

# ACGME Program Requirements for Graduate Medical Education in Geriatric Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2007

## Introduction

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

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

Int.B. Definition and Scope of the Specialty

Int.B.1. Subspecialty training in internal medicine is a voluntary component in the continuum of the educational process; such training should take place after satisfactory completion of an accredited program in internal medicine.

Int.B.2. To be eligible for accreditation, a program must function as an integral part of an accredited residency program in internal medicine.

Int.B.3. There must be a reporting relationship, to ensure compliance with Accreditation Council for Graduate Medical Education (ACGME) accreditation standards, from the program director of the subspecialty program to the program director of the parent internal medicine residency program.

Int.B.4. The discipline must be one for which a certificate or a certificate of added

qualifications is offered by the American Board of Internal Medicine (ABIM). (For editorial purposes, the term subspecialty is used throughout the document for both types of training programs.)

- Int.B.5. Subspecialty programs must provide advanced training to allow the fellow to acquire competency in the subspecialty with sufficient expertise to act as a consultant.
- Int.B.1. An educational program in geriatric medicine must be organized to provide a well-supervised experience at a level sufficient for the fellow to acquire the competence of a physician with added qualifications in the field.
- Int.B.2. The training program must be 12 months in duration, all of which must include clinical experience.

## **I. Institutions**

### **I.A. Sponsoring Institution**

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

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

- I.A.1. The sponsoring institution must:
  - I.A.1.a) demonstrate a commitment to education and research sufficient to support the fellowship program;
  - I.A.1.b) establish the internal medicine subspecialty fellowship within a department of internal medicine or an administrative unit whose primary mission is the advancement of internal medicine education and patient care;
  - I.A.1.c) provide fellow compensation and benefits, faculty, facilities, and resources for education, clinical care, and research required for accreditation;
  - I.A.1.d) ensure that adequate salary support is provided to the program director for the administrative activities of the internal medicine subspecialty program. The program director must not be required to generate clinical or other income to provide this administrative support. It is suggested that this support be 25-50% of the program director's salary, depending on the size of the program; and,
  - I.A.1.e) notify the Review Committee within 60 days of changes in

institutional governance, affiliation, or resources that affect the educational program.

- I.A.2. A sponsoring institution must not place excessive reliance on fellows to meet the service needs of the participating sites.
- I.A.3. Graduate education in the subspecialties of internal medicine requires a major commitment to education by the sponsoring institution. Evidence of such a commitment includes each of the following:
  - I.A.3.a) the minimum number of fellowship positions supported by the institution in each training program must not be less than the number of accredited training years in the program; and,
  - I.A.3.b) the institution must ensure significant research in each subspecialty for which it sponsors a training program.

## **I.B. Participating Sites**

Participating sites include both the primary clinical site and other training sites. The primary clinical site is defined as the health care facility that provides the required training resources, should be the location of the program director's major activity, the location where the fellows spend the majority of their clinical training time, and the primary location of the core program in internal medicine.

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

**The PLA should:**

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
- I.B.1.c) specify the duration and content of the educational experience; and,**
- I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.**

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

- I.B.3. The Review Committee must give prior approval for participation by any

site providing three months or more of education in a 12- or 24-month program, or six months or more of training in a 36-month program.

- I.B.4. Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved by the Review Committee.

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

### **II.A. Program Director**

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

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

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

- II.A.2.b) current certification in the subspecialty by the American Board of Internal Medicine, or specialty qualifications acceptable to the Review Committee;**

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

- II.A.2.d) at least five years of participation as an active faculty member in an ACGME-accredited internal medicine subspecialty fellowship program; and,**

- II.A.2.e) demonstrated experience in geriatric medicine, in education and scholarly activity, and a career commitment to academic geriatric medicine.**

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

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

- II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the**

**ACGME Manual of Policies and Procedures;**

- II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
- II.A.3.c).(1) all applications for ACGME accreditation of new programs;**
  - II.A.3.c).(2) changes in fellow complement;**
  - II.A.3.c).(3) major changes in program structure or length of training;**
  - II.A.3.c).(4) progress reports requested by the Review Committee;**
  - II.A.3.c).(5) responses to all proposed adverse actions;**
  - II.A.3.c).(6) requests for increases or any change to fellow duty hours;**
  - II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;**
  - II.A.3.c).(8) requests for appeal of an adverse action; and,**
  - II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.**
- II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- II.A.3.d).(1) program citations, and/or**
  - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.3.e) seek the prior approval of the Review Committee for any changes in the program that may significantly alter the educational experience of the fellows;**
- II.A.3.f) be responsible for monitoring fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows. Situations that demand excessive service or that consistently produce undesirable stress on fellows must be evaluated and modified;**

- II.A.3.g) dedicate an average of 20 hours per week of his or her professional effort to the internal medicine subspecialty educational program, with sufficient time for administration of the program, and receive institutional support for that administrative time;
- II.A.3.h) participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills;
- II.A.3.i) implement a program of continuous quality improvement in medical education for the faculty, especially as it pertains to the teaching and evaluation of the ACGME Competencies (as outlined in Section IV of this document); and,
- II.A.3.j) be located at the primary clinical site.

**II.B. Faculty**

- II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
- II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**
- II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Internal Medicine, or possess qualifications acceptable to the Review Committee.**
- II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.5. Physician faculty members must meet professional standards of ethical behavior.
- II.B.6. The majority of faculty members must be involved one or more of the following:
  - II.B.6.a) peer-reviewed funding;
  - II.B.6.b) publication of original research or review articles in peer-reviewed journals or chapters in textbooks; or,
  - II.B.6.c) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings.
- II.B.7. The majority of key clinical faculty members must demonstrate evidence of productivity in scholarship through:

- II.B.7.a) peer-reviewed funding; or
- II.B.7.b) publication of original research or review articles in peer-reviewed journals or chapters in textbooks.
- II.B.8. At least one faculty member must be active in scholarship through peer-reviewed funding.
- II.B.9. In addition to the program director, each program must have at least one additional key clinical faculty member with similar qualifications who devote(s) a substantial portion of professional time to the training program.
- II.B.10. The program must ensure that interdisciplinary relationships occur between the fellows and faculty members in physical medicine and rehabilitation, neurology, and psychiatry.
- II.B.11. Appropriate relationships should be maintained between the fellows and faculty members in general surgery, orthopaedic surgery, ophthalmology, otolaryngology, podiatry, urology, gynecology, emergency medicine, dentistry, pharmacy, audiology, physical and occupational therapy, speech therapy, and nursing and social services.

**II.C. Other Program Personnel**

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

- II.C.1. Key Clinical Faculty
  - In addition to the program director, each program must have at least one key clinical faculty (KCF) member. KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the training program. For programs with more than two fellows enrolled during the accredited portion of the training program, a ratio of KCF to fellows of at least 1:1.5 must be maintained.
- II.C.1.a) Qualifications
  - The KCF must:
    - II.C.1.a).(1) be active clinicians with broad knowledge of, experience with, and commitment to the internal medicine subspecialty as a discipline, and,
    - II.C.1.a).(2) have current certification in the subspecialty by the American Board of Internal Medicine or possess qualifications judged by the Review Committee to be acceptable.

- II.C.1.b) In addition to the responsibilities of all individual faculty members, the KCF and the program director are responsible for the planning, implementation, monitoring, and evaluation of the fellows' clinical and research training.
- II.C.2. All clinical faculty members should participate in prescribed faculty development programs designed to enhance the effectiveness of their teaching.
- II.C.3. Additionally, a team or collaborative care of geriatric patients with physician assistants or with nurse practitioners is recommended.

## **II.D. Resources**

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

- II.D.1. Fellows must have clinical experiences in efficient, effective ambulatory and inpatient care settings.
- II.D.1.a) Space and Equipment
- There must be space and equipment for the educational program, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and work/study space.
- II.D.1.b) Facilities
- II.D.1.b).(1) Fellows must have lounge and food facilities during assigned duty hours.
- II.D.1.b).(2) When fellows are assigned night duty in the hospital or are called in from home, they must be provided with on-call facilities that are convenient and that afford privacy, safety, and a restful environment with a secure space for their belongings.
- II.D.1.c) Acute-Care Hospital
- The acute-care hospital central to the geriatric medicine program must be an integral component of a teaching center. It must have the full range of services usually ascribed to an acute-care general hospital, including intensive care units, emergency medicine, operating rooms, diagnostic laboratory and imaging services, and a pathology department.
- II.D.1.d) Long-term Care Institution

- II.D.1.d).(1) One or more long-term care institutions, such as a skilled nursing facility or chronic care hospital, must be affiliated with the geriatric medicine program.
- II.D.1.d).(2) There must be a formal affiliation agreement between each long-term care facility included in the program and the sponsoring institution, in which each institution must acknowledge its responsibility to provide high-quality care, adequate resources, and administrative support for the educational mission.
- II.D.1.d).(3) There must be a letter of agreement between each long-term care facility and the office of the program director of the geriatric medicine program that guarantees the program director appropriate authority at the long-term care institution to carry out the training program.
- II.D.1.d).(4) Fellows must have exposure to sub-acute care and rehabilitation in the long-term care setting.
- II.D.1.d).(5) The total number of beds available must be sufficient to permit a comprehensive educational experience.
- II.D.1.d).(6) The long-term care institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each must be consistent with those promulgated by the Joint Commission on Accreditation of Healthcare Organizations.
- II.D.1.e) Long-term Non-institutional Care
- II.D.1.e).(1) Non-institutional care service, for example, home care, day care, residential care, or assisted living, must be included in the geriatric medicine program to permit fellows to learn to provide care for patients who are homebound but not institutionalized.
- II.D.1.e).(2) It is recommended that the program provide opportunities for experience in day care or day-hospital centers, life care communities, and residential care facilities.
- II.D.1.f) Geriatric Care Team
- The fellow must have experience with physician-directed interdisciplinary geriatric teams.
- II.D.1.f).(1) Essential members include a geriatrician, a nurse, and a social worker/case manager.
- II.D.1.f).(2) Additional members may be included in the team as appropriate, including representatives from disciplines

such as neurology, psychiatry, physical medicine and rehabilitation, physical therapy, occupational therapy and speech therapy, dentistry, pharmacy, psychology, and pastoral care.

II.D.1.f).(3) Regular team conferences must be held as dictated by the needs of the individual patient.

II.D.1.f).(4) Fellows must have interdisciplinary geriatric team experience in more than one setting, which may include:

II.D.1.f).(4).(a) an acute care hospital;

II.D.1.f).(4).(b) a nursing home that includes sub-acute and long-term care;

II.D.1.f).(4).(c) a home care setting; or,

II.D.1.f).(4).(d) a family medicine center, internal medicine center, or other outpatient settings.

II.D.1.g) Other Facilities, Resources, or Support Services

II.D.1.g).(1) Peer interaction is essential for fellows. An accredited training program in at least one relevant specialty other than internal medicine or family medicine must be present at the primary clinical site.

II.D.1.g).(2) Involvement in other health care and community agencies is suggested.

II.D.1.g).(3) Fellows must not be required to provide routine intravenous, phlebotomy, or messenger/transporter services.

II.D.1.g).(4) Fellows' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility

II.D.1.g).(5) The admission and continuing care of patients by fellows must be limited to those patients on the teaching service.

II.D.2. Medical Records

Clinical records that document both inpatient and ambulatory care must be readily available at all times. (See Institutional Requirements, Section II.D.3.d.)

II.D.3. Patient Population

- II.D.3.a) The program must provide a patient population adequate to meet the needs of the training program in the facilities in which the educational experiences take place.
- II.D.3.b) A sufficient number of patients must be available to ensure adequate inpatient and ambulatory experience for each subspecialty fellow.
- II.D.3.c) Elderly patients of both sexes (at least 25% of each gender, cumulative across settings) with a variety of chronic illnesses, at least some of whom have potential for rehabilitation, must be available.
- II.D.3.d) At all facilities used by the program, fellows must be given opportunities to assume meaningful patient responsibility.

#### II.D.4. Death Reviews and Autopsies

- II.D.4.a) All deaths of patients who received care by fellows must be reviewed and autopsies must be performed whenever possible.
- II.D.4.b) Fellows must receive autopsy reports after autopsies are completed on their patients.

#### II.D.5. Support Services

- II.D.5.a) Administrative support must include adequate secretarial and administrative staff and technology to support the program director.
- II.D.5.b) Inpatient clinical support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services, and laboratory and radiologic information retrieval systems that allow prompt access to results.
- II.D.5.c) Consultations from other clinical services in the hospital must be available in a timely manner. All consultations should be performed by or under the supervision of a qualified specialist.

### II.E. Medical Information Access

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

## III. Fellow Appointments

### III.A. Eligibility Criteria

**Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.**

**III.B. Number of Fellows**

**The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.**

III.C. Fellows must have clearly defined written lines of responsibility for all clinical experiences.

III.D. When averaged over any five-year period, a minimum of 75% of fellows in each program must be graduates of ACGME-accredited internal medicine programs. Non-ACGME internal medicine-trained fellows must have at least three years of internal medicine training prior to starting the fellowship. Prior to appointment, the program director must inform non-ACGME-trained applicants in writing of the ABIM policies and procedures that may affect a fellow's eligibility for ABIM certification. (N.B.: Fellows in the subspecialty of geriatric medicine may be graduates of an ACGME-accredited family medicine training program.)

**IV. Educational Program**

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

**IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;**

IV.A.1.a) All major dimensions of the curriculum must be structured educational experiences for which written goals and objectives, a specific methodology for teaching, and a method of evaluation exist.

IV.A.1.b) A written curriculum that comprehensively describes the program, including sites, educational objectives for each component, and topics to be covered in didactic sessions, must be available to fellows and faculty members.

IV.A.1.c) The curriculum must ensure the opportunity for fellows to achieve the cognitive knowledge, physical examination skills, interpersonal skills, professional attitudes, and practical experience required of a physician who specializes in the care of the aged.

IV.A.1.d) The curriculum should be reviewed and revised at least every three years by faculty members and fellows to keep the goals and

objectives current and relevant.

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

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

##### **IV.A.2.a) Patient Care**

**Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:**

IV.A.2.a).(1) are expected to learn the practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness.

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

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

IV.A.2.b).(1) are expected to learn the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

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

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

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

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

##### **IV.A.2.d) Interpersonal and Communication Skills**

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

##### **IV.A.2.e) Professionalism**

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

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

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

**IV.B. Fellows' Scholarly Activities**

Participation in an active research program is an essential component for fellows enrolled in subspecialty fellowship training programs of 12 months or greater duration.

IV.B.1. The program must ensure a meaningful, supervised research experience with appropriate protected time for each fellow—either in blocks or concurrent with clinical rotations—while maintaining the essential clinical experience.

IV.B.2. Fellows must be advised and supervised by qualified faculty members in the conduct of research.

IV.B.3. Fellows must learn the standards of ethical conduct of research, design and interpretation of research studies, responsible use of informed consent, research methodology, and interpretation of data.

IV.B.4. The majority of fellows must demonstrate evidence of recent research productivity through:

IV.B.4.a) publication (manuscripts or abstracts) in peer-reviewed journals, or,

IV.B.4.b) abstracts presented at national specialty meetings.

(N.B.: Training programs in one-year critical care medicine and internal medicine-geriatric medicine are exempt from this requirement relative to research productivity by fellows.)

**IV.C. Didactics**

**IV.C.1. Inpatient and Consultation Teaching**

IV.C.1.a) Teaching and management rounds are usually combined in subspecialty training programs. These rounds must be patient-based sessions in which current cases are presented as a basis for discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management of

the patient, the appropriate use of technology, the incorporation of evidence and patient values in clinical decision making, and disease prevention.

- IV.C.1.b) The total teaching time spent in combined management and teaching rounds must exceed by a minimum of five hours per week the time required to supervise the care of patients.
- IV.C.1.c) As the fellows progress through their training, they should have the opportunity to teach other health professionals and trainees, such as nurses, allied health personnel, medical students, and residents.
- IV.C.2. Conferences and Seminars
  - IV.C.2.a) Conferences must be conducted regularly as scheduled and must be attended by faculty and fellows. At a minimum, these must include:
    - IV.C.2.a).(1) at least one clinical conference weekly;
    - IV.C.2.a).(2) one literature review conference (journal club) monthly;
    - IV.C.2.a).(3) one research conference monthly; and,
    - IV.C.2.a).(4) at least one core curriculum conference weekly, when averaged over one year.
      - IV.C.2.a).(4).(a) The core curriculum conference series must include the basic sciences relevant to the subspecialty.
      - IV.C.2.a).(4).(b) The core curriculum conference series must cover the major clinical topics in the subspecialty.
      - IV.C.2.a).(4).(c) The core curriculum conference series must repeat often enough, or be made available for review on tape or electronically, to afford each fellow an opportunity to attend or review most of the core conference topics.
  - IV.C.2.b) Fellows must participate in formal review of gross and microscopic pathological material from patients who have been under their care.
  - IV.C.2.c) Fellows must participate in planning and conducting conferences.
- IV.C.3. Formal Instruction
  - IV.C.3.a) The curriculum of the program must exhibit, at a minimum, the following content and skills areas:

- IV.C.3.a).(1) current scientific knowledge of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged;
- IV.C.3.a).(2) aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization and chemoprophylaxis against disease. Instruction about and experience with community resources dedicated to these activities should be included;
- IV.C.3.a).(3) geriatric assessment, including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); medication review, the appropriate use of the history; physical and mental examination; and laboratory;
- IV.C.3.a).(4) appropriate interdisciplinary coordination of the actions of multiple health professionals, including physicians, nurses, social workers, dietitians, and rehabilitation experts, in the assessment and implementation of treatment;
- IV.C.3.a).(5) topics of special interest to geriatric medicine, including but not limited to cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment;
- IV.C.3.a).(6) diseases that are especially prominent in the elderly or that have different characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders;
- IV.C.3.a).(7) pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, and adherence;
- IV.C.3.a).(8) psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety;
- IV.C.3.a).(9) the economic aspects of supporting geriatric services, including Title III of the Older Americans Act, Medicare, Medicaid, capitation, and cost containment;
- IV.C.3.a).(10) ethical and legal issues especially pertinent to geriatric medicine, including limitation of treatment, competency,

- guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs;
- IV.C.3.a).(11) general principles of geriatric rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, pulmonary, and neurologic impairments. These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, environmental modification, patient and family education, and psychosocial and recreational counseling;
- IV.C.3.a).(12) management of patients in long-term care settings, including palliative care, knowledge of the administration, regulation, and financing of long-term institutions, and the continuum from short- to long-term care;
- IV.C.3.a).(13) research methodologies related to geriatric medicine, including clinical epidemiology, decision analysis, and critical literature review;
- IV.C.3.a).(14) perioperative assessment and involvement in management;
- IV.C.3.a).(15) iatrogenic disorders and their prevention;
- IV.C.3.a).(16) communication skills with patients, families, professional colleagues, and community groups, including presenting case reports, literature searches, and research papers, when appropriate, to peers and lectures to lay audiences;
- IV.C.3.a).(17) the pivotal role of the family in caring for many elderly and the community resources (formal support systems) required to support both patient and family;
- IV.C.3.a).(18) cultural aspects of aging, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care, and use of an interpreter in clinical care. Also, issues of ethnicity in long-term care, patient education, and special issues relating to urban and rural older persons of various ethnic backgrounds;
- IV.C.3.a).(19) home care, including the components of a home visit, accessing appropriate community resources to provide care in the home setting;
- IV.C.3.a).(20) hospice care, including pain management, symptom relief, comfort care, and end-of-life issues; and,

- IV.C.3.a).(21) behavioral sciences such as psychology/social work.
- IV.C.4. Interdisciplinary Topics
- IV.C.4.a) Fellows should become proficient in the critical assessment of medical literature, medical informatics, clinical epidemiology, and biostatistics.
- IV.C.4.b) Educational experiences should include instruction in the following: clinical ethics, medical genetics, quality assessment, quality improvement, patient safety, risk management, preventive medicine, pain management, end-of-life care, and physician impairment.
- IV.D. Clinical Experiences
- IV.D.1. Ambulatory Care Program
- IV.D.1.a) The ambulatory care program must comprise a minimum of 33% of the fellow's time, and may include home care, adult day health care, home hospice care, and outpatient geriatric rehabilitation.
- IV.D.1.b) Fellows should be responsible for at least five patients each week, and no more than the number for whom adequate teaching can be provided. This must include at least one half-day per week spent in a continuity of care experience.
- IV.D.1.b).(1) This experience must be designed to provide care in a geriatric clinic or internal medicine center to elderly patients who may require the services of multiple medical disciplines, including but not limited to neurology, gynecology, urology, psychiatry, podiatry, orthopaedic surgery, physical medicine and rehabilitation, dentistry, audiology, otolaryngology, and ophthalmology, as well as nursing, social work, and nutrition, among other disciplines.
- IV.D.1.c) Fellows must have the opportunity to provide continuing care and to coordinate the implementation of recommendations from medical specialties and other disciplines in their continuity clinic.
- IV.D.1.d) Experiences in relevant ambulatory specialty and subspecialty clinics (e.g., geriatric psychiatry and neurology) and those that focus on the assessment and management of geriatric syndromes (e.g., falls, incontinence, and osteoporosis) are strongly recommended.
- IV.D.1.e) The program must provide the opportunity for fellows to maintain their basic primary skills during the course of this training. The program must have at least one half-day per week averaged over each month in a continuity of care setting caring for patients of all

ages and both genders. The program must also arrange for contact with a mentor from the primary specialty for each fellow.

IV.D.2. Specific Program Content

IV.D.2.a) Fellows must develop clinical competence in the field of geriatrics, including: the physiology of aging; the pathophysiology that commonly occurs in older persons; atypical presentations of illnesses; functional assessment; concepts of treatment and management in acute care, long-term care, community, and home-care settings; and assessment of cognitive status and affective states.

IV.D.2.b) Clinical experience in the management of elderly patients must include:

IV.D.2.b).(1) direct care for patients in ambulatory, community, and long-term care settings, and consultative and/or direct care in acute inpatient care settings in order to understand the interaction of natural aging and disease as well as the techniques of assessment, therapy, and management;

IV.D.2.b).(2) care for persons who are generally healthy and require primarily preventive health care measures;

IV.D.2.b).(3) understanding of the behavioral aspects of illness, socioeconomic factors, health literacy issues and ethical and legal considerations that may impinge on medical management; and,

IV.D.2.b).(4) care for elderly patients as a consultant providing expert assessments and recommendations in the unique care needs of elderly patients.

IV.D.2.c) A Geriatric Medicine Consultation Program must be formally available in the ambulatory setting, the inpatient service, and/or emergency medicine in the acute-care hospital or at an ambulatory setting administered by the primary teaching institution.

IV.D.2.d) Long-term Care Experience

IV.D.2.d).(1) Fellows must have 12 months of continuing longitudinal clinical experience in the long-term care setting and manage an assigned panel of patients for whom the fellow is the primary provider.

IV.D.2.d).(2) Emphasis during the longitudinal experience should be focused on:

- IV.D.2.d).(2).(a) the approaches to diagnosis and treatment of the acutely and chronically ill, frail elderly in a less technologically sophisticated environment than the acute-care hospital;
- IV.D.2.d).(2).(b) working within the limits of a decreased staff-patient ratio compared with acute care hospitals;
- IV.D.2.d).(2).(c) a much greater awareness of and familiarity with sub-acute care physical medicine and rehabilitation;
- IV.D.2.d).(2).(d) the challenge of the clinical and ethical dilemmas produced by the illness of the very old;
- IV.D.2.d).(2).(e) geriatric pharmacology;
- IV.D.2.d).(2).(f) administrative aspects of long-term care;
- IV.D.2.d).(2).(g) the role of physicians as interdisciplinary team members in the care of the long-term care patient;
- IV.D.2.d).(2).(h) the importance of interaction and communication with the family/caregiver; and,
- IV.D.2.d).(2).(i) the role of palliative care and hospice in the terminally ill.
- IV.D.2.d).(3) The program must provide experience with home visits and hospice care.
- IV.D.2.d).(3).(a) Fellows must be exposed to the organizational and administrative aspects of home health care.
- IV.D.2.d).(3).(b) The program must include experience with continuity of care for home or hospice care patients.
- IV.D.2.d).(4) Additional block time to provide long-term care experience is recommended.
- IV.D.2.e) Identifiable structured didactic and clinical experiences in geriatric psychiatry must be included in the program of each fellow.
- IV.D.3. Procedures
- IV.D.3.a) Fellows must develop a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline.

- IV.D.3.b) Fellows must acquire knowledge of and skill in educating patients about the rationale, technique, and complications of procedures and in obtaining procedure-specific informed consent.
- IV.D.3.c) Faculty supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.
- IV.D.3.d) Each program must:
  - IV.D.3.d).(1) identify key procedures;
  - IV.D.3.d).(2) define a standard for proficiency; and,
  - IV.D.3.d).(3) document achievement of proficiency.

## **V. Evaluation**

### **V.A. Fellow Evaluation**

#### **V.A.1. Formative Evaluation**

- V.A.1.a) The faculty must evaluate fellow performance in a timely manner.**
  - V.A.1.a).(1) The faculty must discuss this evaluation with the fellow at the completion of the assignment.
- V.A.1.b) The program must:**
  - V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
  - V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**
  - V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.**
    - V.A.1.b).(3).(a) This includes formal evaluations of knowledge, skills, and professional growth of fellows and required counseling by the program director.
- V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**
- V.A.1.d) Permanent records of both the evaluation and counseling sessions (and any others that occur) for each fellow must be

maintained in the fellow's file and must be accessible to the fellow and other authorized personnel.

- V.A.1.d).(1) The record of evaluation should document the fellow's achievement of the competencies using appropriate evaluation methods.
- V.A.1.d).(2) The record of evaluation should document that records were maintained by documentation logbook or by an equivalent method to demonstrate that fellows have achieved competence in the performance of invasive procedures. These records must state the indications and complications, and include the names of the supervising physicians. Such records must be of sufficient detail to permit use in future credentialing.
- V.A.1.d).(3) The record of evaluation should document that fellows were evaluated in writing, and that their performance was reviewed with them verbally on completion of each rotation period.
- V.A.1.d).(4) The record of evaluation should document that fellows were evaluated in writing, and that their performance in continuity clinic was reviewed with them verbally on at least a semiannual basis.

**V.A.2. Summative Evaluation**

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

- V.A.2.a) document the fellow's performance during their education, and**
  - V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**
- V.A.2.b).(1) The program director must also prepare annually a written summative evaluation of the clinical competence of each fellow. (N.B.: This summative evaluation is in addition to the completion of the ABIM tracking form.)
  - V.A.2.b).(2) The summative evaluation must stipulate the degree to which the fellow has achieved the level of performance expected in each Competency (i.e., patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice).

V.A.3. Grievance Procedures and Due Process

V.A.3.a) In the event of an adverse annual evaluation, a fellow must be offered an opportunity to address a judgment of academic deficiencies or misconduct before a formally constituted clinical competence committee.

V.A.3.b) There must be a written policy that ensures that academic due process is provided.

**V.B. Faculty Evaluation**

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

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

V.B.3. Provision must be made for fellows to confidentially provide written evaluations of each faculty member at the end of a rotation, and for the evaluations to be reviewed annually with faculty members.

V.B.4. Fellows should evaluate faculty members' effectiveness as teachers; fellows must also evaluate the effectiveness of a rotation or assignment in achieving the goals and objectives identified in the curriculum for that rotation or assignment.

V.B.5. Fellows must have the opportunity to formally assess the effectiveness of ambulatory teaching on an ongoing basis.

V.B.6. The results of the evaluations must be used for faculty member counseling and for selecting faculty members for specific teaching assignments.

**V.C. Program Evaluation and Improvement**

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

**V.C.1.a) fellow performance, and**

**V.C.1.b) faculty development.**

**V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

V.C.3. The program must monitor and track graduate performance, including performance of program graduates on the certification examination.

V.C.3.a) At least 80% of those eligible to take an ABIM subspecialty certifying examination upon completion of their training for the most recent five-year period must have taken an ABIM subspecialty certifying examination. (Note: Five-year rolling pass rate for first-time takers of the ABIM certifying examination will be examined at each program review.)

V.D. Performance Improvement Process

V.D.1. The program should identify and participate in at least one ongoing performance improvement activity which relates to the competencies.

V.D.2. The performance improvement activities must involve both fellows and faculty members in planning and implementing.

V.D.3. The performance improvement activities should result in measurable improvements in patient care or fellowship education.

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

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

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

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

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

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

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

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

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

**understanding and acceptance of their personal role in the following:**

- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
- VI.A.5.b) provision of patient- and family-centered care;**
- VI.A.5.c) assurance of their fitness for duty;**
- VI.A.5.d) management of their time before, during, and after clinical assignments;**
- VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
- VI.A.5.f) attention to lifelong learning;**
- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**

**VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**

**VI.B. Transitions of Care**

- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**
- VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**
- VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.**
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.**

**VI.C. Alertness Management/Fatigue Mitigation**

**VI.C.1. The program must:**

- VI.C.1.a) educate all faculty members and fellows to recognize the**

- signs of fatigue and sleep deprivation;
- VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
- VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.
- VI.D. **Supervision of Fellows**
- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- VI.D.1.a) This information should be available to fellows, faculty members, and patients.
- VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.
- VI.D.3. **Levels of Supervision**
- To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
- VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
- VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
- VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
- VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and**

**responsibility.**

**VI.E. Clinical Responsibilities**

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

**VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow.**

**VI.F. Teamwork**

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

**VI.G. Fellow Duty Hours**

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

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

**VI.G.1.a) Duty Hour Exceptions**

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

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

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

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

**VI.G.2. Moonlighting**

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

**VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**

(as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

**VI.G.3. Mandatory Time Free of Duty**

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

**VI.G.4. Maximum Duty Period Length**

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

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

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

**VI.G.4.c)** In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

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

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

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

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

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

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

Geriatric medicine fellows are considered to be in the final years of education.

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

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

**VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.**

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

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

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

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

**VI.G.7.a) Internal Medicine programs are not allowed to average in-house call over a four-week period.**

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

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

**VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**

**preclude rest or reasonable personal time for each fellow.**

**VI.G.8.b)**

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

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