

**ACGME Program Requirements for
Graduate Medical Education
in Sleep Medicine**

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1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Sleep Medicine**

3
4 **Common Program Requirements (One-Year Fellowship) are in BOLD**

5
6 Where applicable, text in italics describes the underlying philosophy of the requirements in that
7 section. These philosophic statements are not program requirements and are therefore not
8 citable.
9

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 (One-Year Fellowship) are intended to explain the differences.

10
11 **Introduction**

12
13 **Int.A.** *Fellowship is advanced graduate medical education beyond a core*
14 *residency program for physicians who desire to enter more specialized*
15 *practice. Fellowship-trained physicians serve the public by providing*
16 *subspecialty care, which may also include core medical care, acting as a*
17 *community resource for expertise in their field, creating and integrating*
18 *new knowledge into practice, and educating future generations of*
19 *physicians. Graduate medical education values the strength that a diverse*
20 *group of physicians brings to medical care.*

21
22 *Fellows who have completed residency are able to practice independently*
23 *in their core specialty. The prior medical experience and expertise of*
24 *fellows distinguish them from physicians entering into residency training.*
25 *The fellow's care of patients within the subspecialty is undertaken with*
26 *appropriate faculty supervision and conditional independence. Faculty*
27 *members serve as role models of excellence, compassion,*
28 *professionalism, and scholarship. The fellow develops deep medical*
29 *knowledge, patient care skills, and expertise applicable to their focused*
30 *area of practice. Fellowship is an intensive program of subspecialty clinical*
31 *and didactic education that focuses on the multidisciplinary care of*
32 *patients. Fellowship education is often physically, emotionally, and*
33 *intellectually demanding, and occurs in a variety of clinical learning*
34 *environments committed to graduate medical education and the well-being*
35 *of patients, residents, fellows, faculty members, students, and all members*
36 *of the health care team.*

37
38 *In addition to clinical education, many fellowship programs advance*
39 *fellows' skills as physician-scientists. While the ability to create new*
40 *knowledge within medicine is not exclusive to fellowship-educated*
41 *physicians, the fellowship experience expands a physician's abilities to*
42 *pursue hypothesis-driven scientific inquiry that results in contributions to*
43 *the medical literature and patient care. Beyond the clinical subspecialty*
44 *expertise achieved, fellows develop mentored relationships built on an*
45 *infrastructure that promotes collaborative research.*

46
47 **Int.B.** **Definition of Subspecialty**

48 Sleep medicine is a discipline of medical practice in which sleep disorders are
49 assessed using a combination of clinical evaluation and physiological monitoring,
50 and treated using medications, medical devices, surgical procedures, patient
51 education, and behavioral techniques. Sleep medicine fellowships provide
52 advanced education to allow a fellow to acquire competency in the subspecialty
53 with sufficient expertise to act as an independent consultant.
54

55 **Int.C. Length of Educational Program**

56
57 The educational program in sleep medicine must be 12 months in length. (Core)*
58

59 **I. Oversight**

60
61 **I.A. Sponsoring Institution**

62
63 *The Sponsoring Institution is the organization or entity that assumes the*
64 *ultimate financial and academic responsibility for a program of graduate*
65 *medical education consistent with the ACGME Institutional Requirements.*
66

67 *When the Sponsoring Institution is not a rotation site for the program, the*
68 *most commonly utilized site of clinical activity for the program is the*
69 *primary clinical site.*
70

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, a federally qualified health center, a surgery center, an academic and private single-specialty clinic, or an educational foundation.

71
72 **I.A.1. The program must be sponsored by one ACGME-accredited**
73 **Sponsoring Institution. (Core)**
74

75 **I.B. Participating Sites**

76
77 *A participating site is an organization providing educational experiences or*
78 *educational assignments/rotations for fellows.*
79

80 **I.B.1. The program, with approval of its Sponsoring Institution, must**
81 **designate a primary clinical site. (Core)**
82

83 **I.B.1.a)** A sleep medicine fellowship should function as an integral part of
84 an ACGME-accredited residency program in child neurology,
85 internal medicine, neurology, pediatrics, or psychiatry. (Core)
86

87 **I.B.1.b)** The Sponsoring Institution should sponsor only one ACGME-
88 accredited sleep medicine program. (Core)

- 89
90 I.B.1.c) The Sponsoring Institution must ensure that there is a reporting
91 relationship with the program director of the sponsoring core
92 residency program to ensure compliance with the ACGME's
93 accreditation standards; ^(Core)
94
95 **I.B.2.** **There must be a program letter of agreement (PLA) between the**
96 **program and each participating site that governs the relationship**
97 **between the program and the participating site providing a required**
98 **assignment.** ^(Core)
99
100 **I.B.2.a)** **The PLA must:**
101
102 **I.B.2.a).(1)** **be renewed at least every 10 years; and,** ^(Core)
103
104 **I.B.2.a).(2)** **be approved by the designated institutional official**
105 **(DIO).** ^(Core)
106
107 **I.B.3.** **The program must monitor the clinical learning and working**
108 **environment at all participating sites.** ^(Core)
109
110 **I.B.3.a)** **At each participating site there must be one faculty member,**
111 **designated by the program director, who is accountable for**
112 **fellow education for that site, in collaboration with the**
113 **program director.** ^(Core)
114

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

- 115
116 **I.B.4.** **The program director must submit any additions or deletions of**
117 **participating sites routinely providing an educational experience,**

118 required for all fellows, of one month full time equivalent (FTE) or
119 more through the ACGME's Accreditation Data System (ADS). (Core)
120

121 **I.C.** The program, in partnership with its Sponsoring Institution, must engage in
122 practices that focus on mission-driven, ongoing, systematic recruitment
123 and retention of a diverse and inclusive workforce of residents (if present),
124 fellows, faculty members, senior administrative staff members, and other
125 relevant members of its academic community. (Core)
126

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).

127
128 **I.D. Resources**

129
130 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
131 **ensure the availability of adequate resources for fellow education.**
132 (Core)

133
134 **I.D.1.a) Space and Equipment**

135
136 There must be space and equipment for the program, including
137 meeting rooms, examination rooms, computers, visual and other
138 educational aids, and work/study space. (Core)
139

140 **I.D.1.b) Facilities**

141
142 **I.D.1.b).(1)** There must be an outpatient clinic, as well as diagnostic,
143 therapeutic, and research facilities. (Core)
144

145 **I.D.1.b).(2)** Efficient, effective ambulatory and inpatient facilities must
146 be available for fellows' clinical experiences. (Core)
147

148 **I.D.1.b).(3)** Fellows must have access to a lounge facility during
149 assigned duty hours. (Detail)†
150

151 **I.D.1.b).(4)** When fellows are in the hospital, assigned night duty, or
152 called in from home, they must be provided with a secure
153 space for their belongings. (Detail)
154

155 **I.D.1.b).(5)** There must be an appropriately-equipped sleep center
156 which has a minimum of two fully-equipped
157 polysomnography bedrooms and adequate support space.
158 (Core)
159

160 **I.D.1.b).(5).(a)** The sleep center must be accredited by the
161 American Academy of Sleep Medicine. (Core)
162

163 I.D.1.c) Other Support Services
164
165 Inpatient and outpatient systems must be in place to prevent
166 fellows from performing routine clerical functions, such as
167 scheduling tests and appointments, and retrieving records and
168 letters. ^(Detail)
169

170 I.D.1.d) Medical Records
171
172 Access to an electronic health record should be provided. In the
173 absence of an existing electronic health record, institutions must
174 demonstrate institutional commitment to its development and
175 progress toward its implementation. ^(Core)
176

177 I.D.1.e) The Sponsoring Institution and participating sites must:

178
179 I.D.1.e).(1) ensure the availability of appropriate and timely
180 consultation from other specialties. ^(Detail)
181

182 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
183 **ensure healthy and safe learning and working environments that**
184 **promote fellow well-being and provide for:** ^(Core)
185

186 **I.D.2.a) access to food while on duty;** ^(Core)
187

188 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
189 **and accessible for fellows with proximity appropriate for safe**
190 **patient care, if the fellows are assigned in-house call;** ^(Core)
191

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.

192
193 **I.D.2.c) clean and private facilities for lactation that have refrigeration**
194 **capabilities, with proximity appropriate for safe patient care;**
195 ^(Core)
196

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).

197

198	I.D.2.d)	security and safety measures appropriate to the participating site; and, ^(Core)
199		
200		
201	I.D.2.e)	accommodations for fellows with disabilities consistent with the Sponsoring Institution’s policy. ^(Core)
202		
203		
204	I.D.3.	Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. ^(Core)
205		
206		
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208		
209	I.D.4.	The program’s educational and clinical resources must be adequate to support the number of fellows appointed to the program. ^(Core)
210		
211		
212	I.D.4.a)	Patient Population
213		
214	I.D.4.a).(1)	The patient population must have a variety of clinical problems and stages of diseases, including short- and long-term sleep disorders. ^(Core)
215		
216		
217		
218	I.D.4.a).(2)	There must be patients of each gender, with a broad age range, including infants, children, adolescents, and geriatric patients. ^(Core)
219		
220		
221		
222	I.D.4.a).(3)	A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)
223		
224		
225		
226	I.D.4.a).(4)	There must be patients with the major categories of sleep disorders, including:
227		
228		
229	I.D.4.a).(4).(a)	circadian rhythm sleep disorders; ^(Detail)
230		
231	I.D.4.a).(4).(b)	idiopathic hypersomnia; ^(Detail)
232		
233	I.D.4.a).(4).(c)	insomnia; ^(Detail)
234		
235	I.D.4.a).(4).(d)	narcolepsy; ^(Detail)
236		
237	I.D.4.a).(4).(e)	parasomnias; ^(Detail)
238		
239	I.D.4.a).(4).(f)	sleep problems related to other factors and diseases, including medications, and psychiatric and medical disorders; ^(Detail)
240		
241		
242		
243	I.D.4.a).(4).(g)	sleep-related breathing disorders; and, ^(Detail)
244		
245	I.D.4.a).(4).(h)	sleep-related movement disorders. ^(Detail)
246		

247 I.E. *A fellowship program usually occurs in the context of many learners and*
248 *other care providers and limited clinical resources. It should be structured*
249 *to optimize education for all learners present.*

251 I.E.1. Fellows should contribute to the education of residents in core
252 programs, if present. ^(Core)
253

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.

254 II. Personnel

257 II.A. Program Director

259 II.A.1. There must be one faculty member appointed as program director
260 with authority and accountability for the overall program, including
261 compliance with all applicable program requirements. ^(Core)
262

263 II.A.1.a) The Sponsoring Institution's Graduate Medical Education
264 Committee (GMEC) must approve a change in program
265 director. ^(Core)
266

267 II.A.1.b) Final approval of the program director resides with the
268 Review Committee. ^(Core)
269

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 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.

270 II.A.2. The program director must be provided with support adequate for
271 administration of the program based upon its size and configuration.
272 ^(Core)
273

274 II.A.2.a) At a minimum, the program director must be provided with the
275 salary support required to devote 25-50 percent FTE of non-
276 clinical time to the administration of the program. ^(Detail)
277
278

Background and Intent: Twenty five percent FTE is defined as one and one quarter (1.25) days 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.

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II.A.3. Qualifications of the program director:

II.A.3.a) must include subspecialty expertise and qualifications acceptable to the Review Committee; and, ^(Core)

II.A.3.a).(1) The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. ^(Detail)

II.A.3.a).(2) The program director must have at least three years of participation as an active faculty member in an ACGME-accredited education program. ^(Detail)

II.A.3.b) must include current certification in the subspecialty for which they are the program director by the American Board of Family Medicine, Internal Medicine, Psychiatry and Neurology, Otolaryngology – Head and Neck Surgery, Pediatrics, or Psychiatry or by the American Osteopathic Board of Family Physicians, Internal Medicine, Neurology and Psychiatry, or Ophthalmology and Otolaryngology – Head and Neck Surgery, or subspecialty qualifications that are acceptable to the Review Committee. ^(Core)

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. ^(Core)

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; ^(Core)

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.

II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the

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mission(s) of the Sponsoring Institution, and the
mission(s) of the program; ^(Core)

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.

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II.A.4.a).(3) administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; ^(Core)

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

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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)

II.A.4.a).(5) have the authority to approve program faculty members for participation in the fellowship program education at all sites; ^(Core)

II.A.4.a).(6) have the authority to remove program faculty members from participation in the fellowship program education at all sites; ^(Core)

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)

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.

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II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)

- 348 **II.A.4.a).(9)** provide applicants who are offered an interview with
 349 information related to the applicant's eligibility for the
 350 relevant subspecialty board examination(s); ^(Core)
 351
- 352 **II.A.4.a).(10)** provide a learning and working environment in which
 353 fellows have the opportunity to raise concerns and
 354 provide feedback in a confidential manner as
 355 appropriate, without fear of intimidation or retaliation;
 356 ^(Core)
 357
- 358 **II.A.4.a).(11)** ensure the program's compliance with the Sponsoring
 359 Institution's policies and procedures related to
 360 grievances and due process; ^(Core)
 361
- 362 **II.A.4.a).(12)** ensure the program's compliance with the Sponsoring
 363 Institution's policies and procedures for due process
 364 when action is taken to suspend or dismiss, not to
 365 promote, or not to renew the appointment of a fellow;
 366 ^(Core)
 367

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.

- 368
- 369 **II.A.4.a).(13)** ensure the program's compliance with the Sponsoring
 370 Institution's policies and procedures on employment
 371 and non-discrimination; ^(Core)
 372
- 373 **II.A.4.a).(13).(a)** Fellows must not be required to sign a non-
 374 competition guarantee or restrictive covenant.
 375 ^(Core)
 376
- 377 **II.A.4.a).(14)** document verification of program completion for all
 378 graduating fellows within 30 days; ^(Core)
 379
- 380 **II.A.4.a).(15)** provide verification of an individual fellow's
 381 completion upon the fellow's request, within 30 days;
 382 and, ^(Core)
 383

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.

- 384
- 385 **II.A.4.a).(16)** obtain review and approval of the Sponsoring
 386 Institution's DIO before submitting information or
 387 requests to the ACGME, as required in the Institutional
 388 Requirements and outlined in the ACGME Program

389 Director's Guide to the Common Program
390 Requirements. ^(Core)
391

392 **II.B. Faculty**
393

394 *Faculty members are a foundational element of graduate medical education*
395 *– faculty members teach fellows how to care for patients. Faculty members*
396 *provide an important bridge allowing fellows to grow and become practice*
397 *ready, ensuring that patients receive the highest quality of care. They are*
398 *role models for future generations of physicians by demonstrating*
399 *compassion, commitment to excellence in teaching and patient care,*
400 *professionalism, and a dedication to lifelong learning. Faculty members*
401 *experience the pride and joy of fostering the growth and development of*
402 *future colleagues. The care they provide is enhanced by the opportunity to*
403 *teach. By employing a scholarly approach to patient care, faculty members,*
404 *through the graduate medical education system, improve the health of the*
405 *individual and the population.*

406
407 *Faculty members ensure that patients receive the level of care expected*
408 *from a specialist in the field. They recognize and respond to the needs of*
409 *the patients, fellows, community, and institution. Faculty members provide*
410 *appropriate levels of supervision to promote patient safety. Faculty*
411 *members create an effective learning environment by acting in a*
412 *professional manner and attending to the well-being of the fellows and*
413 *themselves.*
414

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.

415
416 **II.B.1. For each participating site, there must be a sufficient number of**
417 **faculty members with competence to instruct and supervise all**
418 **fellows at that location. ^(Core)**
419

420 **II.B.2. Faculty members must:**

421 **II.B.2.a) be role models of professionalism; ^(Core)**

422 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
423 **cost-effective, patient-centered care; ^(Core)**
424
425
426

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.

427
428 **II.B.2.c) demonstrate a strong interest in the education of fellows; ^(Core)**
429

430 **II.B.2.d) devote sufficient time to the educational program to fulfill**
431 **their supervisory and teaching responsibilities; ^(Core)**

- 432
 433 **II.B.2.e)** administer and maintain an educational environment
 434 conducive to educating fellows; ^(Core)
 435
 436 **II.B.2.f)** pursue faculty development designed to enhance their skills;
 437 and, ^(Core)
 438
 439 **II.B.2.g)** encourage and support fellows in scholarly activities. ^(Core)
 440

441 **II.B.3. Faculty Qualifications**

442
 443 **II.B.3.a)** Faculty members must have appropriate qualifications in
 444 their field and hold appropriate institutional appointments.
 445 ^(Core)
 446

447 **II.B.3.b)** Subspecialty physician faculty members must:

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 449 **II.B.3.b).(1)** have current certification in the subspecialty by the
 450 **American Boards** of Family Medicine, Internal Medicine,
 451 Psychiatry and Neurology, Otolaryngology – Head and
 452 Neck Surgery, Pediatrics, or Psychiatry **or the American**
 453 **Osteopathic Boards** of Family Physicians, Internal
 454 Medicine, Neurology and Psychiatry, or Ophthalmology
 455 and Otolaryngology – Head and Neck Surgery, **or**
 456 **possess qualifications judged acceptable to the**
 457 **Review Committee.** ^(Core)
 458

459 **II.B.3.c)** Any non-physician faculty members who participate in
 460 fellowship program education must be approved by the
 461 program director. ^(Core)
 462

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.

- 463
 464 **II.B.3.d)** Any other specialty physician faculty members must have
 465 current certification in their specialty by the appropriate
 466 **American Board of Medical Specialties (ABMS)** member
 467 board or **American Osteopathic Association (AOA)** certifying
 468 board, or possess qualifications judged acceptable to the
 469 **Review Committee.** ^(Core)
 470
 471 **II.B.3.d).(1)** Faculty who are ABMS- or AOA-certified in anesthesiology,
 472 family medicine, internal medicine, neurology,
 473 otolaryngology, pediatrics, psychiatry, pulmonology, should
 474 be available to the program. ^(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.

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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) In addition to the program director, there must be at least one core faculty member certified in sleep medicine by the American Board of Family Medicine, Internal Medicine, Psychiatry and Neurology, Otolaryngology – Head and Neck Surgery, Pediatrics, or Psychiatry or the American Osteopathic Board of Family Physicians, Internal Medicine, Neurology and Psychiatry, or Ophthalmology and Otolaryngology – Head and Neck Surgery. ^(Core)

II.B.4.d) For programs with more than two fellows, there must be at least one core faculty member certified in sleep medicine by the American Board of Family Medicine, Internal Medicine, Psychiatry and Neurology, Otolaryngology – Head and Neck Surgery, Pediatrics, or Psychiatry or the American Osteopathic Board of Family Physicians, Internal Medicine, Neurology and Psychiatry, or Ophthalmology and Otolaryngology – Head and Neck Surgery for every 1.5 fellows. ^(Core)

II.C. Program Coordinator

II.C.1. There must be administrative support for program coordination. ^(Core)

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

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II.D. Other Program Personnel

516 **The program, in partnership with its Sponsoring Institution, must jointly**
517 **ensure the availability of necessary personnel for the effective**
518 **administration of the program.** (Core)

519
520 II.D.1. There must be services available from other health care professionals,
521 including dietitians, language interpreters, nurses, occupational
522 therapists, physical therapists, and social workers. (Detail)

523
524 II.D.2. There must be appropriate and timely consultation from other specialties.
525 (Detail)

526

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.

527

528 **III. Fellow Appointments**

529

530 **III.A. Eligibility Criteria**

531

532 **III.A.1. Eligibility Requirements – Fellowship Programs**

533

534 **All required clinical education for entry into ACGME-accredited**
535 **fellowship programs must be completed in an ACGME-accredited**
536 **residency program, an AOA-approved residency program, a**
537 **program with ACGME International (ACGME-I) Advanced Specialty**
538 **Accreditation, or a Royal College of Physicians and Surgeons of**
539 **Canada (RCPSC)-accredited or College of Family Physicians of**
540 **Canada (CFPC)-accredited residency program located in Canada.**
541 (Core)

542

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).

543

544 **III.A.1.a) Fellowship programs must receive verification of each**
545 **entering fellow's level of competence in the required field,**
546 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
547 **Milestones evaluations from the core residency program.** (Core)

548

549 III.A.1.b) Prior to appointment in the program, each fellow must have
550 completed a core program in anesthesiology, child neurology,
551 family medicine, internal medicine, neurology, otolaryngology,
552 pediatrics, or psychiatry that satisfies the requirements in III.A.1.
553 (Core)

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555 **III.A.1.c) Fellow Eligibility Exception**

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The Review Committee for Internal Medicine, Neurology, Pediatrics and Psychiatry will allow the following exception to the fellowship eligibility requirements:

- 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.

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.

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- III.B.** **The program director must not appoint more fellows than approved by the Review Committee.** (Core)

592 III.B.1. All complement increases must be approved by the Review
593 Committee. ^(Core)

594
595 IV. Educational Program

596
597 *The ACGME accreditation system is designed to encourage excellence and*
598 *innovation in graduate medical education regardless of the organizational*
599 *affiliation, size, or location of the program.*

600
601 *The educational program must support the development of knowledgeable, skillful*
602 *physicians who provide compassionate care.*

603
604 *In addition, the program is expected to define its specific program aims consistent*
605 *with the overall mission of its Sponsoring Institution, the needs of the community*
606 *it serves and that its graduates will serve, and the distinctive capabilities of*
607 *physicians it intends to graduate. While programs must demonstrate substantial*
608 *compliance with the Common and subspecialty-specific Program Requirements, it*
609 *is recognized that within this framework, programs may place different emphasis*
610 *on research, leadership, public health, etc. It is expected that the program aims*
611 *will reflect the nuanced program-specific goals for it and its graduates; for*
612 *example, it is expected that a program aiming to prepare physician-scientists will*
613 *have a different curriculum from one focusing on community health.*

614
615 IV.A. The curriculum must contain the following educational components: ^(Core)

616
617 IV.A.1. a set of program aims consistent with the Sponsoring Institution's
618 mission, the needs of the community it serves, and the desired
619 distinctive capabilities of its graduates; ^(Core)

620
621 IV.A.1.a) The program's aims must be made available to program
622 applicants, fellows, and faculty members. ^(Core)

623
624 IV.A.2. competency-based goals and objectives for each educational
625 experience designed to promote progress on a trajectory to
626 autonomous practice in their subspecialty. These must be
627 distributed, reviewed, and available to fellows and faculty members;
628 ^(Core)

629
630 IV.A.3. delineation of fellow responsibilities for patient care, progressive
631 responsibility for patient management, and graded supervision in
632 their subspecialty; ^(Core)

633

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.

634
635 IV.A.4. structured educational activities beyond direct patient care; and,
636 ^(Core)

637

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.

638

639

**IV.A.5. advancement of fellows’ knowledge of ethical principles
 foundational to medical professionalism. (Core)**

640

641

642

IV.B. ACGME Competencies

643

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.

644

645

**IV.B.1. The program must integrate the following ACGME Competencies
 into the curriculum: (Core)**

646

647

IV.B.1.a) Professionalism

648

649

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

650

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IV.B.1.b) Patient Care and Procedural Skills

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654

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 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.

655

**IV.B.1.b).(1) Fellows must be able to provide patient care that is
 compassionate, appropriate, and effective for the
 treatment of health problems and the promotion of
 health. (Core)**

656

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660

**IV.B.1.b).(1).(a) Fellows must demonstrate competence in the
 diagnosis and management of patients with sleep**

661

662

663		disorders in outpatient and inpatient settings; and,
664		(Core)
665		
666	IV.B.1.b).(1).(b)	Fellows must demonstrate competence as a
667		consultant in both inpatient and outpatient settings.
668		(Core)
669		
670	IV.B.1.b).(2)	Fellows must be able to perform all medical,
671		diagnostic, and surgical procedures considered
672		essential for the area of practice. (Core)
673		
674	IV.B.1.b).(2).(a)	Fellows must demonstrate clinical competence in:
675		
676	IV.B.1.b).(2).(a).(i)	conducting the tests unique to sleep
677		medicine, including electrode and sensor
678		application, calibrations, maintenance of
679		signal integrity, and protocols for initiating
680		and terminating the tests; (Core)
681		
682	IV.B.1.b).(2).(a).(ii)	evaluating, diagnosing and
683		comprehensively treating patients over the
684		entire spectrum of pediatric and adult sleep
685		and circadian rhythm disorders, as well as
686		those medical, neurological, and psychiatric
687		disorders that may present with sleep-
688		related complaints in both the inpatient and
689		outpatient settings; (Core)
690		
691	IV.B.1.b).(2).(a).(iii)	integrating information obtained from patient
692		history, physical examination, physiologic
693		recordings, imaging studies as they relate to
694		sleep disorders, psychometric testing,
695		pulmonary function testing, and biochemical
696		and molecular tests results to arrive at an
697		accurate and timely diagnosis and treatment
698		plan; (Core)
699		
700	IV.B.1.b).(2).(a).(iv)	integrating relevant biological,
701		psychological, social, economic, ethnic, and
702		familial factors into the evaluation and
703		treatment of their patients' sleep disorders;
704		(Core)
705		
706	IV.B.1.b).(2).(a).(v)	interpreting psychological and psychometric
707		tests as they relate to sleep disorders. (Core)
708		
709	IV.B.1.b).(2).(a).(vi)	performing cardiopulmonary resuscitation;
710		(Core)
711		

712	IV.B.1.b).(2).(a).(vii)	performing physical, neurological and mental status examinations relevant to the practice of sleep medicine; ^(Core)
713		
714		
715		
716	IV.B.1.b).(2).(a).(viii)	planning and implementing therapeutic treatment, including pharmaceutical, medical device, behavioral, and surgical therapies; ^(Core)
717		
718		
719		
720		
721	IV.B.1.b).(2).(a).(ix)	selecting the appropriate sleep investigation(s) to facilitate a patient's diagnosis and treatment; and, ^(Core)
722		
723		
724		
725	IV.B.1.b).(2).(a).(x)	scoring and interpreting:
726		
727	IV.B.1.b).(2).(a).(x).(a)	polysomnograms; ^(Core)
728		
729	IV.B.1.b).(2).(a).(x).(b)	multiple sleep latency and maintenance of wakefulness testing; ^(Core)
730		
731		
732		
733	IV.B.1.b).(2).(a).(x).(c)	portable sleep monitor recordings; ^(Core)
734		
735		
736	IV.B.1.b).(2).(a).(x).(d)	actigraphy; ^(Core)
737		
738	IV.B.1.b).(2).(a).(x).(e)	downloads from positive pressure devices; ^(Core)
739		
740		
741	IV.B.1.b).(2).(a).(x).(f)	sleep diaries; and, ^(Core)
742		
743	IV.B.1.b).(2).(a).(x).(g)	standardized scales of sleepiness. ^(Core)
744		
745		

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 knowledge of the neurobiology of sleep and wakefulness, sleep-related anatomy and physiology, and the neural structures mediating circadian rhythms. ^(Core)

This must include:

IV.B.1.c).(1).(a)

fundamental mechanisms of sleep, major theories in sleep medicine, and the generally-accepted facts of basic sleep mechanisms including: ^(Core)

763		
764	IV.B.1.c).(1).(a).(i)	basic neurologic mechanisms controlling sleep and wakefulness; ^(Core)
765		
766		
767	IV.B.1.c).(1).(a).(ii)	cardiovascular physiology and pathophysiology related to sleep and sleep disorders; ^(Core)
768		
769		
770		
771	IV.B.1.c).(1).(a).(iii)	changes in sleep across the life span; ^(Core)
772		
773	IV.B.1.c).(1).(a).(iv)	chronobiology; ^(Core)
774		
775	IV.B.1.c).(1).(a).(v)	endocrine physiology and pathophysiology related to sleep and sleep disorders; ^(Core)
776		
777		
778	IV.B.1.c).(1).(a).(vi)	gastrointestinal physiology and pathophysiology related to sleep and sleep disorders; ^(Core)
779		
780		
781		
782	IV.B.1.c).(1).(a).(vii)	ontogeny of sleep; and, ^(Core)
783		
784	IV.B.1.c).(1).(a).(viii)	respiratory physiology and pathophysiology related to sleep and sleep disorders. ^(Core)
785		
786		
787	IV.B.1.c).(1).(b)	upper airway anatomy, normal and abnormal across the life span; ^(Core)
788		
789		
790	IV.B.1.c).(1).(c)	effects of impaired sleep on bed partners; ^(Core)
791		
792	IV.B.1.c).(1).(d)	nosology for sleep disorders as described in the current edition of The International Classification of Sleep Disorders; ^(Core)
793		
794		
795		
796	IV.B.1.c).(1).(e)	etiopathogenic characterization of sleep disorders; ^(Core)
797		
798		
799	IV.B.1.c).(1).(f)	effects of medications on sleep and sleep disorders; ^(Core)
800		
801		
802	IV.B.1.c).(1).(g)	clinical manifestations of sleep disorders, including: ^(Core)
803		
804		
805	IV.B.1.c).(1).(g).(i)	circadian rhythm disorders; ^(Core)
806		
807	IV.B.1.c).(1).(g).(ii)	disorders of excessive sleepiness; ^(Core)
808		
809	IV.B.1.c).(1).(g).(iii)	interactions between therapies for sleep disorders and other medical, neurologic, and psychiatric treatments; ^(Core)
810		
811		
812		

813	IV.B.1.c).(1).(g).(iv)	insomnia and other disorders of initiating and maintaining sleep; ^(Core)
814		
815		
816	IV.B.1.c).(1).(g).(v)	medical, neurologic, and psychiatric disorders and substance use disorder, including withdrawal syndromes, and displaying symptoms likely to be related to sleep disorders (e.g., the relationship between hypertension and sleep apnea); ^(Core)
817		
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824	IV.B.1.c).(1).(g).(vi)	neonatal and pediatric sleep disorders; ^(Core)
825		
826	IV.B.1.c).(1).(g).(vii)	parasomnias; ^(Core)
827		
828	IV.B.1.c).(1).(g).(viii)	safe infant sleep practices; ^(Core)
829		
830	IV.B.1.c).(1).(g).(ix)	sleep-related breathing disorders in both adults and children; ^(Core)
831		
832		
833	IV.B.1.c).(1).(g).(x)	sleep-related movement disorders; and, ^(Core)
834		
835	IV.B.1.c).(1).(g).(xi)	Sudden Infant Death Syndrome; ^(Core)
836		
837	IV.B.1.c).(1).(h)	diagnostic strategies in sleep disorders including differences between children and adults; ^(Core)
838		
839		
840	IV.B.1.c).(1).(i)	treatment strategies in sleep disorders incorporating:
841		
842		
843	IV.B.1.c).(1).(i).(i)	approaches for obstructive sleep apnea, including nasal CPAP, bilevel and other modes of PAP, maxillofacial and upper airway surgery, oral appliances, and position education; ^(Core)
844		
845		
846		
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848		
849	IV.B.1.c).(1).(i).(ii)	approaches for insomnia, including cognitive-behavioral therapies and pharmacological therapy; ^(Core)
850		
851		
852		
853	IV.B.1.c).(1).(i).(iii)	approaches for narcolepsy and other hypersomnias of central origin; ^(Core)
854		
855		
856	IV.B.1.c).(1).(i).(iv)	approaches for parasomnias; ^(Core)
857		
858	IV.B.1.c).(1).(i).(v)	approaches for circadian rhythm disorders; and, ^(Core)
859		
860		
861	IV.B.1.c).(1).(i).(vi)	understanding the differences in approaches between children and adults. ^(Core)
862		
863		

- 864
865 IV.B.1.c).(1).(j) operation of polysomnographic monitoring
866 equipment, including polysomnographic trouble
867 shooting and ambulatory monitoring methodology.
868 (Core)
869
- 870 IV.B.1.c).(1).(k) financing and regulation of sleep medicine; (Core)
871
- 872 IV.B.1.c).(1).(l) research methods in the clinical and basic sciences
873 related to sleep medicine; (Core)
874
- 875 IV.B.1.c).(1).(m) medical ethics and its application in sleep medicine;
876 (Core)
877
- 878 IV.B.1.c).(1).(n) legal aspects of sleep medicine; and, (Core)
879
- 880 IV.B.1.c).(1).(o) the impact of sleep disorders on the family and
881 society. (Core)
882
- 883 IV.B.1.c).(2) Fellows must demonstrate knowledge of the appropriate
884 indications for, and potential pitfalls, limitations,
885 administration, and interpretation of diagnostic tests used
886 in sleep medicine, including polysomnography, multiple
887 sleep latency testing, maintenance of wakefulness testing,
888 actigraphy, and portable monitoring, to include: (Core)
889
- 890 IV.B.1.c).(2).(a) indications and contraindications for, and proper
891 patient preparation and potential shortcomings of
892 the tests used in sleep medicine; and, (Core)
893
- 894 IV.B.1.c).(2).(b) principles of recording bioelectric signals, including
895 polarity, dipoles, electrodes, derivations, montages,
896 amplifiers, sampling, and digital display. (Core)
897
- 898 **IV.B.1.d) Practice-based Learning and Improvement**
899
- 900 **Fellows must demonstrate the ability to investigate and**
901 **evaluate their care of patients, to appraise and assimilate**
902 **scientific evidence, and to continuously improve patient care**
903 **based on constant self-evaluation and lifelong learning. (Core)**
904

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.

- 905
906 **IV.B.1.e) Interpersonal and Communication Skills**

907
908 **Fellows must demonstrate interpersonal and communication**
909 **skills that result in the effective exchange of information and**
910 **collaboration with patients, their families, and health**
911 **professionals.** ^(Core)
912

913 **IV.B.1.f) Systems-based Practice**

914
915 **Fellows must demonstrate an awareness of and**
916 **responsiveness to the larger context and system of health**
917 **care, including the social determinants of health, as well as**
918 **the ability to call effectively on other resources to provide**
919 **optimal health care.** ^(Core)
920

921 **IV.C. Curriculum Organization and Fellow Experiences**

922
923 **IV.C.1. The curriculum must be structured to optimize fellow educational**
924 **experiences, the length of these experiences, and supervisory**
925 **continuity.** ^(Core)
926

927 **IV.C.1.a) Assignment of rotations must be structured to minimize the**
928 **frequency of rotational transitions, and rotations must be of**
929 **sufficient length to provide a quality educational experience,**
930 **defined by continuity of patient care, ongoing supervision,**
931 **longitudinal relationships with faculty members, and meaningful**
932 **assessment and feedback.** ^(Core)
933

934 **IV.C.1.b) Clinical experiences should be structured to facilitate learning in a**
935 **manner that allows fellows to function as part of an effective**
936 **interprofessional team that works together towards the shared**
937 **goals of patient safety and quality improvement.** ^(Core)
938

939 **IV.C.2. The program must provide instruction and experience in pain**
940 **management if applicable for the subspecialty, including recognition**
941 **of the signs of addiction.** ^(Core)
942

943 **IV.C.3. At least 11 of the 12 months of the program must be devoted to the**
944 **inpatient and ambulatory clinical experiences.** ^(Core)
945

946 **IV.C.4. Fellows must participate in an interdisciplinary care of patients of all ages**
947 **that incorporates aspects of basic science, epidemiology, family**
948 **medicine, internal medicine, neurology, pediatrics, psychiatry, and**
949 **surgery.** ^(Detail)
950

951 **IV.C.5. Clinical experience should include evaluation and follow up of**
952 **hospitalized sleep disorder patients.** ^(Detail)
953

954 **IV.C.6. The core curriculum must include a didactic program based upon the core**
955 **knowledge content in the subspecialty.** ^(Core)
956

957	IV.C.6.a)	Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. ^(Detail)
958		
959		
960		
961	IV.C.6.b)	Fellows must participate in planning and conducting conferences. ^(Detail)
962		
963		
964	IV.C.6.c)	All required core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction. ^(Detail)
965		
966		
967		
968	IV.C.6.d)	Didactic topics should include clinical ethics, interdisciplinary topics, medical genetics, patient safety, physician impairment, preventive medicine, quality assessment, quality improvement, and, risk management. ^(Detail)
969		
970		
971		
972		
973	IV.C.6.e)	Methods for teaching sleep testing should include didactic instruction, interactive discussion, role modeling by faculty and allied staff, self-directed inquiry learning, and direct experience. ^(Detail)
974		
975		
976		
977		
978	IV.C.6.f)	Fellows must be instructed in practice management relevant to sleep medicine. ^(Detail)
979		
980		
981	IV.C.7.	Clinical Experience with Continuity Ambulatory Patients
982		
983	IV.C.7.a)	Fellows must have a continuity ambulatory clinic experience to develop a continuous healing relationship with patients for whom they provide sleep medicine care. This continuity experience should expose fellows to the breadth and depth of the subspecialty. ^(Core)
984		
985		
986		
987		
988		
989	IV.C.7.a).(1)	This experience should average one half-day each week.
990		
991		This should be accomplished by either: ^(Detail)
992		
993	IV.C.7.a).(1).(a)	an experience at one clinic for 12 months; or, ^(Detail)
994		
995	IV.C.7.a).(1).(b)	two consecutive six-month-long experiences at two different clinics. ^(Detail)
996		
997		
998	IV.C.7.a).(2)	Experience must include longitudinal management of patients for whom the fellow is the primary physician under the supervision of a faculty member. ^(Detail)
999		
1000		
1001		
1002	IV.C.7.a).(3)	Each fellow's clinical experiences with ambulatory patients must provide fellows the opportunity to observe and learn the course of disease. ^(Detail)
1003		
1004		
1005		
1006	IV.C.8.	Procedures and Technical Skills
1007		

1008	IV.C.8.a)	Fellows must score and interpret recordings of various diagnostic types, including polysomnograms, multiple sleep latency tests; maintenance of wakefulness test. ^(Core)
1009		
1010		
1011		
1012	IV.C.8.a).(1)	Fellows must score a minimum of 25 recordings during the course of the fellowship. ^(Detail)
1013		
1014		
1015	IV.C.8.a).(1).(a)	At least five of these must be adult recordings; and, ^(Detail)
1016		
1017		
1018	IV.C.8.a).(1).(b)	At least five must be pediatric recordings. Pediatric recordings should include those from infants, children, and adolescents. ^(Detail)
1019		
1020		
1021		
1022	IV.C.8.a).(2)	Fellows must interpret a minimum of 200 polysomnograms with at least 40 from adults and 40 from children. Pediatric polysomnograms should include those from infants, children, and adolescents. ^(Detail)
1023		
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1026		
1027	IV.D.	Scholarship
1028		
1029		<i>Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.</i>
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1038		<i>The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.</i>
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1047	IV.D.1.	Program Responsibilities
1048		
1049	IV.D.1.a)	The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. ^(Core)
1050		
1051		
1052	IV.D.2.	Faculty Scholarly Activity
1053		
1054	IV.D.2.a)	The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)
1055		
1056		
1057	IV.D.2.a).(1)	The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)
1058		

- 1059
 1060 IV.D.2.a).(2) Some members of the faculty must also demonstrate
 1061 scholarship by one or more of the following: ^(Detail)
 1062
 1063 IV.D.2.a).(2).(a) peer-reviewed funding; ^(Detail)
 1064
 1065 IV.D.2.a).(2).(b) publication of original research, case reports, or
 1066 review articles in peer-reviewed journals or
 1067 chapters in textbooks; ^(Detail)
 1068
 1069 IV.D.2.a).(2).(c) publication or presentation of case reports or
 1070 clinical series at local, regional, or national
 1071 professional and scientific society meetings; or,
 1072 ^(Detail)
 1073
 1074 IV.D.2.a).(2).(d) participation in national committees or educational
 1075 organizations. ^(Detail)
 1076

1077 **IV.D.3. Fellow Scholarly Activity**

- 1078
 1079 IV.D.3.a) The program must provide an opportunity for each fellow to
 1080 participate in research or other scholarly activities. ^(Core)
 1081

1082 **V. Evaluation**

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 1084 **V.A. Fellow Evaluation**

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 1086 **V.A.1. Feedback and Evaluation**
 1087

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.

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

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.

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V.A.1.b) Evaluation must be documented at the completion of the assignment. ^(Core)

V.A.1.b).(1) Evaluations must be completed at least every three months. ^(Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: ^(Core)

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, ^(Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. ^(Core)

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.

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V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

- 1116
 1117 **V.A.1.d).(1)** meet with and review with each fellow their
 1118 documented semi-annual evaluation of performance,
 1119 including progress along the subspecialty-specific
 1120 Milestones. ^(Core)
 1121
 1122 **V.A.1.d).(2)** develop plans for fellows failing to progress, following
 1123 institutional policies and procedures. ^(Core)
 1124

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.

- 1125
 1126 **V.A.1.e)** The evaluations of a fellow's performance must be accessible
 1127 for review by the fellow. ^(Core)
 1128
 1129 **V.A.2.** Final Evaluation
 1130
 1131 **V.A.2.a)** The program director must provide a final evaluation for each
 1132 fellow upon completion of the program. ^(Core)
 1133
 1134 **V.A.2.a).(1)** The subspecialty-specific Milestones, and when
 1135 applicable the subspecialty-specific Case Logs, must
 1136 be used as tools to ensure fellows are able to engage
 1137 in autonomous practice upon completion of the
 1138 program. ^(Core)
 1139
 1140 **V.A.2.a).(2)** The final evaluation must:
 1141
 1142 **V.A.2.a).(2).(a)** become part of the fellow's permanent record
 1143 maintained by the institution, and must be
 1144 accessible for review by the fellow in
 1145 accordance with institutional policy; ^(Core)
 1146
 1147 **V.A.2.a).(2).(b)** verify that the fellow has demonstrated the
 1148 knowledge, skills, and behaviors necessary to
 1149 enter autonomous practice; ^(Core)

- 1150
 1151 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
 1152 Competency Committee; and, ^(Core)
 1153
 1154 **V.A.2.a).(2).(d)** be shared with the fellow upon completion of
 1155 the program. ^(Core)
 1156
 1157 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
 1158 **program director.** ^(Core)
 1159
 1160 **V.A.3.a)** **At a minimum the Clinical Competency Committee must**
 1161 **include three members, at least one of whom is a core faculty**
 1162 **member. Members must be faculty members from the same**
 1163 **program or other programs, or other health professionals**
 1164 **who have extensive contact and experience with the**
 1165 **program’s fellows.** ^(Core)
 1166
 1167 **V.A.3.b)** **The Clinical Competency Committee must:**
 1168
 1169 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
 1170 ^(Core)
 1171
 1172 **V.A.3.b).(2)** **determine each fellow’s progress on achievement of**
 1173 **the subspecialty-specific Milestones; and,** ^(Core)
 1174
 1175 **V.A.3.b).(3)** **meet prior to the fellows’ semi-annual evaluations and**
 1176 **advise the program director regarding each fellow’s**
 1177 **progress.** ^(Core)
 1178
 1179 **V.B. Faculty Evaluation**
 1180
 1181 **V.B.1.** **The program must have a process to evaluate each faculty**
 1182 **member’s performance as it relates to the educational program at**
 1183 **least annually.** ^(Core)
 1184

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.

- 1185
1186 **V.B.1.a)** This evaluation must include a review of the faculty member’s
1187 clinical teaching abilities, engagement with the educational
1188 program, participation in faculty development related to their
1189 skills as an educator, clinical performance, professionalism,
1190 and scholarly activities. ^(Core)
1191
1192 **V.B.1.b)** This evaluation must include written, confidential evaluations
1193 by the fellows. ^(Core)
1194
1195 **V.B.2.** Faculty members must receive feedback on their evaluations at least
1196 annually. ^(Core)
1197

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 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.

- 1198
1199 **V.C. Program Evaluation and Improvement**
1200
1201 **V.C.1.** The program director must appoint the Program Evaluation
1202 Committee to conduct and document the Annual Program
1203 Evaluation as part of the program’s continuous improvement
1204 process. ^(Core)
1205
1206 **V.C.1.a)** The Program Evaluation Committee must be composed of at
1207 least two program faculty members, at least one of whom is a
1208 core faculty member, and at least one fellow. ^(Core)
1209
1210 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
1211
1212 **V.C.1.b).(1)** acting as an advisor to the program director, through
1213 program oversight; ^(Core)
1214
1215 **V.C.1.b).(2)** review of the program’s self-determined goals and
1216 progress toward meeting them; ^(Core)
1217
1218 **V.C.1.b).(3)** guiding ongoing program improvement, including
1219 development of new goals, based upon outcomes;
1220 and, ^(Core)
1221
1222 **V.C.1.b).(4)** review of the current operating environment to identify
1223 strengths, challenges, opportunities, and threats as
1224 related to the program’s mission and aims. ^(Core)
1225

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.

- 1226
1227 **V.C.1.c)** The Program Evaluation Committee should consider the
1228 following elements in its assessment of the program:
1229
1230 **V.C.1.c).(1)** fellow performance; ^(Core)
1231
1232 **V.C.1.c).(2)** faculty development; and, ^(Core)
1233
1234 **V.C.1.c).(3)** progress on the previous year's action plan(s). ^(Core)
1235
1236 **V.C.1.d)** The Program Evaluation Committee must evaluate the
1237 program's mission and aims, strengths, areas for
1238 improvement, and threats. ^(Core)
1239
1240 **V.C.1.e)** The annual review, including the action plan, must:
1241
1242 **V.C.1.e).(1)** be distributed to and discussed with the members of
1243 the teaching faculty and the fellows; and, ^(Core)
1244
1245 **V.C.1.e).(2)** be submitted to the DIO. ^(Core)
1246
1247 **V.C.2.** The program must participate in a Self-Study prior to its 10-Year
1248 Accreditation Site Visit. ^(Core)
1249
1250 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
1251 ^(Core)
1252

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.

- 1253
1254 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
1255 *who seek and achieve board certification. One measure of the*
1256 *effectiveness of the educational program is the ultimate pass rate.*
1257
1258 *The program director should encourage all eligible program*
1259 *graduates to take the certifying examination offered by the*

- 1260 *applicable American Board of Medical Specialties (ABMS) member*
 1261 *board or American Osteopathic Association (AOA) certifying board.*
 1262
- 1263 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
 1264 AOA certifying board offer(s) an annual written exam, in the
 1265 preceding three years, the program’s aggregate pass rate of
 1266 those taking the examination for the first time must be higher
 1267 than the bottom fifth percentile of programs in that
 1268 subspecialty. ^{(Outcome)‡}
 1269
- 1270 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
 1271 AOA certifying board offer(s) a biennial written exam, in the
 1272 preceding six years, the program’s aggregate pass rate of
 1273 those taking the examination for the first time must be higher
 1274 than the bottom fifth percentile of programs in that
 1275 subspecialty. ^(Outcome)
 1276
- 1277 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
 1278 AOA certifying board offer(s) an annual oral exam, in the
 1279 preceding three years, the program’s aggregate pass rate of
 1280 those taking the examination for the first time must be higher
 1281 than the bottom fifth percentile of programs in that
 1282 subspecialty. ^(Outcome)
 1283
- 1284 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
 1285 AOA certifying board offer(s) a biennial oral exam, in the
 1286 preceding six years, the program’s aggregate pass rate of
 1287 those taking the examination for the first time must be higher
 1288 than the bottom fifth percentile of programs in that
 1289 subspecialty. ^(Outcome)
 1290
- 1291 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1292 whose graduates over the time period specified in the
 1293 requirement have achieved an 80 percent pass rate will have
 1294 met this requirement, no matter the percentile rank of the
 1295 program for pass rate in that subspecialty. ^(Outcome)
 1296

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.

- 1297
 1298 **V.C.3.f)** Programs must report, in ADS, board certification status
 1299 annually for the cohort of board-eligible fellows that
 1300 graduated seven years earlier. ^(Core)

1301

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.

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VI. The Learning and Working Environment

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Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

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1307

- *Excellence in the safety and quality of care rendered to patients by fellows today*

1308

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1310

- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*

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- *Excellence in professionalism through faculty modeling of:*

1314

1315

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

1316

1317

1318

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

1319

1320

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

1321

1322

1323

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.

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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 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)

1365 VI.A.1.a).(1).(b) The program must have a structure that
1366 promotes safe, interprofessional, team-based
1367 care. ^(Core)
1368

1369 VI.A.1.a).(2) Education on Patient Safety
1370
1371 Programs must provide formal educational activities
1372 that promote patient safety-related goals, tools, and
1373 techniques. ^(Core)
1374

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

1375
1376 VI.A.1.a).(3) Patient Safety Events
1377
1378 *Reporting, investigation, and follow-up of adverse*
1379 *events, near misses, and unsafe conditions are pivotal*
1380 *mechanisms for improving patient safety, and are*
1381 *essential for the success of any patient safety*
1382 *program. Feedback and experiential learning are*
1383 *essential to developing true competence in the ability*
1384 *to identify causes and institute sustainable systems-*
1385 *based changes to ameliorate patient safety*
1386 *vulnerabilities.*
1387

1388 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
1389 clinical staff members must:

1390
1391 VI.A.1.a).(3).(a).(i) know their responsibilities in reporting
1392 patient safety events at the clinical site;
1393 ^(Core)
1394

1395 VI.A.1.a).(3).(a).(ii) know how to report patient safety
1396 events, including near misses, at the
1397 clinical site; and, ^(Core)
1398

1399 VI.A.1.a).(3).(a).(iii) be provided with summary information
1400 of their institution's patient safety
1401 reports. ^(Core)
1402

1403 VI.A.1.a).(3).(b) Fellows must participate as team members in
1404 real and/or simulated interprofessional clinical
1405 patient safety activities, such as root cause
1406 analyses or other activities that include
1407 analysis, as well as formulation and
1408 implementation of actions. ^(Core)
1409

1410 VI.A.1.a).(4) Fellow Education and Experience in Disclosure of
1411 Adverse Events
1412

1413		<i>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.</i>
1414		
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1418		
1419	VI.A.1.a).(4).(a)	All fellows must receive training in how to disclose adverse events to patients and families. ^(Core)
1420		
1421		
1422		
1423	VI.A.1.a).(4).(b)	Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)
1424		
1425		
1426		
1427	VI.A.1.b)	Quality Improvement
1428		
1429	VI.A.1.b).(1)	Education in Quality Improvement
1430		
1431		<i>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.</i>
1432		
1433		
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1435		
1436	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1437		
1438		
1439		
1440	VI.A.1.b).(2)	Quality Metrics
1441		
1442		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1443		
1444		
1445		
1446	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1447		
1448		
1449		
1450	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1451		
1452		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1453		
1454		
1455		
1456	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1457		
1458		
1459		
1460	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1461		
1462		
1463	VI.A.2.	Supervision and Accountability

- 1464
1465 **VI.A.2.a)** *Although the attending physician is ultimately responsible for*
1466 *the care of the patient, every physician shares in the*
1467 *responsibility and accountability for their efforts in the*
1468 *provision of care. Effective programs, in partnership with*
1469 *their Sponsoring Institutions, define, widely communicate,*
1470 *and monitor a structured chain of responsibility and*
1471 *accountability as it relates to the supervision of all patient*
1472 *care.*
- 1473
1474 *Supervision in the setting of graduate medical education*
1475 *provides safe and effective care to patients; ensures each*
1476 *fellow's development of the skills, knowledge, and attitudes*
1477 *required to enter the unsupervised practice of medicine; and*
1478 *establishes a foundation for continued professional growth.*
1479
- 1480 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1481 **appropriately-credentialed and privileged attending**
1482 **physician (or licensed independent practitioner as**
1483 **specified by the applicable Review Committee) who is**
1484 **responsible and accountable for the patient's care.**
1485 (Core)
- 1486
1487 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
1488 **faculty members, other members of the health**
1489 **care team, and patients.** (Core)
- 1490
1491 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
1492 **patient of their respective roles in that patient's**
1493 **care when providing direct patient care.** (Core)
1494
- 1495 **VI.A.2.b)** *Supervision may be exercised through a variety of methods.*
1496 *For many aspects of patient care, the supervising physician*
1497 *may be a more advanced fellow. Other portions of care*
1498 *provided by the fellow can be adequately supervised by the*
1499 *appropriate availability of the supervising faculty member or*
1500 *fellow, either on site or by means of telecommunication*
1501 *technology. Some activities require the physical presence of*
1502 *the supervising faculty member. In some circumstances,*
1503 *supervision may include post-hoc review of fellow-delivered*
1504 *care with feedback.*
1505

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.

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1507	VI.A.2.b).(1)	The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. ^(Core)
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1514	VI.A.2.b).(2)	The program must define when physical presence of a supervising physician is required. ^(Core)
1515		
1516		
1517	VI.A.2.c)	Levels of Supervision
1518		
1519		To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)
1520		
1521		
1522		
1523	VI.A.2.c).(1)	Direct Supervision:
1524		
1525	VI.A.2.c).(1).(a)	the supervising physician is physically present with the fellow during the key portions of the patient interaction. ^(Core)
1526		
1527		
1528		
1529	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. ^(Core)
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1535	VI.A.2.c).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)
1536		
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1539	VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)
1540		
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1543		
1544	VI.A.2.d).(1)	The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. ^(Core)
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1548	VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. ^(Core)
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1553	VI.A.2.d).(3)	Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each
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1556 patient and the skills of the individual resident or
1557 fellow. ^(Detail)

1558
1559 **VI.A.2.e) Programs must set guidelines for circumstances and events**
1560 **in which fellows must communicate with the supervising**
1561 **faculty member(s).** ^(Core)

1562
1563 **VI.A.2.e).(1) Each fellow must know the limits of their scope of**
1564 **authority, and the circumstances under which the**
1565 **fellow is permitted to act with conditional**
1566 **independence.** ^(Outcome)
1567

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

1568
1569 **VI.A.2.f) Faculty supervision assignments must be of sufficient**
1570 **duration to assess the knowledge and skills of each fellow**
1571 **and to delegate to the fellow the appropriate level of patient**
1572 **care authority and responsibility.** ^(Core)
1573

1574 **VI.B. Professionalism**

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1576 **VI.B.1. Programs, in partnership with their Sponsoring Institutions, must**
1577 **educate fellows and faculty members concerning the professional**
1578 **responsibilities of physicians, including their obligation to be**
1579 **appropriately rested and fit to provide the care required by their**
1580 **patients.** ^(Core)
1581

1582 **VI.B.2. The learning objectives of the program must:**

1583
1584 **VI.B.2.a) be accomplished through an appropriate blend of supervised**
1585 **patient care responsibilities, clinical teaching, and didactic**
1586 **educational events;** ^(Core)
1587

1588 **VI.B.2.b) be accomplished without excessive reliance on fellows to**
1589 **fulfill non-physician obligations; and,** ^(Core)
1590

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.

1591
1592 **VI.B.2.c) ensure manageable patient care responsibilities.** ^(Core)

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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.

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VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

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VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:

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VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)

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VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)

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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.

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VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)

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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.

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VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, ^(Outcome)

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VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)

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VI.B.4.d) commitment to lifelong learning; ^(Outcome)

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VI.B.4.e) monitoring of their patient care performance improvement indicators; and, ^(Outcome)

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VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. ^(Outcome)

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1627 VI.B.5. All fellows and faculty members must demonstrate responsiveness
1628 to patient needs that supersedes self-interest. This includes the
1629 recognition that under certain circumstances, the best interests of
1630 the patient may be served by transitioning that patient's care to
1631 another qualified and rested provider. *(Outcome)*
1632

1633 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1634 provide a professional, equitable, respectful, and civil environment
1635 that is free from discrimination, sexual and other forms of
1636 harassment, mistreatment, abuse, or coercion of students, fellows,
1637 faculty, and staff. *(Core)*
1638

1639 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1640 have a process for education of fellows and faculty regarding
1641 unprofessional behavior and a confidential process for reporting,
1642 investigating, and addressing such concerns. *(Core)*
1643

1644 VI.C. Well-Being

1645 *Psychological, emotional, and physical well-being are critical in the*
1646 *development of the competent, caring, and resilient physician and require*
1647 *proactive attention to life inside and outside of medicine. Well-being*
1648 *requires that physicians retain the joy in medicine while managing their*
1649 *own real-life stresses. Self-care and responsibility to support other*
1650 *members of the health care team are important components of*
1651 *professionalism; they are also skills that must be modeled, learned, and*
1652 *nurtured in the context of other aspects of fellowship training.*

1653 *Fellows and faculty members are at risk for burnout and depression.*
1654 *Programs, in partnership with their Sponsoring Institutions, have the same*
1655 *responsibility to address well-being as other aspects of resident*
1656 *competence. Physicians and all members of the health care team share*
1657 *responsibility for the well-being of each other. For example, a culture which*
1658 *encourages covering for colleagues after an illness without the expectation*
1659 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1660 *clinical learning environment models constructive behaviors, and prepares*
1661 *fellows with the skills and attitudes needed to thrive throughout their*
1662 *careers.*
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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.

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VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; ^(Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; ^(Core)

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.

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VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; and, ^(Core)

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.

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VI.C.1.d).(1) Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. ^(Core)

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.

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VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorder. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions. Fellows and

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faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

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>).

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

Background and Intent: Individuals experiencing burnout, depression, a 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.

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VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

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.

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

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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- VI.D. Fatigue Mitigation**
- VI.D.1. Programs must:**
- VI.D.1.a)** educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)
- VI.D.1.b)** educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)
- VI.D.1.c)** encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

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.

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- 1753 **VI.D.2.** Each program must ensure continuity of patient care, consistent
 1754 with the program’s policies and procedures referenced in VI.C.2–
 1755 VI.C.2.b), in the event that a fellow may be unable to perform their
 1756 patient care responsibilities due to excessive fatigue. ^(Core)
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- 1758 **VI.D.3.** The program, in partnership with its Sponsoring Institution, must
 1759 ensure adequate sleep facilities and safe transportation options for
 1760 fellows who may be too fatigued to safely return home. ^(Core)
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- 1762 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
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- 1764 **VI.E.1. Clinical Responsibilities**
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- 1766 The clinical responsibilities for each fellow must be based on PGY
 1767 level, patient safety, fellow ability, severity and complexity of patient
 1768 illness/condition, and available support services. ^(Core)
 1769

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 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.

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- 1771 **VI.E.2. Teamwork**
- 1772
- 1773 **Fellows must care for patients in an environment that maximizes**
 1774 **communication. This must include the opportunity to work as a**
 1775 **member of effective interprofessional teams that are appropriate to**
 1776 **the delivery of care in the subspecialty and larger health system.**
 1777 ^(Core)
 1778
- 1779 **VI.E.2.a)** Contributors to effective interprofessional teams may include
 1780 consulting physicians, psychologists, psychiatric nurses, social
 1781 workers and other professional and paraprofessional mental
 1782 health personnel involved in the evaluation and treatment of
 1783 patients. ^(Detail)
 1784
- 1785 **VI.E.3. Transitions of Care**
- 1786
- 1787 **VI.E.3.a)** **Programs must design clinical assignments to optimize**
 1788 **transitions in patient care, including their safety, frequency,**
 1789 **and structure.** ^(Core)
 1790
- 1791 **VI.E.3.b)** **Programs, in partnership with their Sponsoring Institutions,**
 1792 **must ensure and monitor effective, structured hand-over**
 1793 **processes to facilitate both continuity of care and patient**
 1794 **safety.** ^(Core)
 1795

- 1796 VI.E.3.c) Programs must ensure that fellows are competent in
 1797 communicating with team members in the hand-over process.
 1798 (Outcome)
 1799
- 1800 VI.E.3.d) Programs and clinical sites must maintain and communicate
 1801 schedules of attending physicians and fellows currently
 1802 responsible for care. (Core)
 1803
- 1804 VI.E.3.e) Each program must ensure continuity of patient care,
 1805 consistent with the program’s policies and procedures
 1806 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
 1807 be unable to perform their patient care responsibilities due to
 1808 excessive fatigue or illness, or family emergency. (Core)
 1809
- 1810 VI.F. Clinical Experience and Education
 1811
- 1812 *Programs, in partnership with their Sponsoring Institutions, must design*
 1813 *an effective program structure that is configured to provide fellows with*
 1814 *educational and clinical experience opportunities, as well as reasonable*
 1815 *opportunities for rest and personal activities.*
 1816

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.

- 1817
- 1818 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
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- 1820 Clinical and educational work hours must be limited to no more than
 1821 80 hours per week, averaged over a four-week period, inclusive of all
 1822 in-house clinical and educational activities, clinical work done from
 1823 home, and all moonlighting. (Core)
 1824

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.

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.

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VI.F.2. Mandatory Time Free of Clinical Work and Education

1828 VI.F.2.a) The program must design an effective program structure that
1829 is configured to provide fellows with educational
1830 opportunities, as well as reasonable opportunities for rest
1831 and personal well-being. ^(Core)

1832
1833 VI.F.2.b) Fellows should have eight hours off between scheduled
1834 clinical work and education periods. ^(Detail)

1835
1836 VI.F.2.b).(1) There may be circumstances when fellows choose to
1837 stay to care for their patients or return to the hospital
1838 with fewer than eight hours free of clinical experience
1839 and education. This must occur within the context of
1840 the 80-hour and the one-day-off-in-seven
1841 requirements. ^(Detail)

1842
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.

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1844 VI.F.2.c) Fellows must have at least 14 hours free of clinical work and
1845 education after 24 hours of in-house call. ^(Core)

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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.

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1848 VI.F.2.d) Fellows must be scheduled for a minimum of one day in
1849 seven free of clinical work and required education (when
1850 averaged over four weeks). At-home call cannot be assigned
1851 on these free days. ^(Core)

1852
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.”

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VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. ^(Core)

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

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.

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VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, ^(Detail)

VI.F.4.a).(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

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.

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VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

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

VI.F.5. Moonlighting

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)

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)

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>).

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VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. ^(Core)

VI.F.6.a) Sleep medicine fellowships must not average in-house call over a four-week period. ^(Core)

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.

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VI.F.7. Maximum In-House On-Call Frequency

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

VI.F.8. At-Home Call

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)

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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)

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)

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

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

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

Osteopathic Recognition

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