# NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

## NIHS Program Requirements for Specialty Education in Geriatric Medicine (Emirati Board in Geriatric Medicine)

*The Emirati Board in Geriatric Medicine is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.*

*Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.*

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## Introduction

### Int. A. Preamble

Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.

Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

### Int. B. Definition of Subspecialty

Geriatric medicine fellowships provide advanced education to allow fellows to acquire competency in the subspecialty with sufficient expertise to act as independent primary care providers and consultants.

Geriatrician is a clinician who has the expertise and skills to provide care for the elderly with complexity using a multidisciplinary approach to reduce the limitations in the form of impairments and disabilities resulting from disease and to improve quality of life.

### Int. C. Length of Educational Program

The educational program for geriatric medicine must be 12 months in length. (Core)

## I. Oversight

### I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the National Institute of Health Specialties (NIHS) institutional requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

***Background and Intent***: *Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings.*

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

### I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.

I.B.1. The program, with the approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.1.a) A Geriatric Medicine fellowship must function as an integral part of an NIHS-accredited program in Family Medicine or Internal Medicine. (Core)

I.B.1.b) The Sponsoring Institution must establish the Geriatric Medicine fellowship within a department of Family Medicine or Internal Medicine or an administrative unit whose primary mission is the advancement of Family Medicine or Internal Medicine Geriatric education and patient care.

I.B.1.c) The Sponsoring Institution must ensure that there is a partnership and close collaboration between the program directors of the parent Family Medicine or Internal Medicine residency program and fellowship program to ensure compliance with NIHS accreditation requirements. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern fellow education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for fellows; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of fellows. (Core)

I.B.3. The program must establish a mechanism to monitor the educational activities, including the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member who is board certified in the specialty in which geriatric fellow will rotate in. This faculty member must be designated by the program director to act as rotation educational coordinator. (Core)

***Background and Intent:*** *While all fellowship programs must be sponsored by a single NIHS-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.*

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of at least two weeks full time equivalent (FTE) or more through NIHS Accreditation System. (Core)

I.B.4.a) Fellows who are rotating away from primary clinical site should attend the required didactic sessions or clinical activities in the primary clinical site. (Core)

## I.C. Recruitment

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)

## I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)

I.D.1.a) Space and Equipment

There must be space and equipment for the program, including meeting rooms, examination rooms, computers, visual and other educational aids, and work/study space. (Core)

I.D.1.b) Acute Care Hospital

I.D.1.a)(1) The acute care hospital central to the geriatric medicine program must be an integral component of a teaching center. (Core)

I.D.1.a)(1)(a) The acute care hospital must have the full range of resources typically found in an acute care

hospital, including intensive care units, an emergency medicine service, operating rooms, diagnostic laboratory and imaging services, and pathology services.

I.D.1.c) Long-Term Care Facilities

I.D.1.c)(1) One or more long-term care facilities, such as a skilled nursing facility or chronic care hospital, must be affiliated with the program. (Core)

I.D.1.c)(2) The total number of beds available must be sufficient to facilitate a comprehensive educational experience. (Core)

I.D.1.d) Long-Term Non-Institutional Care Services

I.D.1.d)(1) Non-institutional care services, such as home care, day care, residential care, transitional care, or assisted living, must be included in the program. (Core)

I.D.1. e) Ambulatory Care Facilities

The following must be included in the program: (Core)

I.D.1.e)(1) a nursing home that includes sub-acute and long-term care; (Core)

I.D.1.e)(2) a home care setting; (Core)

I.D.1.e.3 family medicine center, internal medicine office, or other outpatient setting. (Core)

I.D.1.f) Other Support Services

A Geriatric Medicine Consultation Program must be formally available in the ambulatory setting, the inpatient service, and/or emergency medicine service in the acute care hospital or at an ambulatory setting administered by the primary clinical site. (Core)

I.D.1.g) Medical Records

Access to an electronic health record should be provided. (Core)

I.D.1.h) Patient Population

I.D.1.h)(1) The patient population must have a variety of clinical problems and stages of diseases. (Core)

I.D.1.h)(2) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)

I.D.1.h)(3) Elderly patients of each gender (at least 25 percent of each gender, cumulative across settings) with a variety of chronic illnesses or geriatric syndromes at least some of whom have potential for rehabilitation, must be available. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for:

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care, if the fellows are assigned in-house call; (Core)

***Background and Intent:*** *Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows' function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities.*
*Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.*

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

***Background and Intent:*** *Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family.*

I.D.2.d) security and safety measures appropriate to the participating site; (Core)

I.D.2.e) accommodation for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)

I.D.3. Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

### I.E. Other Learners and Health Care Personnel

The presence of other learners and health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not interfere with educational opportunities for the appointed fellows. (Core)

I.E.1. Fellows should contribute to the education of residents in core programs if present. (Core)

***Background and Intent:*** *The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.*

## II. Personnel

### II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) Final approval of the program director resides with the Central Accreditation Committee. (Core)

***Background and Intent:*** *While the NIHS recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the fellowship, and it is this individual's responsibility to communicate with the fellows, faculty members, DIO, GMEC, and the NIHS. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Central Accreditation Committee.*

II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

***Background and Intent****: The success of fellowship programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.*

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 30 percent FTE of non-clinical time to the administration of the program. (Core)

***Background and Intent:*** *Thirty percent FTE is defined as one-and-a-half (1.5) day per week. "Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director.*

II.A.3. Qualifications of the program director:

II.A.3.a) must include subspecialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

***Background and Intent:*** *Leading a program requires knowledge and skills that are established during fellowship and subsequently further developed. The time from completion of fellowship until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.*

*The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.*

*In certain circumstances, the program and Sponsoring Institution may propose, and the Central Accreditation Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.*

II.A.3.b) must be licensed as consultant and have at least three years post fellowship documented experience in Geriatric Medicine, or with a specialty qualification that are acceptable to the Central Accreditation Committee; (Core)

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; (Core)

II.A.3.d) must include ongoing clinical activity; (Core)

***Background and Intent**: A program director is a role model for faculty members and fellows. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and fellows.*

II.A.2.b) Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program director(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core)

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; (Core)

***Background and Intent:** The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an*

*environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.*

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

***Background and Intent:*** *The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the goal of addressing these needs and health disparities.*

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the fellows in each of the NIHS Competency domains; (Core)

***Background and Intent:*** *The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.*

II.A.4.a)(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the fellowship program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

***Background and Intent:*** *The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.*

*There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the fellows.*

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; (Core)

***Background and Intent:*** *A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.*

II.A.4.a)(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(13) document verification of program completion for all graduating fellows; within 30 days; (Core)

II.A.4.a)(14) provide verification of an individual fellow's completion upon the fellow's request, within 30 days; (Core)

***Background and Intent:*** *Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(15) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Common Program Requirements. (Core)

II.A.5. Associate Program Director (APD):

II.A.5.a) Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director. The associate program director must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration, The APD must not work more than 0.7 FTE in a clinical capacity. (Core)

II.A.5.b)(1) This must be demonstrated through clinical schedules over the entire period since the last accreditation visit or since program inception, whichever is shorter. (Detail)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

## II.B. Faculty

Faculty members have a pivotal role in graduate medical education. Faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of geriatricians by demonstrating compassion, commitment to excellence in teaching and elderly patient care, professionalism, and a dedication to lifelong learning. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.

***Background and Intent:*** *"Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.*

II.B.1 There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)

II.B.1.a) There must be appropriate and timely consultations from other specialties. (Core)

II.B.1.b) The ratio of all faculty to fellows must be a minimum of 1:1. (Core)

II.B.2. Faculty members must:

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

***Background and Intent:*** *Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.*

II.B.2.c) demonstrate a strong interest in the education of fellows; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating fellows; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; (Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually. (Core)

***Background and Intent:*** *Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the*

*institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.*

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.3.b) Physician faculty members must:

II.B.3.b)(1) have current license in geriatric medicine or other specialty as required, or possess qualifications judged acceptable to the Central Accreditation Committee. (Core)

II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. (Core)

II.B.4. Core faculty members

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)

***Background and Intent**: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual NIHS Faculty annual survey.*

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. (Core)

II.B.4.c) In addition to the program director, there must be at least one core faculty member who has active certification and valid license in geriatric medicine (specialist or consultant). (Core)

II.B.4.d) For programs with more than two fellows, there must be at least one core faculty member for every 1.5 fellows. (Core)

II.B.4.e At a minimum, the required core faculty members, in aggregate anf excluding program leadership, must be provided with support equal to an average dedicated minimum of .1 FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)

### II.C. Program Coordinator

II.C.1. There must be administrative support for program coordination. (Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. FTE and Additional administrative support must be provided based on the program size as follow. (Core)

***Background and Intent:*** *Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the NIHS. Individuals serving in this role are recognized as program coordinators.*

*The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the NIHS and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows.*

*Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.*

### II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

II.D.1. There must be services available from other health care professionals who frequently work in inter-professional teams with geriatricians, such as dietitians,, nurses, occupational therapists, pharmacists, physical therapists, psychologists, social workers, and speech pathologists. (Core)

## III. Fellow Appointments

### III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS-accredited program: (Core)

III.A.1.a) All required clinical education for entry into NIHS-accredited fellowship programs must be completed in a NIHS-accredited residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or another structured residency program considered acceptable by Central Accreditation Committee. (Core).

III.A.1.b) Prior to appointment in the fellowship, fellows should have completed a family medicine practice or internal medicine program that satisfies the requirements in III.A.1.a). (Core)

III.A.1.b)(1) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.c) Fellow Eligibility Exception

The Central Accreditation Committee will allow the following exception to the fellowship eligibility requirements:

III.A.1.c)(1) An NIHS-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.1.c)(1)(a) Is eligible for license of specialist in Family Medicine Practice or Internal Medicine by UAE Health Authority PQR. (Core)

III.A.1.c)(1)(b) Is evaluated by the program director and fellowship selection committee based on prior training

and review of the summative evaluations of training in the core specialty; (Core)

III.A.1.c)(1)(c) The applicant's exceptional qualifications are reviewed and approved of by the GMEC; (Core)

III.A.1.c)(2) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into NIHS-accredited fellowship programs must be completed in a NIHS-accredited fellowship programs approved by the NIHS. (Core)

III.A.2.a) Prior to appointment in the program, fellows must fulfil the NIHS eligibility criteria. (Core)

## III.B. Number of Fellows

III.B.1. The program director must not appoint more fellows than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in fellow complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of fellows appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.B.4. The number of available fellow positions in the program must be at least two per year. (Detail)

## III.C. Fellows Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)

## IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful geriatrician who provide compassionate care.

### IV.A. Curriculum Components

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates. (Core)

IV.A.2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice which is documented by Milestones evaluation. (Core)

IV.A.2.a) These goals and objectives must be distributed and available to fellows and faculty members. (Core)

IV.A.3. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty. (Core)

IV.A.4. Structured educational activities beyond direct patient care. (Core)

IC.A.4.a) Fellows must be provided with protected time to participate in core didactic activities. (Core)

***Background and Intent**: Patient care-related educational activities, such as morbidity and mortality conferences, tumour boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected.*

IV.A.5. Advancement of fellows' knowledge of ethical principles foundational to medical professionalism. (Core)

IV.A.6. Formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

## IV.B. Defined Core Competencies

IV.B.1. The program must integrate the following Core Competencies into the geriatric medicine curriculum: (Core)

IV.B.1.a) Professionalism:

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles and conduct. (Core)

IV.B.1.b) Patient Care and Procedural Skills

IV.B.1.b)(1) Fellows must be able to provide patient care that is person-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

IV.B.1.b)(1)(a) Fellows must demonstrate clinical competence in:

IV.B.1.b)(1)(a)(i) assessing the functional status of geriatric patients; (Core)

IV.B.1.b)(1)(a)(ii) treating and managing geriatric patients in acute care, long-term care, community, and home care settings; (Core)

IV.B.1.b)(1)(a)(iii) assessing the cognitive status and affective states of geriatric patients; (Core)

IV.B.1.b)(1)(a)(iv) providing appropriate preventive care, and teaching patients and their caregivers regarding self-care; (Core)

IV.B.1.b)(1)(a)(v) providing care that is based on the patient's preferences and overall health; (Core)

IV.B.1.b)(1)(a)(vi) assessing older persons for safety risk, and providing appropriate

recommendations, and when appropriate referral; (Core)

IV.B.1.b)(1)(a)(vii) peri-operative assessment and management; (Core)

IV.B.1.b)(1)(a)(viii) use of an interpreter in clinical care. (Core)

IV.B.1.b)(2) Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

IV.B.1.b)(3) Fellow must be able to assess and manage elderly patient with different levels of complicity by applying the principles of Comprehensive Geriatric Assessment (CGA). (Core)

IV.B.1.c) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social- behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c)(1) Fellows must demonstrate knowledge in the following content areas:

IV.B.1.c)(1)(a) the current science of aging and longevity, including theories of aging, the physiology and natural history of aging, age related changes, epidemiology of aging populations, ageism and diseases of the aged; (Core)

IV.B.1.c)(1)(b) aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization, and chemoprophylaxis against disease; (Core)

IV.B.1.c)(1)(c) 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 and

appropriate use of the history; physical and mental examination; and interpretation of laboratory results; (Core)

IV.B.1.c)(1)(d) the general principles of geriatric rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, pulmonary, and neurologic impairments; (Core)

IV.B.1.c)(1)(d)(i) These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, and, environmental modification, patient and family education, and psychosocial and recreational counseling. (Core)

IV.B.1.c)(1)(e) management of patients in long-term care settings, including palliative care, administration, regulation, and financing of long-term institutions, and the continuum from short- to long-term care; (Core)

IV.B.1.c)(1)(f) the pivotal role of the family in caring for the elderly, and the community resources (formal support systems) required to support both the patient and the family; (Core)

IV.B.1.c)(1)(g) home care, including the components of a home visit, and accessing appropriate community resources to provide care in the home setting; (Core)

IV.B.1.c)(1)(h) hospice care, including pain management, symptom relief, comfort care, and end-of-life issues; (Core)

IV.B.1.c)(1)(i) behavioral sciences, including psychology and social work; (Core)

IV.B.1.c)(1)(j) topics of special interest to geriatric medicine, including cognitive impairment, behavioral and psychological symptoms of dementia (BPSD), depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure

ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment, frailty; (Core)

IV.B.1.c)(1)(k) diseases that are especially prominent in the elderly or that may have atypical characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders; (Core)

IV.B.1.c)(1)(l) pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, de-prescribing, and adherence; (Core)

IV.B.1.c)(1)(m) psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, substance use disorders, other mood disorders, psychotic disorders, intellectual and developmental disabilities and anxiety; (Core)

IV.B.1.c)(1)(n) patient and family education, and psychosocial and recreational counseling for patients requiring rehabilitation care; (Core)

IV.B.1.c)(1)(o) the economic aspects of supporting geriatric services; (Core)

IV.B.1.c)(1)(p) the ethical and legal issues 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 in the context of current local ethical and legal regulations; (Core)

IV.B.1.c)(1)(q) research methodologies related to geriatric decision analysis; (Core)

IV.B.1.c)(1)(r) iatrogenic disorders and their prevention; (Core)

IV.B.1.c)(1)(s) 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, issues of ethnicity in long-term care, and special issues relating to urban and rural older persons of various ethnic backgrounds; (Core)

IV.B.1.c)(1)(t) behavioral aspects of illness, socioeconomic factors, and health literacy issues; (Core)

IV.B.1.c)(1)(u) basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.1.d) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

IV.B.1.e) 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. (Core)

IV.B.1.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

## IV.C. Curriculum Organization and Fellow Experiences

IV.C.1. The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate mix of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)

IV.C.1.a) Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. (Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)

IV.C.3. All 24 of the educational program must be devoted to clinical experience. (Core)

IV.C.3.a) Each fellow must have clinical experience in the care of elderly patients, which includes management of: (Core)

IV.C.3.a)(1) direct care for patients in ambulatory, community, and long-term care settings, and consultative and/or direct care in acute inpatient care settings; (Core)

IV.C.3.a)(2) care for persons who are generally healthy and require primarily preventive health care measures; (Core)

IV.C.3.a)(3) care for elderly patients as a consultant providing expert assessments and recommendations in the unique care needs of elderly patients. (Core)

IV.C.3.b) Ambulatory Care Program

Ambulatory care must comprise a minimum of 33 percent of the 24 month clinical experience. (Detail)

IV.C.3.b)(1) Fellows should be responsible for at least five patient visits each week, including at least one half-day per week spent in a continuity of care experience. (Detail)

IV.C.3.b)(2) Fellows must provide care in a geriatric clinic or family medicine center to elderly patients who may require the services of multiple medical disciplines, including medical sub-specialties, audiology, dentistry, gynecology, neurology, neurosurgery, ophthalmology, orthopedics, general surgery, ENT, physical medicine and rehabilitation, psychiatry, podiatry, and urology. (Detail)

IV.C.3.b)(3) Fellows must provide continuing care and coordinate the implementation of recommendations from medical specialties and other disciplines in their continuity clinic. (Core)

IV.C.3.b)(4) Fellows should have experiences in relevant ambulatory specialty and subspecialty clinics, such as psychiatry and neurology (dementia and movement disorders) and those that focus on the assessment and management of geriatric syndromes, such as falls, incontinence, frailty and osteoporosis. (Detail)

IV.C.3.c) Long-term Care Experience

Each fellow must have 24 months of continuing longitudinal clinical experience in the long-term care setting and manage an assigned panel of patients for whom he or she is the primary provider. (Core)

IV.C.3.c)(1) Fellows must participate in patient care activities in subacute care and rehabilitation in the long-term care setting. (Core)

IV.C.3.c)(2) Fellows should have clinical experience in day-care or day-hospital centers, life care communities, or residential care facilities. (Detail)

IV.C.3.c)(3) Each fellow's longitudinal experience must include:

IV.C.3.c)(3)(a) participating in home visits and hospice care, including organizational and administrative aspects of home health care and experience with continuity of care for home or hospice or palliative care patients; (Core)

IV.C.3.c)(3)(b) structured didactic and clinical experiences in geriatric psychiatry. (Core)

IV.C.3.c)(4) Each fellow's longitudinal experience should include:

IV.C.3.c)(4)(a) diagnosis and treatment of the acutely- and chronically ill and frail elderly in a less technologically sophisticated environment than the acute-care hospital; (Detail)

IV.C.3.c)(4)(b) working within the limits of a decreased staff-patient ratio compared with acute-care hospitals; (Detail)

IV.C.3.c)(4)(c) familiarity with sub-acute care physical medicine and rehabilitation; (Detail)

IV.C.3.c)(4)(d) addressing the clinical and ethical dilemmas produced by the illness of the very old; (Detail)

IV.C.3.c)(4)(e) participating in the administrative aspects of long-term care; (Detail)

IV.C.3.c)(4)(f) interacting and communicating with the family/caregiver; (Detail)

IV.C.3.c)(4)(g) using palliative care and hospice in caring for the terminally ill. (Detail)

IV.C.4.Acute care experiences:

IV.C.4.A. Fellow should have clinical experience in providing care for elderly patients admitted to specialized acute geriatric medicine services. Fellow should spend at least 3 months

IV.C.4.B. Fellow should have clinical experience in providing inpatient geriatric medicine consultations for elderly patients admitted under medical, surgical and psychiatric services. Fellow should spend at least 3 months

IV.C.5.. Additional Fellow Experiences

IV.C.4.a) As fellows progress through their education, they should teach other health professionals and trainees, including allied health personnel, medical students, nurses, and residents. (Detail)

IV.C.4.b) Fellows must participate in training using simulation. (Detail)

IV.C.4.c) Fellows must be involved in other health care and community agencies, such as delivery of health care in community-based settings. (Detail)

IV.C.6 Didactic Curriculum

IV.C.5.a) The core curriculum must include a didactic program based upon the core knowledge content in geriatric medicine. (Core)

IV.C.5.a)(1) Fellows must participate in clinical case conferences, journal clubs, morbidity and mortality or quality improvement conferences, and patient safety conferences. (Core)

IV.C.5.a)(2) All core conferences must have at least one faculty member present and must be scheduled as to ensure peer-peer and peer-faculty interaction. (Detail)

IV.C.5.a)(3) Fellows should have instruction in and experience with community resources that provide aid to their patients. (Detail)

IV.C.5.b) Fellows must be instructed in practice management relevant to geriatric medicine. (Core)

## IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. The fellow should acquire and improve in several skills which include: the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements.

Scholarly activities may include discovery, integration, application, and teaching.

The NIHS recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed journal publications, case-presentation publications
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate scholarly activity by the following methods:

IV.D.2.b)(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium

presentations, reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Core)

IV.D.2.b)(2) peer-reviewed publication incl. case-discussion and letters to the editor. (Core)

IV.D.3. Fellow Scholarly Activity

IV.D.3.a) While in the program, fellows must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Core)

IV.D.3.b) Fellows must participate in scholarly project. (Core)

IV.D.3.b)(1) Fellows must complete a scholarly project relevant to the specialty which was conducted under direct supervision of a faculty member. (Core)

IV.D.3.b)(2) The project, shall be prepared in a form which can be used for publication or presentation and submitted for publication in a specialty specific journal or presented in a national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of project submission for publication, or presentation in a medical conference, will be part of the fellow's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. (Core)

## V. Evaluation

### V.A. Fellow Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring fellow learning and providing ongoing feedback that can be used by fellows to improve their learning.

More specifically, formative evaluations help:

- fellows identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where fellows are struggling and address problems immediately.

Summative evaluation is evaluating a fellow's learning by comparing the fellows against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)

This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.a)(1) The faculty must discuss this evaluation with each fellow at the completion of each assignment. (Core)

V.A.1.a)(2) Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. (Detail)

V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.1.b)(2) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. (Core)

V.A.1.b)(3) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)

V.A.1.c)(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) (Core)

V.A.1.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d)(1) Meet with and review with each fellow their documented semi-annual evaluation of performance, including progress and the specialty-specific Milestones (Core)

V.A.1.d)(1)(a) Review of fellow Case-Logs must be a part of the semi-annual review. (Detail)

V.A.1.d)(2) assist fellow in developing individualized learning plans to capitalize on their strengths and identify areas for growth; (Core)

V.A.1.d)(3) develop plans for fellows failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

V.A.1.e) At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each fellow upon completion of the program. (Core)

V.A.2.a)(1) The geriatric medicine-specific Milestones, and when applicable the specific Case Logs, must be used as tools to document performance and verify that the fellow has demonstrated sufficient competence to be able to engage in autonomous practice upon completion of the program, and once he/she obtain the license to practice in geriatric medicine. (Core)

V.A.2.a)(2) The final evaluation must:

V.A.2.a)(2)(a) 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; (Core)

V.A.2.a)(2)(b) verify that the fellow has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; (Core)

V.A.2.a)(2)(c) consider recommendations from the Clinical Competency Committee (Core)

V.A.2.a)(2)(d) be shared with the fellow upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a)(1) Additional members must be faculty members from the same program or other programs, or other health

professionals who have extensive contact and experience with the program's fellows. (Core)

V.A.3.a)(2) The Program Director has final responsibility for fellow evaluation and promotion decisions. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b)(1) Review all fellows evaluation at least semi-annually; (Core)

V.A.3.b)(2) determine each fellow's progress on achievement of the specialty-specific Milestones; (Core)

V.A.3.b)(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)

## V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the fellows. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

## V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of fellows and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and fellows as a part of continuous improvement plans.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate fellows and the faculty:

V.C.1.c)(5)(a) well-being; (Core)

V.C.1.c)(5)(b) recruitment and retention following institutional policies; (Core)

V.C.1.c)(5)(c) workforce diversity following institutional policies; (Core)

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(e) scholarly activity; (Core)

V.C.1.c)(5)(f) Fellows and Faculty Surveys; (Core)

V.C.1.c)(5)(g) written evaluations of the program (see above). (Core)

V.C.1.c)(6) Aggregate fellow:

V.C.1.c)(6)(a) achievement of the Milestones; (Core)

V.C.1.c)(6)(b) in-training examination results; (Core)

V.C.1.c)(6)(c) board pass and certification rates; (Core)

V.C.1.c)(6)(d) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the fellows; (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws.

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the fellowship program with the aim to improve it. (Detail)

V.C.3. The goal of NIHS-accredited education is to train physicians who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Outcome)

V.C.3.a) Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS to obtain the Certification. (Outcome)

V.C.3.b) Graduates are eligible to sit for the Certification examination for up to three years from the date of completion of fellowship training. (Outcome)

V.C.4. During the fellowship, the fellows are strongly encouraged to sit for an organized Annual In-Training Examination. (Detail)

## VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by fellows today.
- Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice
- Excellence in professionalism through faculty modelling of:
    - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
    - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the fellows, faculty members, and all members of the health care team

### VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Program must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyse the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a)(1)(a) The program, its faculty and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. (Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

***Background and Intent:*** *Optimal patient safety occurs in the setting of a coordinated inter-professional learning and working environment.*

VI.A.1.a)(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a)(3)(a) Fellows, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Fellows must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Fellow Education and Experience in Disclosure of Adverse Events

Patient-centred care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.

VI.A.1.a)(4)(a) All fellows must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary for health care professionals to achieve quality improvement goals.

Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b)(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b)(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Fellows must have the opportunity to participate in inter-professional quality improvement activities. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of fellowship medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a)(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. (Core)

VI.A.2.a)(1)(a) This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a)(1)(b) Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For some 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 appropriate availability of the supervising faculty member, or senior fellow physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when physical presence of a supervising physician is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervising physician is physically present with the fellow during the key portions of the patient interaction. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(3) Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) 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. (Core)

VI.A.2.d)(1) The program director must evaluate each fellow' abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d)(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)

VI.A.2.d)(3) Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)

Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to

delegate to the fellow the appropriate level of patient care authority and responsibility. (Core)

### VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on fellows to fulfill non-physician obligations; (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centred care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

***Background and Intent**: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.*

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

VI.B.4.c)(1) management of their time before, during, and after clinical assignments; (Outcome)

VI.B.4.c)(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition 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. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of fellows, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behaviour and a confidential process for reporting, investigating, and addressing such concerns. (Core)

## VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modelled, learned, and nurtured in the context of other aspects of fellowship training.

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of fellow competence. Physicians and all members of the health care team share responsibility for the well-being of each

other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture, in a clinical learning environment, models constructive behaviors and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; (Core)

VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorders.

The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e)(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another fellow, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence; (Core)

VI.C.1.e)(2) provide access to appropriate tools for self-screening; (Core)

VI.C.1.e)(3) provide access to confidential, affordable mental health assessment, counselling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)

***Background and Intent:*** *Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.*

### VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes;, (Core)

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

## VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes 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 and larger health system. (Core)

VI.E.2.a) Each fellow must have experience participating as a member of a physician-directed interdisciplinary geriatric team in more than one setting. (Core)

VI.E.2.a)(1) This team must include a geriatrician, a nurse, and a social worker/case manager. (Detail)

VI.E.2.a)(2) When appropriate, this team should include representatives from disciplines such as dentistry, neurology, occupational therapy, pastoral care, pharmacy, physical medicine and rehabilitation, physical therapy, psychiatry, psychology, and speech therapy. (Detail)

VI.E.2.a)(3) Physician assistants or nurse practitioners should be available to provide team or collaborative care of geriatric patients. (Detail)

VI.E.2.a)(4) Regular geriatric team conferences must be held as dictated by the needs of the individual patient. (Detail)

***Background and Intent:*** *Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.*

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

**VI.F. Clinical Experience and Education**

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)

There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. (Core)

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a)(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a)(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a)(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.5. Moonlight

Fellows are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one- day-off-in-seven requirements. (Core)

VI.F.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). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. (Core)

VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of fellows at key stages of their graduate medical education.

## Acknowledgement

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