

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Cardiovascular Disease (Internal Medicine)**

3  
4 **Common Program Requirements are in BOLD**  
5 *General Subspecialty Requirements are ITALICIZED*  
6

7 Effective: July 1, 2012  
8

9 **Introduction**

10  
11 **Int.A. Residency is an essential dimension of the transformation of the medical**  
12 **student to the independent practitioner along the continuum of medical**  
13 **education. It is physically, emotionally, and intellectually demanding, and**  
14 **requires longitudinally-concentrated effort on the part of the resident.**  
15

16 **The specialty education of physicians to practice independently is**  
17 **experiential, and necessarily occurs within the context of the health care**  
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**  
19 **proficiency in all the domains of clinical competency requires the resident**  
20 **physician to assume personal responsibility for the care of individual**  
21 **patients. For the resident, the essential learning activity is interaction with**  
22 **patients under the guidance and supervision of faculty members who give**  
23 **value, context, and meaning to those interactions. As residents gain**  
24 **experience and demonstrate growth in their ability to care for patients, they**  
25 **assume roles that permit them to exercise those skills with greater**  
26 **independence. This concept—graded and progressive responsibility—is**  
27 **one of the core tenets of American graduate medical education.**  
28 **Supervision in the setting of graduate medical education has the goals of**  
29 **assuring the provision of safe and effective care to the individual patient;**  
30 **assuring each resident’s development of the skills, knowledge, and**  
31 **attitudes required to enter the unsupervised practice of medicine; and**  
32 **establishing a foundation for continued professional growth.**  
33

34 **Int.B. Cardiovascular disease fellowships provide advanced training education to allow**  
35 **a fellow to acquire competency in the subspecialty with sufficient expertise to act**  
36 **as an independent consultant.**  
37

38 **Int.C. ~~An~~The educational program ~~accredited fellowship~~ in cardiovascular disease**  
39 **must ~~provide~~ be 36 months of supervised graduate medical education in length.**  
40

41 **I. Institutions**

42  
43 **I.A. Sponsoring Institution**  
44

45 **One sponsoring institution must assume ultimate responsibility for the**  
46 **program, as described in the Institutional Requirements, and this**  
47 **responsibility extends to fellow assignments at all participating sites.**  
48

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

- 52
- 53 I.A.1. A cardiovascular disease fellowship must function as an integral part of  
 54 an ACGME-accredited residency program in internal medicine.
- 55
- 56 I.A.2. The sponsoring institution must:
- 57
- 58 I.A.2.a) establish the cardiovascular disease fellowship within a  
 59 department of internal medicine or an administrative unit whose  
 60 primary mission is the advancement of internal medicine  
 61 subspecialty education and patient care; and,  
 62
- 63 I.A.2.b) ~~provide ensure~~ the program director with adequate support for the  
 64 administrative activities of the ~~internal medicine subspecialty~~  
 65 ~~program fellowship~~.
- 66
- 67 I.A.2.b).(1) *The program director must not be required to generate  
 68 clinical or other income to provide this administrative  
 69 support.*
- 70
- 71 I.A.2.b).(2) ~~It is suggested~~ *This support should be 25-50% of the  
 72 program director's salary, or protected time, depending on  
 73 the size of the program.*
- 74
- 75 I.A.3. The sponsoring institution and participating sites must:
- 76
- 77 I.A.3.a) demonstrate that there is a culture of continuous quality  
 78 improvement in the areas of patient care, patient safety, and  
 79 education;
- 80
- 81 I.A.3.b) demonstrate a commitment to quality patient-centered care and  
 82 safety, education, ~~research~~ and scholarship sufficient to support  
 83 the fellowship program; and,  
 84
- 85 I.A.3.c) share appropriate inpatient and outpatient faculty performance  
 86 data with the program director.
- 87
- 88 I.A.3.d) ~~provide fellow compensation, and benefits, faculty, facilities, and  
 89 resources for education, clinical care, and research required for  
 90 accreditation;~~
- 91
- 92 I.A.3.e) ~~notify the Review Committee within 60 days of changes in  
 93 institutional governance, affiliation, or resources that affect the  
 94 educational program as outlined in the Institutional Requirements;  
 95 and~~
- 96
- 97 I.A.3.f) ~~provide at least one fellowship positions in the three-year,  
 98 cardiovascular disease fellowship with no less than one fellow per  
 99 year; and~~

100

101 **I.B. Participating Sites**

102

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

106  
107 The PLA should:

108  
109 **I.B.1.a)** identify the faculty who will assume both educational and  
110 supervisory responsibilities for fellows;

111  
112 **I.B.1.b)** specify their responsibilities for teaching, supervision, and  
113 formal evaluation of fellows, as specified later in this  
114 document;

115  
116 **I.B.1.c)** specify the duration and content of the educational  
117 experience; and,

118  
119 **I.B.1.d)** state the policies and procedures that will govern fellow  
120 education during the assignment.

121  
122 **I.B.2.** The program director must submit any additions or deletions of  
123 participating sites routinely providing an educational experience,  
124 required for all fellows, of one month full time equivalent (FTE) or  
125 more through the Accreditation Council for Graduate Medical  
126 Education (ACGME) Accreditation Data System (ADS).

## 127 128 **II. Program Personnel and Resources**

### 129 130 **II.A. Program Director**

131  
132 **II.A.1.** There must be a single program director with authority and  
133 accountability for the operation of the program. The sponsoring  
134 institution's GMEC must approve a change in program director. After  
135 approval, the program director must submit this change to the  
136 ACGME via the ADS.

137  
138 **II.A.2.** The program director should continue in his or her position for a  
139 length of time adequate to maintain continuity of leadership and  
140 program stability.

141  
142 **II.A.3.** Qualifications of the program director must include:

143  
144 **II.A.3.a)** requisite specialty expertise and documented educational  
145 and administrative experience acceptable to the Review  
146 Committee;

147  
148 **II.A.3.a).(1)** The program director must have at least five years of  
149 participation as an active faculty member in an ACGME-  
150 accredited internal medicine residency or cardiovascular  
151 disease fellowship.

152

- 153 **II.A.3.b)** **current certification in the subspecialty by the American**  
154 **Board of Internal Medicine (ABIM), or subspecialty**  
155 **qualifications acceptable to the Review Committee; and**  
156  
157 **II.A.3.b).(1)** The Review Committee only accepts current ABIM  
158 certification in cardiovascular disease.  
159  
160 **II.A.3.c)** **current medical licensure and appropriate medical staff**  
161 **appointment.**  
162  
163 **II.A.4.** **The program director must administer and maintain an educational**  
164 **environment conducive to educating the fellows in each of the**  
165 **ACGME competency areas. The program director must:**  
166  
167 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**  
168 **education in all sites that participate in the program;**  
169  
170 **II.A.4.b)** **approve a local director at each participating site who is**  
171 **accountable for fellow education;**  
172  
173 **II.A.4.c)** **approve the selection of program faculty as appropriate;**  
174  
175 **II.A.4.d)** **evaluate program faculty and approve the continued**  
176 **participation of program faculty based on evaluation;**  
177  
178 **II.A.4.e)** **monitor fellow supervision at all participating sites;**  
179  
180 **II.A.4.f)** **prepare and submit all information required and requested by**  
181 **the ACGME, including but not limited to the program**  
182 **information forms and annual program fellow updates to the**  
183 **ADS, and ensure that the information submitted is accurate**  
184 **and complete;**  
185  
186 **II.A.4.g)** **provide each fellow with documented semiannual evaluation**  
187 **of performance with feedback;**  
188  
189 **II.A.4.h)** **ensure compliance with grievance and due process**  
190 **procedures, as set forth in the Institutional Requirements and**  
191 **implemented by the sponsoring institution;**  
192  
193 **II.A.4.i)** **provide verification of fellowship education for all fellows,**  
194 **including those who leave the program prior to completion;**  
195  
196 **II.A.4.j)** **implement policies and procedures consistent with the**  
197 **institutional and program requirements for fellow duty hours**  
198 **and the working environment, including moonlighting, and, to**  
199 **that end, must:**  
200  
201 **II.A.4.j).(1)** **distribute these policies and procedures to the fellows**  
202 **and faculty;**

203		
204	<b>II.A.4.j).(2)</b>	<b>monitor fellow duty hours, according to sponsoring</b>
205		<b>institutional policies, with a frequency sufficient to</b>
206		<b>ensure compliance with ACGME requirements;</b>
207		
208	<b>II.A.4.j).(3)</b>	<b>adjust schedules as necessary to mitigate excessive</b>
209		<b>service demands and/or fatigue; and</b>
210		
211	<b>II.A.4.j).(4)</b>	<b>if applicable, monitor the demands of at-home call and</b>
212		<b>adjust schedules as necessary to mitigate excessive</b>
213		<b>service demands and/or fatigue.</b>
214		
215	<b>II.A.4.k)</b>	<b>monitor the need for and ensure the provision of back up</b>
216		<b>support systems when patient care responsibilities are</b>
217		<b>unusually difficult or prolonged;</b>
218		
219	<b>II.A.4.l)</b>	<b>comply with the sponsoring institution's written policies and</b>
220		<b>procedures, including those specified in Institutional</b>
221		<b>Requirements, for selection, evaluation and promotion of</b>
222		<b>fellows, disciplinary action, and supervision of fellows;</b>
223		
224	<b>II.A.4.m)</b>	<b>be familiar with and comply with ACGME and Review</b>
225		<b>Committee policies and procedures as outlined in the ACGME</b>
226		<b>Manual of Policies and Procedures;</b>
227		
228	<b>II.A.4.n)</b>	<b>obtain review and approval of the sponsoring institution's</b>
229		<b>GMEC/DIO before submitting to the ACGME information or</b>
230		<b>requests for the following:</b>
231		
232	<b>II.A.4.n).(1)</b>	<b>all applications for ACGME accreditation of new</b>
233		<b>programs;</b>
234		
235	<b>II.A.4.n).(2)</b>	<b>changes in fellow complement;</b>
236		
237	<b>II.A.4.n).(3)</b>	<b>major changes in program structure or length of</b>
238		<b>training;</b>
239		
240	<b>II.A.4.n).(4)</b>	<b>progress reports requested by the Review Committee;</b>
241		
242	<b>II.A.4.n).(5)</b>	<b>responses to all proposed adverse actions;</b>
243		
244	<b>II.A.4.n).(6)</b>	<b>requests for increases or any change to fellow duty</b>
245		<b>hours;</b>
246		
247	<b>II.A.4.n).(7)</b>	<b>voluntary withdrawals of ACGME-accredited</b>
248		<b>programs;</b>
249		
250	<b>II.A.4.n).(8)</b>	<b>requests for appeal of an adverse action;</b>
251		
252	<b>II.A.4.n).(9)</b>	<b>appeal presentations to a Board of Appeal or the</b>

253 **ACGME; and**  
254  
255 **II.A.4.n).(10) proposals to ACGME for approval of innovative**  
256 **educational approaches.**  
257  
258 **II.A.4.o) obtain DIO review and co-signature on all program**  
259 **information forms, as well as any correspondence or**  
260 **document submitted to the ACGME that addresses:**  
261  
262 **II.A.4.o).(1) program citations; and/or**  
263  
264 **II.A.4.o).(2) request for changes in the program that would have**  
265 **significant impact, including financial, on the program**  
266 **or institution.**  
267  
268 *II.A.4.p) be responsible for monitoring fellow stress, including mental or*  
269 *emotional conditions inhibiting performance or learning, and drug-*  
270 *or alcohol-related dysfunction;*  
271  
272 *II.A.4.p).(1) ~~Both~~ The program director ~~and faculty~~ should provide*  
273 *access to be sensitive to the need for timely provision of*  
274 *confidential counseling and psychological support services*  
275 *to fellows.*  
276  
277 *II.A.4.p).(2) Situations that demand excessive service or that*  
278 *consistently produce undesirable stress on fellows must be*  
279 *evaluated and modified.*  
280  
281 *II.A.4.q) ensure that fellows' service responsibilities are limited to patients*  
282 *for whom the teaching service has diagnostic and therapeutic*  
283 *responsibility.*  
284  
285 *II.A.4.r) dedicate an average of 20 hours per week of his or her*  
286 *professional effort to the ~~internal medicine subspecialty program~~*  
287 *fellowship, including with sufficient time for administration of the*  
288 *program, and receive institutional support for that administrative*  
289 *time.*  
290  
291 *II.A.4.s) participate in academic societies and in educational programs*  
292 *designed to enhance his or her educational and administrative*  
293 *skills;*  
294  
295 *II.A.4.t) have a reporting relationship with the program director of the*  
296 *internal medicine residency program to ensure compliance with*  
297 *~~the~~ ACGME accreditation standards;*  
298  
299 *II.A.4.u) be available ~~located~~ at the primary principal clinical site; and,*  
300  
301 *II.A.4.v) establish a reporting relationship between him or herself and the*  
302 *dependent accredited sub-subspecialty programs.*  
303

- 304 **II.B. Faculty**  
305  
306 **II.B.1. At each participating site, there must be a sufficient number of**  
307 **faculty with documented qualifications to instruct and supervise all**  
308 **fellows at that location.**  
309  
310 **The faculty must:**  
311  
312 **II.B.1.a) devote sufficient time to the educational program to fulfill**  
313 **their supervisory and teaching responsibilities; and to**  
314 **demonstrate a strong interest in the education of fellows;**  
315 **and,**  
316  
317 **II.B.1.b) administer and maintain an educational environment**  
318 **conducive to educating fellows in each of the ACGME**  
319 **competency areas.**  
320  
321 **II.B.2. The physician faculty must have current certification in the**  
322 **subspecialty by the American Board of Internal Medicine, or possess**  
323 **qualifications acceptable by the Review Committee.**  
324  
325 **II.B.3. The physician faculty must possess current medical licensure and**  
326 **appropriate medical staff appointment.**  
327  
328 **II.B.4. The nonphysician faculty must have appropriate qualifications in**  
329 **their field and hold appropriate institutional appointments.**  
330  
331 **II.B.5. The faculty must establish and maintain an environment of inquiry**  
332 **and scholarship with an active research component.**  
333  
334 **II.B.5.a) The faculty must regularly participate in organized clinical**  
335 **discussions, rounds, journal clubs, and conferences.**  
336  
337 **II.B.5.b) Some members of the faculty should also demonstrate**  
338 **scholarship by one or more of the following:**  
339  
340 **II.B.5.b).(1) peer-reviewed funding;**  
341  
342 **II.B.5.b).(2) publication of original research or review articles in**  
343 **peer-reviewed journals or chapters in textbooks;**  
344  
345 **II.B.5.b).(3) publication or presentation of case reports or clinical**  
346 **series at local, regional, or national professional and**  
347 **scientific society meetings; or,**  
348  
349 **II.B.5.b).(4) participation in national committees or educational**  
350 **organizations.**  
351  
352 **II.B.5.c) Faculty should encourage and support fellows in scholarly**  
353 **activities.**

354  
355 II.B.6. *The physician faculty must meet professional standards of ethical*  
356 *behavior.*  
357  
358 II.B.7. Key Clinical Faculty  
359  
360 In addition to the program director, each program must have at least three  
361 Key Clinical Faculty (KCF) members. KCF are attending physicians who  
362 dedicate, on average, 10 hours per week throughout the year to the  
363 program. For programs with more than ~~five-six~~ fellows, ~~enrolled during the~~  
364 ~~accredited portion of the program, a ratio of KCF to fellows of at least 1:~~  
365 there must be at least one KCF for every 1.5 fellows. must be maintained.  
366  
367 II.B.7.a) ~~The program must provide a minimum of four institutionally-based~~  
368 ~~key clinical faculty members, including the program director.~~  
369  
370 II.B.7.b) ~~In programs with an approved complement of more than six~~  
371 ~~fellows, a ratio of key clinical faculty to fellows of at least 1:1.5~~  
372 ~~must be maintained.~~  
373  
374 II.B.7.c) Key Clinical Faculty Qualifications  
375  
376 II.B.7.c).(1) KCF must be active clinicians with ~~broad~~ knowledge of,  
377 experience with, and commitment to cardiovascular  
378 disease as a discipline.  
379  
380 II.B.7.c).(2) KCF must have current ABIM certification in cardiovascular  
381 disease.  
382  
383 II.B.7.d) *Key Clinical Faculty Responsibilities*  
384  
385 II.B.7.d).(1) *In addition to the responsibilities of all individual faculty*  
386 *members, the KCF with and the program director are*  
387 *responsible for the planning, implementation, monitoring*  
388 *and evaluation of the fellows' clinical and research*  
389 *education training.*  
390  
391 II.B.7.d).(2) ~~The majority of~~ *At least 50% of the KCF must demonstrate*  
392 *evidence of productivity in ~~the~~ scholarship, specifically,*  
393 *peer-reviewed funding; publication of original research,*  
394 *review articles, editorials, or case reports in peer-reviewed*  
395 *journals; or chapters in textbooks. as defined in II.B.5.b.(1)*  
396 *or (2) above*  
397  
398 II.B.7.d).(3) At least one of the KCF must:  
399  
400 II.B.7.d).(3).(a) be knowledgeable in the evaluation and  
401 assessment of the ACGME competencies; and,  
402  
403 II.B.7.d).(3).(b) spend significant time in the evaluation of fellows,  
404 including the direct observation of fellows with

405 patients.

406

407 *II.B.7.d).(4) Appointment of one KCF to be an associate program*

408 *director is suggested.*

409

410 *II.B.8. ~~All~~ Clinical faculty members should participate in ~~prescribed~~ faculty*

411 *development programs designed to enhance the effectiveness of their*

412 *teaching.*

413

414 **II.C. Other Program Personnel**

415

416 **The institution and the program must jointly ensure the availability of all**

417 **necessary professional, technical, and clerical personnel for the effective**

418 **administration the program.**

419

420 *II.C.1. There must be services available from other health care professionals,*

421 *including dietitians, language interpreters, nurses, occupational*

422 *therapists, physical therapists, and social workers.*

423

424 *II.C.2. ~~There must be ensure the availability of~~ appropriate and timely*

425 *consultation from other specialties.*

426

427 **II.D. Resources**

428

429 **The institution and the program must jointly ensure the availability of**

430 **adequate resources for fellow education, as defined in the specialty**

431 **program requirements.**

432

433 *II.D.1. Space and Equipment*

434

435 *There must be space and equipment for the ~~educational~~ program,*

436 *including meeting rooms, ~~classrooms~~, examination rooms, computers,*

437 *visual and other educational aids, and work/study space.*

438

439 *II.D.2. Facilities*

440

441 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*

442 *fellows from performing routine clerical functions, including*

443 *scheduling tests and appointments, and retrieving records and*

444 *letters.*

445

446 *II.D.2.b) The sponsoring institution must provide the broad range of*

447 *facilities and clinical support services required to provide*

448 *comprehensive care of adult patients. ~~Fellows must have clinical~~*

449 *~~experiences in efficient, effective ambulatory and inpatient care~~*

450 *~~settings.~~*

451

452 *II.D.2.c) Fellows must have access to a lounge facility during assigned*

453 *duty hours.*

454

455 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*

456 night duty, or called in from home, they must be provided with on-  
457 call facilities that are convenient and that afford privacy, safety,  
458 and a restful environment with a secure space for their  
459 belongings.

460  
461 II.D.3. Laboratory Services

462  
463 Each of the following must be present at the primary clinical site:

464  
465 II.D.3.a) cardiac catheterization laboratories, including cardiac  
466 hemodynamics and a full range of interventional cardiology;

467  
468 II.D.3.b) cardiac radionuclide laboratories;

469  
470 II.D.3.c) cardiac radiology laboratory, including magnetic resonance  
471 imaging (MRI) and computed tomography (CT);

472  
473 II.D.3.d) electrocardiogram (ECG), ambulatory ECG, and exercise testing  
474 laboratories;

475  
476 II.D.3.e) echocardiography laboratories, including Doppler and  
477 transesophageal echocardiography;

478  
479 II.D.3.f) ~~invasive~~ electrophysiology laboratories; and,

480  
481 II.D.3.g) noninvasive vascular laboratory.

482  
483 II.D.3.g).(1) ~~services for placement of pacemakers,~~

484  
485 II.D.3.g).(2) ~~implantable cardioverter/defibrillator, and~~

486  
487 II.D.3.g).(3) ~~follow-up;~~

488  
489 II.D.3.g).(4) ~~pulmonary function laboratories,~~

490  
491 II.D.3.g).(5) ~~peripheral vascular laboratories.~~

492  
493 II.D.4. Other Facilities, Resources, or Support Services

494  
495 The following must be present at the primary clinical site:

496  
497 II.D.4.a) a cardiac coronary-intensive care unit; and,

498  
499 II.D.4.b) an active cardiac surgery program.

500  
501 II.D.5. Medical Records

502  
503 Access to an electronic health record should be provided. In the absence  
504 of an existing electronic health record, institutions must demonstrate  
505 institutional commitment to its development, and progress towards its  
506 implementation.

507  
508 II.D.6. Patient Population  
509  
510 II.D.6.a) The patient population must have a variety of clinical problems  
511 and stages of cardiovascular diseases.  
512  
513 II.D.6.b) *There must be patients of ~~both~~ each gender, with a broad age*  
514 *range, including geriatric patients.*  
515  
516 II.D.6.c) *A sufficient number of patients must be available to enable ~~ensure~~*  
517 *~~adequate inpatient and ambulatory experience for each fellow to~~*  
518 *achieve the required educational outcomes.*  
519  
520 II.E. Medical Information Access  
521  
522 **Fellows must have ready access to specialty-specific and other appropriate**  
523 **reference material in print or electronic format. Electronic medical literature**  
524 **databases with search capabilities should be available.**  
525  
526 III. Fellow Appointments  
527  
528 III.A. Eligibility Criteria  
529  
530 **The program director must comply with the criteria for fellow eligibility as**  
531 **specified in the Institutional Requirements.**  
532  
533 III.A.1. *Prior to appointment in the ~~fellowship program~~, fellows should have*  
534 *completed an ACGME-accredited internal medicine ~~education~~ program.*  
535  
536 III.A.2. *Fellows from ~~non-ACGME-accredited~~ internal medicine ~~education~~*  
537 *programs must have completed at least three years of internal medicine*  
538 *education prior to starting the fellowship.*  
539  
540 III.A.3. *The program director must inform ~~non-ACGME-trained~~ applicants from*  
541 *non-ACGME-accredited programs, prior to appointment and in writing, of*  
542 *the ABIM policies and procedures that ~~may~~ will affect ~~the fellow's~~ their*  
543 *eligibility for ABIM certification.*  
544  
545 III.A.4. *When averaged over any five-year period, a minimum of 75% of fellows in*  
546 *each ~~subspecialty training~~ program must be graduates of an ACGME-*  
547 *accrued internal medicine ~~training~~ program. ~~Non-ACGME internal~~*  
548 *~~medicine trained fellows must have at least three years of internal~~*  
549 *~~medicine training prior to starting fellowship.~~*  
550  
551 III.B. Number of Fellows  
552  
553 **The program director may not appoint more fellows than approved by the**  
554 **Review Committee, unless otherwise stated in the specialty-specific**  
555 **requirements. The program's educational resources must be adequate to**  
556 **support the number of fellows appointed to the program.**  
557

558 III.B.1. *The ~~minimum~~ number of available fellow positions in the training program*  
559 *must be at least one per year ~~not be less than the number of accredited~~*  
560 *~~training years in the program.~~*

561  
562 **III.C. Fellow Transfers**

563  
564 **III.C.1.** **Before accepting a fellow who is transferring from another program,**  
565 **the program director must obtain written or electronic verification of**  
566 **previous educational experiences and a summative competency-**  
567 **based performance evaluation of the transferring fellow.**

568  
569 **III.C.2.** **A program director must provide timely verification of fellowship**  
570 **education and summative performance evaluations for fellows who**  
571 **leave the program prior to completion.**

572  
573 **III.D. Appointment of Fellows and Other Learners**

574  
575 **The presence of other learners (including, but not limited to, residents from**  
576 **other specialties, subspecialty fellows, PhD students, and nurse**  
577 **practitioners) in the program must not interfere with the appointed fellows'**  
578 **education. The program director must report the presence of other learners**  
579 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**  
580

581 **IV. Educational Program**

582  
583 **IV.A. The curriculum must contain the following educational components:**

584  
585 **IV.A.1. Overall educational goals for the program, which the program must**  
586 **distribute to fellows and faculty annually;**

587  
588 **IV.A.2. Competency-based goals and objectives for each assignment at**  
589 **each educational level, which the program must distribute to fellows**  
590 **and faculty annually, in either written or electronic form. These**  
591 **should be reviewed by the fellow at the start of each rotation;**

592  
593 **IV.A.3. Regularly scheduled didactic sessions;**

594  
595 *IV.A.3.a) The core curriculum must include a didactic program based upon*  
596 *the core knowledge content in the subspecialty area.*

597  
598 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*  
599 *review topics covered in conferences that he or she was*  
600 *unable to attend.*

601  
602 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*  
603 *journal clubs, research conferences, and morbidity and*  
604 *mortality or quality improvement conferences.*

605  
606 *IV.A.3.a).(3) All core conferences must have at least one faculty*  
607 *member present, and must be scheduled as to ensure*

608 peer-peer and peer-faculty interaction.

609

610 IV.A.3.b) Patient-based teaching must include direct interaction between

611 fellows and ~~attendings~~ faculty members, bedside teaching,

612 discussion of pathophysiology, and the use of current evidence in

613 diagnostic and therapeutic decisions. The teaching must be:

614

615 | IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and

616 consultative services; and,

617

618 IV.A.3.b).(2) conducted with a frequency and duration ~~sufficient to~~ that

619 ensures a meaningful and continuous teaching relationship

620 between the assigned supervising faculty member(s)

621 ~~teaching attending~~ and fellows.

622

623 IV.A.3.c) Fellows must receive instruction in practice management relevant

624 to cardiovascular disease.

625

626 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**

627 **responsibility for patient management, and supervision of fellows**

628 **over the continuum of the program;**

629

630 **IV.A.5. ACGME Competencies**

631

632 **The program must integrate the following ACGME competencies**

633 **into the curriculum:**

634

635 **IV.A.5.a) Patient Care**

636

637 **Fellows must be able to provide patient care that is**

638 **compassionate, appropriate, and effective for the treatment of**

639 **health problems and the promotion of health. Fellows:**

640

641 IV.A.5.a).(1) must demonstrate competence in the practice of health

642 promotion, disease prevention, diagnosis, care, and

643 treatment of ~~men and women~~ patients of each gender,

644 from adolescence to old age, during health and all stages

645 of illness;

646

647 IV.A.5.a).(2) ~~must have formal instruction, clinical experience, and must~~

648 ~~demonstrate competence in prevention, evaluation, and~~

649 ~~management of the following disorders:~~

650

651 IV.A.5.a).(2).(a) arrhythmias; acute myocardial infarction and other

652 acute ischemic syndromes;

653

654 IV.A.5.a).(2).(b) cardiomyopathy;

655

656 IV.A.5.a).(2).(c) cardiovascular evaluation of patients undergoing

657 noncardiac surgery;

658

659	IV.A.5.a).(2).(d)	congestive heart failure;
660		
661	IV.A.5.a).(2).(e)	coronary heart disease:
662		
663	IV.A.5.a).(2).(e).(i)	acute coronary syndromes; and,
664		
665	IV.A.5.a).(2).(e).(ii)	chronic coronary heart disease.
666		
667	IV.A.5.a).(2).(f)	<u>diseases of the aorta;</u>
668		
669	IV.A.5.a).(2).(g)	heart disease in pregnancy;
670		
671	IV.A.5.a).(2).(h)	hypertension;
672		
673	IV.A.5.a).(2).(i)	infectious and inflammatory heart disease;
674		
675	IV.A.5.a).(2).(j)	lipid disorders <u>and metabolic syndrome;</u>
676		
677	IV.A.5.a).(2).(k)	<u>need for end-of-life (palliative) care;</u>
678		
679	IV.A.5.a).(2).(l)	pulmonary hypertension; <del>pulmonary heart disease-</del>
680		<del>and pulmonary embolism</del>
681		
682	IV.A.5.a).(2).(m)	peripheral vascular disease;
683		
684	IV.A.5.a).(2).(n)	pericardial disease; <del>adult congenital heart disease</del>
685		
686	IV.A.5.a).(2).(o)	<u>thromboembolic disorders;</u> and,
687		
688	IV.A.5.a).(2).(p)	valvular heart disease.
689		
690	IV.A.5.a).(3)	<del>must have formal instruction, clinical experience and</del>
691		<del>demonstrate competence in the performance of the</del>
692		following procedures:
693		
694	IV.A.5.a).(3).(a)	<del>elective</del> <u>direct current</u> cardioversion (each fellow
695		must perform 10);
696		
697	IV.A.5.a).(3).(b)	echocardiography (each fellow must perform a
698		minimum of 75 and interpret a minimum of 150
699		studies, <u>and observe the performance and</u>
700		<u>interpretation of including</u> <del>including</del> transesophageal cardiac
701		studies);
702		
703	IV.A.5.a).(3).(c)	exercise stress testing (each fellow must perform a
704		minimum of 50 stress ECG tests);
705		
706	IV.A.5.a).(3).(d)	right and left heart catheterization, including
707		coronary arteriography (each fellow must
708		participate in a minimum of 100 catheterizations);
709		

710	IV.A.5.a).(3).(e)	<u>conscious sedation;</u>
711		
712	IV.A.5.a).(3).(f)	<del>insertion placement</del> and management of temporary pacemakers, including transvenous and transcutaneous; <del>and,;-(each fellow must place a minimum of 10 temporary pacemakers)</del>
713		
714		
715		
716		
717	IV.A.5.a).(3).(g)	programming and follow-up surveillance of permanent pacemakers <u>and ICDs.</u>
718		
719		
720	IV.A.5.a).(4)	<del>Fellows must have formal instruction, clinical experience, and demonstrate competence in the interpretation of the following:</del>
721		
722		
723		
724	IV.A.5.a).(4).(a)	ambulatory ECG recordings; <del>and (each fellow must interpret a minimum of 50 ambulatory ECG recordings)</del>
725		
726		
727		
728	IV.A.5.a).(4).(b)	electrocardiograms ( <u>each fellow must interpret a minimum of 3500 electrocardiograms;</u>
729		
730		
731	IV.A.5.a).(4).(c)	nuclear cardiology (each fellow must interpret a minimum of 100 radionuclide studies to include SPECT myocardial perfusion imaging and ventriculograms); <del>and Radionuclide studies of myocardial function and perfusion</del>
732		
733		
734		
735		
736		
737	IV.A.5.a).(4).(d)	chest x-rays.
738		
739	IV.A.5.a).(4).(e)	<del>Magnetic resonance imaging (each fellow must interpret a minimum of 25 studies)</del>
740		
741		
742	IV.A.5.a).(4).(f)	<del>Computed tomography (each fellow must interpret a minimum of 50 studies)</del>
743		
744		
745	<b>IV.A.5.b)</b>	<b>Medical Knowledge</b>
746		
747		
748		<b>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:</b>
749		
750		
751		
752	IV.A.5.b).(1)	<i>must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making;</i>
753		
754		
755	IV.A.5.b).(2)	<i>must <del>develop</del> demonstrate a <u>knowledge understanding</u> of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, <u>including the appropriate indications for and use of screening tests/procedures;</u></i>
756		
757		
758		
759		
760		

761		
762	IV.A.5.b).(3)	must demonstrate knowledge of the following content
763		areas:
764		
765	IV.A.5.b).(3).(a)	basic science, including:
766		
767	IV.A.5.b).(3).(a).(i)	cardiovascular anatomy;
768		
769	IV.A.5.b).(3).(a).(ii)	cardiovascular metabolism;
770		
771	IV.A.5.b).(3).(a).(iii)	cardiovascular pathology;
772		
773	IV.A.5.b).(3).(a).(iv)	cardiovascular pharmacology, including
774		drug metabolism, adverse effects,
775		indications, the effects on aging, relative
776		costs of therapy, and the effects of non-
777		cardiovascular drugs upon cardiovascular
778		function;
779		
780	IV.A.5.b).(3).(a).(v)	cardiovascular physiology;
781		
782	IV.A.5.b).(3).(a).(vi)	genetic causes of cardiovascular disease;
783		and,
784		
785	IV.A.5.b).(3).(a).(vii)	molecular biology of the cardiovascular
786		system.
787		
788	IV.A.5.b).(3).(b)	<u>primary and secondary</u> prevention of
789		cardiovascular disease, including:
790		
791	IV.A.5.b).(3).(b).(i)	biostatistics;
792		
793	IV.A.5.b).(3).(b).(ii)	clinical epidemiology;
794		
795	IV.A.5.b).(3).(b).(iii)	<u>cardiac rehabilitation</u> ;
796		
797	IV.A.5.b).(3).(b).(iv)	<u>current and emerging</u> risk factors; and
798		
799	IV.A.5.b).(3).(b).(v)	<u>evaluation and management of patients with</u>
800		cerebrovascular disease.
801		
802	IV.A.5.b).(3).(c)	evaluation and management of patients with:
803		
804	IV.A.5.b).(3).(c).(i)	adult congenital heart disease;
805		
806	IV.A.5.b).(3).(c).(ii)	cardiac trauma;
807		
808	IV.A.5.b).(3).(c).(iii)	cardiac tumors; <del>Preoperative and-</del>
809		<del>postoperative patients</del> Cardiac transplant-
810		patients
811		

812 IV.A.5.b).(3).(c).(iv) cerebrovascular disease; and,  
813  
814 IV.A.5.b).(3).(c).(v) geriatric cardiology. ~~Geriatric patients with~~  
815 ~~cardiovascular disease~~  
816

817 **IV.A.5.c) Practice-based Learning and Improvement**

818  
819 **Fellows must demonstrate the ability to investigate and**  
820 **evaluate their care of patients, to appraise and assimilate**  
821 **scientific evidence, and to continuously improve patient care**  
822 **based on constant self-evaluation and life-long learning.**  
823 **Fellows are expected to develop skills and habits to be able**  
824 **to meet the following goals:**

825  
826 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**  
827 **knowledge and expertise;**

828  
829 **IV.A.5.c).(2) set learning and improvement goals;**

830  
831 **IV.A.5.c).(3) identify and perform appropriate learning activities;**

832  
833 **IV.A.5.c).(4) systematically analyze practice, using quality**  
834 **improvement methods, and implement changes with**  
835 **the goal of practice improvement;**

836  
837 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**  
838 **practice;**

839  
840 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**  
841 **scientific studies related to their patients' health**  
842 **problems;**

843  
844 **IV.A.5.c).(7) use information technology to optimize learning;**

845  
846 **IV.A.5.c).(8) participate in the education of patients, families,**  
847 **students, fellows and other health professionals; and,**

848  
849 **IV.A.5.c).(9) *obtain procedure-specific informed consent by competently***  
850 ***educating patients about rationale, technique, and***  
851 ***complications of procedures.***

852  
853 **IV.A.5.d) Interpersonal and Communication Skills**

854  
855 **Fellows must demonstrate interpersonal and communication**  
856 **skills that result in the effective exchange of information and**  
857 **collaboration with patients, their families, and health**  
858 **professionals. Fellows are expected to:**

859  
860 **IV.A.5.d).(1) communicate effectively with patients, families, and**  
861 **the public, as appropriate, across a broad range of**

- 862 socioeconomic and cultural backgrounds;
- 863
- 864 **IV.A.5.d).(2)** communicate effectively with physicians, other health
- 865 professionals, and health related agencies;
- 866
- 867 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
- 868 team or other professional group;
- 869
- 870 **IV.A.5.d).(4)** act in a consultative role to other physicians and
- 871 health professionals; and,
- 872
- 873 **IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical
- 874 records, if applicable.
- 875

876 **IV.A.5.e) Professionalism**

877

878 **Fellows must demonstrate a commitment to carrying out**

879 **professional responsibilities and an adherence to ethical**

880 **principles. Fellows are expected to demonstrate:**

- 881
- 882 **IV.A.5.e).(1)** compassion, integrity, and respect for others;
- 883
- 884 **IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-
- 885 interest;
- 886
- 887 **IV.A.5.e).(3)** respect for patient privacy and autonomy;
- 888
- 889 **IV.A.5.e).(4)** accountability to patients, society and the profession;
- 890
- 891 **IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient
- 892 population, including but not limited to diversity in
- 893 gender, age, culture, race, religion, disabilities, and
- 894 sexual orientation;
- 895
- 896 **IV.A.5.e).(6)** high standards of ethical behavior, including maintaining
- 897 appropriate professional boundaries and relationships with
- 898 other physicians and other health care team members, and
- 899 avoiding conflicts of interest; and,
- 900
- 901 **IV.A.5.e).(7)** *a commitment to lifelong learning, and an attitude of caring*
- 902 *derived from humanistic and professional values.*

903

904 **IV.A.5.f) Systems-based Practice**

905

906 **Fellows must demonstrate an awareness of and**

907 **responsiveness to the larger context and system of health**

908 **care, as well as the ability to call effectively on other**

909 **resources in the system to provide optimal health care.**

910 **Fellows are expected to:**

911

912	<b>IV.A.5.f).(1)</b>	<b>work effectively in various health care delivery settings and systems relevant to their clinical specialty;</b>
913		
914		
915		
916	<b>IV.A.5.f).(2)</b>	<b>coordinate patient care within the health care system relevant to their clinical specialty;</b>
917		
918		
919	<b>IV.A.5.f).(3)</b>	<b>incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;</b>
920		
921		
922		
923	<b>IV.A.5.f).(4)</b>	<b>advocate for quality patient care and optimal patient care systems;</b>
924		
925		
926	<b>IV.A.5.f).(5)</b>	<b>work in interprofessional teams to enhance patient safety and improve patient care quality; and,</b>
927		
928		
929	<b>IV.A.5.f).(6)</b>	<b>participate in identifying system errors and implementing potential systems solutions.</b>
930		
931		
932	IV.A.6.	<u>Curriculum Organization and Fellow Experiences</u>
933		
934	IV.A.6.a)	A minimum time must be spent in the following areas:
935		
936	IV.A.6.a).(1)	<del>be at least 24 months in of clinical training experience,</del> including inpatient and special experiences;
937		
938		
939	IV.A.6.a).(2)	four months in the cardiac catheterization laboratory;
940		
941	IV.A.6.a).(3)	six months in noninvasive cardiac evaluations, consisting of the following:
942		
943		
944	IV.A.6.a).(3).(a)	three months of echocardiography and Doppler;
945		
946	IV.A.6.a).(3).(b)	two months of nuclear cardiology, to include the fellow's active participation in daily nuclear cardiology study interpretation (a minimum of 80 hours) during the rotation;
947		
948		
949		
950		
951	IV.A.6.a).(3).(c)	<del>Cardiovascular magnetic resonance and other techniques (e.g., electron beam or fast helical computed tomography).</del> <u>one month of experiences in other noninvasive cardiac evaluations, which to includes at least exercise stress testing; ECG interpretation; and ambulatory ECG monitoring (continuous and event recording). This rotation may be done concurrently with other rotations.</u>
952		
953		
954		
955		
956		
957		
958		
959		
960	IV.A.6.a).(3).(d)	experience in cardiac tomography, positron emission tomography, cardiac magnetic resonance
961		

962 imaging, and, peripheral vascular imaging. These  
963 rotations may be done ~~in conjunction with other~~  
964 ~~block rotations or concurrently with other clinical~~  
965 ~~rotations.~~

966

967 IV.A.6.a).(4) two months devoted to electrophysiology; and ~~pacemaker~~  
968 ~~follow-up and ICDs.~~

969

970 IV.A.6.a).(5) ~~There must be at least~~ nine months of non-laboratory  
971 ~~clinical practice activities.~~

972

973 IV.A.6.a).(5).(a) ~~intracardiac electrophysiologic studies each (fellow~~  
974 ~~must have exposure to the performance of a~~  
975 ~~minimum of 20 studies)~~

976

977 IV.A.6.a).(5).(b) ~~intra-aortic balloon counterpulsation;~~

978

979 IV.A.6.a).(5).(c) ~~percutaneous transluminal coronary angioplasty~~  
980 ~~and other interventional procedures;~~

981

982 IV.A.6.a).(5).(d) ~~programming and follow-up surveillance of ICDs~~  
983 ~~and pacemakers; and~~

984

985 IV.A.6.a).(5).(e) ~~pericardiocentesis.~~

986

987 *IV.A.6.b) Fellows must participate in training using simulation.*

988

989 IV.A.6.c) Experience with Continuity Ambulatory Patients

990

991 *Fellows must have continuity ambulatory clinic experience ~~to~~*  
992 *~~develop a continuous healing relationship with patients for whom~~*  
993 *~~they provide cardiovascular care. This continuity experience~~*  
994 *~~should that exposes fellows them to the breadth and depth of~~*  
995 *~~cardiovascular disease.~~*

996

997 IV.A.6.c).(1) This experience should average one half-day each week.

998

999 IV.A.6.c).(2) This experience must include an appropriate distribution of  
1000 patients of ~~both~~ each gender and a diversity of ages, which  
1001 ~~This should be accomplished by~~ through either:

1002

1003 IV.A.6.c).(2).(a) a continuity clinic which provides fellows the  
1004 opportunity to observe and learn the course of  
1005 disease; or,

1006

1007 IV.A.6.c).(2).(b) selected blocks of at least six months which  
1008 address specific areas of cardiovascular disease.

1009

1010 IV.A.6.c).(3) Each fellow should, on average, be responsible for four to  
1011 eight patients during each half-day session.

1012

1013	IV.A.6.c).(4)	The continuing patient care experience should not be
1014		interrupted by more than one month, excluding a fellow's
1015		vacation.
1016		
1017	IV.A.6.c).(5)	<del>It is suggested that</del> Fellows should be informed of the
1018		status of their continuity patients when <u>they such patients</u>
1019		are hospitalized, <u>as clinically appropriate</u> . <del>so the fellows</del>
1020		<del>can make appropriate arrangements to maintain continuity</del>
1021		<del>of care.</del>
1022		
1023	IV.A.6.d)	Procedures and Technical Skills
1024		
1025	IV.A.6.d).(1)	<u>Direct faculty supervision of procedures performed by each</u>
1026		<u>fellow must occur until proficiency has been acquired and</u>
1027		<u>documented by the program director.</u>
1028		
1029	IV.A.6.d).(2)	<del>A skilled preceptor</del> <u>Faculty members</u> must be available to
1030		teach and supervise the fellows in the performance <u>and</u>
1031		<u>interpretation</u> of these procedures. <del>Procedures which</del>
1032		must be documented in each fellow's record, including
1033		indications, outcomes, diagnoses, and supervisor(s).
1034		
1035	IV.A.6.d).(3)	Fellows must have formal instruction and clinical
1036		experience to the performance of the following:
1037		
1038	IV.A.6.d).(3).(a)	<del>fast computed tomography</del> <u>CT</u> ;
1039		
1040	IV.A.6.d).(3).(b)	intra-aortic balloon counterpulsation;
1041		
1042	IV.A.6.d).(3).(c)	intracardiac electrophysiologic studies; <del>(fellows</del>
1043		<del>must have exposure to the performance of a</del>
1044		<del>minimum of 20 studies)</del>
1045		
1046	IV.A.6.d).(3).(d)	<del>magnetic resonance imaging</del> <u>MRI</u> ;
1047		
1048	IV.A.6.d).(3).(e)	percutaneous transluminal coronary angioplasty
1049		and other interventional procedures; and,
1050		
1051	IV.A.6.d).(3).(f)	pericardiocentesis.
1052		
1053	IV.A.6.d).(3).(g)	<del>programming and follow-up surveillance of ICDs</del>
1054		<del>and pacemakers</del>
1055		
1056	IV.A.6.d).(3).(h)	<del>positron emission tomography</del>
1057		
1058	<b>IV.B.</b>	<b>Fellows' Scholarly Activities</b>
1059		
1060	<b>IV.B.1.</b>	<b>The curriculum must advance fellows' knowledge of the basic</b>
1061		<b>principles of research, including how research is conducted,</b>
1062		<b>evaluated, explained to patients, and applied to patient care.</b>
1063		

- 1064 **IV.B.2. Fellows should participate in scholarly activity.**  
 1065  
 1066 *IV.B.2.a The majority of fellows must demonstrate evidence of ~~recent~~*  
 1067 *~~research productivity~~ scholarship conducted during the fellowship*  
 1068 *through one or more of the following:*  
 1069  
 1070 *IV.B.2.a).(1) publication of articles, book chapters, abstracts or case*  
 1071 *reports in peer-reviewed journals;*  
 1072  
 1073 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*  
 1074 *education research;*  
 1075  
 1076 *IV.B.2.a).(3) peer-reviewed funding; or,*  
 1077  
 1078 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or*  
 1079 *national specialty meetings.*  
 1080  
 1081 **IV.B.3. The sponsoring institution and program should allocate adequate**  
 1082 **educational resources to facilitate fellow involvement in scholarly**  
 1083 **activities.**  
 1084  
 1085 **V. Evaluation**  
 1086  
 1087 **V.A. Fellow**  
 1088  
 1089 **V.A.1. Formative Evaluation**  
 1090  
 1091 **V.A.1.a) The faculty must evaluate fellow performance in a timely**  
 1092 **manner during each rotation or similar educational**  
 1093 **assignment, and document this evaluation at completion of**  
 1094 **the assignment.**  
 1095  
 1096 *V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each*  
 1097 *fellow at the completion of ~~the~~ each assignment.*  
 1098  
 1099 *V.A.1.a).(2) Assessment of procedural competence should include a*  
 1100 *formal evaluation process and not be based solely on a*  
 1101 *minimum number of procedures performed.*  
 1102  
 1103 **V.A.1.b) The program must:**  
 1104  
 1105 **V.A.1.b).(1) provide objective assessments of competence in**  
 1106 **patient care, medical knowledge, practice-based**  
 1107 **learning and improvement, interpersonal and**  
 1108 **communication skills, professionalism, and systems-**  
 1109 **based practice;**  
 1110  
 1111 *V.A.1.b).(1).(a) Patient Care*  
 1112  
 1113 *The program must assess the fellow in data*

1114		<u>gathering, clinical reasoning, patient management</u>
1115		<u>and procedures in both the inpatient and outpatient</u>
1116		<u>setting. This assessment must involve direct</u>
1117		<u>observation of fellow-patient encounters.</u>
1118		
1119	V.A. 1.b).(1).(a).(i)	<u>Each program must define a standard</u>
1120		<u>criteria for proficiency competence for all</u>
1121		<u>required and elective procedures.</u>
1122		
1123	V.A. 1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
1124		<u>fellow's logbook or an equivalent method to</u>
1125		<u>demonstrate that each fellow has achieved</u>
1126		<u>competence in the performance of required</u>
1127		<u>procedures.</u>
1128		
1129	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
1130		
1131		<u>The program must use an objective formative</u>
1132		<u>assessment method. The same formative</u>
1133		<u>assessment method must be administered at least</u>
1134		<u>twice during the program.</u>
1135		
1136	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1137		
1138		<u>The program must use performance data to assess</u>
1139		<u>the fellow in:</u>
1140		
1141	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1142		
1143	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
1144		
1145	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1146		<u>and,</u>
1147		
1148	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1149		
1150	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1151		
1152		<u>The program must use both direct observation and</u>
1153		<u>multi-source evaluation, including patients, peers</u>
1154		<u>and non-physician team members, to assess fellow</u>
1155		<u>performance in:</u>
1156		
1157	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1158		
1159	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1160		
1161	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1162		<u>transitions in care; and,</u>
1163		
1164	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>

1165		
1166	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1167		
1168		<u>The program must use multi-source evaluation,</u>
1169		<u>including patients, peers, and non-physician team</u>
1170		<u>members, to assess each fellow's:</u>
1171		
1172	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1173		
1174	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1175		
1176	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1177		<u>relationships with patients and colleagues;</u>
1178		<u>and,</u>
1179		
1180	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1181		
1182	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1183		
1184		<u>The program must use multi-source evaluation,</u>
1185		<u>including peers, and non-physician team members</u>
1186		<u>to assess each fellow's:</u>
1187		
1188	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1189		<u>including transition of care;</u>
1190		
1191	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1192		
1193	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1194		
1195	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1196		<u>participate in improvement activities.</u>
1197		
1198	<b>V.A.1.b).(2)</b>	<b>use multiple evaluators (e.g., faculty, peers, patients,</b>
1199		<b>self, and other professional staff);</b>
1200		
1201	<b>V.A.1.b).(3)</b>	<b>document progressive fellow performance</b>
1202		<b>improvement appropriate to educational level; and</b>
1203		
1204	<b>V.A.1.b).(4)</b>	<b>provide each fellow with documented semiannual</b>
1205		<b>evaluation of performance with feedback.</b>
1206		
1207	V.A.1.b).(4).(a)	<i>Fellows' performance in continuity clinic must be</i>
1208		<i>reviewed with them verbally and in writing at least</i>
1209		<i>semiannually.</i>
1210		
1211	<b>V.A.1.c)</b>	<b>The evaluations of fellow performance must be accessible for</b>
1212		<b>review by the fellow, in accordance with institutional policy.</b>
1213		
1214	<b>V.A.2.</b>	<b>Summative Evaluation</b>
1215		

1216 The program director must provide a summative evaluation for each  
1217 fellow upon completion of the program. This evaluation must  
1218 become part of the fellow's permanent record maintained by the  
1219 institution, and must be accessible for review by the fellow in  
1220 accordance with institutional policy. This evaluation must:

1221  
1222 V.A.2.a) document the fellow's performance during the final period of  
1223 education; and

1224  
1225 V.A.2.b) verify that the fellow has demonstrated sufficient competence  
1226 to enter practice without direct supervision.

1227  
1228 V.B. Faculty Evaluation

1229  
1230 V.B.1. At least annually, the program must evaluate faculty performance as  
1231 it relates to the educational program.

1232  
1233 V.B.2. These evaluations should include a review of faculty's clinical  
1234 teaching abilities, commitment to the educational program, clinical  
1235 knowledge, professionalism, and scholarly activities.

1236  
1237 V.B.3. This evaluation must include at least annual written confidential  
1238 evaluations by fellows.

1239  
1240 V.B.3.a) *In addition, Fellows must have the opportunity to provide  
1241 confidential written evaluations of each supervising faculty  
1242 member at the end of a each rotation.*

1243  
1244 V.B.3.b) *The program director must be reviewed. These evaluations must  
1245 be reviewed with each ~~attending~~ faculty member annually.*

1246  
1247 V.C. Program Evaluation and Improvement

1248  
1249 V.C.1. The program must document formal, systematic evaluation of the  
1250 curriculum at least annually. The program must monitor and track  
1251 each of the following areas:

1252  
1253 V.C.1.a) fellow performance;

1254  
1255 V.C.1.b) faculty development;

1256  
1257 V.C.1.c) graduate performance, including performance of program  
1258 graduates on the certification examination; and,

1259  
1260 V.C.1.c).(1) *At least 80% of program's graduating fellows from those  
1261 eligible to take an ABIM subspecialty certifying  
1262 examination upon completion of their training for the most  
1263 recently defined five year period who are eligible should  
1264 must have taken an the ABIM subspecialty certifying  
1265 examination. (Note: Five-year rolling pass rate for first time*

1266		<del>takers of the ABIM certifying examination will be examined</del>
1267		<del>at each program review).</del>
1268		
1269	V.C.1.c).(2)	<u>At least 80% of a program's graduates taking the ABIM</u>
1270		<u>certifying examination for the first time during the most</u>
1271		<u>recently defined five year period should pass.</u>
1272		
1273	V.C.1.d)	<b>program quality. Specifically:</b>
1274		
1275	V.C.1.d).(1)	<b>Fellows and faculty must have the opportunity to</b>
1276		<b>evaluate the program confidentially and in writing at</b>
1277		<b>least annually.</b>
1278		
1279	V.C.1.d).(2)	<b>The program must use the results of fellows'</b>
1280		<b>assessments of the program together with other</b>
1281		<b>program evaluation results to improve the program.</b>
1282		
1283	V.C.1.d).(3)	<u>At least 80% of the entering fellows should have</u>
1284		<u>completed the program when averaged over a five-year</u>
1285		<u>period.</u>
1286		
1287	V.C.2.	<b>If deficiencies are found, the program should prepare a written plan</b>
1288		<b>of action to document initiatives to improve performance in the</b>
1289		<b>areas listed in section V.C.1. The action plan should be reviewed</b>
1290		<b>and approved by the teaching faculty and documented in meeting</b>
1291		<b>minutes.</b>
1292		
1293	V.C.3.	<u>Representative program personnel, at a minimum to include the program</u>
1294		<u>director, representative faculty, and one fellow, must review program</u>
1295		<u>goals and objectives, and the effectiveness with which they are achieved.</u>
1296		
1297	VI.	<b>Fellow Duty Hours in the Learning and Working Environment</b>
1298		
1299	VI.A.	<b>Professionalism, Personal Responsibility, and Patient Safety</b>
1300		
1301	VI.A.1.	<b>Programs and sponsoring institutions must educate fellows and</b>
1302		<b>faculty members concerning the professional responsibilities of</b>
1303		<b>physicians to appear for duty appropriately rested and fit to provide</b>
1304		<b>the services required by their patients.</b>
1305		
1306	VI.A.2.	<b>The program must be committed to and responsible for promoting</b>
1307		<b>patient safety and fellow well-being in a supportive educational</b>
1308		<b>environment.</b>
1309		
1310	VI.A.3.	<b>The program director must ensure that fellows are integrated and</b>
1311		<b>actively participate in interdisciplinary clinical quality improvement</b>
1312		<b>and patient safety programs.</b>
1313		
1314	VI.A.4.	<b>The learning objectives of the program must:</b>
1315		

- 1316 VI.A.4.a) be accomplished through an appropriate blend of supervised  
 1317 patient care responsibilities, clinical teaching, and didactic  
 1318 educational events; and,  
 1319
- 1320 VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill  
 1321 non-physician service obligations.  
 1322
- 1323 *VI.A.4.b).(1) ~~Fellows' service responsibilities must be limited to patients~~*  
 1324 *~~for whom the teaching service has diagnostic and~~*  
 1325 *~~therapeutic responsibility.~~*  
 1326
- 1327 VI.A.5. The program director and institution must ensure a culture of  
 1328 professionalism that supports patient safety and personal  
 1329 responsibility. Fellows and faculty members must demonstrate an  
 1330 understanding and acceptance of their personal role in the  
 1331 following:  
 1332
- 1333 VI.A.5.a) assurance of the safety and welfare of patients entrusted to  
 1334 their care;  
 1335
- 1336 VI.A.5.b) provision of patient- and family-centered care;  
 1337
- 1338 VI.A.5.c) assurance of their fitness for duty;  
 1339
- 1340 VI.A.5.d) management of their time before, during, and after clinical  
 1341 assignments;  
 1342
- 1343 VI.A.5.e) recognition of impairment, including illness and fatigue, in  
 1344 themselves and in their peers;  
 1345
- 1346 VI.A.5.f) attention to lifelong learning;  
 1347
- 1348 VI.A.5.g) the monitoring of their patient care performance improvement  
 1349 indicators; and,  
 1350
- 1351 VI.A.5.h) honest and accurate reporting of duty hours, patient  
 1352 outcomes, and clinical experience data.  
 1353
- 1354 VI.A.6. All fellows and faculty members must demonstrate responsiveness  
 1355 to patient needs that supersedes self-interest. Physicians must  
 1356 recognize that under certain circumstances, the best interests of the  
 1357 patient may be served by transitioning that patient's care to another  
 1358 qualified and rested provider.  
 1359
- 1360 VI.B. Transitions of Care  
 1361
- 1362 VI.B.1. Programs must design clinical assignments to minimize the number  
 1363 of transitions in patient care.  
 1364
- 1365 VI.B.2. Sponsoring institutions and programs must ensure and monitor

- 1366 effective, structured hand-over processes to facilitate both  
 1367 continuity of care and patient safety.  
 1368
- 1369 **VI.B.3.** Programs must ensure that fellows are competent in communicating  
 1370 with team members in the hand-over process.  
 1371
- 1372 **VI.B.4.** The sponsoring institution must ensure the availability of schedules  
 1373 that inform all members of the health care team of attending  
 1374 physicians and fellows currently responsible for each patient's care.  
 1375
- 1376 **VI.C.** Alertness Management/Fatigue Mitigation  
 1377
- 1378 **VI.C.1.** The program must:  
 1379
- 1380 **VI.C.1.a)** educate all faculty members and fellows to recognize the  
 1381 signs of fatigue and sleep deprivation;  
 1382
- 1383 **VI.C.1.b)** educate all faculty members and fellows in alertness  
 1384 management and fatigue mitigation processes; and,  
 1385
- 1386 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential  
 1387 negative effects of fatigue on patient care and learning, such  
 1388 as naps or back-up call schedules.  
 1389
- 1390 **VI.C.2.** Each program must have a process to ensure continuity of patient  
 1391 care in the event that a fellow may be unable to perform his/her  
 1392 patient care duties.  
 1393
- 1394 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities  
 1395 and/or safe transportation options for fellows who may be too  
 1396 fatigued to safely return home.  
 1397
- 1398 **VI.D.** Supervision of Fellows  
 1399
- 1400 **VI.D.1.** In the clinical learning environment, each patient must have an  
 1401 identifiable, appropriately-credentialed and privileged attending  
 1402 physician (or licensed independent practitioner as approved by each  
 1403 Review Committee) who is ultimately responsible for that patient's  
 1404 care.  
 1405
- 1406 **VI.D.1.a)** This information should be available to fellows, faculty  
 1407 members, and patients.  
 1408
- 1409 **VI.D.1.b)** Fellows and faculty members should inform patients of their  
 1410 respective roles in each patient's care.  
 1411
- 1412 **VI.D.2.** The program must demonstrate that the appropriate level of  
 1413 supervision is in place for all fellows who care for patients.  
 1414  
 1415 Supervision may be exercised through a variety of methods. Some

1416 activities require the physical presence of the supervising faculty  
1417 member. For many aspects of patient care, the supervising  
1418 physician may be a more advanced resident or fellow. Other  
1419 portions of care provided by the fellow can be adequately  
1420 supervised by the immediate availability of the supervising faculty  
1421 member or resident physician, either in the institution, or by means  
1422 of telephonic and/or electronic modalities. In some circumstances,  
1423 supervision may include post-hoc review of fellow-delivered care  
1424 with feedback as to the appropriateness of that care.

1425  
1426 **VI.D.3. Levels of Supervision**

1427  
1428 To ensure oversight of fellow supervision and graded authority and  
1429 responsibility, the program must use the following classification of  
1430 supervision:

1431  
1432 **VI.D.3.a) Direct Supervision – the supervising physician is physically**  
1433 **present with the fellow and patient.**

1434  
1435 **VI.D.3.b) Indirect Supervision:**

1436  
1437 **VI.D.3.b).(1) with direct supervision immediately available – the**  
1438 **supervising physician is physically within the hospital**  
1439 **or other site of patient care, and is immediately**  
1440 **available to provide Direct Supervision.**

1441  
1442 **VI.D.3.b).(2) with direct supervision available – the supervising**  
1443 **physician is not physically present within the hospital**  
1444 **or other site of patient care, but is immediately**  
1445 **available by means of telephonic and/or electronic**  
1446 **modalities, and is available to provide Direct**  
1447 **Supervision.**

1448  
1449 **VI.D.3.c) Oversight – the supervising physician is available to provide**  
1450 **review of procedures/encounters with feedback provided**  
1451 **after care is delivered.**

1452  
1453 **VI.D.4. The privilege of progressive authority and responsibility, conditional**  
1454 **independence, and a supervisory role in patient care delegated to**  
1455 **each fellow must be assigned by the program director and faculty**  
1456 **members.**

1457  
1458 **VI.D.4.a) The program director must evaluate each fellow’s abilities**  
1459 **based on specific criteria. When available, evaluation should**  
1460 **be guided by specific national standards-based criteria.**

1461  
1462 **VI.D.4.b) Faculty members functioning as supervising physicians**  
1463 **should delegate portions of care to fellows, based on the**  
1464 **needs of the patient and the skills of the fellows.**

1465

1466 **VI.D.4.c)** Senior residents or fellows should serve in a supervisory role  
1467 of junior residents in recognition of their progress toward  
1468 independence, based on the needs of each patient and the  
1469 skills of the individual resident or fellow.  
1470

1471 **VI.D.5.** Programs must set guidelines for circumstances and events in  
1472 which fellows must communicate with appropriate supervising  
1473 faculty members, such as the transfer of a patient to an intensive  
1474 care unit, or end-of-life decisions.  
1475

1476 **VI.D.5.a)** Each fellow must know the limits of his/her scope of  
1477 authority, and the circumstances under which he/she is  
1478 permitted to act with conditional independence.  
1479

1480 **VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised  
1481 either directly or indirectly with direct supervision  
1482 immediately available.  
1483

1484 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to  
1485 assess the knowledge and skills of each fellow and delegate to  
1486 him/her the appropriate level of patient care authority and  
1487 responsibility.  
1488

1489 **VI.E. Clinical Responsibilities**  
1490  
1491 The clinical responsibilities for each fellow must be based on PGY-level,  
1492 patient safety, fellow education, severity and complexity of patient  
1493 illness/condition and available support services.  
1494

1495 **VI.F. Teamwork**  
1496  
1497 Fellows must care for patients in an environment that maximizes effective  
1498 communication. This must include the opportunity to work as a member of  
1499 effective interprofessional teams that are appropriate to the delivery of care  
1500 in the specialty.  
1501

1502 **VI.G. Fellow Duty Hours**  
1503

1504 **VI.G.1. Maximum Hours of Work per Week**  
1505  
1506 Duty hours must be limited to 80 hours per week, averaged over a  
1507 four-week period, inclusive of all in-house call activities and all  
1508 moonlighting.  
1509

1510 **VI.G.1.a) Duty Hour Exceptions**  
1511  
1512 A Review Committee may grant exceptions for up to 10% or a  
1513 maximum of 88 hours to individual programs based on a  
1514 sound educational rationale.  
1515

1516		<i>The Review Committee for Internal Medicine will not consider</i>
1517		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1518		<i>week.</i>
1519		
1520	<b>VI.G.1.a).(1)</b>	<b>In preparing a request for an exception the program</b>
1521		<b>director must follow the duty hour exception policy</b>
1522		<b>from the ACGME Manual on Policies and Procedures.</b>
1523		
1524	<b>VI.G.1.a).(2)</b>	<b>Prior to submitting the request to the Review</b>
1525		<b>Committee, the program director must obtain approval</b>
1526		<b>of the institution's GMEC and DIO.</b>
1527		
1528	<b>VI.G.2.</b>	<b>Moonlighting</b>
1529		
1530	<b>VI.G.2.a)</b>	<b>Moonlighting must not interfere with the ability of the fellow</b>
1531		<b>to achieve the goals and objectives of the educational</b>
1532		<b>program.</b>
1533		
1534	<b>VI.G.2.b)</b>	<b>Time spent by fellows in Internal and External Moonlighting</b>
1535		<b>(as defined in the ACGME Glossary of Terms) must be</b>
1536		<b>counted towards the 80-hour Maximum Weekly Hour Limit.</b>
1537		
1538	<b>VI.G.2.c)</b>	<b>PGY-1 residents are not permitted to moonlight.</b>
1539		
1540	<b>VI.G.3.</b>	<b>Mandatory Time Free of Duty</b>
1541		
1542		<b>Fellows must be scheduled for a minimum of one day free of duty</b>
1543		<b>every week (when averaged over four weeks). At-home call cannot</b>
1544		<b>be assigned on these free days.</b>
1545		
1546	<b>VI.G.4.</b>	<b>Maximum Duty Period Length</b>
1547		
1548	<b>VI.G.4.a)</b>	<b>Duty periods of PGY-1 residents must not exceed 16 hours in</b>
1549		<b>duration.</b>
1550		
1551	<b>VI.G.4.b)</b>	<b>Duty periods of PGY-2 residents and above may be</b>
1552		<b>scheduled to a maximum of 24 hours of continuous duty in</b>
1553		<b>the hospital. Programs must encourage fellows to use</b>
1554		<b>alertness management strategies in the context of patient</b>
1555		<b>care responsibilities. Strategic napping, especially after 16</b>
1556		<b>hours of continuous duty and between the hours of 10:00</b>
1557		<b>p.m. and 8:00 a.m., is strongly suggested.</b>
1558		
1559	<b>VI.G.4.b).(1)</b>	<b>It is essential for patient safety and fellow education</b>
1560		<b>that effective transitions in care occur. Fellows may be</b>
1561		<b>allowed to remain on-site in order to accomplish these</b>
1562		<b>tasks; however, this period of time must be no longer</b>
1563		<b>than an additional four hours.</b>
1564		
1565	<b>VI.G.4.b).(2)</b>	<b>Fellows must not be assigned additional clinical</b>

1566 responsibilities after 24 hours of continuous in-house  
1567 duty.

1568  
1569 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own  
1570 initiative, may remain beyond their scheduled period  
1571 of duty to continue to provide care to a single patient.  
1572 Justifications for such extensions of duty are limited  
1573 to reasons of required continuity for a severely ill or  
1574 unstable patient, academic importance of the events  
1575 transpiring, or humanistic attention to the needs of a  
1576 patient or family.

1577  
1578 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:

1579  
1580 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all  
1581 other patients to the team responsible  
1582 for their continuing care; and,

1583  
1584 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to  
1585 care for the patient in question and  
1586 submit that documentation in every  
1587 circumstance to the program director.

1588  
1589 **VI.G.4.b).(3).(b)** The program director must review each  
1590 submission of additional service, and track  
1591 both individual fellow and program-wide  
1592 episodes of additional duty.

1593  
1594 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**

1595  
1596 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight  
1597 hours, free of duty between scheduled duty periods.

1598  
1599 **VI.G.5.b)** Intermediate-level residents should have 10 hours free of  
1600 duty, and must have eight hours between scheduled duty  
1601 periods. They must have at least 14 hours free of duty after 24  
1602 hours of in-house duty.

1603  
1604 Internal medicine subspecialty fellows are considered to be in the  
1605 final years of education.

1606  
1607 **VI.G.5.c)** Residents in the final years of education must be prepared to  
1608 enter the unsupervised practice of medicine and care for  
1609 patients over irregular or extended periods.

1610  
1611 Internal medicine subspecialty fellows are considered to be in the  
1612 final years of education.

1613  
1614 **VI.G.5.c).(1)** This preparation must occur within the context of the  
1615 80-hour, maximum duty period length, and one-day-

1616 off-in-seven standards. While it is desirable that  
1617 fellows in their final years of education have eight  
1618 hours free of duty between scheduled duty periods,  
1619 there may be circumstances when these fellows must  
1620 stay on duty to care for their patients or return to the  
1621 hospital with fewer than eight hours free of duty.

1622  
1623 **VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities  
1624 with fewer than eight hours away from the  
1625 hospital by fellows in their final years of  
1626 education must be monitored by the program  
1627 director.

1628  
1629 *VI.G.5.c).(1).(b)* In unusual circumstances, fellows may remain  
1630 beyond their scheduled period of duty or return  
1631 after their scheduled period of duty to provide care  
1632 to a single patient. Justifications for such  
1633 extensions of duty are limited to reasons of  
1634 required continuity of care for a severely ill or  
1635 unstable patient, academic importance of the  
1636 events transpiring, or humanistic attention to the  
1637 needs of the patient or family. Such episodes  
1638 should be rare, must be of the fellows' own  
1639 initiative, and need not initiate a new 'off-duty  
1640 period' nor require a change in the scheduled 'off-  
1641 duty period.'

1642  
1643 *VI.G.5.c).(1).(c)* Under such circumstances, the fellow must  
1644 appropriately hand over care of all other patients to  
1645 the team responsible for their continuing care, and  
1646 document the reasons for remaining or returning to  
1647 care for the patient in question and submit that  
1648 documentation to the program director.

1649  
1650 *VI.G.5.c).(1).(d)* The program director must review each submission  
1651 of additional service and track both individual  
1652 fellows' and program-wide episodes of additional  
1653 duty.

1654  
1655 **VI.G.6. Maximum Frequency of In-House Night Float**

1656  
1657 **Fellows must not be scheduled for more than six consecutive nights**  
1658 **of night float.**

1659  
1660 **VI.G.7. Maximum In-House On-Call Frequency**

1661  
1662 **PGY-2 residents and above must be scheduled for in-house call no**  
1663 **more frequently than every-third-night (when averaged over a four-**  
1664 **week period).**

1665

1666 VI.G.7.a) *Internal Medicine ~~residency programs are~~ fellowships must not*  
1667 *allowed to average in-house call over a four-week period.*

1668  
1669 **VI.G.8. At-Home Call**

1670  
1671 **VI.G.8.a)** **Time spent in the hospital by fellows on at-home call must**  
1672 **count towards the 80-hour maximum weekly hour limit. The**  
1673 **frequency of at-home call is not subject to the every-third-**  
1674 **night limitation, but must satisfy the requirement for one-day-**  
1675 **in-seven free of duty, when averaged over four weeks.**

1676  
1677 **VI.G.8.a).(1)** **At-home call must not be so frequent or taxing as to**  
1678 **preclude rest or reasonable personal time for each**  
1679 **fellow.**

1680  
1681 **VI.G.8.b)** **Fellows are permitted to return to the hospital while on at-**  
1682 **home call to care for new or established patients. Each**  
1683 **episode of this type of care, while it must be included in the**  
1684 **80-hour weekly maximum, will not initiate a new “off-duty**  
1685 **period”.**

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1687 **VII. Innovative Projects**

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1689 **Requests for innovative projects that may deviate from the institutional, common**  
1690 **and/or specialty specific program requirements must be approved in advance by**  
1691 **the Review Committee. In preparing requests, the program director must follow**  
1692 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**  
1693 **Manual on Policies and Procedures. Once a Review Committee approves a**  
1694 **project, the sponsoring institution and program are jointly responsible for the**  
1695 **quality of education offered to fellows for the duration of such a project.**

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1699 ACGME Approved: February 5, 2011      Effective: July 1, 2012