ACGME Program Requirements for Graduate Medical Education in Brain Injury Medicine

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Editorial Revision: Common Program Requirements Background and Intent below VI.A.2.b) revised, substance use disorder language updated July 1, 2021

VI.A.2.c).(1).(b) inserted, effective July 1, 2021

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ACGME Program Requirements for Graduate Medical Education in Brain Injury Medicine

Common Program Requirements (Fellowship) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.

Introduction

Int.A. ***Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care.***

Fellows who have completed residency are able to practice independently in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering into residency training. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Int.B. **Definition of Subspecialty**

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Brain injury medicine addresses the prevention, diagnosis, treatment, and management of persons with brain injury, including the prevention, diagnosis, and treatment of related medical, physical, psychosocial, and vocational disabilities and complications during the lifetime of the patient.

Int.C. Length of Educational Program

The educational program in brain injury medicine must be 12 months in length. (Core)*

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.1.a) The Sponsoring Institution must be affiliated with hospitals and clinics that provide care for persons with brain injury from acute care through long-term outpatient management. (Core)

I.B.1.b) The Sponsoring Institution must sponsor an ~~Accreditation Council for Graduate Medical Education (~~ACGME~~)~~-accredited program in child neurology, neurology, physical medicine and rehabilitation,

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90 or psychiatry. (Core)

92 I.B.1.c) There must be close collaboration between the affiliated residency program and the brain injury medicine fellowship. (Core)

95 I.B.1.c).(1) There must be evidence of collaboration and oversight from the residency program director, including the integration of lectures into both the affiliated residency and the fellowship curricula, and involvement of fellows and fellowship faculty members in activities of the residency program. (Core)

102 **I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**

107 **I.B.2.a) The PLA must:**

109 **I.B.2.a).(1) be renewed at least every 10 years; and, (Core)**

111 **I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)**

114 **I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)**

117 **I.B.3.a) At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)**

121

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:
- **Identifying the faculty members who will assume educational and supervisory responsibility for fellows**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows**
- **Specifying the duration and content of the educational experience**

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- **Stating the policies and procedures that will govern fellow education during the assignment**

122
123 **I.B.4.** **The program director must submit any additions or deletions of**
124 **participating sites routinely providing an educational experience,**
125 **required for all fellows, of one month full time equivalent (FTE) or**
126 **more through the ACGME's Accreditation Data System (ADS).** (Core)
127
128 I.B.4.a) All participating sites providing clinical experiences should be in
129 the same geographic location as the primary clinical site, limited to
130 a travel time of no more than one hour for rotations requiring daily
131 attendance, unless appropriate overnight accommodations are
132 provided by the program or institution. (Detail)†
133

Specialty-Specific Background and Intent: A participating site offering clinical experiences that occur periodically and are not otherwise available at the primary clinical site is a suitable exception to the requirement limiting travel time to one hour or less.

134
135 **I.C.** **The program, in partnership with its Sponsoring Institution, must engage in**
136 **practices that focus on mission-driven, ongoing, systematic recruitment**
137 **and retention of a diverse and inclusive workforce of residents (if present),**
138 **fellows, faculty members, senior administrative staff members, and other**
139 **relevant members of its academic community.** (Core)
140

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

141
142 **I.D.** **Resources**
143
144 **I.D.1.** **The program, in partnership with its Sponsoring Institution, must**
145 **ensure the availability of adequate resources for fellow education.**
146 (Core)
147
148 I.D.1.a) The program must have access to a service delivery system
149 dedicated to the care of persons with brain injury. (Core)
150
151 I.D.1.b) Resources should include:
152
153 I.D.1.b).(1) an emergency department that treats patients with brain
154 injury; (Detail)
155
156 I.D.1.b).(2) an accredited acute care hospital; (Detail)
157
158 I.D.1.b).(3) an inpatient rehabilitation unit; (Detail)
159
160 I.D.1.b).(4) a designated outpatient clinic for persons with brain injury;

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(Detail)

I.D.1.b).(5) availability of home care and other community reintegration resources; (Detail)

I.D.1.b).(6) other post-acute rehabilitation facilities, such as long-term acute and community-based and residential treatment facilities; and, (Detail)

I.D.1.b).(7) specialty and subspecialty consultant services essential to the care of persons with brain injury, including anesthesiology, diagnostic radiology, emergency medicine, general surgery, internal medicine, neurological surgery, neurology, ophthalmology, orthopaedic surgery, otolaryngology, pediatrics, physical medicine and rehabilitation, and psychiatry. (Detail)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

I.D.2.d) security and safety measures appropriate to the participating site; and, (Core)

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196
197 **I.D.2.e)** **accommodations for fellows with disabilities consistent with**
198 **the Sponsoring Institution's policy.** (Core)
199
200 **I.D.3.** **Fellows must have ready access to subspecialty-specific and other**
201 **appropriate reference material in print or electronic format. This**
202 **must include access to electronic medical literature databases with**
203 **full text capabilities.** (Core)
204
205 **I.D.4.** **The program's educational and clinical resources must be adequate**
206 **to support the number of fellows appointed to the program.** (Core)
207
208 I.D.4.a) The patient population must be of sufficient size and diversity of
209 age, and include persons age 15 and older with new and
210 continuing brain injury dysfunction, in both inpatient and outpatient
211 settings. (Core)
212
213 **I.E.** ***A fellowship program usually occurs in the context of many learners and***
214 ***other care providers and limited clinical resources. It should be structured***
215 ***to optimize education for all learners present.***
216
217 **I.E.1.** **Fellows should contribute to the education of residents in core**
218 **programs, if present.** (Core)
219

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

220
221 **II. Personnel**
222
223 **II.A. Program Director**
224
225 **II.A.1.** **There must be one faculty member appointed as program director**
226 **with authority and accountability for the overall program, including**
227 **compliance with all applicable program requirements.** (Core)
228
229 **II.A.1.a)** **The Sponsoring Institution's Graduate Medical Education**
230 **Committee (GMEC) must approve a change in program**
231 **director.** (Core)
232
233 **II.A.1.b)** **Final approval of the program director resides with the**
234 **Review Committee.** (Core)
235

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the fellowship, and it is this individual's

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responsibility to communicate with the fellows, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

236
237 **II.A.2.** **The program director must be provided with support adequate for**
238 **administration of the program based upon its size and configuration.**
239 **(Core)**
240
241 II.A.2.a) At a minimum, the program director and associate program
242 director(s), as applicable, must be provided with the aggregate
243 salary support required to devote 10 percent FTE of non-clinical
244 time to the administration of the program. Additional support for
245 the program director and the associate program director(s) must
246 be provided based on program size as follows: (Core)
247

Number of Approved Fellow Positions	Minimum Aggregate Program Director/Associate Program Director FTE
1-2	0.1
3 or more	0.15

248
249 II.A.2.b) ~~At a minimum, the program director must be provided with the~~
250 ~~salary support required to devote 10 percent FTE of non-clinical~~
251 ~~time to the administration of the program. (Core)~~
252

Background and Intent: Ten percent FTE is defined as one half day per week.

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

The requirement does not address the source of funding required to provide the specified salary support.

253
254 **II.A.3.** **Qualifications of the program director:**
255
256 **II.A.3.a)** **must include subspecialty expertise and qualifications**
257 **acceptable to the Review Committee; and, (Core)**
258

Specialty-Specific Background and Intent: The Review Committee recommends that an individual spend two years as a faculty member in an ACGME-accredited neurology, physical medicine and rehabilitation, or psychiatry residency or fellowship program prior to taking on the role and responsibilities of program director. This time would allow an individual to gain GME expertise, as well as institutional credibility to direct the fellowship and ensure compliance with the Program Requirements.

Time spent in fellowship education would not count towards the two years of experience as an active faculty member.

259
260 **II.A.3.b)** **must include current certification in the subspecialty for**
261 **which they are the program director by the American Board**

262 **of** Physical Medicine and Rehabilitation or the American Board of
263 Psychiatry and Neurology**, or subspecialty qualifications that**
264 **are acceptable to the Review Committee.** (Core)
265
266 [Note that while the Common Program Requirements deem
267 certification by a certifying board of the American Osteopathic
268 Association (AOA) acceptable, there is no AOA board that offers
269 certification in this subspecialty]

270 **II.A.4. Program Director Responsibilities**
271
272 **The program director must have responsibility, authority, and**
273 **accountability for: administration and operations; teaching and**
274 **scholarly activity; fellow recruitment and selection, evaluation, and**
275 **promotion of fellows, and disciplinary action; supervision of fellows;**
276 **and fellow education in the context of patient care.** (Core)
277
278 **II.A.4.a) The program director must:**
279
280 **II.A.4.a).(1) be a role model of professionalism;** (Core)
281

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

282
283 **II.A.4.a).(2) design and conduct the program in a fashion**
284 **consistent with the needs of the community, the**
285 **mission(s) of the Sponsoring Institution, and the**
286 **mission(s) of the program;** (Core)
287

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

288
289 **II.A.4.a).(3) administer and maintain a learning environment**
290 **conducive to educating the fellows in each of the**
291 **ACGME Competency domains;** (Core)
292

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to

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others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

293
294 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; (Core)**
295
296
297
298
299 **II.A.4.a).(5)** **have the authority to approve program faculty members for participation in the fellowship program education at all sites; (Core)**
300
301
302
303 **II.A.4.a).(6)** **have the authority to remove program faculty members from participation in the fellowship program education at all sites; (Core)**
304
305
306
307 **II.A.4.a).(7)** **have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**
308
309
310

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

311
312 **II.A.4.a).(8)** **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**
313
314
315 **II.A.4.a).(9)** **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); (Core)**
316
317
318
319 **II.A.4.a).(10)** **provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**
320
321
322
323
324
325 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)**
326
327
328
329 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; (Core)**
330
331
332
333

334

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.

335
336 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
337 **Institution's policies and procedures on employment**
338 **and non-discrimination; (Core)**
339
340 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
341 **competition guarantee or restrictive covenant.**
342 **(Core)**
343
344 **II.A.4.a).(14)** **document verification of program completion for all**
345 **graduating fellows within 30 days; (Core)**
346
347 **II.A.4.a).(15)** **provide verification of an individual fellow's**
348 **completion upon the fellow's request, within 30 days;**
349 **and, (Core)**
350

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

351
352 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
353 **Institution's DIO before submitting information or**
354 **requests to the ACGME, as required in the Institutional**
355 **Requirements and outlined in the ACGME Program**
356 **Director's Guide to the Common Program**
357 **Requirements. (Core)**
358
359 **II.B.** **Faculty**
360
361 ***Faculty members are a foundational element of graduate medical education***
362 ***– faculty members teach fellows how to care for patients. Faculty members***
363 ***provide an important bridge allowing fellows to grow and become practice***
364 ***ready, ensuring that patients receive the highest quality of care. They are***
365 ***role models for future generations of physicians by demonstrating***
366 ***compassion, commitment to excellence in teaching and patient care,***
367 ***professionalism, and a dedication to lifelong learning. Faculty members***
368 ***experience the pride and joy of fostering the growth and development of***
369 ***future colleagues. The care they provide is enhanced by the opportunity to***
370 ***teach. By employing a scholarly approach to patient care, faculty members,***
371 ***through the graduate medical education system, improve the health of the***
372 ***individual and the population.***
373

374 ***Faculty members ensure that patients receive the level of care expected***
375 ***from a specialist in the field. They recognize and respond to the needs of***
376 ***the patients, fellows, community, and institution. Faculty members provide***
377 ***appropriate levels of supervision to promote patient safety. Faculty***
378 ***members create an effective learning environment by acting in a***
379 ***professional manner and attending to the well-being of the fellows and***
380 ***themselves.***
381

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.

382
383 **II.B.1.** **For each participating site, there must be a sufficient number of**
384 **faculty members with competence to instruct and supervise all**
385 **fellows at that location. (Core)**
386
387 II.B.1.a) ~~In addition to the program director, there must be at least one~~
388 ~~other FTE faculty member with expertise in brain injury medicine.~~
389 ~~(Detail)~~ [Moved to II.B.4.c) below]
390
391 **II.B.2.** **Faculty members must:**
392
393 **II.B.2.a)** **be role models of professionalism; (Core)**
394
395 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality,**
396 **cost-effective, patient-centered care; (Core)**
397

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

398
399 **II.B.2.c)** **demonstrate a strong interest in the education of fellows; (Core)**
400
401 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
402 **their supervisory and teaching responsibilities; (Core)**
403
404 **II.B.2.e)** **administer and maintain an educational environment**
405 **conducive to educating fellows; (Core)**
406
407 **II.B.2.f)** **regularly participate in organized clinical discussions,**
408 **rounds, journal clubs, and conferences; and, (Core)**
409
410 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
411 **at least annually. (Core)**
412

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in

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a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

413
414 **II.B.3. Faculty Qualifications**
415
416 **II.B.3.a) Faculty members must have appropriate qualifications in**
417 **their field and hold appropriate institutional appointments.**
418 **(Core)**
419
420 **II.B.3.b) Subspecialty physician faculty members must:**
421
422 **II.B.3.b).(1) have current certification in the subspecialty by the**
423 **American Board of** Physical Medicine and Rehabilitation
424 or the American Board of Psychiatry and Neurology **or**
425 **possess qualifications judged acceptable to the**
426 **Review Committee. (Core)**
427
428 [Note that while the Common Program Requirements
429 deem certification by a certifying board of the American
430 Osteopathic Association (AOA) acceptable, there is no
431 AOA board that offers certification in this subspecialty]
432

Specialty-Specific Background and Intent: The program director and faculty members are expected to hold current subspecialty certification in brain injury medicine. Years of practice are not an equivalent to board certification. The onus for documenting evidence for consideration of alternate qualifications is on the program director; however, the determination of whether qualifications are equivalent to certification by the ABPMR or ABPN is a case-by-case judgment call on the part of the Review Committee.

433
434 **II.B.3.c) Any non-physician faculty members who participate in**
435 **fellowship program education must be approved by the**
436 **program director. (Core)**
437

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

438
439 **II.B.3.d) Any other specialty physician faculty members must have**
440 **current certification in their specialty by the appropriate**
441 **American Board of Medical Specialties (ABMS) member**
442 **board or American Osteopathic Association (AOA) certifying**
443 **board, or possess qualifications judged acceptable to the**
444 **Review Committee. (Core)**

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II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)

> **Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the subspecialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.**

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. (Core)

II.B.4.c) To ensure the quality of the educational and scholarly activity of the program, and to provide adequate supervision of fellows, in addition to the program director, there must be at least one other core FTE faculty member with expertise in brain injury medicine. ~~(Detail)~~(Core) [Moved from II.B.1.a)]

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. The program coordinator must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

> **Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.**
>
> **Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.**
>
> **The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows.**

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Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

475
476 **II.D. Other Program Personnel**
477
478 **The program, in partnership with its Sponsoring Institution, must jointly**
479 **ensure the availability of necessary personnel for the effective**
480 **administration of the program.** (Core)
481
482 II.D.1. Appropriately-qualified professional staff members must be available in
483 the disciplines of neuropsychology/psychology, occupational therapy,
484 orthotics and prosthetics, physical therapy, rehabilitation nursing,
485 respiratory therapy, social service, speech-language pathology,
486 therapeutic recreation, and vocational counseling. (Core)
487

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

488
489 **III. Fellow Appointments**
490
491 **III.A. Eligibility Criteria**
492
493 **III.A.1. Eligibility Requirements – Fellowship Programs**
494
495 **All required clinical education for entry into ACGME-accredited**
496 **fellowship programs must be completed in an ACGME-accredited**
497 **residency program, an AOA-approved residency program, a**
498 **program with ACGME International (ACGME-I) Advanced Specialty**
499 **Accreditation, or a Royal College of Physicians and Surgeons of**
500 **Canada (RCPSC)-accredited or College of Family Physicians of**
501 **Canada (CFPC)-accredited residency program located in Canada.**
502 **(Core)**
503

Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).

504
505 **III.A.1.a) Fellowship programs must receive verification of each**
506 **entering fellow's level of competence in the required field,**
507 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
508 **Milestones evaluations from the core residency program.** (Core)
509
510 III.A.1.b) Prior to appointment in the program, fellows must have
511 successfully completed a program in one of the following that

satisfies program requirement III.A.1.: child neurology, neurology, physical medicine and rehabilitation, psychiatry, or sports medicine. (Core)

III.A.1.c) Fellow Eligibility Exception

The Review Committees for Physical Medicine and Rehabilitation and Psychiatry **will allow the following exception to the fellowship eligibility requirements:**

The Review Committee for Neurology will not allow the following exception:

III.A.1.c).(1) **An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)**

III.A.1.c).(1).(a) **evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)**

III.A.1.c).(1).(b) **review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**

III.A.1.c).(1).(c) **verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**

III.A.1.c).(2) **Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)**

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

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In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

552
553 **III.B.** **The program director must not appoint more fellows than approved by the**
554 **Review Committee.** (Core)
555
556 **III.B.1.** **All complement increases must be approved by the Review**
557 **Committee.** (Core)
558
559 **III.C.** **Fellow Transfers**
560
561 **The program must obtain verification of previous educational experiences**
562 **and a summative competency-based performance evaluation prior to**
563 **acceptance of a transferring fellow, and Milestones evaluations upon**
564 **matriculation.** (Core)
565
566 **IV. Educational Program**
567
568 ***The ACGME accreditation system is designed to encourage excellence and***
569 ***innovation in graduate medical education regardless of the organizational***
570 ***affiliation, size, or location of the program.***
571
572 ***The educational program must support the development of knowledgeable, skillful***
573 ***physicians who provide compassionate care.***
574
575 ***In addition, the program is expected to define its specific program aims consistent***
576 ***with the overall mission of its Sponsoring Institution, the needs of the community***
577 ***it serves and that its graduates will serve, and the distinctive capabilities of***
578 ***physicians it intends to graduate. While programs must demonstrate substantial***
579 ***compliance with the Common and subspecialty-specific Program Requirements, it***
580 ***is recognized that within this framework, programs may place different emphasis***
581 ***on research, leadership, public health, etc. It is expected that the program aims***
582 ***will reflect the nuanced program-specific goals for it and its graduates; for***
583 ***example, it is expected that a program aiming to prepare physician-scientists will***
584 ***have a different curriculum from one focusing on community health.***
585
586 **IV.A.** **The curriculum must contain the following educational components:** (Core)
587
588 **IV.A.1.** **a set of program aims consistent with the Sponsoring Institution's**
589 **mission, the needs of the community it serves, and the desired**
590 **distinctive capabilities of its graduates;** (Core)
591
592 **IV.A.1.a)** **The program's aims must be made available to program**
593 **applicants, fellows, and faculty members.** (Core)
594
595 **IV.A.2.** **competency-based goals and objectives for each educational**
596 **experience designed to promote progress on a trajectory to**
597 **autonomous practice in their subspecialty. These must be**

598 **distributed, reviewed, and available to fellows and faculty members;**
599 **(Core)**
600
601 **IV.A.3.** **delineation of fellow responsibilities for patient care, progressive**
602 **responsibility for patient management, and graded supervision in**
603 **their subspecialty; (Core)**
604

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

605
606 **IV.A.4.** **structured educational activities beyond direct patient care; and,**
607 **(Core)**
608

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

609
610 **IV.A.5.** **advancement of fellows' knowledge of ethical principles**
611 **foundational to medical professionalism. (Core)**
612
613 **IV.B.** **ACGME Competencies**
614

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

615
616 **IV.B.1.** **The program must integrate the following ACGME Competencies**
617 **into the curriculum: (Core)**
618
619 **IV.B.1.a)** **Professionalism**
620
621 **Fellows must demonstrate a commitment to professionalism**
622 **and an adherence to ethical principles. (Core)**
623
624 **IV.B.1.b)** **Patient Care and Procedural Skills**
625

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New*

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***Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.**

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

626
627 **IV.B.1.b).(1)** **Fellows must be able to provide patient care that is**
628 **compassionate, appropriate, and effective for the**
629 **treatment of health problems and the promotion of**
630 **health.** **(Core)**
631
632 IV.B.1.b).(1).(a) Fellows must demonstrate proficiency in:
633
634 IV.B.1.b).(1).(a).(i) performing a comprehensive neurologic
635 history and examination, including mental
636 status examination; (Core)
637
638 IV.B.1.b).(1).(a).(ii) evaluating the extent of injury and specific
639 injury patterns; (Core)
640
641 IV.B.1.b).(1).(a).(iii) monitoring the evolution of neurologic
642 impairment from brain injury in order to
643 recognize conditions that may require
644 additional evaluation, consultation, or
645 modification of treatment; (Core)
646
647 IV.B.1.b).(1).(a).(iv) coordinating the transition from acute care
648 to rehabilitation; (Core)
649
650 IV.B.1.b).(1).(a).(v) establishing short- and long-term
651 rehabilitation goals and coordinating the
652 implementation of the rehabilitation program
653 to meet such goals; (Core)
654
655 IV.B.1.b).(1).(a).(vi) diagnosing and coordinating treatment of
656 respiratory complications of the patient with
657 brain injury, including tracheostomies,
658 atelectasis, pneumonia, and tracheal
659 stenosis; (Core)
660
661 IV.B.1.b).(1).(a).(vii) evaluating and coordinating treatment for
662 dysphagia; (Core)
663
664 IV.B.1.b).(1).(a).(viii) evaluating and managing spasticity,
665 including use of intrathecal medication and
666 chemodenervation treatment; (Core)
667
668 IV.B.1.b).(1).(a).(ix) diagnosing and coordinating treatment of

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669 autonomic and sympathetic hyperactivity;
670 (Core)
671
672 IV.B.1.b).(1).(a).(x) evaluating and coordinating treatment of
673 acute and chronic pain; (Core)
674
675 IV.B.1.b).(1).(a).(xi) evaluating and monitoring skin problems
676 using techniques for prevention, including
677 the use of specialized beds and cushions;
678 (Core)
679
680 IV.B.1.b).(1).(a).(xii) diagnosing and managing agitation,
681 emotional and behavioral problems,
682 cognitive impairment, and sleep disorders
683 associated with brain injury; (Core)
684
685 IV.B.1.b).(1).(a).(xiii) evaluating and managing bladder or bowel
686 dysfunction; (Core)
687
688 IV.B.1.b).(1).(a).(xiv) diagnosing and managing musculoskeletal
689 disorders associated with brain injury,
690 including contractures, shoulder pain and
691 subluxation, shoulder hand syndrome, and
692 heterotopic ossification; (Core)
693
694 IV.B.1.b).(1).(a).(xv) identifying the risk of infection and
695 coordinating treatment and infection control,
696 including the judicious use of antimicrobials;
697 (Core)
698
699 IV.B.1.b).(1).(a).(xvi) evaluating and initiating management of
700 complications, including deep venous
701 thrombosis, dizziness, electrolyte
702 disturbances, endocrine disorders,
703 headaches, hydrocephalus, pain, pulmonary
704 embolism, seizure disorders, vertigo, and
705 vision changes; (Core)
706
707 IV.B.1.b).(1).(a).(xvii) performing a functional assessment based
708 on neurological, musculoskeletal, and
709 cardiopulmonary examinations combined
710 with psychological and pre-vocational
711 assessments; (Core)
712
713 IV.B.1.b).(1).(a).(xviii) determining functional goals for self-care,
714 instrumental activities of daily living,
715 communication, mobility, vocational, and
716 avocational activities based on the extent of
717 injury; (Core)
718
719 IV.B.1.b).(1).(a).(xix) determining appropriate motor retraining,

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720 conditioning, orthoses, and other adaptive
721 equipment needed to meet the rehabilitation
722 goals; (Core)
723
724 IV.B.1.b).(1).(a).(xx) assessing the indications for formal neuropsychological testing and interpreting the results as they relate to treatment planning or prognostication; (Core)
725
726
727
728
729 IV.B.1.b).(1).(a).(xxi) determining when inpatient rehabilitation goals have been achieved, finalize discharge plans, and arrange for the appropriate level of post-acute care based on the patient's needs; (Core)
730
731
732
733
734
735 IV.B.1.b).(1).(a).(xxii) developing a program of regular follow-up, evaluation, and preventive health to keep the patient at maximum health and functional status, and coordination with the patient's other care providers; (Core)
736
737
738
739
740
741 IV.B.1.b).(1).(a).(xxiii) monitoring the long-term evolution of neural recovery or decline in order to recognize conditions that may require additional evaluation, consultation, or treatment modification; (Core)
742
743
744
745
746
747 IV.B.1.b).(1).(a).(xxiv) assessing the special needs of adolescents with brain injury, including emotional, behavioral, cognitive, and developmental issues, as well as issues associated with schooling and recreational activities; (Core)
748
749
750
751
752
753 IV.B.1.b).(1).(a).(xxv) diagnosing concussion, especially in sports and recreational activities, managing its complications, and determining appropriateness for return-to-play, return-to-school, and return-to-work; and, (Core)
754
755
756
757
758
759 IV.B.1.b).(1).(a).(xxvi) recognizing the signs and symptoms of blast- and combat-related brain injuries and managing their complications. (Core)
760
761
762
763 **IV.B.1.b).(2)** **Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
764
765
766
767 IV.B.1.b).(2).(a) Fellows must demonstrate proficiency in spasticity management, including the use of modalities, systemic medications, and injections for chemodenervation, as well as familiarity with
768
769
770

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intrathecal delivery systems. (Core)

IV.B.1.c) 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. (Core)

IV.B.1.c).(1) Fellows must demonstrate proficiency in their knowledge of: (Core)

IV.B.1.c).(1).(a) pre-hospital and initial emergency department care of the patient with brain injury; (Core)

IV.B.1.c).(1).(b) the consultative role of brain injury medicine in support of emergency medicine, neurological surgery, neurology, orthopaedic surgery, and other specialties in acute care settings, including intensive and critical care units; (Core)

IV.B.1.c).(1).(c) management of increased intracranial pressure; (Core)

Specialty-Specific Background and Intent: The brain injury medicine physician is expected to have knowledge of how acute medical and surgical management influences outcomes. This competence can be gained through didactics and by providing brain injury medicine consultation to other medical, surgical, or intensivist services primarily managing patients with brain injury.

IV.B.1.c).(1).(d) the natural history and evolution of organ system functioning after brain injury, and the interaction among various organ systems; (Core)

IV.B.1.c).(1).(e) neuropharmacology and psychopharmacology as they relate to the management of cognitive, emotional, executive, and linguistic dysfunction; (Core)

IV.B.1.c).(1).(f) the interaction between brain injury and aging; (Core)

IV.B.1.c).(1).(g) prevention and treatment of secondary complications of brain injury; (Core)

IV.B.1.c).(1).(h) the relationship between known prognostic factors on the ultimate residual functional capacity; (Core)

IV.B.1.c).(1).(i) assessment and functional implications of the spectrum of impaired cognitive functions in brain injury; and, (Core)

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817 IV.B.1.c).(1).(j) consequences of repetitive head injuries and
818 associated neurodegenerative disorders such as
819 chronic traumatic encephalopathy. (Core)
820
821 **IV.B.1.d) Practice-based Learning and Improvement**
822
823 **Fellows must demonstrate the ability to investigate and**
824 **evaluate their care of patients, to appraise and assimilate**
825 **scientific evidence, and to continuously improve patient care**
826 **based on constant self-evaluation and lifelong learning. (Core)**
827

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.

828
829 **IV.B.1.e) Interpersonal and Communication Skills**
830
831 **Fellows must demonstrate interpersonal and communication**
832 **skills that result in the effective exchange of information and**
833 **collaboration with patients, their families, and health**
834 **professionals. (Core)**
835
836 **IV.B.1.f) Systems-based Practice**
837
838 **Fellows must demonstrate an awareness of and**
839 **responsiveness to the larger context and system of health**
840 **care, including the social determinants of health, as well as**
841 **the ability to call effectively on other resources to provide**
842 **optimal health care. (Core)**
843
844 **IV.C. Curriculum Organization and Fellow Experiences**
845
846 **IV.C.1. The curriculum must be structured to optimize fellow educational**
847 **experiences, the length of these experiences, and supervisory**
848 **continuity. (Core)**
849
850 IV.C.1.a) Assignment of rotations must be structured to minimize the
851 frequency of rotational transitions, and rotations must be of
852 sufficient length to provide a quality educational experience,
853 defined by continuity of patient care, ongoing supervision,
854 longitudinal relationships with faculty members, and meaningful
855 assessment and feedback. (Core)
856
857 IV.C.1.b) Clinical experiences should be structured to facilitate learning in a
858 manner that allows fellows to function as part of an effective

859 interprofessional team that works together longitudinally with
860 shared goals of patient safety and quality improvement. (Core)
861
862 **IV.C.2.** **The program must provide instruction and experience in pain**
863 **management if applicable for the subspecialty, including recognition**
864 **of the signs of addiction. (Core)**
865
866 IV.C.3. Each fellow must:
867
868 IV.C.3.a) devote at least three months of his or her clinical experience to the
869 care of hospitalized rehabilitation patients and at least three
870 months to non-hospitalized patients; (Core)
871
872 IV.C.3.b) have an assigned faculty advisor or mentor who must meet with
873 him or her regularly for monitoring and feedback; and, (Core)
874
875 IV.C.3.c) have the opportunity to meet and share experiences with
876 residents in the core program and in other specialties. (Detail)
877
878 IV.C.4. Didactic Curriculum
879
880 IV.C.4.a) The program must have regularly scheduled conferences. (Core)
881
882 IV.C.4.a).(1) These must include case-oriented multi-disciplinary
883 conferences, journal club, and quality improvement
884 seminars relevant to clinical care within the program. (Detail)
885
886 IV.C.4.b) Each fellow must have documented attendance at conferences
887 that provide in-depth coverage of the major topics required for
888 competence in brain injury medicine over the duration of the
889 program. (Core)
890

Specialty-Specific Background and Intent: The program is expected to avoid affiliations with sites at such distances from the primary clinical site as to make fellow attendance at didactics and conferences impractical, unless there is no comparable educational experience at the primary site. The Review Committee accepts a variety of solutions, as long as fellows have the opportunity to experience missed educational instruction. The solutions could include teleconference, webcasting, taped didactics, slides available on a website, and repeating conferences.

891
892 IV.C.4.c) Quality improvement seminars must include discussion of initial,
893 discharge, and follow-up data that have been analyzed regarding
894 the functional outcomes of persons served, as well as other
895 practice improvement activities. (Core)
896
897 **IV.D. Scholarship**
898
899 ***Medicine is both an art and a science. The physician is a humanistic***
900 ***scientist who cares for patients. This requires the ability to think critically,***
901 ***evaluate the literature, appropriately assimilate new knowledge, and***
902 ***practice lifelong learning. The program and faculty must create an***

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903 ***environment that fosters the acquisition of such skills through fellow***
904 ***participation in scholarly activities as defined in the subspecialty-specific***
905 ***Program Requirements. Scholarly activities may include discovery,***
906 ***integration, application, and teaching.***
907
908 ***The ACGME recognizes the diversity of fellowships and anticipates that***
909 ***programs prepare physicians for a variety of roles, including clinicians,***
910 ***scientists, and educators. It is expected that the program's scholarship will***
911 ***reflect its mission(s) and aims, and the needs of the community it serves.***
912 ***For example, some programs may concentrate their scholarly activity on***
913 ***quality improvement, population health, and/or teaching, while other***
914 ***programs might choose to utilize more classic forms of biomedical***
915 ***research as the focus for scholarship.***
916
917 **IV.D.1. Program Responsibilities**
918
919 **IV.D.1.a) The program must demonstrate evidence of scholarly**
920 **activities, consistent with its mission(s) and aims.** (Core)
921
922 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
923 **must allocate adequate resources to facilitate fellow and**
924 **faculty involvement in scholarly activities.** (Core)
925
926 IV.D.1.b).(1) The Sponsoring Institution must provide support to fellows
927 to attend one regional or national professional conference.
928 (Core)
929
930 **IV.D.2. Faculty Scholarly Activity**
931
932 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
933 **accomplishments in at least three of the following domains:**
934 (Core)
935
936 - **Research in basic science, education, translational**
937 **science, patient care, or population health**
938 - **Peer-reviewed grants**
939 - **Quality improvement and/or patient safety initiatives**
940 - **Systematic reviews, meta-analyses, review articles,**
941 **chapters in medical textbooks, or case reports**
942 - **Creation of curricula, evaluation tools, didactic**
943 **educational activities, or electronic educational**
944 **materials**
945 - **Contribution to professional committees, educational**
946 **organizations, or editorial boards**
947 - **Innovations in education**
948
949 **IV.D.2.b) The program must demonstrate dissemination of scholarly**
950 **activity within and external to the program by the following**
951 **methods:**
952

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Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the fellows' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

953
954 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters,**
955 **workshops, quality improvement presentations,**
956 **podium presentations, grant leadership, non-peer-**
957 **reviewed print/electronic resources, articles or**
958 **publications, book chapters, textbooks, webinars,**
959 **service on professional committees, or serving as a**
960 **journal reviewer, journal editorial board member, or**
961 **editor; (Outcome)‡**
962
963 **IV.D.2.b).(2)** **peer-reviewed publication. (Outcome)**
964
965 **IV.D.3. Fellow Scholarly Activity**
966
967 IV.D.3.a) The curriculum must advance fellows' knowledge of the basic
968 principles of research, including how research is conducted,
969 evaluated, explained to patients, and applied to patient care. (Core)
970
971 IV.D.3.b) Fellows should have assigned time to conduct research or other
972 scholarly activities. (Detail)
973
974 IV.D.3.c) Each fellow should demonstrate scholarship through at least one
975 scientific presentation, abstract, or publication. (Outcome)
976

Specialty-Specific Background and Intent: It is suggested that each fellow devote a minimum of one half-day per week to conducting research or to other scholarly activities.

977
978 **V. Evaluation**
979
980 **V.A. Fellow Evaluation**
981
982 **V.A.1. Feedback and Evaluation**
983

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows

to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **fellows identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where fellows are struggling and address problems immediately**

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

984
985 **V.A.1.a)** **Faculty members must directly observe, evaluate, and**
986 **frequently provide feedback on fellow performance during**
987 **each rotation or similar educational assignment.** (Core)
988

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

989
990 **V.A.1.b)** **Evaluation must be documented at the completion of the**
991 **assignment.** (Core)
992
993 **V.A.1.b).(1)** **For block rotations of greater than three months in**
994 **duration, evaluation must be documented at least**
995 **every three months.** (Core)
996
997 **V.A.1.b).(2)** **Longitudinal experiences such as continuity clinic in**
998 **the context of other clinical responsibilities must be**
999 **evaluated at least every three months and at**
1000 **completion.** (Core)
1001
1002 **V.A.1.c)** **The program must provide an objective performance**
1003 **evaluation based on the Competencies and the subspecialty-**
1004 **specific Milestones, and must:** (Core)
1005
1006 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
1007 **patients, self, and other professional staff members);**
1008 **and,** (Core)

1009
1010 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
1011 **Committee for its synthesis of progressive fellow**
1012 **performance and improvement toward unsupervised**
1013 **practice.** (Core)
1014

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

1015
1016 **V.A.1.d)** **The program director or their designee, with input from the**
1017 **Clinical Competency Committee, must:**
1018
1019 **V.A.1.d).(1)** **meet with and review with each fellow their**
1020 **documented semi-annual evaluation of performance,**
1021 **including progress along the subspecialty-specific**
1022 **Milestones.** (Core)
1023
1024 **V.A.1.d).(2)** **assist fellows in developing individualized learning**
1025 **plans to capitalize on their strengths and identify areas**
1026 **for growth; and,** (Core)
1027
1028 **V.A.1.d).(3)** **develop plans for fellows failing to progress, following**
1029 **institutional policies and procedures.** (Core)
1030

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

1031

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V.A.1.e) At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each fellow upon completion of the program. (Core)

V.A.2.a).(1) The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core)

V.A.2.a).(2) The final evaluation must:

V.A.2.a).(2).(a) 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; (Core)

V.A.2.a).(2).(b) verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; (Core)

V.A.2.a).(2).(c) consider recommendations from the Clinical Competency Committee; and, (Core)

V.A.2.a).(2).(d) be shared with the fellow upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b).(1) review all fellow evaluations at least semi-annually; (Core)

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1082 **V.A.3.b).(2)** **determine each fellow's progress on achievement of**
1083 **the subspecialty-specific Milestones; and,** (Core)
1084
1085 **V.A.3.b).(3)** **meet prior to the fellows' semi-annual evaluations and**
1086 **advise the program director regarding each fellow's**
1087 **progress.** (Core)
1088
1089 **V.B.** **Faculty Evaluation**
1090
1091 **V.B.1.** **The program must have a process to evaluate each faculty**
1092 **member's performance as it relates to the educational program at**
1093 **least annually.** (Core)
1094

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

1095
1096 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1097 **clinical teaching abilities, engagement with the educational**
1098 **program, participation in faculty development related to their**
1099 **skills as an educator, clinical performance, professionalism,**
1100 **and scholarly activities.** (Core)
1101
1102 **V.B.1.b)** **This evaluation must include written, confidential evaluations**
1103 **by the fellows.** (Core)
1104
1105 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1106 **annually.** (Core)
1107
1108 **V.B.3.** **Results of the faculty educational evaluations should be**
1109 **incorporated into program-wide faculty development plans.** (Core)
1110

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the

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program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

1111
1112 **V.C. Program Evaluation and Improvement**
1113
1114 **V.C.1.** **The program director must appoint the Program Evaluation**
1115 **Committee to conduct and document the Annual Program**
1116 **Evaluation as part of the program's continuous improvement**
1117 **process.** (Core)
1118
1119 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1120 **least two program faculty members, at least one of whom is a**
1121 **core faculty member, and at least one fellow.** (Core)
1122
1123 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1124
1125 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1126 **program oversight;** (Core)
1127
1128 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1129 **progress toward meeting them;** (Core)
1130
1131 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
1132 **development of new goals, based upon outcomes;**
1133 **and,** (Core)
1134
1135 **V.C.1.b).(4)** **review of the current operating environment to identify**
1136 **strengths, challenges, opportunities, and threats as**
1137 **related to the program's mission and aims.** (Core)
1138

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

1139
1140 **V.C.1.c)** **The Program Evaluation Committee should consider the**
1141 **following elements in its assessment of the program:**
1142
1143 **V.C.1.c).(1)** **curriculum;** (Core)
1144
1145 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
1146 (Core)
1147
1148 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
1149 **Areas for Improvement, and comments;** (Core)
1150
1151 **V.C.1.c).(4)** **quality and safety of patient care;** (Core)
1152

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1153 **V.C.1.c).(5)** **aggregate fellow and faculty:**
1154
1155 **V.C.1.c).(5).(a)** **well-being;** (Core)
1156
1157 **V.C.1.c).(5).(b)** **recruitment and retention;** (Core)
1158
1159 **V.C.1.c).(5).(c)** **workforce diversity;** (Core)
1160
1161 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient**
1162 **safety;** (Core)
1163
1164 **V.C.1.c).(5).(e)** **scholarly activity;** (Core)
1165
1166 **V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys**
1167 **(where applicable); and,** (Core)
1168
1169 **V.C.1.c).(5).(g)** **written evaluations of the program.** (Core)
1170
1171 **V.C.1.c).(6)** **aggregate fellow:**
1172
1173 **V.C.1.c).(6).(a)** **achievement of the Milestones;** (Core)
1174
1175 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1176 (Core)
1177
1178 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** (Core)
1179
1180 **V.C.1.c).(6).(d)** **graduate performance.** (Core)
1181
1182 **V.C.1.c).(7)** **aggregate faculty:**
1183
1184 **V.C.1.c).(7).(a)** **evaluation; and,** (Core)
1185
1186 **V.C.1.c).(7).(b)** **professional development** (Core)
1187
1188 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1189 **program's mission and aims, strengths, areas for**
1190 **improvement, and threats.** (Core)
1191
1192 **V.C.1.e)** **The annual review, including the action plan, must:**
1193
1194 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1195 **the teaching faculty and the fellows; and,** (Core)
1196
1197 **V.C.1.e).(2)** **be submitted to the DIO.** (Core)
1198
1199 **V.C.2.** **The program must participate in a Self-Study prior to its 10-Year**
1200 **Accreditation Site Visit.** (Core)
1201
1202 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1203 (Core)

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1204

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

1205
1206 **V.C.3.** ***One goal of ACGME-accredited education is to educate physicians***
1207 ***who seek and achieve board certification. One measure of the***
1208 ***effectiveness of the educational program is the ultimate pass rate.***
1209
1210 ***The program director should encourage all eligible program***
1211 ***graduates to take the certifying examination offered by the***
1212 ***applicable American Board of Medical Specialties (ABMS) member***
1213 ***board or American Osteopathic Association (AOA) certifying board.***
1214
1215 **V.C.3.a)** **For subspecialties in which the ABMS member board and/or**
1216 **AOA certifying board offer(s) an annual written exam, in the**
1217 **preceding three years, the program's aggregate pass rate of**
1218 **those taking the examination for the first time must be higher**
1219 **than the bottom fifth percentile of programs in that**
1220 **subspecialty.** (Outcome)
1221
1222 **V.C.3.b)** **For subspecialties in which the ABMS member board and/or**
1223 **AOA certifying board offer(s) a biennial written exam, in the**
1224 **preceding six years, the program's aggregate pass rate of**
1225 **those taking the examination for the first time must be higher**
1226 **than the bottom fifth percentile of programs in that**
1227 **subspecialty.** (Outcome)
1228
1229 **V.C.3.c)** **For subspecialties in which the ABMS member board and/or**
1230 **AOA certifying board offer(s) an annual oral exam, in the**
1231 **preceding three years, the program's aggregate pass rate of**
1232 **those taking the examination for the first time must be higher**
1233 **than the bottom fifth percentile of programs in that**
1234 **subspecialty.** (Outcome)
1235
1236 **V.C.3.d)** **For subspecialties in which the ABMS member board and/or**
1237 **AOA certifying board offer(s) a biennial oral exam, in the**
1238 **preceding six years, the program's aggregate pass rate of**
1239 **those taking the examination for the first time must be higher**
1240 **than the bottom fifth percentile of programs in that**
1241 **subspecialty.** (Outcome)
1242

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1243 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1244 **whose graduates over the time period specified in the**
1245 **requirement have achieved an 80 percent pass rate will have**
1246 **met this requirement, no matter the percentile rank of the**
1247 **program for pass rate in that subspecialty.** (Outcome)
1248

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1249
1250 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1251 **annually for the cohort of board-eligible fellows that**
1252 **graduated seven years earlier.** (Core)
1253

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1254
1255 **VI. The Learning and Working Environment**
1256
1257 ***Fellowship education must occur in the context of a learning and working***
1258 ***environment that emphasizes the following principles:***
1259
1260 • ***Excellence in the safety and quality of care rendered to patients by fellows***
1261 ***today***
1262
1263 • ***Excellence in the safety and quality of care rendered to patients by today's***
1264 ***fellows in their future practice***
1265
1266 • ***Excellence in professionalism through faculty modeling of:***
1267

- *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*

- *the joy of curiosity, problem-solving, intellectual rigor, and discovery*

- ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows

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will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** **(Core)**

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. **(Core)**

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

1343 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**

1347 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**

1351 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information of their institution's patient safety reports.** **(Core)**

1355 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**

1362 **VI.A.1.a).(4)** **Fellow Education and Experience in Disclosure of Adverse Events**

1365 ***Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.***

1371 **VI.A.1.a).(4).(a)** **All fellows must receive training in how to disclose adverse events to patients and families.** **(Core)**

1375 **VI.A.1.a).(4).(b)** **Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** **(Detail)**

1379 **VI.A.1.b)** **Quality Improvement**

1381 **VI.A.1.b).(1)** **Education in Quality Improvement**

1383 ***A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.***

1388 **VI.A.1.b).(1).(a)** **Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities.** **(Core)**

1392 **VI.A.1.b).(2)** **Quality Metrics**

1393

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1394 *Access to data is essential to prioritizing activities for*
1395 *care improvement and evaluating success of*
1396 *improvement efforts.*
1397
1398 **VI.A.1.b).(2).(a)** **Fellows and faculty members must receive data**
1399 **on quality metrics and benchmarks related to**
1400 **their patient populations.** (Core)
1401
1402 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
1403
1404 *Experiential learning is essential to developing the*
1405 *ability to identify and institute sustainable systems-*
1406 *based changes to improve patient care.*
1407
1408 **VI.A.1.b).(3).(a)** **Fellows must have the opportunity to**
1409 **participate in interprofessional quality**
1410 **improvement activities.** (Core)
1411
1412 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
1413 **reducing health care disparities.** (Detail)
1414
1415 **VI.A.2.** **Supervision and Accountability**
1416
1417 **VI.A.2.a)** *Although the attending physician is ultimately responsible for*
1418 *the care of the patient, every physician shares in the*
1419 *responsibility and accountability for their efforts in the*
1420 *provision of care. Effective programs, in partnership with*
1421 *their Sponsoring Institutions, define, widely communicate,*
1422 *and monitor a structured chain of responsibility and*
1423 *accountability as it relates to the supervision of all patient*
1424 *care.*
1425
1426 *Supervision in the setting of graduate medical education*
1427 *provides safe and effective care to patients; ensures each*
1428 *fellow's development of the skills, knowledge, and attitudes*
1429 *required to enter the unsupervised practice of medicine; and*
1430 *establishes a foundation for continued professional growth.*
1431
1432 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1433 **appropriately-credentialed and privileged attending**
1434 **physician (or licensed independent practitioner as**
1435 **specified by the applicable Review Committee) who is**
1436 **responsible and accountable for the patient's care.**
1437 (Core)
1438

Specialty-Specific Background and Intent: Advanced nurse practitioners and psychologists may supervise fellows, as appropriate.

1439
1440 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
1441 **faculty members, other members of the health**
1442 **care team, and patients.** (Core)

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1443
1444 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
1445 **patient of their respective roles in that patient's**
1446 **care when providing direct patient care.** (Core)
1447
1448 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
1449 ***For many aspects of patient care, the supervising physician***
1450 ***may be a more advanced fellow. Other portions of care***
1451 ***provided by the fellow can be adequately supervised by the***
1452 ***appropriate availability of the supervising faculty member or***
1453 ***fellow, either on site or by means of telecommunication***
1454 ***technology. Some activities require the physical presence of***
1455 ***the supervising faculty member. In some circumstances,***
1456 ***supervision may include post-hoc review of fellow-delivered***
1457 ***care with feedback.***
1458

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of fellow patient interactions, education and training locations, and fellow skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a fellow gains more experience, even with the same patient condition or procedure. All fellows have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

1459
1460 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate**
1461 **level of supervision in place for all fellows is based on**
1462 **each fellow's level of training and ability, as well as**
1463 **patient complexity and acuity. Supervision may be**
1464 **exercised through a variety of methods, as appropriate**
1465 **to the situation.** (Core)
1466
1467 **VI.A.2.b).(2)** **The program must define when physical presence of a**
1468 **supervising physician is required.** (Core)
1469
1470 **VI.A.2.c)** **Levels of Supervision**
1471
1472 **To promote appropriate fellow supervision while providing**
1473 **for graded authority and responsibility, the program must use**
1474 **the following classification of supervision:** (Core)
1475
1476 **VI.A.2.c).(1)** **Direct Supervision:**
1477
1478 **VI.A.2.c).(1).(a)** **the supervising physician is physically present**
1479 **with the fellow during the key portions of the**
1480 **patient interaction; or,** (Core)
1481
1482 **VI.A.2.c).(1).(b)** **the supervising physician and/or patient is not**
1483 **physically present with the fellow and the**
1484 **supervising physician is concurrently**

1485 **monitoring the patient care through appropriate**
1486 **telecommunication technology.** **(Core)**
1487
1488 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not**
1489 **providing physical or concurrent visual or audio**
1490 **supervision but is immediately available to the fellow**
1491 **for guidance and is available to provide appropriate**
1492 **direct supervision.** **(Core)**
1493
1494 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to**
1495 **provide review of procedures/encounters with**
1496 **feedback provided after care is delivered.** **(Core)**
1497
1498 **VI.A.2.d)** **The privilege of progressive authority and responsibility,**
1499 **conditional independence, and a supervisory role in patient**
1500 **care delegated to each fellow must be assigned by the**
1501 **program director and faculty members.** **(Core)**
1502
1503 **VI.A.2.d).(1)** **The program director must evaluate each fellow's**
1504 **abilities based on specific criteria, guided by the**
1505 **Milestones.** **(Core)**
1506
1507 **VI.A.2.d).(2)** **Faculty members functioning as supervising**
1508 **physicians must delegate portions of care to fellows**
1509 **based on the needs of the patient and the skills of**
1510 **each fellow.** **(Core)**
1511
1512 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to junior**
1513 **fellows and residents in recognition of their progress**
1514 **toward independence, based on the needs of each**
1515 **patient and the skills of the individual resident or**
1516 **fellow.** **(Detail)**
1517
1518 **VI.A.2.e)** **Programs must set guidelines for circumstances and events**
1519 **in which fellows must communicate with the supervising**
1520 **faculty member(s).** **(Core)**
1521
1522 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of**
1523 **authority, and the circumstances under which the**
1524 **fellow is permitted to act with conditional**
1525 **independence.** **(Outcome)**
1526

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

1527
1528 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient**
1529 **duration to assess the knowledge and skills of each fellow**
1530 **and to delegate to the fellow the appropriate level of patient**
1531 **care authority and responsibility.** **(Core)**
1532

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1533 **VI.B. Professionalism**
1534
1535 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
1536 **educate fellows and faculty members concerning the professional**
1537 **responsibilities of physicians, including their obligation to be**
1538 **appropriately rested and fit to provide the care required by their**
1539 **patients.** (Core)
1540
1541 **VI.B.2.** **The learning objectives of the program must:**
1542
1543 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1544 **patient care responsibilities, clinical teaching, and didactic**
1545 **educational events;** (Core)
1546
1547 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
1548 **fulfill non-physician obligations; and,** (Core)
1549

Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

1550
1551 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
1552

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

1553
1554 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1555 **must provide a culture of professionalism that supports patient**
1556 **safety and personal responsibility.** (Core)
1557
1558 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1559 **of their personal role in the:**
1560
1561 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1562
1563 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1564 **including the ability to report unsafe conditions and adverse**
1565 **events;** (Outcome)

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1566

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

1567
1568 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)
1569

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

1570
1571 **VI.B.4.c).(1)** **management of their time before, during, and after**
1572 **clinical assignments; and,** (Outcome)
1573
1574 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1575 **fatigue, and substance use, in themselves, their peers,**
1576 **and other members of the health care team.** (Outcome)
1577
1578 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)
1579
1580 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1581 **indicators; and,** (Outcome)
1582
1583 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1584 **patient outcomes, and clinical experience data.** (Outcome)
1585
1586 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1587 **to patient needs that supersedes self-interest. This includes the**
1588 **recognition that under certain circumstances, the best interests of**
1589 **the patient may be served by transitioning that patient's care to**
1590 **another qualified and rested provider.** (Outcome)
1591
1592 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1593 **provide a professional, equitable, respectful, and civil environment**
1594 **that is free from discrimination, sexual and other forms of**
1595 **harassment, mistreatment, abuse, or coercion of students, fellows,**
1596 **faculty, and staff.** (Core)
1597
1598 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1599 **have a process for education of fellows and faculty regarding**
1600 **unprofessional behavior and a confidential process for reporting,**
1601 **investigating, and addressing such concerns.** (Core)
1602
1603 **VI.C.** **Well-Being**
1604
1605 ***Psychological, emotional, and physical well-being are critical in the***
1606 ***development of the competent, caring, and resilient physician and require***

1607 ***proactive attention to life inside and outside of medicine. Well-being***
1608 ***requires that physicians retain the joy in medicine while managing their***
1609 ***own real life stresses. Self-care and responsibility to support other***
1610 ***members of the health care team are important components of***
1611 ***professionalism; they are also skills that must be modeled, learned, and***
1612 ***nurtured in the context of other aspects of fellowship training.***
1613
1614 ***Fellows and faculty members are at risk for burnout and depression.***
1615 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1616 ***responsibility to address well-being as other aspects of resident***
1617 ***competence. Physicians and all members of the health care team share***
1618 ***responsibility for the well-being of each other. For example, a culture which***
1619 ***encourages covering for colleagues after an illness without the expectation***
1620 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1621 ***clinical learning environment models constructive behaviors, and prepares***
1622 ***fellows with the skills and attitudes needed to thrive throughout their***
1623 ***careers.***
1624

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website. As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

1625
1626 **VI.C.1.** **The responsibility of the program, in partnership with the**
1627 **Sponsoring Institution, to address well-being must include:**
1628
1629 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
1630 **experience of being a physician, including protecting time**
1631 **with patients, minimizing non-physician obligations,**
1632 **providing administrative support, promoting progressive**
1633 **autonomy and flexibility, and enhancing professional**
1634 **relationships; (Core)**
1635
1636 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1637 **compression that impacts fellow well-being; (Core)**
1638
1639 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1640 **fellows and faculty members; (Core)**
1641

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Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

1642
1643 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
1644 **faculty member well-being; and,** **(Core)**
1645

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

1646
1647 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
1648 **medical, mental health, and dental care appointments,**
1649 **including those scheduled during their working hours.**
1650 **(Core)**
1651

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

1652
1653 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
1654 **and substance use disorder. The program, in partnership with**
1655 **its Sponsoring Institution, must educate faculty members and**
1656 **fellows in identification of the symptoms of burnout,**
1657 **depression, and substance use disorder, including means to**
1658 **assist those who experience these conditions. Fellows and**
1659 **faculty members must also be educated to recognize those**
1660 **symptoms in themselves and how to seek appropriate care.**
1661 **The program, in partnership with its Sponsoring Institution,**
1662 **must:** **(Core)**
1663

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

1664
1665 **VI.C.1.e).(1)** **encourage fellows and faculty members to alert the**
1666 **program director or other designated personnel or**
1667 **programs when they are concerned that another**
1668 **fellow, resident, or faculty member may be displaying**
1669 **signs of burnout, depression, a substance use**
1670 **disorder, suicidal ideation, or potential for violence;**
1671 **(Core)**
1672

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Background and Intent: Individuals experiencing burnout, depression, substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting

1673
1674 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1675 **and, (Core)**
1676
1677 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1678 **health assessment, counseling, and treatment,**
1679 **including access to urgent and emergent care 24**
1680 **hours a day, seven days a week. (Core)**
1681

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

1682
1683 **VI.C.2.** **There are circumstances in which fellows may be unable to attend**
1684 **work, including but not limited to fatigue, illness, family**
1685 **emergencies, and parental leave. Each program must allow an**
1686 **appropriate length of absence for fellows unable to perform their**
1687 **patient care responsibilities. (Core)**
1688
1689 **VI.C.2.a)** **The program must have policies and procedures in place to**
1690 **ensure coverage of patient care. (Core)**
1691
1692 **VI.C.2.b)** **These policies must be implemented without fear of negative**
1693 **consequences for the fellow who is or was unable to provide**
1694 **the clinical work. (Core)**
1695

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

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1696
1697 **VI.D. Fatigue Mitigation**
1698
1699 **VI.D.1. Programs must:**
1700
1701 **VI.D.1.a) educate all faculty members and fellows to recognize the**
1702 **signs of fatigue and sleep deprivation; (Core)**
1703
1704 **VI.D.1.b) educate all faculty members and fellows in alertness**
1705 **management and fatigue mitigation processes; and, (Core)**
1706
1707 **VI.D.1.c) encourage fellows to use fatigue mitigation processes to**
1708 **manage the potential negative effects of fatigue on patient**
1709 **care and learning. (Detail)**
1710

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

1711
1712 **VI.D.2. Each program must ensure continuity of patient care, consistent**
1713 **with the program's policies and procedures referenced in VI.C.2–**
1714 **VI.C.2.b), in the event that a fellow may be unable to perform their**
1715 **patient care responsibilities due to excessive fatigue. (Core)**
1716
1717 **VI.D.3. The program, in partnership with its Sponsoring Institution, must**
1718 **ensure adequate sleep facilities and safe transportation options for**
1719 **fellows who may be too fatigued to safely return home. (Core)**
1720
1721 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
1722
1723 **VI.E.1. Clinical Responsibilities**
1724
1725 **The clinical responsibilities for each fellow must be based on PGY**
1726 **level, patient safety, fellow ability, severity and complexity of patient**
1727 **illness/condition, and available support services. (Core)**
1728

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty

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members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

1729

Specialty-Specific Background and Intent: The program director is expected to assess the learning environment with input from faculty members and fellows. The optimal caseload will allow each fellow to see as many cases as possible without being overwhelmed by patient care responsibilities, or without compromising patient safety or a fellow's educational experience.

1730
1731 **VI.E.2. Teamwork**
1732
1733–1737 **Fellows must care for patients in an environment that maximizes 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 subspecialty and larger health system.** **(Core)**
1738

Specialty-Specific Background and Intent: Orthotists, occupational therapists, physical therapists, psychologists, rehabilitation nurses, social workers, speech-language pathologists, therapeutic recreation specialists, and vocational rehabilitation counselors should be included, as appropriate, on the interprofessional teams.

1739
1740 **VI.E.3. Transitions of Care**
1741
1742–1744 **VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** **(Core)**
1745
1746–1749 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** **(Core)**
1750
1751–1753 **VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** **(Outcome)**
1754
1755–1757 **VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care.** **(Core)**
1758
1759–1763 **VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** **(Core)**

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1764
1765 **VI.F. Clinical Experience and Education**
1766
1767 ***Programs, in partnership with their Sponsoring Institutions, must design***
1768 ***an effective program structure that is configured to provide fellows with***
1769 ***educational and clinical experience opportunities, as well as reasonable***
1770 ***opportunities for rest and personal activities.***
1771

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that fellows' duty to "clock out" on time superseded their duty to their patients.

1772
1773 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
1774
1775 **Clinical and educational work hours must be limited to no more than**
1776 **80 hours per week, averaged over a four-week period, inclusive of all**
1777 **in-house clinical and educational activities, clinical work done from**
1778 **home, and all moonlighting.** (Core)
1779

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

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Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

1780
1781 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
1782
1783–1786 **VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being.** (Core)
1787
1788–1789 **VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods.** (Detail)
1790
1791–1796 **VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** (Detail)

1797

Background and Intent: While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

1798
1799 **VI.F.2.c)** **Fellows must have at least 14 hours free of clinical work and**
1800 **education after 24 hours of in-house call.** (Core)
1801

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

1802
1803 **VI.F.2.d)** **Fellows must be scheduled for a minimum of one day in**
1804 **seven free of clinical work and required education (when**
1805 **averaged over four weeks). At-home call cannot be assigned**
1806 **on these free days.** (Core)
1807

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

1808
1809 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
1810
1811 **VI.F.3.a)** **Clinical and educational work periods for fellows must not**
1812 **exceed 24 hours of continuous scheduled clinical**
1813 **assignments.** (Core)
1814
1815 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
1816 **activities related to patient safety, such as providing**
1817 **effective transitions of care, and/or fellow education.**
1818 (Core)
1819

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1820 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
1821 **be assigned to a fellow during this time.** **(Core)**
1822

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

1823
1824 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
1825
1826 **VI.F.4.a)** **In rare circumstances, after handing off all other**
1827 **responsibilities, a fellow, on their own initiative, may elect to**
1828 **remain or return to the clinical site in the following**
1829 **circumstances:**
1830
1831 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
1832 **unstable patient;** **(Detail)**
1833
1834 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
1835 **family; or,** **(Detail)**
1836
1837 **VI.F.4.a).(3)** **to attend unique educational events.** **(Detail)**
1838
1839 **VI.F.4.b)** **These additional hours of care or education will be counted**
1840 **toward the 80-hour weekly limit.** **(Detail)**
1841

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

1842
1843 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
1844 **for up to 10 percent or a maximum of 88 clinical and**
1845 **educational work hours to individual programs based on a**
1846 **sound educational rationale.**
1847
1848 The Review Committee for Physical Medicine and Rehabilitation
1849 will not consider requests for exceptions to the 80-hour limit to the
1850 fellows' work week.
1851
1852 **VI.F.5.** **Moonlighting**
1853

1854 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety.** (Core)
1858
1859 **VI.F.5.b)** **Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)
1862

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

1863
1864 **VI.F.6.** **In-House Night Float**
1865
1866 **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** (Core)
1868

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

1869
1870 **VI.F.7.** **Maximum In-House On-Call Frequency**
1871
1872 **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** (Core)
1874
1875 **VI.F.8.** **At-Home Call**
1876
1877 **VI.F.8.a)** **Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly 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 clinical work and education, when averaged over four weeks.** (Core)
1883
1884 **VI.F.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)
1887
1888 **VI.F.8.b)** **Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** (Detail)
1892

Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other

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forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

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1894 ***
1895

1896 ***Core Requirements:** Statements that define structure, resource, or process elements
1897 essential to every graduate medical educational program.
1898

1899 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for
1900 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
1901 substantial compliance with the Outcome Requirements may utilize alternative or innovative
1902 approaches to meet Core Requirements.
1903

1904 **‡Outcome Requirements:** Statements that specify expected measurable or observable
1905 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
1906 graduate medical education.
1907

1908 **Osteopathic Recognition**
1909 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
1910 Requirements also apply (www.acgme.org/OsteopathicRecognition).

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