



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Geriatric Medicine
(Family Medicine or Internal Medicine)**

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ACGME Program Requirements for Graduate Medical Education in Geriatric Medicine

One-year Common Program Requirements are in BOLD

Introduction

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

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

Int. B. 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.

Int. C. The educational program in geriatric medicine must be 12 months in length. ^(Core)

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. ^(Core)

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. ^(Core)

I.A.1. A geriatric medicine fellowship must function as an integral component of

an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in internal medicine or family medicine. ^(Core)

I.A.2. An ACGME-accredited program in at least one specialty other than internal medicine or family medicine should be present at the primary clinical site. This may be accomplished by affiliation with another educational institution. ^(Core)

I.A.3. The sponsoring institution and participating sites must share appropriate inpatient and outpatient faculty member performance data with the program director. ^(Core)

I.B. Participating Sites

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

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. ^(Detail)

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

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMC must approve a change in program director. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

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

- II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** ^(Core)
- II.A.2.a).(1) The program director must have at least five years of participation as an active faculty member in an ACGME-accredited family medicine or internal medicine residency or geriatric medicine fellowship. ^(Detail)
- II.A.2.b) current certification in the subspecialty by the American Board of Internal Medicine (ABIM), American Board of Family Medicine (ABFM), or subspecialty qualifications that are acceptable to the Review Committee; and,** ^(Core)
- II.A.2.b).(1) The Review Committee only accepts current ABIM or ABFM certification in geriatric medicine. ^(Core)
- II.A.2.c) current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas.** ^(Core)
- The program director must:
- II.A.3.a) prepare and submit all information required and requested by the ACGME;** ^(Core)
- II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** ^(Detail)
- II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** ^(Core)
- II.A.3.c).(1) all applications for ACGME accreditation of new programs; ^(Detail)
- II.A.3.c).(2) changes in fellow complement; ^(Detail)
- II.A.3.c).(3) major changes in program structure or length of training; ^(Detail)
- II.A.3.c).(4) progress reports requested by the Review Committee; ^(Detail)
- II.A.3.c).(5) requests for increases or any change to fellow duty hours; ^(Detail)

- II.A.3.c).(6)** **voluntary withdrawals of ACGME-accredited programs;** ^(Detail)
- II.A.3.c).(7)** **requests for appeal of an adverse action; and,** ^(Detail)
- II.A.3.c).(8)** **appeal presentations to a Board of Appeal or the ACGME.** ^(Detail)
- II.A.3.d)** **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
- II.A.3.d).(1)** **program citations, and/or,** ^(Detail)
- II.A.3.d).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.3.e)** dedicate an average of 20 hours per week of his or her professional effort to the fellowship, with sufficient time for administration of the program; ^(Core)
- II.A.3.f)** have a reporting relationship with the program director of the internal medicine or family medicine residency program under which the fellowship is established to ensure compliance with the ACGME accreditation standards; and, ^(Core)
- II.A.3.g)** demonstrate experience in geriatric medicine, education, scholarly activity, and a career commitment to academic geriatric medicine. ^(Detail)
- II.B. Faculty**
- II.B.1.** **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.** ^(Core)
- II.B.2.** **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.** ^(Core)
- II.B.3.** **The physician faculty must have current certification in the subspecialty by the American Board of Internal Medicine (ABIM), the American Board of Family Medicine (ABFM), or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.4.** **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.5.** Physician faculty members must meet professional standards of ethical behavior. ^(Core)

- II.B.6. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)
- II.B.6.a) Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)
- II.B.6.b) Some members of the faculty should also demonstrate scholarship by one or more of the following: ^(Detail)
- II.B.6.b).(1) peer-reviewed funding; ^(Detail)
- II.B.6.b).(2) publication of original research or review articles in peer-reviewed journals or chapters in textbooks; ^(Detail)
- II.B.6.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)
- II.B.6.b).(4) participation in national committees or educational organizations. ^(Detail)
- II.B.7. Key Clinical Faculty
- In addition to the program director, each program must have at least one Key Clinical Faculty (KCF). ^(Core)
- II.B.7.a) KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the program. ^(Core)
- II.B.7.b) For programs with three fellows or more, there must be at least one KCF for every 1.5 fellows. ^(Core)
- II.B.7.c) Key Clinical Faculty Qualifications:
- II.B.7.c).(1) KCF must be active clinicians with knowledge of, experience with, and commitment to geriatric medicine as a discipline. ^(Core)
- II.B.7.c).(2) KCF must have current certification in geriatric medicine by the ABIM or the ABFM. ^(Core)
- II.B.7.d) Key Clinical Faculty Responsibilities:
- II.B.7.d).(1) In addition to the responsibilities of all individual faculty members, the KCF and the program director are responsible for the planning, implementation, monitoring, and evaluation of the fellows' clinical and research education. ^(Core)
- II.B.7.d).(2) All KCF must demonstrate evidence of scholarly

productivity, specifically peer-reviewed funding, or publication of original research or review articles and editorials; or case reports in peer-reviewed journals, or chapters in textbooks; or publication or presentation of case reports or clinical series at local, regional, or national society meetings; or participation in national committees or educational organizations. ^(Detail)

- II.B.7.d).(3) At least one KCF must demonstrate evidence of scholarly productivity, specifically, peer-reviewed funding; publication of original research, reviewed articles, editorials, or case reports in peer-reviewed journals; or publication of chapters in textbooks. ^(Detail)

II.C. Other Program Personnel

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

- II.C.1. There must be services available from other health care professionals who frequently work in interprofessional teams with geriatricians, such as dietitians, language interpreters, nurses, occupational therapists, pharmacists, physical therapists, psychologists, social workers, and speech pathologists. ^(Core)
- II.C.2. There must be appropriate and timely consultations from other specialties. ^(Core)

II.D. Resources

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

- II.D.1. 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)
- II.D.2. Acute Care Hospital
- II.D.2.a) The acute care hospital central to the geriatric medicine program must be an integral component of a teaching center. ^(Core)
- II.D.2.a).(1) 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. ^(Detail)

II.D.3. Long-Term Care Facilities

II.D.3.a) One or more long-term care facilities, such as a skilled nursing facility or chronic care hospital, must be affiliated with the program. ^(Core)

II.D.3.b) The total number of beds available must be sufficient to permit a comprehensive educational experience. ^(Detail)

II.D.3.c) The long-term care facilities must be approved by the appropriate licensing and accrediting agencies of the state. ^(Detail)

II.D.4. Long-Term Non-Institutional Care Services

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

II.D.5. Ambulatory Care Facilities

One or more of the following must be included in the program: ^(Core)

II.D.5.a) a nursing home that includes sub-acute and long-term care; ^(Core)

II.D.5.b) a home care setting; or, ^(Core)

II.D.5.c) a family medicine center, internal medicine office, or other outpatient setting. ^(Core)

II.D.6. 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)

II.D.7. Medical Records

Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. ^(Core)

II.D.8. Patient Population

II.D.8.a) The patient population must have a variety of clinical problems and stages of diseases. ^(Core)

II.D.8.b) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. ^(Core)

II.D.8.c) Elderly patients of each gender (at least 25 percent of each gender, cumulative across settings) with a variety of chronic illnesses, at least some of whom have potential for rehabilitation, must be available. ^(Core)

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. ^(Core)

Prior to appointment in the program, fellows should have completed a three-year ACGME-accredited internal medicine or family medicine residency; or RCPSC-accredited internal medicine residency or CFPC-accredited family medicine residency located in Canada. ^(Core)

III.A.1. **Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.** ^(Core)

III.A.2. Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

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

III.A.2.a) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** ^(Core)

III.A.2.b) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** ^(Core)

- III.A.2.c)** Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; ^(Core)
- III.A.2.d)** For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)
- III.A.2.e)** Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. ^(Core)
- III.A.2.e).(1)** If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. ^(Core)
- ** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**
- III.A.2.f)** Fellows from non-ACGME- or RCPSC-accredited internal medicine or family medicine programs must have at least three years of internal medicine or family medicine graduate medical education prior to starting the fellowship. ^(Core)
- III.A.2.f).(1)** The program director must inform applicants from non-ACGME- or RCPSC-accredited programs, prior to appointment and in writing, of the ABIM/ABFM policies and procedures that will affect their eligibility for ABIM/ABFM certification. ^(Detail)
- III.A.3.** **The Review Committees for Family Medicine and Internal Medicine allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.** ^(Core)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. ^(Core)

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form. ^(Core)

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: ^(Core)

IV.A.2.a) Patient Care and Procedural Skills

IV.A.2.a).(1) 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: ^(Outcome)

must demonstrate clinical competence in:

IV.A.2.a).(1).(a) assessing the functional status of geriatric patients;
^(Outcome)

IV.A.2.a).(1).(b) treating and managing geriatric patients in acute care, long-term care, community, and home care settings;
^(Outcome)

IV.A.2.a).(1).(c) assessing the cognitive status and affective states of geriatric patients;
^(Outcome)

IV.A.2.a).(1).(d) providing appropriate preventive care, and teaching patients and their caregivers regarding self-care;
^(Outcome)

IV.A.2.a).(1).(e) providing care that is based on the patient's preferences and overall health;
^(Outcome)

IV.A.2.a).(1).(f) assessing older persons for safety risk, and

- providing appropriate recommendations, and when appropriate, referral; (Outcome)
- IV.A.2.a).(1).(g) peri-operative assessment and management; and, (Outcome)
- IV.A.2.a).(1).(h) use of an interpreter in clinical care. (Outcome)
- IV.A.2.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Outcome)**
- IV.A.2.b) Medical Knowledge**
- Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)**
- must demonstrate knowledge in the following content areas:
- IV.A.2.b).(1) the current science of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged; (Outcome)
- IV.A.2.b).(2) aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization, and chemoprophylaxis against disease; (Outcome)
- IV.A.2.b).(3) geriatric assessment, including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; activities of daily living (ADL); the instrumental activities of daily living (IADL); medication review and appropriate use of the history; physical and mental examination; and interpretation of laboratory results; (Outcome)
- IV.A.2.b).(4) the general principles of geriatric rehabilitation, including those applicable to patients with orthopaedic, rheumatologic, cardiac, pulmonary, and neurologic impairments; (Outcome)
- IV.A.2.b).(4).(a) 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. (Outcome)
- IV.A.2.b).(5) 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; ^(Outcome)
- IV.A.2.b).(6) 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; ^(Outcome)
- IV.A.2.b).(7) home care, including the components of a home visit, and accessing appropriate community resources to provide care in the home setting; ^(Outcome)
- IV.A.2.b).(8) hospice care, including pain management, symptom relief, comfort care, and end-of-life issues; ^(Outcome)
- IV.A.2.b).(9) behavioral sciences, including psychology and social work; ^(Outcome)
- IV.A.2.b).(10) topics of special interest to geriatric medicine, including cognitive impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, sensory impairment, pressure ulcers, sleep disorders, pain, senior (elder) abuse, malnutrition, and functional impairment; ^(Outcome)
- IV.A.2.b).(11) 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; ^(Outcome)
- IV.A.2.b).(12) pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, and adherence; ^(Outcome)
- IV.A.2.b).(13) psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety; ^(Outcome)
- IV.A.2.b).(14) patient and family education, and psychosocial and recreational counseling for patients requiring rehabilitation care; ^(Outcome)
- IV.A.2.b).(15) the economic aspects of supporting geriatric services, such as Title III of the Older Americans Act, Medicare, Medicaid, Affordable Care Act capitation, and cost containment; ^(Outcome)
- IV.A.2.b).(16) 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;
(Outcome)

IV.A.2.b).(17) research methodologies related to geriatric medicine, including clinical epidemiology and decision analysis;
(Outcome)

IV.A.2.b).(18) iatrogenic disorders and their prevention; (Outcome)

IV.A.2.b).(19) 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; (Outcome)

IV.A.2.b).(20) behavioral aspects of illness, socioeconomic factors, and health literacy issues; and, (Outcome)

IV.A.2.b).(21) basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Outcome)

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

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

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

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

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

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

IV.A.2.d).(1) Fellows must demonstrate effective communication skills with patients, families, professional colleagues, and community groups. (Outcome)

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. ^(Outcome)

IV.A.2.e).(1) Fellows must demonstrate high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest. ^(Outcome)

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

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

IV.A.3. Curriculum Organization and Fellow Experience

IV.A.3.a) All 12 months of the educational program must be devoted to clinical experience. ^(Core)

IV.A.3.a).(1) Each fellow must have clinical experience in the care of elderly patients, which includes management of: ^(Core)

IV.A.3.a).(1).(a) 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.A.3.a).(1).(b) care for persons who are generally healthy and require primarily preventive health care measures; and, ^(Core)

IV.A.3.a).(1).(c) care for elderly patients as a consultant providing expert assessments and recommendations in the unique care needs of elderly patients. ^(Core)

IV.A.3.a).(2) Ambulatory Care Program

Ambulatory care must comprise a minimum of 33 percent of the 12-month clinical experience. ^(Detail)

IV.A.3.a).(2).(a) 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.A.3.a).(2).(b) 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 audiology, dentistry, gynecology, neurology, ophthalmology, orthopaedics, otolaryngology, physical medicine and rehabilitation, psychiatry, podiatry, and urology. (Detail)

- IV.A.3.a).(2).(c) Fellows must provide continuing care and coordinate the implementation of recommendations from medical specialties and other disciplines in their continuity clinic. (Core)
- IV.A.3.a).(2).(d) Fellows should have experiences in relevant ambulatory specialty and subspecialty clinics, such as psychiatry and neurology, and those that focus on the assessment and management of geriatric syndromes, such as falls, incontinence, and osteoporosis. (Detail)
- IV.A.3.a).(3) Long-term Care Experience
- Each fellow must have 12 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.A.3.a).(3).(a) Fellows must participate in patient care activities in sub-acute care and rehabilitation in the long-term care setting. (Core)
- IV.A.3.a).(3).(b) Fellows should have clinical experience in day-care or day-hospital centers, life care communities, or residential care facilities. (Detail)
- IV.A.3.a).(3).(c) Each fellow's longitudinal experience must include:
- IV.A.3.a).(3).(c).(i) 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 care patients; and, (Core)
- IV.A.3.a).(3).(c).(ii) structured didactic and clinical experiences in geriatric psychiatry. (Core)
- IV.A.3.a).(3).(d) Each fellow's longitudinal experience should include:
- IV.A.3.a).(3).(d).(i) 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.A.3.a).(3).(d).(ii) working within the limits of a decreased staff-patient ratio compared with acute-care hospitals; ^(Detail)
- IV.A.3.a).(3).(d).(iii) familiarity with sub-acute care physical medicine and rehabilitation; ^(Detail)
- IV.A.3.a).(3).(d).(iv) addressing the clinical and ethical dilemmas produced by the illness of the very old; ^(Detail)
- IV.A.3.a).(3).(d).(v) participating in the administrative aspects of long-term care; ^(Detail)
- IV.A.3.a).(3).(d).(vi) interacting and communicating with the family/caregiver; and, ^(Detail)
- IV.A.3.a).(3).(d).(vii) using palliative care and hospice in caring for the terminally ill. ^(Detail)
- IV.A.3.b) Additional Fellow Experiences
- IV.A.3.b).(1) 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.A.3.b).(2) Fellows must participate in training using simulation. ^(Detail)
- IV.A.3.b).(3) Fellows must be involved in other health care and community agencies, such as delivery of health care in community-based settings. ^(Detail)
- IV.A.3.c) Didactic Curriculum
- IV.A.3.c).(1) The core curriculum must include a didactic program based upon the core knowledge content in geriatric medicine. ^(Core)
- IV.A.3.c).(1).(a) Fellows must participate in clinical case conferences, journal clubs, morbidity and mortality or quality improvement conferences, and patient safety conferences. ^(Core)
- IV.A.3.c).(1).(b) 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.A.3.c).(1).(c) Fellows should have instruction in and experience with community resources that provide aid to their

patients.^(Detail)

IV.A.3.c).(2) Fellows must be instructed in practice management relevant to geriatric medicine.^(Core)

IV.B. Fellows' Scholarly Activities

The program must provide an opportunity for each fellow to participate in research or other scholarly activities.^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee.^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.^(Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings.^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.^(Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee.^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually;^(Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and,^(Core)

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal.^(Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner. ^(Core)

V.A.2.a).(1) Faculty members must discuss evaluations with each fellow at least every three months. ^(Core)

V.A.2.a).(2) Evaluation of performance in continuity clinic must be reviewed with each fellow verbally and in writing at least once every three months. ^(Detail)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

V.A.2.b).(1).(a) Patient Care

The program must assess each fellow in data gathering, clinical reasoning, and patient management in both the inpatient and outpatient settings. ^(Core)

V.A.2.b).(1).(a).(i) This assessment must involve direct observation of fellow-patient encounters. ^(Detail)

V.A.2.b).(1).(b) Medical Knowledge

The program must use an objective, formative assessment method, which must be administered at least once during the program. ^(Detail)

V.A.2.b).(1).(c) Practice-based Learning and Improvement

The program must use performance data to assess fellow in:

V.A.2.b).(1).(c).(i) application of evidence-based medicine to patient care; ^(Detail)

V.A.2.b).(1).(c).(ii) practice improvement; ^(Detail)

V.A.2.b).(1).(c).(iii) teaching skills involving peers, patients, residents, and students; and, ^(Detail)

V.A.2.b).(1).(c).(iv)	scholarship. ^(Detail)
V.A.2.b).(1).(d)	<p>Interpersonal and Communication Skills</p> <p>The program must use both direct observation and multi-source evaluation, including patients, peers, and non-physician team members, to assess fellow performance in: ^(Detail)</p>
V.A.2.b).(1).(d).(i)	communication with the patient and family; ^(Detail)
V.A.2.b).(1).(d).(ii)	teamwork; ^(Detail)
V.A.2.b).(1).(d).(iii)	communication with peers, including transitions in care; and, ^(Detail)
V.A.2.b).(1).(d).(iv)	record keeping. ^(Detail)
V.A.2.b).(1).(e)	<p>Professionalism</p> <p>The program must use multi-source evaluation, including patients, peers, and non-physician team members, to assess each fellow's: ^(Detail)</p>
V.A.2.b).(1).(e).(i)	honesty and integrity; ^(Detail)
V.A.2.b).(1).(e).(ii)	ability to meet professional responsibilities; ^(Detail)
V.A.2.b).(1).(e).(iii)	ability to maintain appropriate professional relationships with patients and colleagues; and, ^(Detail)
V.A.2.b).(1).(e).(iv)	commitment to self-improvement. ^(Detail)
V.A.2.b).(1).(f)	<p>Systems-based Practice</p> <p>The program must use multi-source evaluation, including peers and non-physician team members, to assess each fellow's: ^(Detail)</p>
V.A.2.b).(1).(f).(i)	ability to provide care coordination, including transition of care; ^(Detail)
V.A.2.b).(1).(f).(ii)	ability to work in interdisciplinary teams; ^(Detail)
V.A.2.b).(1).(f).(iii)	advocacy for quality of care; and, ^(Detail)
V.A.2.b).(1).(f).(iv)	ability to identify system problems and

participate in improvement activities. (Detail)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and, (Detail)

V.A.2.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) 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; (Detail)

V.A.3.b).(2) document the fellow's performance during their education; and, (Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

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

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

V.B.2.a) Fellows must have the opportunity to provide confidential written evaluations of each supervising faculty member at the end of each rotation. (Detail)

V.B.2.b) The program director must review these evaluations with each faculty member annually. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a) fellow performance; ^(Core)

V.C.2.b) faculty development; ^(Core)

V.C.2.c) progress on the previous year's action plan(s); and, ^(Core)

V.C.2.d) graduate performance, including performance of program graduates on the certification examination. ^(Core)

V.C.2.d).(1) At least 80 percent of a program's graduating fellows from the most recent five-year period who are eligible should take the ABIM or ABFM certifying examination. ^(Outcome)

V.C.2.d).(2) At least 80 percent of a program's graduates taking the

ABIM or ABFM certifying examination for the first time during the most recent five-year period should pass.
(Outcome)

V.C.2.d).(3)

At least 80 percent of entering fellows should have completed the program when averaged over a five-year period. (Outcome)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

V.C.4. Representative program personnel, at a minimum to include the program director, a representative faculty member, and one fellow, must review program goals and objectives and the effectiveness with which they are achieved. (Detail)

VI. Fellow Duty Hours in the Learning and Working Environment

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

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

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

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

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

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

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

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)

- VI.A.6. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
- VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care;** (Outcome)
 - VI.A.6.b) provision of patient- and family-centered care;** (Outcome)
 - VI.A.6.c) assurance of their fitness for duty;** (Outcome)
 - VI.A.6.d) management of their time before, during, and after clinical assignments;** (Outcome)
 - VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;** (Outcome)
 - VI.A.6.f) attention to lifelong learning;** (Outcome)
 - VI.A.6.g) the monitoring of their patient care performance improvement indicators; and,** (Outcome)
 - VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.** (Outcome)
- VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** (Outcome)
- VI.B. Transitions of Care**
- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.** (Core)
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)
 - VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** (Outcome)
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.** (Detail)
- VI.C. Alertness Management/Fatigue Mitigation**
- VI.C.1. The program must:**

- VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)
- VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)
- 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. ^(Detail)

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. ^(Core)

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. ^(Core)

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. ^(Core)

VI.D.1.a) This information should be available to fellows, faculty members, and patients. ^(Detail)

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. ^(Core)

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. ^(Detail)

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision: ^(Core)

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. ^(Core)**
- VI.D.3.b) Indirect Supervision:**
- VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. ^(Core)**
- 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. ^(Core)**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)**
- 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. ^(Core)**
- 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. ^(Core)**
- 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. ^(Detail)**
- 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. ^(Detail)**
- 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. ^(Core)**
- 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. ^(Outcome)**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to**

him/her the appropriate level of patient care authority and responsibility. ^(Detail)

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.F.1. Each fellow must have experience participating as a member of a physician-directed interdisciplinary geriatric team in more than one setting. ^(Core)

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

VI.F.1.b) 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.F.1.c) Physician assistants or nurse practitioners should be available to provide team or collaborative care of geriatric patients. ^(Detail)

VI.F.1.d) Regular geriatric team conferences must be held as dictated by the needs of the individual patient. ^(Detail)

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

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

- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)
- 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. (Detail)
- VI.G.2. Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. (Core)
- 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. (Core)
- VI.G.3. Mandatory Time Free of Duty**
- Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)
- VI.G.4. Maximum Duty Period Length**
- Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)
- VI.G.4.a)** 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. (Detail)
- VI.G.4.b)** 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. (Core)
- VI.G.4.c)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)
- VI.G.4.d)** 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. ^(Detail)

VI.G.4.d).(1)

Under those circumstances, the fellow must:

VI.G.4.d).(1).(a)

appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)

VI.G.4.d).(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. ^(Detail)

VI.G.4.d).(2)

The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. ^(Detail)

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. ^(Outcome)

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

VI.G.5.a).(1)

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

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. ^(Detail)

VI.G.5.a).(1).(b)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6.

Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. ^(Core)

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

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

VI.G.7.a) Geriatric medicine fellowships must not average in-house call over a four-week period. ^(Core)

VI.G.8. At-Home Call

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

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

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. ^(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 residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf