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I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. A sleep medicine fellowship should function as an integral part of an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in family medicine, internal medicine, neurology, otolaryngology, pediatrics, or psychiatry.

I.A.2. The sponsoring institution should ~~must~~ sponsor only one ACGME-accredited sleep medicine program.

I.A.3. The sponsoring institution must provide the program director with adequate support for the administrative activities of the fellowship.

I.A.3.a) The program director must not be required to generate clinical or other income to provide this administrative support.

I.A.3.b) It is suggested this support be 25-50% of the program director's salary, or protected time, depending on the size of the program.

I.A.4. The sponsoring institution and participating sites must:

I.A.4.a) Sponsor ~~only one accredited sleep medicine program~~ demonstrate that there is a culture of continuous quality improvement in the areas of patient care, patient safety, and education;

I.A.4.b) Sponsor ~~an ACGME-accredited core program in family medicine, internal medicine, neurology, otorhinolaryngology, pediatrics or psychiatry~~ demonstrate a commitment to quality patient-centered care and safety, education, and scholarship sufficient to support the fellowship;

I.A.4.c) share appropriate faculty performance data with the program director; and,

I.A.4.d) ~~provide fellowship positions in the one-year, sleep medicine fellowship with no less than one fellow per year; and~~

I.A.4.e) ensure the availability of appropriate and timely consultation from other specialties.

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

- 154
155 **II.A.2.b)** **current certification in the subspecialty by the American**
156 **Board of Family Medicine, Internal Medicine, Neurology,**
157 **Otolaryngology, Pediatrics, or Psychiatry, and certification by the**
158 **applicable ABMS board in sleep medicine or subspecialty**
159 **qualifications that are acceptable to the Review Committee;**
160 **and,**
161
162 **II.A.2.c)** **current medical licensure and appropriate medical staff**
163 **appointment.**
164
165 **II.A.3.** **The program director must administer and maintain an educational**
166 **environment conducive to educating the fellows in each of the**
167 **ACGME competency areas. The program director must:**
168
169 **II.A.3.a)** **prepare and submit all information required and requested by**
170 **the ACGME;**
171
172 **II.A.3.b)** **be familiar with and oversee compliance with ACGME and**
173 **Review Committee policies and procedures as outlined in the**
174 **ACGME Manual of Policies and Procedures;**
175
176 **II.A.3.c)** **obtain review and approval of the sponsoring institution's**
177 **GMEC/DIO before submitting to the ACGME information or**
178 **requests for the following:**
179
180 **II.A.3.c).(1)** **all applications for ACGME accreditation of new**
181 **programs;**
182
183 **II.A.3.c).(2)** **changes in fellow complement;**
184
185 **II.A.3.c).(3)** **major changes in program structure or length of**
186 **training;**
187
188 **II.A.3.c).(4)** **progress reports requested by the Review Committee;**
189
190 **II.A.3.c).(5)** **responses to all proposed adverse actions;**
191
192 **II.A.3.c).(6)** **requests for increases or any change to fellow duty**
193 **hours;**
194
195 **II.A.3.c).(7)** **voluntary withdrawals of ACGME-accredited**
196 **programs;**
197
198 **II.A.3.c).(8)** **requests for appeal of an adverse action;**
199
200 **II.A.3.c).(9)** **appeal presentations to a Board of Appeal or the**
201 **ACGME; and,**
202
203 **II.A.3.d)** **obtain DIO review and co-signature on all program**
204 **information forms, as well as any correspondence or**

- 205 document submitted to the ACGME that addresses:
206
207 **II.A.3.d).(1)** program citations, and/or
208
209 **II.A.3.d).(2)** request for changes in the program that would have
210 significant impact, including financial, on the program
211 or institution.
212
213 **II.A.3.e)** dedicate an average of 20 hours per week of his or her
214 professional effort to the fellowship, with sufficient time for
215 administration of the program;
216
217 **II.A.3.f)** participate in academic societies and educational programs
218 designed to enhance his or her educational and administrative
219 skills;
220
221 **II.A.3.g)** have a reporting relationship with the program director of the
222 sponsoring core residency program to ensure compliance with the
223 ACGME's accreditation standards; and,
224
225 **II.A.3.h)** be available at the primary clinical site.
226
227 **II.B. Faculty**
228
229 **II.B.1. There must be a sufficient number of faculty with documented**
230 **qualifications to instruct and supervise all fellows.**
231
232 **II.B.1.a)** ~~There must be a minimum of 2 key clinical faculty members,~~
233 ~~including the program director. In programs with more than 4~~
234 ~~fellows, a ratio of one key clinical faculty to every 2 fellows must~~
235 ~~be maintained.~~
236
237 **II.B.2. The faculty must devote sufficient time to the educational program**
238 **to fulfill their supervisory and teaching responsibilities and**
239 **demonstrate a strong interest in the education of fellows.**
240
241 **II.B.3. The physician faculty must have current certification in the**
242 **subspecialty by the American Board of Family Medicine, Internal**
243 **Medicine, Neurology, Otolaryngology, Pediatrics, or Psychiatry, and**
244 **certification by the applicable ABMS board in sleep medicine; or possess**
245 **qualifications acceptable to the Review Committee.**
246
247 **II.B.4. The physician faculty must possess current medical licensure and**
248 **appropriate medical staff appointment.**
249
250 **II.B.5.** The physician faculty must meet professional standards of ethical
251 behavior.
252
253 **II.B.6.** The faculty must establish and maintain an environment of inquiry and
254 scholarship with an active research component.
255

- 256 II.B.6.a) The faculty must regularly participate in organized clinical
257 discussions, rounds, journal clubs, and conferences.
258
- 259 II.B.6.b) Some members of the faculty must also demonstrate scholarship
260 by one or more of the following:
261
- 262 II.B.6.b).(1) peer-reviewed funding;
263
- 264 II.B.6.b).(2) publication of original research, case reports, or review
265 articles in peer-reviewed journals or chapters in textbooks;
266
- 267 II.B.6.b).(3) publication or presentation of case reports or clinical series
268 at local, regional, or national professional and scientific
269 society meetings; or,
270
- 271 II.B.6.b).(4) participation in national committees or educational
272 organizations.
273
- 274 II.B.6.c) Faculty should encourage and support fellows in scholarly
275 activities.
276
- 277 II.B.7. Faculty who are ABMS-certified in family medicine, internal medicine,
278 neurology, otolaryngology, pediatrics, psychiatry, pulmonology, should be
279 available to the ~~fellowship~~ program.
280
- 281 II.B.8. Clinical faculty members should participate in faculty development
282 programs designed to enhance the effectiveness of their teaching.
283
- 284 II.B.9. Key Clinical Faculty
285
- 286 In addition to the program director, each program must have at least one
287 Key Clinical Faculty (KCF) member. KCF are attending physicians who
288 dedicate, on average, 10 hours per week throughout the year to the
289 program. For programs with more than four fellows, there must be at least
290 one KCF for every two fellows.
291
- 292 II.B.9.a) Key Clinical Faculty Qualifications:
293
- 294 II.B.9.a).(1) KCF must be active clinicians with knowledge of,
295 experience with, and commitment to sleep medicine as a
296 discipline.
297
- 298 II.B.9.a).(2) KCF must have current ABMS certification in sleep
299 medicine; or possess qualifications acceptable to the
300 Review Committee.
301
- 302 II.B.9.b) Key Clinical Faculty Responsibilities:
303
- 304 II.B.9.b).(1) In addition to the responsibilities of all individual faculty
305 members, the KCF and the program director are
306 responsible for the planning, implementation, monitoring,

307 and evaluation of the fellows' clinical and research
308 education.

309
310 II.B.9.b).(2) At least 50% of the KCF must demonstrate evidence of
311 productivity in scholarship, specifically, peer-reviewed
312 funding, publication of original research, review articles,
313 editorials or case reports in peer-reviewed journals; or
314 chapters in textbooks.

315
316 **II.C. Other Program Personnel**

317
318 **The institution and the program must jointly ensure the availability of all**
319 **necessary professional, technical, and clerical personnel for the effective**
320 **administration of the program.**

321
322 II.C.1. Physicians who are board certified in the following specialties: internal
323 medicine, pulmonology, psychiatry, pediatrics, neurology and
324 otolaryngology must be available to the training program. There must be
325 services available from other health care professionals, including
326 dietitians, language interpreters, nurses, and social workers.

327
328 II.C.2. Nonphysician faculty must have appropriate qualifications in their field
329 and hold appropriate institutional appointments.

330
331 **II.D. Resources**

332
333 **The institution and the program must jointly ensure the availability of**
334 **adequate resources for fellow education, as defined in the specialty**
335 **program requirements.**

336
337 II.D.1. Space and Equipment

338
339 There must be space and equipment for the program, including meeting
340 rooms, examination rooms, computers, visual and other educational aids,
341 and work/study space. pertinent library materials, and diagnostic,
342 therapeutic, and research facilities.

343
344 II.D.2. Facilities

345
346 II.D.2.a) There must be an outpatient clinic, as well as diagnostic,
347 therapeutic, and research facilities.

348
349 II.D.2.b) Efficient, effective ambulatory and inpatient facilities must be
350 available for fellows' clinical experiences.

351
352 II.D.2.c) Fellows must have access to a lounge facility during assigned
353 duty hours.

354
355 II.D.2.d) When fellows are in the hospital, assigned night duty, or called in
356 from home, they must be provided with a secure space for their
357 belongings.

- 358
359 II.D.2.e) There must be an appropriately-equipped sleep center which has
360 a minimum of two fully-equipped polysomnography bedrooms and
361 adequate support space.
362
- 363 II.D.2.e).(1) The sleep center must be accredited by the American
364 Academy of Sleep Medicine ~~or an equivalent body.~~
365
- 366 II.D.3. Other Support Services
367
368 Inpatient and outpatient systems must be in place to prevent fellows from
369 performing routine clerical functions, such as scheduling tests and
370 appointments, and retrieving records and letters.
371
- 372 II.D.4. Medical Records
373
374 Access to an electronic health record should be provided. In the absence
375 of an existing electronic health record, institutions must demonstrate
376 institutional commitment to its development and progress toward its
377 implementation.
378
- 379 II.D.5. Patient Population
380
- 381 II.D.5.a) ~~There must be an adequate number and variety of patients of all~~
382 ~~ages to expose fellows to the broad spectrum of sleep disorders.~~
383 The patient population must have a variety of clinical problems
384 and stages of diseases, including short- and long-term sleep
385 disorders.
386
- 387 II.D.5.b) ~~There must be a balance of age, gender, and short- and long-term~~
388 ~~disorders.~~ There must be patients of each gender, with a broad
389 age range, including infants, children, adolescents, and geriatric
390 patients.
391
- 392 II.D.5.c) A sufficient number of patients must be available to enable each
393 fellow to achieve the required educational outcomes.
394
- 395 II.D.5.d) There must be patients with the major categories of sleep
396 disorders, including:
397
- 398 II.D.5.d).(1) circadian rhythm sleep disorders;
399
- 400 II.D.5.d).(2) idiopathic hypersomnia;
401
- 402 II.D.5.d).(3) insomnia;
403
- 404 II.D.5.d).(4) narcolepsy;
405
- 406 II.D.5.d).(5) parasomnias;
407
- 408 II.D.5.d).(6) sleep problems related to other factors and diseases,

409 including medications, and psychiatric and medical
410 disorders; and,
411
412 II.D.5.d).(7) sleep-related breathing disorders;
413
414 II.D.5.d).(8) sleep-related movement disorders.
415
416 **II.E. Medical Information Access**
417
418 **Fellows must have ready access to specialty-specific and other appropriate**
419 **reference material in print or electronic format. Electronic medical literature**
420 **databases with search capabilities should be available.**
421
422 **III. Fellow Appointments**
423
424 **III.A. Eligibility Criteria**
425
426 **Each fellow must successfully complete an ACGME-accredited specialty**
427 **program and/or meet other eligibility criteria as specified by the Review**
428 **Committee. The program must document that each fellow has met the**
429 **eligibility criteria.**
430
431 III.A.1. Prior to appointment in the program, each fellow~~All applicants entering~~
432 ~~the sleep medicine fellowship~~ must have completed an ACGME-
433 accredited ~~core educational program accredited by the ACGME in one of~~
434 ~~the following specialties in family medicine, internal medicine, neurology,~~
435 ~~otolaryngology, pediatrics, and or psychiatry.~~
436
437 **III.B. Number of Fellows**
438
439 **The program director may not appoint more fellows than approved by the**
440 **Review Committee, unless otherwise stated in the specialty-specific**
441 **requirements. The program’s educational resources must be adequate to**
442 **support the number of fellows appointed to the program.**
443
444 **IV. Educational Program**
445
446 **IV.A. The curriculum must contain the following educational components:**
447
448 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
449 **conclusion of the program. The program must distribute these skills**
450 **and competencies to fellows and faculty annually, in either written**
451 **or electronic form. These skills and competencies should be**
452 **reviewed by the fellow at the start of each rotation;**
453
454 **IV.A.2. ACGME Competencies**
455
456 **The program must integrate the following ACGME competencies**
457 **into the curriculum:**
458
459 **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:

- 460
461
462
463
464
465 IV.A.2.a).(1) ~~must participate in an interdisciplinary care of patients of all~~
466 ~~ages that incorporates aspects of psychiatry, neurology,~~
467 ~~internal medicine, epidemiology, surgery, pediatrics and~~
468 ~~basic science;~~
- 469
470 IV.A.2.a).(2) must demonstrate competence in the diagnosis and
471 management of patients with sleep disorders patients in
472 outpatient and inpatient settings;:
473
- 474 IV.A.2.a).(3) must demonstrate clinical competence in ~~the following~~
475 ~~areas:~~
476
- 477 IV.A.2.a).(3).(a) conducting the tests unique to sleep medicine,
478 including electrode and sensor application,
479 calibrations, maintenance of signal integrity, and
480 protocols for initiating and terminating the tests;
481
- 482 IV.A.2.a).(3).(b) evaluating, diagnosing and comprehensively
483 treating of patients over the entire spectrum of
484 pediatric and adult sleep and circadian rhythm
485 disorders, as well as those medical, neurological,
486 and psychiatric disorders that may present with
487 sleep-related complaints in both the inpatient and
488 outpatient settings;
489
- 490 IV.A.2.a).(3).(c) ~~Integration of~~ integrating information obtained from
491 patient history, physical examination, physiologic
492 recordings, imaging studies as they relate to sleep
493 disorders, psychometric testing, pulmonary function
494 testing, and biochemical and molecular tests results
495 to arrive at an accurate and timely diagnosis and
496 treatment plan;
497
- 498 IV.A.2.a).(3).(d) ~~Integration of~~ integrating relevant biological,
499 psychological, social, economic, ethnic, and familial
500 factors into the evaluation and treatment of their
501 patients' sleep disorders;
502
- 503 IV.A.2.a).(3).(e) interpreting psychological and psychometric tests
504 as they relate to sleep disorders.
505
- 506 IV.A.2.a).(3).(f) performing Ccardiopulmonary resuscitation;
507
- 508 IV.A.2.a).(3).(g) Pperforming physical, neurological and mental
509 status examinations relevant to the practice of
510 sleep medicine;

511		
512	IV.A.2.a).(3).(h)	Proficiency in therapeutic planning and
513		implementing therapeutic treatment,
514		implementation including the ability to formulate,
515		initiate or refer for all major types of treatment
516		including pharmaceutical, medical device,
517		behavioral, and surgical therapies; and,
518		
519	IV.A.2.a).(3).(i)	<u>selecting the appropriate sleep investigation(s) to</u>
520		<u>facilitate a patient's diagnosis and treatment;</u>
521		
522	IV.A.2.a).(3).(j)	<u>scoring and interpreting:</u>
523		
524	IV.A.2.a).(3).(j).(i)	polysomnograms;
525		
526	IV.A.2.a).(3).(j).(ii)	Scoring and interpretation of multiple sleep
527		latency and maintenance of wakefulness
528		testing;
529		
530	IV.A.2.a).(3).(j).(iii)	Scoring and interpretation of portable sleep
531		monitor recordings;
532		
533	IV.A.2.a).(3).(j).(iv)	Scoring and interpretation of actigraphy;
534		
535	IV.A.2.a).(3).(j).(v)	<u>downloads from positive pressure devices;</u>
536		
537	IV.A.2.a).(3).(j).(vi)	<u>sleep diaries; and,</u>
538		
539	IV.A.2.a).(3).(j).(vii)	<u>standardized scales of sleepiness.</u>
540		
541		
542	IV.A.2.a).(4)	<u>Consultations must demonstrate competence as a</u>
543		<u>consultant in both inpatient and outpatient settings.</u>
544		
545	IV.A.2.b)	Medical Knowledge
546		
547		Fellows must demonstrate knowledge of established and
548		evolving biomedical, clinical, epidemiological and social-
549		behavioral sciences, as well as the application of this
550		knowledge to patient care. Fellows:
551		
552	IV.A.2.b).(1)	must demonstrate detailed knowledge of the neurobiology
553		of sleep and wakefulness, sleep-related anatomy and
554		physiology, and the neural structures mediating circadian
555		rhythms. Specifically, the <u>This must include:</u>
556		
557	IV.A.2.b).(1).(a)	fundamental mechanisms of sleep, major theories
558		in sleep medicine, and the generally-accepted facts
559		of basic sleep mechanisms including:
560		

561	IV.A.2.b).(1).(a).(i)	basic neurologic mechanisms controlling sleep and wakefulness;
562		
563		
564	IV.A.2.b).(1).(a).(ii)	cardiovascular physiology and pathophysiology related to sleep and sleep disorders;
565		
566		
567		
568	IV.A.2.b).(1).(a).(iii)	changes in sleep across the life span;
569		
570	IV.A.2.b).(1).(a).(iv)	chronobiology;
571		
572	IV.A.2.b).(1).(a).(v)	endocrine physiology and pathophysiology related to sleep and sleep disorders;
573		
574		
575	IV.A.2.b).(1).(a).(vi)	gastrointestinal physiology and pathophysiology related to sleep and sleep disorders;
576		
577		
578		
579	IV.A.2.b).(1).(a).(vii)	ontogeny of sleep; and,
580		
581	IV.A.2.b).(1).(a).(viii)	respiratory physiology and pathophysiology related to sleep and sleep disorders.
582		
583		
584	IV.A.2.b).(1).(b)	<u>upper airway anatomy, normal and abnormal across the life span;</u>
585		
586		
587	IV.A.2.b).(1).(c)	<u>effects of impaired sleep on bed partners;</u>
588		
589	IV.A.2.b).(1).(d)	nosology for sleep disorders as described in the <u>current</u> edition of the <i>The International Classification of Sleep Disorders</i> ;
590		
591		
592		
593	IV.A.2.b).(1).(e)	etiopathogenic characterization of sleep disorders;
594		
595	IV.A.2.b).(1).(f)	effects of medications on sleep and sleep disorders;
596		
597		
598	IV.A.2.b).(1).(g)	clinical manifestations of sleep disorders, including:
599		
600	IV.A.2.b).(1).(g).(i)	circadian rhythm disorders;
601		
602	IV.A.2.b).(1).(g).(ii)	disorders of excessive sleepiness;
603		
604	IV.A.2.b).(1).(g).(iii)	interactions between therapies for sleep disorders and other medical, neurologic, and psychiatric treatments;
605		
606		
607		
608	IV.A.2.b).(1).(g).(iv)	insomnia and other disorders of initiating and maintaining sleep;
609		
610		

611	IV.A.2.b).(1).(g).(v)	medical, neurologic, and psychiatric disorders <u>and substance abuse, including withdrawal syndromes, and displaying symptoms likely to be related to sleep disorders</u> (e.g., the relationship between hypertension and sleep apnea);
612		
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617		
618	IV.A.2.b).(1).(g).(vi)	neonatal and pediatric sleep disorders;
619		
620	IV.A.2.b).(1).(g).(vii)	parasomnias;
621		
622	IV.A.2.b).(1).(g).(viii)	<u>safe infant sleep practices-related respiratory disorders; and,</u>
623		
624		
625	IV.A.2.b).(1).(g).(ix)	sleep-related breathing disorders <u>in both adults and children;</u>
626		
627		
628	IV.A.2.b).(1).(g).(x)	sleep-related movement disorders; and,
629		
630	IV.A.2.b).(1).(g).(xi)	Sudden Infant Death Syndrome;
631		
632	IV.A.2.b).(1).(h)	diagnostic strategies in sleep disorders including differences between children and adults;
633		
634		
635	IV.A.2.b).(1).(i)	treatment strategies in sleep disorders incorporating the following :
636		
637		
638	IV.A.2.b).(1).(i).(i)	approaches for obstructive sleep apnea, <u>including</u> nasal CPAP, bilevel and other modes of PAP, maxillofacial and upper airway surgery, oral appliances, and position education;
639		
640		
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643		
644	IV.A.2.b).(1).(i).(ii)	approaches for insomnia, to include <u>including</u> cognitive-behavioral therapies and pharmacological therapy;
645		
646		
647		
648	IV.A.2.b).(1).(i).(iii)	approaches for narcolepsy and other hypersomnias of central origin;
649		
650		
651	IV.A.2.b).(1).(i).(iv)	approaches for parasomnias;
652		
653	IV.A.2.b).(1).(i).(v)	approaches for circadian rhythm disorders; and,
654		
655		
656	IV.A.2.b).(1).(i).(vi)	understanding the differences in approaches between children and adults.
657		
658		
659	IV.A.2.b).(1).(j)	operation of polysomnographic monitoring equipment, <u>including</u> polysomnographic trouble shooting and ambulatory monitoring methodology.
660		
661		

662		
663	IV.A.2.b).(1).(k)	financing and regulation of sleep medicine;
664		
665	IV.A.2.b).(1).(l)	research methods in the clinical and basic sciences related to sleep medicine;
666		
667		
668	IV.A.2.b).(1).(m)	medical ethics and its application in sleep medicine;
669		
670	IV.A.2.b).(1).(n)	the legal aspects of sleep medicine; and,
671		
672	IV.A.2.b).(1).(o)	<u>the impact of sleep disorders on the family and society.</u>
673		
674		
675	IV.A.2.b).(2)	must demonstrate knowledge of the appropriate indications <u>for, and</u> potential pitfalls, limitations, administration, and interpretation of diagnostic tests used in sleep medicine, including polysomnography, multiple sleep latency testing, maintenance of wakefulness testing, actigraphy, and portable monitoring, <u>to include:</u>
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681		
682	IV.A.2.b).(2).(a)	<u>indications and contraindications for, and proper patient preparation and potential shortcomings of the tests used in sleep medicine; and,</u>
683		
684		
685		
686	IV.A.2.b).(2).(b)	<u>principles of recording bioelectric signals, including polarity, dipoles, electrodes, derivations, montages, amplifiers, sampling, and digital display.</u>
687		
688		
689		
690	IV.A.2.c)	Practice-based Learning and Improvement
691		
692		Fellows are expected to develop skills and habits to be able to meet the following goals:
693		
694		
695	IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
696		
697		
698		
699	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
700		
701		
702		
703	IV.A.2.c).(3)	<u>demonstrate proficiency in the critical assessment of medical literature, medical informatics, clinical epidemiology, and biostatistics; and,</u>
704		
705		
706		
707	IV.A.2.c).(4)	<u>demonstrate competence as effective teachers, to include teaching peers and patients.</u>
708		
709		
710	IV.A.2.d)	Interpersonal and Communication Skills
711		
712		Fellows must demonstrate interpersonal and communication

713 **skills that result in the effective exchange of information and**
714 **collaboration with patients, their families, and health**
715 **professionals.**

716
717 IV.A.2.d).(1) Fellows must demonstrate the ability to relate to patients
718 and their families, as well as other members of the health
719 care team, with compassion, respect, and professional
720 integrity.

721
722 IV.A.2.d).(2) Fellows must demonstrate the ability to work effectively as
723 a member or leader of a health care team or other
724 professional group.

725
726 IV.A.2.d).(3) Fellows must maintain comprehensive, timely, and legible
727 medical records.

728
729 **IV.A.2.e) Professionalism**

730
731 **Fellows must demonstrate a commitment to carrying out**
732 **professional responsibilities and an adherence to ethical**
733 **principles.**

734
735 Fellows must demonstrate:

736
737 IV.A.2.e).(1) a commitment to ethical principles pertaining to provision
738 or withholding of clinical care, confidentiality of patient
739 information, informed consent, and business practices;

740
741 IV.A.2.e).(2) a commitment to lifelong learning, and an attitude of caring
742 that is derived from humanistic and professional values;

743
744 IV.A.2.e).(3) high standards of ethical behavior, including maintaining
745 appropriate professional boundaries and relationships with
746 other physicians, and avoiding conflicts of interest;

747
748 IV.A.2.e).(4) respect, compassion, and integrity to patients and other
749 members of the health care team; and,

750
751 IV.A.2.e).(5) sensitivity and responsiveness to a patient's culture, age,
752 gender, and disabilities.

753
754 **IV.A.2.f) Systems-based Practice**

755
756 **Fellows must demonstrate an awareness of and**
757 **responsiveness to the larger context and system of health**
758 **care, as well as the ability to call effectively on other**
759 **resources in the system to provide optimal health care.**

760
761 Fellows must demonstrate competence in:

762
763 IV.A.2.f).(1) advocating for quality patient care and optimal patient care

764		<u>systems;</u>
765		
766	IV.A.2.f).(2)	<u>appropriate resource allocation and utilization;</u>
767		
768	IV.A.2.f).(3)	<u>cooperative interaction with other care providers;</u>
769		
770	IV.A.2.f).(4)	leadership skills in the coordination and integration of care
771		across a variety of disciplines and provider types;
772		
773	IV.A.2.f).(5)	<u>participation in identifying system errors and implementing</u>
774		<u>potential system solutions; and,</u>
775		
776	IV.A.2.f).(6)	<u>working in interprofessional teams to enhance patient</u>
777		<u>safety and improve patient care quality.</u>
778		
779	IV.A.3.	<u>Curriculum Organization and Fellow Experiences</u>
780		
781	IV.A.3.a)	At least 11 of the 12 months of the program must be devoted to
782		the inpatient and ambulatory clinical experiences.
783		
784	IV.A.3.b)	<u>Fellows must participate in an interdisciplinary care of patients of</u>
785		<u>all ages that incorporates aspects of basic science, epidemiology,</u>
786		<u>family medicine, internal medicine, neurology, pediatrics,</u>
787		<u>psychiatry, and surgery.</u>
788		
789	IV.A.3.c)	<u>Clinical</u> experience should include evaluation and follow up of
790		hospitalized sleep disorder patients.
791		
792	IV.A.3.d)	<u>The core curriculum must include a didactic program based upon</u>
793		<u>the core knowledge content in the subspecialty.</u>
794		
795	IV.A.3.d).(1)	<u>Fellows must participate in clinical case conferences,</u>
796		<u>journal clubs, research conferences, and morbidity and</u>
797		<u>mortality or quality improvement conferences.</u>
798		
799	IV.A.3.d).(2)	<u>Fellows must participate in planning and conducting</u>
800		<u>conferences.</u>
801		
802	IV.A.3.d).(3)	<u>All required core conferences must have at least one</u>
803		<u>faculty member present and must be scheduled as to</u>
804		<u>ensure peer-peer and peer-faculty interaction.</u>
805		
806	IV.A.3.d).(4)	<u>Didactic topics should include: clinical ethics,</u>
807		<u>interdisciplinary topics, medical genetics, patient safety,</u>
808		<u>physician impairment , preventive medicine, quality</u>
809		<u>assessment, quality improvement, and, risk management.</u>
810		
811	IV.A.3.d).(5)	<u>Methods for teaching sleep testing should include didactic</u>
812		<u>instruction, interactive discussion, role modeling by faculty</u>
813		<u>and allied staff, self-directed inquiry learning, and direct</u>
814		<u>experience.</u>

815		
816	IV.A.3.d).(6)	<u>Fellows must be instructed in practice management relevant to sleep medicine.</u>
817		
818		
819	IV.A.3.e)	<u>Clinical Experience with Continuity Ambulatory Patients</u>
820		
821	IV.A.3.e).(1)	<u>Fellows must have a continuity ambulatory clinic experience to develop a continuous healing relationship with patients for whom they provide sleep medicine care. This continuity experience should expose fellows to the breadth and depth of the subspecialty.</u>
822		
823		
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825		
826		
827	IV.A.3.e).(1).(a)	<u>This experience should average one half-day each week. This should be accomplished by either:</u>
828		
829		
830	IV.A.3.e).(1).(a).(i)	<u>experience at one clinic for 12 months; or,</u>
831		
832	IV.A.3.e).(1).(a).(ii)	<u>two consecutive six-month-long experiences at two different clinics.</u>
833		
834		
835	IV.A.3.e).(1).(b)	Experience must include longitudinal management of patients for whom the fellow is the primary physician (but acting under the supervision of a faculty member).
836		
837		
838		
839		
840	IV.A.3.e).(1).(c)	Each fellow's clinical experiences with ambulatory patients must provide fellows the opportunity to observe and learn the course of disease.
841		
842		
843		
844	IV.A.3.f)	<u>Procedures and Technical Skills</u>
845		
846	IV.A.3.f).(1)	<u>Fellows must score a minimum of 25 recordings of various diagnostic types (such as polysomnograms; a multiple sleep latency test; a maintenance of wakefulness test) during the course of the fellowship. At least five of these must be adult recordings and five must be pediatric recordings. Pediatric recordings should include those from infants, children, and adolescents.</u>
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853		
854	IV.A.3.f).(2)	<u>Fellows must interpret a minimum of 200 polysomnograms with at least 40 from adults and 40 from children. Pediatric polysomnograms should include those from infants, children, and adolescents.</u>
855		
856		
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858		
859	IV.B.	Fellows' Scholarly Activities
860		
861		Each The program must provide an opportunity for <u>each</u> fellow to participate in research or other scholarly activities.
862		
863		
864	V.	Evaluation
865		

866	V.A.	Fellow Evaluation
867		
868	V.A.1.	Formative Evaluation
869		
870	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner.
871		
872		
873	V.A.1.a).(1)	Assessments by a faculty member must occur at least once every two months. Such evaluations are to be communicated to each fellow in a timely manner. The faculty must discuss evaluations with each fellow at least every three months.
874		
875		
876		
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878		
879	V.A.1.b)	The program must:
880		
881	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;
882		
883		
884		
885		
886		
887	V.A.1.b).(1).(a)	<u>Patient Care</u>
888		
889		<u>The program must assess the fellow in data gathering, clinical reasoning, and patient management. This assessment must involve direct observation of fellow-patient encounters.</u>
890		
891		
892		
893		
894	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
895		
896		<u>The program must utilize an objective assessment method, such as an in-service training examination, or chart-stimulated recall).</u>
897		
898		
899		
900	V.A.1.b).(1).(c)	<u>Practice-based Learning and Improvement:</u>
901		
902		<u>The program must use performance data to assess fellows in:</u>
903		
904		
905	V.A.1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
906		
907	V.A.1.b).(1).(c).(ii)	<u>practice improvement; and,</u>
908		
909	V.A.1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients.</u>
910		
911	V.A.1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
912		
913		<u>The program must use both direct observation and multi-source evaluation, including at least patients and non-physician team members, to assess fellow performance in:</u>
914		
915		
916		

917		
918	V.A.1.b).(1).(d).(i)	<u>communication with patients and families;</u>
919		
920	V.A.1.b).(1).(d).(ii)	<u>teamwork;</u>
921		
922	V.A.1.b).(1).(d).(iii)	<u>communication with other health care professionals; and,</u>
923		
924		
925	V.A.1.b).(1).(d).(iv)	<u>record keeping.</u>
926		
927	V.A.1.b).(1).(e)	<u>Professionalism</u>
928		
929		<u>The program must use multi-source evaluation,</u>
930		<u>including at least patients and non-physician team</u>
931		<u>members, to assess fellows':</u>
932		
933	V.A.1.b).(1).(e).(i)	<u>honesty and integrity;</u>
934		
935	V.A.1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
936		
937	V.A.1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
938		<u>relationships with patients and colleagues;</u>
939		<u>and,</u>
940		
941	V.A.1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
942		
943	V.A.1.b).(1).(f)	<u>Systems-based Practice</u>
944		
945		<u>The program must use multi-source evaluation,</u>
946		<u>including non-physician team members, to assess</u>
947		<u>fellows':</u>
948		
949	V.A.1.b).(1).(f).(i)	<u>care coordination;</u>
950		
951	V.A.1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
952		
953	V.A.1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
954		
955	V.A.1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
956		<u>participate in improvement activities.</u>
957		
958	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
959		self, and other professional staff); and,
960		
961	V.A.1.b).(3)	provide each fellow with documented semiannual
962		evaluation of performance with feedback.
963		
964	V.A.1.c)	The evaluation of fellow performance must be accessible for
965		review by the fellow, in accordance with institutional policy.
966		
967	V.A.2.	Summative Evaluation

968		
969		
970		The program director must provide a summative evaluation for each
971		fellow upon completion of the program. This evaluation must
972		become part of the fellow’s permanent record maintained by the
973		institution, and must be accessible for review by the fellow in
974		accordance with institutional policy. This evaluation must:
975	V.A.2.a)	document the fellow’s performance during their education,
976		and
977		
978	V.A.2.b)	verify that the fellow has demonstrated sufficient competence
979		to enter practice without direct supervision.
980		
981	V.B.	Faculty Evaluation
982		
983	V.B.1.	At least annually, the program must evaluate faculty performance as
984		it relates to the educational program.
985		
986	V.B.2.	These evaluations should include a review of the faculty’s clinical
987		teaching abilities, commitment to the educational program, clinical
988		knowledge, professionalism, and scholarly activities. These
989		evaluations must be confidential and must be reviewed with the
990		faculty members annually.
991		
992	V.B.3.	These evaluations must be confidential and must be reviewed with <u>each</u>
993		the faculty member annually.
994		
995	V.C.	Program Evaluation and Improvement
996		
997	V.C.1.	The program must document formal, systematic evaluation of the
998		curriculum at least annually. The program must monitor and track
999		each of the following areas:
1000		
1001	V.C.1.a)	fellow performance,
1002		
1003	V.C.1.b)	faculty development,
1004		
1005	V.C.1.c)	graduate performance, including performance of program
1006		graduates on the certification examination, and
1007		
1008	V.C.1.c).(1)	<i>At least 80% of <u>program’s graduating fellows from those</u></i>
1009		<i><u>eligible to take an ABIM subspecialty certifying</u></i>
1010		<i><u>examination upon completion of their training for the most</u></i>
1011		<i><u>recently defined five-year period who are eligible should</u></i>
1012		<i><u>must have taken an <u>the</u> ABIM subspecialty certifying</u></i>
1013		<i><u>examination. (Note: Five-year rolling pass rate for first time</u></i>
1014		<i><u>takers of the ABIM certifying examination will be examined</u></i>
1015		<i><u>at each program review).</u></i>
1016		

- 1017 V.C.1.c).(2) At least 80% of a program's graduates taking the ABIM
1018 certifying examination for the first time during the most
1019 recently defined five-year period should pass.
1020
1021 V.C.1.d) program quality.
1022
1023 V.C.1.d).(1) Fellows and faculty members must have the opportunity to
1024 evaluate the program confidentially and in writing at least
1025 annually.
1026
1027 V.C.1.d).(2) The program must use the results of fellows' assessments
1028 of the program together with other program evaluation
1029 results to improve the program.
1030
1031 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
1032 **of action to document initiatives to improve performance in the**
1033 **areas listed in section V.C.1. The action plan should be reviewed**
1034 **and approved by the teaching faculty and documented in meeting**
1035 **minutes.**
1036
1037 V.C.3. Representative program personnel, at a minimum to include the program
1038 director, representative faculty, and one fellow, must review program
1039 goals and objectives, and the effectiveness with which they are achieved.
1040
1041 **VI. Fellow Duty Hours in the Learning and Working Environment**
1042
1043 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
1044
1045 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
1046 **faculty members concerning the professional responsibilities of**
1047 **physicians to appear for duty appropriately rested and fit to provide**
1048 **the services required by their patients.**
1049
1050 **VI.A.2. The program must be committed to and responsible for promoting**
1051 **patient safety and fellow well-being in a supportive educational**
1052 **environment.**
1053
1054 **VI.A.3. The program director must ensure that fellows are integrated and**
1055 **actively participate in interdisciplinary clinical quality improvement**
1056 **and patient safety programs.**
1057
1058 **VI.A.4. The learning objectives of the program must:**
1059
1060 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
1061 **patient care responsibilities, clinical teaching, and didactic**
1062 **educational events; and,**
1063
1064 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
1065 **non-physician service obligations.**
1066
1067 **VI.A.5. The program director and sponsoring institution must ensure a**

- 1068 culture of professionalism that supports patient safety and personal
 1069 responsibility. Fellows and faculty members must demonstrate an
 1070 understanding and acceptance of their personal role in the
 1071 following:
 1072
- 1073 VI.A.5.a) assurance of the safety and welfare of patients entrusted to
 1074 their care;
 - 1075 VI.A.5.b) provision of patient- and family-centered care;
 - 1076 VI.A.5.c) assurance of their fitness for duty;
 - 1077 VI.A.5.d) management of their time before, during, and after clinical
 1078 assignments;
 - 1079 VI.A.5.e) recognition of impairment, including illness and fatigue, in
 1080 themselves and in their peers;
 - 1081 VI.A.5.f) attention to lifelong learning;
 - 1082 VI.A.5.g) the monitoring of their patient care performance improvement
 1083 indicators; and,
 1084 VI.A.5.h) honest and accurate reporting of duty hours, patient
 1085 outcomes, and clinical experience data.
- 1086
 1087 VI.A.6. All fellows and faculty members must demonstrate responsiveness
 1088 to patient needs that supersedes self-interest. Physicians must
 1089 recognize that under certain circumstances, the best interests of the
 1090 patient may be served by transitioning that patient's care to another
 1091 qualified and rested provider.
 1092
- 1093 VI.B. Transitions of Care
- 1094 VI.B.1. Programs must design clinical assignments to minimize the number
 1095 of transitions in patient care.
 - 1096 VI.B.2. Sponsoring institutions and programs must ensure and monitor
 1097 effective, structured hand-over processes to facilitate both
 1098 continuity of care and patient safety.
 - 1099 VI.B.3. Programs must ensure that fellows are competent in communicating
 1100 with team members in the hand-over process.
 - 1101 VI.B.4. The sponsoring institution must ensure the availability of schedules
 1102 that inform all members of the health care team of attending
 1103 physicians and fellows currently responsible for each patient's care.
- 1104
 1105 VI.C. Alertness Management/Fatigue Mitigation
- 1106 VI.C.1. The program must:

1119		
1120	VI.C.1.a)	educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
1121		
1122		
1123	VI.C.1.b)	educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
1124		
1125		
1126	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.
1127		
1128		
1129		
1130	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.
1131		
1132		
1133		
1134	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.
1135		
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1137		
1138	VI.D.	Supervision of Fellows
1139		
1140	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.
1141		
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1143		
1144		
1145		
1146	VI.D.1.a)	This information should be available to fellows, faculty members, and patients.
1147		
1148		
1149	VI.D.1.b)	Fellows and faculty members should inform patients of their respective roles in each patient's care.
1150		
1151		
1152	VI.D.2.	The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
1153		
1154		
1155		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.
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1166	VI.D.3.	Levels of Supervision
1167		
1168		To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of
1169		

1170		supervision:
1171		
1172	VI.D.3.a)	Direct Supervision – the supervising physician is physically present with the fellow and patient.
1173		
1174		
1175	VI.D.3.b)	Indirect Supervision:
1176		
1177	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.
1178		
1179		
1180		
1181		
1182	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.
1183		
1184		
1185		
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1188		
1189	VI.D.3.c)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
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1191		
1192		
1193	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.
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1195		
1196		
1197		
1198	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.
1199		
1200		
1201		
1202	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.
1203		
1204		
1205		
1206	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.
1207		
1208		
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1210		
1211	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.
1212		
1213		
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1215		
1216	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.
1217		
1218		
1219		
1220	VI.D.6.	Faculty supervision assignments should be of sufficient duration to

1221		assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.
1222		
1223		
1224		
1225	VI.E.	Clinical Responsibilities
1226		
1227		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.
1228		
1229		
1230		
1231	VI.F.	Teamwork
1232		
1233		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.
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1235		
1236		
1237		
1238	VI.F.1.	Contributors to effective interprofessional teams may include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.
1239		
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1242		
1243	VI.G.	Fellow Duty Hours
1244		
1245	VI.G.1.	Maximum Hours of Work per Week
1246		
1247		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.
1248		
1249		
1250		
1251	VI.G.1.a)	Duty Hour Exceptions
1252		
1253		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.
1254		
1255		
1256		
1257		The Review Committee will not consider requests for exceptions to the 80-hour limit to the fellows' work week.
1258		
1259		
1260	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.
1261		
1262		
1263		
1264	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.
1265		
1266		
1267		
1268	VI.G.2.	Moonlighting
1269		
1270	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational
1271		

1272		program.
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1274	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.
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1278	VI.G.3.	Mandatory Time Free of Duty
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1280		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.
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1284	VI.G.4.	Maximum Duty Period Length
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1286		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.
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1293	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.
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1299	VI.G.4.b)	Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
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1302	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.
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1310	VI.G.4.c).(1)	Under those circumstances, the fellow must:
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1312	VI.G.4.c).(1).(a)	appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
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1316	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.
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1321	VI.G.4.c).(2)	The program director must review each submission of additional service, and track both individual fellow and
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1323 **program-wide episodes of additional duty.**

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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.

Sleep 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) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.'

Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director.

The program director must review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty.

1374 **VI.G.6. Maximum Frequency of In-House Night Float**
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1376 **Fellows must not be scheduled for more than six consecutive nights**
1377 **of night float.**
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1379 **VI.G.7. Maximum In-House On-Call Frequency**
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1381 **Fellows must be scheduled for in-house call no more frequently than**
1382 **every-third-night (when averaged over a four-week period).**
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1384 *VI.G.7.a) Internal medicine fellowships ~~programs are not allowed to~~ must*
1385 *not average in-house call over a four-week period.*
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1387 **VI.G.8. At-Home Call**
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1389 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1390 **count towards the 80-hour maximum weekly hour limit. The**
1391 **frequency of at-home call is not subject to the every-third-**
1392 **night limitation, but must satisfy the requirement for one-day-**
1393 **in-seven free of duty, when averaged over four weeks.**
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1395 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1396 **preclude rest or reasonable personal time for each**
1397 **fellow.**
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1399 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1400 **home call to care for new or established patients. Each**
1401 **episode of this type of care, while it must be included in the**
1402 **80-hour weekly maximum, will not initiate a new “off-duty**
1403 **period”.**
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1407 ACGME Approved: June 11, 2011 Effective: July 1, 2012