



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Adult Congenital Heart Disease
(Internal Medicine)**

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One-Year Common Program Requirements are in BOLD

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. Adult congenital heart disease (ACHD) encompasses the unique knowledge and skills required to care for adult patients who experienced defects in one or more structures of the heart or blood vessels. This care regularly requires coordination of multiple health-related influences or providers, potentially over a prolonged or indefinite timeframe.

Int.C. The educational program in ACHD must be 24 months in length. (Core)*

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. (Core)

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. (Core)

- I.A.1. An ACHD fellowship must function as an integral part of an ACGME-accredited fellowship in cardiovascular disease. ^(Core)
- I.A.2. The sponsoring institution must provide the program director with adequate support (depending on the size of the program, at least 25-50 percent of the program director's salary, or protected time) for the administrative activities of the program. ^(Core)
- I.A.3. The sponsoring institution and participating sites must share appropriate inpatient and outpatient faculty performance data with the program director. ^(Core)

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. ^(Core)**

The PLA should:

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; ^(Detail)**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)**
- I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)**
- I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. ^(Detail)**
- 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). ^(Core)**

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 GMC must approve a change in program director. ^(Core)**
- II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)**

- 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;** ^(Core)
- II.A.2.a).(1) The program director should have at least five years of participation as an active faculty member in an ACGME-accredited fellowship in internal medicine cardiovascular disease, pediatric cardiology, or ACHD. ^(Detail)
- II.A.2.b) current certification in the subspecialty by the American Board of Internal Medicine (ABIM), or subspecialty qualifications that are acceptable to the Review Committee; and,** ^(Core)
- II.A.2.b).(1) The Review Committee only accepts current ABIM certification in ACHD. ^(Core)
- II.A.2.c) current medical licensure and appropriate medical staff appointment.** ^(Core)
- 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.** ^(Core)
- The program director must:
- II.A.3.a) prepare and submit all information required and requested by the ACGME;** ^(Core)
- 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;** ^(Detail)
- II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** ^(Core)
- II.A.3.c).(1) all applications for ACGME accreditation of new programs; ^(Detail)
- II.A.3.c).(2) changes in fellow complement; ^(Detail)
- II.A.3.c).(3) major changes in program structure or length of training; ^(Detail)
- II.A.3.c).(4) progress reports requested by the Review Committee; ^(Detail)
- II.A.3.c).(5) requests for increases or any change to fellow duty

- hours; ^(Detail)
- II.A.3.c).(6) **voluntary withdrawals of ACGME-accredited programs;** ^(Detail)
- II.A.3.c).(7) **requests for appeal of an adverse action; and,** ^(Detail)
- II.A.3.c).(8) **appeal presentations to a Board of Appeal or the ACGME.** ^(Detail)
- II.A.3.d) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
 - II.A.3.d).(1) **program citations, and/or,** ^(Detail)
 - II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.3.e) ensure that fellows' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility; ^(Core)
- II.A.3.f) dedicate an average of 20 hours per week of his or her professional effort to the program, including time for administration of the program; ^(Detail)
- II.A.3.g) have a reporting relationship with the program director of the cardiovascular disease program to ensure compliance with ACGME accreditation standards; and, ^(Core)
- II.A.3.h) be available at the primary clinical site. ^(Detail)

II.B. Faculty

- II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.** ^(Core)
- 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.** ^(Core)
- II.B.3. **The physician faculty must have current certification in the subspecialty by the American Board of Internal Medicine or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.4. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.5. The physician faculty should include members with documented

experience and expertise in:

- II.B.5.a) both inpatient and outpatient management of cardiovascular care of adults with congenital heart disease; ^(Detail)
- II.B.5.b) congenital heart disease surgery in both pediatric and adult patients; ^(Detail)
- II.B.5.c) pediatric and adult congenital heart electrophysiology; ^(Detail)
- II.B.5.d) catheterization of patients with congenital heart lesions, and catheter-based interventions in adult and pediatric patients; ^(Detail)
- II.B.5.e) congenital cardiac and vascular basic and advanced imaging; ^(Detail)
- II.B.5.f) critical care and post-operative management of adults with congenital heart disease; ^(Detail)
- II.B.5.g) pulmonary vascular disease; ^(Detail)
- II.B.5.h) heart failure, mechanical circulatory and ventilator support, and both heart and lung transplantation; and, ^(Detail)
- II.B.5.i) medical research methodology and accomplishment. ^(Detail)
- II.B.6. The physician faculty must meet professional standards of ethical behavior. ^(Core)
- II.B.7. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)
 - II.B.7.a) The members of the faculty should regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)
 - II.B.7.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:
 - II.B.7.b).(1) peer-reviewed funding; ^(Detail)
 - II.B.7.b).(2) publication of original research or review articles in peer-reviewed journals or chapters in textbooks; ^(Detail)
 - II.B.7.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)
 - II.B.7.b).(4) participation in national committees or educational organizations. ^(Detail)

II.B.7.c) Faculty members must encourage and support fellows in scholarly activity. ^(Core)

II.B.8. Key Clinical Faculty

II.B.8.a) In addition to the program director, each program must have at least one Key Clinical Faculty (KCF) member. ^(Core)

II.B.8.b) KCF must be attending physicians who dedicate, on average, 10 hours per week throughout the year to the education program. ^(Core)

II.B.8.c) For programs with more than two fellows, there must be at least one KCF for every 1.5 fellows. ^(Core)

II.B.8.d) Key Clinical Faculty Qualifications

II.B.8.d).(1) KCF must be active clinicians with knowledge of, experience with, and commitment to ACHD as a discipline. ^(Core)

II.B.8.d).(2) KCF must have current ABIM certification in ACHD. ^(Core)

II.B.8.e) Key Clinical Faculty Responsibilities

II.B.8.e).(1) In addition to the responsibilities of all individual faculty members, the KCF and the program director are responsible for the planning, implementation, monitoring and evaluation of the fellows' clinical and research education. ^(Core)

II.B.8.e).(2) At least 50 percent of the KCF should demonstrate evidence of productivity in scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks. ^(Detail)

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. ^(Core)

II.C.1. There should be services available from other health care professionals, including dietitians, language interpreters, clinical pharmacists, nurses, physician assistants or nurse practitioners, occupational therapists, physical therapists, rehabilitation and vocational counselors, psychologists/psychiatrists, and social workers. ^(Detail)

II.C.2. There should be appropriate and timely consultation from other specialties. ^(Detail)

II.C.3. The faculty must include representation from patient advocacy. ^(Core)

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. ^(Core)

II.D.1. Space and Equipment

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

II.D.2. Facilities

II.D.2.a) The sponsoring institution must demonstrate its ability to care for both young and older adult patients within an environment appropriate for their physical, emotional, and intellectual age. ^(Core)

II.D.2.a).(1) This should include access to all aspects of age- and illness- specific health care and health maintenance. ^(Detail)

II.D.2.b) Inpatient and outpatient systems should be in place to prevent fellows from performing routine clerical functions, such as scheduling tests and appointments and retrieving records and letters. ^(Detail)

II.D.2.c) The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients. ^(Core)

II.D.2.d) Fellows should have access to a lounge facility during assigned duty hours. ^(Detail)

II.D.2.e) When fellows are in the hospital, assigned night duty, or called in from home, they should be provided with a secure space for their belongings. ^(Detail)

II.D.3. Medical Records

Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development and progress toward its implementation. ^(Core)

II.D.4. Patient Population

II.D.4.a) The patient population must have a variety of clinical problems and stages of diseases, and must include a full range of patients

with advanced or complex ACHD. ^(Core)

II.D.4.b) There must be patients of each gender, with a broad age range, including geriatric patients. ^(Core)

II.D.4.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)

This must include:

II.D.4.c).(1) at least 200 hospitalized adult patients diagnosed with complications related to congenital heart disease; and, ^(Core)

II.D.4.c).(2) at least 350 ambulatory patient visits (among at least 250 unique individual ambulatory patients) with congenital heart disease. ^(Core)

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. ^(Detail)

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. ^(Core)

III.A.1. The program must document that each fellow has met the eligibility criteria. ^(Detail)

III.A.1.a) Prior to appointment in the program, fellows should have completed a three-year ACGME-accredited cardiovascular disease or pediatric cardiology program. ^(Core)

III.A.1.b) The program director should inform applicants from non-ACGME-accredited programs, prior to appointment and in writing, of the ABIM policies and procedures that will affect their eligibility for ABIM certification. ^(Detail)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-

specific requirements. (Core)

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 at least annually, in either written or electronic form. (Core)

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.2.a) Patient Care and Procedural Skills

IV.A.2.a).(1) 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: (Outcome)

IV.A.2.a).(1).(a) must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness; and, (Outcome)

IV.A.2.a).(1).(b) must demonstrate competence in prevention education, evaluation, and management of inpatients and outpatients with:

IV.A.2.a).(1).(b).(i) atrial septal defects (secundum, primum, venosus); (Outcome)

IV.A.2.a).(1).(b).(ii) ventricular septal defects; (Outcome)

IV.A.2.a).(1).(b).(iii) atrioventricular defects; (Outcome)

IV.A.2.a).(1).(b).(iv) patent ductus arteriosus; (Outcome)

IV.A.2.a).(1).(b).(v) bicommissural and unicommissural aortic valve; (Outcome)

IV.A.2.a).(1).(b).(vi) subvalvular aortic stenosis; (Outcome)

IV.A.2.a).(1).(b).(vii) supra-aortic stenosis; (Outcome)

IV.A.2.a).(1).(b).(viii) aortic coarctation; (Outcome)

IV.A.2.a).(1).(b).(ix)	congenital abnormalities of left-sided inflow, including pulmonary vein disease, cor triatriatum and mitral valve abnormalities; (Outcome)
IV.A.2.a).(1).(b).(x)	pulmonary stenosis (subvalvular, valvular, supra- and peripheral pulmonary stenosis); (Outcome)
IV.A.2.a).(1).(b).(xi)	tetralogy of Fallot; (Outcome)
IV.A.2.a).(1).(b).(xii)	tetralogy of Fallot with pulmonary atresia; (Outcome)
IV.A.2.a).(1).(b).(xiii)	Ebstein anomaly; (Outcome)
IV.A.2.a).(1).(b).(xiv)	single ventricle anatomy (double outlet right ventricle, double inlet left ventricle, pulmonary atresia, hypoplastic left ventricle, tricuspid atresia); (Outcome)
IV.A.2.a).(1).(b).(xv)	D-transposition of the great arteries with atrial switch repair (Senning, Mustard); (Outcome)
IV.A.2.a).(1).(b).(xvi)	D-transposition of the great arteries with arterial switch repair; (Outcome)
IV.A.2.a).(1).(b).(xvii)	L-transposition of the great arteries; (Outcome)
IV.A.2.a).(1).(b).(xviii)	congenital coronary anomalies; (Outcome)
IV.A.2.a).(1).(b).(xix)	Eisenmenger syndrome, and pulmonary hypertension associated with congenital heart disease; (Outcome)
IV.A.2.a).(1).(b).(xx)	syndrome-associated and inherited forms of congenital heart and vascular disease (including Down, Williams, Turner, Noonan, Marfan); (Outcome)
IV.A.2.a).(1).(b).(xxi)	heart failure (including mechanical circulatory support and transplantation) associated with congenital heart disease; (Outcome)
IV.A.2.a).(1).(b).(xxii)	atrial arrhythmias associated with congenital heart disease; (Outcome)
IV.A.2.a).(1).(b).(xxiii)	ventricular arrhythmias associated with congenital heart disease; and, (Outcome)

- IV.A.2.a).(1).(b).(xxiv) pregnancy associated with maternal congenital heart disease. (Outcome)
- IV.A.2.a).(2)** **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** (Outcome)
- IV.A.2.a).(2).(a) must demonstrate competence in ACHD evaluation, to include:
- IV.A.2.a).(2).(a).(i) applying and interpreting approaches to evaluating symptom severity, functional capacity, and health-related quality of life in adult patients with congenital heart disease (Outcome)
- IV.A.2.a).(2).(a).(ii) recognizing clinical features in all forms and etiologies of congenital heart disease; (Outcome)
- IV.A.2.a).(2).(a).(iii) recognizing the indications for, understanding the complications with, and interpreting the results of all diagnostic tests and modalities relevant to evaluating and managing patients with or suspected of having congenital heart disease; in particular, recognizing the impact of such testing on the management of these patients, including: (Outcome)
- IV.A.2.a).(2).(a).(iii).(a) transthoracic ACHD echocardiography; (Outcome)
- IV.A.2.a).(2).(a).(iii).(b) transesophageal ACHD echocardiography; and, (Outcome)
- IV.A.2.a).(2).(a).(iii).(c) diagnostic catheterization. (Outcome)
- IV.A.2.a).(2).(b) must demonstrate competence in ACHD management, to include:
- IV.A.2.a).(2).(b).(i) assigning timing and methods of surveillance for each lesion; (Outcome)
- IV.A.2.a).(2).(b).(ii) surveillance, diagnosis, and both medical and mechanical management of atrial and ventricular arrhythmias in the unoperated and post-operative state; (Outcome)

- IV.A.2.a).(2).(b).(iii) surveillance, diagnosis, and both medical and mechanical management of heart block and conduction abnormalities in the unoperated and post-operative state; (Outcome)
- IV.A.2.a).(2).(b).(iv) recognizing the indications for and prescribing non-pharmacologic, non-device treatment modalities, including diet and exercise; (Outcome)
- IV.A.2.a).(2).(b).(v) recognizing the indications for, prescribing, and monitoring all classes of drugs relevant to patient care; and, (Outcome)
- IV.A.2.a).(2).(b).(vi) recognizing the indications for, understanding the complications with, and interpreting the results of all interventional modalities relevant to managing patients with or suspected of having congenital heart disease; in particular, recognizing the impact of such interventions on the management of these patients, including: (Outcome)
- IV.A.2.a).(2).(b).(vi).(a) interventional catheterization; (Outcome)
- IV.A.2.a).(2).(b).(vi).(b) cardiac and cardiovascular surgery; (Outcome)
- IV.A.2.a).(2).(b).(vi).(c) non-cardiac surgery; and, (Outcome)
- IV.A.2.a).(2).(b).(vi).(d) pregnancy. (Outcome)

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: (Outcome)

- IV.A.2.b).(1) must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, and guidelines-assisted decision making; (Outcome)
- IV.A.2.b).(2) must demonstrate knowledge of indications and contraindications of, limitations and complications with, techniques for, and interpretation of results from those diagnostic and therapeutic procedures (including electrocardiogram (EKG) and electrophysiologic testing and intervention; cardiopulmonary function assessment and exercise testing; transthoracic echocardiography

(TTE) and transesophageal echocardiography (TEE); cardiac and vascular computed tomography (CT) and magnetic resonance imaging (MRI); hemodynamics and catheterization-based imaging and intervention; and surgeries, including peri-operative and procedure-related anesthetics and mechanical cardiopulmonary support techniques) integral to the discipline, to include the appropriate indications for and use of screening tests/procedures; and, ^(Outcome)

- IV.A.2.b).(3) must demonstrate knowledge of basic mechanisms underlying each type of cardiac anomaly as delineated in the “Patient Care” section above, to include:
- IV.A.2.b).(3).(a) principles of cardiac development and anatomy in unrepaired and repaired states for each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(b) principles of physiology in unrepaired and repaired states for each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(c) important genetic associations specific to each individual type of anomaly, particularly as related to outcomes; ^(Outcome)
- IV.A.2.b).(3).(d) childhood palliative and complete surgical and interventional repairs, including the associated intermediate- and longer-term outcomes, for each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(e) expected presenting symptoms, physical examination, and cardiac conduction findings for each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(f) differential diagnosis that includes specific etiologies of and exacerbating factors for each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(g) guidelines-specific recommendations regarding diagnosis and management of each type of anomaly; ^(Outcome)
- IV.A.2.b).(3).(h) lesion-and repair-specific intermediate- and longer-term effects on myocardial function; ^(Outcome)
- IV.A.2.b).(3).(i) lesion- and repair-specific effects on pregnancy and maternal health risk and interventions, and potential complications; ^(Outcome)
- IV.A.2.b).(3).(j) genetics, including common mutations leading to congenital heart disease; and, ^(Outcome)

IV.A.2.b).(3).(k) the impact of age- and development-specific chronic disease skills and psychosocial factors on the manifestation, expression, and management of ACHD across the of lifespan of disease. ^(Outcome)

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; ^(Outcome)

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and, ^(Outcome)

IV.A.2.c).(3) apply new advances to the management and care of their patients. ^(Outcome)

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. ^(Outcome)

IV.A.2.d).(1) Fellows must demonstrate competence in providing consultation and obtaining informed consent. ^(Outcome)

IV.A.2.d).(2) Fellows must demonstrate competence in interacting with patient families, advocates, and guardians, as well as with local, regional, and national patient advocacy groups. ^(Outcome)

IV.A.2.e) Professionalism

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

IV.A.2.e).(1) Fellows must demonstrate high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest. ^(Outcome)

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.
(Outcome)

- IV.A.3. Curriculum Organization and Fellow Experiences
- IV.A.3.a) Any or all of the clinical experiences described below may be organized either as defined blocks of experience or dispersed throughout combined rotations. However, supervisory care must be provided to ensure that during each experience, fellows do not have conflicting assignments that preclude their ability to provide attention to training in that particular experience. The clinical experience must include at least the following: ^(Core)
- IV.A.3.a).(1) at least nine months of inpatient or consultative service that provides comprehensive care for ACHD patients; ^(Core)
- IV.A.3.a).(2) at least three months of comprehensive diagnostic and interventional services and imaging (transthoracic echocardiography (TTE), transesophageal echocardiography (TEE), cardiac computed tomography angiography (CCTA), and cardiac magnetic resonance imaging (CMRI)) for ACHD patients; ^(Core)
- IV.A.3.a).(3) at least two months of ACHD catheterization (diagnostic and interventional), including experience in the limits and applications of measurements and definition of vascular resistance and flows, pressure gradients, and optimal correlation of angiography with physiologic measures and additional imaging modalities; ^(Core)
- IV.A.3.a).(4) at least one month of intensive care and surgical services that provide comprehensive care for ACHD patients, including experience in the optimal transition from pre- to intra- to post-operative care environments, as well as development, provision, and communication of care plans through short-, intermediate- and longer-term post-operative follow-up; ^(Core)
- IV.A.3.a).(5) experience on pediatric, internal medicine, or cardiology services that expand understanding of the multiple organ system and the behavioral and psychosocial ramifications of congenital heart disease over the course of a patient's lifetime; ^(Core)
- IV.A.3.a).(5).(a) For the fellow entering with specialty training in adult cardiovascular disease, this must include at least three months dedicated to a combination of pediatric medicine, adolescent medicine, transition

medicine, and pediatric cardiology. ^(Core)

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

For the fellow entering with specialty training in internal medicine-pediatrics and subspecialty training in pediatric cardiology, this must include at least three months dedicated to a combination of internal medicine, transition medicine, and adult cardiology. ^(Core)

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

For the fellow entering with specialty training in pediatrics and subspecialty training in pediatric cardiology, this must include:

IV.A.3.a).(5).(c).(i)

at least three months of internal medicine; ^(Core)

IV.A.3.a).(5).(c).(ii)

at least three months of adult cardiology; and, ^(Core)

IV.A.3.a).(5).(c).(iii)

attestation of education in core competencies in internal medicine care. ^(Core)

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

continuity ambulatory clinic experience that exposes the fellows to the breadth and depth of ACHD. ^(Core)

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

This experience should average at least one half-day each week. ^(Detail)

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

This experience must include an appropriate distribution of patients of each gender and a diversity of ages, with attention to age-, gender-, or ethnicity-based differences in disease or care disparities when such occur. ^(Core)

This should be accomplished through either:

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

a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, ^(Detail)

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

selected blocks of at least six months which address specific areas of cardiovascular disease as they relate to congenital heart disease. ^(Detail)

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

Each fellow should, on average, be responsible for at least four patients during each half-day session. ^(Detail)

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

The continuity patient care experience should not be interrupted by more than one month, excluding a

fellow's vacation. ^(Detail)

- IV.A.3.a).(6).(e) Fellows should be informed of the status of their continuity patients when such patients are hospitalized, as clinically appropriate. ^(Detail)
- IV.A.3.b) Fellows should participate in training using simulation. ^(Detail)
- IV.A.3.c) The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. ^(Core)
- IV.A.3.c).(1) The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend. ^(Detail)
- IV.A.3.c).(2) Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. ^(Detail)
- IV.A.3.c).(3) All core conferences must have at least one faculty member present, and must be scheduled as to ensure peer-peer and peer-faculty member interaction. ^(Detail)
- IV.A.3.d) Fellows must have clinical experience in:
- IV.A.3.d).(1) caring for patients in the context of a multidisciplinary disease management program; ^(Core)
- IV.A.3.d).(2) end-of-life care; and, ^(Core)
- IV.A.3.d).(3) evaluating patients for cardiac or pulmonary transplant or mechanical assist devices. ^(Core)
- IV.A.3.e) Procedures and Technical Skills
- IV.A.3.e).(1) Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director. ^(Core)
- IV.A.3.e).(2) Faculty members must teach and supervise the fellows in the performance and interpretation of procedures, which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s). ^(Core)
- IV.A.3.e).(3) Fellows must:
- IV.A.3.e).(3).(a) participate in pre-procedural planning, including the indications for a procedure, and the selection of the appropriate sedation and anesthetic agents, procedures, or instruments; and, ^(Core)

IV.A.3.e).(3).(b) demonstrate substantial involvement in post-procedure care. ^(Core)

IV.A.3.f) Fellows should be instructed in practice management relevant to ACHD. ^(Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. Each program should provide dedicated time within at least six of the twenty-four months for fellows to participate in research or other scholarly activity. ^(Core)

This should include:

IV.B.1.a) a research project (with faculty mentorship); or, ^(Detail)

IV.B.1.b) participation with members of the faculty in the initiation and conduct of clinical trials within the department; or, ^(Detail)

IV.B.1.c) participation in quality assurance/quality improvement or process improvement projects. ^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings. ^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. ^(Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

demonstrate that each fellow has achieved competence in the performance of required procedures. ^(Detail)

V.A.2.b).(1).(b)

Medical Knowledge

V.A.2.b).(1).(b).(i)

The program should use an objective formative assessment method. ^(Detail)

V.A.2.b).(1).(b).(ii)

The same formative assessment method should be administered at least twice during the program. ^(Detail)

V.A.2.b).(1).(c)

Practice-based Learning and Improvement

The program should use performance data to assess each fellow in:

V.A.2.b).(1).(c).(i)

application of evidence to patient care; ^(Detail)

V.A.2.b).(1).(c).(ii)

practice improvement; ^(Detail)

V.A.2.b).(1).(c).(iii)

teaching skills involving peers and patients; and, ^(Detail)

V.A.2.b).(1).(c).(iv)

scholarship. ^(Detail)

V.A.2.b).(1).(d)

Interpersonal and Communication Skills

The program should use both direct observation and multi-source evaluation, including patients, peers, and non-physician team members, to assess fellow performance in:

V.A.2.b).(1).(d).(i)

communication with patients and families; ^(Detail)

V.A.2.b).(1).(d).(ii)

teamwork; ^(Detail)

V.A.2.b).(1).(d).(iii)

communication with peers, including transitions in care; and, ^(Detail)

V.A.2.b).(1).(d).(iv)

record keeping. ^(Detail)

V.A.2.b).(1).(e)

Professionalism

The program should use multi-source evaluation, including patients, peers, and non-physician team members, to assess each fellow's:

V.A.2.b).(1).(e).(i)

honesty and integrity; ^(Detail)

- V.A.2.b).(1).(e).(ii) ability to meet professional responsibilities;
(Detail)
- V.A.2.b).(1).(e).(iii) ability to maintain appropriate professional relationships with patients and colleagues; and, (Detail)
- V.A.2.b).(1).(e).(iv) commitment to self-improvement. (Detail)
- V.A.2.b).(1).(f) **Systems-based Practice**
- The program should use multi-source evaluation, including peers and non-physician team members, to assess each fellow's:
- V.A.2.b).(1).(f).(i) ability to provide care coordination, including transition of care; (Detail)
- V.A.2.b).(1).(f).(ii) ability to work in interdisciplinary teams; (Detail)
- V.A.2.b).(1).(f).(iii) advocacy for quality of care; and, (Detail)
- V.A.2.b).(1).(f).(iv) ability to identify system problems and participate in improvement activities. (Detail)
- V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and, (Detail)**
- V.A.2.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)**
- V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. (Detail)**
- V.A.3. Summative Evaluation**
- V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)**
- V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. (Core)**
- This evaluation must:**
- V.A.3.b).(1) 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; ^(Detail)

V.A.3.b).(2) document the fellow's performance during their education; and, ^(Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

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. ^(Detail)

V.B.3. Fellows should have the opportunity to provide confidential written evaluations of each supervising faculty member at the end of each rotation. ^(Detail)

V.B.3.a) These evaluations should be reviewed with each faculty member annually. ^(Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)

- V.C.1.a).(3).(d)** reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)
- V.C.2.** The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)
- The program must monitor and track each of the following areas:
- V.C.2.a)** fellow performance; ^(Core)
- V.C.2.b)** faculty development; ^(Core)
- V.C.2.c)** progress on the previous year’s action plan(s); and, ^(Core)
- V.C.2.d)** graduate performance, including performance of program graduates on the certification examination. ^(Core)
- V.C.2.d).(1)** At least 80 percent of a program’s graduating fellows from the most recently-defined five-year period who are eligible should take the ABIM certifying examination. ^(Outcome)
- V.C.2.d).(2)** At least 80 percent of a program’s graduates taking the ABIM certifying examination for the first time during the most recently-defined five-year period should pass. ^(Outcome)
- V.C.2.d).(3)** At least 80 percent of entering fellows should have completed the program when averaged over a five-year period. ^(Outcome)
- V.C.3.** The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)
- V.C.3.a)** The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)
- 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. ^(Core)
- VI.A.2.** The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational

environment. ^(Core)

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. ^(Core)

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, ^(Core)

VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations. ^(Core)

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.A.6. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)

VI.A.6.b) provision of patient- and family-centered care; ^(Outcome)

VI.A.6.c) assurance of their fitness for duty; ^(Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; ^(Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)

VI.A.6.f) attention to lifelong learning; ^(Outcome)

VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, ^(Outcome)

VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)

VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They 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. ^(Outcome)

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)

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. (Core)

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)

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. (Detail)

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; (Core)

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, (Core)

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. (Detail)

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. (Core)

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. (Core)

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. (Core)

VI.D.1.a) This information should be available to fellows, faculty members, and patients. (Detail)

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care. (Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. (Core)

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. (Detail)

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: (Core)

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. (Core)

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. (Core)

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. (Core)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

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. (Core)

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. (Core)

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. ^(Detail)

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. ^(Detail)

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. ^(Core)

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. ^(Outcome)

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. ^(Detail)

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. ^(Core)

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. ^(Core)

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. ^(Core)

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. ^(Detail)

The Review Committee for Internal 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. (Detail)
- 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. (Detail)
- 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. (Core)
- 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. (Core)
- 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. (Core)
- 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. (Core)
- VI.G.4.a)** 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. (Detail)
- VI.G.4.b)** 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. (Core)
- VI.G.4.c)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)
- VI.G.4.d)** 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. ^(Detail)

VI.G.4.d).(1)

Under those circumstances, the fellow must:

VI.G.4.d).(1).(a)

appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)

VI.G.4.d).(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. ^(Detail)

VI.G.4.d).(2)

The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. ^(Detail)

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. ^(Outcome)

Internal medicine subspecialty 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. ^(Detail)

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. ^(Detail)

VI.G.5.a).(1).(b)

In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the

events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new "off-duty period" nor require a change in the scheduled "off-duty period." (Detail)

VI.G.5.a).(1).(c)

Under such circumstances, the fellow should appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)

VI.G.5.a).(1).(d)

The program director should review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty. (Detail)

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. (Core)

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). (Core)

VI.G.7.a)

Internal medicine fellowships must not average in-house call over a four-week period. (Core)

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. (Core)

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. (Core)

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". (Detail)

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

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

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

Osteopathic Principles Recognition

For programs seeking Osteopathic Principles Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf