

# **INFECTIOUS DISEASES FELLOWSHIP PROGRAMS**

## **FREQUENTLY ASKED QUESTIONS**

The Residency Review Committee for Internal Medicine has answered the following questions from Infectious Diseases fellowship programs. The answers provided represent a summary of the actions previously taken by the Committee. You should not interpret the answers as a second set of standards. The RRC-IM provides these answers to give training programs insight on how the peer review process works. Each program reviewed is unique. The RRC-IM interprets substantial compliance with the Program Requirements that reflect the unique composite of a given program. The Requirements are as stated.

### **Abbreviations Used**

PR = Program Requirement  
PD = Program Director  
APD = Associate Program Director  
Sub = Internal Medicine subspecialty program  
Sub-sub = Subspecialty requiring completion of training in a parent subspecialty (i.e., clinical cardiac electrophysiology, interventional cardiology, transplant hepatology)  
RRC-IM = Residency Review Committee for Internal Medicine  
ACGME = Accreditation council of Graduate Medical Education  
DIO = Designated Institutional Official (usually serves as chair of GMCEC)  
GMCEC = Graduate Medical Education Committee, as required by the IRC  
IRC = Institutional Review Committee  
PIF = Program Information Form  
KCF = Key Clinical Faculty  
Pub = Peer-reviewed publication or other acceptable product of scholarship as defined by the RRC-IM  
ID = Infectious Diseases  
IH = International Health

### **Section I-VII General Subspecialty Program Requirements**

#### Question:

*“Do the General Subspecialty Program Requirements apply to Infectious Diseases?”*

#### Program Requirements:

For Sections I. through VIII., see:

- **ACGME Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine**
- **RRC-IM Web Subspecialty FAQ**

#### Answer:

Absolutely

Infectious Diseases PDs should study carefully the General Subspecialty Program Requirements, and the FAQs related to these PRs. The requirements cover required structural elements in the program such as required institutional support, facilities and resources, key faculty and PD qualifications and responsibilities, conferences, continuity clinic, scholarship and research, evaluation, etc.

Subspecialty fellowship programs are expected to be in full compliance with both the General Subspecialty Program Requirements, and the Subspecialty Specific Program Requirements.

## **International Health Rotations in ID**

### Question:

*“Can we send fellows overseas for an international health experience as part of their training program?”*

### Program Requirement:

Requests for experimentation or innovative projects that may deviate from the institutional, common and specialty specific program requirements must be approved in advance by the RC. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Procedures located in the ACGME Manual on Policies and Procedures. Once a RC approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project. (Experimentation and Innovation, General, Section VII.)

### Answer:

The RRC-IM supports initiatives to promote training in international health (IH) for fellows in ACGME accredited infectious disease programs. However, such rotations may result in non-compliance with a number of other requirements, particularly the General Subspecialty requirements (e.g., continuity clinic, conferences, KCF supervision and mentoring, peer interaction, etc.).

The Committee has drafted the following guidelines in conjunction with the IDSA Program Directors for programs interested in training fellows at an IH.

1. The Committee will review requests for a 2-12 month international health experience on a program-by-program basis. Approval will be as an exception (“Variance”) to the program requirements since accredited training will occur in a location not accessible to site visitor inspection and confirmation. Rotations of less than 6 weeks in duration will not require the following approval process. Those programs that are sending fellows abroad outside the 2 accredited years will not require the following approval process. This includes fellows who take a leave of absence from the 2 accredited years to work abroad, for instance while pursuing research.
2. The Committee will not allow a specialty-wide exception to the General Subspecialty or Infectious Disease Program Requirements
3. Request must be made by written letter to the RRC-IM, with sign-off by the GMCC and the DIO. Only programs with a review cycle of 3 years or longer will be considered for a variance. Programs on short cycles of <3 years should contact the RC-IM to be considered for initiating an exception.
4. Programs must delineate specific competency-based goals and objectives for this experience and the methods by which they will be evaluated.
5. Programs must address how each of the requirements referenced below will be met. For those requirements that cannot be met overseas (e.g., autopsies), the program must demonstrate how the educational experience offsets the unfulfilled program requirement
6. The experience must ensure
  - That there is a continuity experience for fellows at the site
  - That the core conferences are maintained. This may be accomplished in different ways including replication of the core conferences at the site or by electronic participation in home institution conferences, either live or archived.
  - That fellows will be supervised by at least one qualified ID physician who will serve as the Key Clinical Faculty (KCF) for the IH rotation (This KCF must be ABIM certified in the specialty, or have significant ID experience and training documented such that it is acceptable to home institution and the RC). The program should be able to justify to the RC-IM that the supervising physician is in fact adequate to teach the fellows at the distant site.Requests that fail to meet these three criteria will not be approved for a variance.
7. The request must specify how and where the fellow will meet the 12-month HIV longitudinal requirement.

8. The ID program director must maintain full control of all aspects of the experience. This includes
  - Execution of a Program Letter of Agreement between the fellowship program and the supervisor/site director of the fellows' clinical and research experience(s)
  - The appointment of a local Site Director who will be responsible to the program director for the fellows' clinical and research experience(s)  
(note: the Site Director may also serve as the KCF, or these may be separate positions)
  - Monitoring of the quality of the educational experience, and the fellows' compliance with ACGME program requirements
9. All 12 months of clinical training must occur in the United States.
10. The experience must be elective (not required).
11. The site must be approved by the RC-IM in the application letter as a Participating Institution for the program if the rotation is >3 months in duration.
12. The experience must be approved and have sign-off by the DIO of the sponsoring institution.
13. The program must provide evidence of sufficient salary support and institutional/departmental support of salary and institutional benefits. There must be sign-off and approval of this salary and benefits, and prior notification of the fellows as to the level of this salary support and benefits.
14. At completion of the rotation, the fellow will be required to complete an RC-IM developed Fellow Questionnaire which will be returned to the RC-IM in order to track the fellows' experiences.
15. The program must provide the Committee with a progress report on outcomes of the international health experience after the first two years of the variance
16. At the time of the reaccreditation site visit, the program must provide a mechanism for the site visitor to interview the fellows assigned at the international site.
17. As with all exceptions to the Program requirements, the variance must be renewed at the time of each reaccreditation.
18. Sunset Provision: Three years after implementation of this policy (July 2010), the RC-IM will examine carefully all progress reports and reaccreditation reviews of ID programs with approved variances for accredited training in international health outside the United States. Based on this evaluation, the Committee will determine whether to renew, modify, or discontinue these variances.

## **Section VIII - XI Infectious Diseases Program Requirements**

### **Section VIII. Educational Program**

#### **Length of Training**

##### Question:

*“Our infectious diseases fellowship is 3 years in length. Can we spread out the clinical training over 36 months?”*

*“Can we use the time fellows spend in continuity clinic to reduce the block time of 12 months clinical?”*

##### Program Requirement:

A subspecialty educational program in infectious diseases must be organized to provide training and supervised experience at a level sufficient for the fellow to acquire the competency of a specialist in the field. (Educational Program, Definition and Scope of Infectious Diseases Program, Section VIII.A.)

The training program must be 2 years in duration. (Educational Program, Duration of Program, Section VIII.B.)

A minimum of 12 months must be devoted to clinical experiences. (Educational Program, Clinical Training, Section VIII.C.)

[The program director must obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:] major changes in program structure

or length of training. (Program Personnel and Resources, Program Director, Section II.A.4.n.3.)

Answer:

All required training must be completed within the accredited 24-months of training.

An additional year of training (i.e., for research may be required (or offered) by the program, but the required training (at least 12 months clinical, continuity clinic, conferences, and research) must be completed during the accredited two years (24 months) of training:

Time spent in continuity clinic continuity clinic (one-half day weekly x 24 months) may not be used to reduce the minimum block time required for clinical training.

**Section IX. Faculty**

**Minimum Key Clinical Faculty**

Question:

*“What is the minimum number of ABIM-certified KCF for our program.”*

*“How many publications are required by KCF”*

Program Requirement:

See General Subspecialty FAQ for additional details and program requirement.

Answer:

See below for calculation of minimum required key clinical faculty, and the scholarly productivity expected of the KCF.

<b>Infectious Diseases KCF and Research Productivity</b>					
<b>Minimum 3 KCF or 1:1.5 faculty-fellow ratio for programs with 6 or more fellows</b>					
<b>Approved Fellow Complement</b>	<b>Minimum Certified KCF (incl PD)</b>	<b>Majority of Minimum KCF (51%)</b>	<b><u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years</b>	<b><u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)</b>	
2	3	2	2	6	
3	3	2	2	6	
4	3	2	2	6	
5	3	2	2	6	
6	4	3	3	9	
7	5	3	3	9	
8	6	4	4	12	
9	6	4	4	12	
10	7	4	4	12	
11	8	5	5	15	
12	8	5	5	15	
13	9	5	5	15	
14	10	6	6	18	
15	10	6	6	18	
16	11	6	6	18	
17	12	7	7	21	
18	12	7	7	21	

19	13	7	7	21
20	14	8	8	24
21	14	8	8	24
22	15	8	8	24
23	16	9	9	27
24	16	9	9	27
25	17	9	9	27

- Publication = Research publication, review article, or editorial in a peer review journal (PRJ), funded peer-review grant, or book chapter.
- Scholarly case reports acceptable (Sept 2007) if indexed in Pub Med, and copy submitted with PIF
- Peer review publication = indexed in Pub Med (or Medline). If not in Pub Med, PD must supply evidence of peer review
- In press or accepted for publication counts. Submitted or in preparation does not count.
- Abstract, illustration, letter to the editor, presentation, or publication in non-PRJ does not count.
- Peer-reviewed funding (NIH, NCI, or other government-funded or national-foundation funded) counts
- Industry, pharmaceutical, or other non-peer-review grant does not count.
  - Exception: Pharmaceutical studies in which the KCF is the overall PI (lead investigator) for all sites will be accepted as counting as one product of scholarship
- 1 paper = 1 paper; Do not count multi-author papers more than once.
- Count the last three calendar years prior to PIF submission. If site visit is in Sep. 2008, count publications from 2005, 2006, and 2007 as well as 2008.
- Contribute to participation: Only ABIM certified KCF
- Contribute to productivity:
  - Certified KCF
  - Additional sub-specialty KCF (above minimum required, certified or non-certified)
  - Non-physician faculty and faculty in other specialties IF:
    - Contribute to fellow education
- Devote at least 10 hours/ week to the program

## **Section XI. Specific Program Content**

### **Procedures**

#### Question:

*“What procedures does the program need to track for infectious diseases fellows?”*

#### Answer:

There are no required procedures for Infectious Diseases fellowships.

### **Microbiology Laboratory**

#### Question:

*“Can we use an off-site microbiology laboratory at an affiliated institution?”*

#### Program Requirement:

[In addition to the facilities and resources outlined in the Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine, each of the following must be present at the primary training site:] Fellows must have convenient access to a laboratory for clinical microbiology, such that direct and frequent interaction with microbiology laboratory personnel is readily available. (N.B.: This laboratory does not need to be located at the primary training site.) (Facilities and Resources, Diagnostics Laboratory Services, Section X.A.)

#### Answer:

The Committee expects fellows to develop competency in microbiology to the degree expected of an ID

specialist. It invites and encourage programs to develop measures of this competency.

If a microbiology laboratory is not located at the primary training site, the program may utilize the services of an off-site or remote microbiology laboratory. However, the program must demonstrate that this remote lab fulfills the “Convenient access” and “Direct and frequent interaction” clauses. In programs where a remote microbiology laboratory is utilized, the Committee expects, at a minimum:

- A microbiology rotation that includes time spent in that laboratory
- Opportunity to visit this laboratory at other times
- Regular interactions with these micro lab personnel (phone, teleconference, in person, etc.)

## **Clinical Microbiology - Experience**

### Question

*“Does the rotation on Microbiology count towards the 12 months of clinical training?”*

### Program Requirement:

Fellows must receive formal instruction and gain practical experience in clinical microbiology. (Specific Program Content, Technical and Other Skill, Section XI.B.2.)

### Answer

Since the microbiology experience required is practical and clinically oriented in nature, it counts towards the 12 months of clinical training.

## **Immunocompromised Patients**

### Question:

*“How will the RRC require documentation of adequate immunocompromised patients?”*

### Program Requirement:

[Fellows must have clinical experience and demonstrate competence in the evaluation and management of infections in patients with major impairments of host defense.] The teaching services on which fellows work must provide an average of at least 50 consultations per fellow during the period in which fellows are rotating on these services for their clinical training. (Specific Program Content, Technical and Other Skill, Section XI.B.3.a))

Documentation of the number of consultations may be completed for the teaching service overall rather than per fellow, if these numbers are available for the service; in this case, individual fellow logs are not necessary. Otherwise, fellows should document the number of consultations by an individual log. (Specific Program Content, Technical and Other Skill, Section XI.B.3.c))

### Answer:

The Committee does not require fellow logs of specific experiences. It accepts averaging for the teaching/consultation service overall (or fellow case logs if the program uses these).

See also requirements for competency:

- XI.B.3.b(1): Neutropenic patients
- XI.B.3.b(2): Patients with leukemia, lymphoma, or other malignancies
- XI.B.3.b(3): Patients with solid organ or bone marrow transplantation
- XI.B.3.b(4): Patients with patients with HIV/AIDS or patients immunocompromised by other diseases or medical therapies.

## **Consultations**

### Question:

*“How will the RRC require documentation of adequate inpatient consultations?”*

Program Requirement:

The inpatient teaching services on which fellows work must provide an average of at least 250 consultations per fellow during the period the fellows are rotating on these services for their clinical training. These consultations must be provided in a variety of clinical settings, including... (Specific Program Content, Technical and Other Skill, Section XI.B.5.)

Documentation of the number of consultations may be completed for the teaching service overall rather than per fellow, if these numbers are available for the service; in this case, individual fellow logs are not necessary. Otherwise, fellows should document the number of consultations by an individual log. (Specific Program Content, Technical and Other Skill, Section XI.B.3.c))

Answer:

This requirement is used as a measure of the clinical material available for teaching in an ID program. The Committee does not require fellow logs of specific experiences. It accepts averaging for the teaching/consultation service overall (or fellow case logs if the program uses these).

## **HIV Training**

Question:

*“Please explain the requirement for HIV Training”*

Program Requirement:

[Fellows must have clinical experience and demonstrate competence in the evaluation and management of infections in patients with major impairments of host defense.] [This experience includes, but is not limited to:] patients with HIV/AIDS or patients immunocompromised by other diseases or medical therapies. (Specific Program Content, Technical and Other Skill, Section XI.B.3.b)(4))

Ambulatory training must include longitudinal care (at least 12 months of direct supervision of each patient) of at least 20 patients with HIV. (Specific Program Content, Technical and Other Skill, Section XI.B.6.a))

As part of the required conferences and seminars outlined in the Program Requirements for Fellowship Education in the Subspecialties in Internal Medicine, a minimum of 25 hours each year must be devoted to discussion of HIV-related topics. (Specific Program Content, Formal Instruction, Section XI.C.2.)

Answer:

The Committee expects the program to design training in such a way that each fellow will follow at least 20 HIV patients for at least 12 month. Unlike other continuity clinic experiences, this HIV continuity experience may not be broken down into 6 month blocks

The intent is not that the fellow must see 20 HIV patients on day 1 and again on day 365, but rather that the fellow follows an adequate volume of HIV patients (20) for a year (or more).

The program should assign at least 20 HIV patients to the fellow at the start of the academic year (“at least 12 months of direct supervision of each patient”), with the intent of following those patient for 12 months (or more). The fellow may see some patients immediately after starting the clinic, and others (more stable) may not be seen until the second or third month of the clinic. Patients may leave the panel and be replaced. There can be a period of time to build up the panel (4-8 weeks) but the fellow may not build up the panel to 20 over 12 months.

Programs must also document at least 50 hours of HIV instruction over 2 years.

## **25% Gender Rule Exception**

### Question:

*“Most of our fellows’ continuity clinic patients are males with HIV because of the demographics of our patient population. Will we be cited?”*

### Program Requirement:

At a minimum, 25% of patients of either gender must be represented in the fellow’s panel of patients. If this gender distribution is not feasible due to the local epidemiology of HIV, the alternative clinical experiences or didactic instruction must be provided. (Specific Program Content, Technical and Other Skill, Section XI.B.6.c)

### Answer:

The Committee recognized that in many areas, the majority of patients with HIV are male, and that HIV patients are the mainstay of ID continuity clinics. For that reason, the “25% Gender rule” will be waived for ID programs IF the program supplements the training with gender-specific didactics (HIV in women, etc.).