The Addiction Medicine Foundation Program Requirements for Graduate Medical Education in Addiction Medicine

The Addiction Medicine Foundation approved: March 2011
Revised: September 2011
Revised September 2015
Revised (with the Addiction Medicine Fellowship Directors Association): August 2016
The Addiction Medicine Foundation approved: December 2016

Requirements for One-Year Addiction Medicine Fellowships

Introduction

Introduction A

Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's and fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Introduction B

Addiction Medicine Fellowships are multispecialty training programs that focus on the provision of care for persons with unhealthy substance use, substance use disorders and other addictive disorders. Addiction medicine physicians work in diverse settings, including clinical medicine, public health, education, and research. Addiction medicine physicians treat patients across the lifespan who have different degrees of disease severity; from at risk to those with advanced and complicated disease to those in recovery. An addiction medicine fellowship provides fellows with experience in the prevention, clinical evaluation, treatment and long term monitoring of substance related disorders. The training emphasizes the management of medical, psychiatric, and social sequelae in the comprehensive care of these patients and is informed by a wide range of evidence-based interventions.

Introduction C

Duration of Education

The educational program in addiction medicine must be 12 months in length and must be completed in no more than a two-year period.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.*

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

1.A.1 The addiction medicine fellowship training program must be sponsored by an educational institution approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association to offer residency education.

1.A.2 The sponsoring institution must sponsor at least one of the following ACGME-accredited programs: emergency medicine, family medicine, internal medicine, obstetrics-gynecology, pediatrics, preventive medicine or psychiatry

1.A.3 More than one ACGME programs at the same institution may co-sponsor an addiction medicine fellowship.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document:

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.

I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director.**

II.A.1.a) **The program director must submit this change to the ACGME via the ADS.**

II.A.2. **Qualifications of the program director must include:**

II.A.2.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**

II.A.2.b) **current primary certification by any member board of the American Board of Medical Specialties, and current or pending subspecialty certification in addiction medicine or addiction psychiatry, or other subspecialties that incorporate training in addiction medicine acceptable to the Review Committee**

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

II.A.3. **The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas.**

The program director must:

II.A.3.a) **prepare and submit all information required and requested by the ACGME;**

II.A.3.b) **be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**

II.A.3.c) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:**

II.A.3.c).(1) **all applications for ACGME accreditation of new programs;**

II.A.3.c).(2) **changes in fellow complement;**

II.A.3.c).(3) **major changes in program structure or length of training;**

II.A.3.c).(4) **progress reports requested by the Review Committee;**

II.A.3.c).(5) **requests for increases or any change to fellow duty hours;**

II.A.3.c).(6) **voluntary withdrawals of ACGME-accredited programs;**

II.A.3.c).(7) **requests for appeal of an adverse action; and,**

II.A.3.c).(8) **appeal presentations to a Board of Appeal or the ACGME.**

II.A.3.d) **obtain Designated Institutional Official (DIO) review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:**

II.A.3.d).(1) **program citations, and/or,**

II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

II.A.3.e The program director should have a minimum of 0.1 FTE protected time to carry out the educational, administrative, and leadership responsibilities of the fellowship."

II.A.4. The program director must have sufficient time commitment to patient care to maintain clinical skills

II.A.5. The program director must develop and implement a supervision policy that specifies lines of responsibility for program faculty members and fellows.

II.B. Faculty

II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**

II.B.1.a In addition to the program director, there must be at least one other physician faculty with current or pending certification in the subspecialty of addiction medicine or in the subspecialty of addiction psychiatry, or in other subspecialties that incorporate training in addiction medicine acceptable to the Review Committee.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification as delineated in II.A.2.b or possess qualifications judged acceptable to the Review Committee.

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

II.B.5a. Faculty members must participate in scholarly activities appropriate to the subspecialty, including local, regional, and national specialty societies, research, presentations, or publications.

II.B.5b Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. There must be teaching staff available to the program from clinical disciplines such that educational goals of the program can be met.

II.C.2. There must be clinicians available to the program such that fellows receive training in the treatment of substance use disorders and related consequences across the lifespan.

II.C.3. There must be clinicians available to the program with expertise in the proper evaluation and management of pain conditions. such that fellows receive exposure to and gain understanding of the multiple modalities by which pain can be treated. Fellows should receive exposure to and gain understanding of the comprehensive, integrative and interdisciplinary approach to pain management.

II.C.4. Addiction medicine engages physicians from multiple medical specialties, thus fellows should train in settings where there is meaningful clinical interaction, collaboration and consultation with residents, fellows, faculty, and staff.

II.C.5 The program coordinator must have sufficient support and time to effectively carry out their responsibilities.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or CFPC-accredited residency program located in Canada.

III.A.1. Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.

III.A.2. Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

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

III.A.2.a) Assessment 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

III.A.2.b) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and

III.A.2.c) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;**

III.A.2.d) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,**

III.A.2.e) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.**

III.A.2.e).(1) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.**

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program, 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; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:

III.A.3. The Review Committee for addiction medicine does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. (Core)

III.B. Number of Fellows

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

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

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form.**

IV.A.2. **ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum:

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

IV.A.2.a).(1) **Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must demonstrate:(Outcome)**

Competence in comprehensive assessment, diagnosis and treatment of patients with substance-related health problems, substance use disorders and other addictive disorders, along a continuum of care including inpatient/residential, outpatient treatments, early intervention, harm reduction and prevention.(Outcome).

Competence in providing care to patients in different settings such as inpatient medically managed withdrawal programs, substance use disorder treatment programs, consultation services and integrated clinics. (Outcome).

Competence providing care to substance use disorder patients with diversity in age, gender, socio-economic status, limited English proficiency or literacy, and co-morbid medical and psychiatric conditions.(Outcome).

Proficiency in screening, brief Intervention, and motivational interviewing.

The ability to work with a interdisciplinary team that could include other medical specialists, health care providers, counselors, psychologists, family members and other stakeholders involved in the patient's care.

The ability to provide continuity of care to patients.

IV.A.2.a).(2) **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** (Outcome)

IV.A.2.b) **Medical Knowledge**

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

Must demonstrate a level of expertise in the knowledge of those areas appropriate for a subspecialist in addiction medicine, including basic science, prevention, screening, brief intervention and referral, assessment and diagnosis, treatment planning and management.

IV.A.2.b).(1).(a) the medical model of addiction, including a basic knowledge of neurobiology and changes in brain structures associated with addiction.

IV.A.2.b).(1).(b) pharmacology of common psychoactive substances, including alcohol, nicotine, stimulants, sedative-hypnotics, depressants, opioids, inhalants, hallucinogens, and cannabinoids

IV.A.2.b).(1).(c) epidemiology of substance use and use disorders and the genetic and environmental influences on the development and maintenance of these disorders

IV.A.2.b).(1).(d) the impact of substance use in diverse populations and cultures, including women, neonates, children, adolescents, families, the elderly, injury and trauma, military, health care professionals, employees, and/or persons involved in the criminal justice system

IV.A.2.b).(1).(e) common behavioral addictions

IV.A.2.b).(1).(f) prevention, including identification of risk and protective factors,

IV.A.2.b).(1).(g) screening, brief intervention strategies appropriate to substance use risk level, and referral to treatment;

IV.A.2.b).(1).(h) comprehensive substance use assessment including diagnostic interview, use of standardized questionnaires,

lab tests, imaging studies, physical examinations, mental status examinations, consultative reports and collateral information

IV.A.2.b).(1).(i) identification and treatment of common co-occurring conditions such medical psychiatric and pain.

IV.A.2.b).(1).(j) matching patient treatment needs with levels of intervention including crisis services, hospitalization, SUD treatment programs

IV.A.2.b).(1).(k) medication assisted therapies and psychosocial interventions for SUD's across the age spectrum

IV.A.2.b).(1).(l) intoxication and withdrawal management: the mechanisms of alcohol, sedatives, opioid and other drugs and the pharmacotherapies and other modalities used to treat these.

IV.A.2.b).(1).(m) the safe prescribing and monitoring of controlled medications to patients with or without substance use disorders, including experience accessing and interpreting prescription drug monitoring systems.

IV.A.2.b).(1).(n) the effects of substance use, intoxication, and withdrawal on pregnancy and the fetus, and the pharmacologic agents prescribed for the treatment of intoxication , withdrawal and management, including specifically opioid and sedative hypnotic withdrawal

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and, (Outcome)

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

IV.A.2.d) Interpersonal and Communication Skills (ICS)

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Fellows must:

Work collaboratively with other providers and allied health professionals, including physicians, nurses, social workers, counselors, and pharmacists to care for patients with substance-related disorders.

Work collaboratively as members of inter-disciplinary teams as a consultant and as a team leader.

Demonstrate competence in interviewing socioculturally-diverse patients and families in an effective manner which may include those with limited English proficiency, literacy, hearing, sight.

IV.A.2.e) Professionalism

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

Fellows are expected to demonstrate:

Competence in recognizing and appropriately addressing biases in themselves, others, and the health care delivery system

Maintenance of appropriate professional boundaries.

Sensitivity and responsiveness to diverse patients, including sex, age, culture, race, religion, disabilities, and sexual orientation.

Compassion, integrity, and respect for others.

Demonstrate the qualities required to sustain lifelong personal and professional growth:

Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors.

Demonstrate healthy coping mechanisms to respond to stress.

Manage conflict between personal and professional responsibilities.

Practice flexibility and maturity in adjusting to change with the capacity to alter one's behavior.

Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients.

Provide leadership skills that enhance team functioning, the learning environment, and/or the health care delivery system.

Demonstrate self-confidence that puts patients, families, and members of the health care team at ease.

Recognize that ambiguity is part of clinical health care and respond by utilizing appropriate resources in dealing with uncertainty.

IV.A.2.f) **Systems-based Practice**

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.[(Outcome)]

Advocate for quality patient care and assist patients, employers, programs, agencies and governments in managing system complexities, including an awareness of heightened stigma associated with addiction and other systemic barriers to obtaining addiction services.

Explain how medical practices and delivery systems differ from one another, including methods of controlling health care costs and allocating resources and practice and promote cost-effective health care.

IV.A.3. Curriculum Organization and Fellow Experiences
The structured clinical portion of addiction medicine fellowship training must be composed of a variety of learning experiences including: structured clinical rotations, longitudinal outpatient continuity clinical experiences, longitudinal didactic sessions and scholarly activities.

IV.A.3 (1) An average of 4 hours per week must be devoted to longitudinal learning experiences such as didactic sessions; individual or small group tutoring sessions with program faculty, and/or mentored self-directed learning. These experiences must address the core competences of Addiction Medicine. Sessions should reflect the needs of the program and the fellows. At least one faculty should attend each session given by fellows.

IV.A.3 (2) There must be a minimum of 3 months cumulative of out-patient experience, for example: intensive outpatient treatment or “day treatment” programs, addiction medicine consult services in an ambulatory care setting, opioid replacement or maintenance programs (using buprenorphine or methadone), or other medical services where the fellow is directly involved with patient assessment, counseling, treatment planning, and coordination with outpatient services;

IV.A.3 (3) There must be a minimum of 3 months cumulative experience in in-patient rotations, for example: inpatient addiction treatment programs, hospital-based rehabilitation programs, or medically managed residential programs where the fellow is directly involved with patient assessment and treatment planning, which can include the management of withdrawal (i.e., “detoxification”); in an inpatient general medical facility; teaching hospitals (that include acute care beds, critical care units, emergency

departments, neonatal nurseries and NAS units, etc.) where the fellow provides consultation services to other physicians for patients admitted with a primary medical, surgical, obstetrical, or psychiatric diagnosis.

At least one half-day per week for 12 months must be devoted to providing continuity care to a panel of patients who have an addiction disorder. The fellow may serve as either a specialty consultative physician with care focused on the addiction disorder or may serve as a physician who provides comprehensive care for the patient panel, including diagnosis and treatment of substance-related problems and other addictions.

IV.A.3 (4) Time not spent in the above inpatient or outpatient experiences should be spent on program-directed activities or fellow electives.

IV.B. Fellows' Scholarly Activities

IV.B.2.a) The program must provide a supervised, ongoing forum in which fellows explore and analyze emerging scientific evidence pertinent to the practice of medicine.

IV.B.2.b) Fellows must be provided didactic and experiential learning in the scholarship of teaching and leadership and have the opportunity to teach addiction medicine to health care students, trainees and/or professionals.

IV.B.2.c) Additionally, all fellows must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

IV.B.2.d) Fellows must be provided with didactic and experiential learning in leadership.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee.

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

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

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

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

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

V.A.1.b).(1) **The Clinical Competency Committee should:**

V.A.1.b).(1).(a) **review all fellow evaluations semi-annually;**

V.A.1.b).(1).(b) **prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and,**

V.A.1.b).(1).(c) **advise the program director regarding fellow progress, including promotion, remediation, and dismissal.**

V.A.2. Formative Evaluation

V.A.2.a) **The faculty must evaluate fellow performance in a timely manner.**

Faculty must discuss evaluations with each fellow at least every 3 months and include evaluation of longitudinal experiences. This evaluation must include review and discussion of milestones, all required components, those completed, and evaluations of clinical and didactic work by supervisors and teachers.

V.A.2.b) **The program must:**

V.A.2.b).(1) **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;**

V.A.2.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**

V.A.2.b).(3) **provide each fellow with documented semiannual evaluation of performance with feedback.**

V.A.2.c) **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**

V.A.3. Summative Evaluation

V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.**

V.A.3.b) **The program director must provide a summative evaluation for each fellow upon completion of the program.**

This evaluation must:

V.A.3.b).(1) **become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;**

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

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

V.B. Faculty Evaluation

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

Fellows shall have the opportunity to provide confidential written feedback of each supervising faculty at the end of each rotation. The program director must review these evaluations with each faculty member annually. *[As further specified by the Review Committee]*

V.C. Program Evaluation and Improvement

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

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

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

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

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

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

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

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

V.C.1.a).(3).(d) **reviewing the program annually using evaluations of faculty, fellows, and others, as specified below.**

V.C.1.d.(2). After each rotation, the fellow will complete an anonymous evaluation of the rotation.

V.C.2. **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.**

The program must monitor and track each of the following areas:

V.C.2.a) **fellow performance;**

V.C.2.b) **faculty development; and,**

V.C.2.c) **progress on the previous year's action plan(s).**

program effectiveness in achieving its goals and objectives.

V.C.3. **The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored.**

V.C.3.a) **The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. **Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

VI.A.2. **The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**

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

VI.A.4. **The learning objectives of the program must:**

VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**

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

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

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

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

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

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

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

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

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

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

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

VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B. Transitions of Care

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

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

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

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;

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

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. **Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.**

VI.C.3. **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.**

VI.D. Supervision of Fellows

VI.D.1. **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

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

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

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

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member.

For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. **Levels of Supervision**

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

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

VI.D.3.b) **Indirect Supervision:**

VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of**

telephonic and/or electronic modalities, and is available to provide Direct Supervision.

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

VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**

VI.D.4.a) **The program director must evaluate each fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**

VI.D.4.c) **Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**

VI.D.5. **Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**

VI.D.5.a) **Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.** **(Outcome)**

VI.D.6. **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.**

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

Interprofessional teams include consulting physicians, psychologists, nurses, social workers, case managers and other professional/paraprofessional staff involved in evaluating and treating patients.

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

VI.G.4.a) Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.c) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.d) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or

unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.d).(1) **Under those circumstances, the fellow must:**

VI.G.4.d).(1).(a) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**

VI.G.4.d).(1).(b) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**

VI.G.4.d).(2) **The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.**

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) **Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.** **(Outcome)**

VI.G.5.a).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

VI.G.5.a).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.**

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

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

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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

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

VI.G.8. At-Home Call

VI.G.8.a) **Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but**

must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.**

VI.G.8.b) **Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".**

***

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

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

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