRC will begin issuing citations related to this requirement in 2026.

5. How will the proposed revision impact accredited programs?
   Accredited programs will benefit from the formalization and integration of resident/fellow involvement in the PCLE's health care quality improvement efforts.

Requirements: **V.B.2., V.B.2.a-d**)

Requirement Revision (significant change only):

V.B.2. Each PCLE must:

V.B.2.a) provide current information to residents, fellows, and faculty members regarding community health care needs assessments conducted by the PCLE; (Core)

V.B.2.b) provide residents and fellows with the opportunity to engage in clinical learning environment-led activities resulting from these assessments; (Detail)

Background and Intent: The Sponsoring Institution 2025 initiative recommended that Sponsoring Institutions offer enhanced interdisciplinary- and multidisciplinary educational programming and experiences for residents and fellows that support the development of physicians in their professional roles, including clinical leadership skills. Health care organizations have many ways to develop clinical leadership. It is recognized that it is essential to ensure that these programs are available within each Sponsoring Institution.

In order to optimize health systems for learning, each PCLE will ensure that interested residents and fellows have equitable access to clinical leadership development programs. These programs will provide broad exposure across the health care organization, and will be viewed as a supplement to, and not a substitute for, any leadership programs offered within clinical departments or specialty areas of the PCLE. In PCLEs providing multispecialty patient care services, access to the program may not be limited to residents or fellows in specific specialty or subspecialty programs.

V.B.2.c) provide residents and fellows with opportunities to participate in a longitudinal clinical leadership development program or pathway; (Core)

V.B.2.d) maintain a central repository of the site's clinical quality improvement projects, including identification of resident- and fellow-led projects and monitoring of project statuses and outcomes; (Core) and,

Background and Intent: Organizational financial stability affects clinical and educational operations, and decisions regarding commitment to GME need to be informed by the financial performance of a PCLE.

V.B.2.e) provide information at least annually to the DIO and the GMEC regarding the health care organization's financial performance as it relates to the status of organizational operations and the safety and quality of patient care. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   This requirement intends to improve multiple aspects of health care quality and resident/fellow education.

   Residents and fellows should be engaged in health care organizations' community health care needs assessments to enhance their ability to address those needs. Through inclusion in these assessments, residents and fellows will be better able to understand social and environmental factors affecting patient populations and their health. Additionally, residents and fellows will be more prepared to collaborate with the PCLE to participate in activities developed to advance health care equity.

   Health care systems are becoming increasingly complex. There is a need to identify physicians who are interested in entering clinical leadership so they may be engaged in

formalized pathways or programs to develop their skills in administration, leadership, and management in concert with their clinical skills. This requirement is intended to provide access to interested residents/fellows to develop skills that will enhance their ability to serve as leaders in health care systems.

Creation of a central repository of clinical quality improvement projects of the PCLE that includes resident and fellow projects, monitors their statuses, and evaluates their outcomes, will provide an important resource for improving health care quality.

Institutional awareness of the financial status of health care organizations serving as PCLEs is essential for the integrated leadership of the Sponsoring Institution and PCLE to plan and operationalize safety and quality efforts.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   As described in the rationale and Background and Intent, this requirement is focused on improvement of health care quality in resident/fellow education.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement addresses continuity of patient care as an aspect of health care quality.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Some amount of dedicated administrative, educational, and human resources will be needed to create the engagement and resources specified in this requirement. This will include resource allocation of time to educate residents/fellows and faculty members regarding the community health needs assessments conducted by the PCLE and initiatives resulting from those assessments. The Sponsoring Institution should work with the PCLE to develop an appropriate clinical leadership program or pathway. There may also be a need to enhance quality improvement project processes and data management tools to ensure residents have access to information regarding health care quality initiatives and opportunities to participate in these activities. The IRC will begin issuing citations for this requirement as follows:

   V.B.2.a) – citations begin in 2026
   V.B.2.b) – citations begin in 2027
   V.B.2.c) – citations begin in 2028
   V.B.2.d) – citations will begin in 2027 for maintenance of a central repository, and in 2028 for monitoring project statuses and outcomes
   V.B.2.e) – citations begin in 2027

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions should engage programs in the implementation of this requirement.

Proposed Requirements: **V.B.3., V.B.3.a), V.B.3.a).(1-4)**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: It is well established that there are social and environmental factors that place populations at risk for disparities in health and health care. Organizational recognition of these issues and educational programming provide an important early step toward organizational improvement that addresses important related issues such as structural racism, implicit bias, cultural humility, and health and health care equity.

In addition to any educational efforts in this area, PCLEs need to pursue the implementation of performance-based measurements that are relevant both to patient care provided by residents, fellows, and faculty members and to health care equity for populations served by the PCLE.

V.B.3. Each PCLE, in collaboration with the Sponsoring Institution, must:

V.B.3.a) provide all residents/fellows with longitudinal training in the areas of: (Core)

V.B.3.a).(1) the effect of bias in health care delivery; (Core)

V.B.3.a).(2) cultural humility; (Core)

V.B.3.a).(3) health and health care equity relevant to the patient populations served by the PCLE; (Core) and

V.B.3.a).(4) the impact of racism and other societal factors on health care delivery and health outcomes. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. It is well established that social and environmental factors place populations at risk for disparities in health and health care. This requirement is intended to provide residents/fellows with longitudinal training in recognizing and making improvements in issues such as structural racism, implicit bias, cultural humility, health and health care equity, and health outcomes relevant to the patient population served by the PCLE.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Resident/fellow education will be improved by recognition and action related to social factors affecting health and health care.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will benefit continuity of patient care as an aspect of health care quality.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Dedicated administrative, educational, and human resources will be needed to create longitudinal training. Additionally, resources of faculty member time and other dedicated personnel may be necessary. Recognizing developmental and resource needs related to this requirement, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions and PCLEs should engage programs in the development of this training.

Proposed Requirements: **V.B.4., V.B.4.a-b)**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: Resident, fellow, and faculty member engagement in interprofessional quality improvement is to be aligned and integrated with a PCLE's priorities for sustained improvements in patient care. Sponsoring Institution and PCLE leaders are responsible for ensuring that residents, fellows, and faculty members experience complete cycles of improvement, including the steps of measuring the success of the improvement activities, and modifying the actions to address subsequent quality improvement cycles (i.e., plan, do, study, act), as warranted.

V.B.4. Each PCLE, in partnership with the DIO and program directors, must:

V.B.4.a) engage residents, fellows, and faculty members in quality improvement educational activities that address PCLE quality improvement metrics or systems-based challenges; and, (Core)

V.B.4.b) ensure that residents, fellows, and faculty members actively engage in interprofessional continuous quality improvement that is aligned with PCLE priorities. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. This requirement intends to expand engagement of residents/fellows and faculty members in complete cycles of interprofessional quality improvement aimed at improving patient care at the PCLE. By participating in activities to improve processes impacting health care delivery, residents and fellows will be better able to lead health care improvement and collaborate in the use of data to evaluate and modify plans.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement will improve resident/fellow education by providing residents and fellows with the skills necessary to contribute to and sustain improvements in health care quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will likely improve continuity of patient care as an aspect of health care quality.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Some amount of dedicated administrative, educational, and human resources will be needed to develop quality improvement educational activities and engage residents/fellows

in quality improvement in the PCLE. Dedicated time of faculty members and administrative personnel may be needed. Recognizing developmental and resource needs related to this requirement, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions should engage programs in the implementation of this requirement.

Proposed Requirement: **V.C.1., V.C.1.a-b)**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: In partnership with residency and fellowship programs, leaders of Sponsoring Institutions and PCLEs participate in the oversight of resident/fellow transitions of patient care between settings (e.g., transfers of patient care between services or facilities), recognizing their importance to patient safety and teaming. The standardization of transitions does not denote the creation of a single or uniform process. Clinical learning environments and their GME community will be encouraged to find solutions that standardize essential properties of processes to transition patient care between settings while allowing for additional specialty- or unit-specific components as needed. The interprofessional working group applies an integrated perspective to the oversight of patient care transitions in the PCLE.

In patient care settings, active strategies for reviewing and revising transition-of-care related policies and procedures involve input from residents, fellows, faculty members, and other members of the care team. These transitions involve care team workflow, patient throughput, medication reconciliation, and interprofessional care planning. Passive strategies include periodic review of patient safety event reports and patient safety event investigations in which care transitions or communication issues are contributing factors, including any resulting actions taken and their effectiveness.

All transitions in patient care are points of vulnerability, posing inherent risks for patient safety due to incomplete or inadequate communication. As such, the PCLE's approach to optimizing care transitions benefits from the engagement of multiple interprofessional team members in developing, maintaining, monitoring, and enforcing relevant policies and procedures.

V.C.1. The leadership of the Sponsoring Institution must meet periodically with the interprofessional working group of each PCLE to:

V.C.1.a) review resident/fellow hand-offs, addressing standardization, oversight, and continuous quality improvement. (Core)

V.C.1.b) review and revise policies and procedures for transitions between patient care settings in which residents/fellows are involved, including review of both active and passive strategies. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. Transitions of patient care occur across a variety of settings, including transitions between health care settings, services, and facilities. All transitions in patient care are points of vulnerability and pose challenges of incomplete or inadequate communication in patient care within a PCLE. This requirement focuses on learner-to-learner hand-offs and transitions of care between patient care opportunities as focus areas for the interprofessional working group.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Improving transitions of care involving residents and fellows will enhance education and improve patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement seeks to improve continuity of patient care by acknowledging the need for clear processes in hand-offs and transitions between care settings.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The effort of the institutional GME leaders and the interprofessional working group of the PCLE will be needed to implement this requirement. Recognizing the new processes and workflows that may need to be developed, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions should engage programs in the implementation of this Requirement The requirement provides flexibility for Sponsoring Institutions, PCLEs, and programs to incorporate specialty- or unit-specific policies and procedures in the review of care transitions.

Proposed Requirements: **V.D.1., V.D.1.a-c), V.D.1.c).(1-3)**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: Patient care requires the combined efforts of a team of various professionals. Although physicians have primary responsibility for supervising and overseeing care provided by residents and fellows, many clinical care team members, through their participation in patient care, are able to contribute important insights regarding the quality of resident/fellow supervision and identify opportunities for enhanced GME oversight. If institutional oversight of resident/fellow supervision is not integrated with the clinical learning environment, executive leaders may only learn of deficiencies if they rise to the level of patient harm. Just as health care organizations' analyses of near misses and close calls will be used to prevent harm to patients, GME and PCLE leaders will engage in proactive surveillance and communication related to the supervision of residents and fellows, with measurable actions focused on ameliorating potential supervision issues. Tools such as joint goal-setting exercises; follow-up to see if goals were achieved and root causes of challenges were identified; dashboards; and regularly scheduled meetings can build relationships and facilitate a shared vision among GME and clinical learning environment leaders. Therefore, it is

important for oversight of supervision to be informed by an interprofessional working group within a PCLE. This oversight will be:

- proactive, seeking out and anticipating issues before they arise, with annual goal setting and monitoring to guide progress toward meeting goals, and improvements in supervision as warranted;
- timely, with regard to exchanging and acting upon information about newly identified issues and concerns; and,
- integrative, examining the impact on GME and clinical learning environment joint efforts to optimize patient safety, professionalism, and well-being.

In partnership with residency and fellowship programs, interprofessional leadership of a PCLE evaluates the impact of resident and fellow supervision on patient safety, professionalism, and well-being. Interprofessional oversight of GME supervision recognizes the roles and contributions of multiple professions in clinical learning environments, and, by engaging a PCLE's leaders, enhances communication with interprofessional teams and facilitates support for the evaluation and enhancement of supervision at the program level. Evaluations of GME supervision will include input from frontline care practitioners and should focus on the identification of general themes and issues based on analyses of aggregated data, without identifying specific residents, fellows, or faculty members.

When implementing information systems for verification of the level of supervision required for residents and fellows to perform patient procedures, PCLEs are encouraged to engage interprofessional teams in determining the level of detail required to make the databases functional, as indicated by the provision of necessary information to care team members and assurance that members of the care team are able to use the systems during episodes of patient care.

V.D.1. The Sponsoring Institution and interprofessional working group of each PCLE must:

V.D.1.a) engage in purposeful regular collaboration around GME supervision that is proactive, timely, and integrative; (Core)

V.D.1.b) ensure that each PCLE periodically conducts an evaluation of GME supervision that solicits input and feedback from various interprofessional members of the clinical care team; (Core) and,

V.D.1.c) ensure systems for verification of the level of supervision required for residents and fellows to perform patient procedures that: (Core)

V.D.1.a).(1). set expectations for use of the systems; (Detail)

V.D.1.a).(2). provide the clinical care team with training to use the systems; and, (Detail)

V.D.1.a).(3). monitor and improve the use of the systems. (Detail)

1. Describe the Institutional Review Committee's rationale for this revision:

The full rationale is provided in Background and Intent. This requirement is intended to ensure that the Sponsoring Institution's GME leadership and PCLE's interprofessional leadership engage in meaningful oversight of resident/fellow supervision. By supporting and proactively evaluating resident/fellow supervision, Sponsoring Institutions and PCLEs will take advantage of opportunities for improvement and will address potential supervision issues before they present a risk to patient safety.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement will improve resident/fellow education, patient safety, and quality by ensuring the integration of GME and the PCLE in addressing supervision.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will enhance continuity of patient care insofar as it is related to the supervision of residents and fellows.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Time and effort will be required to further integrate the supervision resources, policies, and procedures of the Sponsoring Institution and the PCLE. Recognizing the new processes and workflows that may need to be developed, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions and PCLEs should engage programs in the implementation of this requirement.

Proposed Requirements: **V.E.1-2.**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: The ACGME Common Program Requirements and Institutional Requirements have increasingly recognized shared responsibilities of Sponsoring Institutions and programs related to resident and fellow well-being. Sponsoring Institutions and PCLEs share responsibility for well-being at an organizational level by identifying and addressing health care systems issues (e.g., prolonged wait times and delays, ineffective communications or workflow, high workforce turnover) that affect the well-being of residents and fellows as well as other members of clinical care teams.

V.E.1. The Sponsoring Institution, in partnership with the interprofessional working group of each PCLE and the leaders of organization-wide well-being efforts, must establish a process of regular GMEC review of issues affecting resident, fellow, and faculty physician well-being, addressing the patient care systems-based factors that contribute to acute and chronic fatigue and burnout. (Core)

V.E.2. The interprofessional working group of each PCLE must provide the governance of the PCLE with an annual report of well-being issues affecting residents, fellows, and

faculty members, including related follow-up assessments, improvement actions, and evaluation of efforts. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. This requirement is intended to engage the GME and clinical learning environment leadership in addressing systems factors that affect the well-being of residents/fellows, faculty members, and other care team members. Identification of these issues will provide an opportunity for the Sponsoring Institution and the interprofessional leaders of the PCLE to collaborate on implementing solutions that will lead to salutary policies, procedures, and practices.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Resident/fellow education will improve in an environment that recognizes and addresses systems-based factors that affect well-being. Systematic attention to the well-being of health care practitioners is a key component of the Quintuple Aim of improving patient experience, health outcomes, clinician well-being while reducing costs and achieving health equity for the US health care system.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement will not directly impact continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Time and effort will be required to further engage the interprofessional leaders of the Sponsoring Institution and the PCLE in systematic attention to improving well-being. Recognizing the new processes and workflows that may need to be developed, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions and PCLEs should engage programs in the implementation of this requirement.

Proposed Requirements: **V.F.1., V.F.1.a), V.F.1.a).(1-4), V.F.1.b)**
Existing Requirement: **None**

Background and Intent: Professional values are shared among physicians, across various members of clinical care teams, and within health care organizations. To ensure patient safety and health care quality, Sponsoring Institutions and PCLEs share responsibility for promoting these professional values with clear expectations and commitment backed by interventions when persistent unprofessional behavior is identified.

It is essential that leaders of a PCLE, in cooperation with a Sponsoring Institution's GMEC, regularly convene conversations about the organization's role in supporting professionalism. These conversations will include representatives from the GME community (e.g., DIOs, program directors, residents, and fellows), other members of health care teams, and patient representatives (e.g., representatives from a PCLE's patient advisory council or equivalent) with a focus on advancing professionalism and optimizing the environment for residents,

fellows, and the other members of the clinical care team. In this context, the organization's role in supporting professionalism in the PCLE can provide a basis for interprofessional learning.

To achieve this goal, Sponsoring Institution and PCLE leaders define and communicate core professional values, and evaluate PCLE performance in realizing those values. Professionalism issues may involve various members of the clinical care team, and the engagement of human resources personnel in these conversations is beneficial. Aggregated findings pertaining to professionalism at the organizational level will be communicated within a PCLE, and will be included in the annual report of the AIR provided to the Sponsoring Institution's governing body and the chief executive officer(s) of the PCLE(s).

Requirement Revision (significant change only):

III.F.1. The Sponsoring Institution, in partnership with the interprofessional working group of each PCLE, must:

III.D.1.a) establish a joint process of regular GMEC review of persistent professionalism issues within the clinical care environment that affect resident and fellow education and patient safety, including the following topics: (Core)

III.D.1.a).(1) interprofessional interactions; (Detail)

III.D.1.a).(2) issues identified by the PCLE's patients and their families; (Detail)

III.D.1.a).(3) issues identified by the PCLE's residents and fellows and medical staff; and (Detail)

III.D.1.a).(4) performance in meeting the PCLE's expectations for disclosure of conflicts of interest by faculty members at the start of each resident's/fellow's clinical rotation. (Detail)

III.D.1.b) report aggregated, deidentified, summarized findings of GMEC reviews of persistent professionalism issues annually to PCLE governance, including improvement actions and an evaluation of their efficacy. (Core)

Background and Intent: Medical staff by-laws set clear expectations for faculty member and other medical staff supervision and education of residents and fellows. These formal expectations will guide faculty member and medical staff interactions with learners and other members of the interprofessional care team.

VI.F.2. The medical staff by-laws or equivalent of each PCLE must define the roles and responsibilities of faculty members and other medical staff physicians who serve in teaching roles. (Core)

Background and Intent: Unaddressed conflicts of interest in health care organizations erode trust among health care providers and patients. As health care operations and financing become more complex, new types of conflicts are challenging organizations and physicians to balance the needs of patients and communities with individual and corporate self-interest. Organizational responses to conflicts of interest may be internalized by residents and fellows as part of their professional formation. To promote a professional setting for GME,

interprofessional leaders of a Sponsoring Institution and a PCLE have a responsibility to identify conflicts at an individual and organizational level. Recording the conflicts of interest within a PCLE is necessary step in mitigating potential harm to resident and fellow education and patient care.

VI.F.3. The interprofessional working group of each PCLE, the DIO, and the GMEC must develop an annual list of perceived organizational and personal conflicts of interests of medical staff members that may have a substantial adverse effect on GME performance. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationales are provided in Background and Intent. These requirements were developed to establish clear expectations for interprofessional relationships across clinical care teams and the health care organization that serves as PCLE. Clear expectations and interventions to address persistent unprofessional behavior at the organizational level are essential in ensuring patient safety and health care quality. These requirements address common professionalism issues that may present challenges to safety and quality, and are not intended to address investigations, actions, or monitoring related to individuals' professional behavior, which are addressed by human resources, medical staff, or other mechanisms. Organizational support for common professional behaviors fosters progressive development of these behaviors by residents/fellows. In addition, identification of conflicts of interest among faculty members is an important component of an organization's professional responsibilities.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   These requirements will improve resident/fellow education by contributing to a culture of trust and transparency in which the organization instructs and reinforces residents/fellows in their adoption of professional behaviors that will be retained throughout their careers.

3. How will the proposed requirement or revision impact continuity of patient care?
   These requirements will not directly affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   It will require time for the integrated Sponsoring Institution and PCLE leadership to develop policies, procedures, and processes corresponding with these requirements. At least some dedicated administrative support will be needed for implementation. Recognizing the new processes and workflows that may need to be developed, the IRC will begin issuing citations in 2027.

5. How will the proposed revision impact accredited programs?
   Sponsoring Institutions and PCLEs should engage programs in the implementation of these requirements.

Proposed Requirement: **VI.G.**
Existing Requirement: **None**

Requirement Revision (significant change only):

Background and Intent: Residents, fellows, and faculty members are key contributors to a PCLE's disaster response. GME and PCLE leaders will work together in planning, preparedness, and management to ensure the appropriate engagement with programs. GME and PCLE integration facilitates the safe participation of residents, fellows, and faculty members when caring for patients during a disaster.

V.G. Disaster Planning, Preparedness, and Management: The DIO or designee must be part of the disaster planning, preparedness, and management program at each PCLE. (Core)

1. Describe the Institutional Review Committee's rationale for this revision:
   The full rationale is provided in Background and Intent. In a health care organization's disaster planning, preparedness, and management, the DIO should be part of the team assigning the roles of GME personnel in disaster response.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The DIO's involvement in disaster planning, preparedness, and management at the PCLE will promote the safe activation of GME personnel and resources during disasters.

3. How will the proposed requirement or revision impact continuity of patient care?
   This requirement enhances continuity of patient care in disaster planning, preparedness, and management.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Additional resources are not required to engage the DIO in ongoing disaster readiness activities of health care organizations. The IRC will begin citations for this requirement in 2026.

5. How will the proposed revision impact accredited programs?
   The requirement will ensure programs' appropriate engagement in disaster response.