

Internal Medicine Residency Programs FAQ	
Institutions	
Question	Answer
How can programs minimize "conflict" between inpatient and outpatient rotations? [Program Requirement I.A.1.c)]	<ul style="list-style-type: none"> This requirement was written to encourage programs to be innovative in balancing the inherent conflicts between inpatient and outpatient responsibilities. Methods for doing this include, but are not limited to: having an effective handoff process and responsible team member to cover the inpatient service when residents are in their clinics; scheduling blocks with increased continuity clinic when residents are not on inpatient rotations, so that they can have less or no clinic during their inpatient rotations; handling outpatient issues by a member of a resident "firm system" when other members of the team are on busy inpatient rotations. There will be a question on the Resident Survey that addresses this issue and it will be verified at the time of a site visit.
What does the committee consider as part of the range of simulation? [Program Requirement I.A.2.j)]	<ul style="list-style-type: none"> The committee does NOT expect each program to use a simulator or have a simulation center. Simulation means that learning about patient care occurs in a setting that does not include actual patients. This could include OSCEs, standardized patients, patient simulators, or electronic simulation of codes, procedures, and other clinical scenarios.
What does the committee consider as examples of electronic medical records? [Program Requirement I.A.2.k)]	<ul style="list-style-type: none"> Residents must have access to an electronic health record (EHR). An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all training sites and does not have to be comprehensive. A system that simply reports lab results or radiology results does not meet this definition of an EHR.
Program Personnel and Resources	
Question	Answer
What is acceptable training for core faculty who will serve as competency evaluators? [Program Requirement II.C.3. – II.C.3.d)]	<ul style="list-style-type: none"> The requirements now require an identified group of core faculty, based on the size of the program. An important role for these faculty is to serve as competency evaluators for the program. As described in the requirements, these faculty must be specifically trained in the evaluation and assessment of the ACGME competencies. This can be achieved through participation in workshops offered through APDIM, the ABIM, or the ACGME, or through local GME faculty development programs that focus on competency assessment. The evaluators must have ongoing training in these areas. The program should be able to document that the evaluators have been active in the assessment of residents.
Educational Program	
Question	Answer
Can nurse practitioners or physician assistants supervise Medicine residents or fellows on inpatient rotations? [Program Requirement IV.A.2.c)(1)] [Program Requirement VI.B]	<ul style="list-style-type: none"> Although the committee believes that it is important for Medicine residents and fellows to acquire experience in leading and participating in healthcare teams including those with non physicians (eg: nurse practitioners or physician assistants), overall supervision of all clinical care rendered by residents and fellows is the responsibility of the physician faculty and the attending physician of record. Non physicians are not permitted to independently supervise Medicine residents and fellows on inpatient rotations. Nevertheless, the attending physician may delegate an appropriately qualified non physician to assist a resident or fellow in performing a procedure. However, the ultimate responsibility for supervision remains the responsibility of the attending physician.
Can a faculty member board-certified in Anesthesia or Surgical Critical Care Medicine by the ABMS or board-certified in Critical Care Medicine by the American Osteopathic Association supervise Medicine housestaff in the Critical Care Units? [Program Requirement IV.A.2.c)(1)(a)]	<ul style="list-style-type: none"> No. The RRC-IM 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 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.
How will the committee assess gender diversity? [Program Requirement IV.A.2.c).(1).(f)]	<ul style="list-style-type: none"> At the time of a site visit, the committee will examine data related to gender diversity across the ambulatory portion of the training. It expected that residents will have a minimum of 25% of patients of each gender.
How should programs count the 30-month period? [Program Requirement IV.A.2.c).(1).(g).(ii).(b)]	<ul style="list-style-type: none"> The 30-month time frame was established to assure a minimum duration of time in which residents would provide care to their panel of patients while allowing flexibility for programs. The time begins when the resident sees a patient of his/her practice and ends 30 months later. The clinic does not have to occur weekly to allow for flexibility in scheduling. However, the longitudinal experience cannot be interrupted by more than a month, not inclusive of vacation.
How does the committee define 130	<ul style="list-style-type: none"> The 130 continuity clinic sessions should be distinct half-day sessions in

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continuity clinic sessions? [Program Requirement IV.A.2.c).(1).(g).(ii).(c)]	<p>which the residents provide longitudinal care to their panel of patients. This will generally occur in a single setting. Time spent in this clinical setting in which the resident does not provide care to their panel of patients does not count toward the 130 sessions, but can be included in the broader ambulatory time. Urgent care visits by patients who are part of the resident's panel or who are part of the practice panel to which the resident belongs will count towards the 130 clinic sessions. It should be emphasized that time spent in a general urgent care clinic where unassigned patients or patients with physicians who are not part of the practice panel will not count towards the 130 clinic sessions. While home visits and group visits are encouraged, these also do not count toward the 130 sessions.</p> <ul style="list-style-type: none"> • In certain circumstances, sessions from two well-integrated continuity clinics (two sites) could be counted toward the 130 sessions. Both sites would have to consider the resident as part of their continuity practice and the resident would have to be accessible to patients in both sites and meet all of the other requirements outlined in this section. • Each program will individually determine how each resident achieves his/her own panel of patients and how that panel may be shared with other providers in the practice (e.g. with nurse practitioners, other residents, and faculty). Residents will be asked whether they follow a panel of patients as part of the Resident Survey.
Given the change in clinic requirements (130 clinics, all in the same site), what should be done for the residents who have been working under the pre-2009 requirements? [Program Requirement IV.A.2.c).(1).(g).(ii).(c)]	<ul style="list-style-type: none"> • The RRC will "grandfather" the current residents and require a phase-out of the alternating weekly clinics (VA-Other) and ask for one primary clinic with 130 visits for all PGY-1s as of July 1, 2009. Programs that wanted to maintain a different model could apply for an educational innovations exception.
What does the committee accept as details of performance data? [Program Requirement IV.A.2.c).(1).(g).(ii).(d)]	<ul style="list-style-type: none"> • Each program should identify appropriate measures that will be reported to and acted upon by the residents. These measures need to be specific to a resident's panel of patients, and not to a practice as a whole. These could include data on patient satisfaction, data regarding chronic medical problems (diabetes, hypertension, coronary artery disease, etc.), and information about preventive health care (immunization rates, cancer screening rates, etc.). The evaluation of these performance data can also occur through the use of the ABIM PIMs or through chart audits/reviews.
What does the committee expect in terms of resident accessibility between outpatient visits? [Program Requirement IV.A.2.c).(1).(g).(ii).(e)]	<ul style="list-style-type: none"> • Programs should develop mechanisms to allow residents to participate in the management of their continuity panel of patients between outpatient visits. These could include: improved communication processes to allow residents to address phone calls on their patients; notification of residents when their patients have been seen by other primary care or subspecialty physicians; notification when a resident's patient is admitted to the hospital. This will be assessed through the Resident Survey.
What certification is considered acceptable to direct a critical care unit?	<ul style="list-style-type: none"> • An ABMS-certified critical care specialist must be the director of a combined MICU-SICU unit. An ABIM-certified critical care specialist must be the director of a MICU-CCU unit or MICU unit. An ABIM-certified cardiologist must be the director of a CCU unit.
Evaluation	
Question	Answer
What is expected for the multi-source evaluations? [Program Requirement V.A.1.b).(2).	<ul style="list-style-type: none"> • Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the resident being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). The evaluation of forms distributed to these individuals do not have to each ask about the same items, but should reflect the general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).