Frequently Asked Questions: Neurology
(FAQs related to Neurology Program Requirements effective July 1, 2023)
Review Committee for Neurology
ACGME

Question	Answer
Introduction	
What is required to change program format, e.g., from a three-year format to a four-year format? *[Program Requirement: Int.C.1.a)-b)]*	Any changes in a program's format should be requested through the Accreditation Data System (ADS), as a change in format will also necessitate a review for a change to the program's resident complement. Program directors must specify in the educational rationale they provide for the request what type of program format they currently have, the format to which they seek to change, and why the format change is requested.
Oversight	
What are the Review Committee's expectations for adequate facilities and space for the program? *[Program Requirement: I.D.1.a)]*	The Review Committee's expectations include the following: • Conference facilities must be available to the neurology program. • Residents and faculty members must have access to study or workspace, desks, and locked storage cabinets or lockers. • Secure, conveniently located computer and reference material access must be available for use in patient care areas, resident and faculty office areas, and call rooms. • Confidential dictation space must be available. • Research resources should include laboratory space and equipment, computer and statistical consultation services. • Sharing of administrative offices, study areas or conference facilities is acceptable as long as it does not prohibit resident teaching, service or learning. • Although not all resources need to be directly on site, access to resources should be available at each site as necessary for patient care.
What are the Review Committee's expectations for adequate diagnostic resources related to diagnostic therapeutic services? *[Program Requirement: I.D.1.a).(2)]*	Resources, such as laboratory facilities, imaging facilities/diagnostic radiology, electronic medical records, dictation and record keeping support, computer access, phlebotomy support, patient and specimen transport, nursing and IV support, and clerical support, must be available for all programs. Diagnostic resources should include: a) Electrodiagnosis • EEG

Question	Answer
	• Ambulatory EEGs • Video-EEG monitoring • Intra-operative monitoring • Evoked potentials- visual, auditory, somatosensory • EMG/NCV • Single fiber studies b) Diagnostic Radiological Services • MRI and MRA • PET • CT • Angiography c) Genetic testing Diagnostic therapeutic services should include: a) Psychiatric services b) Genetic counseling services c) Interventional neuroradiology d) Occupational therapy e) Pain management f) Rehabilitation medicine g) Physical therapy h) Radiation oncology service i) Psychology services j) Social services k) Speech therapy

Question	Answer
Personnel	
What is the minimum support required for a program director and, if applicable, associate/assistant program director(s)? *[Program Requirements: II.A.2. and II.A.2.a)]*	The ACGME recognizes that dedicated time is needed to support the administration of the program, and those needs increase with the number of resident positions in the program. There must be one program director who takes overall responsibility for the management of the program. Some programs may benefit from an education leadership team that includes additional associate/assistant program directors. The program leadership team must receive full-time equivalent (FTE) support according to the table provided in Program Requirement II.A.2.a). This time encompasses all of the administrative duties of the program leadership team, including, but not limited to program compliance, resident recruitment, ensuring that residents receive proper education, monitoring of the clinical learning environment, and overall oversight. The protected time for administration of the program may be divided among the program director and any associate/assistant program directors. It should be noted that these reflect the minimum dedicated time and support requirements. Depending on the needs of the program and experience of the program leadership, additional support may be warranted.
Is it required for a program to have an associate/assistant program director? *[Program Requirements: II.A.2. and II.A.2.a)]*	The program director's role must include ongoing clinical activity, and not be solely administrative. Therefore, programs requiring 1.0 or more FTE for the program leadership team according to the table in Program Requirement II.A.2.a) must have one or more associate/assistant program directors. Programs requiring less than 1.0 FTE for the program leadership team may operate under the sole oversight of a single program director as long as that individual's duties include ongoing clinical activity.

Question	Answer
Do PGY-1 residents count toward the total resident complement when calculating the minimum support required for the program director and program leadership team? *[Program Requirements: II.A.2. and II.A.2.a)]*	Some neurology residencies are accredited for four years, and the neurology program director provides primary administrative oversight for the entire residency experience, including the PGY-1 year. In those programs, the PGY-1 residents count toward the total resident complement when calculating the minimum support required for the neurology program leadership team. Other neurology residencies are accredited for three years. Residents matriculating at these programs complete their PGY-1 year under the primary administrative oversight of a distinct accredited program, either at the same or different institution. These PGY-1 residents do not count toward the resident complement when calculating the minimum support for the neurology program leadership team.
Where must the program director have a staff appointment if the Sponsoring Institution is not a clinical site? *[Program Requirement: II.A.3.d)]*	If the Sponsoring Institution is a non-clinical site, such as a medical school, the program director must have a staff appointment at the primary clinical site.
If a program does not have faculty members with expertise in particular disciplines, how should it ensure its residents have exposure to all of the areas listed in the Program Requirements? *[Program Requirement: II.B.1.b)]*	Resident exposure to all the disciplines identified in the Program Requirements may occur through several methods. Residents may learn from a general neurologist who sees a high volume of patients with a particular problem, even if that faculty member is not formally listed as an expert in this area. Residents may also work with multi-disciplinary specialists or rotate to other clinical sites to obtain exposure to all required disciplines.
What is considered regular participation in organized clinical discussions, rounds, journal clubs, and conferences? *[Program Requirement: II.B.2.e)]*	Faculty members should participate in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research, such as research design and statistical analysis) and the provision of support for residents' participation, as appropriate, in scholarly activities.
Resident Appointments	

Question	Answer
Assuming eight months of the PGY-1 are completed in non-neurologic disciplines (primarily internal medicine), how flexible can the remaining four months of the PGY-1 be in terms of educational experiences? *[Program Requirement: III.A.2.b).(1)]*	The remaining four months may be spent in emergency medicine, family medicine, internal medicine, neurology, or pediatrics. Dedicated rotations in the coronary care unit and medical intensive care unit are encouraged in the PGY-1 during non-neurology months but are not required. Neurology residents in the PGY-1 may have a neurology continuity clinic during the year, but this is not required and does not count toward their required continuity clinic experience during PGY-2-4.

Question	Answer
When should a program request a temporary increase in resident complement versus a permanent increase in resident complement? *[Program Requirements: III.B. and III.B.1.]*	The Review Committee for Neurology defines temporary and permanent complement increases as follows: **Temporary Complement Increases** Temporary complement increases are intended to address only a few extenuating circumstances, usually involving a current resident needing to extend education and training. This could be due to resident performance concerns (e.g., resident needing remediation before graduating) or excessive time away from the program (e.g., extended medical leave during residency) that impact the achievement of competence. Temporary increases must not be multi-year requests or submitted with intent to annually renew. Temporary increases are intended to extend the training for current residents who need to finish the program off cycle. The Review Committee's Executive Director reviews temporary increase requests for a three-month duration or less. Requests for greater than three months require Committee review. Under special circumstances, such as a program's participation in the ACGME's Advancing Innovation in Residency Education (AIRE) program or similar initiatives, temporary increases will be reviewed and approved by the Review Committee on a case-by-case basis. **Permanent Complement Increases** Permanent complement increases should be requested when the program desires to expand the total resident complement in an ongoing manner to a total higher than currently approved (as published on the ACGME's Accreditation Data System (ADS) public site). This type of request should occur only after the program director carefully weighs the educational impact of adding residents to the currently approved complement and obtains institutional support for the proposed complement expansion. It is imperative that programs plan well in advance for permanent complement increases. Candidates must not be matched into a program before such a request is approved by the Review Committee.

Question	Answer
When is a resident considered a transferring resident? *[Program Requirement: III.C.1.]*	Residents are considered transferring residents under several conditions, including: • when moving from one program to another within the same or different Sponsoring Institution; and, • when entering as a PGY-2 in a three-year program requiring a preliminary year, even if the resident was simultaneously accepted into the preliminary PGY-1 program and the neurology program as part of the Match (e.g., accepted to both programs right out of medical school) Before accepting a transferring resident, the "receiving" program director must obtain written or electronic verification of prior education from the current program director. Verification includes evaluations, rotations completed, procedural/operative experience, Milestones reports, and a summative competency-based performance evaluation. The term “transfer resident” and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and is then accepted into a subsequent residency or fellowship program.
Can a program accept a transfer resident if the program director has documentation showing the request for the transferring resident’s summative competency-based performance evaluation from the previous program(s), even if it has not been received yet? *[Program Requirement: III.C.1.]*	No, a program director should not accept such a resident, as there is no verification of what the resident has previously completed.
Educational Program	
How can a program confirm that its curriculum includes all required educational components? *[Program Requirement: Section IV.A.]*	Program directors can use the checklist in Appendix I at the end of this FAQ document to determine if all required curricular components are included as part of the educational program.

Question	Answer
Is it mandatory that a program have a primary inpatient neurology service and separate consultation service? *[Program Requirement: IV.C.3.]*	Yes, every program must include rotations in which residents have primary patient care responsibilities, including admitting and discharging patients, and writing orders. A consultative service in neurology where residents provide guidance to other primary services would not be sufficient.
If a program is comprised of 13 four-week blocks in a year, does it meet the requirement for one year of broad clinical experience in general internal medicine? *Program Requirements: IV.C., IV.C.4. and IV.C.4.a)-b)]*	Yes, one four-week block is an acceptable alternative to a one-month rotation, so at least eight four-week blocks would meet the requirement.
How much time must a resident spend in the continuity clinic if the resident cannot participate due to a rotation such as ICU or due to being out on leave? *[Program Requirement: IV.C.6.a).(2).(a)]*	The spirit of the continuity clinic is that of an organized, continuous, and supervised clinical experience in which one's clinic patient panel is followed over a long period of time on a weekly basis. An outpatient clinic where the same patients cannot be followed over a long period of time will not fulfill the requirement. Scheduling of continuity clinics may be deferred during a busy inpatient month in which inpatient continuity of care is paramount (e.g., neurocritical care or night float rotations). Although there may be a few gaps based on rotations such as ICU or night float, the same total number of continuity clinics (40 per year minimum) must be seen with the same patient panel in the same academic year. If weekly continuity clinics are occasionally deferred in the manner described above, then the program director must provide evidence at the time of the site visit that each resident has completed at least 40 continuity clinics per year for each of the three years during PGY-2-4.

Question	Answer
Can continuity clinics be scheduled by clustering them into blocks of time, separate from inpatient rotations, rather than scheduling them weekly? *[Program Requirement: IV.C.6.a).(2).(a)]*	Continuity clinics may be scheduled separately from inpatient rotations as an alternative to weekly clinics, as long as: 1) the clinics adhere to the spirit of a longitudinal experience of patient care over the 36 months of residency, with residents seeing their own patients over time, rather than simply seeing outpatients; and 2) there are at least 40 total continuity clinics per year; and 3) clinic blocks are held not more than six weeks apart. A change to the weekly format of continuity clinics should be noted as a Major Change for the program in ADS, and evidence of this continuity clinic must be provided to the Accreditation Field Representatives during an accreditation site visit and/or to the Review Committee when requested.
What criteria should an off-site elective meet? *[Program Requirement: IV.C.6.b)]*	Off-site elective time may be considered, if: • The program director has oversight of curriculum and education. • The residents are evaluated based on that curriculum and education. • Physicians available to educate residents at the host site meet qualification requirements. • There is a completed Program Letter of Agreement, specifying curriculum, supervision, and evaluation. • The elective is not available at the Sponsoring Institution. • The elective is not a core requirement. • The designated institutional official (DIO) and Graduate Medical Education Committee (GMEC) of the Sponsoring Institution have approved the elective.
Can a psychiatry rotation taken at another institution during an intern year be credited for the psychiatry rotation required for neurology? *[Program Requirement: IV.C.6.d)]*	If the psychiatry rotation is to count, the program should have the following documentation on file: 1. Goals and objectives for the completed psychiatry rotation 2. A signed statement by the internship program director and the resident stating that the goals and objectives were accomplished 3. Evaluation(s) of the resident by immediate supervisors of the psychiatry rotation If the program can provide this documentation, the experience can be approved. If this documentation is not provided, the resident must repeat a psychiatry rotation.

Question	Answer
What types of conferences count as national professional conferences? *[Program Requirement: IV.C.9.]*	Residents must attend a national specialty-specific conference. This may include general neurology meetings, such as the American Academy of Neurology meetings, or subspecialty meetings in an area in which they have a particular interest. Since many programs budget money for conference travel, books, or computer software, finding a conference for each resident to attend during the three years should not be a burden.
What are examples of acceptable resident scholarly activity? *[Program Requirement: IV.D.3.a)]*	Examples of resident scholarship include: participation in research; publication and presentation at national and regional meetings; preparation and presentation of neurological topics at educational conferences and programs; organization and administration of educational programs; and activity related to professional leadership. Peer-review activities and quality of care programming, as well as presentations at departmental conferences would also qualify.

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<tr><th>Question</th><th>Answer</th></tr>
<tr><td colspan="2">Evaluation</td></tr>
<tr><td>How can a program provide objective assessments of resident competence?

[Program Requirement: V.A.1.c)]</td><td>See the table below for examples.

<table>
<tr><th>Competency Area</th><th>Examples of Documentation</th></tr>
<tr><td>Patient Care and Procedural Skills</td><td>Milestones, Objective Structured Clinical Examinations (OSCEs), mini-clinical evaluation exercise (mini-CEX), direct observation, structured case discussions, role-play or simulation, chart review, etc.</td></tr>
<tr><td>Medical Knowledge</td><td>Milestones, American Academy of Neurology’s Residency In-service Training Exam (RITE), OSCEs, global assessment, direct observation, structured case discussions, other exams, etc.</td></tr>
<tr><td>Practice-based Learning and Improvement</td><td>Milestones, resident portfolios, global assessment, conferences presented by residents, patient education materials developed by residents, quality performance measures, chart review, etc.</td></tr>
<tr><td>Interpersonal and Communication Skills</td><td>OSCEs, Milestones, Neurology Clinical Evaluation Exercise (NEX), global assessment, direct observation, multi-source feedback, patient surveys, role-play or simulation, etc.</td></tr>
<tr><td>Professionalism</td><td>Milestones, resident portfolios, global assessment, direct observation, multi-source feedback, patient surveys, etc.</td></tr>
<tr><td>Systems-Based Practice</td><td>Milestones, resident portfolios, global assessment, multi-source feedback, quality measures, chart review, etc.</td></tr>
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<tr><td>Who needs to evaluate residents?

[Program Requirements: V.A.1.c).(1)-V.A.1.c).(1).(a)]</td><td>Multiple evaluators should be used, including faculty members, other residents, patients, the residents themselves, and other professional staff members. In addition, each resident must be evaluated by at least one ABPN-certified child neurologist and two ABPN-certified neurologists. Refer to the ABPN website for information regarding required Neurology Clinical Skills Evaluation and clinical skills verification.</td></tr>
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Question	Answer
What types of information should be reviewed when performing the annual internal program evaluation? *[Program Requirement: V.C.]*	Some specific examples of information programs should use in their reviews are: • De-identified resident and faculty member comments • Sponsoring Institution's GMEC review, if applicable • Resources available at each participating site • Quality of supervision • Goals and objectives • ACGME Faculty and Resident Survey results • Meeting minutes • RITE scores • Milestones • Faculty member and resident scholarly activity • Board pass rate in last year This list is not meant to be exhaustive.
The Learning and Working Environment	
Which licensed independent practitioners may contribute to residents' education? *[Program Requirement: VI.A.2.a).(2)]*	Licensed practitioners include health care professionals who are licensed in the state and have appropriate credentials to provide patient care. These may include advanced practice providers or psychologists, for example.
What is an optimal clinical workload? *[Program Requirement: VI.E.1.]*	The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills, and abilities when determining the appropriate clinical workload for each resident.
Is there a maximum number of patients that can be cared for by a single resident, i.e., does the Review Committee mandate patient caps? *[Program Requirement: VI.E.1.a)]*	No. The Review Committee recognizes the need for flexibility in service structures across programs and does not consider it feasible to establish a universal patient cap or individual caps for all variations in service structure. The responsibility to monitor resident workload remains in the hands of the program director and should be based on patient needs, patient safety data, and the needs and abilities of individual residents. Therefore, the program director may institute patient caps.

Question	Answer
Who should be included in the interprofessional teams? *[Program Requirement: VI.E.2.]*	Nurses, pharmacists, physician assistants, psychologists, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.
Must every interprofessional team include representation from every profession listed above? *[Program Requirement: VI.E.2.]*	No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case.

Appendix I

Educational Program Checklist	Yes/No
1. Are overall educational goals for the program distributed to the residents annually? (IV.A.2.)	
2. Are goals and objectives competency-based? (IV.A.2.)	
3. Are the goals and objectives specific to each rotation AND each educational level? (IV.A.2.)	
4. Are didactic sessions scheduled on a regular basis? (IV.A.4.)	
5. Are residents required to attend seminars, conferences, and journal clubs? (IV.C.8.)	
6. Do didactics include the full spectrum of neurological disorders across the lifespan? (IV.C.9.)	
7. Do didactics include the basic science curriculum? (IV.C.10.)	
8. Do residents attend at least one national professional conference? (IV.C.9.)	
9. Are residents clearly informed about their patient care responsibilities? (IV.A.3.)	
10. Are residents provided progressive responsibility for patient management? (IV.A.3.)	
11. Are residents provided supervision throughout the program? (IV.A.3.)	
12. Are residents provided a combination of patient care, teaching and research experiences? (IV.C.3.)	
13. Do patient care responsibilities include inpatient experiences? (IV.C.3.)	
14. Do patient care responsibilities include outpatient experiences? (IV.C.3.)	
15. Do patient care responsibilities include consultation experiences? (IV.C.3.)	
16. Did the first year of the 48 months of education include either: eight months in internal medicine with primary responsibility in patient care; OR six months in internal medicine with primary responsibility in patient care, and at least two months' time in a combination of the following: one or more months in pediatrics; emergency medicine; internal medicine; or family medicine. (IV.C.4.-IV.C.4.b))	
17. Did residents have four months or less of neurology during this preliminary year? (IV.C.5.)	
18. During the last 36 months of education, do residents have a minimum of 18 FTE months of clinical adult neurology experience? (IV.C.6.a))	
19. Does the 18 FTE months of clinical adult neurology experience provide at least six months of inpatient adult neurology? (IV.C.6.a).(1))	
20. Does the 18 FTE months of clinical adult neurology experience provide at least six months of outpatient adult neurology? (IV.C.6.a).(1))	
21. Do the residents have a longitudinal/continuity half-day clinic throughout the program? (IV.C.6.a).(2))	
22. Do residents have at least three months elective time? (IV.C.6.b))	
23. Do residents have at least three FTE months in clinical child neurology? (IV.C.6.c))	

24. Do residents have at least one FTE month in clinical psychiatry? (IV.C.5.d))	
25. Do residents have clinical teaching rounds supervised by faculty at least five days per week? (IV.C.6.e))	
26. Do residents receive exposure to acute patient management in various settings such as ICU or ED? (IV.C.6.f))	
27. Do residents receive experience in neuroimaging? (IV.C.7.a))	