

ACGME Program Requirements for Graduate Medical Education in Pediatric Rehabilitation Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2011

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. Pediatric rehabilitation medicine utilizes an interdisciplinary approach to address the prevention, diagnosis, treatment, and management of congenital and childhood-onset physical impairments, including related or secondary medical, physical, functional, cognitive, psychosocial, and vocational limitations or conditions, with an understanding of the life course of the disability.

Int.C. The educational program in pediatric rehabilitation medicine must be 24 months in length.

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.A.1. An accredited pediatric rehabilitation medicine fellowship must be sponsored by either a pediatric hospital or by the sponsoring institution for an ACGME-accredited physical medicine and rehabilitation residency. In all cases, there must be close collaboration between the core program and the pediatric rehabilitation fellowship.
- I.A.2. The program director must not be required to generate clinical or other income to provide this support. The support should be a minimum of 10 percent of the program director's annual salary depending on the size of the program.
- I.A.3. The sponsoring institution must provide financial resources, including salaries, fringe benefits, and opportunities for fellows' continuing education.

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. All participating sites providing clinical experiences should be in the same geographic location as the primary clinical site, limited to a travel time of no more than one hour for rotations requiring daily attendance, unless appropriate overnight accommodations are provided by the program or institution.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of 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 subspecialty by the American Board of Physical Medicine and Rehabilitation, or subspecialty qualifications that are acceptable to the Review Committee; and,

II.A.2.c) current medical licensure and appropriate medical staff appointment.

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) develop and implement, in cooperation with the program director of the core residency, a written supervision policy that specifies lines of responsibility for faculty members and fellows, as well as residents;
- II.A.3.f) ensure that fellows entering at the PRM-2 level achieve the required PRM-1 competencies by the completion of the PRM-2 year; and,
- II.A.3.g) monitor fellow stress, including mental or emotional conditions inhibiting performance or learning.
 - II.A.3.g).(1) The program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows.

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 subspecialty by the American Board of Physical Medicine and Rehabilitation, or possess qualifications acceptable to the Review Committee.**

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

II.B.5. The faculty should participate in scholarly activities in pediatric rehabilitation medicine through one or more of the following:

II.B.5.a) peer-reviewed funding;

II.B.5.b) publication of original research or review articles in peer-reviewed journals or chapters in textbooks;

II.B.5.c) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.d) participation in national committees or educational organizations.

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.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. The program must have access to a service delivery system dedicated to the care of persons with pediatric rehabilitative disorders. Resources must include:

II.D.1.a) inpatient pediatric rehabilitation beds;

II.D.1.b) a designated outpatient clinic or examination area for patients with pediatric rehabilitative disorders;

II.D.1.c) transitional services for home care, community entry, and schooling;

II.D.1.d) equipment, electrodiagnostic devices, radiology services, laboratory services, and clinical rehabilitation facilities necessary to provide appropriate care to patients with pediatric rehabilitative disorders;

II.D.1.e) facilities for teaching;

II.D.1.f) a medical records system that allows for efficient case retrieval; and,

- II.D.1.g) specialty and subspecialty consulting services essential to the care of patients with pediatric rehabilitative disorders, including:
- II.D.1.g).(1) anesthesiology, diagnostic radiology, emergency medicine, general surgery, medical genetics, neurological surgery, neurology, orthopaedic surgery, pathology, pediatrics, pediatric surgery, plastic surgery, psychiatry, and urology.
- II.D.2. The patient population must be of sufficient size and diversity of pediatric age groups to allow fellows to care for an adequate number of patients, in both inpatient and outpatient settings, in all pediatric rehabilitative diagnostic categories.
- II.D.3. Fellows must be provided with prompt, reliable systems for communication and interactions with supervisory physician faculty members.

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.

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. To be eligible for appointment at the PRM-1 level, fellows must have completed a physical medicine and rehabilitation residency accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC).
- III.A.1.a) The educational program for these fellows must be 24 months in length.
- III.A.2. To be eligible for appointment at the PRM2 level, fellows must have completed either ACGME- or RCPSC-accredited residency programs in both physical medicine and rehabilitation and pediatrics, or a combined physical medicine and rehabilitation and pediatrics program approved by the American Board of Physical Medicine and Rehabilitation and the American Board of Pediatrics.
- III.A.2.a) The educational program for these fellows must be 12 months in length.

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) Written objectives for each clinical rotation at each level of education must be provided to each fellow.

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. Fellows:

IV.A.2.a).(1) completing the PRM-1 year must demonstrate competency in:

IV.A.2.a).(1).(a) initial patient evaluation, including pertinent information relevant to the patient's impairments, medical conditions, functional limitations, cognition, psychosocial issues, and educational or vocational limitations;

IV.A.2.a).(1).(b) implementing general pediatric rehabilitative therapeutic management, including early intervention, age-appropriate functional training, programs of therapy, play (avocation), therapeutic exercise, electrical stimulation and other modalities, communication strategies, oral motor interventions, discharge planning, educational and vocational planning, transitional planning, adjustment to disability support, and prevention strategies;

IV.A.2.a).(1).(c) incorporating psychological, social, and behavioral

- aspects of rehabilitation management, including family-centered care for pediatric patients;
- IV.A.2.a).(1).(d) identifying and managing common pediatric rehabilitation medical conditions and complications, including nutrition, bowel management, bladder management, gastroesophageal reflux, skin protection, pulmonary hygiene and protection, sensory impairments, sleep disorders, spasticity, thromboembolism prophylaxis, swallowing dysfunction, seizure management, and behavioral problems; and,
- IV.A.2.a).(1).(e) selecting and interpreting diagnostic studies commonly ordered in pediatric rehabilitation medicine, including radiographic imaging, laboratory data, genetic testing, urodynamics and electrodiagnostic studies.
- IV.A.2.a).(2) completing the PRM-2 year must demonstrate competency in:
- IV.A.2.a).(2).(a) prescribing age-appropriate assistive devices and technology to assist environmental accessibility, including orthotics, prosthetics, wheelchairs and positioning, activities of daily living (ADL) aids, interfaces and environmental controls, augmentative/alternative communication, and electrical stimulation;
- IV.A.2.a).(2).(b) rehabilitation management of common pediatric rehabilitation problems, including:
- IV.A.2.a).(2).(b).(i) musculoskeletal disorders and trauma, including sports injuries;
- IV.A.2.a).(2).(b).(ii) cerebral palsy;
- IV.A.2.a).(2).(b).(iii) spinal dysraphism, and other congenital anomalies;
- IV.A.2.a).(2).(b).(iv) spinal cord injury;
- IV.A.2.a).(2).(b).(v) traumatic and other acquired brain injuries;
- IV.A.2.a).(2).(b).(vi) limb deficiency/amputation;
- IV.A.2.a).(2).(b).(vii) neuromuscular disorders; and,
- IV.A.2.a).(2).(b).(viii) peripheral nerve injuries.

IV.A.2.a).(2).(c) performing pediatric rehabilitation medicine procedures, including spasticity management.

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. Fellows:

IV.A.2.b).(1) completing the PRM-1 year must demonstrate basic knowledge of:

IV.A.2.b).(1).(a) normal growth and development, including physical growth, developmental skills-attainment (language and communication skills, physical skills, cognitive skills, emotional skills and maturity, and academic achievement/learning skills), transitional issues, metabolic status, biomechanics, the effects of musculoskeletal development on function, sexuality, avocational interest development, wellness and health promotion, and aging issues for adults with congenital or childhood onset disabilities;

IV.A.2.b).(1).(b) growth and development for children with congenital and childhood onset disabilities, throughout the life course; and,

IV.A.2.b).(1).(c) medicolegal aspects of care, including child protective services and guardianship.

IV.A.2.b).(2) completing the PRM-2 year must demonstrate competence in their knowledge of:

IV.A.2.b).(2).(a) the clinical course of, and functional prognosis for, common pediatric rehabilitation problems, as well as burns and rheumatologic and connective tissue disorders that are common in the pediatric population;

IV.A.2.b).(2).(b) applications, efficacy, and selection of pediatric rehabilitation medicine assessment tools, including general health measures, developmental attainment measures, general functional measures, and specific outcomes measures; and,

IV.A.2.b).(2).(c) administration and principles of organizational behaviors and leadership, quality assurance, cost efficiency, and regulations pertaining to systems of care, including external reviews, inpatient services,

outpatient services, home care, and school-based programs.

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;**
- IV.A.2.c).(2) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and,**
- IV.A.2.c).(3) teach other hospital personnel, including medical students, residents, and other fellows, about pediatric rehabilitation medicine.
- IV.A.2.c).(3).(a) Demonstrated teaching skills must include:
 - IV.A.2.c).(3).(a).(i) developing objectives and curriculum plans;;
 - IV.A.2.c).(3).(a).(ii) effectively using audiovisual aids and other teaching materials; and,
 - IV.A.2.c).(3).(a).(iii) evaluating teaching outcomes.

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.d).(1) Fellows must demonstrate competence by the completion of the PRM-1 year in requesting appropriate medical/surgical consultations from other specialties.
- IV.A.2.d).(2) Fellows must demonstrate competence by the completion of the PRM-2 year in:
 - IV.A.2.d).(2).(a) providing consultation to physiatrists, pediatricians, and other clinicians regarding pediatric rehabilitation issues; and,
 - IV.A.2.d).(2).(b) eliciting information from, and providing counseling to families and patients in an age-appropriate manner.

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.2.f).(1)

Fellows must demonstrate a management style compatible with an interdisciplinary team process.

IV.A.3.

Curriculum Organization and Fellow Experiences

IV.A.3.a)

Fellows entering the program at any level:

IV.A.3.a).(1)

must have an assigned faculty advisor/mentor.

IV.A.3.a).(1).(a)

The faculty advisor/mentor must be responsible for the educational experience according to a written plan developed at the beginning of the program.

IV.A.3.a).(1).(b)

The faculty advisor/mentor must meet regularly with the program director and fellow for appropriate monitoring and feedback, and for adjustment of the written plan as appropriate.

IV.A.3.a).(2)

must participate in meeting and sharing experiences with residents in the core program and in other specialties; and,

IV.A.3.a).(3)

must follow individual patients longitudinally, as well as encounter a wide variety of patient problems.

IV.A.3.b)

Fellows entering the program at the PRM-1 level must:

IV.A.3.b).(1)

devote at least three months of their clinical experience to inpatient pediatric rehabilitation and three months of their clinical experience to outpatient pediatric rehabilitation medicine, as well as:

IV.A.3.b).(1).(a)

a minimum of six additional months of inpatient and/or outpatient pediatric rehabilitation medicine clinical experience;

IV.A.3.b).(1).(b)

a minimum of two FTE months of dedicated research time;

- IV.A.3.b).(1).(c) clinical rotations and didactics that ensure proficiency in medical management of common pediatric problems; and,
- IV.A.3.b).(1).(d) additional experiences in pediatric rehabilitation medicine or relevant pediatric subspecialties, surgical subspecialties, or electives.
- IV.A.3.c) Fellows entering the program at the PRM-2 level must:
- IV.A.3.c).(1) devote at least three months of their clinical experience to inpatient pediatric rehabilitation medicine and three months of their clinical experience to outpatient pediatric rehabilitation medicine.
- IV.A.3.c).(1).(a) The remaining time must be devoted to pediatric rehabilitation medicine or relevant pediatric subspecialties, surgical subspecialties, or electives, including a minimum of one FTE month of dedicated time for research. This must be consistent with the written plan developed and monitored by the advisor/mentor.
- IV.A.3.d) Didactic Curriculum
- IV.A.3.d).(1) The program must have conferences that include case-oriented multidisciplinary conferences, journal clubs, and quality management seminars relevant to clinical care in pediatric rehabilitation medicine.
- IV.A.3.d).(2) The program must have a curriculum taught by faculty members and augmented by a guided reading program, to address the fundamentals for managing patients with pediatric rehabilitation medicine disorders, including pathophysiology, clinical manifestations, and problem management
- IV.A.3.d).(3) For fellows entering at the PRM-1 level, the didactic curriculum must address the competencies to be achieved by the completion of that year.
- IV.A.3.d).(4) For fellows entering at any level, the curriculum must provide in-depth coverage of the major topics in pediatric rehabilitation medicine.
- IV.A.3.d).(4).(a) At a minimum, there must be twice-monthly conference time attended by all fellows, with documented attendance.
- IV.A.3.d).(5) The program should provide instruction in the economics of health care and current health care management issues,

including cost-effective patient care, practice management, preventive care, quality improvement, prevention of medical error, resource allocation, and clinical outcomes.

IV.A.3.d).(5).(a)

Quality improvement seminars must include discussion of initial, discharge, and follow-up data that have been analyzed regarding the functional outcomes of persons served, as well as other practice improvement activities that will help engage fellows in maintenance of certification.

IV.A.3.d).(6)

The program must provide instruction in administration through the use of specific approaches, including:

IV.A.3.d).(6).(a)

guided reading and discussion of issues related to regional and national access to care, resources, workforce, and financing appropriate to the subspecialty; and,

IV.A.3.d).(6).(b)

active participation by fellows in discussions about organization and management of a subspecialty service within the local delivery system, including:

IV.A.3.d).(6).(b).(i)

staffing a service or unit;

IV.A.3.d).(6).(b).(ii)

drafting policies or procedures;

IV.A.3.d).(6).(b).(iii)

leading interdisciplinary meetings;

IV.A.3.d).(6).(b).(iv)

developing proposals for new space or equipment;

IV.A.3.d).(6).(b).(v)

program development; and,

IV.A.3.d).(6).(b).(vi)

collaborating within and beyond the institution.

IV.B. Fellows' Scholarly Activities

IV.B.1.

The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2.

Fellows should participate in structured, supervised research education.

IV.B.3.

Each fellow should demonstrate scholarship through at least one scientific presentation, abstract, or publication.

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.B.3. Faculty evaluation by fellows should be conducted annually and kept confidential.**

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.** At least 50 percent of a program's graduates from the preceding five years should take the certifying examination.
- V.C.4.** At least 50 percent of a program's graduates from the preceding five years, taking the American Board of Physical Medicine and Rehabilitation certifying examination for pediatric rehabilitation medicine for the first time, must pass.

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**
- To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
- VI.D.3.b).(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.b).(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.c) 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.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.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 Physical Medicine and Rehabilitation 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 in the final years of education must be prepared to enter the unsupervised practice of medicine and care for

patients over irregular or extended periods.

Fellows in the subspecialties of physical medicine and rehabilitation 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 in their final years of education 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 in their final years of education 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”.

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