**ACGME Program Requirements for Graduate Medical Education**

**in Pain Medicine**

**Summary and Impact of Major Requirement Revisions**

Directions: The Impact Statement is a complementary document to proposals for new requirements or to revisions of current requirements. For each major requirement revision, list the requirement reference number, and the original requirement showing additions (underline) and deletions (strikethrough). Then describe how the revision impacts the program and the institution as indicated. Use the format below to report this information.

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<thead>
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<th>Requirement #: I.B.1.a)</th>
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<tr>
<td>Requirement Revision (significant change only):</td>
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<td>I.B.1.a) Only multidisciplinary programs will be accredited. A multidisciplinary program in pain medicine must be conducted in an institution and/or its affiliates-participating sites that sponsor(s) ACGME-accredited residencies in at least two of the following specialties: anesthesiology; physical medicine and rehabilitation; and child neurology/ or neurology, and physical medicine and rehabilitation. <em>(Core)</em> [Moved from I.B.3.]</td>
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1. **Describe the Review Committee’s rationale for this revision:** This revision was made at the request of the Review Committee for Neurology, after child neurology was approved as a stand-alone specialty rather than a subspecialty of neurology. The case was made that there exist ACGME-accredited pain programs at children’s hospitals that appear to be meeting the requirements, therefore there are few reason not to let the change be implemented.

2. **How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?** Provided programs sponsored by a child neurology program in fact meet the requirements, it is likely to have little impact on fellow education, patient safety, and patient care quality. The primary concern is that all the pain medicine requirements related to the treatment of adults continue to be an integral part of all fellows’ pain medicine education and training experience.

3. **How will the proposed requirement or revision impact continuity of patient care?** It will not impact continuity of patient care.

4. **Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?** No

5. **How will the proposed revision impact other accredited programs?** It is unclear how this may impact other accredited programs. It is anticipated that several children’s hospitals may wish to start pain programs; these programs would still need to have either an accredited anesthesiology or physical medicine and rehabilitation program in order to receive accreditation.

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1. Describe the Review Committee’s rationale for this revision: **It was felt that limitation to a specific location was artificial and overly restrictive.**

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **This will increase flexibility for programs to use the most appropriate pain management center for their local needs.**

3. How will the proposed requirement or revision impact continuity of patient care? **It will not.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **It will not.**

5. How will the proposed revision impact other accredited programs? **It will not.**

**Requirement: II.A.2.a)**

Programs with one to two fellows must provide a minimum of 10 percent FTE protected time for the program director. (Core)

1. Describe the Review Committee’s rationale for this revision: **Given the opportunity presented by the new Common Program Requirements, the Review Committees felt detailing a minimum level of program director support for a pain fellowship would clarify expectations for subspecialty programs. The 10 percent minimum protected time for a program with two fellows and the additional one percent per fellow beyond two brings the subspecialty requirements in line with the requirements of several specialties, including neurology and physical medicine and rehabilitation.**

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **It will ensure each program commits the needed resources to the administrative oversight of pain medicine programs and, by extension, ensure each**
program is able to provide fellows with an effective educational experience. It is unlikely to have an impact on patient safety.

3. How will the proposed requirement or revision impact continuity of patient care? **It will not impact patient care.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **While it may require a modest increase of support from some programs, the Review Committee believes it will not impact the majority of programs, most of which already commit this level of support to their program directors.**

5. How will the proposed revision impact other accredited programs? **It is unlikely to impact other accredited programs.**

**Requirement #: II.B.1.a) and II.B.3.b).(2)**

**Requirement Revision (significant change only):**

**II.B.1.a) At least three faculty members, including the program director, with expertise in pain At least three faculty members with expertise in pain medicine, including the program director, must be involved in pain medicine subspecialty education, and these must equal at least two FTEs. These numbers include the program director.** [Moved from II.B.2.a) and split with II.B.3.b).(2) below]  

**II.B.3.b).(2) Faculty members must also possess subspecialty certification in pain medicine, with both certificates recognized by the American Board of Medical Specialties, and The faculty as a whole must possess expertise across the domains of acute and chronic pain, and pain in patients who require palliative care.** [Moved from II.B.2.a) and split with II.B.1.a) above]

1. Describe the Review Committee’s rationale for this revision: **The faculty subspecialty certification requirement is covered in what is now II.B.3.b).(2), which includes the osteopathic boards and replaces the outdated ABMS-only language.**

Having faculty members from two different core specialties emphasizes the multidisciplinary nature and ensures more of a balance from each discipline that participates in the fellowship. Specialties deemed appropriate include those that can sponsor a program, plus psychiatry and other core specialties that have awarded pain certification in the past.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **Requiring a minimum of two board-certified pain medicine subspecialists in programs will ensure fellows are educated and trained to the highest and most current standard in the practices of each discipline contributing to the field of pain medicine.**

3. How will the proposed requirement or revision impact continuity of patient care? **The revision will not impact continuity of patient care.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? The revision may have a modest impact on institutions inasmuch as they may have to recruit board-certified pain medicine specialists to serve as faculty members in their programs if they currently do not have qualified subspecialists.

5. How will the proposed revision impact other accredited programs? The revision will not impact other accredited programs.

Requirement II.B.3.d).(1)

Requirement Revision (significant change only):

II.B.3.d).(1) The faculty must include faculty members from ACGME-accredited programs in at least two of the following: anesthesiology; physical medicine and rehabilitation; psychiatry; and child neurology or neurology. (Core) Qualified physicians with specialty expertise from three of the four cooperating disciplines involved in pain medicine must have a continuous and meaningful role in the fellowship. (Core) [Moved from II.B.2.c]

1. Describe the Review Committee’s rationale for this revision: The intent is to permit more flexibility with regard to the multidisciplinary composition of programs’ faculty, enhancing the opportunity to add new pain medicine programs in order to meet the current demands of the population.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? The requirement will ensure the availability of fully trained and certified subspecialists to care for the increasing number of pain patients in the US.

3. How will the proposed requirement or revision impact continuity of patient care? It is unlikely to significantly impact the continuity of patient care. There is a possibility it will contribute to a modest increase in the number of pain subspecialists available to the US pain patient population.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? It is unlikely to impact the institutional resources available to programs.

5. How will the proposed revision impact other accredited programs? The change is unlikely to impact other accredited programs.

Requirement #: IV.B.1.b).(1).(a).(ii), IV.B.1.b).(1).(a).(iii).(a), and IV.B.1.b).(1).(b).(iv)

Requirement Revision (significant change only):

Lead-in: Fellows must demonstrate the following competencies:

IV.B.1.b).(1).(a).(ii) performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in fifteen patients; and, (Outcome)(Core) [Moved from IV.A.5.a).(1).(a).(ii)]

IV.B.1.b).(1).(a).(ii).(a) Faculty members must verify this experience in a minimum of five observed
patient examinations. [Moved from IV.A.5.a).(1).(a).(ii).(a)]

IV.B.1.b).(1).(a),(iii) Identifying significant findings of basic neuro-imaging. \((\text{Outcome})\)(Core) [Moved from IV.A.5.a).(1).(a).(iii)]

IV.B.1.b).(1).(a),(iii).(a) Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain. on a minimum of 15 CT and/or MRI studies. \((\text{Outcome})\)(Core) [Moved from IV.A.5.a).(1).(a).(iii).(a)]

IV.B.1.b).(1).(a),(iii).(b) Neuro-imaging studies must be drawn from the following areas: brain; cervical; thoracic; and lumbar spine. \((\text{Outcome})\)(Core) [Moved from IV.A.5.a).(1).(a),(ii).b)

IV.B.1.b).(1).(a),(iii).(c) Neuro-imaging Image/study identification training shall be verified by a faculty member from an ACGME-accredited residency program in child neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. \((\text{Detail})\) [Moved from II.B.2.e)]

IV.B.1.b).(1).(b) must demonstrate the following competencies in physical medicine and rehabilitation. \((\text{Outcome})\) [Formerly IV.A.5.a).(1).(b)]

IV.B.1.b).(1).(b),(ii) identifying and prescribing rehabilitation interventions for specific spine and musculoskeletal conditions; \((\text{Core})\)

IV.B.1.b).(1).(b),(iii) Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients. \((\text{Core})\) [Moved from IV.A.5.a).(1).(b),(i),(a)]

IV.B.1.b).(1).(b),(iv) developing patient rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and, including: \((\text{Outcome})\)(Core) [Moved from IV.A.5.a).(1).(b),(ii)]

IV.B.1.b).(1).(b),(iv),(a) Fellows must demonstrate proficiency in the clinical evaluation and development of a rehabilitation plan development of a minimum of five patients. \((\text{Core})\) [Moved from IV.A.5.a).(1).(b),(ii),(a)]

IV.B.1.b).(1).(b),(v) identifying patients best suited for multidisciplinary team pain management, including patients with psychiatric and psychosocial risk factors and designing patient-specific programs in these situations; \((\text{Core})\)

1. Describe the Review Committee’s rationale for this revision: The outcomes are still considered important, however the minimum numbers were removed to allow flexibility for programs and to recognize that each individual may need a different experience to reach competency. The required numbers were removed for the same rationale for other required outcomes in the patient care section.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? The intent is to permit programs to determine fellows’ procedural competence within the local context of their clinical settings and institutions.
3. How will the proposed requirement or revision impact continuity of patient care? **It is unlikely to impact the continuity of patient care.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **As the previous minimums required were not very high, it is unlikely to impact the institutional resources available to programs.**

5. How will the proposed revision impact other accredited programs? **While institutions may find discussions of balancing case volume and type a little easier due to the flexibility being given to programs, the change is unlikely to impact other accredited programs.**

Requirement #: IV.B.1.b).(1).(b).(v)

Requirement Revision (significant change only):
[Lead in—Fellows must demonstrate competency in the following:]

IV.B.1.b).(1).(b).(v) identifying patients best suited for multidisciplinary team pain management, including patients with psychiatric and psychosocial risk factors and designing patient-specific programs in these situations; and, *(Core)*

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1. Describe the Review Committee’s rationale for this revision: **The Committees consider it essential that programs design their fellows' experience to focus on the delivery of multidisciplinary team-based care. This team-based care, including psychiatry, is important for patients with these extra risk factors. The Review Committees believe fellows must see, learn to diagnose, and manage patients individually.**

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? By ensuring a multi-disciplinary approach to pain medicine, fellows will develop the competence to address all aspects to pain and to maximize a therapeutic plan.

3. How will the proposed requirement or revision impact continuity of patient care? **It may improve continuity of care.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No additional resources are required**

5. How will the proposed revision impact other accredited programs? **It will not impact other programs.**

Requirement #: IV.B.1.b).(1).(c)-(c).(ii).(b)

Requirement Revision (significant change only):

IV.B.1.b).(1).(c) must demonstrate the following competencies in psychiatry: *(Outcome)* [Formerly IV.A.5.a).(1).(c)]

IV.B.1.b).(1).(c).(i) carrying out a complete and detailed psychiatric history with special attention to psychiatric and pain comorbidities; *(Outcome)* [Moved from IV.A.5.a).(1).(c).(i)]
IV.B.1.b).(1).(c).(ii) conducting a complete mental status examination; and, \(^{(Outcome)}\) \(^{(Core)}\) \([\text{Moved from IV.A.5.a).(1).(c).(ii)}\]

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<td>IV.B.1.b).(1).(c).(ii).(a)</td>
<td>A complete mental status examination must be conducted on a minimum of 15 patients. (^{(Core)}) ([\text{Formerly IV.A.5.a).(1).(c).(ii)}.(a)}]</td>
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<td>IV.B.1.b).(1).(c).(ii).(b)</td>
<td>Each fellow must demonstrate proficiency in conducting a complete mental status examination this ability in five patients to a faculty observer. (^{(Core)}) ([\text{Formerly IV.A.5.a).(1).(c).(ii).b)]]</td>
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1. Describe the Review Committee’s rationale for this revision: As with many of the minimums required for procedures, this requirement was limiting flexibility to foster competence in fellows using a variety of methodologies. Because the performance and trajectory of a fellow’s growth toward competency varies significantly between individuals, feedback suggests that establishing a number as a requirement does a disservice both to those individuals who master a procedure with a few cases, as well as to those who need significantly more experience before their program determines they are ready to practice without supervision.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The Review Committees’ intent is to permit programs to determine fellow procedural competence within the local context of their clinical settings and institutions.**

3. How will the proposed requirement or revision impact continuity of patient care? **It is unlikely to impact continuity of patient care.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **As the previous minimums required were not very high, it is unlikely to impact the institutional resources available to programs.**

5. How will the proposed revision impact other accredited programs? **While institutions may find discussions of balancing case volume and type a little easier due to the flexibility being given to programs, the change is unlikely to impact other accredited programs.**

**Requirement #:** IV.B.1.b).(2).(a).(i) - IV.B.1.b).(2).(a).(v).(a)

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<td>IV.B.1.b).(2).(a).(i)</td>
<td><strong>obtaining intravenous access,</strong> (^{(Outcome)}) ([\text{Formerly IV.A.5.a).(2).(a).(i)}]</td>
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<td>IV.B.1.b).(2).(a).(i).(a)</td>
<td><strong>Intravenous access must be obtained in a minimum of 15 patients</strong> (^{(Core)}) ([\text{Formerly IV.A.5.a).(2).(a).(i).(a)}]</td>
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<td>IV.B.1.b).(2).(a).(ii)</td>
<td><strong>basic airway management that at a minimum includes competency in mask ventilation,</strong> (^{(Outcome)}) (^{(Core)}) ([\text{Moved from IV.A.5.a).(2).(a).(ii)}]</td>
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| IV.B.1.b).(2).(a).(ii).(a) | This must include a minimum of mask ventilation in 15 patients. | (Core) 
Formerly IV.A.5.a).(2).(a).(ii).(a) |
| IV.B.1.b).(2).(a).(iii) | Endotracheal intubation; advanced airway management; | (Outcome)(Core) 
Moved from IV.A.5.a).(iii) |
| IV.B.1.b).(2).(a).(iii).(a) | This must include experience with laryngeal mask airway and/or endotracheal intubation as a back-up if mask ventilation is unsuccessful. | (Core) |
| IV.B.1.b).(2).(a).(iii).(b) | Endotracheal intubation must be performed on 15 patients. | (Core) 
Formerly IV.A.5.a).(2).(a).(iii).(a) |
| IV.B.1.b).(2).(a).(iv) | Basic life support and advanced cardiac life support; | (Outcome)(Core) 
Moved from IV.A.5.a).(2).(a).(iv) |
| IV.B.1.b).(2).(a).(v) | Management of sedation, and including exposure to administration of moderate procedural sedation. | (Outcome)(Core) 
Moved from IV.A.5.a).(2).(a).(v) |
| IV.B.1.b).(2).(a).(v).(a) | This must include direct administration of sedation to a minimum of 15 patients. | (Core) 
Formerly IV.A.5.a).(2).(a).(v).(a) |

1. Describe the Review Committee’s rationale for this revision: The pain medicine physician does procedures which frequently require sedation. The requirement for intubation was replaced with the more realistic need for basic skills of bag valve mask and a back-up method, such as laryngeal mask airway. The number of patients was removed for previously stated reasons, and the complications were spelled out in more detail.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? Fellows will gain the necessary knowledge and skills to safely provide sedation for the procedure and improve overall patient safety.

3. How will the proposed requirement or revision impact continuity of patient care? The requirement will improve physician-to-physician communication as well as collaboration with nursing colleagues.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? No additional resources required.

5. How will the proposed revision impact other accredited programs? It will have no impact.

Requirement #: IV.B.1.b).(2).(a).(vi) - IV.B.1.b).(2).(a).(vii)

Requirement Revision (significant change only):

[Fellows must demonstrate competence in:]

IV.B.1.b).(2).(a).(vi) administration of neuraxial analgesia, including placement thoracic or lumbar epidural injections using an interlaminar technique; recognizing and managing
physiologic perturbations associated with neuraxial anesthesia/analgesia, including development of motor and sensory loss and cardiovascular and respiratory changes. [Moved from IV.A.5.a).(2).(a).(vi)]

IV.B.1.b).(2).(a).(vi).(a) A minimum of 15 thoracic or lumbar epidural injections using an interlaminar technique must be completed. [Moved from IV.A.5.a).(2).(a).(vi).]

IV.B.1.b).(2).(a).(vii) recognizing and managing physiologic perturbations associated with intravascular injection of local anesthetics, including mental status changes, seizure, and cardiovascular collapse; and, [Core]

1. Describe the Review Committee’s rationale for this revision: During pain procedures, a fellow may be the only physician present when the use of local anesthetics result in complications. The pain medicine physician must be able to recognize such complications and to resuscitate these patients.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? It will enhance patient safety and quality.

3. How will the proposed requirement or revision impact continuity of patient care? It is unlikely to impact continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? It is unlikely to necessitate additional resources.

5. How will the proposed revision impact other accredited programs? It will not impact other accredited programs.

Requirement #: IV.B.1.b).(2).(a).(viii) through IV.B.1.b).(2).(a).(viii).(h)

Requirement Revision (significant change only):
Fellows must demonstrate competence in:

IV.B.1.b).(2).(a).(viii) performing interventional treatments, including; [Core]

IV.B.1.b).(2).(a).(viii).(a) epidural injections: new interlaminar, transfominal and caudal; [Detail]

IV.B.1.b).(2).(a).(viii).(b) at least 25 image-guided spinal intervention; [Moved from IV.A.6.b).(4).(b).(i)]

IV.B.1.b).(2).(a).(viii).(c) at least 10 trigger point injections; [Moved from IV.A.6.b).(4).(b).(ii)]

IV.B.1.b).(2).(a).(vii).(d) facet and medial branch blocks; [Detail]

IV.B.1.b).(2).(a).(vii).(e) at least 10 neuroablative procedures; [Moved from IV.A.6.b).(4).(b).(iii)]

IV.B.1.b).(2).(a).(vii).(f) at least five joint and bursa injections; [Moved from IV.A.6.b).(4).(b).(iv)]
### IV.B.1.b).(2).(a).(vii).(g) at least five neuromodulation sympathetic blocks; and,  
\[ \text{(Detail) [Moved from IV.A.6.b).(4).(b).(v)]} \]

### IV.B.1.b).(2).(a).(vii).(h) Peripheral Nerve Blocks. at least five nerve blocks, including a variety of blocks such as intercostal blocks, ilioinguinal blocks, genitofemoral blocks, and lateral femoral cutaneous blocks.  
\[ \text{(Detail) [Moved from IV.A.6.b).(4).(b).]} \]

1. Describe the Review Committee’s rationale for this revision: Programs will have greater flexibility in curriculum design, allowing fellows to develop competence without a specific number of procedures.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? The requirement improves the education experience for fellows by allowing the program director to adapt to the needs of an individual fellow.

3. How will the proposed requirement or revision impact continuity of patient care? There will be no impact on patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? There is no need for additional institutional resources.

5. How will the proposed revision impact other accredited programs? There will be no impact on other accredited programs.

Requirement#: IV.B.1.b).(2).(b) – (b).(iii)

**Requirement Revision (significant change only):**

### IV.B.1.b).(2).(b) Interventional Experience (Core) Fellows should demonstrate competence in:  
\[ \text{(Moved from IV.A.6.b).(4)]} \]

### IV.B.1.b).(2).(b).(i) The ACGME recognizes that interventional pain medicine is an evolving discipline. Programs shall not be required to offer all techniques to their trainees. However, the program director of an ACGME-accredited Pain Medicine Training Program must demonstrate that fellows are exposed to a didactic curriculum that includes topics in Interventional Pain Treatment (see Medical Knowledge), and that fellows receive a range of direct, hands-on experience with a range of interventional pain treatment techniques. At the conclusion of the training period, the program director must prepare a final report for each fellow that clearly documents the specific interventional techniques with which fellows demonstrate competence.  
\[ \text{(Core) [Moved from IV.A.6.b).(4).a]} \]

### IV.B.1.b).(2).(b).(ii) To establish this experience, the fellow must document involvement with a minimum of 60 patients who undergo interventional procedures in the following categories:  
\[ \text{(Core) [Moved from IV.A.6.b).(4).b]} \]

### IV.B.1.b).(2).(b).(iii) neuromodulation and managing intervertebral disc procedures (e.g., spinal cord stimulation, peripheral nerve stimulation, electrical stimulation, and targeted drug delivery).  
\[ \text{(Detail)} \]

1. Describe the Review Committee’s rationale for this revision: Rather than requiring the program director to attest to fellow competence, the requirement was recrafted to reflect...
the type of clinical experience fellows should receive in order to achieve competence in a range of interventional pain treatment techniques.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? The requirement provides greater flexibility in making clinical learning assignments, allowing the program director to maximize learning opportunities.

3. How will the proposed requirement or revision impact continuity of patient care? It will not.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? It will not.

How will the proposed revision impact other accredited programs? There will be no impact on other programs.

Requirement #: IV.B.1.b).(2).(c) through IV.B.1.b).(2).(c).(iv).(a).(ii)

Requirement Revision (significant change only):

IV.B.1.b).(2).(c). Fellows must demonstrate competence in interventional procedures and processes, including the following management skills:

IV.B.1.b).(2).(c).(i) recognizing risks and complications; (Core)

IV.B.1.b).(2).(c).(ii) obtaining a complete informed consent identifying the appropriate risks and potential benefits of each procedure, including sedation; and, (Detail)

IV.B.1.b).(2).(c).(iii) identifying and mitigating risks for the following intervening factors: infection risk, opioid use including the use of antagonists, anti-coagulation, pacemaker, and other implanted devices; and, (Detail)

IV.B.1.b).(2).(c).(iv) managing patients receiving opioids, including an understanding of opioid agreements, risk mitigation tools, and appropriate use of drug screening. (Core)

IV.B.1.b).(2).(c).(iv).(a) Fellows must demonstrate competence in:

IV.B.1.b).(2).(c).(iv).(a).(i) recognizing substance use disorders; and, (Detail)

IV.B.1.b).(2).(c).(iv).(a).(ii) identifying treatment options for addiction, including medication-assisted treatment for opioid use disorder. (Detail)

1. Describe the Review Committee’s rationale for this revision: With opioid use disorder at an all-time high in the US, there is an increased need for pain specialists knowledgeable in all aspects of the diagnosis and management of patients with opioid addiction, including risk management.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? The revision will improve graduates’ knowledge and management of patients with opioid addiction.
3. How will the proposed requirement or revision impact continuity of patient care? The requirement will improve patient care in an area in which few physicians have adequate expertise.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? There will be no need for additional institutional resources.

5. How will the proposed revision impact other accredited programs? There will be no impact on other accredited programs.

Requirement #: IV.B.1.c).(1).(b).through IV.B.1.c).(1).(b).(ii).(h)

Requirement Revision (significant change only):
[Fellows must demonstrate competence in their knowledge of:]

IV.B.1.c).(1).(b) treatment of pain, including; [Moved from IV.A.5.b).(2)]

IV.B.1.c).(1).(b).(i) drug treatment of:

IV.B.1.c).(1).(b).(i).(a) Drug Treatment I: opioids; [Formerly IV.A.5.b).(2).(a)]

IV.B.1.c).(1).(b).(i).(b) Drug Treatment II: antipyretic analgesics; [Formerly IV.A.5.b).(2).(b)]

IV.B.1.c).(1).(b).(i).(c) Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs; [Moved from IV.A.5.b).(2).(c)]

IV.B.1.c).(1).(b).(i).(d) nonsteroidal anti-inflammatory drugs; and; [Moved from IV.A.5.b).(2).c]

IV.B.1.c).(1).(b).(i).(e) opioids. [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii) systemic opioids, to include; [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).a) management of acute or chronic pain in the opioid tolerant patient. [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).b) pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).c) mechanism of action; [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).d) chemical structure; [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).e) mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents [Moved from IV.A.5.b.(2).c]

IV.B.1.c).(1).(b).(ii).f) use of patient controlled-analgesic systems. [Moved from IV.A.5.b.(2).c]
IV.B.1.c).1.(b).ii.(g) post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and, *(Core)*

IV.B.1.c).1.(b).ii.(h) management of acute or chronic pain in the opioid tolerant patient. *(Core)*

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<tr>
<th>Requirement</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>1.</strong> Describe the Review Committee’s rationale for this revision: <strong>The nuances of the best use of opioids in treating pain require that pain medicine fellows develop this competence.</strong></td>
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<tr>
<td><strong>2.</strong> How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? <strong>This revision will improve the care of patients requiring opioid medication.</strong></td>
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<tr>
<td><strong>3.</strong> How will the proposed requirement or revision impact continuity of patient care? <strong>There will be no impact on continuity of patient care.</strong></td>
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<tr>
<td><strong>4.</strong> Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? <strong>This requirement will not need additional resources.</strong></td>
<td></td>
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<tr>
<td><strong>5.</strong> How will the proposed revision impact other accredited programs? <strong>There will be no impact.</strong></td>
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**Requirement #: IV.C.3.a).1(1) and IV.C.3.a).1(a)**

**Requirement Revision (significant change only):**

**IV.C.3.a).1(1) Outpatient (Continuity Clinic) Pain Experience; *(Core)* [Moved from IV.A.6.b).1]****

**IV.C.3.a).1(a) Continuity experience will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary model of chronic pain management. To this end, the pain medicine fellows should attend a supervised outpatient clinic at least one half-day, approximately weekly, when averaged throughout the year of the program. *(Core)* Fellows may be absent from continuity clinic experience only if the rotation site is more than one hour from the core institution. The maximum allowable time away may be no more than four months. This will provide a minimum of eight months experience (full-time equivalent of at least 60 half-days). *(Detail)* [Moved from IV.A.6.b).1(a)]****

**Specialty Background and Intent: Continuity experience will provide fellows with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary model of chronic pain management. This clinical experience may be interspersed and may be half-day experiences.**

**1.** Describe the Review Committee’s rationale for this revision: **This revision decreases confusion and gives the program director greater flexibility for curriculum design while improving fellows’ educational experience.**

**2.** How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The requirement provides greater flexibility in curriculum design allowing the program director to maximize learning opportunities.**
3. How will the proposed requirement or revision impact continuity of patient care? **There will be greater flexibility and may enhance the ability of patients to obtain clinic appointments.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **There will be no need for additional institutional resources.**

5. How will the proposed revision impact other accredited programs? **There will be no impact on other programs.**

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<th>Requirement #: IV.C.3.a).(6) – (6).(a)</th>
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<tbody>
<tr>
<td>Requirement Revision (significant change only):</td>
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<tr>
<td>IV.C.3.a).(6) Pediatric Experience. <em>(Core)</em></td>
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<tr>
<td>[Formerly IV.A.6.b).(7)]</td>
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<tr>
<td>IV.C.3.a).(6).(a) Experience with the assessment and treatment of pain in children is strongly encouraged. <em>(Detail)</em></td>
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<td>[Formerly IV.A.6.b).(7).(a)]</td>
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1. Describe the Review Committee’s rationale for this revision: **This detail requirement caused a great deal of confusion and was too vague to be of use.**

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **This requirement was not helpful and deletion will decrease confusion among programs.**

3. How will the proposed requirement or revision impact continuity of patient care? **No impact anticipated.**

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **It will require fewer institutional resources.**

5. How will the proposed revision impact other accredited programs? **It is likely to have no impact.**

<table>
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<tr>
<th>Requirement #: IV.C.3.b) through IV.C.3.b).(2).(b)</th>
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<tr>
<td>Requirement Revision (significant change only):</td>
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<tr>
<td>IV.C.3.b) The didactic curriculum must be prepared by the program director, who, together with the teaching staff, prepare and comply faculty, must ensure: <em>(Detail)</em> [Moved from II.A.4.p)]</td>
</tr>
<tr>
<td>IV.C.3.b).(1) the curriculum complies with the written goals for the program. All educational components of the program should be related to the program goals. The program design must be approved by the Review Committee as part of the regular review process. A written statement of the educational objectives must be given to each fellow; and, <em>(Detail)</em> [Moved from II.A.4.p)]</td>
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<tr>
<td>IV.C.3.b).(2) ensure that pain medicine conferences be are held regularly, at least monthly. <em>(Detail)</em> [Moved from II.A.4.q)]</td>
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IV.C.3.b).(2).a) These should include morbidity and mortality conferences, journal reviews, and research seminars. (Moved from II.A.4.q).(1)]

IV.C.3.b).(2).b) There should be active participation in the planning and presentation of these conferences by fellows and faculty members. (Moved from II.A.4.q).(2)]

1. Describe the Review Committee’s rationale for this revision: Regular conferences were defined more precisely to offer more clarity.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? Expectations for the didactic curriculum are more clear and easier to follow.

3. How will the proposed requirement or revision impact continuity of patient care? No impact anticipated.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? N/A

5. How will the proposed revision impact other accredited programs? N/A