

Transplant Hepatology Fellowship Programs FAQ	
General Subspecialty Requirements	
Question	Answer
<p>Do the General Subspecialty Program Requirements apply to transplant hepatology? [see: ACGME Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine] [see: RRC-IM General Subspecialty FAQ]</p>	<ul style="list-style-type: none"> • Absolutely. Transplant hepatology program directors should study carefully the General Subspecialty Program Requirements, and the FAQs related to these program requirements. The requirements cover required structural elements in the program such as required institutional support, facilities and resources, key faculty and program director qualifications and responsibilities, conferences, continuity clinic, scholarship and research, evaluation, etc. • Subspecialty fellowship programs are expected to be in full compliance with <u>both</u> the General Subspecialty Program Requirements, and the Subspecialty Specific Program Requirements. • Please note that transplant hepatology is considered a dependent internal medicine sub-sub specialty of gastroenterology. Programs must be in substantial compliance with the General Subspecialty program requirements as well as the transplant hepatology program requirements.
<p>Will the RRC-IM allow any exceptions to this requirement for applicant qualifications? [Program Requirement III.F.]</p>	<ul style="list-style-type: none"> • The RRC-IM will approve exceptions to the prior training rule for: <ul style="list-style-type: none"> ○ A fully trained international medical graduate gastroenterologist coming to the US for only 1-year of transplant hepatology training. The program must notify this individual in writing that this training will not lead to ABIM certification and must not exceed the approved resident complement for the program. (Note that programs cannot accept more than 25% of entering fellows who have not completed ACGME accredited internal medicine residency and gastroenterology fellowship, when averaged over a 5-year period). ○ Fellows that have been accepted for training prior to the July 2007 accreditation date. This exception will only be allowed for the 2007-2008 academic year. • The RRC-IM will also consider, by written request only, an exception for individuals who have completed two years of training in an ACGME-accredited gastroenterology program and wish to complete their transplant hepatology fellowship prior to completion of their third year of gastroenterology training. Requests may only be made if the individual has completed all of the clinical gastroenterology training, including the five months of required hepatology training. Decisions will be made on an individual program basis.
<p>How do the Conference Requirements apply to TH programs? Can we use other forms of didactics to fulfill conference requirements? [Program Requirement IV.D.2. – IV.D.2.b)] [Program Requirement IV.D.3.a) – IV.D.3.b)]</p>	<p>The RRC-IM 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"> • Four (once weekly, averaged over 1 year) <u>core curriculum conferences</u>. 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"> ○ The core curriculum is a planned, year-long course in the subspecialty of advanced and transplant hepatology. ○ The core curriculum conference series must cover the major topics in the subspecialty of advanced and transplant hepatology ○ The core curriculum conference series is <u>distinct</u> from a case conference, though it may be case based.

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- The core curriculum conferences are so sub-specialty specific that a separate conference series is necessary, and cannot be shared between the gastroenterology program and the transplant hepatology program.
- A separate basic science conference is no longer required for subspecialty programs. Instead basic sciences should be covered at the required core curriculum conferences and clinical case conferences.
- Four (once weekly) clinical case conferences
 - The clinical case conference is the presentation of a patient(s) currently or recently cared for by the faculty and fellows, with a discussion of the relevant pathological material, radiographic and laboratory data, multidisciplinary perspectives, and relevant literature.
 - Case conferences provide a forum for fellows and faculty to discuss a variety of issues related to the specialty: pathophysiology, diagnosis, management, evolving therapeutics, ethical considerations, etc.
 - The clinical case conferences are so sub-specialty specific that a separate conference series is necessary, and cannot be shared between the gastroenterology program and the transplant hepatology program.
 - A separate M&M or CPC is not required for subspecialty programs. But pathological material must be reviewed at the required core curriculum conferences and clinical case conferences.
- One (once monthly) journal club
 - A TH program may combine journal club with the parent gastroenterology program if:
 - All TH fellows attend the journal club at least monthly (not just when TH or hepatology topics are discussed)
 - Key TH faculty from the sub-specialty attend the same conference with the fellows (not just when TH or hepatology topics are discussed)
 - Topics in TH are discussed regularly
 - TH fellows are to be exposed to and discussing both the recent and classic literature in the sub-specialty.
- One (once monthly) research conference
 - 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.
 - A TH program may combine research conference with the parent gastroenterology program if:
 - All TH fellows attend the same research conference at least monthly (not just when TH or hepatology topics are discussed)
 - Key faculty and researchers in the sub-specialty attend the same conference with the fellows (not just when TH or hepatology topics are discussed)
 - Topics in the sub-specialty are discussed regularly at the research conference.

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	<p><u>Web-Based Learning</u></p> <ul style="list-style-type: none"> • Principle: There are many potential advantages to e-learning venues, but two major concerns: <ul style="list-style-type: none"> ○ What is the quality of the educational product? ○ Did the learning actually take place? • Programs may use Web-based instruction or other forms of electronic learning for some of the <u>Core Curriculum Conferences</u> provided the following criteria are met. <ul style="list-style-type: none"> ○ E-learning should be considered as an adjunct to Core Curriculum conferences presented by the faculty. ○ E-learning venues must satisfy the following criteria in order to be substituted for a traditional didactic conference: <ul style="list-style-type: none"> ○ The educational content must be reviewed and approved by the Key Clinical Faculty. ○ Commercially-produced modules must be reviewed and endorsed by a professional society committed to the area under consideration, in order to assure competent and unbiased sources of educational material. ○ The e-learning must be followed by a discussion (in a formal set-aside session) with key faculty in order to answer questions, provide relevance, and to demonstrate the importance of the learning venue and topic. Video-conferencing or tele-conferencing can be used for this purpose ○ There must be tracking by the fellow and the program to insure that the fellow completed the prescribed module. An educational portfolio of learning, with subsequent reflection upon practice-based learning experiences, is suggested as the most appropriate measure of competency. <p><u>Horizontal Disciplines</u></p> <ul style="list-style-type: none"> • Principle: Ethics, QA/QI, medical legal, end-of-life, etc. should be covered during residency and gastroenterology fellowship. • It is not necessary for TH to have separate conferences specifically devoted to ethics, end of life issues, quality improvement, etc. • Instead, these topics should be discussed as appropriate during the case conferences, research conference, journal club, and core curriculum conference series, as well as during case-based learning (teaching rounds, during procedure supervision, clinic, etc.).
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Educational Program Question	Answer
Can a TH program exist without an accredited gastroenterology program? [Program Requirement VIII.A]	<ul style="list-style-type: none"> • Transplant hepatology must function as a dependent sub-specialty of an ACGME accredited gastroenterology program. • The major site of fellowship training must be at the same institution that sponsors the internal medicine residency program and the gastroenterology fellowship program, or at a participating institution where there is a continuous presence of the sponsoring institution's core residents, gastroenterology fellows, and faculty.
Can my program accept trainees into the transplant hepatology program that have not completed a 3-year ACGME-accredited gastroenterology program? Can	<ul style="list-style-type: none"> • All accredited training must be completed within one year; programs may offer additional (research or other) non-accredited training years, but the accredited training may not be spread out over 2 or more years. • When the ACGME approved the program requirements for

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training be spread over 2 years? [Program Requirement VIII. B.]	<p>Transplant Hepatology, the specialty was designated as a dependent subspecialty of gastroenterology. The ACGME does not accredit training that does not lead to certification. The ABIM requires gastroenterology certification for all candidates seeking certification in transplant hepatology.</p> <ul style="list-style-type: none"> • Therefore the ACGME requirements for accredited training programs in transplant hepatology require that fellows entering the program have completed the gastroenterology training in an ACGME-accredited program both to (1) Ensure eligibility for certification at the completion of training and to (2) Ensure that all fellows entering the program have completed the minimum hepatology training (i.e. 5 months of clinical hepatology under the direction of a hepatology key clinical faculty member, endoscopic variceal hemostasis management in at least 20 patients including 5 active bleeders, etc.) required of a gastroenterologist prior to entering advanced hepatology training. • Training must be sequential, that is: fellows should complete three years of accredited gastroenterology training prior to entering a TH fellowship.
What are the research requirements for TH fellows? [Program Requirement IV.B.2. - IV.B.2.a).(1)] [Program Requirement VIII.C.]	<p>Principles:</p> <ul style="list-style-type: none"> • TH training requirements are designed as 12 months of intensive CLINICAL training. • TH fellows must <u>participate in</u> scholarly activity, but cannot be held to the same research standard as fellows in 2-year and 3-year programs where up to 50% of training may be spent in research • Thus, TH fellows can meet the Scholarship Requirement by: <ul style="list-style-type: none"> ○ A research project (with faculty mentorship), <u>or</u> ○ Participation with the faculty in the initiation and conduct of clinical trials within the department, <u>or</u> ○ Participation in QA/QI or process improvement projects
How much of the TH program must be devoted to clinical training? [Program Requirement XI.C.]	<ul style="list-style-type: none"> • A TH fellowship is intended to be a one-year <u>clinical</u> training program. While fellows must be exposed to research and scholarly activity, the training program must fulfill minimum clinical training requirements. <ul style="list-style-type: none"> ○ The RRC-IM, in conjunction with the transplant hepatology advisory committee, has determined that <u>at least 80% of accredited training must be clinical.</u> ○ Up to 20% of training may be research, either concurrent or in blocks. <ul style="list-style-type: none"> ▪ Continuity clinic may not be interrupted during research blocks; there may be no purely research months. ▪ New programs will not be accredited with < 80% clinical training. • All accredited training must be completed within the 12-month training program. An additional (non-accredited) research year may be offered following the accredited year, but required experiences may not be spread out over the additional time.
Faculty Question	Answer
How many gastroenterology and Hepatology Faculty must the program have in order to be accredited? [Program Requirement IX.A.]	As of July 1, 2011, all transplant hepatology programs with a complement of 1-3 fellows must have, at a minimum, two gastroenterology and transplant hepatology certified key clinical faculty, one of whom is the program director.
What are the certification requirements for the program director and the key clinical	<ul style="list-style-type: none"> • Only ABIM certification is acceptable; no other credentials are accepted. • The RRC-IM does not grant waivers for the ABIM-certification

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faculty? [Program Requirement II.C.1.a.)] [Program Requirement IX.C.]	<p>requirement (for program directors or for key clinical faculty). Rationale: The RRC-IM uses ABIM certification as one of its major outcome measures. 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 now has a pathway for certification of faculty who were not trained in an ACGME accredited program.</p> <ul style="list-style-type: none"> • The RRC-IM will withhold accreditation of new programs that are not led by ABIM-subspecialty-certified internists. • The Committee standard for subspecialty program director certification is as follows: The Subspecialty IM program director must be ABIM-certified, and must maintain certification in the internal medicine subspecialty. i.e., The Subspecialty program director may allow core internal medicine certification to lapse, but must maintain certification in subspecialty (e.g., gastroenterology) • In Sub-Subspecialties, the program director and key clinical faculty must maintain primary subspecialty certification and sub-subspecialty certification <p><u>EXCEPTION FOR THE INITIAL PHASE OF NEW PROGRAM APPLICATIONS IN TRANSPLANT HEPATOLOGY</u></p> <ul style="list-style-type: none"> • The RRC-IM recognizes that the program director and key clinical faculty will not have had the opportunity to obtain certification in transplant hepatology at the time of the initial application phase. Therefore the Committee will accept the following as equivalent credentials only for the initial phase of accreditation: <ul style="list-style-type: none"> ◦ Consistent with ABIM policy, the RRC-IM will only consider (1) An active ABIM certification in gastroenterology <u>plus</u> (2) Significant experience in transplant hepatology as equivalent credentials to serve as program director and key clinical faculty for transplant hepatology programs. • After July 1, 2011, all program directors and key clinical faculty must have active ABIM certificates in gastroenterology <u>and</u> transplant hepatology.
Facilities and Resources	
Question	Answer
Why is UNOS Approval Required? [Program Requirement X.A.]	<ul style="list-style-type: none"> • The Committee considers a member in good standing in UNOS to be one measure that the transplant program has met minimum standards for quality and safety, and therefore fellow education. • If the transplant program loses its good standing in UNOS, the program ceases to be in compliance with ACGME requirements for fellowship education in Transplant Hepatology. It is the responsibility of the Transplant Hepatology program director to inform the ACGME RC-IM should the transplant program lose its status in UNOS.
What type of interaction with transplant surgeons is expected? [Program Requirement X.C.1.]	<ul style="list-style-type: none"> • Liver transplant medicine is predicated on close cooperation with transplant surgery. The burden of responsibility for clinical management shifts during the patient's clinical course: predominantly medical management prior to transplantation, predominantly surgical management in the perioperative phase, with reversion to medical management thereafter. • Important clinical decisions, such as placement or removal from the transplant list, are taken collectively by the transplant team. The fellow and transplant hepatology faculty must share responsibilities within this paradigm of cooperative care. • Note: Surgeons or other specialists who are not gastroenterology-

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	certified hepatologists may not serve as key clinical faculty.
What type of interaction with pathologists is expected? [Program Requirement X.C.2.]	<ul style="list-style-type: none"> • Regular scheduled review of pathology with a liver hepatologist is the norm in transplant programs during Clinical Case Conferences and Core Curriculum Conferences. • This should be supplemented by day to day review and analysis of pathology in accordance with the needs of clinical care.
Specific Program Content Question	Answer
What procedures does the program need to track for transplant hepatology fellows? [Program Requirement XI.B.]	<u>Transplant Hepatology procedures that must be documented in fellow's procedure log:</u> <ul style="list-style-type: none"> • Liver Biopsy --performance of at least 30 percutaneous liver biopsies, including allograft
What are the requirements for liver biopsy? If fellows had an adequate liver biopsy experience during gastroenterology fellowship, do they need to perform additional procedures during TH fellowship? [Program Requirement XI.B. – XI.B.2.c)]	<ul style="list-style-type: none"> • These requirements dovetail with the requirement for a close educational interaction with liver transplant pathology. The Committee expects that the transplant hepatology fellow will share in the analysis of the data leading to a decision to biopsy the patient's liver, perform the biopsy (at least 30 during the transplant hepatology training program), and then he/she reviews the slides at the microscope with the pathologist. • The 30 biopsies can be a mix of native and allograft livers, but must include some allograft biopsies. The biopsies can be performed at the bedside, with hand held ultrasound guidance, or in the radiology department with the fellow as primary operator. They are in addition to the required number in the Gastroenterology training program. Note that effective July 2007, gastroenterology fellows are no longer required to perform liver biopsies. • This review of pathology should occur in the setting of regular review of liver biopsy material generated within the program.
Must native and allograft liver biopsies be generated from the sponsoring institution? [Program Requirement XI.B.2.b.]	The required 200 native and allograft biopsies must be generated in the setting of regular review of liver biopsy material generated within the program or contained within its archives.

APPENDIX I

RRC-IM Calculation of Minimum Key Clinical Faculty (KCF) and Key Clinical Faculty (KCF) Scholarship Participation/Productivity Transplant Hepatology				
Minimum 2 KCF or 1:1.5 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	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
<ul style="list-style-type: none"> • Publication = Research publication, review article, or editorial in a peer review journal (PRJ), funded peer-review grant, or book chapter. • Scholarly case reports acceptable (Sept 2007) if indexed in Pub Med, and copy submitted with PIF • Peer review publication = indexed in Pub Med (or Medline). If not in Pub Med, PD must supply evidence of peer review • In press or accepted for publication counts. Submitted or in preparation does not count. • Abstract, illustration, letter to the editor, presentation, or publication in non-PRJ does not count. • Peer-reviewed funding (NIH, NCI, or other government-funded or national-foundation funded) counts • Industry, pharmaceutical, or other non-peer-review grant does not count. <ul style="list-style-type: none"> • Exception: Pharmaceutical studies in which the KCF is the overall PI (lead investigator) for all sites will be accepted as counting as one product of scholarship • 1 paper = 1 paper; Do not count multi-author papers more than once. • Count the last three calendar years prior to PIF submission. If site visit is in Sep. 2008, count publications from 2005, 2006, and 2007 as well as 2008. • <u>Contribute to participation:</u> Only ABIM certified KCF • <u>Contribute to productivity:</u> <ul style="list-style-type: none"> • Certified KCF • Additional sub-specialty KCF (above minimum required, certified or non-certified) • Non-physician faculty and faculty in other specialties IF: <ul style="list-style-type: none"> ▪ Contribute to fellow education ▪ Devote at least 10 hours/ week to the program 				