Obesity Medicine Fellowship Council

Subspecialty Fellowship Program Requirements for

Graduate Medical Education in Pediatric Obesity Medicine

Initial approval: February 27, 2026

Introduction

Int. I. Definition of Graduate Medical Education

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 clinical 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 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 medical literature and patient care beyond the clinical subspecialty.

Int. II. Definition of the Subspecialty

Pediatric obesity medicine physicians provide respectful, evidence-based, effective care to patients with or at-risk of obesity and its complications. Pediatric obesity medicine physicians often serve as clinical leaders of an interdisciplinary team involving nutrition, physical activity, and psychological support, in addition to pharmacological management and peri-procedural care. Pediatric obesity medicine physicians manage obesity-related complications as well as engage in obesity prevention activities.

Int. III. Length of Educational Program

The educational program in pediatric obesity medicine must be at least 12 months in length.

I. Oversight

I.A. Sponsoring Institution

I.A.1. 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 OMFC Requirements.

I.A.2. 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.

I.A.3. 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 including, but not limited to a university, a medical school, a teaching hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, an educational consortium, a teaching health center, a physician group practice, a federally qualified health center, a surgery center, an academic and private single-specialty clinic, or an educational foundation

I.A.4 The Sponsoring Institution must sponsor ACGME accredited programs, ideally in pediatrics or family medicine at minimum.

I.A.5 The educational program in pediatric obesity medicine should not negatively affect the education of the residents in the affiliated pediatrics or family medicine residency program(s).

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 approval of its Sponsoring Institution, must designate a primary clinical site.

A pediatric obesity medicine program will be approved only if the Sponsoring Institution also sponsors an ACGME-accredited program in at least one of the following specialties: pediatrics, family medicine, or internal medicine-pediatrics.

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating location offsite that governs the relationship

between the program and the participating site providing a required assignment.

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

I.B.2.a).(1) be renewed at least every 10 years;

I.B.2.a).(2) be approved by the program director; and,

I.B.2.a).(3) if required by the Sponsoring Institution, be approved by the designated institutional official (DIO).

I.B.3. The program must monitor the clinical learning and working environment at all participating sites.

I.B.3.a) At each participating site, there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. This faculty member may also be the program director.

I.C. Workforce Recruitment and Retention

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.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. Qualifications of the program director must include:

II.A.1.a at least three years of experience as a clinician and/or teacher in pediatric obesity medicine; and,

II.A.1.b be a Diplomate of the American Board of Obesity Medicine (ABOM).

II.A.2. The program director and, as applicable, the program's leadership team must be provided with adequate support for the administration of the program based upon its size and configuration.

II.A.2.a) Program leadership must be provided with support equal to a dedicated minimum time specified below for administration of the program.

Number of Approved Fellow Positions	Minimum Support (FTE) for program director	Recommended Support for Faculty*
1-6	0.1	0.2
7+	0.2	0.3

*This support may be for the program director only or divided among the program director and one or more associate, assistant, or co-program directors, or core faculty.

II.B. **Faculty**

II.B.1. There must be at least two core faculty members, including the program director, who each have at least three years of experience in pediatric obesity medicine. All physicians who are core faculty should ideally be ABOM Diplomates.

II.B.2. Faculty members must be available for the education of fellows with the following specialized expertise:

II.B.2.a) comprehensive management of pediatric patients with obesity, which includes lifestyle, behavioral, pharmacotherapy, medical management of surgical patients, and

II.B.2.b) metabolic-bariatric surgery.

II.B.3. Faculty members should be available to participate in the education of fellows from the following medical specialties:

II.B.3.a) Adult obesity medicine;

II.B.3.b) Other specialties related to pediatric obesity medicine as applicable, (e.g., pediatric endocrinology, pediatric gastroenterology and hepatology, pediatric cardiology, pediatric sleep medicine, adolescent gynecology, clinical genetics and genomics)

II.B.3.c) Other specialties related to adult obesity medicine, as applicable (e.g., women's health, endobariatrics, adult sleep medicine and others.

II.C. **Other Program Personnel**

II.C.1. To ensure effective interdisciplinary and interprofessional practice in pediatric obesity medicine, the following personnel with experience treating patients with obesity must be involved in fellows' clinical training:

II.C.1.a) nutrition professionals, such as registered dietitian nutritionists;

II.C.1.b) mental health and behavioral professionals, such as psychologists or social workers; and

II.C.1.c) physical activity professionals, such as exercise physiologists, sports medicine professionals, trainers, or physical therapists.

II.D. **Resources**

II.D.1 Clinical facilities and services, including comprehensive laboratory, pathology, and imaging services, must be available. In addition, the program must:

II.D.1.a ensure the program has adequate space available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space;

II.D.1.b ensure that appropriate in-person or remote/virtual consultations, including those done using telecommunication technology, are available in settings in which fellows work;

II.D.1.c) provide access to an electronic health record (EHR);

II.D.1.d) provide access to adequate outpatient clinical space to deliver longitudinal care for patients with overweight or obesity.

II.D.1.e) have a pediatric obesity medicine specialty clinic available for dedicated clinical experiences in pediatric obesity medicine. This specialty clinic should be interprofessional, where other healthcare professionals are embedded within the clinic or alternatively the clinic has an established relationship with providers of these services who may not be embedded within the clinic.

II.D.2 Medical equipment to accommodate the routine care of patients with overweight/obesity, including appropriately sized chair(s), exam table(s), scale(s), and sphygmomanometer(s) with appropriate circumference cuffs, must be available.

II.D.3. An adequate number and variety of patients with overweight/obesity, ranging across all stages of childhood, must be available to provide a broad experience for fellows and to meet the educational needs of the program.

II.D.3.a) There must be a metabolic-bariatric surgery service that performs these surgical procedures on adolescents available for fellow education.

II.D.3.a).(1) At a minimum, procedures performed should include Roux-en-Y gastric bypass and sleeve gastrectomy.

II.D.4. The program should have access to services and/or equipment to perform testing specific to pediatric obesity medicine, such as indirect calorimetry and body composition.

II.D.5. 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:

II.D.5.a access to food while on duty;

II.D.5.b safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care if working overnight;

II.D.5.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;

II.D.5.d) security and safety measures appropriate to the participating site; and,

II.D.5.e) accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy.

II.D.6 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.

II.D.7. Program Coordinator

II.D.7.a) There must be a program coordinator.

II.D.7. b) The program coordinator must be provided with dedicated time and support, at the discretion of the sponsoring department, adequate for administration of the program based on its size and configuration.

III. Fellow Appointment

III.A. Eligibility Criteria

III.A.1. Prior to appointment in the program, fellows should have completed an ACGME-accredited residency program in pediatrics, internal medicine-pediatrics, or family medicine program. The pediatric obesity medicine fellowship program may accept fellows who have completed other ACGME-accredited residency programs (e.g., preventive medicine or surgery) if acceptable to the Sponsoring Institution's Graduate Medical Education Committee or other designated review committee.

IV. Specialty-Specific Educational Program

IV.A. **OMFC Competencies**

IV.A.1. The program must integrate the following aspects of the obesity medicine body of knowledge into the curriculum.

IV.A.1.a) Professionalism

IV.A.1.a).(1) Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. Fellows must:

IV.A.1.a).(1).(a) demonstrate ethical behavior and integrity when counseling patients with overweight/obesity, as well as their families; and,

IV.A.1.a).(1).(b) display compassion and respect toward all patients with overweight/obesity as well as their families.

IV.A.1.a).(1).(c) implement, maintain or improve operational policies and protocols that support obesity care delivery (e.g., templates, schedules, clinical workflows, follow-ups)

IV.A.1.a).(1).(d) Comply with state and federal prescribing policies (e.g., controlled substances, off label medications, obesity medications)

IV.A.1.a).(1).(d) Navigate insurance coverage for treatments (e.g., billing, prior authorization and appeal processes)

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

IV.A.1.b).(1) Fellows must provide patient care that is compassionate, evidence based, and personalized for the treatment of health problems and the promotion of health. Fellows must demonstrate competence in:

IV.A.1.b).(1).(a) eliciting a comprehensive obesity-focused medical history that includes weight, nutrition, eating behavior, physical activity, sleep, medications, and social drivers of health;

IV.A.1.b).(1).(b) performing and documenting a comprehensive physical examination for the assessment of obesity and its related diseases and complications; performing and documenting a comprehensive physical examination for the assessment of genetic, syndromic and secondary obesity;

IV.A.1.b).(1).(c) applying clinical reasoning skills when ordering and interpreting appropriate laboratory and diagnostic tests during the evaluation of patients with overweight/obesity;

IV.A.1.b).(1).(d) using evidence-based models of health behavior change to assess patients' readiness to change and effectively counsel patients for weight management; and,

IV.A.1.b).(1).(e) engaging patients and their support systems in shared decision-making by incorporating their values, needs, and preferences in the development of a comprehensive, personalized obesity treatment plan.

IV.A.1.b).(2) Fellows must be able to perform all medical and diagnostic procedures considered essential for the area of practice. Fellows must demonstrate competence in the:

IV.A.1.b).(2).(a) use of laboratory evaluation, including appropriate test selection for screening and diagnosis of obesity-related diseases and complications as for monitoring response and adverse effects of obesity treatment; and,

IV.A.1.b).(2).(b) use of radiological and other diagnostic procedures, including appropriate test selection for screening and diagnosis of obesity-related diseases and complications as for monitoring response and adverse effects of obesity treatment.

IV.A.1.c) Medical Knowledge

IV.A.1.c).(1) 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 must demonstrate knowledge of:

IV.A.1.c).(1).(a) anthropometric assessments and clinical evaluation of energy expenditure;

IV.A.1.c).(1).(b) energy homeostasis and weight regulation;

IV.A.1.c).(1).(c) etiologies, mechanisms, and biology of obesity across the life course;

IV.A.1.c).(1).(d) obesity epidemiology;

IV.A.1.c).(1).(e) obesity-related diseases and complications, and corresponding benefits of weight reduction in these conditions; and,

IV.A.1.c).(1).(f) the application of the following in developing a comprehensive, personalized obesity treatment care plan:

IV.A.1.c).(1).(f).(i) principles of obesity treatment guidelines;

IV.A.1.c).(1).(f).(ii) behavioral and psychological interventions;

IV.A.1.c).(1).(f).(iii) nutrition interventions;

IV.A.1.c).(1).(f).(iv) physical activity interventions;

IV.A.1.c).(1).(f).(v) pharmacologic treatments that influence body weight;

IV.A.1.c).(1).(f).(vi) surgical and procedural treatments of obesity;

IV.A.1.c).(1).(f).(vii) principles of primary, secondary, and tertiary prevention of obesity; and,

IV.A.1.c).(1).(f).(viii) emerging treatment modalities.

IV.A.1.d) Practice-Based Learning and Improvement

IV.A.1.d).(1) 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. Fellows must demonstrate ability to:

IV.A.1.d).(1).(a) evaluate strengths and deficiencies in knowledge of pediatric obesity medicine, and set and achieve goals for improvement;

IV.A.1.d).(1).(b) use resources to locate, interpret, and apply evidence from scientific studies regarding obesity, its related diseases and complications, and treatment;

IV.A.1.d).(1).(c) use information technology related to obesity treatment to optimize delivery of care, including electronic health records, software applications, and related devices (such as accelerometers, resting metabolic rate, and body composition analysis technology); and,

IV.A.1.d).(1).(d) educate patients, students, residents, and other health professionals about obesity and the assessment, prevention, and treatment of this chronic disease.

IV.A.1.d).(2) Fellows should demonstrate ability to:

IV.A.1.d).(2).(a) analyze practice systems using quality improvement methods to monitor and optimize obesity care;

IV.A.1.e) Interpersonal and Communication Skills

IV.A.1.e).(1) Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, patients' families, and other health professionals. Fellows must:

IV.A.1.e).(1).(a) use appropriate language in verbal, non-verbal, and written communication that is non-stigmatizing, non-judgmental, respectful, and empathetic when communicating with patients with obesity or communicating with colleagues and other members of the health care team; and,

IV.A.1.e).(1).(c) demonstrate cultural awareness regarding perception of desired weight and preferred body shape when communicating with patients, patients' families, and other members of the health care team.

IV.A.1.f) Systems-Based Practice

IV.A.1.f).(1) Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including social drivers of health, as well as the ability to call effectively on other resources in the system to produce optimal care. Fellows must:

IV.A.1.f).(1).(a) advocate for policies that are respectful and minimize the impact of weight bias;

IV.A.1.f).(1).(b) apply critical appraisal of scientific articles and research methods in the field of pediatric obesity medicine;

IV.A.1.f).(1).(c) demonstrate awareness of the costs of obesity intervention and prevention with regards to the individual, health care system, and community;

IV.A.1.f).(1).(d) work collaboratively within an interdisciplinary team dedicated to obesity treatment and prevention.

IV.A.1.f).(2) Fellows should:

IV.A.1.f).(2).(a) advocate for health system and public health policies to improve obesity treatment and prevention;

IV.A.1.f).(2).(b) use chronic disease treatment and prevention models to advance obesity intervention and prevention efforts within the clinical, community, and public policy domains; and,

IV.B. **Regularly Scheduled Educational Activities**

IV.B.1. Fellows must have a formally structured educational program in the clinical and basic sciences related to pediatric obesity medicine. Educational activities combined with scholarly activities should be at least 180 hours, or 4 hours/week over the course of the program.

IV.B.2. Fellows must participate in conferences that may include, but are not limited to lectures, seminars, case discussions, research seminars, and journal clubs.

IV.B.3. Fellows should also participate in directed readings relevant to pediatric obesity medicine as part of the structured educational program.

IV.B.4. The structured educational program must include:

IV.B.4.a) anthropometric measurements and clinical assessment of energy expenditure and its application to patient care;

IV.B.4.b) behavioral and psychological assessments and interventions;

IV.B.4.b).(1) This must include behavioral interventions, including behavioral counseling techniques, cognitive behavioral therapy, and self-monitoring.

IV.B.4.b).(2) This must include general concepts, such as disordered eating and body image disturbance, as well as the psychological effects of obesity and its management.

IV.B.4.c) emerging obesity treatment modalities;

IV.B.4.d) energy homeostasis and weight regulation across the life course;

IV.B.4.e) etiologies, mechanisms, and biology of obesity across the life course;

IV.B.4.e).(1)	This must include determinants of obesity, including behavioral, cultural, environmental, epigenetic, fetal environment, microbiome, genetic, and lifestyle.
IV.B.4.e).(2)	This must include genetic/syndromic obesity and secondary causes of obesity.
IV.B.4.e).(3)	This must include physiology and pathophysiology of obesity, including neuroenterohormonal mechanisms and obesity-related cell physiology.
IV.B.4.f)	nutrition assessments and interventions;
IV.B.4.f).(1)	This must include general concepts, including macro and micronutrients, gastrointestinal sites of nutrient absorption, vitamin and mineral metabolism, screening and diagnosis of vitamin and mineral deficiencies.
IV.B.4.f).(2)	This must include nutritional interventions, including calories, macro and micronutrient composition, meal replacements, and low- and very low-calorie diets.
IV.B.4.g)	obesity epidemiology;
IV.B.4.g).(1)	This must include incidence, prevalence, and demographic distribution across the life cycle.
IV.B.4.h)	obesity-related diseases and complications;
IV.B.4.h).(1)	This must include diagnosis and management of common obesity-related diseases and complications, such as hypertension, glucose intolerance, type 2 diabetes mellitus, dyslipidemia, metabolic dysfunction-associated steatotic liver disease, gastroesophageal reflux disease, asthma, idiopathic intracranial hypertension, polycystic ovarian syndrome, and eating disorders
IV.B.4.i)	obesity treatment guidelines;
IV.B.4.j)	pharmacological management;
IV.B.4.j).(1)	This must include general concepts related to obesity medications, including benefits, dose effects; drug interactions, indications, and contraindications; monitoring and follow-up; potential adverse effects; rates and magnitude of response; and risks.
IV.B.4.j).(2)	This must include advanced concepts, including off-label use, combination obesity medication therapy, and pharmacologic management of complex patients.

IV.B.4.j).(3) This must include management of weight-gain-promoting medications.

IV.B.4.k) physical activity assessments and interventions;

IV.B.4.k).(1) This must include general concepts, including body composition, biomechanics, cardiorespiratory fitness, and kinesiology.

IV.B.4.k).(2) This must include understanding physical activity interventions, including exercise prescription.

IV.B.4.l) Interventions for weight-loss maintenance;

IV.B.4.m) principles of primary, secondary, and tertiary prevention of obesity;

IV.B.4.n) principles of adult obesity medicine; and

IV.B.4.o) surgical and procedural interventions.

IV.B.4.o).(1) This must include general concepts, including types of metabolic-bariatric surgical procedures, benefits and risks, indications and contraindications, pre-operative and post-operative assessment, potential complications, and long-term post-operative care (medical, nutritional, psychological management).

IV.B.4.o).(2) This must include advanced concepts in metabolic-bariatric surgery, including post-operative use of obesity medications, management of weight recurrence, and peri-operative management of complex patients.

IV.B.4.o).(3) This must include general concepts, including types of endoscopic and other minimally invasive procedures for obesity, benefits and risks, indications and contraindications, pre-procedural assessment, potential complications, and long-term post-procedural care.

IV.B.5. Pediatric obesity medicine conferences must occur regularly and must involve active participation by the fellow(s) in planning and implementation.

IV.B.5.a) Faculty members should regularly attend and present at the conferences.

IV.C. **Clinical Experiences**

IV.C.1. Fellows must participate in the care of patients with overweight/obesity with a broad spectrum of disease severity and obesity-related diseases and complications.

IV.C.1.a) Fellows must spend at least 700 hours or four 4-hour sessions/week caring for patients in the pediatric obesity medicine specialty clinic.

IV.C.1.b) As part of this experience, fellows must have longitudinal responsibility for providing care to patients throughout their educational program that is supervised by one or more members of the pediatric obesity medicine faculty. This may be accomplished by the fellow having their own panel of patients or by participating in the care of a consistent patient panel under their Attending.

IV.C.1.b).1. This experience must be at least 350 hours or two 4-hour sessions/week over the course of the program.

IV.C.1.b).2. This must include longitudinal care of outpatients or patients enrolled in a defined weight management program.

IV.C.1.b).3. The panel of patients must represent the spectrum of overweight/obesity, include new evaluations and follow-up visits, and obesity-related diseases and complications that fellows are likely to encounter in practice.

IV.C1.b).4. As appropriate, fellows must employ a comprehensive interdisciplinary approach to longitudinal management of patients with overweight/obesity.

IV.C.2. Programs must offer clinical experiences that emphasize the interprofessional collaborative practice of pediatric obesity medicine, which is key to safe, high-quality, accessible, equitable, patient-centered care and enhanced population health outcomes. Interprofessional clinical experiences must include nutritional assessment and management, psychology and mental health, and physical activity; experiences with group visits should be included. The goals of these experiences include:

IV.C.2.a) Work with team members to maintain a climate of shared values, ethical conduct, and mutual respect.

IV.C.2.b) Use the knowledge of one’s own role and team members’ expertise to address individual health outcomes.

IV.C.2.c) Communicate in a responsive, responsible, respectful, and compassionate manner with team members.

IV.C.2.d) Apply values and principles of teamwork to adapt one's own role in a variety of team settings.

IV.C.3. Fellows must have a longitudinal experience in nutritional assessment and management of patients who have obesity and its related diseases and complications.

IV.C.3.a) This experience must be at least 20 hours over the course of the program, working directly with a registered dietitian nutritionist or a healthcare professional with a recognized expertise in obesity-focused nutrition therapy.

IV.C.3.b) This experience must include nutritional management or collaborative management of nutritional issues in patients with overweight/obesity and its related diseases and complications.

IV.C.4. Fellows must have a clinical experience in psychology or mental health.

IV.C.4.a) This experience must be at least 20 hours over the course of the program, including at least 8 hours working directly with a professional in the list below.

IV.C.4.b) This experience should include psychological assessment, management and/or collaborative management of patients with psychiatrists, psychologists, counselors, and/or therapists for the treatment of mental health conditions related to overweight obesity, and obesity-related diseases and complications. While this experience may include preoperative psychological assessments in preparation for metabolic bariatric surgery and bariatric support groups, it should also include opportunities to see non-surgical mental health care.

IV.C.4.c) An additional experience should be at least 8 hours over the course of the program focused on eating disorders and behavioral feeding problems (e.g., Avoidant Restrictive Food Intake Disorder) with a professional who treats children and adolescents.

IV.C.5. Fellows must have an experience with a professional in physical activity, exercise physiology, sports medicine, exercise training, physical medicine and rehabilitation, or physical therapy. These healthcare professionals may or may not specialize in the care of patients with obesity, but patients with obesity must be treated within the clinical setting.

IV.C.5.a) The experience should be at least 8 hours over the course of the program.

IV.C.6. Programs must offer clinical experiences that emphasize multidisciplinary collaboration key for the practice of pediatric obesity medicine.

Multidisciplinary clinical experiences must include metabolic-bariatric surgery and electives in related disciplines; experiences should include adult obesity medicine. The goals of these experiences include:

IV.C.6.a) Work with other specialties to maintain a climate of shared values, ethical conduct, and mutual respect.

IV.C.6.b) Use the knowledge of one's own scope of practice and other fields' expertise to address individual health outcomes.

IV.C.6.c) Communicate in a responsive, responsible, respectful, and compassionate manner with other specialists.

IV.C.7. Fellows must have an experience in metabolic-bariatric surgery.

IV.C.7.a) This experience must include at least 40 hours working in a bariatric surgery program which offers care to adolescent patients. Up to 80 hours with a metabolic-bariatric surgical program is recommended to achieve optimal competency.

IV.C.7.b) This experience must include opportunities to evaluate patients pre-operatively and monitor patients post-operatively following metabolic-bariatric surgical procedures, as well as management of post-operative complications. Fellows must have the opportunity to work directly with a metabolic-bariatric surgeon. The experience may include time in the operating room, inpatient settings, or outpatient settings.

IV.C.7.c) An additional experience should be at least 8 hours over the course of the program working with an adult bariatric surgery program.

IV.C.8. Fellows should have an experience with group visits.

IV.C.8.a) This experience may include physician-led group visits for obesity care, group behavioral programs, or group nutrition programs.

IV.C.8.b) This experience should be at least 4 hours over the course of the program.

IV.C.9. Fellows should have experience in adult obesity medicine.

IV.C.9.a) This experience should be at least 20 hours over the course of the program. If the trainee anticipates including the care of adults in their future practice (e.g., family medicine or internal medicine-pediatrics physicians), the amount of time should be at least 280 hours over the course of the program.

IV.C.10. Fellows must have elective experiences in disciplines related to pediatric obesity medicine. These experiences should be at least 96 hours over the

course of the program and may include pediatric endocrinology, pediatric sleep medicine, pediatric cardiology, pediatric gastroenterology and hepatology, adolescent gynecology, clinical genetics and genomics, or others.

IV.C.11. Fellows should have elective experiences in disciplines related to adult obesity medicine, which may include women's health, endobariatrics, adult sleep medicine, and others.

IV.D. **Scholarly Activity**

IV.D.1. Fellows' Scholarly Activity

IV.D.1.a) The program must have a core curriculum in scholarship.

IV.D.1.b) Each fellow must participate in a scholarly project under the guidance of the program director or a designated mentor.

IV.D.1.b).(1) The experience must include opportunities for scholarly activity in research, quality improvement, education, or advocacy either within or across programs.

IV.D.1.b).(2) The experience should culminate in presentation, a written report, publication, or delivery of educational content.

IV.D.1.c) Fellows must have a longitudinal scholarly experience during their educational program.

IV.D.1.c).(1) The program must provide protected time for each fellow to take part in scholarly activity. Scholarly activity combined with educational activities should be at least 180 hours or 4 hours/week over the course of the program.

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Faculty members should regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

IV.D.2.b) The faculty leadership must demonstrate dissemination of scholarly activity appropriate to pediatric obesity medicine within and external to the program by the following methods:

faculty 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.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. A Clinical Competency Committee must be appointed by the program director.

V.A.1.a) At a minimum, the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must include faculty members or other health professionals who have extensive contact and experience with the program's fellows. For example, preceptors from interprofessional or other elective rotations can be invited to serve on the Clinical Competency Committee. Additional members may include faculty from other programs.

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

V.A.1.b).(1) review all fellow evaluations at least semi-annually;

V.A.1.b).(2) determine each fellow's progress on achievement of the subspecialty-specific competencies; and,

V.A.1.b).(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress.

V.A.2. Feedback and Evaluation

V.A.2.a) For clinical experiences of greater than three months in duration where the fellow is involved in direct care of the patient (not only shadowing), evaluation must be documented at least every three months.

V.A.2.b). Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion.

V.A.2.c) Faculty members must directly observe and should provide feedback on interprofessional and other elective rotations.

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

V.A.2.d) The program director or their designee, with input from the Clinical Competency Committee, must

V.A.2.d).(1) meet with and review with each fellow their documented semi-annual evaluation of performance

V.A.2.d).(2) develop plans for fellows failing to progress, following institutional policies and procedures.

V.A.2.d).(3) The evaluations of a fellow's performance must be accessible for review by the fellow.

V.A.3. Final Evaluation

V.A.3.a) The program director must provide a final evaluation for each fellow upon completion of the program.

V.A.3.a).(1) The final evaluation should:

V.A.3.a).(1).(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;

V.A.3.a).(1).(b) verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and,

V.A.3.a).(1).(c) be shared with the fellow upon completion of the program.

V.B. **Faculty Evaluation**

V.B.1. The program must have a process to evaluate each core pediatric obesity medicine faculty member's performance as it relates to the educational program at least annually.

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, professionalism, and scholarly activities.

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

V.B.2. Faculty members must receive feedback on their evaluations once they have been evaluated by a minimum of 4 trainees (This may take 4 years)

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

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

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

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

V.C.1.b).(1) review of the program's self-determined goals and progress toward meeting them;

V.C.1.b).(2) guiding ongoing program improvement, including development of new goals, based upon outcomes; and,

V.C.1.b).(3) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

V.C.1.c) The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program.

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

V.C.1.e) The Annual Program Evaluation, including the action plan, should be distributed to and discussed with the fellows and the members of the teaching faculty. If required by the Sponsoring Institution, the Annual Program Evaluation should be submitted to the DIO.

VI. The Learning and Working Environment

By requiring that a Sponsoring Institution has an ACGME-accredited Pediatrics, Internal Medicine or Family Medicine residency program, the learning and working environmental protections outlined below must already be available at the organization. Therefore, the Pediatric Obesity Medicine fellowship program should ensure that fellows have appropriate access to these existing organizational resources to meet these requirements.

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

• Appreciation for the privilege of providing care for patients

• Commitment to the well-being of the students, residents, 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

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).(2) Patient Safety Events

Reporting, investigation, and follow-up of safety 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).(2).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(2).(a).(i) know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and,

VI.A.1.a).(2).(a).(ii) be provided with summary information of their institution’s patient safety reports.

VI.A.1.a).(2).(b) Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

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 graduate 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) Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

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

VI.A.2.a).(2) 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.

VI.A.2.b) Levels of Supervision

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

VI.A.2.b).(1) Direct Supervision:

VI.A.2.b).(1).(a) the supervising physician is physically present with the fellow during the key portions of the patient interaction; or,

VI.A.2.b).(1).(b) the supervising physician and/or patient is not physically present with the fellow, and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

VI.A.2.b).(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.

VI.A.2.b).(3) Oversight – the supervising physician is available to provide review of encounters with feedback provided after care is delivered.

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

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow should be assigned by the program director and faculty members.

VI.A.2.d).(1) The program director should evaluate each fellow's abilities based on specific criteria.

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.

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

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

VI.A.2.e).(1) 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.

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.

VI.B Professionalism

VI.B.1 Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients.

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

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

VI.B.2.b) ensure manageable patient care responsibilities; and,

VI.B.2.c) include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.

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.

VI.B.4 Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.

VI.B.5 Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff.

VI.B.6. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

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 modeled, 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 resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. 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.I.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

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

VI.C.1.b) policies and programs that encourage optimal fellow and faculty member well-being; and,

VI.C.1.b).(1) Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

VI.C.1.c) education of fellows and faculty members in:

VI.C.1.c).(1) identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions;

VI.C.1.c).(2) recognition of these symptoms in themselves and how to seek appropriate care; and,

VI.C.1.c).(3) access to appropriate tools for self-screening.

VI.C.1.d) providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

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 medical, parental, or caregiver leave. Each program must allow at least 6 weeks of absence for fellows unable to perform their patient care responsibilities without penalty. Additional leave policy details are at the discretion of the institution.

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

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.

VI.D. Fatigue Mitigation

VI.D.1. Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.

VI.D.2. 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.

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.

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system.

VI.E.2.a) The program must provide educational experiences that allow fellows to interact with and learn from other health care professionals, such as physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dietitians, to achieve effective, interdisciplinary, and interprofessional team-based care.

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.

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

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

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, clinical work done from home, and all moonlighting.

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

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

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

VI.F.2.c) Fellows should 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.

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.

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. Additional patient care responsibilities must not be assigned to a fellow during this time.

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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events.

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

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and

must not interfere with the fellow's fitness for work nor compromise patient safety.

VI.F.5.b) Time spent by fellows in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit.

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.

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).

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. 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 clinical work and education, when averaged over four weeks.

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

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