Frequently Asked Questions: Neurology
Review Committee for Neurology
(FAQs related to Neurology Program Requirements effective July 1, 2023)
ACGME

Question	Answer
Introduction	
What is the procedure for changing the format of a program, such as transitioning from a three-year to a four-year format? *[Program Requirements: Int.C.1.a)-b)]*	Requests to change a program's format must be submitted via the Accreditation Data System (ADS). This request for format alteration requires a review of the program's resident complement. In the request, program directors must provide an educational rationale. This rationale should detail the current program format, the proposed new format, and the reasons behind the requested change.
Oversight	
What are the Review Committee's expectations for adequate facilities and space for the program? *[Program Requirements: I.D.1.a); IV.D.1.b)]*	The Review Committee's expectations include the following: • Conference facilities must be available to the neurology program. • Residents and faculty members will have access to study or workspace, desks, and locked storage cabinets or lockers. • Confidential dictation space will be available. • Residents will have access to research resources, including laboratory space and equipment, computer access, and statistical consultation services. • Sharing of administrative offices, study areas, or conference facilities is acceptable as long as it does not prohibit resident teaching, service, or learning. • Although not all resources need to be directly on site, access to resources will be available at each site as necessary for patient care.

What is meant by “ready access to specialty-specific and other appropriate reference material in print or electronic format . . . [including] access to electronic medical literature databases with full text capabilities”? *[Program Requirement: I.D.3.]*	Common Program Requirement I.D.3. is parallel to ACGME Institutional Requirement II.E.2. Sponsoring Institutions are expected to provide access to medical literature that supports patient care and education in compliance with ACGME requirements. Access to medical literature cannot be solely restricted to physical locations with limited hours. Access to full-text reference materials may be provided online or in print and may be supported by processes such as interlibrary loans. The availability of a computer or mobile device with internet access alone may provide access to a wide range of relevant reference material. Many Sponsoring Institutions and programs purchase subscriptions to information resources and services to supplement open access materials. As with other programmatic resources, interpretation of the requirement may depend on unique circumstances of participating sites, programs, faculty members, and residents. Residents and faculty members may provide valuable input to Sponsoring Institutions and programs regarding the adequacy of available medical literature resources.

Question	Answer
Personnel	
What is the minimum support required for a program director and, if applicable, associate/assistant program director(s)? *[Program Requirements: II.A.2. and II.A.2.a)]*	The ACGME recognizes that dedicated time is needed to support the administration of the program, and those needs increase with the number of resident positions in the program. There must be one program director who takes overall responsibility for the management of the program. Some programs may benefit from an education leadership team that includes additional associate/assistant program directors. The program leadership team must receive full-time equivalent (FTE) support according to the table provided in Program Requirement II.A.2.a). This time encompasses all of the administrative duties of the program leadership team, including, but not limited to program compliance, resident recruitment, ensuring that residents receive proper education, monitoring of the clinical learning environment, and overall oversight. It is important to note that the Review Committee for Neurology considers approved resident complement rather than filled resident complement when assessing program director/program leadership support for administration of the program. The protected time for administration of the program may be divided among the program director and any associate/assistant program directors. It should be noted that these reflect the minimum dedicated time and support requirements. Depending on the needs of the program and experience of the program leadership, additional support may be warranted.
Is it required for a program to have an associate/assistant program director? *[Program Requirements: II.A.2., II.A.2.a), and II.B.2.-II.B.3.b).(1)]*	The program director's role must include ongoing clinical activity, and not be solely administrative. Therefore, programs requiring 1.0 or more FTE for the program leadership team according to the table in Program Requirement II.A.2.a) must have one or more associate/assistant program directors. Programs requiring less than 1.0 FTE for the program leadership team may operate under the sole oversight of a single program director as long as that individual's duties include ongoing clinical activity. Associate/assistant program directors must have current certification in the specialty from the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Board of Neurology and Psychiatry (AOBNP).

Question	Answer
Do PGY-1 residents count toward the total resident complement when calculating the minimum support required for the program director/program leadership team? *[Program Requirements: II.A.2. and II.A.2.a)]*	Some neurology residencies are accredited for four years, and the neurology program director provides primary administrative oversight for the entire residency experience, including the PGY-1 year. In those programs, the PGY-1 residents count toward the total resident complement when calculating the minimum support required for the neurology program leadership team. Other neurology residencies are accredited for three years. Residents matriculating at these programs complete their PGY-1 under the primary administrative oversight of a distinct accredited program, either at the same or different institution. These PGY-1 residents do not count toward the resident complement when calculating the minimum support for the neurology program leadership team. The minimum program leadership FTE is based on the total approved resident positions listed in ADS, not on the total filled resident positions.
Is a physician with ABPN certification in neurology with special qualification in child neurology qualified to be a neurology program director? *[Program Requirement: II.A.3.b)]*	Yes, a physician with ABPN certification in neurology with special qualification in child neurology is qualified to be a neurology program director.
Where must the program director have a staff appointment if the Sponsoring Institution is not a clinical site? *[Program Requirement: II.A.3.d)]*	If the Sponsoring Institution is a non-clinical site, such as a medical school, the program director must have a staff appointment at the primary clinical site.
If a program does not have faculty members with expertise in particular disciplines, how should it ensure its residents have exposure to all of the areas listed in the Program Requirements? *[Program Requirement: II.B.1.b)]*	Resident exposure to all the disciplines identified in the Program Requirements may occur through several methods. Residents may learn from a general neurologist who sees a high volume of patients with a particular problem, even if that faculty member is not formally listed as an expert in this area. Residents may also work with multi-disciplinary specialists or rotate to other clinical sites to obtain exposure to all required disciplines.

What is considered regular participation by faculty members in organized clinical discussions, rounds, journal clubs, and conferences? *[Program Requirement: II.B.2.e)]*	Formal didactic educational activities should include experienced faculty members who provide commentary and clinical insights to augment the information being presented in organized clinical discussions, rounds, journal clubs, and conferences. All faculty members do not need to participate in all didactic activities. However, it is inappropriate for residents to consistently lead organized didactic experiences without a faculty presence.
What is the minimum support required for a program coordinator? *[Program Requirement: II.C.2.a)]*	The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. The minimum program coordinator FTE is based on the total approved resident positions listed in ADS, not on the total filled resident positions.
Resident Appointments	
Question	**Answer**
Assuming eight months of the PGY-1 are completed in non-neurologic disciplines (primarily internal medicine), how flexible can the remaining four months of the PGY-1 be in terms of educational experiences? *[Program Requirements: III.A.2.b).(1)-III.A.2.b).(2).(a) and IV.C.4.a)-IV.C.4.b)]*	The remaining four months of educational experiences may be arranged at the discretion of program leadership.
Can some of the internal medicine rotations during the PGY-1 be on internal medicine specialty or subspecialty consult services? *[Program Requirements: III.A.2.b).(1)-(2) and IV.C.4.a)-IV.C.4.b)]*	Yes, some of the rotations during the PGY-1 can be on internal medicine specialty or subspecialty consult services. The PGY-1 must also include rotations in internal medicine with primary responsibility in patient care.

Question	Answer
When should a program request a temporary increase in resident complement versus a permanent increase in resident complement? *[Program Requirement: III.B.]*	The Review Committee for Neurology defines temporary and permanent complement increases as follows: **Temporary Complement Increases** Temporary complement increases are intended to address only a few extenuating circumstances, usually involving a current resident needing to extend education and training. The circumstances could be due to resident performance concerns (e.g., resident needing remediation before graduating) or excessive time away from the program (e.g., extended medical leave during residency) that impact the achievement of competence. Temporary increases must not be multi-year requests or submitted with intent to annually renew. Temporary increases are intended to extend education and training for current residents who need to finish the program off cycle. *Temporary complement increases for a period of 90 days or less do not require a request for approval.* Requests for greater than 90 days require Committee review. Under special circumstances (e.g., a program's participation in the ACGME's Advancing Innovation in Residency Education (AIRE) program or similar initiatives), temporary increases will be reviewed and considered by the Review Committee on a case-by-case basis. **Permanent Complement Increases** Permanent complement increases should be requested when the program desires to expand the total resident complement in an ongoing manner to a total higher than currently approved (as published on the ACGME's ADS public site). A permanent increase should be requested even if the position will be filled temporarily (i.e., funding is available temporarily). The position need not be filled each year. This type of request should occur only after the program director carefully weighs the educational impact of adding residents to the currently approved complement and obtains institutional support for the proposed complement expansion. It is imperative that programs plan well in advance for permanent complement increases. Candidates must not be matched into a program before such a request is approved by the Review Committee. Per ACGME Policies and Procedures, programs with statuses of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation with Warning, or Probationary Accreditation may not request a permanent increase in resident complement.

Question	Answer
When is a resident considered a transferring resident? *[Program Requirements: III.C. and III.C.1.]*	Residents are considered transferring residents under several conditions, including: • when moving from one program to another within the same or different Sponsoring Institution; and, • when entering as a PGY-2 in a three-year program requiring a preliminary year, even if the resident was simultaneously accepted into the preliminary PGY-1 program and the neurology program as part of the Match (i.e., accepted to both programs right out of medical school). Before accepting a transferring resident, the "receiving" program director must obtain written or electronic verification of prior educational experiences and performance from the program from which the resident is transferring. Documentation includes evaluations, rotations completed, procedural experience, and a summative competency-based performance evaluation. While a Milestones evaluation cannot be used in the decision to accept a transferring resident, a Milestones evaluation must be obtained upon matriculation. The term "transfer resident" and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and is then accepted into a subsequent residency or fellowship program.
Is it permissible for a program to accept a transfer resident prior to receiving the required documentation? *[Program Requirements: III.C. and III.C.1.]*	No, a program director must not accept a transfer resident without receiving verification of the resident's previous educational experiences and performance. A request for this documentation is not sufficient; the program must wait until all required documentation is received to accept the transfer.
Educational Program	
How can a program confirm that its curriculum includes all required educational components? *[Program Requirements: IV.A.-IV.C.]*	Program directors can use the checklist in Appendix I at the end of this FAQ document to determine if all required curricular components are included as part of the educational program.

Is it mandatory that a program have a primary inpatient neurology service and separate neurology consultation service? *[Program Requirement: IV.C.3.a)]*	Yes, every program must include rotations in which residents have primary patient care responsibilities, including admitting and discharging patients, and writing orders. A consultative service in neurology where residents provide guidance to other primary services would not be sufficient.
In the context of a 48-month program format, where the first year consists of 13 four-week blocks, would eight of these four-week blocks satisfy the requirement for a broad clinical experience in internal medicine? *Program Requirements: IV.C.4.-IV.C.4.b)]*	A single four-week block can be considered equivalent to a one-month rotation. Therefore, a minimum of eight four-week blocks would fulfill the requirement for a broad clinical experience in internal medicine.
In programs offering the 48-month format, is neurology continuity clinic required during the first year of the program? *[Program Requirements: IV.C.4. and IV.C.6.a).(2).(a)]*	No, neurology continuity clinic is not required during the first year of the program (PGY-1), which focuses on a broad clinical experience in internal medicine. If there is a neurology continuity clinic during the PGY-1, it does not count toward the residents' required continuity clinic experience during the PGY-2-4.
How much time must a resident spend in the continuity clinic if the resident cannot participate due to a rotation such as neurocritical care? *[Program Requirements: IV.C.6.a).(2).(a)-(b)]*	The spirit of the continuity clinic is that of an organized, longitudinal, and supervised clinical experience in which one's clinic patient panel is followed over a long period of time. A program may organize its continuity clinic in either the traditional weekly clinic over the duration of the program or in blocks (X + Y continuity clinic model). An outpatient clinic where the same patients cannot be followed over a long period of time will not fulfill the requirement. Scheduling of continuity clinics may be deferred during a busy inpatient month in which inpatient continuity of care is paramount (e.g., neurocritical care or night float rotations). The longitudinal/continuity clinic must occur no less frequently than every sixth week (i.e., it must not be interrupted by more than five weeks). Any time that a resident is on medical, parental, or caregiver leave does not count toward the time allowed between continuity clinics.

	Although there may be a few gaps based on rotations such as ICU or night float, the same total number of continuity clinics (40 per year minimum) must be seen with the same patient panel in the same academic year. If weekly continuity clinics are occasionally deferred in the manner described above, then the program director must provide evidence at the time of the site visit that each resident has completed at least 40 continuity clinics per year for each of the three years during PGY-2-4.
Can continuity clinics be scheduled by clustering them into blocks of time, separate from inpatient rotations, rather than scheduling them weekly (i.e., can an X + Y continuity clinic model be employed)? *[Program Requirements: IV.C.6.a).(2).(a)-(b)]*	Continuity clinics may be scheduled separately from inpatient rotations as an alternative to weekly clinics, as long as: 1) the clinics adhere to the spirit of a longitudinal experience of patient care over the 36 months of residency, with residents seeing their own patients over time, rather than simply seeing outpatients; 2) there are at least 40 total continuity clinics per year; and 3) continuity clinic occurs no less frequently than every sixth week. A change to the weekly format of continuity clinics should be noted in the Major Changes section in the program's ADS profile, and evidence of this continuity clinic must be provided to the Accreditation Field Representatives during an accreditation site visit and/or to the Review Committee when requested.
If a resident requires leave in an academic year, can the number of required continuity clinics be prorated? *[Program Requirement: IV.C.6.a).(2).(a)]*	Yes, if a resident requires medical, parental, or caregiver leave in an academic year, the number of required continuity clinics can be prorated. A resident requiring leave does not need to make up continuity clinics to meet the 40 continuity clinics per year requirement.
Can a psychiatry rotation taken at another institution during the PGY-1 be credited for the psychiatry rotation required for neurology? *[Program Requirement: IV.C.6.d)]*	If the psychiatry rotation is to count, the program should have the following documentation on file: 1. Goals and objectives for the completed psychiatry rotation 2. A signed statement by the PGY-1 program director and the resident stating that the goals and objectives were accomplished 3. Evaluation(s) of the resident by immediate supervisors of the psychiatry rotation If the program can provide this documentation, the experience can be approved. If this documentation is not provided, the resident must repeat a psychiatry rotation.

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<tr><td>What types of conferences count as national professional conferences?

[Program Requirement: IV.C.11.]</td><td>Each resident must attend at least one national specialty-specific conference. Appropriate conferences may include a general neurology meeting, such as the American Academy of Neurology Annual Meeting, or a subspecialty meeting in an area in which the resident has a particular interest.</td></tr>
<tr><td>How do programs demonstrate faculty scholarly activity?

[Program Requirements: IV.D.2.a)-b).(1)]</td><td>Among their faculty scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:
Research in basic science, education, translational science, patient care, or population health
Peer-reviewed grants
Quality improvement and/or patient safety initiatives
Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
Contribution to professional committees, educational organizations, or editorial boards
Innovations in education
The program will be reviewed in aggregate. This requirement does not mean that each faculty member must have activity in three domains.

Dissemination of scholarly activity by the program must be demonstrated by the following methods: Peer-reviewed publications, faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, nonpeer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, serving as a journal reviewer, journal editorial board member, or editor.</td></tr>
<tr><td>What are examples of acceptable resident scholarly activity?

[Program Requirement: IV.D.3.a)]</td><td>Examples of resident scholarship include participation in research; publication and presentation at national and regional meetings; preparation and presentation of neurological topics at educational conferences and programs; organization and administration of educational programs; and activity related to professional leadership. Peer-review activities and quality of care programming, as well as presentations at departmental conferences, would also qualify.</td></tr>
<tr><td colspan="2">Evaluation</td></tr>
<tr><td>How can a program provide objective assessments of resident competence?</td><td>See the table below for examples.

<table><tr><th>Competency Area</th><th>Examples of Documentation</th></tr></table></td></tr>
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<tr><td>[Program Requirement: V.A.1.c)]</td><td><table>
<tr><td>Patient Care and Procedural Skills</td><td>Milestones, Objective Structured Clinical Examinations (OSCEs), mini-clinical evaluation exercise (mini-CEX), direct observation, structured case discussions, role-play or simulation, chart review, etc.</td></tr>
<tr><td>Medical Knowledge</td><td>Milestones, American Academy of Neurology’s Residency In-Service Training Exam (RITE), OSCEs, global assessment, direct observation, structured case discussions, other exams, etc.</td></tr>
<tr><td>Practice-Based Learning and Improvement</td><td>Milestones, resident portfolios, global assessment, conferences presented by residents, patient education materials developed by residents, quality performance measures, chart review, etc.</td></tr>
<tr><td>Interpersonal and Communication Skills</td><td>OSCEs, Milestones, Neurology Clinical Evaluation Exercise (NEX), global assessment, direct observation, multi-source feedback, patient surveys, role-play or simulation, etc.</td></tr>
<tr><td>Professionalism</td><td>Milestones, resident portfolios, global assessment, direct observation, multi-source feedback, patient surveys, etc.</td></tr>
<tr><td>Systems-Based Practice</td><td>Milestones, resident portfolios, global assessment, multi-source feedback, quality measures, chart review, etc.</td></tr>
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<tr><td>Who needs to evaluate residents?

[Program Requirements: V.A.1.c).(1)-V.A.1.c).(1).(a)]</td><td>Multiple evaluators should be used, including faculty members, peers, patients, self, and other professional staff members. In addition, each resident must be evaluated by a minimum of three faculty members who are ABPN- or AOBNP-certified neurologists, including at least one child neurologist. Refer to the ABPN website for information regarding required Neurology Clinical Skills Evaluation and clinical skills verification.</td></tr>
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Question	Answer
The Learning and Working Environment	
With regard to the requirement for provision of data to residents and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided? *[Program Requirement: VI.A.1.a).(3).(a)]*	Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Gainey, and National Surgical Quality Improvement Program.
Which licensed independent practitioners may contribute to residents' education? *[Program Requirements: VI.A.2.-VI.A.2.a).(1).(a)]*	Licensed practitioners include health care professionals who are licensed in the state and have appropriate credentials to provide patient care. Examples of these professionals include advanced practice providers and psychologists.
What does the Review Committee consider to be an optimal clinical workload? *[Program Requirement: VI.E.1.]*	The program director must assess the learning environment, including patient safety; complexity of patient illness/condition; available support services; and level of knowledge, skills, and abilities when determining the appropriate clinical workload for each resident.
Is there a maximum number of patients that can be cared for by a single resident, i.e., does the Review Committee mandate patient caps? *[Program Requirement: VI.E.1.a)]*	No. The Review Committee recognizes the need for flexibility in service structures across programs and does not consider it feasible to establish a universal patient cap or individual caps for all variations in service structure. The responsibility to monitor resident workload remains in the hands of the program director and should be based on patient needs, patient safety data, and the needs and abilities of individual residents. Therefore, the program director may institute patient caps.
Who should be included in the interprofessional teams? *[Program Requirement: VI.E.2.]*	Nurses, pharmacists, advanced practice providers, psychologists, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.

Must every interprofessional team include representation from every profession listed above? *[Program Requirement: VI.E.2.]*	No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case.

Appendix I

Educational Program Checklist	Yes/No
Are program aims made available to program applicants, residents, and faculty members? (IV.A.1.)	
Are goals and objectives for each educational experience competency-based? (IV.A.2.)	
Are the goals and objectives specific to each educational experience/rotation AND each educational level? (IV.A.2.)	
Is there a broad range of structured didactic activities and are residents provided with protected time to participate in core didactic activities? (IV.A.4. and IV.A.4.a))	
Are there formal educational activities that promote patient safety-related goals, tools, and techniques? (IV.A.5.)	
Are residents required to attend seminars, conferences, and journal clubs? (IV.C.8.)	
Do didactics include the full spectrum of neurological disorders across the lifespan? (IV.C.9.)	
Do residents have protected time to attend core didactic activities? (IV.A.4.a))	
Do didactics include the basic science curriculum? (IV.C.10.)	
Do residents attend at least one national professional conference? (IV.C.11.)	
Are residents clearly informed about their patient care responsibilities? (IV.A.3.)	
Are residents provided progressive responsibility for patient management? (IV.A.3.)	
Are residents provided graded supervision throughout the program? (IV.A.3.)	
Do residents demonstrate competence in the assessment and management of outpatients and inpatients with neurological disorders across the lifespan, including those who require emergency and intensive care? (IV.B.1.b).(1).(a))	
Are residents provided a combination of patient care, teaching, and research experiences? (IV.C.3.)	
Do patient care responsibilities include primary responsibility for management of inpatients with neurologic disorders? (IV.C.3.a))	
Do patient care responsibilities include outpatient experiences? (IV.C.3.a))	
Do patient care responsibilities include consultation experiences? (IV.C.3.a))	
Does the first year of the 48 months of education include either: eight months in internal medicine with primary responsibility in patient care; OR six months in internal medicine with primary responsibility in patient care, and at least two months' time in a combination of the following: one or more months in pediatrics; emergency medicine; internal medicine; or family medicine? (IV.C.4.-IV.C.4.b))	
Do residents have four months or less of neurology during the preliminary year? (IV.C.5.)	
During the last 36 months of education, do residents have a minimum of 18 FTE months of clinical adult neurology experience? (IV.C.6.a))	
Does the 18 FTE months of clinical adult neurology experience provide at least six months of inpatient adult neurology? (IV.C.6.a).(1))	

Does the 18 FTE months of clinical adult neurology experience provide at least six months of outpatient adult neurology, with at least three of those six outpatient months outside the longitudinal/continuity clinic? (IV.C.6.a).(2) and IV.C.6.a).(2).(c))	
Does the outpatient experience include a longitudinal/continuity clinic with attendance by each resident at a minimum of 40 half-day clinics a year throughout the program, not interrupted by more than five weeks? (IV.C.6.a).(2).(a)-(b))	
Do residents have at least three months of elective time? (IV.C.6.b))	
Do residents have at least three FTE months in clinical child neurology? (IV.C.6.c))	
Do residents have at least one FTE month in clinical psychiatry? (IV.C.6.d))	
Do residents have clinical teaching rounds supervised by faculty members at least five days per week? (IV.C.6.e))	
Do residents receive exposure to acute patient management in various settings such as intensive care unit or emergency department? (IV.C.6.f))	
Do residents receive experience in neuroimaging? (IV.C.7.a))	