tion. Many departments were founded by leaders who, in the late 1960s and 1970s era of activism, social movements, community health centers, and Community Oriented Primary Care, had an understanding that family medicine departments needed to make explicit their commitment to community engagement and health system change. Among departments that have not always had "community" in their name, however, there has been a clear move in this direction in recent years; in the past decade, the percentage of departments of family medicine that include "community" in their titles has increased from 36% to 41%.

What does this change signify? Perhaps it shows a growing appreciation of social determinants of health and the role of family medicine clinicians, teachers, and researchers in addressing these community factors. From a series of posts on the ADFM Chairs' listserv over the last few years, it is clear that many departments have changed their name to better acknowledge what they were already doing, with a scope of work focusing on clinical family medicine AND on health generation, upstream prevention, and care in the community in interprofessional teams. Some listserv comments noted that the change was a decision to outwardly signify a commitment to providing primary care and training in underserved communities, including community-based services such as student-run free clinics, health screenings in churches, and food pantries. One chair remarked that adding "community" to the department's name was a way to highlight "a commitment to a culture and set of academic and professional skills that are distinct from, but complementary to, Family Medicine."

In the national context of growing attention to social determinants and movement of health systems towards a population-health model, we anticipate that this trend toward expanded departmental names will continue. Our organization may be the Association of Departments of Family Medicine, but the scope of our association's work will need to encompass the broader activities of our member departments that span boundaries with their focus on community and population health.

Amanda Weidner, MPH; Kevin Grumbach, MD; Valerie Gilchrist, MD, MPH; Steven Zweig, MD, MSPH; Ardis Davis, MSW

AFMRD Association of Family Medicine Residency Directors **From the Association of Family Medicine Residency Directors**

Ann Fam Med 2019;17:186-187. https://doi.org/10.1370/afm.2376.

PREPARING FOR THE 2019 ACGME COMMON PROGRAM REQUIREMENTS—WHAT'S NEW?

The Accreditation Council of Graduate Medical Education (ACGME) periodically conducts a thorough review of the Common Program Requirements to ensure they reflect the latest best evidence regarding resident education as it relates to patient safety, supervision, and competency development. To this end, the ACGME strives to meet the dual responsibility of educating and training the next generation of physicians while ensuring the safety of patients and residents. As its name implies, the Common Program Requirements are applicable to all residency programs, regardless of specialty. After a 45-day public comment period, the ACGME approved the next major revision, to be effective July 1, 2019.[1]

The latest Common Program Requirements stress 4 areas, (1) patient safety and quality improvement, (2) physician well-being, (3) team-based care, and (4) clinical and educational work hours. Table 1 highlights only a few of those changed areas important for family medicine program directors.

The Review Committee for Family Medicine (RC-FM) may provide additional specification to these Common Program Requirements, but only when permitted. By the publication of this article, the RC-FM should have published our specialty-specific changes for a 45-day public review and comment. There are some new Common Program Requirements listed that are less restrictive than our current RC-FM requirements, as listed in Table 2. It is essential that program directors review the final requirements and prepare for their implementation by July 1, 2019.

These new Common Program Requirements better define some important areas in resident education but also add additional burden to the program director and faculty in terms of teaching and administrative burden. We encourage program directors to discuss these changes on the AFMRD discussion forum so that we all may learn from each other how we can best implement these new changes.

W. Fred Miser, MD, MA, FAAFP
James Haynes, MD, FAAFP

Table 1. ACGME Program Requirements That Affect Program Directors

Section	Requirement
1.C.	Recruitment and retention of a diverse and inclusive workforce of residents, faculty, and others—policies and procedures must be in place related to minorities underrepresented in medicine and medical leadership; the annual program evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce (also see V.C.1.c).(5).(c).
1.D.2.	Healthy and safe learning and working environments that promote resident well-being; provide for access to food while on duty; access to refrigeration where food may be stored; safe, quiet, clean and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care (even when overnight call is not required); and clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care.
II.A.4.	Program director responsibilities—have the authority to remove program faculty members from participation in the residency program education; document verification of program completion for all graduating residents, and an individual resident's completion upon the resident's request, within 30 days.
II.B.2	Faculty regularly participate in organized clinical discussions, rounds, journal clubs, and conferences (has changed from a detailed to a core requirement).
II.C.	At a minimum the program coordinator must be supported at 50% FTE (at least 20 hours per week) for administrative time (RC-FM may further specify).
IV.B.	Identified additional areas to teach and assess—resident communication related to care goals, including when appropriate, end-of-life goals, social determinants of health, health care finances, and its impact on individual patients' health decisions, pain management and signs of addiction.
IV.D.	Faculty scholarship may now be defined by 1 of 2 domains; the RC-FM will choose 1 of these domains.
V.A.	Block rotations and longitudinal experiences (such as continuity clinic) greater than 3 months in duration must be evaluated at least every 3 months and at completion.
V.A.2.	The language has changed for the final evaluation. It must now verify that the "*resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.*"
V.C.1.	The annual program evaluation must now include a SWOT analysis (strengths, challenges, opportunities, and threats) as related to the program's mission and aims. The elements needed in the annual program evaluation have expanded (to include workforce diversity).
VI.A.	An emphasis is placed on reporting of patient safety events and training residents how to disclose adverse events to patients and families.
VI.C.	Areas of resident well-being have been better defined and enhanced.
VI.E.	Patient care and education through multidisciplinary teams are emphasized.
VI.F.	Terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." Work from home is better defined.

FTE = full-time equivalent; RC-FM = Review Committee-Family Medicine.

Table 2. 2019 Common Requirements vs 2017 RC-FM Requirements

Area	2019 Common Program Requirements	2017 RC-FM Requirements
Protected salary support for program director	At least 20% (8 hours per week)	At least 70% (28 hours per week)
Qualifications of the program director	At least 3 years of documented educational and/or administrative experience	At minimum 5 years of clinical experience in family medicine, with 2 years as a core faculty member
Faculty scholarly activity	One of 2 domains defined (IV.D.2.a) and (IV.D.S.b).(s)	One area defined (II.B.5)
First-time board passage rate	At least 80% pass rate	At least 90% from the preceding 5 years

RC-FM = Review Committee for Family Medicine

References

1. Accredition Council of Graduate Medical Education. ACGME common program requirements (residency). https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. Updated Jun 10, 2018. Accessed Dec 17, 2018.