ACGME Program Requirements for
Graduate Medical Education
in Clinical Informatics
(Subspecialty of Anesthesiology,
Emergency Medicine, Medical Genetics, Pathology,
Pediatrics, or Preventive Medicine)

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in Clinical Informatics

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

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 fellow physician to assume personal responsibility for the care of individual patients. For the 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 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 responsibility 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 development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Clinical informatics is the subspecialty of all medical specialties that transforms health care by analyzing, designing, implementing, and evaluating information and communication systems to improve patient care, enhance access to care, advance individual and population health outcomes, and strengthen the clinician-patient relationship.

Physicians who practice clinical informatics draw from the broader field of biomedical and health informatics as they apply informatics methods, concepts, and tools to the practice of medicine. Thus, they must understand the culture, boundaries, and complexities of the field. Further, the stakeholders, structures, and processes that constitute the health system affect the information and knowledge needs of health care professionals and influence the selection and implementation of clinical information processes and systems.

Physicians who practice clinical informatics collaborate with other health care and information technology professionals and provide consultative services that use their knowledge of patient care combined with their understanding of informatics concepts, methods, and tools to improve clinical practice by:

Int.B.1. leading initiatives designed to enhance health care quality and access through the procurement, customization, development, implementation, management, evaluation, and continuous improvement of clinical information systems;

52		
53	Int.B.2.	securing the legal and ethical use of clinical information;
54		
55	Int.B.3.	assessing information and knowledge needs of health care professionals
56		and patients;
57		
58	Int.B.4.	characterizing, evaluating, and refining clinical processes;
59		
60	Int.B.5.	analyzing, developing, implementing, and refining clinical decision
61		support systems; and,
62		
63	Int.B.6.	participating in projects designed to use technology to promote patient
64		care that is safe, efficient, effective, timely patient-centered and equitable.
65		
66	Int.C.	The educational program in clinical informatics must be 24 months in length. (Core)
67		
68	Int.C.1.	Fellows must complete the program within 48 months of matriculation.
69		(Core)
70		

I.   Institutions

I.A.   Sponsoring Institution

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

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

I.A.1.   A clinical informatics fellowship must function as an integral part of an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in anesthesiology, emergency medicine, medical genetics, pathology, pediatrics, or preventive medicine. (Core)

I.A.2.   There must be an institutional policy governing the educational resources committed to the fellowship that ensures collaboration among multiple disciplines and professions involved in educating fellows. (Core)

I.A.3.   There may be only one ACGME-accredited clinical informatics program within a sponsoring institution. (Detail)

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. (Detail)

The PLA should:

103		
104	**I.B.1.a)**	**identify the faculty who will assume both educational and**
105		**supervisory responsibilities for fellows;** (Detail)
106		
107	**I.B.1.b)**	**specify their responsibilities for teaching, supervision, and**
108		**formal evaluation of fellows, as specified later in this**
109		**document;** (Detail)
110		
111	**I.B.1.c)**	**specify the duration and content of the educational**
112		**experience; and,** (Detail)
113		
114	**I.B.1.d)**	**state the policies and procedures that will govern fellow**
115		**education during the assignment.** (Detail)
116		
117	**I.B.2.**	**The program director must submit any additions or deletions of**
118		**participating sites routinely providing an educational experience,**
119		**required for all fellows, of one month full time equivalent (FTE) or**
120		**more through the Accreditation Council for Graduate Medical**
121		**Education (ACGME) Accreditation Data System (ADS).** (Core)
122		
123	**II.**	**Program Personnel and Resources**
124		
125	**II.A.**	**Program Director**
126		
127	**II.A.1.**	**There must be a single program director with authority and**
128		**accountability for the operation of the program. The sponsoring**
129		**institution's GMEC must approve a change in program director.** (Core)
130		
131	**II.A.1.a)**	**The program director must submit this change to the ACGME**
132		**via the ADS.** (Core)
133		
134	**II.A.2.**	**The program director should continue in his or her position for a**
135		**length of time adequate to maintain continuity of leadership and**
136		**program stability.** (Detail)
137		
138	**II.A.3.**	**Qualifications of the program director must include:**
139		
140	**II.A.3.a)**	**requisite specialty expertise and documented educational**
141		**and administrative experience acceptable to the Review**
142		**Committee;** (Core)
143		
144	**II.A.3.b)**	**current certification in the subspecialty** of clinical informatics
145		by a member board of **the American Board** of Medical
146		Specialties**, or subspecialty qualifications that are acceptable**
147		**to the Review Committee;** (Core)
148		
149	**II.A.3.c)**	**current medical licensure and appropriate medical staff**
150		**appointment; and,** (Core)
151		
152	II.A.3.d)	at least five years of experience in clinical informatics. (Detail)
153		

| 154 | **II.A.4.** | **The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas.** (Core) |

155		
156		
157		
158		**The program director must:**
159		
160	**II.A.4.a)**	**oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;** (Core)
161		
162		
163	**II.A.4.b)**	**approve a local director at each participating site who is accountable for fellow education;** (Core)
164		
165		
166	**II.A.4.c)**	**approve the selection of program faculty as appropriate;** (Core)
167		
168	**II.A.4.d)**	**evaluate program faculty;** (Core)
169		
170	**II.A.4.e)**	**approve the continued participation of program faculty based on evaluation;** (Core)
171		
172		
173	**II.A.4.f)**	**monitor fellow supervision at all participating sites;** (Core)
174		
175	**II.A.4.g)**	**prepare and submit all information required and requested by the ACGME;** (Core)
176		
177		
178	**II.A.4.g).(1)**	**This includes but is not limited to the program information forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete.** (Core)
179		
180		
181		
182		
183	**II.A.4.h)**	**ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;** (Detail)
184		
185		
186		
187	**II.A.4.i)**	**provide verification of fellowship education for all fellows, including those who leave the program prior to completion;** (Detail)
188		
189		
190		
191	**II.A.4.j)**	**implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting,** (Core)
192		
193		
194		
195	**II.A.4.j).(1)**	**and, to that end, must:**
196		
197	**II.A.4.j).(2)**	**distribute these policies and procedures to the fellows and faculty;** (Detail)
198		
199		
200	**II.A.4.j).(3)**	**monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** (Core)
201		
202		
203		
204	**II.A.4.j).(4)**	**adjust schedules as necessary to mitigate excessive**

205		service demands and/or fatigue; and, (Detail)
206		
207	II.A.4.j).(5)	if applicable, monitor the demands of at-home call and
208		adjust schedules as necessary to mitigate excessive
209		service demands and/or fatigue. (Detail)
210		
211	II.A.4.k)	monitor the need for and ensure the provision of back up
212		support systems when patient care responsibilities are
213		unusually difficult or prolonged; (Detail)
214		
215	II.A.4.l)	comply with the sponsoring institution's written policies and
216		procedures, including those specified in the Institutional
217		Requirements, for selection, evaluation and promotion of
218		fellows, disciplinary action, and supervision of fellows; (Detail)
219		
220	II.A.4.m)	be familiar with and comply with ACGME and Review
221		Committee policies and procedures as outlined in the ACGME
222		Manual of Policies and Procedures; (Detail)
223		
224	II.A.4.n)	obtain review and approval of the sponsoring institution's
225		GMEC/DIO before submitting information or requests to the
226		ACGME, including: (Core)
227		
228	II.A.4.n).(1)	all applications for ACGME accreditation of new
229		programs; (Detail)
230		
231	II.A.4.n).(2)	changes in fellow complement; (Detail)
232		
233	II.A.4.n).(3)	major changes in program structure or length of
234		training; (Detail)
235		
236	II.A.4.n).(4)	progress reports requested by the Review Committee;
237		(Detail)
238		
239	II.A.4.n).(5)	responses to all proposed adverse actions; (Detail)
240		
241	II.A.4.n).(6)	requests for increases or any change to fellow duty
242		hours; (Detail)
243		
244	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited
245		programs; (Detail)
246		
247	II.A.4.n).(8)	requests for appeal of an adverse action; (Detail)
248		
249	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the
250		ACGME; and,(Detail)
251		
252	II.A.4.n).(10)	proposals to ACGME for approval of innovative
253		educational approaches. (Detail)
254		
255	II.A.4.o)	obtain DIO review and co-signature on all program

256		information forms, as well as any correspondence or
257		document submitted to the ACGME that addresses: (Detail)
258		
259	**II.A.4.o).(1)**	program citations, and/or, (Detail)
260		
261	**II.A.4.o).(2)**	request for changes in the program that would have
262		significant impact, including financial, on the program
263		or institution. (Detail)
264		
265	**II.B.**	**Faculty**
266		
267	**II.B.1.**	At each participating site, there must be a sufficient number of
268		faculty with documented qualifications to instruct and supervise all
269		fellows at that location. (Core)
270		
271	II.B.1.a)	In addition to the program director, there must be at least two
272		faculty members. (Core)
273		
274	II.B.1.a).(1)	The faculty members and program director should equal at
275		least two FTE. (Detail)
276		
277		The faculty must:
278		
279	**II.B.1.b)**	devote sufficient time to the educational program to fulfill
280		their supervisory and teaching responsibilities; and to
281		demonstrate a strong interest in the education of fellows, and
282		(Core)
283		
284	**II.B.1.c)**	administer and maintain an educational environment
285		conducive to educating fellows in each of the ACGME
286		competency areas. (Core)
287		
288	**II.B.2.**	The physician faculty must have current certification in the
289		**subspecialty** of clinical informatics by a member board of **the American**
290		**Board of** Medical Specialties (ABMS), **or possess qualifications**
291		**judged acceptable to the Review Committee.** (Core)
292		
293	II.B.2.a).(1)	At least one of the physician faculty members must be
294		certified in clinical informatics by a member board of the
295		ABMS. (Core)
296		
297	**II.B.3.**	The physician faculty must possess current medical licensure and
298		appropriate medical staff appointment. (Core)
299		
300	**II.B.4.**	The nonphysician faculty must have appropriate qualifications in
301		their field and hold appropriate institutional appointments. (Core)
302		
303	**II.B.5.**	The faculty must establish and maintain an environment of inquiry
304		and scholarship with an active research component. (Core)
305		
306	**II.B.5.a)**	The faculty must regularly participate in organized clinical

307		discussions, rounds, journal clubs, and conferences. (Detail)
308		
309	**II.B.5.b)**	**Some members of the faculty should also demonstrate**
310		**scholarship by one or more of the following:**
311		
312	**II.B.5.b).(1)**	**peer-reviewed funding;** (Detail)
313		
314	**II.B.5.b).(2)**	**publication of original research or review articles in**
315		**peer-reviewed journals, or chapters in textbooks;** (Detail)
316		
317	**II.B.5.b).(3)**	**publication or presentation of case reports or clinical**
318		**series at local, regional, or national professional and**
319		**scientific society meetings; or,** (Detail)
320		
321	**II.B.5.b).(4)**	**participation in national committees or educational**
322		**organizations.** (Detail)
323		
324	**II.B.5.c)**	**Faculty should encourage and support fellows in scholarly**
325		**activities.** (Core)
326		
327	**II.C.**	**Other Program Personnel**
328		
329		**The institution and the program must jointly ensure the availability of all**
330		**necessary professional, technical, and clerical personnel for the effective**
331		**administration of the program.** (Core)
332		
333	II.C.1.	Administrative support must include a program coordinator to provide
334		adequate administrative and technological support to the fellowship. (Detail)
335		
336	**II.D.**	**Resources**
337		
338		**The institution and the program must jointly ensure the availability of**
339		**adequate resources for fellow education, as defined in the specialty**
340		**program requirements.** (Core)
341		
342	II.D.1.	There must be space and equipment for the educational program,
343		including meeting rooms, classrooms, computers, Internet access, visual
344		and other educational aids, and work/study space. (Detail)
345		
346	II.D.2.	The primary clinical site must operate a clinical information system that is
347		able to: (Core)
348		
349	II.D.2.a)	collect, store, retrieve, and manage health and wellness data and
350		information; (Core)
351		
352	II.D.2.b)	provide clinical decision support; and,(Core)
353		
354	II.D.2.c)	support ambulatory, inpatient, and remote care settings, as
355		needed. (Core)
356		
357	**II.E.**	**Medical Information Access**

358		
359		**Fellows must have ready access to specialty-specific and other appropriate**
360		**reference material in print or electronic format. Electronic medical literature**
361		**databases with search capabilities should be available.** (Detail)
362		

363 **III.**   **Fellow Appointments**

365 **III.A.**   **Eligibility Criteria**

367   **The program director must comply with the criteria for fellow eligibility as**
368   **specified in the Institutional Requirements.** (Core)

370 III.A.1.   Prior to appointment in the program, each fellow must have successfully
371   completed an ACGME-accredited residency program. **(Core)**

373 **III.B.**   **Number of Fellows**

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

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

382 **III.C.**   **Fellow Transfers**

384 **III.C.1.**   **Before accepting a fellow who is transferring from another program,**
385   **the program director must obtain written or electronic verification of**
386   **previous educational experiences and a summative competency-**
387   **based performance evaluation of the transferring fellow.** (Detail)

389 **III.C.2.**   **A program director must provide timely verification of fellowship**
390   **education and summative performance evaluations for fellows who**
391   **may leave the program prior to completion.** (Detail)

393 **III.D.**   **Appointment of Fellows and Other Learners**

395   **The presence of other learners (including, but not limited to, residents from**
396   **other specialties, subspecialty fellows, PhD students, and nurse**
397   **practitioners) in the program must not interfere with the appointed fellows'**
398   **education.** (Core)

400 **III.D.1.**   **The program director must report the presence of other learners to**
401   **the DIO and GMEC in accordance with sponsoring institution**
402   **guidelines.** (Detail)

404 **IV.**   **Educational Program**

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

408 **IV.A.1.**   **Overall educational goals for the program, which the program must**

409		make available to fellows and faculty; (Core)
410		
411	**IV.A.2.**	**Competency-based goals and objectives for each assignment at**
412		**each educational level, which the program must distribute to fellows**
413		**and faculty at least annually, in either written or electronic form;** (Core)
414		
415	**IV.A.3.**	**Regularly scheduled didactic sessions;** (Core)
416		
417	**IV.A.4.**	**Delineation of fellow responsibilities for patient care, progressive**
418		**responsibility for patient management, and supervision of fellows**
419		**over the continuum of the program; and,** (Core)
420		
421	**IV.A.5.**	**ACGME Competencies**
422		
423		**The program must integrate the following ACGME competencies**
424		**into the curriculum:** (Core)
425		
426	**IV.A.5.a)**	**Patient Care and Procedural Skills**
427		
428	**IV.A.5.a).(1)**	**Fellows must be able to provide patient care that is**
429		**compassionate, appropriate, and effective for the**
430		**treatment of health problems and the promotion of**
431		**health. Fellows must:** (Outcome)
432		
433	IV.A.5.a).(1).(a)	demonstrate competence in the leverage of
434		information and communication technology to:
435		(Outcome)
436		
437	IV.A.5.a).(1).(a).(i)	use informatics across the dimensions of
438		health care: health promotion, disease
439		prevention, diagnosis, and treatment of
440		individuals and their families across the
441		lifespan; (Outcome)
442		
443	IV.A.5.a).(1).(a).(ii)	use informatics tools to improve
444		assessment, interdisciplinary care planning,
445		management, coordination, and follow-up of
446		patients; (Outcome)
447		
448	IV.A.5.a).(1).(a).(iii)	use informatics tools, such as electronic
449		health records or personal health records, to
450		facilitate the coordination and
451		documentation of key events in patient care,
452		such as family communication, consultation
453		around goals of care, immunizations,
454		advance directive completion, and
455		involvement of multiple team members as
456		appropriate; and, (Outcome)
457		
458	IV.A.5.a).(1).(a).(iv)	use informatics tools to promote
459		confidentiality and security of patient data.

460		(Outcome)
461		
462	IV.A.5.a).(1).(b)	demonstrate skill in fundamental programming,
463		data base design, and user interface design;
464		(Outcome)
465		
466	IV.A.5.a).(1).(c)	demonstrate competence in the identification of
467		changes needed in organizational processes and
468		clinician practices to optimize health system
469		operational effectiveness; (Outcome)
470		
471	IV.A.5.a).(1).(d)	demonstrate competence in the analysis of patient
472		care workflow and processes to identify information
473		system features that will support improved quality,
474		efficiency, effectiveness, and safety of clinical
475		services; (Outcome)
476		
477	IV.A.5.a).(1).(e)	demonstrate competence in the assessment of
478		user needs for a clinical information or
479		telecommunication system or application; (Outcome)
480		
481	IV.A.5.a).(1).(f)	combine an understanding of informatics concepts,
482		methods, and tools to develop, implement, and
483		refine clinical decision support systems; and,
484		(Outcome)
485		
486	IV.A.5.a).(1).(g)	evaluate the impact of information system
487		implementation and use on patient care and users.
488		(Outcome)
489		

IV.A.5.a).(2)   **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.** (Outcome)

IV.A.5.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 knowledge of:

503	IV.A.5.b).(1)	fundamental informatics vocabulary, concepts, models,
504		and theories; (Outcome)
505		
506	IV.A.5.b).(2)	the health care environment, to include how business
507		processes and financial considerations, including
508		resourcing information technology, influence health care
509		delivery and the flow of data among the major domains of
510		the health system; (Outcome)

511		
512	IV.A.5.b).(3)	how information systems and processes enhance or
513		compromise the decision making and actions of health
514		care team members; (Outcome)
515		
516	IV.A.5.b).(4)	process improvement or change management for health
517		care processes; (Outcome)
518		
519	IV.A.5.b).(5)	fundamental information system concepts, including
520		project management, the life cycle of information systems,
521		the constantly evolving capabilities of information
522		technology and health care, and the technical and non-
523		technical issues surrounding system implementation;
524		(Outcome)
525		
526	IV.A.5.b).(6)	the impact of clinical information systems on users and
527		patients; (Outcome)
528		
529	IV.A.5.b).(7)	strategies to support clinician users and promote clinician
530		adoption of systems; (Outcome)
531		
532	IV.A.5.b).(8)	clinical decision support, use, and implementation; (Outcome)
533		
534	IV.A.5.b).(9)	evaluation of information systems to provide feedback for
535		system improvement; (Outcome)
536		
537	IV.A.5.b).(10)	leadership in organizational change, fostering
538		collaboration, communicating effectively, and managing
539		large scale projects related to clinical information systems;
540		and, (Outcome)
541		
542	IV.A.5.b).(11)	risk management and mitigation related to patient safety
543		and privacy. (Outcome)
544		
545	**IV.A.5.c)**	**Practice-based Learning and Improvement**
546		
547		**Fellows must demonstrate the ability to investigate and**
548		**evaluate their care of patients, to appraise and assimilate**
549		**scientific evidence, and to continuously improve patient care**
550		**based on constant self-evaluation and life-long learning.**
551		(Outcome)
552		
553		**Fellows are expected to develop skills and habits to be able**
554		**to meet the following goals:**
555		
556	**IV.A.5.c).(1)**	**identify strengths, deficiencies, and limits in one's**
557		**knowledge and expertise;** (Outcome)
558		
559	**IV.A.5.c).(2)**	**set learning and improvement goals;** (Outcome)
560		
561	**IV.A.5.c).(3)**	**identify and perform appropriate learning activities;**

562		(Outcome)
563		
564	**IV.A.5.c).(4)**	**systematically analyze practice using quality**
565		**improvement methods, and implement changes with**
566		**the goal of practice improvement;** (Outcome)
567		
568	**IV.A.5.c).(5)**	**incorporate formative evaluation feedback into daily**
569		**practice;** (Outcome)
570		
571	**IV.A.5.c).(6)**	**locate, appraise, and assimilate evidence from**
572		**scientific studies related to their patients' health**
573		**problems;** (Outcome)
574		
575	**IV.A.5.c).(7)**	**use information technology to optimize learning; and,**
576		(Outcome)
577		
578	**IV.A.5.c).(8)**	**participate in the education of patients, families,**
579		**students, fellows and other health professionals.**
580		(Outcome)
581		
582	**IV.A.5.d)**	**Interpersonal and Communication Skills**
583		
584		**Fellows must demonstrate interpersonal and communication**
585		**skills that result in the effective exchange of information and**
586		**collaboration with patients, their families, and health**
587		**professionals.** (Outcome)
588		
589		**Fellows are expected to:**
590		
591	**IV.A.5.d).(1)**	**communicate effectively with patients, families, and**
592		**the public, as appropriate, across a broad range of**
593		**socioeconomic and cultural backgrounds;** (Outcome)
594		
595	**IV.A.5.d).(2)**	**communicate effectively with physicians, other health**
596		**professionals and health related agencies;** (Outcome)
597		
598	IV.A.5.d).(2).(a)	Fellows must demonstrate the ability to serve as a
599		liaison between information technology
600		professionals, administrators, and clinicians. (Outcome)
601		
602	**IV.A.5.d).(3)**	**work effectively as a member or leader of a health care**
603		**team or other professional group;** (Outcome)
604		
605	**IV.A.5.d).(4)**	**act in a consultative role to other physicians and**
606		**health professionals; and,** (Outcome)
607		
608	**IV.A.5.d).(5)**	**maintain comprehensive, timely, and legible medical**
609		**records, if applicable.** (Outcome)
610		
611	**IV.A.5.e)**	**Professionalism**
612		

613		**Fellows must demonstrate a commitment to carrying out**
614		**professional responsibilities and an adherence to ethical**
615		**principles.** (Outcome)
616		
617		**Fellows are expected to demonstrate:**
618		
619	**IV.A.5.e).(1)**	**compassion, integrity, and respect for others;** (Outcome)
620		
621	**IV.A.5.e).(2)**	**responsiveness to patient needs that supersedes self-**
622		**interest;** (Outcome)
623		
624	**IV.A.5.e).(3)**	**respect for patient privacy and autonomy;** (Outcome)
625		
626	**IV.A.5.e).(4)**	**accountability to patients, society and the profession;**
627		(Outcome)
628		
629	IV.A.5.e).(4).(a)	Fellows must demonstrate the ability to recognize
630		the causes and prevention of security breaches and
631		their consequences to the individual, system,
632		organization, and society at large. (Outcome)
633		
634	**IV.A.5.e).(5)**	**sensitivity and responsiveness to a diverse patient**
635		**population, including but not limited to diversity in**
636		**gender, age, culture, race, religion, disabilities, and**
637		**sexual orientation; and,** (Outcome)
638		
639	IV.A.5.e).(6)	sensitivity to the impact information system changes have
640		on practice patterns and physician-patient relations. (Outcome)
641		
642	**IV.A.5.f)**	**Systems-based Practice**
643		
644		**Fellows must demonstrate an awareness of and**
645		**responsiveness to the larger context and system of health**
646		**care, as well as the ability to call effectively on other**
647		**resources in the system to provide optimal health care.**
648		(Outcome)
649		
650		**Fellows are expected to:**
651		
652	**IV.A.5.f).(1)**	**work effectively in various health care delivery**
653		**settings and systems relevant to their clinical**
654		**specialty;** (Outcome)
655		
656	**IV.A.5.f).(2)**	**coordinate patient care within the health care system**
657		**relevant to their clinical specialty;** (Outcome)
658		
659	**IV.A.5.f).(3)**	**incorporate considerations of cost awareness and**
660		**risk-benefit analysis in patient and/or population-**
661		**based care as appropriate;** (Outcome)
662		
663	**IV.A.5.f).(4)**	**advocate for quality patient care and optimal patient**

664		**care systems;** (Outcome)
665		
666	**IV.A.5.f).(5)**	**work in interprofessional teams to enhance patient**
667		**safety and improve patient care quality;** (Outcome)
668		
669	**IV.A.5.f).(6)**	**participate in identifying system errors and**
670		**implementing potential systems solutions;** (Outcome)
671		
672	IV.A.5.f).(6).(a)	Fellows must demonstrate the ability to recognize
673		one's own role and the role of systems in
674		prevention and disclosure of medical error. (Outcome)
675		
676	IV.A.5.f).(7)	identify, evaluate, and implement systems improvement
677		based on clinical practice or patient and family satisfaction
678		data in personal practice, in team practice, and within
679		institutional settings; (Outcome)
680		
681	IV.A.5.f).(8)	demonstrate knowledge of the various settings and related
682		structures for organizing, regulating, and financing care for
683		patients; (Outcome)
684		
685	IV.A.5.f).(9)	analyze the impact of business strategies on information
686		technology; (Outcome)
687		
688	IV.A.5.f).(10)	analyze patient care workflow and processes; (Outcome)
689		
690	IV.A.5.f).(11)	identify information system features that will support
691		improved quality, efficiency, effectiveness, and safety of
692		clinical services; (Outcome)
693		
694	IV.A.5.f).(12)	analyze systems for potential unintended consequences of
695		changes; and, (Outcome)
696		
697	IV.A.5.f).(13)	demonstrate awareness of issues related to patient
698		privacy. (Outcome)
699		
700	IV.A.6.	Curriculum Organization and Fellow Experiences
701		
702	IV.A.6.a)	Fellows must participate in planning and in conducting
703		conferences. (Detail)
704		
705	IV.A.6.b)	Fellows must have clearly defined, written descriptions of
706		responsibilities and a reporting structure for all educational
707		assignments. (Core)
708		
709	IV.A.6.c)	Educational assignments must be designed to provide fellows with
710		exposure to different types of clinical and health information
711		systems. (Core)
712		
713	IV.A.6.d)	Educational assignments should have a particular focus (or foci),
714		such as: (Detail)

715		
716	IV.A.6.d).(1)	bioinformatics/computational biology; (Detail)
717		
718	IV.A.6.d).(2)	laboratory information systems/pathology informatics; (Detail)
719		
720	IV.A.6.d).(3)	remote systems/telemedicine; (Detail)
721		
722	IV.A.6.d).(4)	algorithm development; (Detail)
723		
724	IV.A.6.d).(5)	diagnostics; (Detail)
725		
726	IV.A.6.d).(6)	imaging; (Detail)
727		
728	IV.A.6.d).(7)	public health informatics; (Detail)
729		
730	IV.A.6.d).(8)	clinical translational research; (Detail)
731		
732	IV.A.6.d).(9)	regulatory informatics; (Detail)
733		
734	IV.A.6.d).(10)	information technology business strategy and
735		management; (Detail)
736		
737	IV.A.6.d).(11)	data organization/user interface; and, (Detail)
738		
739	IV.A.6.d).(12)	specialty-specific focus. (Detail)
740		
741	IV.A.6.e)	Educational assignments should be conducted within at least
742		three of the following settings: inpatient, ambulatory, remote
743		applications, government agencies, industry, health record
744		banking, or consulting firms. (Detail)
745		
746	IV.A.6.f)	Each fellow must have an individualized learning plan that is
747		specific to his or her primary specialty. (Core)
748		
749	IV.A.6.g)	Fellows should have long-term assignments to integrate their
750		knowledge and prior experience in a clinical setting that poses
751		real-world clinical informatics challenges. (Core)
752		
753	IV.A.6.g).(1)	Each fellow must participate as a member of at least one
754		interdisciplinary team that is addressing clinical informatics
755		needs for the health system. (Core)
756		
757	IV.A.6.g).(1).(a)	This experience must include analyzing issues,
758		planning, and implementing recommendations from
759		the team. (Detail)
760		
761	IV.A.6.g).(1).(b)	The interdisciplinary team should include
762		physicians, nurses, other health care professionals,
763		administrators, and information technology/system
764		personnel. (Detail)
765		

766	IV.A.6.g).(1).(c)	Each fellow should be an active participant in a team or teams for at least 12 months. (Detail)
767		
768		
769	IV.A.6.h)	Fellows should spend at least one half-day per week maintaining their skills in their primary specialty areas. (Detail)
770		
771		
772	IV.A.6.h).(1)	The program should not require that the fellows provide more than, on average, 12 hours per week in clinical practice outside the requirements of the clinical informatics program. (Detail)
773		
774		
775		
776		

IV.B.   Fellows' Scholarly Activities

IV.B.1.   The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2.   Fellows should participate in scholarly activity. (Core)

IV.B.3.   The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. (Detail)

V.   Evaluation

V.A.   Fellow Evaluation

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

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

V.A.1.a).(1)   Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)

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

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

V.A.1.b).(1).(a)   review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b)   prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

815	**V.A.1.b).(1).(c)**	**advise the program director regarding resident**
816		**progress, including promotion, remediation,**
817		**and dismissal.** (Detail)
818		
819	**V.A.2.**	**Formative Evaluation**
820		
821	**V.A.2.a)**	**The faculty must evaluate fellow performance in a timely**
822		**manner during each rotation or similar educational**
823		**assignment, and document this evaluation at completion of**
824		**the assignment.** (Core)
825		
826	**V.A.2.b)**	**The program must:**
827		
828	**V.A.2.b).(1)**	**provide objective assessments of competence in**
829		**patient care and procedural skills, medical knowledge,**
830		**practice-based learning and improvement,**
831		**interpersonal and communication skills,**
832		**professionalism, and systems-based practice based**
833		**on the specialty-specific Milestones;** (Core)
834		
835	**V.A.2.b).(2)**	**use multiple evaluators (e.g., faculty, peers, patients,**
836		**self, and other professional staff);** (Detail)
837		
838	**V.A.2.b).(3)**	**document progressive fellow performance**
839		**improvement appropriate to educational level; and,**
840		(Core)
841		
842	**V.A.2.b).(4)**	**provide each fellow with documented semiannual**
843		**evaluation of performance with feedback.** (Core)
844		
845	V.A.2.b).(4).(a)	The semiannual evaluation should include review of
846		an individualized learning e-portfolio, which may
847		include IT applications used, projects participated
848		in, presentations given, team/committee work,
849		courses taken, externships, or other educational
850		product. (Detail)
851		
852	**V.A.2.c)**	**The evaluations of fellow performance must be accessible for**
853		**review by the fellow, in accordance with institutional policy.**
854		(Detail)
855		
856	**V.A.3.**	**Summative Evaluation**
857		
858	**V.A.3.a)**	**The specialty-specific Milestones must be used as one of the**
859		**tools to ensure fellows are able to practice core professional**
860		**activities without supervision upon completion of the**
861		**program.** (Core)
862		
863	**V.A.3.b)**	**The program director must provide a summative evaluation**
864		**for each fellow upon completion of the program.** (Core)
865		

866		This evaluation must:
867		
868	V.A.3.b).(1)	become part of the fellow's permanent record
869		maintained by the institution, and must be accessible
870		for review by the fellow in accordance with
871		institutional policy; (Detail)
872		
873	V.A.3.b).(2)	document the fellow's performance during the final
874		period of education; and, (Detail)
875		
876	V.A.3.b).(3)	verify that the fellow has demonstrated sufficient
877		competence to enter practice without direct
878		supervision. (Detail)
879		
880	**V.B.**	**Faculty Evaluation**
881		
882	**V.B.1.**	At least annually, the program must evaluate faculty performance as
883		it relates to the educational program. (Core)
884		
885	**V.B.2.**	These evaluations should include a review of the faculty's clinical
886		teaching abilities, commitment to the educational program, clinical
887		knowledge, professionalism, and scholarly activities. (Detail)
888		
889	**V.B.3.**	This evaluation must include at least annual written confidential
890		evaluations by the fellows. (Detail)
891		
892	**V.C.**	**Program Evaluation and Improvement**
893		
894	**V.C.1.**	The program director must appoint the Program Evaluation
895		Committee (PEC). (Core)
896		
897	**V.C.1.a)**	The Program Evaluation Committee:
898		
899	**V.C.1.a).(1)**	must be composed of at least two program faculty
900		members and should include at least one resident;
901		(Core)
902		
903	**V.C.1.a).(2)**	must have a written description of its responsibilities;
904		and, (Core)
905		
906	**V.C.1.a).(3)**	should participate actively in:
907		
908	**V.C.1.a).(3).(a)**	planning, developing, implementing, and
909		evaluating educational activities of the
910		program; (Detail)
911		
912	**V.C.1.a).(3).(b)**	reviewing and making recommendations for
913		revision of competency-based curriculum goals
914		and objectives; (Detail)
915		
916	**V.C.1.a).(3).(c)**	addressing areas of non-compliance with

| 917 | | ACGME standards; and, ^(Detail) |

917   **ACGME standards; and,** (Detail)

918

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

922

923 **V.C.2.**   **The program, through the PEC, must document formal, systematic**
924   **evaluation of the curriculum at least annually, and is responsible for**
925   **rendering a written and Annual Program Evaluation (APE).** (Core)

926

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

928

929 **V.C.2.a)**   **resident performance;** (Core)

930

931 **V.C.2.b)**   **faculty development;** (Core)

932

933 **V.C.2.c)**   **graduate performance, including performance of program**
934   **graduates on the certification examination;** (Core)

935

936 **V.C.2.d)**   **program quality; and,** (Core)

937

938 **V.C.2.d).(1)**   **Residents and faculty must have the opportunity to**
939   **evaluate the program confidentially and in writing at**
940   **least annually, and** (Detail)

941

942 **V.C.2.d).(2)**   **The program must use the results of residents' and**
943   **faculty members' assessments of the program**
944   **together with other program evaluation results to**
945   **improve the program.** (Detail)

946

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

948

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

953

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

956

957 **VI.**   **Fellow Duty Hours in the Learning and Working Environment**

958

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

960

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

965

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

| 968 | | environment. ^(Core) |

968   environment. (Core)

969

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

973

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

975

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

979

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

982

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

986

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

989

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

992

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

994

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

996

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

999

1000   **VI.A.6.e)**   **recognition of impairment, including illness and fatigue, in**
1001   **themselves and in their peers;** (Outcome)

1002

1003   **VI.A.6.f)**   **attention to lifelong learning;** (Outcome)

1004

1005   **VI.A.6.g)**   **the monitoring of their patient care performance improvement**
1006   **indicators; and,** (Outcome)

1007

1008   **VI.A.6.h)**   **honest and accurate reporting of duty hours, patient**
1009   **outcomes, and clinical experience data.** (Outcome)

1010

1011   **VI.A.7.**   **All fellows and faculty members must demonstrate responsiveness**
1012   **to patient needs that supersedes self-interest. They must recognize**
1013   **that under certain circumstances, the best interests of the patient**
1014   **may be served by transitioning that patient's care to another**
1015   **qualified and rested provider.** (Outcome)

1016

1017   **VI.B.**   **Transitions of Care**

1018

1019	**VI.B.1.**	**Programs must design clinical assignments to minimize the number of transitions in patient care.** (Core)
1020		
1021		
1022	**VI.B.2.**	**Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)
1023		
1024		
1025		
1026	**VI.B.3.**	**Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** (Outcome)
1027		
1028		
1029	**VI.B.4.**	**The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.** (Detail)
1030		
1031		
1032		
1033		
1034	**VI.C.**	**Alertness Management/Fatigue Mitigation**
1035		
1036	**VI.C.1.**	**The program must:**
1037		
1038	**VI.C.1.a)**	**educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;** (Core)
1039		
1040		
1041	**VI.C.1.b)**	**educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,** (Core)
1042		
1043		
1044	**VI.C.1.c)**	**adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.** (Detail)
1045		
1046		
1047		
1048	**VI.C.2.**	**Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.** (Core)
1049		
1050		
1051		
1052	**VI.C.3.**	**The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.** (Core)
1053		
1054		
1055		
1056	**VI.D.**	**Supervision of Fellows**
1057		
1058	**VI.D.1.**	**In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.** (Core)
1059		
1060		
1061		
1062		
1063		
1064	**VI.D.1.a)**	**This information should be available to fellows, faculty members, and patients.** (Detail)
1065		
1066		
1067	**VI.D.1.b)**	**Fellows and faculty members should inform patients of their respective roles in each patient's care.** (Detail)
1068		
1069		

1070	**VI.D.2.**	**The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.** (Core)
1071		
1072		
1073		**Supervision may be exercised through a variety of methods. Some**
1074		**activities require the physical presence of the supervising faculty**
1075		**member. For many aspects of patient care, the supervising**
1076		**physician may be a more advanced resident or fellow. Other**
1077		**portions of care provided by the fellow can be adequately**
1078		**supervised by the immediate availability of the supervising faculty**
1079		**member or fellow physician, either in the institution, or by means of**
1080		**telephonic and/or electronic modalities. In some circumstances,**
1081		**supervision may include post-hoc review of fellow-delivered care**
1082		**with feedback as to the appropriateness of that care.** (Detail)
1083		
1084	**VI.D.3.**	**Levels of Supervision**
1085		
1086		**To ensure oversight of fellow supervision and graded authority and**
1087		**responsibility, the program must use the following classification of**
1088		**supervision:** (Core)
1089		
1090	**VI.D.3.a)**	**Direct Supervision – the supervising physician is physically**
1091		**present with the fellow and patient.** (Core)
1092		
1093	**VI.D.3.b)**	**Indirect Supervision:**
1094		
1095	**VI.D.3.b).(1)**	**with direct supervision immediately available – the**
1096		**supervising physician is physically within the hospital**
1097		**or other site of patient care, and is immediately**
1098		**available to provide Direct Supervision.** (Core)
1099		
1100	**VI.D.3.b).(2)**	**with direct supervision available – the supervising**
1101		**physician is not physically present within the hospital**
1102		**or other site of patient care, but is immediately**
1103		**available by means of telephonic and/or electronic**
1104		**modalities, and is available to provide Direct**
1105		**Supervision.** (Core)
1106		
1107	**VI.D.3.c)**	**Oversight – the supervising physician is available to provide**
1108		**review of procedures/encounters with feedback provided**
1109		**after care is delivered.** (Core)
1110		
1111	**VI.D.4.**	**The privilege of progressive authority and responsibility, conditional**
1112		**independence, and a supervisory role in patient care delegated to**
1113		**each fellow must be assigned by the program director and faculty**
1114		**members.** (Core)
1115		
1116	**VI.D.4.a)**	**The program director must evaluate each fellow's abilities**
1117		**based on specific criteria. When available, evaluation should**
1118		**be guided by specific national standards-based criteria.** (Core)
1119		
1120	**VI.D.4.b)**	**Faculty members functioning as supervising physicians**

1121		should delegate portions of care to fellows, based on the
1122		needs of the patient and the skills of the fellows. (Detail)
1123		
1124	**VI.D.4.c)**	**Fellows should serve in a supervisory role of junior residents**
1125		**in recognition of their progress toward independence, based**
1126		**on the needs of each patient and the skills of the individual**
1127		**resident or fellow.** (Detail)
1128		
1129	**VI.D.5.**	**Programs must set guidelines for circumstances and events in**
1130		**which fellows must communicate with appropriate supervising**
1131		**faculty members, such as the transfer of a patient to an intensive**
1132		**care unit, or end-of-life decisions.** (Core)
1133		
1134	**VI.D.5.a)**	**Each fellow must know the limits of his/her scope of**
1135		**authority, and the circumstances under which he/she is**
1136		**permitted to act with conditional independence.** (Outcome)
1137		
1138	**VI.D.5.a).(1)**	**In particular, PGY-1 residents should be supervised**
1139		**either directly or indirectly with direct supervision**
1140		**immediately available.** (Core)
1141		
1142	**VI.D.6.**	**Faculty supervision assignments should be of sufficient duration to**
1143		**assess the knowledge and skills of each fellow and delegate to**
1144		**him/her the appropriate level of patient care authority and**
1145		**responsibility.** (Detail)
1146		
1147	**VI.E.**	**Clinical Responsibilities**
1148		
1149		**The clinical responsibilities for each fellow must be based on PGY-level,**
1150		**patient safety, fellow education, severity and complexity of patient**
1151		**illness/condition and available support services.** (Core)
1152		
1153	**VI.F.**	**Teamwork**
1154		
1155		**Fellows must care for patients in an environment that maximizes effective**
1156		**communication. This must include the opportunity to work as a member of**
1157		**effective interprofessional teams that are appropriate to the delivery of care**
1158		**in the specialty.** (Core)
1159		
1160	**VI.G.**	**Fellow Duty Hours**
1161		
1162	**VI.G.1.**	**Maximum Hours of Work per Week**
1163		
1164		**Duty hours must be limited to 80 hours per week, averaged over a**
1165		**four-week period, inclusive of all in-house call activities and all**
1166		**moonlighting.** (Core)
1167		
1168	**VI.G.1.a)**	**Duty Hour Exceptions**
1169		
1170	**VI.G.1.a).(1)**	**A Review Committee may grant exceptions for up to 10**
1171		**percent or a maximum of 88 hours to individual**

1172		programs based on a sound educational rationale. (Detail)
1173		
1174		
1175	VI.G.1.a).(2)	In preparing a request for an exception the program
1176		director must follow the duty hour exception policy
1177		from the ACGME Manual on Policies and Procedures.
1178		(Detail)
1179		
1180	VI.G.1.a).(3)	Prior to submitting the request to the Review
1181		Committee, the program director must obtain approval
1182		of the institution's GMEC and DIO. (Detail)
1183		
1184	VI.G.2.	Moonlighting
1185		
1186	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1187		to achieve the goals and objectives of the educational
1188		program. (Core)
1189		
1190	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1191		(as defined in the ACGME Glossary of Terms) must be
1192		counted towards the 80-hour Maximum Weekly Hour Limit.
1193		(Core)
1194		
1195	VI.G.2.c)	PGY-1 residents are not permitted to moonlight. (Core)
1196		
1197	VI.G.3.	Mandatory Time Free of Duty
1198		
1199		Fellows must be scheduled for a minimum of one day free of duty
1200		every week (when averaged over four weeks). At-home call cannot
1201		be assigned on these free days. (Core)
1202		
1203	VI.G.4.	Maximum Duty Period Length
1204		
1205	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
1206		duration. (Core)
1207		
1208	VI.G.4.b)	Duty periods of PGY-2 residents and above may be
1209		scheduled to a maximum of 24 hours of continuous duty in
1210		the hospital. (Core)
1211		
1212	VI.G.4.b).(1)	Programs must encourage fellows to use alertness
1213		management strategies in the context of patient care
1214		responsibilities. Strategic napping, especially after 16
1215		hours of continuous duty and between the hours of
1216		10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)
1217		
1218	VI.G.4.b).(2)	It is essential for patient safety and fellow education
1219		that effective transitions in care occur. Fellows may be
1220		allowed to remain on-site in order to accomplish these
1221		tasks; however, this period of time must be no longer
1222		than an additional four hours. (Core)

1223		
1224	**VI.G.4.b).(3)**	**Fellows must not be assigned additional clinical**
1225		**responsibilities after 24 hours of continuous in-house**
1226		**duty.** (Core)
1227		
1228	**VI.G.4.b).(4)**	**In unusual circumstances, fellows, on their own**
1229		**initiative, may remain beyond their scheduled period**
1230		**of duty to continue to provide care to a single patient.**
1231		**Justifications for such extensions of duty are limited**
1232		**to reasons of required continuity for a severely ill or**
1233		**unstable patient, academic importance of the events**
1234		**transpiring, or humanistic attention to the needs of a**
1235		**patient or family.** (Detail)
1236		
1237	**VI.G.4.b).(4).(a)**	**Under those circumstances, the fellow must:**
1238		
1239	**VI.G.4.b).(4).(a).(i)**	**appropriately hand over the care of all**
1240		**other patients to the team responsible**
1241		**for their continuing care; and,** (Detail)
1242		
1243	**VI.G.4.b).(4).(a).(ii)**	**document the reasons for remaining to**
1244		**care for the patient in question and**
1245		**submit that documentation in every**
1246		**circumstance to the program director.**
1247		(Detail)
1248		
1249	**VI.G.4.b).(4).(b)**	**The program director must review each**
1250		**submission of additional service, and track**
1251		**both individual fellow and program-wide**
1252		**episodes of additional duty.** (Detail)
1253		
1254	**VI.G.5.**	**Minimum Time Off between Scheduled Duty Periods**
1255		
1256	**VI.G.5.a)**	**PGY-1 residents should have 10 hours, and must have eight**
1257		**hours, free of duty between scheduled duty periods.** (Core)
1258		
1259	**VI.G.5.b)**	**Intermediate-level residents should have 10 hours free of**
1260		**duty, and must have eight hours between scheduled duty**
1261		**periods. They must have at least 14 hours free of duty after 24**
1262		**hours of in-house duty.** (Core)
1263		
1264	**VI.G.5.c)**	**Residents in the final years of education must be prepared to**
1265		**enter the unsupervised practice of medicine and care for**
1266		**patients over irregular or extended periods.** (Outcome)
1267		
1268		**Clinical informatics fellows are considered to be in the final**
1269		**years of education.**
1270		
1271	**VI.G.5.c).(1)**	**This preparation must occur within the context of the**
1272		**80-hour, maximum duty period length, and one-day-**
1273		**off-in-seven standards. While it is desirable that**

1274		residents in their final years of education have eight
1275		hours free of duty between scheduled duty periods,
1276		there may be circumstances when these fellows must
1277		stay on duty to care for their patients or return to the
1278		hospital with fewer than eight hours free of duty. (Detail)
1279		
1280	VI.G.5.c).(1).(a)	Circumstances of return-to-hospital activities
1281		with fewer than eight hours away from the
1282		hospital by residents in their final years of
1283		education must be monitored by the program
1284		director. (Detail)
1285		
1286	VI.G.6.	Maximum Frequency of In-House Night Float
1287		
1288		Fellows must not be scheduled for more than six consecutive nights
1289		of night float. (Core)
1290		
1291	VI.G.7.	Maximum In-House On-Call Frequency
1292		
1293		PGY-2 residents and above must be scheduled for in-house call no
1294		more frequently than every-third-night (when averaged over a four-
1295		week period). (Core)
1296		
1297	VI.G.8.	At-Home Call
1298		
1299	VI.G.8.a)	Time spent in the hospital by fellows on at-home call must
1300		count towards the 80-hour maximum weekly hour limit. The
1301		frequency of at-home call is not subject to the every-third-
1302		night limitation, but must satisfy the requirement for one-day-
1303		in-seven free of duty, when averaged over four weeks. (Core)
1304		
1305	VI.G.8.a).(1)	At-home call must not be so frequent or taxing as to
1306		preclude rest or reasonable personal time for each
1307		fellow. (Core)
1308		
1309	VI.G.8.b)	Fellows are permitted to return to the hospital while on at-
1310		home call to care for new or established patients. Each
1311		episode of this type of care, while it must be included in the
1312		80-hour weekly maximum, will not initiate a new "off-duty
1313		period". (Detail)
1314		
1315		***

1316
1317 ***Core Requirements**: Statements that define structure, resource, or process elements essential to every
1318 graduate medical educational program.
1319 **Detail Requirements**: Statements that describe a specific structure, resource, or process, for achieving
1320 compliance with a Core Requirement. Programs in substantial compliance with the Outcome
1321 Requirements may utilize alternative or innovative approaches to meet Core Requirements.
1322 **Outcome Requirements**: Statements that specify expected measurable or observable attributes
1323 (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
1324 education.