

ACGME Program Requirements for Graduate Medical Education in Geriatric Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2006

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s and fellow’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. These programs must exist in conjunction with and be an integrated part of a family medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Their existence should not compromise the integrity of the core program.

Int.C. An educational program in geriatric medicine must be organized to provide a well-supervised experience at a level sufficient for fellows to acquire the competence of a physician with added qualifications in this field.

Int.D. The program must be 12 months in duration, all of which must include clinical experience.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. Participation by any site providing more than three months of education must be approved by the Review Committee.

I.B.4. A member of the teaching staff of each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and responsibility for the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

- II.A.2. Qualifications of the program director must include:**
- II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - II.A.2.b) current certification in the specialty by the American Board of Family Medicine or Internal Medicine, or specialty qualifications that are acceptable to the Review Committee;**
 - II.A.2.b).(1) Program directors must possess a Certificate of Added Qualification (CAQ) in Geriatric Medicine from the same Board.
 - II.A.2.c) current medical licensure and appropriate medical staff appointment; and,**
 - II.A.2.d) demonstrated experience in geriatric medicine, as well as in education and scholarly activity, and must have a career commitment to academic geriatric medicine.**
- II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:**
- II.A.3.a) prepare and submit all information required and requested by the ACGME;**
 - II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
 - II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - II.A.3.c).(1) all applications for ACGME accreditation of new programs;
 - II.A.3.c).(2) changes in fellow complement;
 - II.A.3.c).(3) major changes in program structure or length of training;
 - II.A.3.c).(4) progress reports requested by the Review Committee;
 - II.A.3.c).(5) responses to all proposed adverse actions;
 - II.A.3.c).(6) requests for increases or any change to fellow duty hours;

- II.A.3.c).(7) **voluntary withdrawals of ACGME-accredited programs;**
- II.A.3.c).(8) **requests for appeal of an adverse action; and,**
- II.A.3.c).(9) **appeal presentations to a Board of Appeal or the ACGME.**
- II.A.3.d) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
 - II.A.3.d).(1) **program citations, and/or**
 - II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.3.e) prepare a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of fellows at each level of education and for each major rotation or other program assignment;
 - II.A.3.e).(1) This statement must be distributed to fellows and members of the teaching staff and be readily available for review.
- II.A.3.f) select fellows for appointment to the program in accordance with institutional and departmental policies and procedures; and,
- II.A.3.g) supervise fellows through explicit written descriptions of supervisory lines of responsibility for the care of patients.
 - II.A.3.g).(1) Such guidelines must be communicated to all members of the program staff.
 - II.A.3.g).(2) Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
- II.B. **Faculty**
 - II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
 - II.B.2. **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**

II.B.3. The physician faculty must have current certification in the specialty by the American Board of Family Medicine, or possess qualifications acceptable to the Review Committee.

II.B.3.a) The physician faculty must also hold a CAQ in geriatric medicine.

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.5. The faculty must demonstrate sound clinical and teaching abilities, a commitment to their own continuing medical education, and participation in scholarly activities.

II.B.5.a) Although not all members of the teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity.

II.B.5.a).(1) Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

II.B.6. In addition to the program director, each program must have at least one additional key clinical faculty member with similar qualifications who devotes a substantial portion of professional time to the program.

II.B.7. For programs with more than two fellows, a ratio of one faculty member to 1.5 fellows must be maintained.

II.B.8. The program must ensure that interdisciplinary relationships occur between the geriatric fellows and faculty members in neurology, physical medicine and rehabilitation, and psychiatry.

II.B.9. Appropriate relationships should be maintained between the geriatric fellows and faculty members in audiology, dentistry, emergency medicine, general surgery, gynecology, nursing and social services, orthopaedic surgery, ophthalmology, otolaryngology, pharmacy, physical and occupational therapy, podiatry, speech therapy, and urology.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. A team or collaborative care with physician assistants or nurse practitioners is recommended.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.

- II.D.1. Fellows must have ready access to a major medical library, either at the institution where the fellows are located or through arrangement with convenient nearby institutions.
- II.D.2. Acute-Care Hospital
 - II.D.2.a) The acute-care hospital central to the geriatric medicine program must be an integral component of a teaching center.
 - II.D.2.b) The acute-care hospital must have the full range of services usually ascribed to an acute-care general hospital, including intensive care units, emergency medicine, operating rooms, diagnostic laboratory and imaging services, and a pathology department.
- II.D.3. Long-Term Care Institution(s)
 - II.D.3.a) One or more long-term care institutions, such as a skilled nursing facility or chronic care hospital, must be affiliated with the program.
 - II.D.3.b) There must be a formal affiliation agreement between each long-term care facility included in the program and the sponsoring institution, in which each institution must acknowledge its responsibility to provide high-quality care, adequate resources, and administrative support for the educational mission.
 - II.D.3.c) There must be a letter of agreement between each long-term care facility and the office of the program director that guarantees the program director appropriate authority at the long-term care institution to carry out the educational program.
 - II.D.3.d) Fellows must have exposure to sub-acute care and rehabilitation in the long-term care setting.
 - II.D.3.e) The total number of beds available must be sufficient to permit a comprehensive educational experience.
 - II.D.3.f) The long-term care institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each must be consistent with those promulgated by the Joint Commission on Accreditation of Healthcare Organizations.
- II.D.4. Long-Term Non-Institutional Care

II.D.4.a) Non-institutional care service (e.g., home care, day care, residential care, or assisted living) must be included in the program to permit fellows to learn to provide care for patients who are homebound but not institutionalized.

II.D.4.b) It is recommended that the program provide opportunities for experience in day-care or day-hospital centers, life-care communities, and residential care facilities.

II.D.5. Other Facilities, Resources, or Support Services

II.D.5.a) An accredited program in at least one relevant specialty other than internal medicine or family medicine must be present at the primary clinical site. This may be accomplished by affiliation with another educational institution for the enrichment of the educational experience.

II.D.5.b) Involvement in other health care and community agencies is suggested.

II.D.6. Patient Population

II.D.6.a) The program must provide a patient population to meet the needs of the program in the facilities in which the educational experiences take place.

II.D.6.b) Elderly patients of both sexes (at least 25% of each gender, cumulative across settings) with a variety of chronic illnesses, at least some of whom have potential for rehabilitation, must be available.

II.D.6.c) At all facilities used by the program, fellows must be given opportunities to assume meaningful patient responsibility.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

II.E.1. There must be access to an on-site library or to a collection of appropriate texts and journals in each site participating in the program.

II.E.2. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

III.A.1. Fellows should have satisfactorily completed an ACGME-accredited residency in family medicine or internal medicine, or a family medicine residency that has been accredited by either the College of Family Physicians of Canada or the American Osteopathic Association.

III.A.1.a) Candidates who have not completed an ACGME-accredited residency in the specialties listed above may participate in the program, but may not be eligible to sit for the certification examination for a CAQ in these specialties. If accepted into the program, they must be so advised in writing by the program director, with the inclusion of a statement encouraging them to contact their primary specialty Board for verification.

III.B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.1.a) The program director and teaching staff must prepare and comply with written educational goals for the program.

IV.A.1.b) All educational components of the fellowship must be related to these goals, and should be structured educational experiences for which a specific methodology and method of evaluation exist.

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.2.a) Patient Care

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- IV.A.2.a).(1) Fellows must develop clinical competence in the field of geriatrics, including:
- IV.A.2.a).(1).(a) the physiology of aging;
 - IV.A.2.a).(1).(b) the pathophysiology that commonly occurs in older persons;
 - IV.A.2.a).(1).(c) atypical presentations of illnesses;
 - IV.A.2.a).(1).(d) functional assessment;
 - IV.A.2.a).(1).(e) concepts of treatment and management in acute-care, long-term care, community, and home care settings; and,
 - IV.A.2.a).(1).(f) assessment of cognitive status and affective states.

IV.A.2.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

- IV.A.2.c).(1) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,**
- IV.A.2.c).(2) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.**

IV.A.2.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.A.2.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

IV.A.3. The program must provide the opportunity for fellows to maintain their basic primary skills during the course of the fellowship.

IV.A.4. The program must arrange for contact with a mentor for each fellow from his or her primary specialty.

IV.A.5. The program must have at least one half-day per week, averaged over each month, in a continuity of care setting caring for patients of all ages and both genders.

IV.A.6. Curriculum

IV.A.6.a) All major dimensions of the curriculum must be structured educational experiences for which written goals and objectives, a specific methodology for teaching, and a method of evaluation exist.

IV.A.6.b) A written curriculum that comprehensively describes the program, including sites, educational objectives for each component, and topics to be covered in didactic sessions, must be available to fellows and faculty.

IV.A.6.c) The curriculum must ensure the opportunity for fellows to achieve the cognitive knowledge, physical examination skills, interpersonal skills, professional attitudes, and practical experience required of a physician who specializes in the geriatric medicine.

IV.A.7. Pathology

IV.A.7.a) All deaths of patients who receive primary care by fellows should be reviewed, and autopsies should be performed whenever possible.

IV.A.7.b) Fellows must receive autopsy reports after autopsies are completed on their patients.

IV.A.8. Teaching Opportunities

As fellows progress through the program, they should have the opportunity to teach other health professionals and trainees, such as nurses, allied health personnel, medical students, and residents.

IV.A.9. Clinical Experiences

The following components must be provided in the program:

- IV.A.9.a) Fellows must provide direct care for patients in ambulatory, community, and long-term care settings, and consultative and/or direct care in acute inpatient care settings, in order to understand the interaction of natural aging and disease, as well as the techniques of assessment, therapy, and management.
- IV.A.9.b) Fellows must provide care for persons who are generally healthy and require primarily preventive health care measures.
- IV.A.9.c) Fellows must have an understanding of the behavioral aspects of illness, socioeconomic factors, health literacy issues, and ethical and legal considerations that may impinge on medical management.
- IV.A.9.d) Fellows must provide care as a consultant providing expert assessments and recommendations regarding the unique care needs of elderly patients.
- IV.A.9.e) Geriatric Medicine Consultation Program

This program must be formally available in the ambulatory setting, the inpatient service, and/or emergency medicine in the acute-care hospital or at an ambulatory setting administered by the primary teaching institution.
- IV.A.9.f) Ambulatory Care Program
 - IV.A.9.f).(1) The ambulatory care program must comprise a minimum of 33% of fellows' time, and may include home care, adult day health care, home hospice care, and outpatient geriatric rehabilitation.
 - IV.A.9.f).(2) Fellows should be responsible for at least five patients each week, and no more than the number for whom adequate teaching can be provided. This must include at least one half-day per week spent in a continuity of care experience.
 - IV.A.9.f).(2).(a) This experience must be designed to provide care, in a geriatric clinic or family medicine center, to elderly patients who may require the services of multiple medical disciplines, including audiology, dentistry, gynecology, neurology, urology,

psychiatry, ophthalmology, orthopaedic surgery, otolaryngology, physical medicine and rehabilitation, and podiatry, as well as nursing, nutrition, and social work.

- IV.A.9.f).(3) Fellows must have the opportunity to provide continuing care and to coordinate the implementation of recommendations from medical specialties and other disciplines in their continuity clinic.
- IV.A.9.f).(4) Experiences in relevant ambulatory specialty and subspecialty clinics (e.g., geriatric psychiatry and neurology) and those that focus on the assessment and management of geriatric syndromes (e.g., falls, incontinence, and osteoporosis) are strongly recommended.
- IV.A.9.g) Long-Term Care Experience
- Each fellow must have 12 months of continuing longitudinal clinical experience in the long-term care setting, and manage an assigned panel of patients as the primary provider.
- IV.A.9.g).(1) Emphasis during the longitudinal experience should focus on:
- IV.A.9.g).(1).(a) the approaches to diagnosis and treatment of the acutely- and chronically-ill and frail elderly in a less technologically-sophisticated environment than the acute-care hospital;
- IV.A.9.g).(1).(b) working within the limits of a decreased staff-patient ratio compared with acute-care hospitals;
- IV.A.9.g).(1).(c) a much greater awareness of and familiarity with sub-acute care physical medicine and rehabilitation;
- IV.A.9.g).(1).(d) the challenge of the clinical and ethical dilemmas produced by the illness of the very old;
- IV.A.9.g).(1).(e) geriatric pharmacology;
- IV.A.9.g).(1).(f) administrative aspects of long-term care;
- IV.A.9.g).(1).(g) the role of physicians as interdisciplinary team members in the care of the long-term care patient;
- IV.A.9.g).(1).(h) the importance of interaction and communication with the family/caregiver; and,

- IV.A.9.g).(1).(i) the role of palliative care and hospice with the terminally-ill.
- IV.A.9.g).(2) The program must provide experience with home visits and hospice care.
- IV.A.9.g).(2).(a) Fellows must be exposed to the organizational and administrative aspects of home health care.
- IV.A.9.g).(2).(b) The program must include experience with continuity of care for home or hospice care patients.
- IV.A.9.g).(3) Additional block time to provide long-term care experience is recommended.
- IV.A.9.h) Geriatric Psychiatry
Identifiable structured didactic and clinical experiences in geriatric psychiatry must be included in the program of each fellow.
- IV.A.10. Formal Instruction
The curriculum of the program must exhibit, as a minimum, the following content and skill areas:
 - IV.A.10.a) current scientific knowledge of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged;
 - IV.A.10.b) aspects of preventive medicine, including exercise, immunization and chemoprophylaxis against disease, nutrition, oral health, and screening;
 - IV.A.10.b).(1) Instruction about and experience with community resources dedicated to these activities should be included.
 - IV.A.10.c) geriatric assessment, including affective, cognitive, economic, functional status, environmental, medical, and social support aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); medication review and the appropriate use of the history; physical and mental examination; and laboratory;
 - IV.A.10.d) appropriate interdisciplinary coordination of the actions of multiple health professionals, including physicians, nurses, social workers, dieticians, and rehabilitation experts, in the assessment and implementation of treatment;
 - IV.A.10.e) topics of special interest to geriatric medicine, including but not

- limited to cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment;
- IV.A.10.f) diseases that are especially prominent in the elderly or that have different characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders;
- IV.A.10.g) pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, and adherence;
- IV.A.10.h) psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety;
- IV.A.10.i) the economic aspects of supporting geriatric services, including Title III of the Older Americans Act, Medicare, Medicaid, capitation, and cost containment;
- IV.A.10.j) the ethical and legal issues especially pertinent to geriatric medicine, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs;
- IV.A.10.k) the general principles of geriatric rehabilitation, including those applicable to patients with orthopaedic, rheumatologic, cardiac, pulmonary, and neurologic impairments;
- IV.A.10.k).(1) These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, environmental modification, patient and family education, and psychosocial and recreational counseling.
- IV.A.10.l) management of patients in long-term care settings, including palliative care, knowledge of the administration, regulation, and financing of long-term institutions, and the continuum from short- to long-term care;
- IV.A.10.m) research methodologies related to geriatric medicine, including clinical epidemiology, decision analysis, and critical literature review;
- IV.A.10.n) peri-operative assessment and involvement in management;
- IV.A.10.o) iatrogenic disorders and their prevention;

- IV.A.10.p) communication skills with patients, families, professional colleagues, and community groups, including presenting case reports, literature searches, and research papers, when appropriate, to peers and lectures to lay audiences;
- IV.A.10.q) the pivotal role of the family in caring for the elderly and the community resources (formal support systems) required to support both patients and families;
- IV.A.10.r) cultural aspects of aging, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care, and the use of an interpreter in clinical care, as well as issues of ethnicity in long-term care, patient education, and special issues relating to urban and rural older persons of various ethnic backgrounds;
- IV.A.10.s) home care, including the components of a home visit and accessing appropriate community resources to provide care in the home setting;
- IV.A.10.t) hospice care, including pain management, symptom relief, comfort care, and end-of-life issues; and,
- IV.A.10.u) behavioral sciences such as psychology/social work.

IV.B. Fellows' Scholarly Activities

- IV.B.1. The program must provide support for fellow participation in scholarly activities, and offer guidance and technical support (e.g., research design, statistical analysis) for fellows involved in research.
- IV.B.2. Fellows must participate in journal clubs and research conferences.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) The faculty must evaluate fellow performance in a timely manner.**
- V.A.1.b) The program must:**
- V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

- V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,
- V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.
- V.A.2. **Summative Evaluation**
- The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:
- V.A.2.a) document the fellow's performance during their education, and
- V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.
- V.B. **Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.C. **Program Evaluation and Improvement**
- V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
- V.C.1.a) fellow performance, and
- V.C.1.b) faculty development
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
- V.C.3. There should also be periodic evaluation of the use of resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the

volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of fellows.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
- VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
 - VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.**
- VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
 - VI.A.5.b) provision of patient- and family-centered care;**
 - VI.A.5.c) assurance of their fitness for duty;**
 - VI.A.5.d) management of their time before, during, and after clinical assignments;**
 - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
 - VI.A.5.f) attention to lifelong learning;**

- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize 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.
- VI.B. Transitions of Care
 - VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
- VI.C. Alertness Management/Fatigue Mitigation
 - VI.C.1. The program must:
 - VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
 - VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
 - VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
 - VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.
- VI.D. Supervision of Fellows

- VI.D.1.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- VI.D.1.a)** This information should be available to fellows, faculty members, and patients.
- VI.D.1.b)** Fellows and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.
- VI.D.3.** Levels of Supervision
- VI.D.3.a)** To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:
- VI.D.3.b)** Direct Supervision – the supervising physician is physically present with the fellow and patient.
- VI.D.3.c)** Indirect Supervision:
- VI.D.3.c).(1)** with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- VI.D.3.c).(2)** with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

- VI.D.3.d) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
- VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
- VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.**
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.**
- VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow.**
- VI.F. Teamwork**
- Fellows must care for patients in an environment that maximizes effective 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 specialty.**

VI.F.1. Geriatric Care Team

VI.F.1.a) Fellows must have experience with physician-directed interdisciplinary geriatric teams.

VI.F.1.a).(1) Essential members include a geriatrician, a nurse, and a social worker/case manager.

VI.F.1.a).(2) Additional members may be included in the team as appropriate, including representatives from disciplines such as dentistry, neurology, occupational therapy and speech therapy, pastoral care, pharmacy, physical medicine and rehabilitation, physical therapy, psychiatry, and psychology.

VI.F.1.a).(3) Regular team conferences must be held as dictated by the needs of each individual patient.

VI.F.1.b) Fellows must have interdisciplinary geriatric team experience in more than one setting, which may include:

VI.F.1.b).(1) an acute-care hospital;

VI.F.1.b).(2) a nursing home that includes sub-acute and long-term care;

VI.F.1.b).(3) a home care setting; and,

VI.F.1.b).(4) a family medicine center, internal medicine center, or other outpatient settings.

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
- VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- VI.G.2.** **Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- VI.G.3.** **Mandatory Time Free of Duty**
- Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- VI.G.4.** **Maximum Duty Period Length**
- Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- VI.G.4.a)** It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- VI.G.4.b)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- VI.G.4.c)** In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
- VI.G.4.c).(1)** Under those circumstances, the fellow must:

- VI.G.4.c).(1).(a)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- VI.G.4.c).(1).(b)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
- Geriatric medicine fellows are considered to be in the final years of education.
- VI.G.5.a).(1)** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
- VI.G.5.a).(1).(a)** Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.
- VI.G.5.a).(1).(b)** The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
- VI.G.6. Maximum Frequency of In-House Night Float**
- Fellows must not be scheduled for more than six consecutive nights of night float.
- VI.G.7. Maximum In-House On-Call Frequency**

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

ACGME Approved: September 12, 2005 Effective Date: July 1, 2006
Revised Common Program Requirements Effective: July 1, 2011