

**ACGME Program Requirements for
Graduate Medical Education
in Geriatric Medicine**

Proposed focused revision; posted for review and comment November 16, 2020

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48
49 Geriatric medicine fellowships provide advanced education to allow fellows to
50 acquire competency in the subspecialty with sufficient expertise to act as
51 independent primary care providers and consultants.

52
53 **Int.C. Length of Educational Program**

54
55 The educational program in geriatric medicine must be 12 months in length. (Core)*
56

57 **I. Oversight**

58
59 **I.A. Sponsoring Institution**

60
61 *The Sponsoring Institution is the organization or entity that assumes the*
62 *ultimate financial and academic responsibility for a program of graduate*
63 *medical education consistent with the ACGME Institutional Requirements.*

64
65 *When the Sponsoring Institution is not a rotation site for the program, the*
66 *most commonly utilized site of clinical activity for the program is the*
67 *primary clinical site.*
68

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, a federally qualified health center, a surgery center, an academic and private single-specialty clinic, or an educational foundation.

69
70 **I.A.1. The program must be sponsored by one ACGME-accredited**
71 **Sponsoring Institution. (Core)**

72
73 **I.B. Participating Sites**

74
75 *A participating site is an organization providing educational experiences or*
76 *educational assignments/rotations for fellows.*

77
78 **I.B.1. The program, with approval of its Sponsoring Institution, must**
79 **designate a primary clinical site. (Core)**

80
81 **I.B.1.a)** A geriatric medicine fellowship must function as an integral
82 component of an Accreditation Council for Graduate Medical
83 Education (ACGME)-accredited program in internal medicine or
84 family medicine. (Core)

85
86 **I.B.1.b)** An ACGME-accredited program in at least one specialty other
87 than internal medicine or family medicine should be present at the
88 primary clinical site. This may be accomplished by affiliation with

- 89 another educational institution. ^(Core)
90
91 I.B.1.c) The sponsoring institution must ensure that there is a reporting
92 relationship with the program director of the internal medicine or
93 family medicine residency program under which the fellowship is
94 established to ensure compliance with the ACGME accreditation
95 standards. ^(Core)
96
97 **I.B.2. There must be a program letter of agreement (PLA) between the**
98 **program and each participating site that governs the relationship**
99 **between the program and the participating site providing a required**
100 **assignment.** ^(Core)
101
102 **I.B.2.a) The PLA must:**
103
104 **I.B.2.a).(1) be renewed at least every 10 years; and,** ^(Core)
105
106 **I.B.2.a).(2) be approved by the designated institutional official**
107 **(DIO).** ^(Core)
108
109 **I.B.3. The program must monitor the clinical learning and working**
110 **environment at all participating sites.** ^(Core)
111
112 **I.B.3.a) At each participating site there must be one faculty member,**
113 **designated by the program director, who is accountable for**
114 **fellow education for that site, in collaboration with the**
115 **program director.** ^(Core)
116

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for fellows**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern fellow education during the assignment**

117

118 **I.B.4.** The program director must submit any additions or deletions of
119 participating sites routinely providing an educational experience,
120 required for all fellows, of one month full time equivalent (FTE) or
121 more through the ACGME’s Accreditation Data System (ADS). ^(Core)
122

123 **I.C.** The program, in partnership with its Sponsoring Institution, must engage in
124 practices that focus on mission-driven, ongoing, systematic recruitment
125 and retention of a diverse and inclusive workforce of residents (if present),
126 fellows, faculty members, senior administrative staff members, and other
127 relevant members of its academic community. ^(Core)
128

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution’s mission and aims. The program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

129
130 **I.D. Resources**

131
132 **I.D.1.** The program, in partnership with its Sponsoring Institution, must
133 ensure the availability of adequate resources for fellow education.
134 ^(Core)

135
136 **I.D.1.a)** Space and Equipment

137
138 There must be space and equipment for the program, including
139 meeting rooms, examination rooms, computers, visual and other
140 educational aids, and work/study space. ^(Core)
141

142 **I.D.1.b)** Acute Care Hospital

143
144 **I.D.1.b).(1)** The acute care hospital central to the geriatric medicine
145 program must be an integral component of a teaching
146 center. ^(Core)
147

148 **I.D.1.b).(1).(a)** The acute care hospital must have the full range of
149 resources typically found in an acute care hospital,
150 including intensive care units, an emergency
151 medicine service, operating rooms, diagnostic
152 laboratory and imaging services, and pathology
153 services. ^{(Detail)†}
154

155 **I.D.1.c)** Long-Term Care Facilities

156
157 **I.D.1.c).(1)** One or more long-term care facilities, such as a skilled
158 nursing facility or chronic care hospital, must be affiliated
159 with the program. ^(Core)
160

161 **I.D.1.c).(2)** The total number of beds available must be sufficient to
162 permit a comprehensive educational experience. ^(Detail)

- 163
 164 I.D.1.c).(3) The long-term care facilities must be approved by the
 165 appropriate licensing and accrediting agencies of the state.
 166 (Detail)
 167
 168 I.D.1.d) Long-Term Non-Institutional Care Services
 169
 170 Non-institutional care services, such as home care, day care,
 171 residential care, transitional care, or assisted living, must be
 172 included in the program. (Core)
 173
 174 I.D.1.e) Ambulatory Care Facilities
 175
 176 One or more of the following must be included in the program:
 177 (Core)
 178
 179 I.D.1.e).(1) a nursing home that includes sub-acute and long-term
 180 care; (Core);
 181
 182 I.D.1.e).(2) a home care setting; or, (Core)
 183
 184 I.D.1.e).(3) a family medicine center, internal medicine office, or other
 185 outpatient setting. (Core)
 186
 187 I.D.1.f) Other Support Services
 188
 189 A Geriatric Medicine Consultation Program must be formally
 190 available in the ambulatory setting, the inpatient service, and/or
 191 emergency medicine service in the acute care hospital or at an
 192 ambulatory setting administered by the primary clinical site. (Core)
 193
 194 I.D.1.g) Medical Records
 195
 196 Access to an electronic health record should be provided. In the
 197 absence of an existing electronic health record, institutions must
 198 demonstrate institutional commitment to its development, and
 199 progress towards its implementation. (Core)
 200
 201 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
 202 **ensure healthy and safe learning and working environments that**
 203 **promote fellow well-being and provide for:** (Core)
 204
 205 **I.D.2.a) access to food while on duty;** (Core)
 206
 207 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
 208 **and accessible for fellows with proximity appropriate for safe**
 209 **patient care, if the fellows are assigned in-house call;** (Core)
 210

<p>Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the</p>

ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

- 211
212 I.D.2.c) clean and private facilities for lactation that have refrigeration
213 capabilities, with proximity appropriate for safe patient care;
214 (Core)
215

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

- 216
217 I.D.2.d) security and safety measures appropriate to the participating
218 site; and, (Core)
219

- 220 I.D.2.e) accommodations for fellows with disabilities consistent with
221 the Sponsoring Institution's policy. (Core)
222

- 223 I.D.3. Fellows must have ready access to subspecialty-specific and other
224 appropriate reference material in print or electronic format. This
225 must include access to electronic medical literature databases with
226 full text capabilities. (Core)
227

- 228 I.D.4. The program's educational and clinical resources must be adequate
229 to support the number of fellows appointed to the program. (Core)
230

- 231 I.D.4.a) Patient Population

- 232
233 I.D.4.a).(1) The patient population must have a variety of clinical
234 problems and stages of diseases. (Core)
235

- 236 I.D.4.a).(2) A sufficient number of patients must be available to enable
237 each fellow to achieve the required educational outcomes.
238 (Core)
239

- 240 I.D.4.a).(3) Elderly patients of each gender (at least 25 percent of
241 each gender, cumulative across settings) with a variety of
242 chronic illnesses, at least some of whom have potential for
243 rehabilitation, must be available. (Core)
244

- 245 I.E. ***A fellowship program usually occurs in the context of many learners and
246 other care providers and limited clinical resources. It should be structured
247 to optimize education for all learners present.***
248

249 I.E.1. Fellows should contribute to the education of residents in core
250 programs, if present. ^(Core)
251

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

252
253 II. Personnel

254
255 II.A. Program Director

256
257 II.A.1. There must be one faculty member appointed as program director
258 with authority and accountability for the overall program, including
259 compliance with all applicable program requirements. ^(Core)

260
261 II.A.1.a) The Sponsoring Institution's Graduate Medical Education
262 Committee (GMEC) must approve a change in program
263 director. ^(Core)

264
265 II.A.1.b) Final approval of the program director resides with the
266 Review Committee. ^(Core)
267

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the fellowship, and it is this individual's responsibility to communicate with the fellows, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

268
269 II.A.2. The program director must be provided with support adequate for
270 administration of the program based upon its size and configuration.
271 ^(Core)

272
273 II.A.2.a) At a minimum, the program director must be provided with the
274 salary support required to devote 20 percent FTE of non-clinical
275 time to the administration of the program. ^(Core)
276

Background and Intent: Twenty percent FTE is defined as one day per week.

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

The requirement does not address the source of funding required to provide the specified salary support.

277

- 278 **II.A.3. Qualifications of the program director:**
279
280 **II.A.3.a) must include subspecialty expertise and qualifications**
281 **acceptable to the Review Committee; and, (Core)**
282
283 **II.A.3.b) must include current certification in the subspecialty for**
284 **which they are the program director by the American Board**
285 **of Internal Medicine (ABIM), American Board of Family Medicine**
286 **(ABFM) or by the American Osteopathic Board of Internal**
287 **Medicine (AOBIM), American Osteopathic Board of Family**
288 **Physicians (AOBFP), or subspecialty qualifications that are**
289 **acceptable to the Review Committee. (Core)**
290
291 **II.A.3.b).(1) The Review Committee only accepts current ABIM, ABFM,**
292 **AOBIM, or AOBFP certification in geriatric medicine. (Core)**
293

294 **II.A.4. Program Director Responsibilities**
295

296 **The program director must have responsibility, authority, and**
297 **accountability for: administration and operations; teaching and**
298 **scholarly activity; fellow recruitment and selection, evaluation, and**
299 **promotion of fellows, and disciplinary action; supervision of fellows;**
300 **and fellow education in the context of patient care. (Core)**
301

302 **II.A.4.a) The program director must:**
303

304 **II.A.4.a).(1) be a role model of professionalism; (Core)**
305

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

306
307 **II.A.4.a).(2) design and conduct the program in a fashion**
308 **consistent with the needs of the community, the**
309 **mission(s) of the Sponsoring Institution, and the**
310 **mission(s) of the program; (Core)**
311

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

312

313 **II.A.4.a).(3)** administer and maintain a learning environment
314 conducive to educating the fellows in each of the
315 ACGME Competency domains; ^(Core)
316

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

317
318 **II.A.4.a).(4)** develop and oversee a process to evaluate candidates
319 prior to approval as program faculty members for
320 participation in the fellowship program education and
321 at least annually thereafter, as outlined in V.B.; ^(Core)
322

323 **II.A.4.a).(5)** have the authority to approve program faculty
324 members for participation in the fellowship program
325 education at all sites; ^(Core)
326

327 **II.A.4.a).(6)** have the authority to remove program faculty
328 members from participation in the fellowship program
329 education at all sites; ^(Core)
330

331 **II.A.4.a).(7)** have the authority to remove fellows from supervising
332 interactions and/or learning environments that do not
333 meet the standards of the program; ^(Core)
334

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

335
336 **II.A.4.a).(8)** submit accurate and complete information required
337 and requested by the DIO, GMEC, and ACGME; ^(Core)
338

339 **II.A.4.a).(9)** provide applicants who are offered an interview with
340 information related to the applicant's eligibility for the
341 relevant subspecialty board examination(s); ^(Core)
342

343 **II.A.4.a).(10)** provide a learning and working environment in which
344 fellows have the opportunity to raise concerns and
345 provide feedback in a confidential manner as
346 appropriate, without fear of intimidation or retaliation;
347 ^(Core)
348

- 349 II.A.4.a).(11) ensure the program’s compliance with the Sponsoring
 350 Institution’s policies and procedures related to
 351 grievances and due process; ^(Core)
 352
- 353 II.A.4.a).(12) ensure the program’s compliance with the Sponsoring
 354 Institution’s policies and procedures for due process
 355 when action is taken to suspend or dismiss, not to
 356 promote, or not to renew the appointment of a fellow;
 357 ^(Core)
 358

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution’s policies and procedures, and will ensure they are followed by the program’s leadership, faculty members, support personnel, and fellows.

- 359 II.A.4.a).(13) ensure the program’s compliance with the Sponsoring
 360 Institution’s policies and procedures on employment
 361 and non-discrimination; ^(Core)
 362
- 363 II.A.4.a).(13).(a) Fellows must not be required to sign a non-
 364 competition guarantee or restrictive covenant.
 365 ^(Core)
 366
- 367 II.A.4.a).(14) document verification of program completion for all
 368 graduating fellows within 30 days; ^(Core)
 369
- 370 II.A.4.a).(15) provide verification of an individual fellow’s
 371 completion upon the fellow’s request, within 30 days;
 372 and, ^(Core)
 373
 374

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

- 375 II.A.4.a).(16) obtain review and approval of the Sponsoring
 376 Institution’s DIO before submitting information or
 377 requests to the ACGME, as required in the Institutional
 378 Requirements and outlined in the ACGME Program
 379 Director’s Guide to the Common Program
 380 Requirements. ^(Core)
 381
- 382 II.B. Faculty
- 383 *Faculty members are a foundational element of graduate medical education*
 384 *– faculty members teach fellows how to care for patients. Faculty members*
 385 *provide an important bridge allowing fellows to grow and become practice*
 386 *ready, ensuring that patients receive the highest quality of care. They are*
 387 *role models for future generations of physicians by demonstrating*
 388
 389

390 *compassion, commitment to excellence in teaching and patient care,*
391 *professionalism, and a dedication to lifelong learning. Faculty members*
392 *experience the pride and joy of fostering the growth and development of*
393 *future colleagues. The care they provide is enhanced by the opportunity to*
394 *teach. By employing a scholarly approach to patient care, faculty members,*
395 *through the graduate medical education system, improve the health of the*
396 *individual and the population.*

397
398 *Faculty members ensure that patients receive the level of care expected*
399 *from a specialist in the field. They recognize and respond to the needs of*
400 *the patients, fellows, community, and institution. Faculty members provide*
401 *appropriate levels of supervision to promote patient safety. Faculty*
402 *members create an effective learning environment by acting in a*
403 *professional manner and attending to the well-being of the fellows and*
404 *themselves.*
405

Background and Intent: “Faculty” refers to the entire teaching force responsible for educating fellows. The term “faculty,” including “core faculty,” does not imply or require an academic appointment or salary support.

406
407 **II.B.1.** For each participating site, there must be a sufficient number of
408 faculty members with competence to instruct and supervise all
409 fellows at that location. ^(Core)
410

411 II.B.1.a) There must be appropriate and timely consultations from other
412 specialties. ^(Core)
413

414 **II.B.2.** Faculty members must:

415
416 **II.B.2.a)** be role models of professionalism; ^(Core)
417

418 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,
419 cost-effective, patient-centered care; ^(Core)
420

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

421
422 **II.B.2.c)** demonstrate a strong interest in the education of fellows; ^(Core)
423

424 **II.B.2.d)** devote sufficient time to the educational program to fulfill
425 their supervisory and teaching responsibilities; ^(Core)
426

427 **II.B.2.e)** administer and maintain an educational environment
428 conducive to educating fellows; and, ^(Core)
429

430 **II.B.2.f)** pursue faculty development designed to enhance their skills.
431 ^(Core)
432

433 **II.B.3. Faculty Qualifications**
434
435 **II.B.3.a) Faculty members must have appropriate qualifications in**
436 **their field and hold appropriate institutional appointments.**
437 **(Core)**
438

439 **II.B.3.b) Subspecialty physician faculty members must:**
440

441 **II.B.3.b).(1) have current certification in the subspecialty by the**
442 **American Board of Internal Medicine (ABIM), the**
443 **American Board of Family Medicine (ABFM) or the**
444 **American Osteopathic Board of Internal Medicine**
445 **(AOBIM), American Osteopathic Board of Family**
446 **Physicians (AOBFP), or possess qualifications judged**
447 **acceptable to the Review Committee. (Core)**
448

449 **II.B.3.c) Any non-physician faculty members who participate in**
450 **fellowship program education must be approved by the**
451 **program director. (Core)**
452

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

453
454 **II.B.3.d) Any other specialty physician faculty members must have**
455 **current certification in their specialty by the appropriate**
456 **American Board of Medical Specialties (ABMS) member**
457 **board or American Osteopathic Association (AOA) certifying**
458 **board, or possess qualifications judged acceptable to the**
459 **Review Committee. (Core)**
460

461 **II.B.4. Core Faculty**
462

463 **Core faculty members must have a significant role in the education**
464 **and supervision of fellows and must devote a significant portion of**
465 **their entire effort to fellow education and/or administration, and**
466 **must, as a component of their activities, teach, evaluate, and provide**
467 **formative feedback to fellows. (Core)**
468

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the subspecialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

469

470 **II.B.4.a)** **Core faculty members must be designated by the program**
471 **director.** ^(Core)

472
473 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
474 **Faculty Survey.** ^(Core)
475

476 **II.B.4.c)** In addition to the program director, there must be at least one core
477 faculty member certified in geriatric medicine by the ABIM, ABFM,
478 AOBIM, or AOBFP. ^(Core)
479

480 **II.B.4.d)** For programs with more two fellows, there must be at least one
481 core faculty member certified in geriatric medicine by the ABIM,
482 ABFM, AOBIM, or AOBFP for every 1.5 fellows. ^(Core)
483

484 **II.C. Program Coordinator**

485
486 **II.C.1. There must be administrative support for program coordination.** ^(Core)
487

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

488
489 **II.D. Other Program Personnel**
490

491 **The program, in partnership with its Sponsoring Institution, must jointly**
492 **ensure the availability of necessary personnel for the effective**
493 **administration of the program.** ^(Core)
494

495 **II.D.1.** There must be services available from other health care professionals
496 who frequently work in interprofessional teams with geriatricians, such as
497 dietitians, language interpreters, nurses, occupational therapists,
498 pharmacists, physical therapists, psychologists, social workers, and
499 speech pathologists. ^(Core)
500

Background and Intent: 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.

501
502 **III. Fellow Appointments**
503

504 **III.A. Eligibility Criteria**
505

506 **III.A.1. Eligibility Requirements – Fellowship Programs**
507

508 **All required clinical education for entry into ACGME-accredited**
509 **fellowship programs must be completed in an ACGME-accredited**
510 **residency program, an AOA-approved residency program, a**
511 **program with ACGME International (ACGME-I) Advanced Specialty**
512 **Accreditation, or a Royal College of Physicians and Surgeons of**
513 **Canada (RCPSC)-accredited or College of Family Physicians of**

514
515
516

Canada (CFPC)-accredited residency program located in Canada.
(Core)

Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).

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III.A.1.a) Fellowship programs must receive verification of each entering fellow’s level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)

III.A.1.b) Prior to appointment in the program, fellows should have completed a three-year residency program in internal medicine or family medicine that satisfies the requirements in III.A.1. (Core)

III.A.1.c) Fellow Eligibility Exception

The Review Committee for Family Medicine and Internal Medicine will allow the following exception to the fellowship eligibility requirements:

III.A.1.c).(1) An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.1.c).(1).(a) evaluation by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)

III.A.1.c).(1).(b) review and approval of the applicant’s exceptional qualifications by the GMEC; and, (Core)

III.A.1.c).(1).(c) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.1.c).(2) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United

States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

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III.B. The program director must not appoint more fellows than approved by the Review Committee. ^(Core)

III.B.1. All complement increases must be approved by the Review Committee. ^(Core)

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and subspecialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. The curriculum must contain the following educational components: ^(Core)

IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; ^(Core)

IV.A.1.a) The program's aims must be made available to program applicants, fellows, and faculty members. ^(Core)

596 **IV.A.2.** competency-based goals and objectives for each educational
597 experience designed to promote progress on a trajectory to
598 autonomous practice in their subspecialty. These must be
599 distributed, reviewed, and available to fellows and faculty members;
600 (Core)

601
602 **IV.A.3.** delineation of fellow responsibilities for patient care, progressive
603 responsibility for patient management, and graded supervision in
604 their subspecialty; (Core)
605

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

606
607 **IV.A.4.** structured educational activities beyond direct patient care; and,
608 (Core)
609

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

610
611 **IV.A.5.** advancement of fellows' knowledge of ethical principles
612 foundational to medical professionalism. (Core)
613

614 **IV.B. ACGME Competencies**
615

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

616
617 **IV.B.1.** The program must integrate the following ACGME Competencies
618 into the curriculum: (Core)
619

620 **IV.B.1.a) Professionalism**

621
622 Fellows must demonstrate a commitment to professionalism
623 and an adherence to ethical principles. (Core)
624

625 **IV.B.1.b) Patient Care and Procedural Skills**
626

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]’s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality*. *Health Affairs*. 2008; 27(3):759-769.) In addition, there should be a focus on improving the clinician’s well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

- 627
- 628 **IV.B.1.b).(1)** **Fellows must be able to provide patient care that is**
- 629 **compassionate, appropriate, and effective for the**
- 630 **treatment of health problems and the promotion of**
- 631 **health.** ^(Core)
- 632
- 633 IV.B.1.b).(1).(a) Fellows must demonstrate clinical competence in:
- 634
- 635 IV.B.1.b).(1).(a).(i) assessing the functional status of geriatric
- 636 patients; ^(Core)
- 637
- 638 IV.B.1.b).(1).(a).(ii) treating and managing geriatric patients in
- 639 acute care, long-term care, community, and
- 640 home care settings; ^(Core)
- 641
- 642 IV.B.1.b).(1).(a).(iii) assessing the cognitive status and affective
- 643 states of geriatric patients; ^(Core)
- 644
- 645 IV.B.1.b).(1).(a).(iv) providing appropriate preventive care, and
- 646 teaching patients and their caregivers
- 647 regarding self-care; ^(Core)
- 648
- 649 IV.B.1.b).(1).(a).(v) providing care that is based on the patient’s
- 650 preferences and overall health; ^(Core)
- 651
- 652 IV.B.1.b).(1).(a).(vi) assessing older persons for safety risk, and
- 653 providing appropriate recommendations,
- 654 and when appropriate, referral; ^(Core)
- 655
- 656 IV.B.1.b).(1).(a).(vii) peri-operative assessment and
- 657 management; and, ^(Core)
- 658
- 659 IV.B.1.b).(1).(a).(viii) use of an interpreter in clinical care. ^(Core)
- 660
- 661 **IV.B.1.b).(2)** **Fellows must be able to perform all medical,**
- 662 **diagnostic, and surgical procedures considered**
- 663 **essential for the area of practice.** ^(Core)
- 664
- 665 **IV.B.1.c)** **Medical Knowledge**
- 666

667		Fellows must demonstrate knowledge of established and
668		evolving biomedical, clinical, epidemiological and social-
669		behavioral sciences, as well as the application of this
670		knowledge to patient care. ^(Core)
671		
672	IV.B.1.c).(1)	Fellows must demonstrate knowledge in the following
673		content areas:
674		
675	IV.B.1.c).(1).(a)	the current science of aging and longevity,
676		including theories of aging, the physiology and
677		natural history of aging, pathologic changes with
678		aging, epidemiology of aging populations, and
679		diseases of the aged; ^(Core)
680		
681	IV.B.1.c).(1).(b)	aspects of preventive medicine, including nutrition,
682		oral health, exercise, screening, immunization, and
683		chemoprophylaxis against disease; ^(Core)
684		
685	IV.B.1.c).(1).(c)	geriatric assessment, including medical, affective,
686		cognitive, functional status, social support,
687		economic, and environmental aspects related to
688		health; activities of daily living (ADL); the
689		instrumental activities of daily living (IADL);
690		medication review and appropriate use of the
691		history; physical and mental examination; and
692		interpretation of laboratory results; ^(Core)
693		
694	IV.B.1.c).(1).(d)	the general principles of geriatric rehabilitation,
695		including those applicable to patients with
696		orthopaedic, rheumatologic, cardiac, pulmonary,
697		and neurologic impairments; ^(Core)
698		
699	IV.B.1.c).(1).(d).(i)	These principles should include those
700		related to the use of physical medicine
701		modalities, exercise, functional activities,
702		assistive devices, and, environmental
703		modification, patient and family education,
704		and psychosocial and recreational
705		counseling. ^(Core)
706		
707	IV.B.1.c).(1).(e)	management of patients in long-term care settings,
708		including palliative care, administration, regulation,
709		and financing of long-term institutions, and the
710		continuum from short- to long-term care; ^(Core)
711		
712	IV.B.1.c).(1).(f)	the pivotal role of the family in caring for the elderly,
713		and the community resources (formal support
714		systems) required to support both the patient and
715		the family; ^(Core)
716		
717	IV.B.1.c).(1).(g)	home care, including the components of a home

718		visit, and accessing appropriate community
719		resources to provide care in the home setting; ^(Core)
720		
721	IV.B.1.c).(1).(h)	hospice care, including pain management,
722		symptom relief, comfort care, and end-of-life
723		issues; ^(Core)
724		
725	IV.B.1.c).(1).(i)	behavioral sciences, including psychology and
726		social work; ^(Core)
727		
728	IV.B.1.c).(1).(j)	topics of special interest to geriatric medicine,
729		including cognitive impairment, depression and
730		related disorders, falls, incontinence, osteoporosis,
731		fractures, sensory impairment, pressure ulcers,
732		sleep disorders, pain, senior (elder) abuse,
733		malnutrition, and functional impairment; ^(Core)
734		
735	IV.B.1.c).(1).(k)	diseases that are especially prominent in the
736		elderly or that may have atypical characteristics in
737		the elderly, including neoplastic, cardiovascular,
738		neurologic, musculoskeletal, metabolic, and
739		infectious disorders; ^(Core)
740		
741	IV.B.1.c).(1).(l)	pharmacologic problems associated with aging,
742		including changes in pharmacokinetics and
743		pharmacodynamics, drug interactions, over-
744		medication, appropriate prescribing, and
745		adherence; ^(Core)
746		
747	IV.B.1.c).(1).(m)	psychosocial aspects of aging, including
748		interpersonal and family relationships, living
749		situations, adjustment disorders, depression,
750		bereavement, and anxiety; ^(Core)
751		
752	IV.B.1.c).(1).(n)	patient and family education, and psychosocial and
753		recreational counseling for patients requiring
754		rehabilitation care; ^(Core)
755		
756	IV.B.1.c).(1).(o)	the economic aspects of supporting geriatric
757		services, such as Title III of the Older Americans
758		Act, Medicare, Medicaid, Affordable Care Act
759		capitation, and cost containment; ^(Core)
760		
761	IV.B.1.c).(1).(p)	the ethical and legal issues pertinent to geriatric
762		medicine, including limitation of treatment,
763		competency, guardianship, right to refuse
764		treatment, advance directives, designation of a
765		surrogate decision maker for health care, wills, and
766		durable power of attorney for medical affairs; ^(Core)
767		
768	IV.B.1.c).(1).(q)	research methodologies related to geriatric

769 medicine, including clinical epidemiology and
 770 decision analysis; ^(Core)
 771
 772 IV.B.1.c).(1).(r) iatrogenic disorders and their prevention; ^(Core)
 773
 774 IV.B.1.c).(1).(s) cultural aspects of aging, including knowledge
 775 about demographics, health care status of older
 776 persons of diverse ethnicities, access to health
 777 care, cross-cultural assessment of culture-specific
 778 beliefs and attitudes towards health care, issues of
 779 ethnicity in long-term care, and special issues
 780 relating to urban and rural older persons of various
 781 ethnic backgrounds; ^(Core)
 782
 783 IV.B.1.c).(1).(t) behavioral aspects of illness, socioeconomic
 784 factors, and health literacy issues; and, ^(Core)
 785
 786 IV.B.1.c).(1).(u) basic principles of research, including how research
 787 is conducted, evaluated, explained to patients, and
 788 applied to patient care. ^(Core)
 789

IV.B.1.d)

Practice-based Learning and Improvement

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. ^(Core)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability 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.

The intention of this Competency is to help a fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.

797
 798 **IV.B.1.e) Interpersonal and Communication Skills**
 799
 800 **Fellows must demonstrate interpersonal and communication**
 801 **skills that result in the effective exchange of information and**
 802 **collaboration with patients, their families, and health**
 803 **professionals. ^(Core)**

IV.B.1.f)

Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. ^(Core)

- 812
813 **IV.C. Curriculum Organization and Fellow Experiences**
814
- 815 **IV.C.1. The curriculum must be structured to optimize fellow educational**
816 **experiences, the length of these experiences, and supervisory**
817 **continuity.** ^(Core)
818
- 819 IV.C.1.a) Assignment of rotations must be structured to minimize the
820 frequency of rotational transitions, and rotations must be of
821 sufficient length to provide a quality educational experience,
822 defined by continuity of patient care, ongoing supervision,
823 longitudinal relationships with faculty members, and meaningful
824 assessment and feedback. ^(Core)
825
- 826 IV.C.1.b) Clinical experiences should be structured to facilitate learning in a
827 manner that allows fellows to function as part of an effective
828 interprofessional team that works together towards the shared
829 goals of patient safety and quality improvement. ^(Core)
830
- 831 **IV.C.2. The program must provide instruction and experience in pain**
832 **management if applicable for the subspecialty, including recognition**
833 **of the signs of addiction.** ^(Core)
834
- 835 IV.C.3. All 12 months of the educational program must be devoted to clinical
836 experience. ^(Core)
837
- 838 IV.C.3.a) Each fellow must have clinical experience in the care of elderly
839 patients, which includes management of: ^(Core)
840
- 841 IV.C.3.a).(1) direct care for patients in ambulatory, community, and
842 long-term care settings, and consultative and/or direct care
843 in acute inpatient care settings; ^(Core)
844
- 845 IV.C.3.a).(2) care for persons who are generally healthy and require
846 primarily preventive health care measures; and, ^(Core)
847
- 848 IV.C.3.a).(3) care for elderly patients as a consultant providing expert
849 assessments and recommendations in the unique care
850 needs of elderly patients. ^(Core)
851
- 852 IV.C.3.b) Ambulatory Care Program
853
854 Ambulatory care must comprise a minimum of 33 percent of the
855 12-month clinical experience. ^(Detail)
856
- 857 IV.C.3.b).(1) Fellows should be responsible for at least five patient visits
858 each week, including at least one half-day per week spent
859 in a continuity of care experience. ^(Detail)
860
- 861 IV.C.3.b).(2) Fellows must provide care in a geriatric clinic or family
862 medicine center to elderly patients who may require the

863		services of multiple medical disciplines, including
864		audiology, dentistry, gynecology, neurology,
865		ophthalmology, orthopaedics, otolaryngology, physical
866		medicine and rehabilitation, psychiatry, podiatry, and
867		urology. ^(Detail)
868		
869	IV.C.3.b).(3)	Fellows must provide continuing care and coordinate the
870		implementation of recommendations from medical
871		specialties and other disciplines in their continuity clinic.
872		^(Core)
873		
874	IV.C.3.b).(4)	Fellows should have experiences in relevant ambulatory
875		specialty and subspecialty clinics, such as psychiatry and
876		neurology, and those that focus on the assessment and
877		management of geriatric syndromes, such as falls,
878		incontinence, and osteoporosis. ^(Detail)
879		
880	IV.C.3.c	Long-term Care Experience
881		
882		Each fellow must have 12 months of continuing longitudinal
883		clinical experience in the long-term care setting, and manage an
884		assigned panel of patients for whom he or she is the primary
885		provider. ^(Core)
886		
887	IV.C.3.c).(1)	Fellows must participate in patient care activities in sub-
888		acute care and rehabilitation in the long-term care setting.
889		^(Core)
890		
891	IV.C.3.c).(2)	Fellows should have clinical experience in day-care or day-
892		hospital centers, life care communities, or residential care
893		facilities. ^(Detail)
894		
895	IV.C.3.c).(3)	Each fellow's longitudinal experience must include:
896		
897	IV.C.3.c).(3).(a)	participating in home visits and hospice care,
898		including organizational and administrative aspects
899		of home health care and experience with continuity
900		of care for home or hospice care patients; and, ^(Core)
901		
902	IV.C.3.c).(3).(b)	structured didactic and clinical experiences in
903		geriatric psychiatry. ^(Core)
904		
905	IV.C.3.c).(4)	Each fellow's longitudinal experience should include:
906		
907	IV.C.3.c).(4).(a)	diagnosis and treatment of the acutely- and
908		chronically-ill and frail elderly in a less
909		technologically sophisticated environment than the
910		acute-care hospital; ^(Detail)
911		
912	IV.C.3.c).(4).(b)	working within the limits of a decreased staff-patient
913		ratio compared with acute-care hospitals; ^(Detail)

914		
915	IV.C.3.c).(4).(c)	familiarity with sub-acute care physical medicine and rehabilitation; ^(Detail)
916		
917		
918	IV.C.3.c).(4).(d)	addressing the clinical and ethical dilemmas produced by the illness of the very old; ^(Detail)
919		
920		
921	IV.C.3.c).(4).(e)	participating in the administrative aspects of long-term care; ^(Detail)
922		
923		
924	IV.C.3.c).(4).(f)	interacting and communicating with the family/caregiver; and, ^(Detail)
925		
926		
927	IV.C.3.c).(4).(g)	using palliative care and hospice in caring for the terminally ill. ^(Detail)
928		
929		
930	IV.C.4.	Additional Fellow Experiences
931		
932	IV.C.4.a)	As fellows progress through their education, they should teach other health professionals and trainees, including allied health personnel, medical students, nurses, and residents. ^(Detail)
933		
934		
935		
936	IV.C.4.b)	Fellows must participate in training using simulation. ^(Detail)
937		
938	IV.C.4.c)	Fellows must be involved in other health care and community agencies, such as delivery of health care in community-based settings. ^(Detail)
939		
940		
941		
942	IV.C.5.	Didactic Curriculum
943		
944	IV.C.5.a)	The core curriculum must include a didactic program based upon the core knowledge content in geriatric medicine. ^(Core)
945		
946		
947	IV.C.5.a).(1)	Fellows must participate in clinical case conferences, journal clubs, morbidity and mortality or quality improvement conferences, and patient safety conferences. ^(Core)
948		
949		
950		
951		
952	IV.C.5.a).(2)	All core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction. ^(Detail)
953		
954		
955		
956	IV.C.5.a).(3)	Fellows should have instruction in and experience with community resources that provide aid to their patients. ^(Detail)
957		
958		
959		
960	IV.C.5.b)	Fellows must be instructed in practice management relevant to geriatric medicine. ^(Core)
961		
962		
963	IV.D.	Scholarship
964		

965 **Medicine is both an art and a science. The physician is a humanistic**
966 **scientist who cares for patients. This requires the ability to think critically,**
967 **evaluate the literature, appropriately assimilate new knowledge, and**
968 **practice lifelong learning. The program and faculty must create an**
969 **environment that fosters the acquisition of such skills through fellow**
970 **participation in scholarly activities as defined in the subspecialty-specific**
971 **Program Requirements. Scholarly activities may include discovery,**
972 **integration, application, and teaching.**

974 **The ACGME recognizes the diversity of fellowships and anticipates that**
975 **programs prepare physicians for a variety of roles, including clinicians,**
976 **scientists, and educators. It is expected that the program's scholarship will**
977 **reflect its mission(s) and aims, and the needs of the community it serves.**
978 **For example, some programs may concentrate their scholarly activity on**
979 **quality improvement, population health, and/or teaching, while other**
980 **programs might choose to utilize more classic forms of biomedical**
981 **research as the focus for scholarship.**

982
983 **IV.D.1. Program Responsibilities**

984
985 **IV.D.1.a) The program must demonstrate evidence of scholarly**
986 **activities, consistent with its mission(s) and aims. ^(Core)**

987
988 **IV.D.2. Faculty Scholarly Activity**

989
990 **IV.D.2.a) The faculty must establish and maintain an environment of inquiry**
991 **and scholarship with an active research component. ^(Core)**

992
993 **IV.D.2.a).(1) Faculty members must regularly participate in organized**
994 **clinical discussions, rounds, journal clubs, and**
995 **conferences. ^(Detail)**

996
997 **IV.D.2.a).(2) Some members of the faculty should also demonstrate**
998 **scholarship by one or more of the following: ^(Detail)**

999
1000 **IV.D.2.a).(2).(a) peer-reviewed funding; ^(Detail)**

1001
1002 **IV.D.2.a).(2).(b) publication of original research or review articles in**
1003 **peer-reviewed journals or chapters in textbooks;**
1004 **^(Detail)**

1005
1006 **IV.D.2.a).(2).(c) publication or presentation of case reports or**
1007 **clinical series at local, regional, or national**
1008 **professional and scientific society meetings; or,**
1009 **^(Detail)**

1010
1011 **IV.D.2.a).(2).(d) participation in national committees or educational**
1012 **organizations. ^(Detail)**

1013
1014 **IV.D.3. Fellow Scholarly Activity**

1015

1016 IV.D.3.a) The program must provide an opportunity for each fellow to
1017 participate in research or other scholarly activities. ^(Detail)

1018
1019 **V. Evaluation**

1020
1021 **V.A. Fellow Evaluation**

1022
1023 **V.A.1. Feedback and Evaluation**
1024

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- fellows identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where fellows are struggling and address problems immediately

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

1025
1026 **V.A.1.a)** Faculty members must directly observe, evaluate, and
1027 frequently provide feedback on fellow performance during
1028 each rotation or similar educational assignment. ^(Core)
1029

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

1030
1031 **V.A.1.b)** Evaluation must be documented at the completion of the
1032 assignment. ^(Core)

- 1033
 1034 **V.A.1.b).(1)** **Evaluations must be completed at least every three**
 1035 **months.** (Core)
 1036
 1037 **V.A.1.c)** **The program must provide an objective performance**
 1038 **evaluation based on the Competencies and the subspecialty-**
 1039 **specific Milestones, and must:** (Core)
 1040
 1041 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
 1042 **patients, self, and other professional staff members);**
 1043 **and,** (Core)
 1044
 1045 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
 1046 **Committee for its synthesis of progressive fellow**
 1047 **performance and improvement toward unsupervised**
 1048 **practice.** (Core)
 1049

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

- 1050
 1051 **V.A.1.d)** **The program director or their designee, with input from the**
 1052 **Clinical Competency Committee, must:**
 1053
 1054 **V.A.1.d).(1)** **meet with and review with each fellow their**
 1055 **documented semi-annual evaluation of performance,**
 1056 **including progress along the subspecialty-specific**
 1057 **Milestones.** (Core)
 1058
 1059 **V.A.1.d).(2)** **develop plans for fellows failing to progress, following**
 1060 **institutional policies and procedures.** (Core)
 1061

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a

faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

- 1062
1063 **V.A.1.e)** The evaluations of a fellow's performance must be accessible
1064 for review by the fellow. ^(Core)
1065
1066 **V.A.2.** Final Evaluation
1067
1068 **V.A.2.a)** The program director must provide a final evaluation for each
1069 fellow upon completion of the program. ^(Core)
1070
1071 **V.A.2.a).(1)** The subspecialty-specific Milestones, and when
1072 applicable the subspecialty-specific Case Logs, must
1073 be used as tools to ensure fellows are able to engage
1074 in autonomous practice upon completion of the
1075 program. ^(Core)
1076
1077 **V.A.2.a).(2)** The final evaluation must:
1078
1079 **V.A.2.a).(2).(a)** become part of the fellow's permanent record
1080 maintained by the institution, and must be
1081 accessible for review by the fellow in
1082 accordance with institutional policy; ^(Core)
1083
1084 **V.A.2.a).(2).(b)** verify that the fellow has demonstrated the
1085 knowledge, skills, and behaviors necessary to
1086 enter autonomous practice; ^(Core)
1087
1088 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
1089 Competency Committee; and, ^(Core)
1090
1091 **V.A.2.a).(2).(d)** be shared with the fellow upon completion of
1092 the program. ^(Core)
1093
1094 **V.A.3.** A Clinical Competency Committee must be appointed by the
1095 program director. ^(Core)
1096
1097 **V.A.3.a)** At a minimum the Clinical Competency Committee must
1098 include three members, at least one of whom is a core faculty
1099 member. Members must be faculty members from the same
1100 program or other programs, or other health professionals
1101 who have extensive contact and experience with the
1102 program's fellows. ^(Core)
1103
1104 **V.A.3.b)** The Clinical Competency Committee must:
1105
1106 **V.A.3.b).(1)** review all fellow evaluations at least semi-annually;
1107 ^(Core)

- 1108
 1109 **V.A.3.b).(2)** determine each fellow’s progress on achievement of
 1110 the subspecialty-specific Milestones; and, ^(Core)
 1111
 1112 **V.A.3.b).(3)** meet prior to the fellows’ semi-annual evaluations and
 1113 advise the program director regarding each fellow’s
 1114 progress. ^(Core)
 1115
 1116 **V.B. Faculty Evaluation**
 1117
 1118 **V.B.1.** The program must have a process to evaluate each faculty
 1119 member’s performance as it relates to the educational program at
 1120 least annually. ^(Core)
 1121

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program’s faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

- 1122
 1123 **V.B.1.a)** This evaluation must include a review of the faculty member’s
 1124 clinical teaching abilities, engagement with the educational
 1125 program, participation in faculty development related to their
 1126 skills as an educator, clinical performance, professionalism,
 1127 and scholarly activities. ^(Core)
 1128
 1129 **V.B.1.b)** This evaluation must include written, confidential evaluations
 1130 by the fellows. ^(Core)
 1131
 1132 **V.B.2.** Faculty members must receive feedback on their evaluations at least
 1133 annually. ^(Core)
 1134

Background and Intent: The quality of the faculty’s teaching and clinical care is a determinant of the quality of the program and the quality of the fellows’ future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members’ teaching, scholarship, professionalism, and quality care.

This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

- 1135
1136 **V.C. Program Evaluation and Improvement**
1137
1138 **V.C.1. The program director must appoint the Program Evaluation**
1139 **Committee to conduct and document the Annual Program**
1140 **Evaluation as part of the program's continuous improvement**
1141 **process. (Core)**
1142
1143 **V.C.1.a) The Program Evaluation Committee must be composed of at**
1144 **least two program faculty members, at least one of whom is a**
1145 **core faculty member, and at least one fellow. (Core)**
1146
1147 **V.C.1.b) Program Evaluation Committee responsibilities must include:**
1148
1149 **V.C.1.b).(1) acting as an advisor to the program director, through**
1150 **program oversight; (Core)**
1151
1152 **V.C.1.b).(2) review of the program's self-determined goals and**
1153 **progress toward meeting them; (Core)**
1154
1155 **V.C.1.b).(3) guiding ongoing program improvement, including**
1156 **development of new goals, based upon outcomes;**
1157 **and, (Core)**
1158
1159 **V.C.1.b).(4) review of the current operating environment to identify**
1160 **strengths, challenges, opportunities, and threats as**
1161 **related to the program's mission and aims. (Core)**
1162

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

- 1163
1164 **V.C.1.c) The Program Evaluation Committee should consider the**
1165 **following elements in its assessment of the program:**
1166
1167 **V.C.1.c).(1) fellow performance; (Core)**
1168
1169 **V.C.1.c).(2) faculty development; and, (Core)**
1170
1171 **V.C.1.c).(3) progress on the previous year's action plan(s). (Core)**
1172
1173 **V.C.1.d) The Program Evaluation Committee must evaluate the**
1174 **program's mission and aims, strengths, areas for**
1175 **improvement, and threats. (Core)**
1176
1177 **V.C.1.e) The annual review, including the action plan, must:**

- 1178
 1179 V.C.1.e).(1) be distributed to and discussed with the members of
 1180 the teaching faculty and the fellows; and, (Core)
 1181
 1182 V.C.1.e).(2) be submitted to the DIO. (Core)
 1183
 1184 V.C.2. The program must participate in a Self-Study prior to its 10-Year
 1185 Accreditation Site Visit. (Core)
 1186
 1187 V.C.2.a) A summary of the Self-Study must be submitted to the DIO.
 1188 (Core)
 1189

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [Self-Study process](#), as well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

- 1190
 1191 V.C.3. *One goal of ACGME-accredited education is to educate physicians*
 1192 *who seek and achieve board certification. One measure of the*
 1193 *effectiveness of the educational program is the ultimate pass rate.*
 1194
 1195 *The program director should encourage all eligible program*
 1196 *graduates to take the certifying examination offered by the*
 1197 *applicable American Board of Medical Specialties (ABMS) member*
 1198 *board or American Osteopathic Association (AOA) certifying board.*
 1199
 1200 V.C.3.a) For subspecialties in which the ABMS member board and/or
 1201 AOA certifying board offer(s) an annual written exam, in the
 1202 preceding three years, the program’s aggregate pass rate of
 1203 those taking the examination for the first time must be higher
 1204 than the bottom fifth percentile of programs in that
 1205 subspecialty. (Outcome)‡
 1206
 1207 V.C.3.b) For subspecialties in which the ABMS member board and/or
 1208 AOA certifying board offer(s) a biennial written exam, in the
 1209 preceding six years, the program’s aggregate pass rate of
 1210 those taking the examination for the first time must be higher
 1211 than the bottom fifth percentile of programs in that
 1212 subspecialty. (Outcome)
 1213
 1214 V.C.3.c) For subspecialties in which the ABMS member board and/or
 1215 AOA certifying board offer(s) an annual oral exam, in the
 1216 preceding three years, the program’s aggregate pass rate of
 1217 those taking the examination for the first time must be higher

- 1218 than the bottom fifth percentile of programs in that
 1219 subspecialty. ^(Outcome)
 1220
 1221 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
 1222 AOA certifying board offer(s) a biennial oral exam, in the
 1223 preceding six years, the program’s aggregate pass rate of
 1224 those taking the examination for the first time must be higher
 1225 than the bottom fifth percentile of programs in that
 1226 subspecialty. ^(Outcome)
 1227
 1228 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1229 whose graduates over the time period specified in the
 1230 requirement have achieved an 80 percent pass rate will have
 1231 met this requirement, no matter the percentile rank of the
 1232 program for pass rate in that subspecialty. ^(Outcome)
 1233

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

- 1234
 1235 **V.C.3.f)** Programs must report, in ADS, board certification status
 1236 annually for the cohort of board-eligible fellows that
 1237 graduated seven years earlier. ^(Core)
 1238

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates’ performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

- 1239
 1240 **VI. The Learning and Working Environment**
 1241
 1242 *Fellowship education must occur in the context of a learning and working*
 1243 *environment that emphasizes the following principles:*
 1244

- 1245 • ***Excellence in the safety and quality of care rendered to patients by fellows***
- 1246 ***today***
- 1247
- 1248 • ***Excellence in the safety and quality of care rendered to patients by today’s***
- 1249 ***fellows in their future practice***
- 1250
- 1251 • ***Excellence in professionalism through faculty modeling of:***
- 1252
- 1253 ○ ***the effacement of self-interest in a humanistic environment that supports***
- 1254 ***the professional development of physicians***
- 1255
- 1256 ○ ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
- 1257
- 1258 • ***Commitment to the well-being of the students, residents, fellows, faculty***
- 1259 ***members, and all members of the health care team***
- 1260

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program’s accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

- 1261
- 1262 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
- 1263
- 1264 **VI.A.1. Patient Safety and Quality Improvement**
- 1265
- 1266 ***All physicians share responsibility for promoting patient safety and***
- 1267 ***enhancing quality of patient care. Graduate medical education must***
- 1268 ***prepare fellows to provide the highest level of clinical care with***
- 1269 ***continuous focus on the safety, individual needs, and humanity of***
- 1270 ***their patients. It is the right of each patient to be cared for by fellows***
- 1271 ***who are appropriately supervised; possess the requisite knowledge,***

1272 *skills, and abilities; understand the limits of their knowledge and*
1273 *experience; and seek assistance as required to provide optimal*
1274 *patient care.*

1275
1276 *Fellows must demonstrate the ability to analyze the care they*
1277 *provide, understand their roles within health care teams, and play an*
1278 *active role in system improvement processes. Graduating fellows*
1279 *will apply these skills to critique their future unsupervised practice*
1280 *and effect quality improvement measures.*

1281
1282 *It is necessary for fellows and faculty members to consistently work*
1283 *in a well-coordinated manner with other health care professionals to*
1284 *achieve organizational patient safety goals.*

1285
1286 **VI.A.1.a) Patient Safety**

1287
1288 **VI.A.1.a).(1) Culture of Safety**

1289
1290 *A culture of safety requires continuous identification*
1291 *of vulnerabilities and a willingness to transparently*
1292 *deal with them. An effective organization has formal*
1293 *mechanisms to assess the knowledge, skills, and*
1294 *attitudes of its personnel toward safety in order to*
1295 *identify areas for improvement.*

1296
1297 **VI.A.1.a).(1).(a)** The program, its faculty, residents, and fellows
1298 must actively participate in patient safety
1299 systems and contribute to a culture of safety.
1300 (Core)

1301
1302 **VI.A.1.a).(1).(b)** The program must have a structure that
1303 promotes safe, interprofessional, team-based
1304 care. (Core)

1305
1306 **VI.A.1.a).(2) Education on Patient Safety**

1307
1308 Programs must provide formal educational activities
1309 that promote patient safety-related goals, tools, and
1310 techniques. (Core)

1311

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

1312
1313 **VI.A.1.a).(3) Patient Safety Events**

1314
1315 *Reporting, investigation, and follow-up of adverse*
1316 *events, near misses, and unsafe conditions are pivotal*
1317 *mechanisms for improving patient safety, and are*
1318 *essential for the success of any patient safety*
1319 *program. Feedback and experiential learning are*
1320 *essential to developing true competence in the ability*

1321 *to identify causes and institute sustainable systems-*
1322 *based changes to ameliorate patient safety*
1323 *vulnerabilities.*

1324
1325 **VI.A.1.a).(3).(a)** Residents, fellows, faculty members, and other
1326 clinical staff members must:

1327
1328 **VI.A.1.a).(3).(a).(i)** know their responsibilities in reporting
1329 patient safety events at the clinical site;
1330 (Core)

1331
1332 **VI.A.1.a).(3).(a).(ii)** know how to report patient safety
1333 events, including near misses, at the
1334 clinical site; and, (Core)

1335
1336 **VI.A.1.a).(3).(a).(iii)** be provided with summary information
1337 of their institution's patient safety
1338 reports. (Core)

1339
1340 **VI.A.1.a).(3).(b)** Fellows must participate as team members in
1341 real and/or simulated interprofessional clinical
1342 patient safety activities, such as root cause
1343 analyses or other activities that include
1344 analysis, as well as formulation and
1345 implementation of actions. (Core)

1346
1347 **VI.A.1.a).(4)** Fellow Education and Experience in Disclosure of
1348 Adverse Events

1349
1350 *Patient-centered care requires patients, and when*
1351 *appropriate families, to be apprised of clinical*
1352 *situations that affect them, including adverse events.*
1353 *This is an important skill for faculty physicians to*
1354 *model, and for fellows to develop and apply.*

1355
1356 **VI.A.1.a).(4).(a)** All fellows must receive training in how to
1357 disclose adverse events to patients and
1358 families. (Core)

1359
1360 **VI.A.1.a).(4).(b)** Fellows should have the opportunity to
1361 participate in the disclosure of patient safety
1362 events, real or simulated. (Detail)†

1363
1364 **VI.A.1.b)** Quality Improvement

1365
1366 **VI.A.1.b).(1)** Education in Quality Improvement

1367
1368 *A cohesive model of health care includes quality-*
1369 *related goals, tools, and techniques that are necessary*
1370 *in order for health care professionals to achieve*
1371 *quality improvement goals.*

1372		
1373	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1374		
1375		
1376		
1377	VI.A.1.b).(2)	Quality Metrics
1378		
1379		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1380		
1381		
1382		
1383	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1384		
1385		
1386		
1387	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1388		
1389		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1390		
1391		
1392		
1393	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1394		
1395		
1396		
1397	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1398		
1399		
1400	VI.A.2.	Supervision and Accountability
1401		
1402	VI.A.2.a)	<i>Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.</i>
1403		
1404		
1405		
1406		
1407		
1408		
1409		
1410		
1411		<i>Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.</i>
1412		
1413		
1414		
1415		
1416		
1417	VI.A.2.a).(1)	Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. ^(Core)
1418		
1419		
1420		
1421		
1422		

- 1423
- 1424 VI.A.2.a).(1).(a) This information must be available to fellows,
1425 faculty members, other members of the health
1426 care team, and patients. ^(Core)
- 1427
- 1428 VI.A.2.a).(1).(b) Fellows and faculty members must inform each
1429 patient of their respective roles in that patient's
1430 care when providing direct patient care. ^(Core)
- 1431
- 1432 VI.A.2.b) *Supervision may be exercised through a variety of methods.
1433 For many aspects of patient care, the supervising physician
1434 may be a more advanced fellow. Other portions of care
1435 provided by the fellow can be adequately supervised by the
1436 appropriate availability of the supervising faculty member or
1437 fellow, either on site or by means of telecommunication
1438 technology. Some activities require the physical presence of
1439 the supervising faculty member. In some circumstances,
1440 supervision may include post-hoc review of fellow-delivered
1441 care with feedback.*
- 1442

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of fellow patient interactions, education and training locations, and fellow skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a fellow gains more experience, even with the same patient condition or procedure. All fellows have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

- 1443
- 1444 VI.A.2.b).(1) The program must demonstrate that the appropriate
1445 level of supervision in place for all fellows is based on
1446 each fellow's level of training and ability, as well as
1447 patient complexity and acuity. Supervision may be
1448 exercised through a variety of methods, as appropriate
1449 to the situation. ^(Core)
- 1450
- 1451 VI.A.2.b).(2) The program must define when physical presence of a
1452 supervising physician is required. ^(Core)
- 1453
- 1454 VI.A.2.c) Levels of Supervision
- 1455
- 1456 To promote appropriate fellow supervision while providing
1457 for graded authority and responsibility, the program must use
1458 the following classification of supervision: ^(Core)
- 1459
- 1460 VI.A.2.c).(1) Direct Supervision:
- 1461
- 1462 VI.A.2.c).(1).(a) the supervising physician is physically present
1463 with the fellow during the key portions of the
1464 patient interaction. ^(Core)

- 1465
1466 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not**
1467 **providing physical or concurrent visual or audio**
1468 **supervision but is immediately available to the fellow**
1469 **for guidance and is available to provide appropriate**
1470 **direct supervision.** ^(Core)
1471
- 1472 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to**
1473 **provide review of procedures/encounters with**
1474 **feedback provided after care is delivered.** ^(Core)
1475
- 1476 **VI.A.2.d)** **The privilege of progressive authority and responsibility,**
1477 **conditional independence, and a supervisory role in patient**
1478 **care delegated to each fellow must be assigned by the**
1479 **program director and faculty members.** ^(Core)
1480
- 1481 **VI.A.2.d).(1)** **The program director must evaluate each fellow’s**
1482 **abilities based on specific criteria, guided by the**
1483 **Milestones.** ^(Core)
1484
- 1485 **VI.A.2.d).(2)** **Faculty members functioning as supervising**
1486 **physicians must delegate portions of care to fellows**
1487 **based on the needs of the patient and the skills of**
1488 **each fellow.** ^(Core)
1489
- 1490 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to junior**
1491 **fellows and residents in recognition of their progress**
1492 **toward independence, based on the needs of each**
1493 **patient and the skills of the individual resident or**
1494 **fellow.** ^(Detail)
1495
- 1496 **VI.A.2.e)** **Programs must set guidelines for circumstances and events**
1497 **in which fellows must communicate with the supervising**
1498 **faculty member(s).** ^(Core)
1499
- 1500 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of**
1501 **authority, and the circumstances under which the**
1502 **fellow is permitted to act with conditional**
1503 **independence.** ^(Outcome)
1504

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

- 1505
1506 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient**
1507 **duration to assess the knowledge and skills of each fellow**
1508 **and to delegate to the fellow the appropriate level of patient**
1509 **care authority and responsibility.** ^(Core)
1510
- 1511 **VI.B. Professionalism**
1512

1513 **VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must
1514 educate fellows and faculty members concerning the professional
1515 responsibilities of physicians, including their obligation to be
1516 appropriately rested and fit to provide the care required by their
1517 patients. ^(Core)
1518

1519 **VI.B.2.** The learning objectives of the program must:

1520
1521 **VI.B.2.a)** be accomplished through an appropriate blend of supervised
1522 patient care responsibilities, clinical teaching, and didactic
1523 educational events; ^(Core)
1524

1525 **VI.B.2.b)** be accomplished without excessive reliance on fellows to
1526 fulfill non-physician obligations; and, ^(Core)
1527

Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

1528
1529 **VI.B.2.c)** ensure manageable patient care responsibilities. ^(Core)
1530

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

1531
1532 **VI.B.3.** The program director, in partnership with the Sponsoring Institution,
1533 must provide a culture of professionalism that supports patient
1534 safety and personal responsibility. ^(Core)
1535

1536 **VI.B.4.** Fellows and faculty members must demonstrate an understanding
1537 of their personal role in the:

1538
1539 **VI.B.4.a)** provision of patient- and family-centered care; ^(Outcome)
1540

1541 **VI.B.4.b)** safety and welfare of patients entrusted to their care,
1542 including the ability to report unsafe conditions and adverse
1543 events; ^(Outcome)
1544

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

1545
1546
1547

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

1548

1549 **VI.B.4.c).(1)**

management of their time before, during, and after clinical assignments; and, (Outcome)

1550

1551

1552 **VI.B.4.c).(2)**

recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

1553

1554

1555

1556 **VI.B.4.d)**

commitment to lifelong learning; (Outcome)

1557

1558 **VI.B.4.e)**

monitoring of their patient care performance improvement indicators; and, (Outcome)

1559

1560

1561 **VI.B.4.f)**

accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

1562

1563

1564 **VI.B.5.**

All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

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1570 **VI.B.6.**

Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)

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1576 **VI.B.7.**

Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

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1581 **VI.C. Well-Being**

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Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being

1586 *requires that physicians retain the joy in medicine while managing their*
1587 *own real-life stresses. Self-care and responsibility to support other*
1588 *members of the health care team are important components of*
1589 *professionalism; they are also skills that must be modeled, learned, and*
1590 *nurtured in the context of other aspects of fellowship training.*

1591
1592 *Fellows and faculty members are at risk for burnout and depression.*
1593 *Programs, in partnership with their Sponsoring Institutions, have the same*
1594 *responsibility to address well-being as other aspects of resident*
1595 *competence. Physicians and all members of the health care team share*
1596 *responsibility for the well-being of each other. For example, a culture which*
1597 *encourages covering for colleagues after an illness without the expectation*
1598 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1599 *clinical learning environment models constructive behaviors, and prepares*
1600 *fellows with the skills and attitudes needed to thrive throughout their*
1601 *careers.*

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

- 1603
1604 **VI.C.1. The responsibility of the program, in partnership with the**
1605 **Sponsoring Institution, to address well-being must include:**
1606
1607 **VI.C.1.a) efforts to enhance the meaning that each fellow finds in the**
1608 **experience of being a physician, including protecting time**
1609 **with patients, minimizing non-physician obligations,**
1610 **providing administrative support, promoting progressive**
1611 **autonomy and flexibility, and enhancing professional**
1612 **relationships; (Core)**
1613
1614 **VI.C.1.b) attention to scheduling, work intensity, and work**
1615 **compression that impacts fellow well-being; (Core)**
1616
1617 **VI.C.1.c) evaluating workplace safety data and addressing the safety of**
1618 **fellows and faculty members; (Core)**
1619

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that

monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

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VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; and, ^(Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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VI.C.1.d).(1) Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. ^(Core)

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

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VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (<http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>).

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VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another fellow, resident, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a

negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

- 1650
1651 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
1652 and, ^(Core)
1653
1654 VI.C.1.e).(3) provide access to confidential, affordable mental
1655 health assessment, counseling, and treatment,
1656 including access to urgent and emergent care 24
1657 hours a day, seven days a week. ^(Core)
1658

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

- 1659
1660 VI.C.2. There are circumstances in which fellows may be unable to attend
1661 work, including but not limited to fatigue, illness, family
1662 emergencies, and parental leave. Each program must allow an
1663 appropriate length of absence for fellows unable to perform their
1664 patient care responsibilities. ^(Core)
1665
1666 VI.C.2.a) The program must have policies and procedures in place to
1667 ensure coverage of patient care. ^(Core)
1668
1669 VI.C.2.b) These policies must be implemented without fear of negative
1670 consequences for the fellow who is or was unable to provide
1671 the clinical work. ^(Core)
1672

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

- 1673
1674 VI.D. Fatigue Mitigation
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- 1676 VI.D.1. Programs must:
- 1677
- 1678 VI.D.1.a) educate all faculty members and fellows to recognize the
- 1679 signs of fatigue and sleep deprivation; ^(Core)
- 1680
- 1681 VI.D.1.b) educate all faculty members and fellows in alertness
- 1682 management and fatigue mitigation processes; and, ^(Core)
- 1683
- 1684 VI.D.1.c) encourage fellows to use fatigue mitigation processes to
- 1685 manage the potential negative effects of fatigue on patient
- 1686 care and learning. ^(Detail)
- 1687

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

- 1688
- 1689 VI.D.2. Each program must ensure continuity of patient care, consistent
- 1690 with the program's policies and procedures referenced in VI.C.2–
- 1691 VI.C.2.b), in the event that a fellow may be unable to perform their
- 1692 patient care responsibilities due to excessive fatigue. ^(Core)
- 1693
- 1694 VI.D.3. The program, in partnership with its Sponsoring Institution, must
- 1695 ensure adequate sleep facilities and safe transportation options for
- 1696 fellows who may be too fatigued to safely return home. ^(Core)
- 1697
- 1698 VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care
- 1699
- 1700 VI.E.1. Clinical Responsibilities
- 1701
- 1702 The clinical responsibilities for each fellow must be based on PGY
- 1703 level, patient safety, fellow ability, severity and complexity of patient
- 1704 illness/condition, and available support services. ^(Core)
- 1705

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential

responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

1706		
1707	VI.E.2.	Teamwork
1708		
1709		Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the subspecialty and larger health system.
1710		
1711		
1712		
1713		(Core)
1714		
1715	VI.E.2.a)	Each fellow must have experience participating as a member of a physician-directed interdisciplinary geriatric team in more than one setting. (Core)
1716		
1717		
1718		
1719	VI.E.2.a).(1)	This team must include a geriatrician, a nurse, and a social worker/case manager. (Detail)
1720		
1721		
1722	VI.E.2.a).(2)	When appropriate, this team should include representatives from disciplines such as dentistry, neurology, occupational therapy, pastoral care, pharmacy, physical medicine and rehabilitation, physical therapy, psychiatry, psychology, and speech therapy. (Detail)
1723		
1724		
1725		
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1727		
1728	VI.E.2.a).(3)	Physician assistants or nurse practitioners should be available to provide team or collaborative care of geriatric patients. (Detail)
1729		
1730		
1731		
1732	VI.E.2.a).(4)	Regular geriatric team conferences must be held as dictated by the needs of the individual patient. (Detail)
1733		
1734		
1735	VI.E.3.	Transitions of Care
1736		
1737	VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)
1738		
1739		
1740		
1741	VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)
1742		
1743		
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1745		
1746	VI.E.3.c)	Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)
1747		
1748		
1749		
1750	VI.E.3.d)	Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)
1751		
1752		
1753		

1754 VI.E.3.e) Each program must ensure continuity of patient care,
1755 consistent with the program’s policies and procedures
1756 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
1757 be unable to perform their patient care responsibilities due to
1758 excessive fatigue or illness, or family emergency. ^(Core)
1759

1760 VI.F. Clinical Experience and Education

1761
1762 *Programs, in partnership with their Sponsoring Institutions, must design*
1763 *an effective program structure that is configured to provide fellows with*
1764 *educational and clinical experience opportunities, as well as reasonable*
1765 *opportunities for rest and personal activities.*
1766

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that fellows’ duty to “clock out” on time superseded their duty to their patients.

1767
1768 VI.F.1. Maximum Hours of Clinical and Educational Work per Week

1769
1770 Clinical and educational work hours must be limited to no more than
1771 80 hours per week, averaged over a four-week period, inclusive of all
1772 in-house clinical and educational activities, clinical work done from
1773 home, and all moonlighting. ^(Core)
1774

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling

While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour

maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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- VI.F.2. Mandatory Time Free of Clinical Work and Education**
- VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)**
- VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. ^(Detail)**

1786 VI.F.2.b).(1) There may be circumstances when fellows choose to
1787 stay to care for their patients or return to the hospital
1788 with fewer than eight hours free of clinical experience
1789 and education. This must occur within the context of
1790 the 80-hour and the one-day-off-in-seven
1791 requirements. ^(Detail)
1792

Background and Intent: While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

1793
1794 VI.F.2.c) Fellows must have at least 14 hours free of clinical work and
1795 education after 24 hours of in-house call. ^(Core)
1796

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

1797
1798 VI.F.2.d) Fellows must be scheduled for a minimum of one day in
1799 seven free of clinical work and required education (when
1800 averaged over four weeks). At-home call cannot be assigned
1801 on these free days. ^(Core)
1802

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

1803
1804 VI.F.3. Maximum Clinical Work and Education Period Length

1805
1806 VI.F.3.a) Clinical and educational work periods for fellows must not
1807 exceed 24 hours of continuous scheduled clinical
1808 assignments. ^(Core)
1809

1810 VI.F.3.a).(1) Up to four hours of additional time may be used for
1811 activities related to patient safety, such as providing
1812 effective transitions of care, and/or fellow education.
1813 (Core)

1814
1815 VI.F.3.a).(1).(a) Additional patient care responsibilities must not
1816 be assigned to a fellow during this time. (Core)
1817

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

1818
1819 VI.F.4. Clinical and Educational Work Hour Exceptions

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1821 VI.F.4.a) In rare circumstances, after handing off all other
1822 responsibilities, a fellow, on their own initiative, may elect to
1823 remain or return to the clinical site in the following
1824 circumstances:

1825
1826 VI.F.4.a).(1) to continue to provide care to a single severely ill or
1827 unstable patient; (Detail)

1828
1829 VI.F.4.a).(2) humanistic attention to the needs of a patient or
1830 family; or, (Detail)

1831
1832 VI.F.4.a).(3) to attend unique educational events. (Detail)

1833
1834 VI.F.4.b) These additional hours of care or education will be counted
1835 toward the 80-hour weekly limit. (Detail)
1836

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

1837
1838 VI.F.4.c) A Review Committee may grant rotation-specific exceptions
1839 for up to 10 percent or a maximum of 88 clinical and
1840 educational work hours to individual programs based on a
1841 sound educational rationale.

1842
1843 The Review Committees will not consider requests for exceptions
1844 to the 80-hour limit to the fellows' work week.

- 1845
 1846 VI.F.4.c).(1) In preparing a request for an exception, the program
 1847 director must follow the clinical and educational work
 1848 hour exception policy from the *ACGME Manual of*
 1849 *Policies and Procedures.* (Core)
 1850
 1851 VI.F.4.c).(2) Prior to submitting the request to the Review
 1852 Committee, the program director must obtain approval
 1853 from the Sponsoring Institution's GMEC and DIO. (Core)
 1854

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all fellows should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

- 1855
 1856 VI.F.5. Moonlighting
 1857
 1858 VI.F.5.a) Moonlighting must not interfere with the ability of the fellow
 1859 to achieve the goals and objectives of the educational
 1860 program, and must not interfere with the fellow's fitness for
 1861 work nor compromise patient safety. (Core)
 1862
 1863 VI.F.5.b) Time spent by fellows in internal and external moonlighting
 1864 (as defined in the ACGME Glossary of Terms) must be
 1865 counted toward the 80-hour maximum weekly limit. (Core)
 1866

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at <http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>).

- 1867
 1868 VI.F.6. In-House Night Float
 1869
 1870 Night float must occur within the context of the 80-hour and one-
 1871 day-off-in-seven requirements. (Core)
 1872

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

- 1873
 1874 VI.F.7. Maximum In-House On-Call Frequency
 1875
 1876 Fellows must be scheduled for in-house call no more frequently than
 1877 every third night (when averaged over a four-week period). (Core)
 1878
 1879 VI.F.7.a) Geriatric medicine fellowships must not average in-house call over
 1880 a four-week period. (Core)

1881		
1882	VI.F.8.	At-Home Call
1883		
1884	VI.F.8.a)	Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. ^(Core)
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1891	VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. ^(Core)
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1895	VI.F.8.b)	Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)
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Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

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1902 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

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1905 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

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1910 **‡Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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1914 **Osteopathic Recognition**

1915 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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