

<b>Subspecialties of Internal Medicine FAQ</b>	
<b>Institutions and Participating Sites</b>	
<b>Question</b>	<b>Answer</b>
Ours is a small (3 fellow) program. What portion of my salary as a Sub program director should be provided by the institution? [Program Requirement I.A.1.d)]	<p>There are multiple administrative responsibilities and expectations for the subspecialty program director, including: developing and implementing the curriculum, planning and coordinating didactic conferences, evaluating the fellows/faculty/program, giving feedback to fellows and faculty, selecting faculty for teaching assignments, conducting semi-annual reviews, preparing the PIF, implementing the competencies, etc.</p> <ul style="list-style-type: none"> <li>• The Review Committee requires that each sub program director be provided with adequate time to fulfill these <u>administrative</u> responsibilities.</li> <li>• Programs will be cited if: <ul style="list-style-type: none"> <li>○ The program director judges that the salary support is inadequate to cover time spent carrying out the <u>administrative responsibilities</u> of fellowship</li> <li>○ The program director is required to generate clinical income to cover the cost of this administrative time.</li> </ul> </li> <li>• Note that 25-50% of the program director's salary is a suggested range to account for the different time commitment between small and large fellowships.</li> </ul>
What are the Review Committee's expectations for programs with participating sites that are geographically distant/remotely located from the primary teaching site? [Program Requirement I.B.– I.B.4.)	<p>The Review Committee considers a participating site "remote" if it requires extended travel (consistently more than one hour each way) or the radius between the site and the primary site exceeds 60 miles. The Review Committee expects the following when participating sites are remote:</p> <ol style="list-style-type: none"> <li>1. The program has provided appropriate education rationale for the use of the remote site in ADS.</li> <li>2. The Program Director has final authority over all aspects of training at the remote site.</li> <li>3. If experiences at the remote site will be required experiences, this information will need to be disclosed to all applicants prior to entering the program.</li> <li>4. No more than 25% of the educational experience can occur at remote sites.</li> <li>5. The program will need to ensure the fellows have housing available at the remote sites, at no cost to the fellows.</li> <li>6. The program will need to establish a mechanism that allows: <ol style="list-style-type: none"> <li>a. Fellows to participate in conferences at the primary site (electronically), or make available conferences with similar educational value at the remote site;</li> <li>b. Faculty at the remote site to interact with faculty at the primary site; and</li> <li>c. Fellows at the remote site to interact with other fellows at the primary site.</li> </ol> </li> </ol> <p>(July 2011 RC Meeting)</p>
What is the difference between master affiliation agreements and program letters of agreement? [Program Requirement I.B. – I.B.1.d)] [Institutional Requirement I.C.2. – I.C.3.]	<ul style="list-style-type: none"> <li>• Master affiliation agreements (MAA, also referred to as institutional agreements) are agreements between a sponsoring institution and all major participating institutions involved in residency and fellowship education. These are developed and maintained by the DIO, GMEC, and the sponsoring institution.</li> <li>• In contrast to master affiliation agreements, <u>program letters of agreement</u> (PLAs) originate at the program (instead of the institutional) level. Each accredited program must develop and maintain PLAs with participating sites involved in educating fellows. Program directors are responsible for the PLAs.</li> <li>• PLAs provide the Review Committee details on the educational rationale for designated assignments and include</li> </ul>

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	<p>information on supervision, evaluation, educational content, length of assignment and policy and procedures for each off-site assignment.</p> <p>The primary purposes of the PLA are to 'protect' the residents/ fellows and ensure an appropriate educational experience. So, unlike master affiliation agreements, which tend to be complex legal documents, program letters of agreement are intended to be short, less formal documents (approximately one-two pages in length) that specify, as simply as possible, the points noted above.</p> <ul style="list-style-type: none"> <li>• The Review Committee requires PLAs for <u>all routine rotations</u> where residents/ fellows rotate, even if less than 1 month duration. The PLA must be current (within past 5 years), and signed by the subspecialty program director and the site coordinator of the rotation (e.g., the local site director or the medical director).</li> <li>• Agreements should be updated whenever there are changes in program director or site director, resident/ fellow assignments or revisions to the items specified in the program requirements.</li> <li>• The Review Committee does not require a PLA for one-time electives.</li> <li>• A PLA is not required for a rotation within an integrated (i.e., same health center with shared faculty) institution.</li> <li>• See the ACGME FAQ on master affiliation agreements and program letters of agreement for more information.</li> </ul>
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<p>Does our program need to notify the Review Committee of a new rotation if we have adequate affiliation agreements? [Program Requirement I.B.3]</p>	<p>Review Committee notification and approval depends upon the <u>total duration of the assignment</u>.</p> <ul style="list-style-type: none"> <li>• The program must notify the Review Committee and receive approval for rotations to institutions where fellows rotate routinely for 3 months or 6 months (depending on length of the accredited training program).             <ul style="list-style-type: none"> <li>○ For 12- month programs (e.g., geriatrics), Review Committee approval is required for rotations where fellows will spend 3 months or more of training.</li> <li>○ For 24- month programs (e.g., endocrinology), Review Committee approval is required for rotations where fellows will spend 3 months or more of training.</li> <li>○ For 36-month programs (e.g., cardiology, pulm-cc), Review Committee approval is required for rotations where fellows will spend 6 months or more of training</li> </ul> </li> <li>• These same criteria will be used to determine which institutions are listed as participating institutions in WebADS.</li> </ul>
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<p>Program Director Qualifications Question</p>	<p>Answer</p>
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Are Co-Program Directors allowed?  
[Program Requirement II.A.1.]

Co-directors are not accepted by the Review Committee. The Review Committee expects there to be one individual with the responsibility and authority for all aspects of the program

- In combined programs (hematology-oncology, pulmonary-critical care) if the program director is not certified in both specialties, there must be a key clinical faculty certified in the other specialty with administrative responsibility for educational content of that specialty.
- Programs may identify one associate program director (e.g., the program director of the future) who participates heavily in the operations of the program under the direction of the program director, but this individual must have sufficient administrative time and resources.
- At all times, the single program director must have at least 20 hours/ week dedicated to the fellowship program.

Review Committee Accepted Dual Roles				
APD	+	SEC	=	YES
CF	+	SEC	=	YES
SPD	+	SEC	=	YES
APD	+	SD	=	YES
APD	+	CF	=	<b>NO</b>
M/P PD	+	APD	=	YES
IM PD	+	SPD	=	<b>NO</b>
SPD	+	APD	=	YES

PD = Program Director  
 APD = Internal Medicine Associate Program Director  
 SEC = Subspecialty Education Coordinator  
 CF = Core Faculty  
 SPD = Subspecialty Program Director  
 SD = Site Director  
 IM PD = Internal Medicine Program Director  
 M/P PD = Medicine/Pediatrics Program Director

Does the Review Committee grant waivers for ABIM certification of the program director, if we can demonstrate 'equivalent credentials'?  
[Program Requirement II.A.3. – II.A.3.b)]

- Only ABIM specialty certification is acceptable; no other credentials are accepted by the Review Committee.
- The Review Committee does not grant waivers for the ABIM-certification program requirement (for program directors or for key clinical faculty).
  - Rationale: The Review Committee uses ABIM certification as one of its major outcome measures. Furthermore, the ABIM publicly publishes program pass rates, and individual certification status. A major goal and outcome of each IM subspecialty training program has been the training of ABIM-certified graduates. ABIM-certified program director (and key clinical faculty) demonstrate to the trainees the value and importance of ABIM certification by becoming ABIM certified and by maintaining certification in the subspecialty. Note that the ABIM has a pathway for certification of faculty who were not trained in an ACGME accredited program.
- The Review Committee will withhold accreditation of new programs that are not led by ABIM-subspecialty-certified internists
- The Review Committee standard for subspecialty program director certification is as follows:
  - The subspecialty program director must be ABIM-

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	<p>certified, and must maintain certification in the internal medicine subspecialty.</p> <ul style="list-style-type: none"> <li>▪ i.e., the subspecialty program director may allow core certification to lapse, but must maintain certification in <u>subspecialty</u>.</li> <li>▪ In combined fellowships (hematology-oncology, pulmonary-critical care) the program director must maintain certification in at least one subspecialty.</li> </ul> <ul style="list-style-type: none"> <li>○ In Sub-Subs, the program director must maintain primary subspecialty certification <ul style="list-style-type: none"> <li>▪ CCEP: cardiology <u>and</u> CCEP certification</li> <li>▪ IC: cardiology <u>and</u> IC certification</li> <li>▪ Transplant Hepatology: gastroenterology <u>and</u> (July 1, 2011) transplant hepatology</li> </ul> </li> <li>○ See Geriatrics FAQ for family medicine certified program directors and key clinical faculty</li> <li>○ In IM-Sleep Medicine: the program director may be certified in Sleep Medicine by the ABSM or certification by a member board of the ABMS until January 1, 2012 <ul style="list-style-type: none"> <li>▪ See Appendix III below</li> </ul> </li> </ul> <p><b>Exceptions to program director Certification Requirements:</b>  <b>[See Appendix III below]</b></p> <p><u>Sleep Medicine:</u>  Sleep program director may be ABMS certified in Neurology, Psychiatry, Pediatrics, ENT <u>IF:</u></p> <ul style="list-style-type: none"> <li>• The program director maintains sleep certification</li> <li>• There is another ABIM-certified key clinical faculty who is also sleep certified</li> </ul> <p><u>Geriatrics:</u>  Geriatrics program director may be ABFM certified <u>IF:</u></p> <ul style="list-style-type: none"> <li>• Trained in an ACGME-accredited internal medicine geriatrics fellowship, or in a family medicine geriatrics fellowship.</li> <li>• Maintain current ABFM geriatrics CAQ</li> <li>• 5 years or more experience as a geriatrics faculty member in an <u>internal medicine</u> residency or in an <u>internal medicine</u> IM-Geriatrics fellowship.</li> <li>• Demonstrate the ability to establish and maintain an environment of inquiry and scholarship to the same degree as required for IM-subspecialty key clinical faculty. <ul style="list-style-type: none"> <li>○ Actively engaged in the scholarship of discovery or dissemination (See III.B.4) as evidenced by at least three (3) products of scholarship in any of the following categories in the past three years: peer-review manuscripts, peer-review grants, book chapters, review articles in peer-review publications, or editorials in peer-review publications.</li> <li>○ Abstracts and presentations alone will not meet this requirement.</li> </ul> </li> <li>• Recommended by the core internal medicine residency director for outstanding teaching and administrative ability</li> </ul>
<p>Does the Review Committee grant waivers for the 5-year faculty requirement for program director qualifications?  [Program Requirement II.A.3.d)</p>	<p>The Review Committee feels strongly that five years as internal medicine subspecialty faculty in an ACGME-accredited fellowship program is an important prerequisite for the responsibilities of the program director in order to have adequate subspecialty and GME expertise, and sufficient institutional creditability to direct a training</p>

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	<p>program and to ensure compliance with the program requirements.</p> <ul style="list-style-type: none"> <li>• Waivers for the 5-year faculty experience program requirement are <b>not</b> granted.</li> <li>• The Review Committee requires the program director of an internal medicine subspecialty program to have at least 5 years experience as a subspecialty faculty in a teaching hospital.</li> <li>• This experience does not include time spent in fellowship training.</li> </ul> <p>However, the rules for program director qualifications are different for <u>new subspecialty programs</u>.</p> <ul style="list-style-type: none"> <li>• Instead of requiring the program director of a new subspecialty program to have been a key clinical faculty in a subspecialty fellowship, the Review Committee requires at least 5 years functioning as a faculty subspecialist either in a subspecialty fellowship, in a core residency program, or a combination thereof. This allows institutions to start new fellowship programs with existing faculty, rather than recruiting the program director from outside of the institution.</li> </ul>
Program Director Responsibilities Question	Answer
<p>Can the Review Committee clarify the extent or limitations of the program directors responsibilities for the subspecialty fellowship? [Program Requirement II.A.4. – II.A.4.u)]</p>	<p>The Review Committee expects that the program director will have full responsibility and full authority for <u>all</u> aspects of the training program. This includes:</p> <ul style="list-style-type: none"> <li>• The program director must monitor fellow experiences and exercise the program director authority when the need arises (e.g., fellows complain about a faculty member, the program director determines a rotation has insufficient educational value, etc.).</li> <li>• The program director must have the authority to make all fellow assignments.</li> <li>• The program director must have the authority to revise clinical rotations as necessary to maintain fellow education.</li> <li>• The program director must have the authority to remove fellows from services judged by the program director to have insufficient educational value.</li> <li>• The program director must have the authority to deny admitting privileges to the inpatient subspecialty teaching service for selected physicians who fail to support the educational program.</li> <li>• The program director must have the authority to remove selected faculty from teaching assignments based on fellow evaluations or issues of faculty competence/ expertise.</li> <li>• Authority may be shared (e.g., with the division chief), if the same effect can be demonstrated (e.g., resolution of problem faculty, educationally marginal rotations).</li> </ul>
<p>What changes in the program require notification of (or approval by) the Review Committee by the program director? [Program Requirement II.A.4.n).(2)] [Program Requirement I.A.1.e)]</p>	<p>The following changes require Review Committee notification and/ or approval:</p> <ul style="list-style-type: none"> <li>• Major disruptions in the institutional affiliation, governance, stability, etc. require immediate Review Committee notification via Web ADS.</li> <li>• A major loss of program faculty (i.e., the program no longer meets the minimum number of key clinical faculty required in the program requirements) requires immediate Review Committee notification as well as update Web ADS.</li> <li>• Programs must request approval for all complement increases, even temporary increases (e.g., maternity leave</li> </ul>

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	<p>extends fellow's training by 3 months; when the fellow returns the program is 1 over the limit)</p> <ul style="list-style-type: none"> <li>▪ Rationale: to avoid discrepancies with the WebADS database.</li> <li>▪ Complement changes are very easily accomplished using WebADS on-line.</li> <li>▪ Note: programs must complete the Response to Citations in Web ADS. Complement increases will not be considered if this section of Web ADS is not completed.</li> </ul> <ul style="list-style-type: none"> <li>• A complement increase requires documentation of adequate patient population, procedural opportunities, staff, facilities, faculty, research opportunities, and an educational rationale for increase.</li> <li>• Review Committee approval is <u>required</u> for             <ol style="list-style-type: none"> <li>1) Tracks that include interrupted training (e.g., MPH sandwiched between accredited training years)</li> <li>2) Adding a track (a program structure available to a subset of fellows in the program) or major alterations in program structure requires Review Committee notification and prior approval.</li> <li>3) Training that results in interruption of continuity clinic for 6 or more weeks (e.g., an overseas rotation) The Review Committee must be notified and approval will be via the expedited review process. The Review Committee reviews all such tracks (and other variances) at each subsequent accreditation review.</li> </ol> </li> <li>• Review Committee approval is <u>not required</u> for:             <ol style="list-style-type: none"> <li>1) Individual variations in training (e.g., parental leave, medical leave of absence)</li> <li>2) Individual interruptions in training that are not part of an established track (e.g., an individual fellow obtaining an MPH or PhD between years 1 and 3)</li> <li>3) Fellows in additional <u>non-accredited</u> years of training (e.g., extra year of research) do not count against complement.</li> <li>4) A program that is under its approved complement, unless the reduction will be permanent.</li> </ol> </li> <li>• The Review Committee will not grant a permanent increase in fellow complement under the following circumstances:             <ul style="list-style-type: none"> <li>○ If the program's last accreditation status included a warning.</li> <li>○ In the interval between the time of the site visit and posting on WebADS of the letter of notification (typically ~ 60 days following the Review Committee's meeting).</li> <li>○ If the Web ADS response to citations section has not been completed.</li> </ul> </li> </ul>
<p>What the Review Committee will accept as documentation of compliance with the work hours rules? Will fellow self report be sufficient, if supported by clearly structured, written schedule plans? Or will the Review Committee insist on objective documentation of time in/out (i.e., time card system)? [Program Requirement II.A.4.j) –</p>	<ul style="list-style-type: none"> <li>• The Review Committee defers to programs and institutions the specifics of documentation of compliance with duty hours requirements.</li> <li>• The Review Committee will rely on fellow reporting (i.e., the fellow questionnaire, the ACGME resident survey, and the fellow interview at the site visit) and review of fellow schedules in its accreditation decision regarding duty hours compliance.</li> <li>• The Review Committee will consider additional information collected by the program (e.g., duty hour logs, periodic surveys, etc.) in its determination of compliance.</li> </ul>

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II.A.4.k)]	<ul style="list-style-type: none"> <li>Programs may be asked to respond to concerns identified in the ACGME resident survey between site visits, and the Review Committee expects the program to be able to document substantial compliance.</li> </ul>
<p>Program requirements for endocrinology require two years of training. Our endocrinology program is three years in length in order to add an additional year of research. Can we stretch out the required clinical training over the three years? [Program Requirement II.A.4.p)]</p>	<ul style="list-style-type: none"> <li>No. All required training must be completed within the accredited years of training.</li> <li>Additional year(s) of training (i.e., research) may be required, or offered, by the program, but the required training (as set forth in the program requirements), must be completed during the accredited years of training – during the accredited one year (IC, CCEP, geriatrics, 1-year critical care, sleep, transplant hepatology), three years (cardiology, GI, heme-onc, pulm-CC) or two years (all other fellowships).</li> <li>Some programs encourage additional continuity clinic and additional clinical experiences during the additional (unaccredited) year, but these must be over and above the required training, which must be completed during the accredited training years.</li> <li>Modifications of training for combined training (e.g., critical care – infectious diseases), or extended training for MPH, are reviewed case-by-case by the Review Committee and requires prior approval by the Review Committee – based on educational rationale, individual accommodation versus proposed routine program element, interrupted training (clinical and didactic), etc. These also require prior approval from the sponsor’s GMEC/DIO and/or ABIM.</li> </ul>
<p>How should the program director monitor fellow stress? [Program Requirement II.A.4.q)]</p>	<p>The Review Committee expects that the program director will monitor the well-being of fellows in the program through a variety of sources: faculty evaluations, peer and other 360 evaluations, semiannual reviews, administrative meetings with the fellows, reports from key clinical faculty, and day-to-day observations. Fellows should feel comfortable discussing concerns and problems with the faculty and program director. The program director should make appropriate interventions (e.g., referral to employee assistance program) as needed.</p>
<p>What is required for program director and key clinical faculty educational CME? [Program Requirement II.A.4.s) – II.A.4.t)]</p>	<ul style="list-style-type: none"> <li><u>Program director</u>: The program director must demonstrate his/her own professional CME to improve both <u>education</u> (teaching, specialty expertise) and <u>administrative</u> (GME) skills. Examples: APDIM or AAIM meetings, ACGME conferences, subspecialty program director meetings, etc.</li> <li><u>Key clinical faculty</u>: The program director and/or DIO must organize CME for faculty regarding <u>fellowship education and competencies</u>. <ul style="list-style-type: none"> <li>This faculty development can occur in a variety of ways (e.g., faculty meetings, web-based faculty curricula, assigned readings, e-mail updates, focused instruction, etc.) that promote continuous improvement of the faculty.</li> <li>Locally organized meetings are acceptable (and encouraged).</li> <li>Faculty attendance at specialty meetings alone is insufficient, unless special sessions on fellowship education and competencies are included in the sessions attended.</li> </ul> </li> </ul>
<b>Faculty Question</b>	<b>Answer</b>
<p>Can a faculty member board-certified in anesthesia or surgical critical care medicine by the ABMS or board-certified in critical</p>	<ul style="list-style-type: none"> <li>No. The Review Committee does not approve of, or accept non-ACGME trained internists or non-ABIM certified physicians serving as teaching attendings or attendings-of-record on inpatient</li> </ul>

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<p>care medicine by the American Osteopathic Association (AOA) supervise medicine house staff in the critical care units? [Program Requirement IV.A.2.c)(1)(a)]</p>	<p>internal medicine services including the medical critical care units. This includes cross-coverage by other attendings for the attending-of-record on nights, weekends and holidays. However, this does not preclude non-ABIM certified intensivists from supervising medicine residents and fellows taking elective or required rotations in non-medical intensive care units. It also does not preclude consultation by these individuals if required for patient care or for procedural supervision.</p>
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<p>Can you please explain how many publications are required of the key clinical faculty? Can we count abstracts and presentations at specialty meetings? [Program Requirement II.B.5 – II.B.5.f)]</p>	<p>The Review Committee requires that all fellows train in an environment of inquiry, scholarship, and research productivity.</p> <p>The Review Committee requires that key clinical faculty demonstrate both participation and productivity in scholarship of discovery and dissemination as evidenced by:</p> <ul style="list-style-type: none"> <li>• Participation standard: 50% of the certified, minimum-required-number of key clinical faculty must demonstrate at least 1 acceptable product of scholarship in the past three years. (See definition of acceptable products of scholarship below)</li> <li>• Productivity standard: Total acceptable products of scholarship for all key clinical faculty (including non-certified) must = at least 1 product per year x 3 years x 50% of the minimum required key clinical faculty. (See table)</li> </ul> <p><b>Acceptable Product of Scholarship – Definition</b></p> <p>The Review Committee defines acceptable products of scholarship for key clinical faculty – to meet key clinical faculty scholarship requirements – as follows:</p> <ul style="list-style-type: none"> <li>• Publication of original research manuscripts in a peer-reviewed journal</li> <li>• Publication of a review article in a peer-review journal</li> <li>• Publication of an editorial in a peer-review journal</li> <li>• Peer-review funding of research such as NIH, NCI, or other external funding organizations             <ul style="list-style-type: none"> <li>• Non peer-review funding, such as industry funding or internal institutional funding, or multicenter industry funding, or other non peer-review grant does not count                 <ul style="list-style-type: none"> <li>▪ Exception: Pharmaceutical studies in which the key clinical faculty is the overall PI (lead investigator) for all sites will be accepted as counting as one product of scholarship</li> </ul> </li> </ul> </li> <li>• Publication of a book chapter published in medical textbooks (full citation required including publisher and date)             <ul style="list-style-type: none"> <li>• This includes chapters published in specialty society review texts, such as MKSAP, NephSAP, ACCSAP, the Geriatrics Review Syllabus, etc.</li> </ul> </li> <li>• Publication of a case report indexed in Pub Med             <ul style="list-style-type: none"> <li>• A copy of the case report must be included with PIF</li> <li>• Case reports published as an abstract, letter, correspondence, or illustration do not count</li> </ul> </li> <li>• Publications in peer reviewed journals that are in press may be counted.             <ul style="list-style-type: none"> <li>• Submitted or in preparation <u>does not count</u></li> </ul> </li> <li>• Abstracts, presentations, letters-to-editor, correspondence, or illustrations do not count</li> <li>• The Review Committee defines a peer-review publication as a journal indexed in Pub Med (or MEDLINE).             <ul style="list-style-type: none"> <li>• For publications not listed by Pub Med or MEDLINE, the program must so indicate in the citation listed in</li> </ul> </li> </ul>
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	<p>the PIF, and the program must:</p> <ul style="list-style-type: none"> <li>• Demonstrate evidence that the journal is indexed by an abstracting and indexing resource with a documented process for selection pr peer-reviewed publications</li> </ul> <p style="text-align: center;">Or</p> <ul style="list-style-type: none"> <li>• Provide evidence of peer review in the PIF (e.g. instruction to author page)</li> </ul> <p style="text-align: center;">Or</p> <ul style="list-style-type: none"> <li>• Description of the peer review process (external reviewers, editor's/reviewer's comments)</li> </ul> <p>1 paper = 1 paper; Multi-author papers may not be counted twice for faculty productivity</p> <p>Count the last three calendar years prior to PIF submission. If the site visit is in September 2008, programs should count publications from 2005, 2006, and 2007 as well as 2008.</p> <p>Summary/Example: for a 6-fellow endo, heme, ID, neph,onc, pulm, or rheum program, 4 key clinical faculty (including program director) are required. Two of these 4 must have at least one publication (as defined) in the three calendar years preceding submission of the PIF. ALL key clinical faculty (minimum number plus any additional key clinical faculty) must have produced at least six such publications.</p> <p>See summary of key clinical faculty minimum numbers and research productivity in <b>Appendix I</b></p>
<p>How can we obtain an exception to the key clinical faculty certification requirements? [Program Requirement II.C. – II.C.2.]</p>	<p>The Review Committee applies faculty certification requirement only to the program director and the minimum number of required key clinical faculty.</p> <ul style="list-style-type: none"> <li>• The <u>minimum required</u> number of key clinical faculty (the minimum number varies by specialty and by the number of fellows approved) must be ABIM certified and maintain certification in the subspecialty (see Appendix 1)</li> <li>• key clinical faculty may allow core certification to lapse <ul style="list-style-type: none"> <li>○ Cardiology Sub-Sub key clinical faculty (CCEP, IC) must maintain both cardiology and sub-sub certification</li> <li>○ Transplant Hepatology key clinical faculty must be gastroenterology certified; after July 1, 2011 they must maintain both GI and Transplant Hepatology certification</li> </ul> </li> <li>• Extra key clinical faculty (over minimum number required) do not need ABIM certification <ul style="list-style-type: none"> <li>○ They may not contribute to the key clinical faculty scholarship <u>participation</u> standard</li> <li>○ Additional key clinical faculty <u>may</u> contribute to key clinical faculty scholarship <u>productivity</u> standard IF they meet all other key clinical faculty criteria.</li> <li>○ Non-key clinical faculty other faculty do <u>not</u> need ABIM certification.</li> </ul> </li> </ul> <p>Key clinical faculty responsibilities are 10 hours/ week (average) devoted to the program, and:</p> <ul style="list-style-type: none"> <li>• Supervision</li> <li>• Teaching (Including conferences)</li> </ul>

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	<ul style="list-style-type: none"> <li>• Scholarship</li> <li>• Specialty expertise</li> <li>• Mentorship</li> <li>• Commitment (to the fellows, the Competencies, the program, etc.)</li> </ul>
<b>Resources</b>	
<b>Question</b>	<b>Answer</b>
What is meant by a death review? If autopsy reports are posted on the electronic laboratory information system, will that meet the requirements for autopsy reports? [Program Requirement II.D.4. – II.D.4.b)]	<ul style="list-style-type: none"> <li>• AS OF JULY 2010, THE REVIEW COMMITTEE DETERMINED THAT AUTOPSY REPORTS WILL NO LONGER BE REQUIRED FOR THE SUBSPECIALTIES.</li> </ul>
<b>Fellow Appointment</b>	
<b>Question</b>	<b>Answer</b>
What does the Review Committee require in the written lines of responsibility? [Program Requirement III.E.]	Written lines of responsibility (LOR) must spell out <u>reporting relationships</u> and <u>supervisory responsibilities</u> between all learners and supervisors on all teaching services e.g., on an MICU rotation, the patient care responsibilities, supervisory responsibilities, and reporting relationships must be stipulated (for interns, residents, fellows, and attendings) in writing and available to all learners and supervisors.
Does the Review Committee limit the number of international or osteopathic graduates appointed to subspecialty fellowship programs? [Program Requirement III.F.]	<ul style="list-style-type: none"> <li>• The Review Committee does <u>not</u> limit the number of international medical graduates or osteopathic graduates appointed to a fellowship program...as long as they have completed an ACGME-accredited IM residency.</li> <li>• The Review Committee <u>does</u> limit the percentage of fellows who enter fellowship <u>without having completed an ACGME-accredited residency in internal medicine.</u></li> <li>• The Review Committee requires fellowship programs to maintain a rolling 5-year average of at least 75% of its current and former fellows having been graduates of an ACGME-accredited internal medicine residency program.</li> <li>• Thus, up to 25% of fellows in the past 5 years may have completed internal medicine residency in osteopathic, international, or other non-ACGME-accredited internal medicine residency programs. For these appointees, the program must ensure that: <ul style="list-style-type: none"> <li>○ All appointees have <u>at least 3 years of internal medicine training</u> (e.g., in osteopathic or international internal medicine residency) prior to appointment. <ul style="list-style-type: none"> <li>▪ This is to ensure adequate competency in internal medicine because these fellows will be eligible to supervise internal medicine residents</li> </ul> </li> <li>○ All appointees are <u>notified in writing</u> that they <u>will not be eligible for ABIM certification</u> without repeating residency training at an ACGME-accredited IM residency program. <ul style="list-style-type: none"> <li>▪ This is to prevent fellows from accepting an appointment under the mistaken impression that they will be able to obtain ABIM certification in the subspecialty at the completion of training.</li> </ul> </li> </ul> </li> </ul>
<b>Educational Program</b>	
<b>Question</b>	<b>Answer</b>
Must faculty review goals and	No. The Review Committee does not expect faculty to review goals

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objectives with fellows at the start of each assignment? [Common Program Requirement IV.A.2.]	and objectives with fellows at the start of each rotation.
How will the Review Committee assess whether the teaching is sufficient to ensure a meaningful and continuous relationship between the assigned supervising faculty and the fellow? [Program Requirement IV.A.3.b).(2)]	Interactions between the faculty and fellows must occur in a manner that allows faculty to assess each individual fellow and allows each fellow the opportunity to learn from and assess each faculty member. It is expected that the faculty teaching and supervision will be of a frequency and duration to support delegation to fellows of patient care authority and progressive responsibility commensurate with their demonstrated knowledge and skills, and for fellows to learn from the faculty the knowledge and skills of the subspecialty. Compliance with this requirement will be determined by examining information provided in the PIF, the fellow survey and the results of fellow interviews by the site visitor. (January 2011 RRC Meeting)
What are the minimum requirements for compliance with the competency requirements? [Program Requirement IV.A.5. – IV.A.5.f).(6)]	<ul style="list-style-type: none"> <li>• The Review Committee will examine fellowship programs carefully at the time of each accreditation review for evidence of the following: <ul style="list-style-type: none"> <li>○ A competency-based written curriculum</li> <li>○ Awareness and understanding of the competencies and outcomes by all fellows</li> <li>○ Awareness and understanding of the competencies and outcomes by faculty</li> <li>○ Competency-based semi-annual reviews by the program director</li> <li>○ Competency-based global ratings by faculty</li> <li>○ Competency-based advancement criteria (revised 1/1/08 14 IM_SA_3/20/08)</li> <li>○ The use of direct observation and reflection exercises to assess competency i.e., mini-CEX, OSCE, checklists, simulators, etc.</li> <li>○ The use of problem based learning and improvement exercises to assess competency i.e., chart audit, portfolios, vignettes, chart stimulated recall, etc.</li> <li>○ A system to log procedural competency with procedure logs (<b>See Appendix II</b>)</li> <li>○ The use of multi-Source (360) evaluations to assess competency (i.e., patients, peers, nurses, etc.)</li> <li>○ The use of competency-based summative evaluations</li> <li>○ At least one active competency-based performance improvement project at all times</li> </ul> </li> </ul>
What are the research/ scholarship requirements for fellows? Must all fellows publish? [Program Requirement IV.B. – IV.B.2.a)(4)(b)]	<p>All fellows must train in an environment of scholarship, inquiry and research.</p> <ul style="list-style-type: none"> <li>• At a minimum, the Review Committee expects all fellows to have: <ul style="list-style-type: none"> <li>○ A research mentor</li> <li>○ At least one research project to be completed during training</li> <li>○ Sufficient protected time – either in blocks or time concurrent with clinical rotations – to complete the project.</li> <li>○ Exceptions: <ul style="list-style-type: none"> <li>▪ No fellow research is required for geriatrics or for 1-year critical care programs (2-year critical care programs must meet the fellow research requirements).</li> <li>▪ Fellows in CCEP, IC, transplant, and sleep must participate in scholarly activity that is more broadly defined because of the</li> </ul> </li> </ul> </li> </ul>

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	<p>limited duration of training (i.e., research projects, enrollment of patients in clinical trials, or QI/ performance improvement projects).</p> <p>The Review Committee also expects fellows to demonstrate evidence of productivity in scholarship.</p> <ul style="list-style-type: none"> <li>• This productivity can be scholarship of discovery or dissemination (the key clinical faculty standard) <u>or</u> scholarship of application such as abstracts and presentations.</li> <li>• The productivity must reflect research/ scholarship completed during fellowship, although the publication/ presentation may occur after the fellow completes the program.</li> <li>• At the time of the PIF submission, 50% of the fellows in the <u>previous three graduating classes</u> must demonstrate at least one of the following:             <ul style="list-style-type: none"> <li>○ Manuscript(s) published</li> <li>○ Case Reports published</li> <li>○ Abstract(s) published in journal, or specialty abstract book</li> <li>○ Abstract(s) presented at national specialty society meeting</li> </ul> </li> <li>• 1-year programs are exempt from the <u>fellow</u> research productivity requirement.</li> </ul>
<p>We have recently developed an affiliation with another institution that will provide salary support for additional fellows. Can our fellowship program develop a track for some of our fellows to spend most or all of their training at this site? [Program Requirement IV.C.2.]</p>	<ul style="list-style-type: none"> <li>• <u>Stand-alone fellowship tracks are not allowed.</u></li> <li>• That is, the program may not establish a track for a subset of fellows who spend the majority of their training at a site separate from the core residency program.</li> <li>• Institutions may <u>only</u> sponsor fellowship training as a dependent subspecialty of the core internal medicine residency program.</li> <li>• The major site of fellowship training must be at the same institution that sponsors the internal medicine residency program, or may be based at a participating institution where there is a <u>continuous presence of the sponsoring institution's core internal medicine residents and faculty.</u></li> <li>• The fellowship program may develop affiliations and rotations at other participating institutions, as long as the fellow's continuity experience is maintained as required by the relevant program requirements for continuity clinic.</li> <li>• The program director may excuse fellows from continuity clinic up three non-consecutive months over a three year fellowship, two non-consecutive months over a two year fellowship, or one month for a one year fellowship.</li> </ul>
<p>Why does the Review Committee require that there be a reporting relationship to the core program? We meet periodically to discuss the relationship of fellows and residents in the hospital. Does that fulfill this requirement? [Program Requirement IV.C.3.]</p>	<ul style="list-style-type: none"> <li>• The Review Committee requires that each subspecialty program director <u>reports to</u> the core program director. The purpose of this requirement is to ensure that the subspecialty program director uses the experience and oversight of the core program director to:             <ul style="list-style-type: none"> <li>○ Understand and comply with the subspecialty program requirements</li> <li>○ Understand and implement competency-based educational program, QI projects, etc.</li> <li>○ Ensure that the subspecialty and core program director coordinate changes in the residency or fellowship that may have an impact on either program.</li> </ul> </li> <li>• The Review Committee expects the core program director to provide <u>oversight</u> of all IM subspecialty programs. Oversight may be accomplished in a variety of ways, such as:             <ul style="list-style-type: none"> <li>○ Joint participation in departmental subspecialty fellowship committee</li> <li>○ Joint meeting with the DIO</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>○ Periodic meetings between core and subspecialty program director</li> <li>○ Etc.</li> <li>○ Note: Simply meeting to discuss interface of fellows and core residents, core resident rotations, etc. is insufficient.</li> <li>• The Review Committee will examine each fellowship program carefully for the presence of core program director oversight of the fellowship.</li> <li>• The subspecialty program director will cited when a reporting relationship to the core program director is not clearly present</li> <li>• The core program director will cited when multiple subs have similar citations (e.g., curriculum, evaluation, continuity clinic) suggesting lack of oversight for compliance with subspecialty program requirements.</li> <li>• In Sub-Subspecialties             <ul style="list-style-type: none"> <li>○ The Review Committee expects the parent Sub program director to provide oversight of the Sub-Sub. The oversight can be through the parent Sub program director (i.e., core • cardiology • IC) or simultaneous (i.e., core • cardiology and IC) but the effect must be the same.</li> </ul> </li> </ul>
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<p>Does the Review Committee still require a basic science conference or an M&amp;M conference for fellows? What does the Review Committee mean by a core curriculum conference series? How many required conferences must the program provide each month? Is the number of required conferences the same for a small, 1-year program?          [Program Requirement IV.D.2.a – IV.D.2.a.(4)(c)]</p>	<p>The Review Committee requires the program to provide at least 10 conferences per month attended by fellows <u>and</u> faculty:</p> <ul style="list-style-type: none"> <li>• Four (once weekly, averaged over 1 year) <u>core curriculum conferences</u></li> <li>• Programs may front-load some or all of the core curriculum conference series at the beginning of the year, as long as the total core curriculum conferences average at least one per week. Averaging is not permitted for other required conferences.             <ul style="list-style-type: none"> <li>○ The core curriculum is a planned course in the subspecialty.</li> <li>○ It must cover the major topics in the subspecialty</li> <li>○ It must incorporate the multidisciplinary topics listed in IV.D.2. as well as education in the recognition and effects of sleep deprivation.                 <ul style="list-style-type: none"> <li>▪ Programs need not produce separate conferences on each topic, but each interdisciplinary topic must be included in core conference series, or discussion at case conferences, research conferences, and/or journal clubs.</li> </ul> </li> <li>○ It is <u>distinct</u> from a case conference, though it may be case based.</li> <li>○ Basic science conference no longer required for the subspecialties. Instead basic sciences should be covered at core curriculum and case conferences.</li> </ul> </li> <li>• Four (once weekly) <u>clinical case conferences</u> <ul style="list-style-type: none"> <li>○ Include review of pathologic material.</li> <li>○ A separate M&amp;M or CPC is not required <u>for</u> subspecialties; however, pathological material must be reviewed at the required fellow case conferences.</li> </ul> </li> <li>• One (once monthly) <u>journal club</u></li> <li>• One (once monthly) <u>research conference</u> <ul style="list-style-type: none"> <li>○ While this conference may include didactics on research methodology, the primary purpose of the research conference is for fellows and faculty in the subspecialty to discuss current and future research projects in the subspecialty division.</li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>○ Fellows in geriatrics and 1-year critical care programs are not required to participate in research conferences.</li> <li>• There must be a mechanism for fellows who miss a core curriculum conference (day off, post-call, vacation, off-campus rotation, etc.) to recoup or make up the missed educational experience. The Committee accepts a variety of solutions, as long as fellows have the <u>opportunity</u> to experience missed core curriculum conferences. The solutions to this issue are all local, and depend partially on why fellows miss conference (post-call, day-off, away rotation). Note that the standard applies to <u>core curriculum</u> conferences. A variety of solutions are acceptable, including but not limited to: <ul style="list-style-type: none"> <li>○ Videotaping</li> <li>○ Web casting</li> <li>○ Making slides available on the web</li> <li>○ Repeating conferences</li> <li>○ A parallel conference series at the off-site location</li> </ul> </li> </ul> <p>The program requirements state that faculty (key clinical faculty) must attend required core conferences, and that fellows must participate in (some) required conferences, both planning and presentation. Thus, the Review Committee expects:</p> <ul style="list-style-type: none"> <li>• Fellows must prepare and present some conferences. Each fellow is expected to present periodically at case conferences, at research conferences, and at journal club with faculty mentorship.</li> <li>• Fellows may also participate in the preparation and presentation of selected core curriculum conferences. However, the core curriculum conferences are intended to be a course in the specialty directed at the fellows. Thus, key clinical faculty must be intimately involved in the planning and presentation of the core curriculum conferences.</li> <li>• Key clinical faculty must be involved in all of the 10 required monthly conferences.</li> <li>• Programs will be cited for core conferences where fellows present to fellows without key clinical faculty in attendance.</li> </ul>
<p>Must all fellows participate in formal review of gross and microscopic pathological material from patients who have been under their care? [Program Requirement IV.E.1.a)]</p>	<p>Only fellows in <u>geriatric</u> or <u>cardiovascular disease</u> fellowship programs do not have to participate in formal review of gross and microscopic pathological material from patients who have been under their care.</p>
<p>Does the faculty supervising fellows in clinic need to be present, on-site, during the fellow's clinical encounter with the patient? [Program Requirement IV.E.1.a)]</p>	<p>The Review Committee expects that the ultimate supervision of fellows will be from a physician faculty member.</p> <ul style="list-style-type: none"> <li>• That supervision must be on-site (i.e., not by telephone) and concurrent (i.e., in outpatient settings, the fellow must present the case to the physician faculty prior to the patient leaving clinic). <ul style="list-style-type: none"> <li>○ Remote control supervision (e.g., attending available by phone) is not acceptable in outpatient settings</li> <li>○ Rationale: The attending must have the opportunity to interview/ examine all patients at the time he/ she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary.</li> </ul> </li> </ul> <p>Faculty assigned to clinic must have resident/ fellow teaching and supervision as their primary mission.</p> <ul style="list-style-type: none"> <li>• Faculty must not be expected to see their own patients simultaneously IF this negatively impacts their supervisory and teaching responsibilities.</li> </ul>
<p>What are the regulations regarding continuity clinic in subspecialty</p>	<p>Subspecialty programs may organize their continuity clinics in either the traditional weekly clinic over the duration of the program, or in</p>

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<p>programs? [Program Requirement IV.E.2. – IV.E.2.g)]</p>	<p>blocks of weekly clinics no shorter than 6 months duration. This allows fellows to be exposed ...to the breadth and depth of the subspecialty... to observe and to learn the course of disease and... to develop a continuous healing relationship with patients for whom they provide subspecialty care....</p> <ul style="list-style-type: none"> <li>• The Review Committee requires fellows to attend a continuity clinic at least one half-day each week, except that the program director may excuse fellows from clinic up to 4 weeks/year in addition to vacation.</li> <li>• The program director may excuse fellows from continuity clinic up to three non-consecutive months over a three year fellowship, two non-consecutive months for a two year fellowship, or one month for a one year fellowship</li> <li>• The continuity clinic must occur throughout accredited training, including research.</li> <li>• Time spent in continuity clinic cannot be deducted from required clinical training.             <ul style="list-style-type: none"> <li>○ e.g., a 36-month heme-onc program requires at least 18 months clinical, PLUS 18 additional months of continuity clinic during research.</li> </ul> </li> <li>• Continuity clinic blocks may be no shorter than 6 months, but may be longer.</li> <li>• If the program uses alternating clinics (i.e., alternating continuity clinics every other week), then the minimum block is 12 months.</li> <li>• The Review Committee no longer requires tracking of new and return patients.             <ul style="list-style-type: none"> <li>○ 4-8 is averaged over the year, and applies <u>only</u> to continuity clinic (not to other ambulatory experiences).</li> </ul> </li> <li>• There is no rule in the subspecialties specifying the minimum number of weekly clinics per fellow (i.e., the 108 rule in core internal medicine programs.). Therefore:             <ul style="list-style-type: none"> <li>○ The program director may excuse fellows from up to 4 weeks of continuity clinic <u>per year</u> (not counting vacation).</li> <li>○ Each fellow's continuity clinic must therefore occur 48 weeks (52 minus 4) per year, not counting vacation, unless the Review Committee grants a variance (i.e., for away rotations).</li> <li>○ Pulmonary and critical care medicine fellows have reduced continuity clinic requirements.</li> </ul> </li> </ul>
<p>How can subspecialty programs meet the 25% gender requirement? [Program Requirement IV.E.2.c)]</p>	<ul style="list-style-type: none"> <li>• For <u>subspecialties</u> (but not for core residency programs) the gender rule can be <u>averaged over the duration of the program</u>. Over the duration of accredited training, the patient population must consist of at least 25% from each gender.</li> <li>• In subspecialties, the 25% gender mix rule is applied primarily to continuity clinics.             <ul style="list-style-type: none"> <li>○ However, if the inpatient experience is exclusively (or nearly so) male or female, the program will be cited for gender inadequacy.</li> <li>○ If the inpatient or outpatient experience lacks exposure to geriatric patients, the program will be cited for geriatric inadequacy.</li> </ul> </li> <li>• Therefore, programs can use VA clinics in 6-month blocks combined with non-VA clinics, as long as the gender mix over the duration of the accredited program (i.e., 1-year, 2-year, 3*-year) is at least 25% averaged across each fellow's continuity clinics.</li> </ul>
<p>What procedures must be tracked in the fellow's procedure log? [Program Requirement IV.E.3. –</p>	<p>Each specialty has developed a list of required procedures for which fellows must develop:</p> <ul style="list-style-type: none"> <li>• ...a comprehensive understanding of indications,</li> </ul>

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IV.E.3.d).(3)]	<p>contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline....</p> <ul style="list-style-type: none"> <li>• ...knowledge of and skill in educating patients about the rationale, technique, and complications of procedures, and in obtaining procedure-specific informed consent....</li> <li>• Competency in performance and interpretation.</li> </ul> <p>See <b>Appendix II</b> below for the list of procedures which must be tracked for each specialty.</p>
Evaluation Question	Answer
Are competency-based semi-annual evaluations required? [Program Requirement V.A.1.b.1] [Program Requirement V.A.1.b.4.]	Yes. In addition to the program director personally performing the evaluations, feedback on performance related to each of the 6 ACGME competencies must be documented either on a standardized form or by narrative.
What is expected for the multi-source evaluations? [Program Requirement V.A.1.b).(2)]	Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the fellow being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). The evaluation forms distributed to these individuals do not have to ask the same items, but should reflect the general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).
Do the semi-annual evaluations of fellow performance need to be done by the program director, or can these be delegated to another key clinical faculty? [Program Requirement V.A.4.b).(4)(a)]	<ul style="list-style-type: none"> <li>• The Subspecialty program director must perform all semiannual reviews personally. <ul style="list-style-type: none"> <li>○ Note difference from core program requirements where the core program director may designate semi-annual review to an associate program director or other designee.</li> </ul> </li> </ul>
We have an electronic evaluation system. Do we need to maintain paper records as well? [Program Requirement V.A.1.d)]	<ul style="list-style-type: none"> <li>• Electronic records are sufficient and need not be archived in print format as long as they are securely maintained, backed up, and accessible for use by the fellow, program, and institution.</li> <li>• Per ACGME: If the program uses an electronic system, it should always maintain a paper record of <u>the final evaluation at completion of training</u>. For fellows with academic or other performance problems, there should be additional hard-copy records, because the electronic evaluation parameters may not be appropriate or sufficient in cases where remediation, probation, non-renewal or dismissal needs to be documented.</li> </ul>
Why were we cited for inadequate faculty feedback; our faculty return rate on evaluations is over 90% [Program Requirement V.A.1.d).(3)]	This requirement stipulates that the attending complete and return a written or electronic evaluation form <u>and</u> provide the fellow with verbal face-to-face feedback at completion of the rotation.
How should fellow performance in continuity clinic be evaluated? [Program Requirement V.A.1.d).(4)]	Fellow performance in continuity clinic needs to be documented semi-annually, and must be provided by faculty with whom they have a significant, longitudinal precepting relationship. The feedback must be provided both verbally and in writing. A distinct evaluation tool for this experience may make documentation efficient. Semi-annual feedback from the program director does not meet this requirement unless the program director has a direct precepting relationship with the trainee.
What are the requirements for a final summative fellow evaluation? [Program Requirement V.A.2. – V.A.2.b).(2)]	<ul style="list-style-type: none"> <li>• Use of the ABIM tracking form alone does not fulfill the requirement for a final summative evaluation.</li> <li>• Programs must prepare a final evaluation for each fellow. <ul style="list-style-type: none"> <li>○ That review must summarize performance during the final period of residency.</li> <li>○ It should include verification about the fellow's professional competency to enter the practice of medicine</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>▪ While the final summary statement does not need to use the exact words demonstrated sufficient professional ability to practice competently and independently, the final verification must contain an equivalent statement that attests to the fellow's professional competency to begin practice in that specialty.</li> <li>○ The final evaluation must be maintained for future credentialing, privileging, and letters of evaluation</li> </ul>
<p>Are fellows expected to evaluate faculty at end of each rotation? What are the expectations? [Program Requirement V.B.3.a) – b)]</p>	<ul style="list-style-type: none"> <li>• The Review Committee acknowledges that some attending assignments to teaching activities may not be tightly linked to the month-long delimited rotations/assignments. For such situations, evaluations of faculty do not need to take place at the end of the monthly rotation, since the fellow may not have had enough exposure to that attending to meaningfully evaluate the attending. However, at a minimum, the Review Committee expects that fellows will evaluate the faculty member's performance/teaching ability at least quarterly. (July 2011 RC Meeting)</li> </ul>
<p>What are the requirements for faculty evaluations? [Program Requirement V.B. – V.B.7.]</p>	<ul style="list-style-type: none"> <li>• Each fellow must have the opportunity to evaluate each faculty member with whom they work, at the end of each rotation period.</li> <li>• Evaluations must be confidential <ul style="list-style-type: none"> <li>○ The faculty evaluation does <u>not</u> need to be anonymous.</li> <li>○ Confidentiality means that the faculty members being evaluated are blinded to the identity of the fellow completing the faculty evaluation. <ul style="list-style-type: none"> <li>▪ Signed faculty evaluation forms potentially violate fellow confidentiality, and are therefore prohibited.</li> <li>▪ The program may track returns of the evaluations (e.g., tracking of electronic evaluations, signing of the return envelope) as long as the program takes special precautions to assure that the names are used only to track returns, and are never available to the faculty member being evaluated.</li> </ul> </li> </ul> </li> <li>• The fellows' evaluations of the faculty must be reviewed with the faculty annually <ul style="list-style-type: none"> <li>○ And fellow confidentiality must be maintained in review process</li> </ul> </li> <li>• The program must use the fellow evaluations for selection of faculty for teaching assignments.</li> </ul>
<p>What are the requirements for program evaluation? [Program Requirement V.C. – V.C.2.]</p>	<ul style="list-style-type: none"> <li>• Each fellow must have the opportunity to evaluate the program confidentially and in writing at least annually.</li> <li>• Programs must have a process in place for an <u>annual</u> program internal review of the faculty, curriculum, facilities, etc. (defined in V.C.1).</li> <li>• This process is separate and distinct from the GMCEC internal reviews that are required mid-cycle by the IRC. <ul style="list-style-type: none"> <li>○ In other words, the program conducts annual internal reviews.</li> <li>○ These annual reviews are rolled up to the institutional GMCEC review.</li> </ul> </li> <li>• The review panel must include at least one fellow and at least one faculty (may include more than one fellow or faculty).</li> <li>• The results of the review must be documented by minutes and a summary report</li> <li>• Annual review process must include documented review of</li> </ul>

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	<ul style="list-style-type: none"> <li>○ Faculty evaluations of the program</li> <li>○ Fellow evaluations of program and faculty</li> <li>○ The elements stipulated above:             <ul style="list-style-type: none"> <li>▪ utilization of the resources available to the program</li> <li>▪ contribution of each institution participating in the program</li> <li>▪ financial and administrative support of the program</li> <li>▪ volume and variety of patients available to the program for educational purposes</li> <li>▪ effectiveness of inpatient and ambulatory teaching</li> <li>▪ performance of faculty members</li> <li>▪ quality of supervision of fellows</li> </ul> </li> </ul> <p>If a program has a process to perform this function monthly – say by means of a standing committee of program director/ key clinical faculty/ fellow representatives – then this may meet the Review Committee’s standards. However, the evaluation of the program is more than just the summary of all end-of-rotation evaluations. It must include the evaluation of the total didactic and clinical program (curriculum, faculty, conferences, etc.). Therefore, with a monthly process consisting of shorter meetings to look at pieces of the program throughout the year (i.e., the faculty and rotation evaluations of the past month), there is the potential that the group might miss the big (summative) picture that one gets by looking at all evaluations in total.</p>
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<b>Duty Hours and the Learning Environment</b>	<b>Question</b>	<b>Answer</b>
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<p>What is adequate availability of the faculty for supervision in the hospital? What is adequate faculty availability in the clinic?          One of our attendings sees private patients in his office 1 block from the fellows’ clinic and reviews the cases with the fellows at the end of the half-day. Fellows can call him with questions at any time.          [Program Requirement VI.B.]          [Program Requirement II.B.1 – II.B.1.a)]          [Program Requirement IV.E.1.a)]          [Program Requirement IV.E.3.c)]</p>	<ul style="list-style-type: none"> <li>• Fellows must be supervised in all settings, and the supervision must be on site.</li> <li>• In inpatient settings, supervision need not be continuous. Fellows may supervise interns and residents with faculty availability. In inpatient settings, supervision can occur at specified times such as teaching rounds, with immediate availability at all other times.</li> <li>• In outpatient settings, supervision must be continuously available and on-site. Appropriate supervision cannot occur after the patient has left the clinic. Off-site ambulatory supervision (e.g., attending available by phone if fellow has questions) is not acceptable in outpatient settings. Rationale: The attending must have the opportunity to interview/ examine all patients at the time he/ she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary.</li> <li>• Geriatric Fellowship Exceptions:             <ul style="list-style-type: none"> <li>○ Home care visit exception: The Review Committee allows geriatrics fellows to complete home care visits without on site faculty supervision. On-site supervision may be provided by a physician extender or nurse operating under physician-directed care protocols or orders. An attending faculty physician must always be available by phone. This exception to on-site outpatient supervision rule and does not extend to other settings or other fellowships. (Note: This exception is for geriatric medicine fellowships only.)</li> <li>○ <u>Unscheduled (urgent) visits by fellows to their continuity patients in long-term care settings:</u> Many training programs are affiliated with community nursing homes that are not located on the campus of the program’s home institution, and it is the standard of practice in most nursing homes that physicians be on site only when attending to patient care. Because fellows are expected to be the primary care</li> </ul> </li> </ul>
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	<p>providers for patients in this setting, they are encouraged to make visits to the nursing home for these patients for unscheduled urgent visits. These may occur at times when attending faculty are not on site. In this situation, the attending faculty is not required to supervise the fellow on site, but must be available by phone. Furthermore, the fellow must discuss the care of the patient by phone with that attending at the time the patient is being seen by the fellow in the long-term care facility. This exception DOES NOT APPLY to routinely scheduled rounds on fellows' continuity patients in long-term care. For these visits, attending faculty are expected to be on site and available to examine patients jointly with the fellow.</p>
<p>Some programs have interpreted the standard for averaging the 80-hour weekly limit, call frequency and days off as allowing a constantly rolling 4-week average. Does the use of a rolling average comply with the common duty hour standards? [Program Requirement VI.G.1]</p>	<p>Averaging must be done by individual clinical rotation or by four-week (or five-week on 5-week months) block. Nowhere do the standards call for a rolling average.</p> <ul style="list-style-type: none"> <li>• Rationale: A rolling average is not acceptable, because it may make it possible to average across high and low duty hour rotations to hide a compliance problem.</li> <li>• Essentially, because the duty hour requirements are minimum standards, the rotations with the greatest hours and frequency of call must comply with the common duty hour standards.</li> <li>• In addition, call frequency should be averaged for periods with call, e.g., it is not appropriate to include call rotations and ambulatory rotations that do not include call together in the numerator or the denominator to calculate on-call frequency.</li> <li>• If a fellow is on vacation for one week in a four-week month, the hours for that rotation should be averaged over the remaining three weeks.</li> </ul> <p>The following do <u>not</u> count against the 80-hour work week:</p> <ul style="list-style-type: none"> <li>• Travel between home and work</li> <li>• Home call (unless called in) or pager call</li> <li>• Reading and study away from clinic/ hospital</li> <li>• Time spent in the library that is not part of assigned duty</li> <li>• Time spent on the phone during home call</li> <li>• Personal activities</li> <li>• Research outside of research rotations</li> <li>• External moonlighting</li> </ul>
<p>What if fellows voluntarily choose to work more than 80 hours per week? [Program Requirement VI.G.1.a)]</p>	<p>Programs and institutions must develop systems to insure that fellows are neither required, nor permitted, to violate this or other duty-hour standards.</p>
<p>How does the Review Committee define a day off? [Program Requirement VI.G.3. – VI.G.4.b)(3)(b)]</p>	<ul style="list-style-type: none"> <li>• Each fellow must receive 24 consecutive hours off duty (no beeper call) four days per (4-week) month. <ul style="list-style-type: none"> <li>◦ In a 5-week month, fellows must have 5 days off.</li> </ul> </li> <li>• The RRC does not allow schedules that prohibit one day off for 2+ weeks because they are paired with bookend ambulatory rotations with weekends off. <ul style="list-style-type: none"> <li>◦ See rolling average standard described in the 80-hour work week.</li> </ul> </li> <li>• Most programs have a 30-36 hour period of scheduled time off each week. In circumstances where the scheduled day-off is exactly 24 hours, (and no more), the RRC-IM would examine closely at the time of the site visit: <ul style="list-style-type: none"> <li>◦ The actual amount of time off, to be sure that it actually is not less than 24 hours.</li> <li>◦ Compliance with the 80-hour work week</li> </ul> </li> </ul>
<p>Does the 10-hour break apply to home call? [Program Requirement VI.G.8.b)]</p>	<ul style="list-style-type: none"> <li>• The Review Committee expects full compliance with the 10-hour break rule.</li> <li>• The 10-hour break rule is not applied to home call or</li> </ul>

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	<p>moonlighting.</p> <ul style="list-style-type: none"> <li>o e.g., a fellow on home call who is called into the hospital from 1:00 – 2:00 AM may return for regular duties at 7:00 AM. Note that the time spent in the hospital counts against the 80-hour work week.</li> </ul>
<p>Which standards apply to time in the hospital after being called in from home call? Is it permissible for fellows to take call from home for extended periods, such as a month? [Program Requirement VI.G.8. – VI.G.8.b)]</p>	<ul style="list-style-type: none"> <li>• For call taken from home (pager call), the time the fellow spends in the hospital after being called in is counted toward the weekly duty hour limit. The only other numeric duty hour standard that applies is that one day in seven must be free of all patient care responsibilities, which includes home call.</li> <li>• The ACGME also requires that programs monitor the intensity and workload resulting from home call, through periodic assessment of the frequency of being called into the hospital and the length and intensity of the in-house activities.</li> <li>• The requirement that one day in seven must be free of patient care responsibilities would prohibit a fellow from being assigned home call for an entire month.</li> <li>• Home call is <u>not</u> subject to the following Duty Hours requirements: <ul style="list-style-type: none"> <li>o 10-hour break</li> <li>o 24+6 continuous duty</li> <li>o 1-in-3 call frequency</li> </ul> </li> <li>• When home call becomes de-facto in house call (because of service load), programs will be cited for excessive service.</li> <li>• While on home call or pager call, fellows must have one 24-hour period per week completely free of all clinical and educational responsibilities. The pager must be turned off and signed out so that the fellow is unavailable for clinical responsibilities.</li> <li>• If programs schedule a week of home call, one of those days must be completely free of any beeper responsibility. This means giving the pager to the attending, OR getting another fellow (i.e., on research) to cover it. It would also be acceptable for a program to schedule the day off on a home call schedule after seven days of home call, i.e., if a program gave the fellow the eighth day off completely (home call Monday – Sunday, then Monday completely off), that would also be acceptable.</li> </ul>
<p>Why does the ACGME distinguish between in-house/ internal moonlighting, which is counted under the weekly duty hour limit, and external moonlighting, which is not included? [Program Requirement VI.G.2. – VI.G.2.c)]</p>	<p>The ACGME has three reasons for counting in-house moonlighting toward the weekly duty hours.</p> <ul style="list-style-type: none"> <li>• The first is to apply the same standard to all hours fellows spend in teaching institutions, whether they are part of the required educational program or are spent moonlighting in-house.</li> <li>• The second reason is to prevent institutions from inappropriately using in-house moonlighting to replace clinical service activities that fellows covered previously as part of the educational program.</li> <li>• The third reason is that the ACGME's purview extends to teaching programs and sponsoring institutions, but not fellow activities outside of their educational program. Many perceive the ACGME does not have the right to curtail moonlighting or place all moonlighting hours under a weekly duty hour limit. In contrast, <u>individual programs and institutions</u> have the authority to prohibit or limit fellow moonlighting, and may do so formally via the fellow contract.</li> </ul>
<b>Experimentation and Innovation</b>	
<b>Question</b>	<b>Answer</b>
<p>What does the RRC consider an adequate or acceptable performance improvement project? [Program Requirement VII.A. – VII.A.3.]</p>	<p>Programs need to be engaged in a process of continual improvement.</p> <ul style="list-style-type: none"> <li>• The project should relate to one or more of the ACGME competencies and should improve the program as a whole.</li> <li>• The role of the fellows in the development, data collection, and analysis should be evident (i.e., using the fellows to collect data only is not sufficient involvement).</li> </ul>

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- The scope of these projects should be broader than correcting a prior Review Committee citation or improving knowledge in a narrow area.
- The annual program review is an ideal source for acceptable performance improvement projects.
- Examples of acceptable performance improvement projects would be;
  - Fellows and faculty in a program perform a patient satisfaction survey on their continuity patients. They determine that the patients are unhappy with the long waiting time to be seen. The fellows and faculty meet with the clinic support personnel and study the clinic procedures that lead to delays. They devise new appointment and clinic procedures that minimize patient waits. A repeat survey is performed and documents improved patient satisfaction.
  - Fellows and faculty perform a chart review of continuity patients and find that only 5% of the time do they document counseling patients to stop smoking. They devise an educational program for the fellows on smoking cessation counseling, place posters in the clinic and provide handouts for the patients. Repeat chart reviews show improvement in the counseling of patients.
- Normally participation in an established hospital QA/QI program does not meet this standard. However, if participation in a hospital program identifies a problem within the training program that needs improvement, the fellows and faculty meet and plan how to correct the deficiency, they take an action to improve/resolve the problem, and they measure for improvement when action is taken; this would meet the standard.

# Appendix I

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity				
Endocrinology, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Diseases, and Rheumatology				
Minimum 3 KCF or 1:1.5 faculty-fellow ratio for programs with 6 or more fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
2	3	2	2	6
3	3	2	2	6
4	3	2	2	6
5	3	2	2	6
6	4	2	2	6
7	5	3	3	9
8	6	3	3	9
9	6	3	3	9
10	7	4	4	12
11	8	4	4	12
12	8	4	4	12
13	9	5	5	15
14	10	5	5	15
15	10	5	5	15
16	11	6	6	18
17	12	6	6	18
18	12	6	6	18
19	13	7	7	21
20	14	7	7	21
21	14	7	7	21
22	15	8	8	24
23	16	8	8	24
24	16	8	8	24
25	17	9	9	27
26	18	9	9	27
27	18	9	9	27
28	19	10	10	30
29	20	10	10	30
30	20	10	10	30

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Cardiovascular Disease				
Minimum 4 KCF or 1:1.5 faculty-fellow ratio for programs with 7 or more fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
3	4	2	2	6
4	4	2	2	6
5	4	2	2	6
6	4	2	2	6
7	5	3	3	9
8	6	3	3	9
9	6	3	3	9
10	7	4	4	12
11	8	4	4	12
12	8	4	4	12
13	9	5	5	15
14	10	5	5	15
15	10	5	5	15
16	11	6	6	18
17	12	6	6	18
18	12	6	6	18
19	13	7	7	21
20	14	7	7	21
21	14	7	7	21
22	15	8	8	24
23	16	8	8	24
24	16	8	8	24
25	17	9	9	27
26	18	9	9	27
27	18	9	9	27
28	19	10	10	30
29	20	10	10	30
30	20	10	10	30
31	21	11	11	33

**RRC-IM Calculation of Minimum Key Clinical Faculty (KCF)  
and  
Key Clinical Faculty (KCF) Scholarship Participation/Productivity  
Gastroenterology**

**Minimum 4 KCF\* or 1:1.5 faculty-fellow ratio for programs with 7 or more fellows**

<b>Approved Fellow Complement</b>	<b>Minimum Certified KCF (incl PD)</b>	<b>Minimum Hepatology KCF (incl PD)</b>	<b>Minimum Advanced Endoscopy KCF (incl PD)</b>	<b>Majority of Minimum KCF (50%)</b>	<b><u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]</b>	<b><u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]</b>
2	4	1	1	2	2	6
3	4	1	1	2	2	6
4	4	1	1	2	2	6
5	4	1	1	2	2	6
6	4	1	1	2	2	6
7	5	1	1	3	3	9
8	6	1	1	3	3	9
9	6	1	1	3	3	9
10	7	1	1	4	4	12
11	8	1	1	4	4	12
12	8	1	1	4	4	12
13	9	1	1	5	5	15
14	10	1	1	5	5	15
15	10	1	1	5	5	15
16	11	1	1	6	6	18
17	12	1	1	6	6	18
18	12	1	1	6	6	18
19	13	1	1	7	7	21
20	14	1	1	7	7	21
21	14	1	1	7	7	21
22	15	1	1	8	8	24
23	16	1	1	8	8	24
24	16	1	1	8	8	24
25	17	1	1	9	9	27

**RRC-IM Calculation of Minimum Key Clinical Faculty (KCF)  
and  
Key Clinical Faculty (KCF) Scholarship Participation/Productivity  
Pulmonary Diseases/Critical Care Medicine**

**Minimum 6 KCF or 1:1.5 faculty-fellow ratio for programs with 10 or more fellows**

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Minimum Certified <u>PULM</u> KCF (incl PD)	Minimum Certified <u>CCM</u> KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
2	6	3	3	3	3	9
3	6	3	3	3	3	9
4	6	3	3	3	3	9
5	6	3	3	3	3	9
6	6	3	3	3	3	9
7	6	3	3	3	3	9
8	6	3	3	3	3	9
9	6	3	3	3	3	9
10	7	3/4*	3/4*	4	4	12
11	8	4	4	4	4	12
12	8	4	4	4	4	12
13	9	4/5*	4/5*	5	5	15
14	10	5	5	5	5	15
15	10	5	5	5	5	15
16	11	5/6*	5/6*	6	6	18
17	12	6	6	6	6	18
18	12	6	6	6	6	18
19	13	6/7*	6/7*	7	7	21
20	14	7	7	7	7	21
21	14	7	7	7	7	21
22	15	7/8*	7/8*	8	8	24
23	16	8	8	8	8	24
24	16	8	8	8	8	24
25	17	8/9*	8/9*	9	9	27

\*Where odd number of KCF is required, program may have an uneven number, such as 3 CCM and 4 Pulm KCF for a required KCF of 7. Faculty members with dual board certification can be counted as either Pulm or CCM.

**RRC-IM Calculation of Minimum Key Clinical Faculty (KCF)  
and  
Key Clinical Faculty (KCF) Scholarship Participation/Productivity  
Hematology/Medical Oncology**

**Minimum 6 KCF or 1:1.5 faculty-fellow ratio for programs with 10 or more fellows**

<b>Approved Fellow Complement</b>	<b>Minimum Certified KCF (incl PD)</b>	<b>Minimum Certified <u>HEME</u> KCF (incl PD)</b>	<b>Minimum Certified <u>ONC</u> KCF (incl PD)</b>	<b>Majority of Minimum KCF (50%)</b>	<b><u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]</b>	<b><u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]</b>
2	6	3	3	3	3	9
3	6	3	3	3	3	9
4	6	3	3	3	3	9
5	6	3	3	3	3	9
6	6	3	3	3	3	9
7	6	3	3	3	3	9
8	6	3	3	3	3	9
9	6	3	3	3	3	9
10	7	3	3	4	4	12
11	8	3	3	4	4	12
12	8	3	3	4	4	12
13	9	3	3	5	5	15
14	10	3	3	5	5	15
15	10	3	3	5	5	15
16	11	3	3	6	6	18
17	12	3	3	6	6	18
18	12	3	3	6	6	18
19	13	3	3	7	7	21
20	14	3	3	7	7	21
21	14	3	3	7	7	21
22	15	3	3	8	8	24
23	16	3	3	8	8	24
24	16	3	3	8	8	24
25	17	3	3	9	9	27

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Critical Care Medicine				
Minimum 3 KCF or 1:1 faculty-fellow ratio for programs with 4 or more fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
2	3	2	2	6
3	3	2	2	6
4	4	2	2	6
5	5	3	3	9
6	6	3	3	9
7	7	4	4	12
8	8	4	4	12
9	9	5	5	15
10	10	5	5	15
11	11	6	6	18
12	12	6	6	18
13	13	7	7	21
14	14	7	7	21
15	15	8	8	24
16	16	8	8	24
17	17	9	9	27
18	18	9	9	27
19	19	10	10	30
20	20	10	10	30

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Interventional Cardiology, Geriatric Medicine, Transplant Hepatology				
Minimum 2 KCF or 1:1.5 faculty-fellow ratio for programs with 4 or more fellows fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
2	2	1	1	3
3	2	1	1	3
4	3	2	2	6
5	4	2	2	6
6	4	2	2	6
7	5	3	3	9
8	6	3	3	9

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Clinical Cardiac Electrophysiology				
Minimum 2 KCF or 1:1 faculty-fellow ratio for programs with 3 or more fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
1	2	1	1	3
2	2	1	1	3
3	3	2	2	6
4	4	2	2	6
5	5	3	3	9
6	6	3	3	9
7	7	4	4	12
8	8	4	4	12

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Sleep Medicine				
Minimum 3 KCF or 1:2 faculty-fellow ratio for programs with 5 or more fellows				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years [259]	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs) [259]
1	3	2	2	6
2	3	2	2	6
3	3	2	2	6
4	3	2	2	6
5	3	2	2	6
6	3	2	2	6
7	4	2	2	6
8	4	2	2	6
9	5	3	3	9
10	5	3	3	9
11	6	3	3	9
12	6	3	3	9
13	7	4	4	12
14	7	4	4	12
15	8	4	4	12
16	8	4	4	12

## Appendix II

### RRC-IM Required Procedure Log Documentation for Internal Medicine Subspecialties

The General Program Requirements for Internal Medicine Subspecialties require documentation of procedural experience and tracking of this experience by the program.

The RRC-IM requires documentation of procedural experience for the following procedures. Additional (optional) procedures may be documented, but all fellows in the subspecialty must log and track the required procedures.

Sub-Specialty	Procedures that Must be Documented
<b>Cardiology</b>	<ol style="list-style-type: none"> <li>1. Elective cardioversion</li> <li>2. Insertion and management of temporary pacemakers, including transvenous and transcutaneous</li> <li>3. Programming and follow-up surveillance of permanent pacemakers</li> <li>4. Bedside right heart catheterization</li> <li>5. Right and left heart catheterization including coronary arteriography</li> <li>6. Exercise stress testing</li> <li>7. Echocardiography, including transesophageal cardiac studies</li> </ol>
<b>- Clinical Cardiac Electrophysiology</b>	<ol style="list-style-type: none"> <li>1. Electrophysiology invasive diagnostic/interventional catheter procedures               <ul style="list-style-type: none"> <li>- Intracardiac procedures related to supraventricular arrhythmia</li> <li>- Electrode catheter introduction</li> <li>- Electrode catheter positioning in atria, ventricles, coronary sinus, His bundle area, and pulmonary artery</li> <li>- Stimulating techniques to obtain conduction times and refractory periods and to initiate and terminate tachycardias</li> </ul> </li> <li>2. Therapeutic catheter ablation procedures</li> <li>3. Implantation of cardioverter/defibrillators and pacemakers</li> </ol>
<b>- Interventional Cardiology</b>	<ol style="list-style-type: none"> <li>1. Right and left heart catheterization including coronary arteriography, ventriculography, and hemodynamic measurements</li> <li>2. Intravascular ultrasound</li> <li>3. Doppler flow, intracoronary pressure measurement and monitoring, and coronary flow reserve</li> <li>4. Coronary interventions               <ul style="list-style-type: none"> <li>- Femoral and brachial/radial cannulation of normal and abnormally located coronary ostia</li> <li>- Application and usage of balloon angioplasty, stents, and other commonly used interventional devices</li> </ul> </li> </ol>
<b>Critical Care</b>	<ol style="list-style-type: none"> <li>1. Chest tube insertion</li> <li>2. Endotracheal intubation</li> <li>3. Arterial Line insertion</li> <li>4. Central venous line insertion</li> <li>5. Pulmonary artery catheter insertion</li> <li>6. Thoracentesis</li> <li>7. Therapeutic bronchoscopy</li> </ol>
<b>Endocrinology</b>	Thyroid aspiration biopsy

<b>Gastroenterology</b>	<ol style="list-style-type: none"> <li>1. Flexible sigmoidoscopy (colonoscopy may be substituted)</li> <li>2. Diagnostic upper gastrointestinal endoscopy (EGD)</li> <li>3. Colonoscopy, including biopsy and polypectomy</li> <li>4. Esophageal dilation</li> <li>5. Percutaneous gastrostomy</li> <li>6. Therapeutic upper and lower gastrointestinal endoscopy, including variceal and non-variceal hemorrhage (The variceal and non-variceal could be separated out to make it 5 categories)</li> </ol> <p>Note: Liver biopsy is no longer a required procedure for gastroenterology programs.</p>
<b>Geriatrics</b>	No required procedures
<b>Hematology</b>	<ol style="list-style-type: none"> <li>1. Bone Marrow aspirate and biopsy</li> </ol>
<b>Hematology-Oncology</b>	<ol style="list-style-type: none"> <li>1. Bone Marrow aspirate and biopsy</li> </ol>
<b>Oncology</b>	<ol style="list-style-type: none"> <li>1. Bone Marrow aspirate and biopsy</li> </ol>
<b>Infectious Diseases</b>	No required procedures
<b>Nephrology</b>	<ol style="list-style-type: none"> <li>1. Placement of temporary vascular access for hemodialysis and related procedures.</li> <li>2. Percutaneous biopsy of autologous and native transplants.</li> </ol>
<b>Pulmonary</b>	<ol style="list-style-type: none"> <li>1. Fiberoptic bronchoscopy procedures including those with <ul style="list-style-type: none"> <li>- transbronchial biopsies</li> <li>- bronchoalveolar lavage</li> <li>- transbronchial needle aspiration</li> <li>- bronchial biopsies</li> </ul> </li> <li>2. Chest tube insertion</li> <li>3. Endotracheal intubation</li> <li>4. Arterial Line insertion</li> <li>5. Central venous line insertion</li> <li>6. Pulmonary artery catheter insertion</li> <li>7. Thoracentesis</li> <li>8. Cardiopulmonary exercise testing</li> </ol>
<b>Pulmonary-Critical Care</b>	<ol style="list-style-type: none"> <li>1. Fiberoptic bronchoscopy procedures including those with <ul style="list-style-type: none"> <li>- transbronchial biopsies</li> <li>- bronchoalveolar lavage</li> <li>- transbronchial needle aspiration</li> <li>- bronchial biopsies</li> </ul> </li> <li>2. Chest tube insertion</li> <li>3. Endotracheal intubation</li> <li>4. Arterial Line insertion</li> <li>5. Central venous line insertion</li> <li>6. Pulmonary artery catheter insertion</li> <li>7. Thoracentesis</li> <li>8. Cardiopulmonary exercise testing</li> </ol>
<b>Sleep</b>	No required procedures
<b>Rheumatology</b>	<ol style="list-style-type: none"> <li>1. Diagnostic aspiration and/ or therapeutic injection of bursae, joints, entheses and tendon sheaths.</li> <li>2. Analysis by light and compensated polarized light microscopy of</li> </ol>

	synovial fluid.
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# Appendix III

## Faculty Qualifications Judged Acceptable by the RRC-IM

### Program Director, Associate Program Director(s), Key Clinical Faculty, and Educational Coordinators

- Core IM Residency Programs
- IM Subspecialty Fellowship Programs

#### RRC-IM Policy:

In core internal medicine programs, the RRC-IM accepts only ABIM certification qualifications for the program director (PD), the minimum number of required associate program director(s) (APD), the minimum number of required key clinical faculty (KCF), and the 11 education coordinators (EC).

In subspecialty internal medicine fellowship programs, the RRC-IM accepts only ABIM certification qualifications for the program director (PD), and for the minimum number of required key clinical faculty (KCF).

The RRC-IM does not accept Equivalent Qualifications for such faculty except in the following special cases for Sleep Medicine and Geriatric Medicine:

#### Sleep Medicine

##### **Sleep Medicine Key Clinical Faculty**

###### **- IM-Sleep Medicine Fellowship Programs**

The RRC-IM will accept trained, qualified faculty in sleep medicine with ABMS-Board certification in internal medicine, psychiatry, neurology, pediatrics, or otolaryngology to serve as a Key Clinical Faculty in Sleep (Medicine) fellowship programs. Yet, Key Clinical Faculty in the fellowship must include internal medicine ABIM-certified member(s).

The Committee requires KCF to be certified in Sleep Medicine. Until January 1, 2012, the committee will accept certification in Sleep Medicine by the American Board of Sleep Medicine or certification by a member board of the American Board of Medical Specialties as evidence of meeting these requirements. After January 1, 2012, only certification in Sleep Medicine by a member board of the American Board of Medical Specialties will be acceptable. For program accredited by the Internal Medicine RC, at least 1 Key Clinical Faculty member must be certified in Internal Medicine or one of its subspecialties by the American Board of Internal Medicine.

##### **Sleep Medicine Program Director**

###### **- IM-Sleep Medicine Fellowship Programs**

The RRC-IM will accept trained faculty in sleep medicine with ABMS-Board certification in internal medicine, psychiatry, neurology, pediatrics, or otolaryngology to serve as the Program Director in Sleep (Medicine) fellowship programs. But the other Key Clinical Faculty in the Sleep (Medicine) fellowship must be ABIM-Board certified in internal medicine.

The committee requires the PD to be certified in Sleep Medicine. Until January 1, 2012, the committee will accept certification in Sleep Medicine by the American Board of Sleep Medicine or certification by a member board of the American Board of Medical Specialties as evidence of meeting these requirements. After January 1, 2012, only certification in Sleep Medicine by a member board of the American Board of Medical Specialties will be acceptable. For program accredited by the Internal Medicine RC, at least 1 Key Clinical Faculty member must be certified in Internal Medicine or one of its subspecialties by the American Board of Internal Medicine.

#### Geriatrics

##### **Geriatrics Key Clinical Faculty and Geriatric Educational Coordinator**

###### **- IM-Geriatrics Fellowship Programs**

###### **- Core IM Residency Programs**

The RRC-IM will accept Family-Medicine trained faculty with a current ABFM certification in geriatrics to serve as a Key Clinical Faculty in Geriatrics fellowship programs, or as an Education Coordinator (EC) or Key Clinical Faculty for Geriatrics in IM core residency programs.

Such faculty must meet the following conditions:

- 1) The faculty must be trained in an ACGME-accredited Internal Medicine Geriatrics fellowship, or a Family-Medicine Geriatrics fellowship.
- 2) The faculty must maintain certification by the ABFM in Family Medicine and in Geriatrics.
- 3) The faculty must demonstrate to the Core IM residency director (EC/ KCF) or to the subspecialty geriatrics fellowship director (KCF) excellence in geriatrics education, as measured by faculty evaluations.
- 4) In Internal Medicine - Geriatrics fellowships, either the PD or the KCF must be ABIM certified in geriatrics.

In addition, the RRC-IM will allow family-practice trained geriatricians with an ABIM or ABFP certification in geriatrics to act as admitting or teaching attendings on IM-Geriatrics inpatient or consultation services at the discretion of the program director.

### **Geriatrics Program Director - IM - IM-Geriatrics Fellowship Programs**

The RRC-IM will accept Family-Medicine trained faculty with a current certification in geriatrics from the ABFM to serve as program director in an internal medicine geriatrics fellowship programs who fulfill the following criteria.

Such candidates must fulfill the above criteria for key clinical faculty, and each of the following criteria:

- 1) The PD candidate must have 5 years or more experience as a geriatrics faculty member in an internal medicine residency or in an internal medicine IM-Geriatrics fellowship.
- 2) The PD candidate must demonstrate the ability to establish and maintain an environment of inquiry and scholarship to the same degree as required for IM-Subspecialty KCF.
  - The candidate must be actively engaged in the Scholarship of Discovery or Dissemination (See III.B.4) as evidenced by at least three (3) products of scholarship in any of the following categories in the past three years: peer-review manuscripts, peer-review grants, book chapters, review articles in peer-review publications, or editorials in peer-review publications.
  - Abstracts and presentations alone will not meet this requirement.
- 3) The PD candidate must be recommended by the Core IM residency director for outstanding teaching and administrative ability.
- 4) The candidate must be approved by the RRC-IM (see procedure below)

In addition, the exceptions to the program director credentials will be limited to IM-Geriatrics programs in departments of medicine with an accreditation history of substantial compliance with the Institutional Requirements and the Program Requirements for both core residency and subspecialty fellowships in the most recent accreditation cycle.

There must be at least one internal medicine certified key clinical faculty member or program director in a program granted an exception.

### **Procedure**

Requests for an exception to the IM-Geriatric PD qualifications must be made directly to the RRC-IM Executive Director via email (jvasilias@acgme.org), and the request must document fulfillment of the above criteria. The request must be approved by the GMCC and signed off by the core program director and the DIO. If granted, such exceptions will require review and renewal at each accreditation review.

All other cases must meet the conditions as stated and will be reviewed at the time of the next scheduled program review. Violation will result in a citation.