

**Frequently Asked Questions: Physical Medicine and Rehabilitation**  
**Review Committee for Physical Medicine and Rehabilitation**  
**ACGME**

Questions	Answers
<b>Sponsoring Institution</b>	
What does the Review Committee consider to be sufficient protected time and financial support for the program director? [Program Requirement I.A]	It is important that the program director not be required to earn the portion of his or her salary devoted to program administration by clinical activity or research grants. The institution needs to work out the details of the source of this funding (sponsoring institution, hospital, department, etc.) and ensure that it happens. At a minimum, the sponsoring institution and program should provide time and funding to support at least 20% full-time equivalency (FTE) and should provide an additional 1% per resident (includes PGY-1 residents). This support may be shared by a program director and one or more associate program directors.
How are programs that co-sponsor combined education in physical medicine and rehabilitation and another specialty accredited? [Program Requirement I.A.2]	The ACGME does not accredit these combined programs. Proposals for combined education programs in internal medicine and physical medicine and rehabilitation or pediatrics and physical medicine and rehabilitation must be submitted by the respective program directors to each applicable specialty Board for approval.
<b>Program Director</b>	
Does the Review Committee grant waivers for current American Board of Physical Medicine and Rehabilitation (ABPMR) certification for the program director? [Program Requirement II.A.3.b]	No. The Review Committee uses ABPMR certification as one of its major outcome measures and an ABPMR-certified program director demonstrates to the residents the value and importance of Board certification.
Does the Review Committee grant waivers if the program director is not based at a major participating site? [Program Requirement II.A.3.f]	Although the requirement states that the program director “must” be based at a major participating site, he or she does not need to be <i>clinically</i> based at that site. The Review Committee will consider a waiver for a program director who does not have an appointment at a major site, but he or she will be expected to demonstrate a presence at educational resident meetings and activities.
What kind of meetings fulfill the requirement that the program director participate in continuing education activities related to graduate medical education (GME)? [Program Requirement II.A.4.r]	The goal of this requirement is to promote the sharing of ideas and continuous program improvement. Examples of acceptable activities include local or regional GME conferences, the annual Residency/Fellowship Directors’ Workshop at the Association of Academic Physiatrists, as well as the ACGME’s Annual Educational Conference.
<b>Faculty</b>	
What qualifications are acceptable to the Review Committee for physician faculty members without current ABPMR certification in physical medicine and rehabilitation? [Program Requirement II.B.2]	Years of practice are not an equivalent to board certification. The onus of documenting evidence for consideration of alternate qualifications is on the program director, however the determination of whether qualifications are equivalent to certification by the ABPMR is a case-by-case judgment call on the part of the Review Committee. In some instances, a significant record of publication in peer-reviewed journals is considered evidence of adequate specialty qualifications.

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<p>What is an appropriate range of faculty member involvement in scholarly activities?  <i>[Program Requirement II.B.5.b]</i></p>	<p>At least 50% of a program's core faculty members must participate in the scholarship of discovery (as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal), dissemination (as evidenced by review articles or chapters in textbooks), or application (as evidenced by the publication or presentation of, for example, case reports, clinical series, or lectures and workshops at local, regional, or national professional and scientific society meetings; or by participation in national committees or leadership roles in professional or academic societies). Participation by core faculty members in teaching, journal clubs, and research mentoring should be documented in the "concise summary of role/responsibilities in the program" section of each faculty member's curriculum vitae (CV).</p>
<b>Resources</b>	
<p>Under what circumstances can a subacute rehabilitation service count toward the inpatient requirement?  <i>[Program Requirement II.D.1]</i></p>	<p>A subacute rotation may only be counted toward the inpatient requirement if the resident has the same direct and primary responsibility for an assigned group of patients as on an acute inpatient rehabilitation service. An attending physician must round daily (a minimum of five times/week) to supervise and teach the resident on a subacute rotation.</p>
<p>What is an appropriate inpatient census and are there any circumstances in which residents can participate in other activities without fractionally reducing the time counted toward the inpatient requirement?  <i>[Program Requirement II.D.1]</i></p>	<p>It is the program director's responsibility to ensure that the number of inpatients available for each resident is adequate. Insufficient experience will not meet educational needs and an excessive patient load implies an inappropriate reliance on residents for service. A minimum of 12 months of inpatient experience is required. Because patient acuity may vary significantly by hospital, the expectation for an average daily census of eight patients may be averaged over the experiences for the whole 12 months. In settings with a census greater than 14, programs should provide additional medical support to residents to ensure safe patient care. Inpatient residents may see their own discharged patients in follow-up care, may engage in procedures on their inpatients, and may perform the initial consult on patients who will be admitted to inpatient rehabilitation. In-house night call may not be counted toward the inpatient requirement.</p>
<b>Resident appointments</b>	
<p>Can the program director increase the residency complement without ACGME approval?  <i>[Program Requirement III.B.3]</i></p>	<p>No. All changes in resident complement must be submitted to ACGME via the Accreditation Data System (ADS), and must be prior-approved by the Review Committee.</p>
<p>Are residents who matched to the program at the PGY-2 level considered transferring residents?  <i>[Program Requirement III.C.1]</i></p>	<p>Yes. The program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of an entering PGY-2 resident. A sample form is available on the Review Committee web page at <a href="http://www.acgme.org/acWebsite/RRC_340/340_links.asp">http://www.acgme.org/acWebsite/RRC_340/340_links.asp</a>.</p>

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Educational Program	
<p>What qualifies as “significant experience” in the care of patients with musculoskeletal disorders?  <i>[Program Requirement IV.A.5.a).(3)]</i></p>	<p>A significant experience in musculoskeletal disorders is at least four months of outpatient clinics, which can include management of patients with acute and chronic pain disorders, sports injuries, occupational injuries, rheumatologic conditions, and training in use of musculoskeletal ultrasound. When a patient with a musculoskeletal disorder needs an electrodiagnostic evaluation, a resident may perform the study without the program having to fractionally account for that time in calculating the outpatient experience.</p>
<p>What is expected of a resident in terms of demonstrating competence in assessment of disability and impairment and familiarity with the ratings of disability and impairment?  <i>[Program Requirement IV.A.5.a).(6).(c)]</i></p>	<p>Residents are <i>not expected</i> to learn disability and impairment ratings. However, residents must learn to formulate an assessment and plan for each patient based on that patient’s impairment, disabilities, or functional limitations.</p>
<p>What are the Review Committee’s expectations involvement in approximately 200 electrodiagnostic consultations per resident?  <i>[Program Requirement IV.A.5.a).(6).(e)]</i></p>	<p>Each resident is expected to be involved in 200 electrodiagnostic consultations. Ideally, each resident should perform all 200 consultations. The combination of observed and performed electrodiagnostic studies should not exceed 25% for observation and should be at least 75% performed and interpreted by the resident under appropriate supervision. Each patient encounter may only be counted as one consultation, even if multiple electromyographies (EMGs) or nerve conduction studies (NCSs) are performed during an examination, and may only be counted as “performed” by one resident. Only one resident may count an “observed” study on a patient. Somatosensory-evoked potentials may be counted toward the electrodiagnostic consultation requirement, but are not required.</p>
<p>What injection techniques should residents learn?  <i>[Program Requirement IV.A.5.a).(6).(f)]</i></p>	<p>Therapeutic and diagnostic injection techniques include those for spasticity management, as well as joint, soft tissue, and axial injections. It is expected that residents will achieve competence in injections for spasticity management and joint and soft tissue injections and that they will learn indications, contraindications, and recognition and management of complications for, and have exposure to, axial injections. Although use of musculoskeletal ultrasound is growing in the field, it is not yet an expectation of the Review Committee that residents have exposure to or hands-on experience with it.</p>
<p>What therapeutic modalities should residents learn to prescribe?  <i>[Program Requirement IV.A.5.a).(6).(h)]</i></p>	<p>Residents should learn to prescribe at least the following modalities: hot and cold packs, ultrasound, Transcutaneous electrical nerve stimulation (TENS), and electrical stimulation.</p>
<p>What experiences are expected for residents to attain competence in pediatric rehabilitation?  <i>[Program Requirement IV.A.5.a).(6).(j)]</i></p>	<p>In addition to didactics addressing pediatric rehabilitation, residents should have two months of clinical experiences that <i>may include</i> inpatient pediatric rehabilitation and pediatric rehabilitation consults, but <i>must include</i> outpatient management of the common disabling disorders of childhood, including cerebral palsy and muscular dystrophy. Outpatient experiences may be under the supervision of attending physicians in pediatric rehabilitation and related specialties, such as pediatric neurology, pediatric neurological surgery, neuro-developmental pediatrics, or pediatric orthopaedics.</p>

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<p>What experience is expected for evaluation and application of cardiac and pulmonary rehabilitation as related to physiatric responsibilities? <i>[Program Requirement IV.A.5.a.(7).(j)]</i></p>	<p>These experiences include management of patients with deconditioning, modification of therapies for patients with cardiac disease, and invasive and non-invasive ventilation. Rotations in formal cardiac or pulmonary rehabilitation programs are not required.</p>
<p>Can residents conduct didactic instruction? <i>[Program Requirement IV.A.5.b).(1)]</i></p>	<p>While residents are expected to learn to teach and may provide some of the didactics or seminars, the primary responsibility for teaching lies with the faculty. Residents should present at journal club. Supervision of resident teaching in didactics, seminars, or journal clubs by one or more faculty members is required.</p>
<p>What are acceptable ways for residents to review didactic instruction if they are unable to attend a presentation? <i>[Program Requirement IV.A.5.b).(1)]</i></p>	<p>Required clinical activities may not be scheduled during didactic time, although residents may receive pages related to their patients or for consultation requests. The program director should monitor the burden of pages received and make alternative coverage arrangements if residents are disturbed too frequently during didactics. The Review Committee accepts a variety of solutions as long as residents have the opportunity to experience missed educational instruction. Solutions may include: teleconference, webcasting, taped didactics, slides available on a website, and repeating conferences.</p>
<p>What are the expectations for inpatient teaching rounds five times per week? <i>[Program Requirement IV.A.5.b).(2)]</i></p>	<p>On inpatient rotations, it is expected that faculty members will round daily (Monday-Friday) with residents and provide clinical teaching in the context of patient care.</p>
<p>What qualifies as an equivalently-structured program in anatomy? <i>[Program Requirement IV.A.5.b).(5)]</i></p>	<p>Residents must have instruction in neuromusculoskeletal anatomy. This should include supervised teaching of residents in an anatomy laboratory for dissection or study of prosected cadavers. If a cadaver laboratory experience is not included in the anatomy curriculum, didactic instruction in anatomy must be supplemented with visual aids, such as slide pictures, simulation models, or online virtual anatomy websites.</p>
<p>How should residents demonstrate that they identify strengths, deficiencies, and limits in their knowledge and expertise; set learning and improvement goals; and identify and perform appropriate learning activities? <i>[Program Requirement IV.A.5.c).(1)-(3)]</i></p>	<p>Throughout their education, residents should engage in reflection on their knowledge and expertise and write a learning plan to address deficiencies and limits. The semi-annual formative evaluation process should include an assessment of these plans and the performance of learning activities by each resident. A learning portfolio is one means by which a resident can review his or her strengths and opportunities to improve over the span of the educational program.</p>
<p>Is a resident continuity clinic required? <i>[Program Requirement IV.A.5.f).(10)]</i></p>	<p>No. If there is no resident continuity clinic, residents must participate in faculty clinics that provide follow-up care for patients with long-term disabilities.</p>
<p>How should residents participate in scholarly activity? <i>[Program Requirement IV.B.2]</i></p>	<p>Residents should investigate one topic in depth. Outcomes of this research/investigation could include: a chapter or review article; a local, regional, or national presentation; a case report/series presented as a poster or platform presentation at a national meeting; preparation or submission of a manuscript for publication; or a research project.</p>

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<b>Evaluation</b>	
<p>How should a program use the results of the self-assessment examination provided by the American Academy of Physical Medicine and Rehabilitation (AAPMR)? [Program Requirement V.A.1.d)]</p>	<p>The self-assessment examination from the AAPMR should be used to guide program improvement and resident self-directed learning. However, it is not sufficiently reliable or valid to be used for advancement of a resident to an increased level of responsibility, or for promotion or graduation decisions.</p>
<p>Can the final evaluation submitted to the ABPMR be used to meet the requirements of documentation of a resident's performance during the final period of education and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision? [Program Requirement V.A.2.a)-b)]</p>	<p>Yes, the final evaluation submitted to the ABPMR can serve as verification of a resident's competence to enter practice independently, to satisfy this portion of the summative evaluation requirement.</p> <p>Programs that are considered in non-compliance with this requirement might receive the following citation:</p> <p style="text-align: center;"><i>“At the time of the site visit, it was reported that summative evaluations had not been completed for all residents who have completed the program.”</i></p> <p>The major reason for this citation is that the cited programs did not specifically verify through documentation in the summative evaluation, "...that the resident has demonstrated sufficient competency to enter practice without direct supervision" (PR V.A.2.b)). Having the completed, signed copy of the ABPMR application form on-hand for review at the time of a site visit <i>will satisfy the requirement</i>. There is a link to the ABPMR website on the Review Committee's web page on the ACGME website, or program directors may contact the Board directly with questions.</p>
<b>Duty Hours</b>	
<p>Are there any non-physician licensed independent practitioners who may supervise residents? [Program Requirement: VI.D.1]</p>	<p>Advanced nurse practitioners and psychologists may supervise residents, as appropriate.</p>
<p>Under what circumstances can a PGY-1 resident be supervised indirectly with supervision immediately available? [Program Requirement: VI.D.5.a).(1)]</p>	<p>PGY-1 residents participate in a variety of rotations, including in emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, and surgery, or in subspecialties of internal medicine and surgery, as well as up to one month in physical medicine and rehabilitation. Each of these programs must assess the independence of each PGY-1 resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available.</p> <p>These different rotations necessitate different sets of skills. That is, if a PGY-1 resident is deemed to have progressed to indirect supervision with supervision immediately available while on the internal medicine service, this may not be the case in a subsequent rotation such as emergency medicine or surgery.</p> <p>When PGY-1 residents are assigned to physical medicine and rehabilitation rotations, second- or</p>

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	third-year (or higher) residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on-site to supervise these first-year residents.
What is the appropriate patient load for residents? <i>[Program Requirement: VI.E]</i>	PGY-1 residents work on primarily non- physical medicine and rehabilitation rotations. Their workload must comply with the respective specialty-specific clinical responsibilities requirements. For PGY-2-4 residents on inpatient services, the physical medicine and rehabilitation program director must make an assessment of the learning environment with input from faculty members and residents. The optimal case load will allow each resident to see a variety of patients without being overwhelmed by patient care responsibilities, or without compromising his or her educational experience or patient safety. Inpatient loads should generally be a minimum of eight patients averaged over the inpatient rotations, and should not generally exceed 14. There may be situations when lower loads are appropriate due to severity of illness or when higher loads are appropriate due to lower acuity of illness or team support, such as with hospitalists or mid-level providers.
Who should be included in the interprofessional teams? <i>[Program Requirement: VI.F]</i>	As is outlined in PR II.C.1, appropriately credentialed professional staff members in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, social service, speech-language pathology, therapeutic recreation, and vocational counseling, should be integrated into residents' didactic and clinical experience whenever relevant.
What is the minimum time off between scheduled duty periods for intermediate level residents? <i>[Program Requirement: VI.G.5.b)]</i>	Physical medicine and rehabilitation differs from other specialties in that patient admissions are planned, generally occur in the daytime, and emergency procedures are not done in the middle of the night. While many programs "front-load" the inpatient time during the PGY-2, any type of rotation can occur in any year. The Committee considers PGY-2 and -3 residents as intermediate-level residents. They should have 10 hours free of duty and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
Are there any circumstances under which PGY-4 residents can have fewer than eight hours free of duty or work beyond 24 hours of in-house duty? <i>[Program Requirement: VI.G.5.c)]</i>	No. Residents do not typically work in stratified teams on inpatient rotations. A PGY-4 resident on an inpatient rotation is providing primary care in the same manner as a PGY-2 or -3 resident would. Therefore, the PGY-4 resident should have 10 hours free of duty and must have eight hours between scheduled duty periods. PGY-4 residents must have 14 hours free of duty after 24 hours of in-house duty.

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