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

Question	Answer
Introduction	
What should be included in the educational rationale for programs seeking a 48-month program format? *[Program Requirements: Int.C. and Int.D.]*	The educational rationale for a 48-month program format should: 1. describe a more in-depth curriculum in areas related to emergency medicine, not just additional clinical rotations • Examples: Focused experiences in ultrasound (US), Emergency Medical Services (EMS), health administration, research, toxicology, critical care, etc. 2. describe the expected skillset/outcome residents will obtain by completing the additional 12 months of the program • Examples: US certification, global health, increased scholarly activity, including work toward a Master of Public Health or Master of Education degree, etc. 3. describe graduated responsibilities for fourth-year residents • Example: supervision of junior residents by fourth-year emergency medicine residents on critical care rotations
Institutions	
If a program uses a multi-hospital system that includes separate emergency departments located at separate sites, but references these separate sites under one hospital name, how should the program represent this configuration? *[Program Requirement: I.B.4]*	Each emergency department location is considered an additional participating site, and programs should list and describe each emergency department separately. Additionally, the annual patient volumes and critical care volumes at each site cannot be aggregated under one hospital name and should also be listed separately with their respective site.
What does the Review Committee consider to be geographically distant from the Sponsoring Institution? *[Program Requirement: I.B.5.]*	The Review Committee considers a participating site to be geographically distant if it requires extended travel (consistently more than half an hour each way) or if the distance between the site and the Sponsoring Institution exceeds 30 miles.

Question	Answer
If a program wants to establish a rotation at a site that is not in geographic proximity to the Sponsoring Institution, what accommodations should the program provide? *[Program Requirement: I.B.5.]*	If a program establishes an affiliation with a site that is not in close geographic proximity to the Sponsoring Institution due to special resources provided there, the program should ensure that residents are provided with adequate transportation to and from the site. If the site is of such distance that daily travel between the site and the Sponsoring Institution is unfeasible or burdensome, the program may need to provide housing arrangements for residents while on rotation there.
What other specialty programs should be present at the Sponsoring Institution to demonstrate a major educational commitment to emergency medicine education? *[Program Requirement: I.B.7.]*	Examples of other ACGME-accredited programs in specialties that indicate a major educational commitment by the Sponsoring Institution to emergency medicine education include internal medicine, obstetrics and gynecology, and surgery. Residents' educational experience will be enhanced by exposure to other specialties and their academically-focused educational programs, particularly as related to faculty education and supervision, and through promotion of peer-to-peer collaboration and team building among specialties.
Program Personnel and Resources	
What educational and administrative experience is acceptable for a new program director? *[Program Requirements: II.A.3.a) and II.A.3.d)]*	Educational and administrative experience(s) acceptable to the Review Committee when considering a new program director include: • Experience as an assistant/associate program director or site director • Administrative program experience, such as serving on the program's Clinical Competency Committee (CCC), Program Evaluation Committee, or Graduate Medical Education Committee, or serving as a fellowship program director • Leadership role in the program, such as Chair of the department, Chair of the CCC, Research Director, etc. An individual's administrative and educational experiences should be from the most recent three-year period.

Question	Answer
Why must a program director have at least three years' experience as a core faculty member in an ACGME-accredited emergency medicine program? *[Program Requirement: II.A.3.d)]*	The administration of a program is so complex that experience with and understanding of program operations are necessary for program director candidates. This is why the Review Committee believes that to ensure that programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents an optimal learning experience, the program director should have a minimum of three years' experience as a core faculty member in an accredited emergency medicine program. The Committee will also accept core faculty experience in an American Osteopathic Association (AOA)-approved program. It is desirable that the core faculty experience occurred in the program the program director will lead, and should have occurred within the most recent three-year period.
How do core faculty members demonstrate time devoted to the educational program? *[Program Requirement: II.B.1.a)]*	Core faculty members can demonstrate time devoted to the education program through active participation in, development of, and provision of: the didactic curriculum; research activities, including mentoring of residents in scholarly activities; clinical teaching of residents; and administrative activities, such as curriculum development, completing resident evaluation assessments, and mentoring/advising residents. While there is no stated minimum for how much time should be devoted, it should be adequate enough to meet the residents' needs. The adequacy of the time spent will be assessed via the annual ACGME Resident Survey.
What other faculty qualifications are acceptable to the Review Committee? *[Program Requirement: II.B.2.]*	The Review Committee would accept faculty members' certification by the American Osteopathic Board of Emergency Medicine (AOBEM), and certification by a subspecialty board sponsored or co-sponsored by the American Board of Emergency Medicine (ABEM). It would also accept for faculty appointment recent residency or fellowship graduates (within the past two years) actively working toward certification by these boards.

Question	Answer
Are there any qualification requirements specific to emergency medicine faculty members related to supervision? *[Program Requirement: II.B.2.]*	Faculty members providing supervision to emergency medicine residents on emergency medicine rotations must have appropriate qualifications relative to the patient population for which they are providing the supervision. For example, a faculty member certified in pediatrics and pediatric emergency medicine would be qualified to supervise emergency medicine residents on pediatric cases, but not adult cases. Emergency medicine residents rotating in a pediatric emergency department where there are also pediatric emergency medicine fellows in an ACGME-accredited program are subject to the pediatric emergency medicine requirements related to faculty qualifications and supervision. Faculty qualifications for supervision in an ACGME-accredited pediatric emergency medicine program include certification in pediatric emergency medicine, pediatrics, or emergency medicine (two pediatric emergency medicine program faculty members must be certified in pediatric emergency medicine). In all other instances, faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the Emergency Department.
Can non-ABEM-/non-AOBEM-certified faculty members see patients in the Emergency Department? *[Program Requirement: II.B.2.]*	The presence of non-ABEM/non-AOBEM-certified faculty members in the Emergency Department is acceptable only if they do not directly supervise residents.
Which physician faculty members are included in the required core program faculty-to-resident ratio of 1-to-3? *[Program Requirement: II.B.6.]*	The core physician faculty members counted in this ratio include the Chair/Chief of Emergency Medicine, the program director, associate program director(s) if applicable, and other faculty members who meet the definition of a core physician faculty member. Faculty members must be certified by the ABEM or AOBEM, or certified in pediatric emergency medicine by the American Board of Pediatrics, to be considered core faculty members.
What are examples of acceptable scholarly activity for faculty members? *[Program Requirements: II.B.6.d)-II.B.6.d).(1).(a)]*	It is critical that faculty members participate in scholarly activity in order to appropriately mentor residents and enhance the educational program. Acceptable faculty scholarly activity includes: 1. Peer Review - This includes original contributions of knowledge published in

Question	Answer
	journals indexed in PubMed and listed in Thomson Reuters (formerly ISI) Web of Knowledge or MEDLINE®. Abstracts, editorials, or letters to the editor do not qualify. Submissions to online venues, with the exception of Med Ed PORTAL, do not qualify. 2. Non-Peer Review - This includes all submissions to journals or online venues that do not fulfill peer-review criteria. This also includes abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process. This category also includes educational videos, DVDs, and podcasts. 3. Textbooks/Chapters - This includes submissions for which the faculty member served as editor, section editor, or chapter author. 4. Presentation at Local/Regional/National Organizations - This includes invited presentations, such as abstracts (posters), expert panel discussions, serving as a forum leader, grand rounds presentations, or interdisciplinary grand rounds presentations within the Sponsoring Institution. Grand rounds or other didactic presentations do not qualify unless presented at a department other than emergency medicine. The expectation is that this presentation is of original work. Instruction of or participation in certification courses, such as Advanced Cardiovascular Life Support (ACLS), Advanced Trauma Life Support (ATLS), or Pediatric Advanced Life Support (PALS), do not qualify. 5. Committee Leadership - This includes elected or appointed positions in nationally recognized organizations. Membership alone does not qualify. 6. Editorial Services - This includes serving as an editor, editorial board member, reviewer, or content expert. Serving as an abstract reviewer or grant reviewer also qualifies. 7. Grants - This can only be satisfied by receipt of a grant.

Question	Answer
Are there any Review Committee considerations in meeting the requirement for core faculty peer-reviewed publications? *[Program Requirement: II.B.6.d).(1).(a)]*	The program's core faculty members must demonstrate significant contributions in the form of peer-reviewed publications related to the specialty or subspecialty areas of emergency medicine. If multiple core faculty members were involved as co-authors on the same peer-reviewed publication in a journal indexed in PubMed, the Review Committee will count the PubMed ID number entered in the Accreditation Data System (ADS) toward each participating faculty member, but will count it only once for the program. It is the Review Committee's expectation that this requirement be fulfilled by participation by all core faculty members, and not by one or two prolific authors with multiple publications.
Why is there a faculty staffing ratio, how is it calculated, and does it need to be calculated for all areas of the Emergency Department? *[Program Requirement: II.B.8.]*	It is important that each program maintain sufficient levels of faculty staffing coverage in the Emergency Department in order to ensure adequate clinical instruction and supervision, as well as efficient, high quality clinical operations. The Review Committee uses a faculty staffing ratio of 4.0 patients per faculty hour or less as a guideline in this determination. This may be calculated in the following manner: (Patient visits per year/faculty hours per day)/365 days per year = Patients per faculty hour Example: (70,000 patients per year/55 faculty hours per day)/365 days per year = approximately 3.5 patients per faculty hour Faculty staffing ratios only need to be provided for acute critical care areas, and not for fast track or urgent care areas.
How can a program demonstrate adequate program coordinator support for the number of residents in the program? *[Program Requirements: II.C.1.a)-e)]*	When it reviews a program, the Review Committee would expect to see the required FTE program coordinator and support personnel for the number of residents in the program as indicated under "Program Leadership" in ADS. If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see at least two program coordinator names listed in ADS. To add support personnel in ADS, click on "+ add personnel" in the "Program Profile, Program Leadership" section.

Question	Answer
	Support personnel whose time is divided across several programs (such as emergency medical services, toxicology, and the core emergency medicine program) must have the time devoted to each program as described in each of the respective sets of Program Requirements. Example: If a Sponsoring Institution has an emergency medicine program approved for 24 residents, requiring a 1.0 FTE program coordinator, and also has a fellowship program in emergency medical services, requiring at least 0.2 FTE program coordinator time for the fellowship program, both requirements must be met. Therefore, the EMS fellowship program cannot use the 1.0 FTE emergency medicine program coordinator to provide support to the fellowship.
What is considered adequate space for patient care? *[Program Requirement: II.D.1.a)]*	The Review Committee recommends that the Emergency Department have one treatment room for every 2000 visits, and a minimum of 120 square feet for every individual patient care space. Each treatment room should be approximately 500 gross square feet (including walls, hallways, staff stations, etc.). For example, an Emergency Department with 40,000 annual patient visits should have 20 treatment rooms with a total of 10,000 square feet. Rapid emergency rooms (ERs; fast track, or urgent care) should have one treatment room for every 4000 patient visits.
What should a written consultation protocol include? *[Program Requirement: II.D.4.a)]*	Such a protocol should include written agreements for the transfer of patients to a designated hospital that provides the needed clinical services.
What are the maximum average throughput times for the Emergency Department? *[Program Requirement: II.D.4.b)]*	The suggested maximum average throughput times for Emergency Department patients is four hours for discharged patients, and eight hours for admitted patients to arrive on the floor, excluding observation patients.
How can programs calculate their critical care numbers? *[Program Requirement: II.D.6.a)]*	As programs determine their critical care patient volume at the primary site, resources can include: Emergency Department billing and coding numbers, and trauma and intensive care unit (ICU) admissions.

Question	Answer
Resident Appointments	
Can a program accept a resident transferring from an AOA-approved program? *[Program Requirements: III.A.1.a) and III.A.2.]*	The Review Committee understands that during the transition to a single GME accreditation system, ACGME-accredited programs may wish to accept residents seeking to transfer from an AOA-approved program. Programs that accept such transfer residents will not jeopardize their accreditation status if they remain within their approved resident complement or obtain Review Committee approval of an increase, if needed. In these circumstances, the program director of the accepting program will determine what credit may be given for prior training, as well as how much further training is necessary to complete the ACGME-accredited program. It is the responsibility of the program director to ensure that each resident is made aware of the requirements for eligibility for certification by the applicable American Board of Medical Specialties member board and AOA certifying board.
If a fellowship program exercises the "exceptionally qualified applicant" eligibility option in recruiting a fellow, and the fellow intends to seek board certification through the ABEM, are there any considerations that should be taken under advisement? *[Program Requirement: III.A.2.b)]*	When recruiting a new fellow, if programs determine that an applicant has not completed an ACGME-accredited residency program and does not meet the eligibility criteria in requirement III.A.2., they may exercise the fellow eligibility exception option for exceptionally qualified applicants. When exercising this option for fellows seeking certification through the ABEM, programs must be aware that completing an ACGME-accredited fellowship program is not by itself sufficient to meet the ABEM eligibility requirements for subspecialty certification. Programs must contact the ABEM directly to determine an applicant's eligibility for certification.
Why is the minimum number of residents set to 18? *[Program Requirement: III.B.2.]*	A minimum of 18 residents is needed to foster a sense of both the program's and the department's identities. Additionally, 18 residents ensures a major impact in the Emergency Department to allow for meaningful attendance at emergency medicine conferences, to provide for progressive resident responsibility, and impact as resident teachers. The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year.
How can a new program meet the requirement for a minimum of 18 residents? *[Program Requirement: III.B.2.]*	The Review Committee understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by Year 3 in a three-year program and by Year 4 in a four-year program.

Question	Answer
Why does the Review Committee review resident attrition? *[Program Requirement: III.B.2.]*	Resident attrition may impact residents' work and learning environment, and may serve as an indicator for an unstable educational environment.
Educational Program	
Can programs use the Emergency Medicine Milestones as goals and objectives? *[Program Requirement: IV.A.2.]*	The required goals and objectives are **not** the Milestones. The Milestones are a competency assessment tool and should not be the only measure used in conducting resident evaluations. Program evaluation tools can be Milestones-based, but the Milestones themselves do not meet the criteria for goals and objectives.
What types of experiences *do not* qualify as didactic experiences? *[Program Requirement: IV.A.3.a)]*	Daily experiences, such as morning report or change of shift teaching, at which not all residents are consistently present and which are informal, do not meet the requirements for didactic experiences.
What are some suggested formats or methodologies for planned didactic experiences? *[Program Requirement: IV.A.3.c)*	Recommendations for educational activities include small-group techniques, such as break-out groups, serially repeated conference sessions, or practicum sessions, or large-group planned educational activities.
How much individualized interactive instruction is acceptable and what qualifies? *[Program Requirement: IV.A.3.c).(1)]*	Programs may utilize individualized interactive instruction, such as web-based learning, for up to 20 percent of the planned educational experiences or didactics (i.e., on average, one hour out of the five hours per week of planned educational activity). The goal of individualized interactive instruction is to allow program directors to adjust curricular needs to the individual needs of each resident. It is important to note that simply reading or answering questions does not meet the requirements for planned educational activities. In order for an activity to qualify as individualized interactive instruction, the following four criteria should be met: 1. The program director must monitor resident participation. 2. There must be an evaluation component. 3. There must be faculty oversight.

Question	Answer
	4. The activity must be monitored for effectiveness. Examples of individualized interactive instruction include: • A resident prepares for and takes a quiz or test, and receives timely feedback about his or her performance from a faculty member. • A resident spends additional time in the simulation lab or cadaver/animal lab because he or she needs more practice with a certain procedure. • Residents who are doing poorly on quizzes/tests participate in board review study sessions with colleagues or faculty members. Attestation and completion pages are not acceptable to the Review Committee as evaluation. Use of audio, video, or podcasts alone constitutes passive learning and is not considered interactive learning. Proprietary systems that allow for real-time questions and answers qualify as active/interactive participation.
Why is there a requirement that each core faculty member attend, on average per year, at least 20 percent of planned didactic experiences? *[Program Requirement: IV.A.3.c).(3)]*	Core faculty members' attendance at conferences and other resident didactics gives residents the opportunity to benefit from their perspective, experience, and discussion. It also demonstrates their commitment to the educational program.
How does the Review Committee verify resident attendance at 70 percent of the planned emergency medicine didactic experiences? *[Program Requirement: IV.A.3.c).(5)]*	Verification is crosschecked by reviewing an eight-week conference block and averaging resident attendance for that eight-week period.

Question	Answer
How does the Review Committee define a major resuscitation? *[Program Requirement: IV.A.5.a).(2).(a).(v)]*	A major resuscitation is patient care for which prolonged physician attention is needed, and interventions—such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g., cut downs, central line insertion, tube thoracostomy, endotracheal intubations)—are necessary for stabilization and treatment. Each resident must have the opportunity to make admission recommendations and direct resuscitations.
Other than minimum numbers, is there anything else that the program should demonstrate with regard to assessment of resident competence? *[Program Requirements: IV.A.5.a).(2).(c).-IV.A.5.a).(2).(c).(xvii).(a)]*	The Review Committee expects programs to assess the competence of residents in performing all key index procedures. At the time of its review, the program will need to demonstrate how it assesses resident competence for three procedures, one of which must be Emergency Department bedside ultrasound.
In meeting the requirement for four months of critical care, can programs consider experiences in step-down units, Emergency Department critical care units, or anesthesiology rotations? *[Program Requirement: IV.A.6).(a).(1)]*	No, experiences in step-down units, critical care/trauma units in the Emergency Department, and anesthesiology rotations do not count toward the critical care requirement. The intent of the requirement is for the resident to learn acute decision making and resuscitative skills outside the Emergency Department that can be applied in future Emergency Department patient care.
How are longitudinal pediatric experiences calculated? *[Program Requirement: IV.A.6.a).(2)]*	To calculate longitudinal pediatric patient encounters, multiply the number of general Emergency Department months or four-week blocks by the percent of pediatric patients. For example, if 15 percent of patients are pediatric and the resident spends 20 months in the Emergency Department (i.e., 20 months x .15 = 3 or the equivalent of 3 months), the resident would need two additional months of dedicated pediatric experiences.
What should a program do if it does not have enough pediatric patient visits to meet the requirement? *[Program Requirement: IV.A.6.a).(2)]*	A program that doesn't meet the required numbers of pediatric patient visits can balance a deficit of patients by offering dedicated rotations in the care of infants and children.

Question	Answer
Can pediatric critical care months count toward the critical care months required? *[Program Requirements: IV.A.6.(a).(1) and IV.A.6.a).(2).(b)]*	Yes, months spent in a pediatric critical care setting also satisfy the four-month critical care requirements.
What are the Review Committee's expectations for resident scholarly activity? *[Program Requirement: IV.B.2.]*	The Review Committee expects all residents to participate in scholarly activity by the end of residency. Examples of acceptable resident scholarly activity include: 1. Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in journals indexed in PubMed, including original contributions of knowledge published in journals listed in Thomson Reuters (formerly ISI), Web of Knowledge, or MEDLINE®. Abstracts, editorials, or letters to the editor do not qualify. Submissions to online venues, with the exception of Med Ed PORTAL, do not qualify. 2. Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, letters to the editor of peer-reviewed journals, educational videos, DVDs, and podcasts. 3. Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author. 4. Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader. 5. Participation in Research – This refers to active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research,

Question	Answer
	as well as active participation in an Emergency Department quality improvement project.
Evaluation	
What does the Review Committee expect for multi-source resident evaluations? *[Program Requirement: V.A.2.b).(2)]*	The Review Committee expects all of the following evaluators to be used for multi-source evaluations: • faculty members • peers • patients • the residents themselves • other professional staff members
How will resident advancement be affected if a resident needs remediation? *[Program Requirement: V.A.2.e)]*	Deficiencies in specific areas do not necessarily mean a resident should be held back in progressing to the next year or level of education; however, plans must be in place to support such residents in achieving the required competencies.
The Learning and Working Environment	
Can residents be supervised by licensed independent practitioners? *[Program Requirement: VI.A.2.a).(1)]*	The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a faculty physician member during these situations is required.
Can residents from other specialties supervise emergency medicine residents? *[Program Requirement:* VI.A.2.b).(1)*]*	Residents from other specialties must not supervise emergency medicine residents on any rotation in the Emergency Department. Residents from other specialties can supervise emergency medicine residents on rotations in clinical areas related to their graduate medical education training and expertise.
Under what circumstances can a first-year resident be supervised indirectly with direct supervision immediately available? *[Program Requirement: VI.A.2.e).(1).(a)]*	Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with direct supervision immediately available. Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with direct supervision immediately available while rotating in the Emergency Department, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as medical intensive care unit (MICU) or trauma surgery.

Question	Answer
What does the Review Committee consider an optimal clinical workload? *[Program Requirement: VI.E.1.]*	A resident in the Emergency Department at the very beginning of the program should have a smaller workload than a resident at the same level in the same rotation at the end of that academic year. Each program must adhere to its graduated responsibility policy. This may vary by area of service, and based upon each individual's level of achieved competence (knowledge, skills, and attitudes) and upon patient acuity. The Milestones must be used to assess each resident's competence. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of resident education.
How much time should a resident have off between emergency medicine shifts? *[Program Requirements: VI.E.1.a).(1)-VI.E.1.a).(1).(a)]*	In emergency medicine, the scheduled clinical shift is the basis for the required time off and considers additional clinical time after the assigned shift is completed toward the total clinical and educational work hours each week (finishing documentation, transitions in care, etc.). A resident must have at minimum a scheduled break equal to the scheduled length of the shift within the 24-hour period that includes the shift. All time (clinical and educational) counts toward the total average time cap per week. Didactic and other educational experiences count toward weekly clinical and educational work hour limits but are not considered when calculating time off between clinical shifts. Example: If a resident works a 10-hour shift (9:00 p.m. to 7:00 a.m.) and then attends a conference until 11:00 a.m., he/she must have 10 hours off before returning to his/her next clinical shift (starting from the 11:00 a.m. end time of the conference, meaning that the resident should not return to clinical work until 9:00 p.m. If the resident chooses not to attend the conference, the 10-hour break begins at 7:00 a.m. when the clinical shift ends). Conference time is added in the calculation of clinical and educational work hours for the week when the resident is present.

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<tr><th>Question</th><th>Answer</th></tr>
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<tr><th>Clinical Shift in the Emergency Department Tuesday</th><th>Break Wednesday</th><th>Conferences Wednesday</th><th>Clinical Shift in the Emergency Department Wednesday</th></tr>
<tr><td>9:00 p.m.-7:00 a.m.</td><td>(10 hours)</td><td>7:00 -11:00 a.m.</td><td>9:00 p.m.-7:00 a.m.</td></tr>
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Example:
If a resident works from 4:00 p.m. to midnight, has a conference from 8:00 a.m. to noon, and then works again at 4:00 p.m., this is compliant, since there is a scheduled eight-hour break in a 24-hour period. There is no expectation for an additional eight-hour break after the conference.

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<tr><th>Clinical Shift in the Emergency Department Tuesday</th><th>Break Wednesday</th><th>Conferences Wednesday</th><th>Clinical Shift in the Emergency Department Wednesday</th></tr>
<tr><td>4:00 p.m.-12:00 a.m.</td><td>(8 hours)</td><td>8:00 a.m.-12:00 p.m.</td><td>4:00 p.m.-12:00 a.m.</td></tr>
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The Review Committee does not have an expectation regarding time off between block didactic sessions followed by a clinical shift; however, programs must review the appropriateness of resident attendance at conferences following an evening or night shift based on the duration of the program’s clinical shifts, didactic schedule, and resident fatigue. Residents should be provided the opportunity to adjust their individual attendance at didactic sessions scheduled between clinical shifts when necessary to mitigate excessive fatigue. The program should ensure the required time off between clinical shifts to allow adequate rest for each resident based on his/her individual schedule.
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<tr><td>Are residents permitted to moonlight?

[Program Requirements: VI.E.1.a).(2) and VI.F.5.b)]</td><td>Emergency medicine residents may moonlight. However, the hours spent moonlighting in the Emergency Department count toward the 72 total hours per week on emergency medicine rotations. Hours spent moonlighting outside of the Emergency Department count toward the 80-hour weekly limit.</td></tr>
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Question	Answer
Who should be included in interprofessional teams? *[Program Requirement: VI.E.2.]*	Examples of professional personnel who may be part of interprofessional teams, all members of which must participate in the education of residents, include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.
When determining the one-day-off in seven, how should at-home call be considered? *[Program Requirement: VI.F.2.d)]*	At-home call, including sick call or back-up call, should not be assigned during the required one day free from clinical experience and education every week.
What are considered on-call hours and how should they be factored when determining clinical and educational work hours? *[Program Requirement: VI.F.8.a)-b)]*	On-call hours include scheduled sick call or back-up call. When determining clinical and educational work hours, only the hours spent in the hospital after being called in to provide patient care are considered. The clinical and educational work period begins at the time the resident reports for duty.

Question	Answer
Other	
Which faculty members should be included in the Faculty Roster in ADS? *[Program Requirements: II.B.6.a) and II.B.6.c)]*	The Review Committee only expects core faculty members to be identified on the Faculty Roster in the Accreditation Data System (ADS). The program director, assistant/associate program director, and chair/chief of emergency medicine are required to be listed as core faculty members. All other core faculty members are designated at the discretion of the program. Other faculty members that could be considered include the physician faculty members of both the Clinical Competency Committee and the Program Evaluation Committee. When selecting core faculty members, programs should make this determination based on the following criteria: • Devotes at least 15 hours per week to resident education and administration • Takes the annual ACGME Faculty Survey • Records annual scholarly activity for ADS Annual Update • Does not average more than 28 clinical hours in the Emergency Department per week • Is clinically active and devotes the majority of his/her professional efforts to the program • Encourages and supports residents in scholarly activities, including being a research mentor • Establishes and maintains an environment of inquiry and scholarship with an active research component • Attends at least 20 percent of the planned didactic experiences • Evaluates the competency domains; or works closely with and supports the program director/program administration; or assists in developing and implementing evaluation systems Other faculty members who dedicate more than 15 hours per week and whose primary role is clinical supervision of the residents, but who provide no other support to the program, should not be entered in ADS.

Question	Answer
How must a request for a permanent change in resident complement be submitted?	A request for a change in resident complement, as with a request for a change in program format, must be submitted through ADS. The designated institutional official (DIO) of the Sponsoring Institution must sign off on the change in ADS before it can be processed and acted upon by the Review Committee. Additional data that must be submitted with the request in ADS are outlined in the "Requests for Changes in Resident Complement" document posted on the Documents and Resources page of the Emergency Medicine section of the ACGME website.
How long does it take for the Review Committee to communicate its decisions regarding complement change requests?	Normally, the Committee is able to respond with an answer to a request for a complement change in approximately two to three weeks. Occasionally, requests will need to be reviewed at the time of the Committee's next meeting. Review Committee staff members at the ACGME will contact the program to indicate if this is the case. Complement increase requests will not be reviewed between the date the agenda closes for a Committee meeting and the last date of that meeting. In order to be reviewed within two to three weeks of submission, all complement increase requests must be submitted through ADS, and approved by the DIO in ADS, no later than the agenda closing dates posted on the bottom right-hand side of the main page of the Emergency Medicine section of the ACGME website.
Are emergency medicine residents required to obtain or maintain life support certification(s)?	No, the Review Committee believes residency education in emergency medicine establishes expertise in acute cardiac life support beyond that which is taught in an Advanced Cardiac Life Support, Advanced Trauma Life Support, Basic Life Support, or Pediatric Advanced Life Support certification course.