Graduate Medical Education Operations: Challenges and Causes

Key Compliance Duties and Ongoing Challenges

U.S. residency and fellowship programs face several recurrent operational tasks mandated by the Accreditation Council for Graduate Medical Education (ACGME). Chief among these are:

- Timely submission of annual program data via the Accreditation Data System (ADS)
- Conducting Annual Program Evaluations (APEs) with action plans for improvement
- Adapting to evolving educational standards, notably the transition to competency-based Milestones and participation in the Clinical Learning Environment Review (CLER) program

These requirements ensure programs continuously monitor and improve their training quality. In practice, however, many programs struggle to keep up, even though the ACGME provides extensive guidance and resources. For example, ACGME notes that programs "must meet [various] standards… [Program Directors] must also ensure the accuracy and timeliness of program record-keeping and submit data to their institutions and the ACGME," since such data directly inform accreditation decisions. Failure to comply can result in citations or special reviews; one institutional policy explicitly lists "non-compliance with administrative duties, including failure to submit ACGME-required data or complete an annual program evaluation," as grounds for corrective review.

TMS Associates supports healthcare executives by leveraging our Talent Advisory Services—including organizational design consultation, market and competitor analysis, and compensation benchmarking—to clarify governance structures, define clear workflows for ADS and APE responsibilities, and align institutional resourcing with ACGME timelines. This upfront strategic clarity ensures that data submissions and evaluations are completed on schedule, reducing citation risk and protecting Medicare's GME investments.

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Evolving standards have compounded this load. Program directors and faculty have had to implement the ACGME's competency-based framework (the six Core Competencies and associated Milestones) and the CLER program. ACGME itself observed that "Program directors and faculty members struggled since the launch of the Outcome Project to understand what the Competencies meant and, more importantly, what they should 'look like' in practice," hindering early curricular and assessment changes. The initial Milestones rollout (circa 2013) required programs to form Clinical Competency Committees and report trainee progress semi-annually. Similarly, CLER (established in 2015) mandates resident engagement in patient safety, quality improvement, and systems-level initiatives—domains that fall outside many directors' traditional roles. Especially in smaller programs, keeping pace and documenting these activities for accreditation has been challenging, creating widespread "do more" pressure on already busy faculty.

Why Physician-Led Programs Struggle with Administration

Most residency programs are led by physicians—expert clinicians and educators who often lack formal training or the bandwidth to handle complex administrative tasks. Peer-reviewed studies and surveys identify four primary drivers of operational strain:

1. Heavy Administrative Workload vs. Limited Time

   The number one barrier cited by program directors is the lack of time for compliance tasks (ADS updates, APE preparation, Milestone evaluations) on top of clinical and teaching duties. Although ACGME historically mandated protected non-clinical time (e.g., 50% FTE for residency directors), protections were reduced in 2019. A commentary in the *Journal of Graduate Medical Education* reports that by 2022, a six-fellow subspecialty program director's protected time fell from 20 hours/week to just 8 hours/week. In a 2021–22 survey, 84% of nephrology fellowship directors reported never receiving their required 20 hours per week, with a median protected time of 10 hours per week (8 hours for small programs). Over 70% indicated that they needed an additional 5 hours weekly to manage duties effectively.

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2. Insufficient Administrative Support and Training

   Many programs rely on program coordinators for day-to-day compliance. When coordinators are insufficient in number, undertrained, or lack authority, the burden shifts to physician leaders. ACGME's Outcome Project found "administrative workload and insufficient monetary support" to be principal barriers to compliance. Conversely, coordinators with formal GME training and mentorship achieve significantly better compliance outcomes—fewer delayed start/graduation dates, higher on-time reporting, and improved site-visit readiness.

3. Competing Clinical Responsibilities

   Urgent patient care and teaching duties often take precedence over administrative tasks. Without dedicated FTE for GME administration, program directors defer paperwork, risking late submissions and citations. The ACGME's move to continuous oversight (annual ADS updates) has made delays more immediately consequential.

4. Navigating New Educational Paradigms

   Implementing Milestones and CLER requires new assessment methods, faculty development, and the integration of quality and safety. The ACGME literature acknowledges that early confusion over competencies "hampered curricular changes… and development of better assessment methods," necessitating nearly two decades for refinement. Smaller programs, with limited faculty, feel this strain acutely.

5. Resource and Budget Constraints

   Despite growing requirements, GME funding seldom covers expanded administrative needs. DIOs "struggle to acquire additional budgetary support" even as work intensifies. Without funding for coordinators or data systems, compliance work often falls back on physician-educators, increasing the risk of errors and delays.

To address these gaps, TMS Associates offers Recruitment Services—ranging from rapid interim, contingent, and retained searches—for program directors, core faculty, and experienced GME administrators. By filling critical leadership and support roles

swiftly, we bolster programs' operational capacity and safeguard accreditation continuity.

Consequences of Operational Weaknesses in GME

When GME leaders struggle administratively, impacts include:

- **Accreditation Outcomes**: Continuous ACGME monitoring, including data submissions and site visits, results in citations for missed deadlines or poor metrics. Persistent non-compliance can lead to probation or the withdrawal of accreditation, resulting in program closure, resident transfers, and the loss of Medicare GME funding. Common citations include incomplete APEs and late Milestone evaluations.
- **Educational Quality and Patient Care**: Over-committed directors have less time for teaching and mentorship. Reduced faculty engagement risks reverting training to a service-only model, which could impact board pass rates and resident competency. Lapses in duty-hour monitoring can also compromise patient safety.
- **Burnout and Leadership Turnover**: A survey of internal medicine program directors found that ~33% met burnout criteria annually, and nearly 50% considered resigning within 12 months. Turnover disrupts program continuity and may itself violate accreditation standards.

TMS Associates combats these outcomes with Retention and Career Advisory—providing extended leadership coaching, performance tracking, and career development that reduce turnover risk, maintain engagement, and preserve institutional memory, which is critical for accreditation stability and the protection of GME funding.

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Mitigation Strategies and Examples of Improvement

Effective institutional strategies include:

- **Investing in Dedicated Administrative Personnel**: Empowering skilled program coordinators—often TAGME-certified—and centralizing GME offices for shared resources improves on-time reporting and site-visit readiness.
- **Ensuring Clear Reporting Structures and Collaboration**: Dual-reporting ("dotted line") arrangements link GME coordination to hospital quality/compliance offices. Cleveland Clinic's model uses regular internal audits and shared oversight to ensure adequate funding, personnel, and dedicated teaching time for accreditation success.
- **Restoring Protected Time for GME Duties**: Specialty societies have advocated for the restoration of pre-2019 protected time. Some health systems exceed ACGME minimums, appointing associate program directors to share the load and secure sufficient non-clinical hours for compliance activities.
- **Leveraging Technology and Process Improvements**: Adoption of residency management platforms (e.g., MedHub, New Innovations) automates Milestone reporting, flags missing evaluations, and issues deadline reminders. ACGME's instructional content—such as "avoiding common errors in the ADS annual update"—further streamlines data entry.
- **Cultivating a Supportive Culture**: Institutions that tie compliance metrics to faculty incentives, integrate GME leadership into promotion criteria, and involve system leadership in accreditation reviews foster collective responsibility. Addressing "lack of faculty support" and "resident resistance" through transparent communication and recognition enhances compliance efforts.

Throughout these strategies, TMS Associates' Talent Advisory Services inform staffing models and budgets via market analysis and compensation benchmarking; Recruitment Services swiftly source the right leaders and administrators; and Retention and Career Advisory ensures those individuals remain engaged and effective. Together, these services create a resilient leadership and administrative

pipeline that underpins accreditation readiness, workforce continuity, and protection of Medicare's GME investment.

Sources

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