CAATE RESIDENCY & FELLOWSHIP STANDARDS
STANDARD VIDEO LIBRARY SCRIPTS

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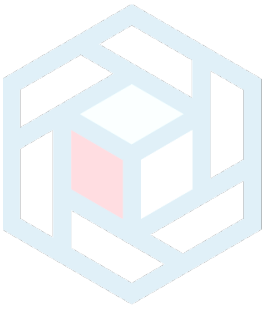
Standard 1
The program has a written mission statement that addresses the specialized preparation of residents and aligns with the mission of the sponsoring organization.

Residency and fellowship programs must have a mission statement that states how the program addresses the specialized preparation of residents or fellows in the specialty or subspecialty area. A mission statement is a formal summary of the aims and values of an institution, organization, or program. The aim of the mission statement is to provide insight into programmatic goals, objectives, and program specific outcomes and should be clearly linked to the essential components of the program framework, including strategic planning. The mission statement must align with the mission of the sponsoring organization, and programs are encouraged to seek out individuals at their organization who may be able to assist in crafting a mission statement that captures the mission of the program and aligns with the sponsoring organization.

To demonstrate sufficient evidence for this standard, a program must be able to demonstrate how the program's mission statement addresses the specialized preparation of the residents or fellows while aligning with the mission statement of the sponsoring organization. This can be accomplished by comparing the program and organization missions, discussing their overarching alignment, and providing uploaded copies of the mission statements for each associated organizational unit. Programs may also find it useful to clearly link the program mission statement to the specialty or subspecialty area of focus to ensure alignment of program elements with the program mission.



Standard 2
The program has developed, implemented, and evaluated a framework that describes how the program is designed to achieve its mission and that guides program design, delivery, and assessment.

Annotation: This written framework describes essential program elements and how they're connected; these elements include core principles of the program, strategic planning, goals and expected outcomes, curricular design (both didactic and clinical planning and sequencing), and the comprehensive assessment plan. The framework is evaluated and refined on an ongoing basis.

The framework includes program-specific and resident or fellow-specific outcomes defined by the program; these outcomes include measures of resident or fellow learning, quality of instruction, quality of clinical development, and overall program effectiveness. Programs must minimally incorporate the learner achievement measures identified in Standard 5 as outcomes. Improvement plans must include targeted goals and specific action plans for the communication and implementation of the program.

The programmatic framework is the foundation for developing and implementing a residency or fellowship program. At the onset of program creation, program faculty and stakeholders should discuss both program inputs and the intended outcomes of the program. Program inputs are the efforts the program puts forward to deliver the program and are the essential elements the program will create, leverage, and implement. Program outcomes, simply put, are learners that demonstrate specialist and subspecialist proficiency in their areas of practice. The purpose of establishing a framework is to evaluate what resources are needed develop a specialist or sub-specialist within their organization. As a program communicates its framework, the historical context from which the program was developed, and its progression since it started, should be shared. As the program changes over its years of implementation and accreditation, it is essential to evaluate its effectiveness and actively engage in quality improvement. The framework serves as the guide for quality assessment relative to program delivery, (the inputs), and the graduating specialists or sub-specialists, (the outcomes).

Programs will complete their comprehensive programmatic review using the CAATE's online accreditation software that will help organize narrative responses and allow the program to upload evidence to demonstrate adherence to each accreditation standard. The framework standard is connected to several other standards, and it serves as an umbrella standard for standards 3, 4, 5, and 6. These standards all reference how the program engages core faculty and stakeholders in developing and evaluating the framework itself, as well as the ways the program assesses the learners as they progress toward becoming specialists or sub-specialists through its comprehensive assessment plan. Standard 2 is also directly associated with the outcomes standards, standards 32 to 39.

Programs must ensure the essential programs elements of the framework align with the program's mission. Programs use the framework to deliver the program. The data collected through the framework is evaluated and used to guide program quality improvement. Programs will narratively describe the development of the program's framework, including the details of the essential elements of the program, and how the framework guides the program's achievement of its mission. Within this narrative, the program should describe how each of these components connect. For example, how the program's mission aligns with the defined outcomes and how the curricular design, sequencing and delivery achieve these outcomes. The program will provide a narrative that describes how the specialty or sub-specialty was identified, how the program has implemented the framework, and how the program has evaluated the framework on an ongoing basis. This includes what personnel are involved, in what way they serve the program, and how this leads to program quality. The narrative should provide an overview of the program and how all the program elements interact to progressively develop the learner. Program elements include the core principles of the program, the strategic planning, goals and expected outcomes, curricular design (both didactic and clinical planning and sequencing), and the comprehensive assessment plan. Core principles serve as the foundation for the program and should be built on the individual strengths of the organization and what it has to offer. The strategic planning includes both the program development at its onset and the periodic review of program inputs and outcomes. Program planning should be intentional and individualized to the data being collected about the effectiveness of its delivery and the quality of

the outcomes. Periodic review should result in adjusting goals and outcomes relative to the development of specialists and sub-specialists. The program's curricular design should detail how the program intends to develop the learner's knowledge, skills, and abilities in the specialty or sub-specialty area and the comprehensive assessment plan should outline the assessment tools used to assess program inputs and intended outcomes.

For programs currently in development, notes or minutes should be taken and will help provide context for the framework's narrative. For programs that are established but are seeking accreditation for the first time or programs that have been accredited, this is an ideal time to re-evaluate the essential elements of the program to ensure they are serving the mission of the program and resulting in learners demonstrating the knowledge, skills, and abilities of a specialist or sub-specialist. Regular, ongoing evaluation of the learners is a critical part of the comprehensive assessment plan; however, programs often overlook assessments of program delivery, which rounds out the comprehensive assessment plan. Examples of competency-based assessment tools in athletic training, specific to ACGME core competencies, specialty, and sub-specialty areas include The Athletic Training Milestones or the Standardized Patient Evaluation Tool, which are detailed in Standard 4.

As peer reviewers begin to review the program, they will likely start by reviewing the program framework to get a global picture and understanding of how the program is designed and delivered. Peer reviewers will work with the program to identify how the framework includes all the required program components: the program's core principles, strategic planning, goals, expected outcomes, curricular design (didactic and clinical planning and sequencing), and the comprehensive assessment plan. The narrative should help the peer reviewers see how the program implements the framework and assesses its learners, and the program itself, to ensure there is knowledge, skills, and abilities of a specialist or sub-specialist in the area of practice. This narrative and associated uploads serve as a critical foundation for the peer reviewers to understand the program and should be very detailed.

It is common for clinical educators like those facilitating residency and fellowship programs to experience challenges with standards related to assessment, as this is not part of their typical training. For help with standards related to assessment you may leverage stakeholders, similar residency or fellowship programs within your organization, peer programs in the profession, and the various CAATE resources to help support the development of the framework and assessment tools. The most critical components of the framework and its related assessment standards are ensuring that the program's mission is met and that meeting that mission is ensured by using assessments that measure specialization and sub-specialization.

Standard 3
Development, implementation, and evaluation of the framework engages all core faculty and include other stakeholders as determined by the program.

All core faculty must participate in the development, implementation, and evaluation of the framework on an ongoing basis. The nature and extent of participation by each core faculty member and other stakeholders is determined by the program.

The purpose of Standard 3 is to ensure the program uses transparent and informed decision-making when developing, implementing, and evaluating the programmatic framework. Standard 3 requires all core faculty to participate in the development, implementation, and evaluation of the framework on an ongoing basis, but the nature and extent of participation by each core faculty and other stakeholders is determined by the program. Typically, expertise and organizational strengths will help programs determine how to leverage the skills of their core faculty and personnel. The goal of this standard is so that the burden of responsibility to ensure program quality does not rest solely on the program director. The collaborative nature of developing, implementing, and evaluating the program will ensure all program personnel are motivated toward the program's success. By incorporating varying experience, expertise, and perspectives involved in the framework process, programs can improve the quality of framework planning by identifying potential weaknesses and better aligning the actions of the program with the learner outcomes.

To provide sufficient evidence for Standard 3, the program should aim to describe the role and responsibilities of each core faculty member and identified stakeholder. The program can address this standard by submitting a written description or a table listing the roles and responsibilities of each core faculty member and stakeholder. Additional evidence might include meeting minutes, email exchanges, and assigned deliverables, etc. by each core faculty member and stakeholder that verify they were engaged in the framework development, implementation, and evaluation.

Standard 4
Programs must use appropriate assessments to measure a resident or fellow's progression towards advanced clinical practice.

Programs must measure and assess acquisition of competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents or fellows from the beginning of their education through completion of their respective programs to the advanced practice of their specialties. Programs must also measure themselves to include program personnel and sites where residents or fellows practice clinically.

The purpose of Standard 4 is to ensure that residency or fellowship programs are meeting the desired level of quality through every stage of developing an advanced clinical practice specialist or subspecialist. Specifically, the purpose is to assess both the program and the learners to ensure the program is advancing the learner's practice. Programs must measure and assess learner's progressive development and outcomes. Programs should be actively engaged in evaluating learner knowledge, skills, attitudes, and performance relative to the specialty or sub-specialty area at onset, throughout, and at the completion of the program as evidence of advanced clinical practice. Examples of competency-based assessment tools in athletic training, specific to ACGME core competencies, specialty, and sub-specialty areas include The Athletic Training Milestones. Another example, if programs are using standardized patients, is the Standardized Patient Evaluation Tool, which is a measure of healthcare core competence. Programs should select and implement valid and reliable assessment tools to demonstrate progressively advanced clinical practice. Both aforementioned tools have demonstrated content validity.

Programs are also responsible for assessing their program faculty and the clinical sites where a learner clinically practices determining their ability to provide learners with opportunities to progress toward advanced clinical practice. These assessments should include the quality of mentorship and educating, the degree to which the environment is safe to learn and offering the necessary frequency, depth, and breadth of exposure and experience to the area of specialty or subspecialty. Appropriate assessments of program faculty and clinical sites may include feedback from learners through surveys and exit interviews as well as clinical encounter data or chart auditing.

To provide sufficient evidence of Standard 4, programs should select appropriate assessment measures and describe why those measures and methods were chosen. Programs can provide evidence by uploading examples of assessment tools used within their program to measure learner advanced clinical practice in the identified specialty or sub-specialty, quality of instruction, quality of clinical development, and overall program effectiveness.

Standard 5
The program collects resident or fellow achievement measures on an annual basis.

The following achievement measures must be collected:

- *Program completion rate*
- *Resident or fellow placement rate*
- *Summative tool that assesses resident or fellow readiness for advance practice in specialty/subspecialty area*

Standard 5 is intended to ensure that programs are regularly assessing learner achievement. In Standard 4, the assessment focuses on tools to progressively measure advanced practice, which is most often done during the learning process and offers feedback at various time points. This is formative assessment. In Standards 32 through 39, the focus is on assessing learning outcomes relative to the ACGME core competencies, which should be both formative and summative, meaning at the conclusion of the program to ensure the learning outcomes have been met before successful completion of the program. Standard 5 is specific to culminating or summative outcomes that address both the learner individually, as well as the program's ability to progress the learner to completion and placement. Programmatically, learners should be able to progress, successfully compete the program, and be placed in employment commensurate with their training and experience. These are broad measures of achievement for the programmatic inputs and outputs relative to learner performance and progression. Similar to Standard 4, tools focused on progressively measuring advanced practice can be used as the summative tool to assess learner readiness for advance practice in the specialty/subspecialty area. Programs may consider using their summative tool for readiness for advanced practice as well as formative feedback periodically throughout the program to raise awareness for the learner about their progress. Learners have an expectation that the program is structured to help them be ready for advanced practice in the specialty and subspeciality area, thus regular evaluation of these achievement metrics is important to ensure program quality.

To demonstrate compliance with this standard, programs must collect data for each learner's achievement measures and update these data within the program's electronic accreditation account each year. Data from the program's account is used by CAATE to create the Program Outcomes and Information webpage for each program. This webpage includes the required program learner achievement outcomes. Standard 30 addresses the necessity for these data, and others, to be publicly available, which enhances program transparency and ensures program quality to the public as well as potential applicants.

Standard 6
The results of the program's comprehensive assessment plan are used for continued program improvement.

The program analyzes the extent to which it meets its program-specific outcomes and creates an action plan for program improvement and identified deficiencies. The action plan minimally includes identification of responsible person or persons, a listing of resources needed, a timeframe, and a strategy to modify the plan as needed.

Accreditation is a voluntary quality assurance process in which programs evaluate learner and program outcomes, which may be quantitative or qualitative, to determine the achievement of the program's goals and mission and to demonstrate compliance with the accreditation standards. At the heart of this process is continuous quality improvement. Quality improvement is a structured, data driven process to evaluate systems and outcomes that includes identification of areas for improvement, selection and implementation of measurable changes, and analysis of changes to ensure progression towards established benchmarks. Successful quality improvement efforts are a continual process that leads to measurable improvement over time. Analyzing program outcomes and comprehensive assessment plan data provides programs with a roadmap to improving those areas in need and helps to facilitate quality improvement in CAATE-accredited programs.

In reference to Standard 2, programs must develop a comprehensive assessment plan as part of the program framework. The comprehensive assessment plan is designed to evaluate the program-identified outcomes, which, at a minimum, include the learner achievement measures identified in Standards 4 and 5. As a reminder, the program framework requires the comprehensive assessment plan to include measures of progressive learner learning, quality of didactic and clinical instruction, quality of clinical development, and overall program effectiveness and the comprehensive assessment plan should include tools that measure and assess competency-based developmental outcomes that can be demonstrated progressively by a learner.

This specific standard focuses on the program's use of the comprehensive assessment plan results to analyze the extent to which the program meets its program-specific outcomes and to provide an opportunity to use these results to drive program improvement. Programs will be expected to demonstrate their engagement in the quality improvement process by analyzing comprehensive assessment plan data and developing an action plan. Programs are encouraged to look at all outcomes, address those that fail to meet program benchmarks, and to look at successful outcomes to determine if improvements can be made. Improvement plans must consist of targeted goals and the ways the program will communicate the plan to those who will be responsible. The plan should also identify resources needed, a timeline and benchmarks for improvement, and the specific strategies that will be used to improve the deficient outcome.

During program development, or at key inflection points in the program's history, programs will find it helpful to consider the process of quality improvement. When a program has a framework and comprehensive assessment plan with a clear identification of program goals, objectives, and outcomes and to establish a benchmark for the expected level of achievement of each, the data will be more useful in the improvement process. As the action plan is created, programs should define a clear plan for addressing outcome results that do not meet their set benchmarks. The narrative should outline the data collected, the analysis, and the process for developing the action plan. In addition, programs should document the process throughout to track their efforts as that documentation can be useful evidence to meet this standard.

Standard 9
The program must be a minimum of twelve consecutive months with a continuous full-time practice commitment.

Full-time practice is based on a minimum of 40 hours of clinical practice per week over a 12-month (52 week) residency/fellowship. The resident/fellow is a full-time employee of the organization and eligible for benefits, including paid time off, during their employment term.

Residency and fellowship programs must allow sufficient time for learners to practice in the specialty or subspecialty area to ensure optimal educational experiences. The program must create an environment that allows learners adequate time to acquire the required knowledge, skills and abilities necessary for patient care. A minimum of 12 consecutive months with a continuous full-time practice commitment is required for programs to ensure learners can acquire and demonstrate competence in all knowledge, skills, and abilities that are considered essential for the specialty or subspecialty area of practice. Full-time practice is based on a minimum of 40 hours of clinical practice. The learner must be a full-time employee of the organization and eligible for benefits, including paid time off. If a program is longer than 12 consecutive months, they will need to demonstrate how they ensure continuous full-time practice of the learners throughout the duration of the program.

To demonstrate sufficient evidence, programs need to demonstrate the employment length is at least 12 consecutive months, demonstrate they are treated as full time employees of the sponsoring organization, and demonstrate clinical practice for a minimum of 40 hours per week outside of didactic components of the program to ensure adequate time for specialty or subspecialty development. Programs must develop a plan to identify how learners are able to demonstrate competence in the specialty or subspecialty area across the 12-month residency or fellowship period. This can be accomplished with a short narrative describing the length of the program, discussing rotations or experience models, the full-time employee status of learners, and/or allotted benefits. Programs will need to upload documentation such as acceptance letters with dates of employment, rotations or experience models mapped out, full-time employee status documentation or allotted benefits.

Standard 10

The program ensures well rounded and comprehensive clinical practice experiences that expose the residents or fellows to the full spectrum of the subspecialty area.

The program is designed to provide a full-time practice experience in the specialty or subspecialty area. The full-time practice experience must occur over at least 12 months, with a minimum of 1664 hours of clinical practice dedicated within the specialty or subspecialty area. Of the 1664 clinical practice hours in the specialty or subspecialty area, 500 hours of that time must be mentored. An additional 260 hours of didactic work is required during the duration of the program. The experiences should be planned, ongoing and consistent per the identified area of specialization or sub-specialization of the resident or fellow and should intentionally expose the resident or fellow to a diverse spectrum of the specialty or subspecialty area.

Programs are required to provide comprehensive clinical practice experiences for learners that are outlined by their clinical progression plan. These experiences are designed to ensure the learner receives adequate real-world clinical experience and mentorship that progressively demonstrates the qualities and characteristics of a specialist or subspecialist. The clinical practice experiences must span a period of at least 12 months. Programs offered beyond 12 months should be consistent with the program goals and learners should be engaged in the specialty area throughout the duration of the program. Clinical practice experiences will vary for each learner and should offer sufficient patient encounters that ensure the learner is able to practice in the specialty or subspeciality area a majority of the time, a minimum of 1664 hours. Clinical practice experiences must include a formal mentored relationship with a specialist or subspecialist in the focused area of practice. The relationship should provide time to discuss goals, issues, challenges, and successes throughout the residency or fellowship program. The required 500 mentored clinical practice hours allow the learner to progressively gain autonomy while providing the mentor with an opportunity to assess the needs of the learner. Mentored time by a core faculty or affiliate faculty member is likely to be inversely related, where the time spent with the learner will be higher in the beginning of the program and decrease as the learner progresses to autonomous specialty or subspecialty practice. Additionally, the program is required to provide planned didactic coursework of at least 260 hours that compliments the clinical practice experiences in the specialty or subspecialty area.

To demonstrate sufficient evidence to meet this standard, the program should have and upload the complete clinical progression plan for each learner. These individualized plans may, and can change, based off the needs of each learner to provide learner-centered education. In addition, programs should provide a narrative describing the clinical, didactic, and scholarship experiences offered by the program. In this narrative, the time spent on each component of learner development should be quantified and evidenced. Finally, programs should upload a clear and detailed program sequencing document, which provides a breakdown of clinical experience hours in the specialty or subspecialty area, mentored time in the specialty or subspecialty area, and time on didactic work for each learner. Programs may choose to use a system, like color-coding or symbols, to bring clarity to the sequencing document. This organizational system should clearly indicate each part of learner preparation and a legend may be useful for peer reviewers, less familiar with the day-to-day operations of the program.

Standard 11

The program must provide a comprehensive plan for the residents or fellows that provides a logical progression of graded-authority and responsibility for autonomous patient-care experiences within the specialty area and inclusive of the ACGME Core Competencies.

The program is designed to provide a progressive yearly minimum of 500 mentored hours in the specialty area. This mentored time is likely to be inversely related (higher at the beginning of their residency that becomes less as the resident progresses to autonomous specialty practice)

Standard 11 ensures programs have a process for individualized mentorship and progressive growth throughout the program. A mentor is a person who serves as a guide for the learner and demonstrates qualities such as a listener, facilitator, challenger, role model, goal setter, and advocate. Ideally, a learner will have more structured mentorship at the beginning of the program, which diminishes over time, as the learner demonstrates proficiency in the specialty or subspeciality area. Decisions to increase autonomy should be made using the assessments outlined in the comprehensive assessment plan that show the learner has met the specified benchmarks to progress. At the onset of the relationship, mentorship should include planned time to develop patient care and procedure skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice, the ACGME core competencies, in relation to their specialty or subspecialty area. As the learner approaches program completion, a more peer relationship may exist as the learner plans for the future as a specialist or subspecialist.

The program must provide a mechanism for the learner to document these hours to ensure they meet the minimum of 500 mentored hours. Documentation of quantified hours can be completed in a word-processing document, an electronic database, or a hand-written chart that includes the meeting minutes and topics discussed. This evidence must be uploaded and the program must provide a narrative to describe the comprehensive plan for progression, which will include the ways in which the program evaluates performance to progress autonomy and adjust mentorship. The program will need to share about how learner performance is communicated formally and informally to the learner throughout the program. This should be consistent with the program's planned sequencing and benchmarking.

Standard 12

The program ensures a well-rounded and comprehensive didactic curriculum that actively engages the residents or fellows to the full spectrum of the specialty or subspecialty area and the ACGME Core Competencies.

The program is designed to provide a progressive yearly minimum of 260 hours of didactic curriculum that is planned, ongoing and consistent per the identified area of specialization of the residency. The didactic curriculum must use multimodal learning strategies, engage the resident across the diverse spectrum of the specialty area and must impact clinical practice.

Programs must have a didactic curriculum to engage learners in the full spectrum of the specialty or subspeciality area. The ways in which the program chooses to engage learners should be consistent with program goals and align with the comprehensive assessment plan. Specifically, the ways in which the program educates should match the learning outcomes and the ways in which the learners are assessed. Examples of didactic instruction might include in-person or virtual lectures, seminars and discussion, learner presentations, journal clubs, labs, or project-based learning. Learning activities should be evidence-based and should develop the learner's knowledge, skills, and abilities in the specialty or subspecialty area as well as the ACGME core competencies. Programs must provide evidence that instructional content includes compassionate, appropriate, and effective care for health problems and the promotion of health; established and evolving biomedical, clinical epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient-centered care; methods to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care based on constant self-evaluation and lifelong learning; interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals; professionalism and an adherence to ethical principles; and systems-based practice.

To demonstrate sufficient evidence to meet the standard, programs need to describe how the didactic curriculum is intentional at developing the learner in the specialty or subspecialty area. Programs will need a written explanation of how their didactic program accounts dedicated instruction for each domain of the ACGME Core Competencies, as well as instruction relative to the specialty and subspecialty. It will be critical to describe how the didactic curriculum complements the clinical experiences in the specialty and subspecialty area and how it impacts patient care delivery. In addition to the narrative, the program should include the learner-centered curriculum plan, and similar to the clinical progression plan shared in Standard 10 or the program sequence in Standard 11, programs may choose to use an organizational system to clearly communicate how the curriculum is delivered and how it might be integrated with the clinical experiences. This organizational system should clearly indicate each part of learner preparation and a legend may be useful for peer reviewers, less familiar with the day-to-day operations of the program.

Standard 13
The program must provide a defined and planned scholarship experience within the specialty/subspecialty area and the ACGME Core Competencies.

The program must ensure an intentional plan for each resident/fellow is implemented that relates back to patient care within the specialty/subspecialty area and the core competencies, resulting in dissemination.

The residency or fellowship program must include opportunities to engage in scholarship which should demonstrate progressive growth over the course of the program. Scholarly engagement may include discovery, integration, application, engagement, teaching, and learning. Clinical scholarship, which may be more typically the scholarship of integration, application, and engagement, may include learner-initiated activities such as organized clinical discussions, journal clubs, case study development, or conference presentation. The scholarship of discovery may offer opportunities to collaborate with affiliate faculty or institutions in the creation of new knowledge, applicable to clinical practice, specifically in the specialty or subspecialty area and the ACGME core competencies. The scholarship activity selected should be integrated into clinical practice, complementing learner growth. All scholarship activity should advance the learner on the path to specialty or subspecialty and ultimately seek to improve patient care. All learner scholarly activities must align with the ACGME Core Competencies, including patient care, medical knowledge, interpersonal communication skills, professionalism, practice-based learning and improvement, and systems-based practice.

To demonstrate compliance, programs should provide a narrative that describes the scholarly expectations of the learner and how the learner can meet scholarly expectations. Programs should provide evidence of learner scholarly work and metrics by which the work was assessed. In addition, programs should provide evidence of how learner scholarly activity is utilized in clinical practice or in presentation.

Standard 14

The program demonstrates systematic diversity, equity, inclusion and social justice efforts in its development, design and delivery.

Programs advance diversity, equity, inclusion and social justice through a variety of efforts. These can include (but are not limited to) the following:

- *participating in sponsoring organization efforts to advance diversity, equity, inclusion and social justice;*
- *incorporating diversity, equity, inclusion and social justice across the program curriculum;*
- *recruiting and retaining diverse faculty, residents, fellows, and mentors;*
- *improving faculty (including PD, core faculty and affiliate faculty) and mentors understanding and integration of diversity, equity, inclusion and social justice;*
- *implementing policies that support a climate of equity and inclusion, free of harassment and discrimination;*
- *community engagements and/or scholarly endeavors that are reflective of diversity, equity, inclusion and social justice; and*
- *gathering program data that informs the programs diversity, equity, inclusion and social justice efforts. Sources may include, but are not limited to, demographic reports, retention reports, equity analysis, climate data, participation in DEI activities, competency development, program evaluations, and interviews/focus group data.*

Diversity, equity, inclusion, and social justice efforts are core values of the CAATE. Embodiment of these values are vital to delivering patient-centered care and needed to address health inequities in underserved and minoritized communities. Effective programs embrace diversity, equity, inclusion, and social justice initiatives throughout the programs' framework through inclusive curricula, reflective of diverse patient populations, safe and inclusive learning environments, recruitment and retention of faculty, learners, and mentors, faculty development initiatives, policies and procedures, and scholarly endeavors.

To demonstrate sufficient evidence, programs must ensure the intentional incorporation of diversity, equity, inclusion, and social justice initiatives through a program-specific systematic plan. Programs will need to provide descriptions of how diversity, equity, inclusion, and social justice initiatives have been implemented within the program and the sponsoring organization. This can be accomplished in many ways, including identifying inclusive systems of practice, faculty development, learner recruitment, clinical care delivery, pathway programs and curricular development. Some examples of evidence to support implementation of diversity, equity, inclusion, and social justice efforts could include, but are not limited to:

- Having faculty and learners attend organizational-level diversity, equity, inclusion, and social justice didactic sessions
- Specific diversity, equity, inclusion, and social justice content woven throughout the curriculum through the various learning activities
- Intentional faculty development in various diversity, equity, inclusion, and social justice topics
- Holistic approaches to recruitment of diverse faculty and learners
- Equitable creation and implementation of policies that aim to diversity, equity, inclusion, and social justice initiatives

Programs should consider multiple ways to integrate diversity, equity, inclusion, and social justice initiatives throughout the program.

- Describe the current efforts (e.g., sponsoring organization, department, and program) in advancing diversity, equity, inclusion, and social justice within program development, design and delivery across didactic and clinical practice
- Identify the sources of sponsoring organization and program data used to inform diversity, equity, inclusion and social justice efforts
- Upload: Provide the relevant program data and analysis that informs the program's diversity, equity, inclusion and social justice efforts

Standard 15
The program must be identified as an athletic training residency or fellowship in a specialty or subspecialty area in all organizational publications.

Consistency and clarity in language used to identify and refer to the program and the specialty or subspecialty area of practice is important for prospective and current learners as well as other stakeholders. Identifying an area of practice is important to reflect the unique requirements and expectations of the program. The program must include whether it is an athletic training residency or fellowship program and include the specialty or subspecialty area of focus in all organizational publications describing the program. This includes webpages, promotional materials, and any official organization documents.

The CAATE has identified the following as approved residency specialty areas; Prevention and Wellness, Urgent and Emergency Care, Primary Care, Orthopaedics, Rehabilitation, Behavioral Health, Pediatrics, and Performance Enhancement. Programs must demonstrate how the design of their residency program focuses within one of these approved areas of specialty clinical practice. Fellowship programs are advanced education and intensive programs developed to enter more subspecialized areas of practice, which must be defined by the fellowship program. A subspecialty is considered a narrow field within specialization. The CAATE has not defined Fellowship subspecialty areas, however, has a new fellowship proposal process in which a program will need to provide justification for the new subspecialty area and demonstrate that there is a current need for Athletic Trainers wit this subspecialty training.

To address this standard, programs will need to describe how the program is identified in all organizational publications and upload official organization documentation that verifies appropriate and accurate program listing. To demonstrate sufficient evidence for this standard, programs need to have accurate and current information on the program's website as well as a functioning hyperlink to the program's CAATE Program Information and Outcomes webpage. This includes an upload of the official completion certificate for the program, URLs or webpages that describe the program, all official organization documents describing the program, and any promotional materials that verify the program is listed as an athletic training residency or fellowship in a specialty or subspecialty area. Programs must be listed as an athletic training residency or fellowship and must include the specialty or subspecialty area of practice in all organizational materials and publications.

Standard 16
There is an organizational structure with leadership and administrative personnel to support the operations of the program.

The intent of this standard is to ensure the operations for the residency/fellowship program include operational resources, legitimized practice settings, and organizational structure.

Effective educational leadership is integral to learner achievement and influences teaching quality, curriculum alignment, and programmatic culture. Administrative support for the operations of the program is crucial to improve teaching effectiveness and promote learning success. Effective programs have organizational structures and resources to support the success of the program, even beyond the assigned personnel. There is a commitment to ensuring appropriate resources are directed to the program and a belief in the value of the program within the organization. The organizational structure, inclusive of leadership and administrative personnel, should contribute to the programs stated mission, goals, and expected program outcomes. Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

To demonstrate sufficient evidence, programs must have a clearly defined reporting structure that aligns with the mission, goals, and expected outcomes. This structure may or may not align with the business or healthcare organizational structure; programs should communicate both, if they differ from the educational structure. This should include a description of how all members contribute to the overall program. Additionally, if there are outside funding sources that offset the cost of the program, the program must describe how those funds are used for program development and growth. Programs must provide evidence of the organizational structure, budget table and, if applicable, the external accrediting agency verification to guarantee the legitimacy of the health care facility.

Standard 17
All sites where residents/fellows are involved in education (excluding the sponsoring organization) have a current affiliation agreement or memorandum of understanding that is endorsed by the appropriate administrative authority at both the sponsoring organization and site.

When the administration oversight of the program personnel differs from the affiliate site, affiliation agreements or memorandum of understanding must be obtained from all parties. All sites (excluding the sponsoring organization) must have affiliation agreements or memoranda of understanding.

Programs may utilize a variety of clinical sites that reflect the health care needs of the community and the educational needs of the learners outside of the sponsoring organization. Learners may complete educational opportunities or experiences outside of the sponsoring organization to meet program requirements. In any instance where a learner is involved in education outside of the sponsoring organization, a current affiliation agreement or a memorandum of understanding, properly endorsed, is required. The purpose of the affiliation relationship in a written contract is to ensure that both parties have a clear understanding as to their rights and responsibilities. Once appropriate parties at both the sponsoring organization and clinical site agree and sign the agreement, learners are able to obtain educational experiences within the boundaries of that agreement.

To demonstrate sufficient evidence, programs must execute an affiliation agreement or memorandum of understanding with all sites where learners are involved in educational opportunities, outside of the sponsoring organization. These formal agreements must be signed and dated by individuals with administrative or signature authority and must include personnel from each entity with an interest in the affiliation agreement or memorandum of understanding.

To address this standard, programs must describe the process that ensures that there is an executed affiliation agreement or memorandum of understanding with all required sites where learners are involved in clinical and educational development. Programs must provide copies of affiliation agreements or memoranda of understanding for all active clinical sites where learners may have educational opportunities, outside of the sponsoring organization. Programs must ensure that each agreement has the appropriate signatures, and that all signees have the appropriate signature authority. Additionally, programs must ensure that for clinical sites where the administrative oversight of the program personnel differs from the affiliate site, such as a sports medicine clinic that provides athletic training services to a secondary school, that all parties are represented within that affiliation agreement or memorandum of understanding.

Standard 18

The program director is a full-time employee of the sponsoring organization. The program director's experience and qualifications must include the following:

- **An earned post-baccalaureate degree**
- **Content expertise in the specialty or subspecialty area**
- **Certification and in good standing with the Board of Certification**
- **Current state athletic training credential and in good standing with the state regulatory agency in the state in which the program is housed (in states with regulation)**
- **Verified NPI number with appropriate healthcare field designation**
- **Engages in scholarship**
- **Engaged clinically within the specialty or subspecialty area**
- **Must be active at local, state, regional, and/or national levels**

Program directors must be full-time employees of the sponsoring organization and must be qualified core faculty. Like the core faculty, program directors must have the necessary credentials, have content expertise, be engaged in scholarship and engaged clinically in the specialty or subspecialty area. Program directors must also be active at the local, state, regional and/or national levels, which helps ensure faculty are cognizant of issues facing the profession and advocacy efforts. This standard is similar to Standard 21 for the qualifications of core faculty, but different than Standard 19, which focuses on the specific administrative responsibilities of the program director.

Content expertise is advanced knowledge and training in current concepts and best practices in a specialty or subspecialty area of athletic training. Content expertise is achieved through mechanisms such as advanced education, clinical practice experiences, clinical research, other forms of scholarship, and continuing education. The program director's content expertise must be aligned with the specialty or subspecialty area of the program. The program director's scholarly engagement may include discovery, integration, application, engagement, teaching, and learning. Clinical scholarship, which may be more typically the scholarship of integration, application, and engagement, may include organized clinical discussions, journal clubs, case study development, or conference presentations. The scholarship of discovery includes the creation of new knowledge in the specialty or subspecialty area and the ACGME core competencies. The program director must be clinically engaged, meaning they are facilitating the learning experiences of residents or fellows through activities like direct patient care, clinical mentoring, or clinical research/scholarship activities; however, programs have the autonomy to define how the program director is clinically engaged.

To demonstrate sufficient evidence for this standard, the program needs to provide the program director is a content expert in the specialty or subspecialty area, aligned with the program; has BOC certification and is in good standing; is licensed or certified in the state, as applicable; has an NPI number; engages in scholarship; is clinically engaged; and is active in local, state, regional, or national professional committees/etc. Programs can use a table, professional portfolio, or other format to document their evidence.

Programs directors must demonstrate knowledge, skills, attitudes, and abilities within the specialty or subspecialty areas with evidence of content expertise and scholarly engagement. There are multiples ways of meeting this standard and it will likely look different across faculty and may be variable by program as well. Programs should reflect on why they believe the program director is considered a content expert and compile evidence that shows how their content expertise is directly related to specialty or subspecialty area. Programs must describe all the ways in which the program director can demonstrate content expertise and how they are continuing to grow their knowledge over time to ensure delivery of the best information to the learners. Programs should define clinical engagement, if the program uses activities other than or in addition to direct patient care, clinical mentoring, or clinical research/scholarship activities. Then the program must document and characterize how the program director is engaged clinically in the specialty or subspecialty area.

Standard 19

There is a single program director with the authority and accountability for the operations of the program. The program director has adequate protected time to oversee and advance the residency program, with consideration given to the size and complexity of the program. This includes the following responsibilities:

- **Program planning and operation, including development of the framework**
- **Program evaluation**
- **Oversight of the quality of clinical and didactic education**
- **Maintenance of accreditation**
- **Input into budget management**
- **Input on the selection, evaluation and development of program personnel**
- **Input on the selection, evaluation and mentorship of resident or fellow**
- **Mentorship of the program personnel as they interact with the resident or fellow**
- **Oversight of resident or fellow clinical progression**
- **Conducts essential orientation activities**

The program director must be provided with support and time adequate for administration of the program based upon its size and configuration

Residency or fellowship programs are facilitated by a single program director with oversight of all aspects of the program. The program director serves as the primary program facilitator to ensure a quality educational experience. To effectively operate in this role, the program director must have protected time dedicated to operating the program. The protected time may vary by program, due to individual and organizational differences; however, it must be sufficient to account for the size and complexity of the program.

The program director is responsible for program design and delivery, which includes planning and implementation of the framework and continuous evaluation of the program activities. Program directors oversee the quality of clinical and didactic education, meaning both the delivery of those program elements and ensuring learners are meeting the necessary progressive benchmarks at various points throughout the program. The program director must have a comprehensive knowledge of the program to ensure quality. To do this, the program director must have the requisite knowledge of the programmatic framework and work to ensure that all aspects of the program are contributing to the positive growth of the learners over time. The program director also serves as the conduit between the clinical and didactic components of the program, including scholarly activities, promoting integration of these elements. The program director is also responsible for the oversight of clinical progression, from orientation through the time to completion. This allows for appropriate, consistent, and quality feedback to the learner over time.

Program directors are responsible for the selection, evaluation, and development of program personnel and learners, relative to the residency or fellowship program in conjunction with organizational hiring practices. Program directors are responsible for mentoring program personnel on their interactions with residents or fellows. Administratively, the program director is responsible for maintaining accreditation and programmatic budget management.

To demonstrate sufficient evidence for this standard, the programs must describe the program director's responsibilities, how their time is protected to carry out program operations, and how they decide on assigned workload for the program director. The narrative must detail how this time is sufficient to complete the duties of the role. The program's job description, redacted for personal information must be uploaded and accompanied by evidence detailing the comprehensive roles and responsibilities of the program director.

Standard 20
Program personnel numbers are sufficient to meet the needs of the program.

Standard 20 ensures that there are enough program personnel to meet the learning outcomes and overall needs of the program. Program personnel includes those individuals associated with the delivery, assessment, and development of the residency/fellowship program. These include the program director, core faculty, and affiliated faculty members. Standard 2, which outlines the framework and clarifies the goals of the program, should guide how many personnel are necessary to ensure effective program delivery. Programs should consider their unique environments to guide these decisions.

Programs must have sufficient personnel that are able to dedicate the necessary time to educate, mentor clinical practice, and facilitate scholarship for all learners. Specifically, personnel dedicated to clinical mentorship must be collectively available for facilitating the clinical learning experiences for at least 500 hours over the course of the program. Personnel dedicated to didactic instruction must be collectively available to educate for at least 260 hours over the course of the program.

Demonstration of compliance by the program should communicate how the program's number of personnel are sufficient to advance the learners and meet the programmatic outcomes. To do this effectively, programs should first review their framework and overall goals and then map personnel responsibilities to their framework. Programmatic outcomes data should inform whether the number of personnel are sufficient to meet the goals. An analysis of effective clinical instruction data can be used to help guide your narrative to demonstrate needs are being met with the personnel allotted if data supports. Or, if the data does not support that there are sufficient personnel, this may be an opportunity to detail program needs.

Standard 21
The core faculty experience and qualifications must include the following:

- **An earned post-baccalaureate degree**
- **Content expertise in the specialty or subspecialty area**
- **Certification and in good standing with the Board of Certification**
- **Current state credential and in good standing with the state regulatory agency in the state in which the program is housed (in states with regulation**
- **Verified NPI number with appropriate healthcare field designation**
- **Engages in scholarship**
- **Currently practicing clinically in the specialty or subspecialty area**
- **Active at local, state, regional, and/or national levels**
- **Conducts essential orientation activities**

Program core faculty must meet educational, certification, and state credential qualifications. In order to best prepare learners, program core faculty must demonstrate content expertise and current clinical practice in the specialty or subspecialty area. The intention of core faculty currently practicing clinically in the specialty/sub-specialty area is designed to allow for core faculty to play an active role in direct mentorship during patient care in the specialty/sub-specialty area. This must include engagement in scholarly activities. This can include presentation of evidence-based patient cases or journal clubs, quality improvement projects, or more formal involvement in the dissemination of new knowledge. The purpose behind engagement with evidence-based learning is to ensure better patient outcomes and development of specialty/sub-specialty knowledge.

Program core faculty must also be active at the local, state, regional and/or national levels, which helps ensure faculty are cognizant of issues facing the profession and advocacy efforts. Demonstration of these leadership activities also promotes the importance of involvement to the learners.

Finally, program core faculty must conduct activities to help learners become oriented to the site. Appropriate onboarding may include review of the mission and vision, organizational charts, policies and procedures, and chain of communication. By incorporating orientation sessions, the learner should feel more connected to the organization and comfortable contributing appropriately to the mission.

Content expertise is advanced knowledge and training in current concepts and best practices in a specialty or subspecialty area of athletic training. Content expertise is achieved through mechanisms such as advanced education, clinical practice experiences, clinical research, other forms of scholarship, and continuing education. A faculty member's role within the athletic training residency or fellowship should be directly related to the person's content expertise. Scholarly engagement may include discovery, integration, application, engagement, teaching, and learning. Clinical scholarship, which may be more typically the scholarship of integration, application, and engagement, may include organized clinical discussions, journal clubs, case study development, or conference presentations. The scholarship of discovery may offer opportunities to collaborate with affiliate faculty or institutions in the creation of new knowledge, applicable to clinical practice, specifically in the specialty or subspecialty area and the ACGME core competencies.

To demonstrate sufficient evidence for this standard, programs must show evidence of content expertise and scholarly engagement. A professional portfolio or table can be used to demonstrate how the program believes each of the core faculty are content experts actively engaged in professional and scholarly activities. There are multiple ways of meeting this standard and it will likely look different across faculty and may be variable by program as well. It is important that programs reflect on why they believe each of the core faculty are considered content experts and compile evidence that shows how their content expertise is directly related to their individual role within the program. Often, length of time in a position is thought to characterize content expertise; however, this metric lacks specificity for demonstrating expertise. If programs wish to use clinical practice experience, metrics such as patient encounters in the specialty or subspeciality area are more indicative of application of skills in the area of expertise. But, this is only one way to communicate content expertise and programs should make sure to describe all the ways in which core faculty demonstrate content expertise and should identify how the core

faculty are continuing to grow their knowledge over time to ensure delivery of the best information to the learners.

Standard 22

The core faculty has adequate protected time to assist with and advance the residency or fellowship program, with consideration given to the size and complexity of the program. Core faculty must function to:

- **Support the program director in program and curricular development**
- **Uphold the ACGME Core Competencies within clinical practice**
- **Administer and maintain an educational environment conducive to the development of the residents or fellows**
- **Mentor residents or fellows during clinical practice to expand their depth and breadth of knowledge and skills in the program's specialty or subspecialty area**
- **Provide instruction and assessment of the advanced knowledge, skills, and clinical abilities of the specialty or subspecialty area**

Programs must ensure core faculty have adequate protected time to facilitate the residency or fellowship program. Core faculty are critical to curricular design and delivery in collaboration with the program director, as well as ensuring they are modeling high quality clinical practice and mentoring learners in the clinical environment. To maximize learner success, programs should ensure all faculty have sufficient time to advance the objectives of the program and engage in these programmatic activities.

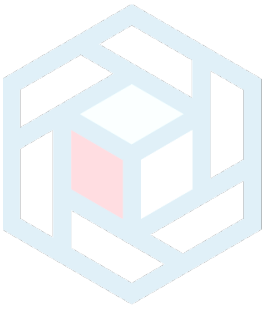
To provide sufficient evidence for this standard, programs should detail the role of each core faculty member and their workload. An accompanying narrative should provide enhanced descriptions of each core faculty member's role, relative to program administrative support, mentoring, clinical practice, instruction and assessment. The program must also outline the process for how workload is assigned across the program and how each core faculty has protected time to do the work of delivering a residency or fellowship program.

Standard 23
The affiliate faculty must have appropriate qualifications in their field in order to contribute to the development of the resident or fellow

Describe how those qualifications are related to their role in the program

Programs may choose to integrate affiliate faculty into the program. The affiliate faculty must have the appropriate qualifications in their field to contribute. Programs must be accountable for identifying and documenting the qualifications and expertise of affiliate faculty. This should, of course, include their credentials, but should also characterize their expertise relative to their role in the program. Potentially different than core faculty, affiliate faculty do not necessarily need to have content expertise in the specialty or subspecialty area. For instance, programs may identify affiliate faculty that have content expertise in the ACGME core competencies, scholarship activities, or practice leadership development, just to name a few. Programs should embrace the autonomy to identify, deploy, and evaluate affiliate faculty in ways that best serve the program.

To provide sufficient evidence for this standard, programs should verify all affiliate faculty possess appropriate qualifications. Similar to establishing content area expertise for core faculty, programs should detail and characterize the expertise of the affiliate faculty and relate that to their role in the program through narrative description and documented evidence of the affiliate faculty's expertise.



Standard 24
The program has a medical director that supports the program.

Programs must have a medical director who is a licensed allopathic or osteopathic physician, who is currently certified by an American Board of Medical Specialties or American Osteopathic Association approved specialty board. The role of the medical director must be one of active involvement and support for both the profession and the program. The involvement of a medical director should be collaborative and supportive for the program. The medical director shall collaborate with program administrators to guide the development of program goals and outcomes and to ensure current practice standards as well as benchmarks for specialization or sub-specialization are included throughout the residency or fellowship program.

To demonstrate evidence for this standard, programs will need to describe how the medical director is actively involved and supports the residency or fellowship program to ensure current practice standards for the specialty or subspecialty areas are met. Programs should detail, with examples, how the medical director is actively involved and supports the program. Programs will also need to provide the medical director's current license, and a work agreement, contract appointment letter, or memorandum of understanding outlining the relationship between the medical director and the program.

Standard 25
The program ensures the availability of adequate curricular resources for residents/fellows and program personnel.

Curricular resources are adequate to achieve the program's stated mission, goals, and expected program outcomes.

Programs must ensure there are adequate resources available to support essential programmatic components including clinical, physical, and technical resources required to meet the development, delivery, and assessment needs of the program as well the needs of the learner. When evaluating available resources, programs should consider on-site and off-site options that may exist through partnerships.

To demonstrate sufficient evidence, programs must provide a list of available resources that may include digital or physical teaching resources, access to standardized or simulated patients, open access to journals or other educational materials, library access, computer access, and access to appropriate workspaces for clinical and didactic components of the program. In addition, programs must describe how these resources are aligned with the mission and goals and are adequate to meet programmatic outcomes.

Standard 26
The number of work hours performed during the program must be in compliance with organizational and federal policy and must not exceed the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME)

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical and didactic work done from home, and all moonlighting as outlined by the ACGME.

Accurate documentation of work hours, including the breakdown for each activity allows the learner and the program to ensure appropriate working conditions are maintained and comply with ACGME duty hours rules. Documented work hours ~~documented~~ must include all clinical, didactic, and moonlighting hours that the learner completes on a weekly basis. Moonlighting activities are those activities completed by a learner, independent from the program in their capacity as an athletic trainer. All moonlighting activities must be approved by the program director. Tracking this information over a four-week period and obtaining an average is important to allow for adjustments to be made in a learner's schedule to meet individual needs while ensuring a sustained training effort that culminates in an experience that exemplifies clinical specialization or sub-specialization.

Programs must collect hours logs, in digital or physical format, to monitor learner work hours in addition to self-monitoring completed by the learner. To demonstrate sufficient evidence, a program must provide access to all hours logs with the breakdown of clinical, didactic, and moonlighting hours completed. These hours logs must demonstrate proof that a learner does not work more than 80 hours per week averaged over a four-week period. To ensure accurate documentation of work hours, program directors should educate the learner on how to appropriately document time and activities that comprise each category; clinical, didactic, and moonlighting. Additionally, programs must provide the link where learners can access the ACGME Duty Hours definitions.

Standard 27
The program must provide residents or fellows sufficient financial support to fulfill the responsibilities of the program.

Moonlighting must not interfere with the ability of the resident or fellow to achieve the goals and objectives of the program. Moonlighting time must be counted toward the 80-hour work week limitation as defined by ACGME duty hours. The intent of this Standard is for the program to show how it is protecting against the resident's or fellow's need to seek outside employment.

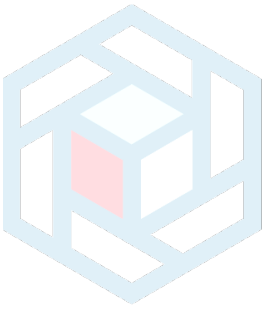
Programs must demonstrate that the salary is sufficient and that learners do not need to have additional sources of income, resulting in moonlighting, during their time in the program. Moonlighting activities are those activities completed by a learner, independent from the program in their capacity as an athletic trainer. All moonlighting activities must be approved by the program director and must be counted toward the 80-hour work week limitation as defined by ACGME duty hours. This allows the learner to focus on developing the knowledge, skills, behaviors, and attitudes, of a specialist or subspecialist through engaging in the core requirements of the program.

To demonstrate sufficient evidence, programs must submit the salary ranges or data used to determine learner financial support. This may include, but is not limited to how the financial support was determined based on cost of living in the area, housing provided, or how per diem or moonlighting opportunities are built into the program, if at all, to supplement income. This can also be benchmarked to peer programs. Programs must also provide benchmarks for all benefits, such as insurance or meal plans provided, travel reimbursement or discounts, or professional development reimbursement as compared to full time staff. The compensation package should be commensurate with full-time athletic training staff.

Standard 28
The program and its stakeholders foster civil, equitable, and professional learning environments that are free from harassment and discrimination.

Ensuring safety is important for a learner's success in a program. Civil, equitable, professional learning environments free from harassment and discrimination allow for learners to feel comfortable asking for help, admitting mistakes, raising concerns, suggesting ideas, and challenging ways of working and the ideas of others on the team, including the ideas of those in authority, without fear. Safe learning environments provide the knowledge that mistakes will be handled justly and fairly, fostering an environment of trust and respect. Additionally, fostering continued growth through equitable learning environments and knowledge sharing creates the optimal opportunity for learning.

To demonstrate sufficient evidence, programs must have a protocol or process for fostering civil, equitable, and professional behavior in the learning environment and how to handle behaviors that violate the policy. This policy may be specific to the program or written by the sponsoring organization. In addition, programs must identify sources of programmatic data that demonstrate ongoing assessment of learning environments. Examples of this data may include program stakeholder evaluations of the learning environment, learner evaluations of the learning environment, or other methods used to ensure environments are free from harassment and discrimination.



Standard 29
The program maintains appropriate resident or fellow records in secure locations. Records must include the following:

- **Admission applications and supporting documents**
- **Individualized plans**
- **Disciplinary actions/remediation**
- **Outcomes/Assessments**
- **Scholarship**
- **Acceptance of program terms**

Residency or fellowship programs maintain a variety of learner records that are used to track learner admissions, individualized plans, disciplinary actions, outcomes/assessments, scholarship, and acceptance of program terms or learning and employment. Resident or fellow records must be stored in secure locations to maintain learner privacy. This standard is written to ensure that programs adequately protect learner records by maintaining these records in a secure location and to ensure programs adhere to relevant legal and ethical standards to protect confidential information.

To demonstrate sufficient evidence for this standard, the program must maintain all learner records in a secure location. Programs must describe where all learner records maintained by the program and institution and discuss how these records are kept secure in these locations.

Standard 30
Prospective and accepted residents/fellows are provided with publicly accessible information about the program to include the following:

- **Program Policies & Procedures including grievance, family leave, withdrawal and/or termination, and academic dishonesty policies**
- **Admission requirements**
- **Employee retention requirements**
- **Program completion requirements**
- **Organizational fair practice policies including nondiscrimination policies and protection of health and safety of the resident/fellow**
- **Salary and financial responsibility (program related costs)**
- **Aggregate data for the following resident/fellow achievement measures: program completion rate, resident/fellow placement rate**
- **Mission and programmatic goals**

The program must include a hyperlink to the program's "CAATE Program Information and Outcomes" web page on the home page of the athletic training resident/fellowship program. The Program Information and Outcomes page includes aggregate data for the following achievement measures:

- *Program completion rate*
- *Resident/fellow placement rate*

Prospective and current learners must have access to accurate and current information about the program. In addition, programs must verify that all information populated for the Institutional Program and Profile page is current and accurate on eAccred. This ensures that learners have access to program requirements, expectations, and outcomes of the program so they can make informed decisions. Specifically, employment-related policies related to retention, organizational fair practice, non-discrimination, health and safety, and compensation must be made available to learners. In addition, academic policies including grievance and academic integrity policies and procedures as well as mechanisms for leave, withdrawal, and termination must be clearly communicated to learners. Finally, programmatic outcomes, including program completion, ~~retention~~, and placement rates should be publicly available and clear for prospective learners to use to inform their decisions about applying and enrolling in the residency or fellowship program.

To demonstrate sufficient evidence for this standard, programs need to have accurate and current information on the program's website as well as a functioning hyperlink to the program's CAATE Program Information and Outcomes webpage. Publicly accessible information must include the program's policy and procedures, fair practice and inclusion policies, admission requirements, employee retention requirements, program completion requirements, salary, program related costs, funding, or scholarships, if applicable. The CAATE Program Information and Outcomes web page provides learners with aggregated data for the program's completion rate, and placement rate.

Programs will need to describe in detail how prospective and current learners are informed about the program and institution requirements, expectations, policies and procedures, as well as, how and where they can access the information. Programs must detail how exactly the information is publicly accessible to current and prospective learners. Programs can provide digital copies by uploading or a hyperlink or hyperlinks to where the information is listed on the program or institution's website.

Standard 31
Program policies, procedures and practices provide for compliance with accreditation policies and procedures, including the following:

- **Maintenance of accurate information, easily accessible to the public, on the program website regarding accreditation status and current resident/fellow achievement measures**
- **Timely submission of required fees and documentation, including reports of program completion rates and resident/fellow placement rates**
- **Timely notification of expected or unexpected substantive changes with the program and of any change in organization accreditation status or legal authority to provide resident/fellow education**

Associated due dates are established by the CAATE and are available in the CAATE Policy and Procedure manual. Programs are not required to submit evidence of compliance for this standard within a self-study. Evidence of compliance is required only when programs are responding to specific inquiry from the CAATE about potential noncompliance. The nature of evidence requested will depend on the nature of the inquiry.

Prospective and current learners need to have accurate and relevant information about the program to make informed decisions. The intention of this standard is to protect learners and ensure there is access to necessary information regarding program policies, procedures and practices, including accreditation status and learner achievement measures. Access to this information helps to maintain transparency and enables informed decision making.

To maintain good standing, the program must also have a plan for continued submission of fees, documentation, and updated program data on a consistent basis so that CAATE compliance is preserved. This includes submitting annual reports in a timely manner as well as reporting changes in organization accreditation status or unexpected changes within the program.

To demonstrate sufficient evidence, a program needs to ensure that program policies, procedures, and practices, including accreditation status and learner achievement measures are accessible for future and current learners as well as the public. This can be online through either downloadable documents or hyperlinks on the program's webpage. The information should be easy to locate and updated as changes are made. The program must ensure that all links and posted information are up to date, complete, and accurate. The program must have a plan and document how required information is distributed as well as discussed with the learner to minimize confusion, increase transparency of expectations and outcomes, and provide better program and learner satisfaction.

Associated due dates are established by the CAATE and are available in the CAATE Policy and Procedure manual. Programs are not required to submit evidence for this standard within a self-study. Evidence is required only when programs are responding to specific inquiries from the CAATE. The nature of the evidence requested will depend on the nature of the inquiry.

Standard 32
Residents/fellows must demonstrate the ability to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

The program must demonstrate resident/fellow knowledge and skills in the area of Patient Care and Procedural Skills.

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in Patient Care and Procedural Skills, as described by the ACGME core competencies. Learners must demonstrate continual development of knowledge, skills, behaviors, and attitudes regarding patient care that integrates patient values, minimizes barriers to healthcare, abides by ethical and professional guidelines, and uses the best available evidence in the treatment of health problems and the promotion of health. The patient care and procedural skills competency encompasses humanistic and holistic healthcare, cultural competence, effective diagnosis and management through the use of data collection, problem-solving, complex decision-making, and care planning that results in patient independence.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to foster patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Programs must address the learner's professional interactions with patients that account for the unique characteristics, needs, and goals of patients. Programs must provide opportunities for learners to incorporate patient values and cultural beliefs and practices within care plans. This includes opportunities to engage in patient interviews and physical exams to target patient concerns, synthesize data to inform differential diagnoses and appropriately apply effective diagnostic tools or procedures. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes to effectively manage patients who may have a broad spectrum of clinical disorders within the specialty or subspecialty area. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to the compassionate, patient-centered care at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Patient Care and Procedural Skills competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, such as journal clubs, critical appraisal of relevant literature, grand rounds, reflection activities, standardized patients and simulation, and clinical experiences. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive improvement in compassionate, patient-centered care. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of patient care and procedural skills.

Standard 33
Residents/fellows must demonstrate knowledge of established and evolving biomedical, clinical epidemiological and social behavioral sciences, as well as the application of this knowledge to patient centered care.

The program must demonstrate resident/fellow knowledge and skills in the area of Medical Knowledge.

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in Medical Knowledge, as described by the ACGME core competencies. Learners must demonstrate continual development of knowledge, skills, behaviors, and attitudes regarding established and evolving biomedical, clinical, epidemiological, and social-behavioral science, as well as the application of this knowledge to patient care. The medical knowledge competency encompasses basic sciences, diagnostic testing and procedures, as well as the breadth and depth of athletic training practice.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to Programs must provide opportunities within clinical, didactic, and scholarship components for learners to demonstrate appropriate medical knowledge to care for individual patients and patient populations. This includes accurate interpretation of complex diagnostic tests, understanding rationale and risks associated with common procedures, synthesizing scientific knowledge in managing common medical conditions, and possessing knowledge to successfully incorporate basic and clinical science to diagnose and treat uncommon, ambiguous, and complex conditions. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes to effectively manage patients who may have a broad spectrum of clinical disorders within the specialty or subspecialty area. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to medical knowledge at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Medical Knowledge competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, such as journal clubs, critical appraisal of medical literature, evidence to practice reviews, grand rounds, case presentations, standardized patients and simulation, and clinical experiences. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive improvement in medical knowledge. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of medical knowledge.

Standard 34
Residents/fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate, scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The program must demonstrate resident/fellow knowledge and skills in the area of Practice-Based Learning and Improvement.

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in Practice-Based Learning and Improvement, as described by the ACGME core competencies. Learners must demonstrate the ability to self-reflect on patient care, engage in evidence-based practice, measure quality of care to improve and continuously learn. The Practice-Based Learning and Improvement competency encompasses the ability to locate, appraise and assimilate evidence, as well as the ability to monitor, audit, and improve oneself and the systems one works in.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to demonstrate evidence-based practice by analyzing and integrating evidence from scientific studies related to patient health problems. Learners should also demonstrate competency in quality improvement by using a systematic method to address an identified area of weakness as well as establish protocols for continuous review and comparison of practice procedures and outcomes to implement changes that address deficiencies in care. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes to effectively evaluate evidence and improve the quality of their care across a broad spectrum of clinical disorders within the specialty or subspecialty area. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to practice-based learning and improvement at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Practice-Based Learning and Improvement competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, such as grand rounds, case presentations, quality improvement initiatives, professional development planning, standardized patients and simulation, and incorporating formative feedback into clinical experiences. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive practice-based learning and improvement. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of practice-based learning and improvement.

Standard 35
Residents/fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with appropriate stakeholders.

Examples should include, but not limited to, the exchange of information and collaboration with patients, families, health professionals, other healthcare providers.

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in Interpersonal and Communication Skills, as described by the ACGME core competencies. Learners must demonstrate the ability to communicate effectively with patients, families, health professionals, and other healthcare providers. The Interpersonal and Communication Skills competency encompasses effective communication with patients and caregivers in both routine and challenging situations, incorporating patient-specific preference into the plan of care, and recognizing non-verbal cues and uses non-verbal communication skills in patient encounters. Programs should also provide opportunities for learners to educate the public and other stakeholders. Learners should be able to engage in collaborative communication with members of interprofessional teams and be able to appropriately mitigate conflict. Learners must also demonstrate competence in using health information technology, including accessing and maintaining health records systems, adhering to state and federal guidelines, and utilizing records as a primary means of data collection for ongoing assessment of quality care.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to demonstrate growth and competency in interpersonal skills and communication. Learners must demonstrate competency in communicating effectively with patients, families, stakeholders, and the public, as well as work in interprofessional teams. Learners must demonstrate the ability to accurately document patient care and use health records effectively. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes to effectively engage with patients and their support systems who may have a broad spectrum of clinical disorders within the specialty or subspecialty area. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to interpersonal and communication skills at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Interpersonal and Communication Skills competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, such as grand rounds, interprofessional learning and practice, standardized patients and simulation, and clinical experiences. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive improvement in communicating with patients, families, health professionals, and other healthcare providers. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of interpersonal and communication skills.

Standard 36
Residents/fellows must demonstrate a commitment to professionalism and an adherence to ethical principles.

Examples should include, but not limited to, practice plan surveys; patient satisfaction surveys; demonstrations of competence in compassion, integrity, and respect for others; responsiveness to patient needs; respect for patient privacy and autonomy; accountability to patients, society, and the profession; respect and responsiveness to diverse patient populations; ability to practice cultural proficiency, foster cultural humility and demonstrate respect in patient care; ability to recognize and develop a plan for one's own personal and professional well-being; and appropriately disclosing and addressing conflict or duality of interest

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in Professionalism, as described by the ACGME core competencies. Learners must consistently demonstrate professional and ethical behavior, including the fundamental principles of patient welfare, patient autonomy, and social justice. The Professionalism competency encompasses the process of professionalization, professional and respectful interactions with patients, caregivers, interprofessional team members, and other stakeholders, professional conduct and accountability, and integrity and ethical behavior in professional conduct.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to demonstrate professional and ethical behavior. Programs must address the learner's professional interactions with patients, caregivers, interprofessional team members, and other stakeholders. Programs must provide opportunities for learners to demonstrate professional and ethical behavior through interactions with others. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes of professionalism and ethical practice. Learners must demonstrate honest, respectful, and forthright clinical interactions, accountability for their own practice and the practice of others, a willingness to assume responsibility for their work, and advocacy for their patients as well as the profession. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to professional and ethical practice at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Professionalism competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, and specifically those learning opportunities used to meet Standards 32 through 35, ensuring integrity and ethical behavior in completing those activities. In addition, learning activities relative to scholarship, outlined in Standard 13, also offer an opportunity for learners to demonstrate ethical practices. Finally, standardized patients, simulation, and clinical experiences should offer an opportunity to learn, practice, and assess professionalism. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive improvement in professional and ethical practice. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of professionalism.

Standard 37

Residents/fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care including the social determinants of health and health literacy as well as the ability to call effectively on other resources to provide optimal health care

The program must demonstrate fellow knowledge and skills in the area of Systems-Based Practice. Fellows should analyze the impact of health literacy and social determinants of health on patient care and outcomes to determine healthcare strategies that empower patients and improve outcomes.

Programs must develop a plan to identify the specific knowledge, skills, behaviors, and attitudes that are required, as well as provide educational experiences as needed for their learners to demonstrate competency in systems-based practice, as described by the ACGME core competencies. Learners must demonstrate continual development of knowledge, skills, behaviors, and attitudes regarding complex systems and healthcare providers' roles within them. Systems-based practice encompasses quality improvement, patient safety, cost-containment and the overall cost of health care, interprofessional team-based care, advocacy for individual and community health, and health information technology to improve communication.

To demonstrate sufficient evidence, a program must ensure that systems are in place that provide learning experiences and assessment measures through didactic, clinical, and scholarship components of the program to appreciate the larger healthcare system and their role in evaluating and improving it. Programs must address the learner's ability to identify systemic causes of medical error, adhere to patient care protocols to enhance patient safety and prevent medical errors, address patient specific barriers to cost-effective care, and engage in community education and policy change to improve health of patients and communities. Programs must provide opportunities for learners to incorporate systems-based practice. In addition, programs should ensure that learners develop the knowledge, skills, behaviors, and attitudes to effectively engage, evaluate, and improve the systems in which they work. Programs must also demonstrate how performance measures are collected and appraised to ensure learner progression. Programs must evaluate learner knowledge, skills, attitudes, and performance relative to systems-based care at onset, throughout, and at the completion of the program as evidence of advanced clinical practice.

Programs will need to provide descriptions of the learning experiences, assessments, and learner benchmarks for the Systems-Based Care competency. Learning experiences must include didactic, clinical, and scholarship integration of the competency. Programs may choose to use a variety of mechanisms for learning experiences, such as quality improvement initiatives and clinical experiences. The program is encouraged to use multiple evaluators or forms of evaluation, for example, faculty, peers, patients, self, and other professional staff, as well as train evaluators for accurate assessment. Performance measures must be interwoven throughout the program. The outcomes of these assessments must be formally shared with the learners. On an individual level, programs should work with learners to use their performance data to drive systems-based improvement. Programs must also appraise aggregate data to evaluate programmatic effectiveness in delivering learning experiences in this competency area and these data and associated analyses must be shared with all associated program personnel.

To demonstrate sufficient evidence, programs should describe the learning activities, how assessment data is collected, analyzed, and integrated into the overall framework and plan for program improvement, as well as for the individual learner. Programs must also provide examples of outcomes data used to verify sufficient performance of systems-based care.

Standard 38
Residency or fellowship programs must demonstrate an increase in depth and breadth of an individual's global acquisition of knowledge and abilities in the ACGME Core Competencies.

The program must use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff). Must be interwoven across clinical, didactic, and scholarship components. Must document progressive resident or fellow performance improvement appropriate to educational level. The outcomes of these assessments must be formally shared with all associated program personnel.

The ACGME core competencies describe the specific knowledge, skills, and attitudes in the following areas: patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and system-based practice. The ACGME developed The Milestones as a means of establishing criteria to evaluate how well providers deliver healthcare across the core competency areas. In graduate medical education, The Milestones, are historically used to evaluate residents and fellows in their specialty and subspecialty practice; however, the core competencies themselves are areas of practice consistent across healthcare providers, regardless of profession or focused area of practice. Thus, the core competencies can be used to define high-quality healthcare across the continuum of learning in athletic training.

Relative to Standard 38, programs are expected to increase the depth and breadth of knowledge and abilities in the ACGME core competency areas. Programs must have learning opportunities that are specifically designed to increase learner depth and breadth of knowledge and abilities in the ACGME core competencies. Valid and reliable assessment tools should be used to measure learner development. Examples include the Standardized Patient Evaluation Tool and the Athletic Training Milestones. Programs must use multiple evaluators and must evaluate learners across the didactic, clinical, and scholarship learning experiences.

Programs will describe what tools they use to demonstrate learner progression in Standard 4. In the narrative for Standard 38, the program must describe how those tools are used to increase depth and breadth of knowledge and skills relative to the ACGME core competencies. In addition to describing how the assessment tools are used, programs must also describe how learners use formal and informal feedback pertaining to the ACGME core competencies to increase their knowledge and abilities throughout the program. Programs will have individualized plans for each learner, reflective of learner progression in the program. To demonstrate sufficient evidence, programs must describe how they use the individualized plans to guide their actions, the education, mentorship, and scholarship learning activities, to increase learner depth and breadth in the core competency areas. Lastly, programs who effectively demonstrate sufficient evidence with this standard must describe how outcomes data are used to verify an acceptable level of performance.

Standard 39
Residents or fellows must demonstrate an increase in depth and breadth of knowledge, skills, behaviors and abilities across the specialty or subspecialty area.

The program must use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff). Must be interwoven across clinical, didactic, and scholarship within the specialty or subspecialty area. Must document progressive resident or fellow performance improvement in the specialty or subspecialty area. The outcomes of these assessments must be formally shared with all associated program personnel.

The Athletic Training Milestones have established criteria to evaluate how well athletic trainers deliver healthcare in some of the specialty and subspecialty areas; specifically in orthopedics, behavioral health, pediatrics, primary care, and rehabilitation, but not yet in prevention and wellness, urgent and emergent care, and performance enhancement. These Milestones can be used to evaluate residents and fellows in their specialty and subspecialty practice.

Relative to Standard 39, programs are expected to increase the depth and breadth of knowledge, skills, behaviors, and abilities in the specialty or subspecialty area. Programs must have learning opportunities that are specifically designed to increase learner depth and breadth of knowledge, skills, behaviors, and abilities in the specialty or subspecialty area. Programs are responsible for increasing the depth and breadth of the knowledge, skills, behaviors, and abilities of the learner and the aim is of course that the learner, upon completion, is able to demonstrate expertise in the specialty or subspecialty area. But, it is also critically important that the learner demonstrates the qualities of a lifelong learner who employes the necessary tactics and strategies to continue growing their knowledge, skills, behaviors, and abilities across the lifetime of their career. Valid and reliable assessment tools should be used to measure learner development. As mentioned, the Athletic Training Milestones are an example of a valid and reliable assessment tool for measuring not just knowledge, but the practice of athletic training. In the event a valid and reliable tool is not available in the literature, programs should use evidence to guide the criteria for evaluation in the specialty or subspecialty area. Programs must use multiple evaluators and must evaluate learners across the didactic, clinical, and scholarship learning experiences.

Programs will describe what tools they use to demonstrate learner progression in Standard 4. In the narrative for Standard 39, the program must describe how those tools are used to increase depth and breadth of knowledge, skills, behaviors, and abilities in the specialty or subspecialty area. In addition to describing how the assessment tools are used, programs must also describe how learners use formal and informal feedback pertaining to the specialty or subspecialty area to increase their knowledge and abilities throughout the program. Programs will have individualized plans for each learner, reflective of learner progression in the program. To demonstrate sufficient evidence, programs must describe how they use the individualized plans to guide their actions, the education, mentorship, and scholarship learning activities, to increase learner depth and breadth in the specialty or subspecialty area. Lastly, programs who effectively demonstrate sufficient evidence with this standard must describe how outcomes data are used to verify an acceptable level of performance.

Standard 40
Residency or fellowship programs must identify curricular content to be taught within the specialty or subspecialty area through a strategic and deliberate process

A BOC practice analysis should be incorporated into the program's assessment for determining the appropriate curricular content, where one exits. If a practice analysis does not currently exist for the specialty or subspecialty area of the program, a clear process with support should occur in order to define what will be taught and how that will be linked to programmatic outcomes.

If available, a BOC practice analysis should be used to define the curricular content for a residency or fellowship program. In lieu of a practice analysis, programs are responsible for identifying the curricular content that aligns with the specialty or subspecialty area of the program. Peer programs in similar medicine or health professions, when available, may serve as a valuable resource to establish and validate curricular content. When several programs exist in a specialty or subspecialty area, programs should consider developing a consortium to establish shared curricular content standards across the focused area of practice. In addition, curricular content should be grounded in contemporary evidence of the specialty or subspecialty area. To identify curricular content, the program should evaluate the desired outcomes or expectations of a high-quality program, the role of assessment, the status of learner achievement and program content. Identification of key issues and trends within specialty and subspecialty areas allows programs to address the needs of learners and current expectations of the field. Programs must identify curricular content to be included in their program to align with their specialty or subspecialty area. This process should be strategic and thoughtful to ensure learners develop advanced practice knowledge and skills within their specialty or subspeciality area.

To demonstrate sufficient evidence for this standard, the program must describe the process and provide the resources used to determine the content for the curriculum. Programs should describe the rationale and process for how they approached choosing resources to identify the content for the program. Programs should consider using the broad BOC practice analysis as the foundational knowledge, skills, abilities, and behaviors that learners will bring with them to their residency or fellowship program from their professional preparation and/or practice experiences. Programs should then explain how they built upon the BOC practice analysis as a foundation to develop advanced practice knowledge, skills, abilities, and behaviors in the specialty or subspecialty areas for residents or fellows in the program. When available, a specialty or subspecialty practice analysis could be used to define the curricular content in the specialty or subspecialty area as well as differentiate foundational and specialty or subspecialty curricular content.