ACGME Program Requirements for Graduate Medical Education in Internal Medicine
Summary and Impact of Major Requirement Revisions

Requirement: Int.B.

Requirement Revision (significant change only):

Internists are specialists who care for adult patients through comprehensive, clinical problem solving. They integrate the history, physical examination and all available data to deliver, direct, and coordinate care across varied clinical settings. Internists are diagnosticians who manage the care of patients who present with undifferentiated, complex illnesses and comorbidities; promote health in communities; collaborate with colleagues; and lead, mentor, and serve multidisciplinary teams. Internists integrate care across organ systems and disease processes throughout the adult lifespan. They are expert communicators, creative and adaptable to the changing needs of patients and the health care environment. Internists embrace lifelong learning and the privilege and responsibility of educating patients, populations, and other health professionals. The discipline is characterized by a compassionate, cognitive, scholarly, relationship-oriented approach to comprehensive patient care.

The successful, fulfilled internist maintains this core function and these core values. Internists find meaning and purpose in caring for individual patients with increased efficiency through well-functioning teams, and are equipped and trained to manage change effectively and lead those teams. They understand and manage the business of medicine to optimize cost-conscious care for their patients. They apply data management science to population and patient applications and help solve the clinical problems of their patients and their community. Internists communicate fluently and are able to educate and clearly explain complex data and concepts to all audiences, especially patients. They collaborate with patients to implement health care ethics in all aspects of their care. Internists display emotional intelligence in their relationships with colleagues, team members, and patients, maximizing both their own and their teams’ well-being. They are dedicated professionals who have the knowledge, skills, and attitudes to effectively use all available resources, and bring intellectual curiosity and human warmth to their patients and community.

Internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

1. Describe the Review Committee’s rationale for this revision:

The Review Committee developed this vision of the internist to clearly articulate the core functions and values of internal medicine that are foundational, and to describe what is needed to move the specialty forward through the Program Requirements. This vision defines what the Review Committee hopes to see in the graduates of internal medicine residency programs, the faculty members, and the broader internal medicine community. The Committee developed this
vision after it participated in a series of workshops using a scenario-based strategic planning technique. The purpose of using this technique and having the workshops was to proactively, rigorously, and creatively contemplate what the specialty of internal medicine, the internist, and the patients of the future would look like. General insights from these workshops are provided in this Executive Summary (which can also be found in the Internal Medicine section of the ACGME website):

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   Although this is a vision statement and functions as an introduction to the Program Requirements, the Review Committee expects that the tenets expressed will encourage and promote program improvements and innovation in resident education, patient safety, and patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

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Requirement: I.D.1.a).(4)

Requirement Revision (significant change only):

[The program, in partnership with its Sponsoring institution, must:] The program, in partnership with its Sponsoring Institution and participating sites, must provide access to an electronic health record; in the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. and, (Core) [Previously I.D.1.c)]

1. Describe the Review Committee’s rationale for this revision:

   The Committee revised this requirement to make clear that programs must have access to an electronic health record (EHR). The Committee believes that most programs and institutions have implemented or are in the process of implementing an EHR to more efficiently store and access patient health information and to be in compliance with other regulating entities, like CMS. The Committee also created a Background and Intent box to provide further guidance on expectations related to the EHR, including clarifying that an EHR does not have to be present at all participating sites, and does not have to include every element of patient care information.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will improve resident education and patient care because residents will have ready access to vital patient care information.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will continue to improve resident education and patient care because residents and other health care providers in the health care system will have ready access to vital patient care information.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This may necessitate additional institutional resources depending on where program and institutions are at with regards to implementing an EHR.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

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Requirement: II.B.2.i)

Requirement Revision (significant change only):

There must be faculty members with expertise in the analysis and interpretation of practice data, data management science and clinical decision support systems, and managing emerging health issues. (Core)

1. Describe the Review Committee's rationale for this revision:

   Advances in technology will significantly impact and redefine patient care. As such, programs will need to ensure there are faculty members with knowledge, skills, or experience in the analysis and interpretation of practice data, and who are able to analyze and evaluate the validity of decisions from advanced data management and clinical decision support systems.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will improve resident education because it will ensure faculty members are skilled and experienced to supervise and teach these critical skills to enable residents to provide quality patient care to their patients.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This may necessitate additional institutional resources to either educate and develop existing faculty members or recruit new ones.
5. How will the proposed revision impact other accredited programs?

This should not affect other accredited programs.

<table>
<thead>
<tr>
<th>Number of Approved Resident Positions</th>
<th>Minimum number of ABIM- or AOBIM- Core Faculty **</th>
<th>Number of Approved Resident Positions</th>
<th>Minimum Number of ABIM- or AOBIM-certified Core Faculty Members</th>
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<tr>
<td>&lt;30</td>
<td>3</td>
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<td>30-39</td>
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<td>200-209</td>
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**NOTE: At its February 2020 meeting the ACGME Board of Directors approved a change to the Common Program Requirements to allow Review Committees to specify support for core
faculty members. Subsequently, at its June 2020 meeting the Board determined that additional review was necessary. The decision was driven by a need to acknowledge and be sensitive to the present and ongoing financial crisis many Sponsoring Institutions are facing as a result of the COVID pandemic.

The Board approved the formation of a task force to examine the principles that should guide creation of requirements that quantify support for the effort required to participate in the educational program of residents and fellows. The task force is charged with reviewing ACGME Common and specialty requirements relating to the duties, functions, dedicated time, and FTE support of and for program directors, assistant/associate program directors, program coordinators, and core faculty members, and making recommendations to the Board regarding potential revision of these.

The group will begin its work over the summer and present a preliminary report to the Board in September. All proposed specialty-specific requirements related to core faculty members will be deferred in the interim. The Review Committee will develop and propose language for core faculty support after the Board provides guidance on this issue. The requirements related to FTE support for program directors, assistant/associate program directors, and program coordinators may need to be revisited as well.

Specialty-Specific Background and Intent: The duties of the program director, associate program director(s), and internal medicine core faculty members are separate and distinct. As such, the minimum required internal medicine core faculty members are in addition to the program director and the associate program director(s). One individual cannot “count” as both an associate program director and internal medicine core faculty member.

Educational responsibilities for the minimum required internal medicine core faculty members:
The requirement related to support for core internal medicine faculty members is intended to ensure these faculty members have sufficient protected time to meet the following educational responsibilities:

- Membership on the Clinical Competency Committee
- Participation in the annual program review as Chair or member of the Program Evaluation Committee
- Implementation and analysis of the outcome of action plans developed by the Program Evaluation Committee
- Significant participation in recruitment and selection, including efforts related to the program’s commitment to diversity
- Advising, mentoring, and coaching residents (co-creating, implementing, and monitoring individualized learning plans)
- Designing and overseeing remediation plans
- Supporting/overseeing residents in the development/assessment of quality improvement/patient safety projects
- Supporting/overseeing residents in the conduct of their scholarly work, including the dissemination of such work through presentations, posters/abstracts, and peer-reviewed publications
- Significant participation in educational activities (didactics, lab, or simulation)
- Overseeing faculty development for the program’s faculty members
• Designing and implementing simulation and standardized patients for teaching and assessment
• Developing, implementing, and assessing one or more of the major components of the curriculum, such as patient safety, quality, health disparities, or core didactics
• Designing and implementing the program’s assessment strategies, making certain there are robust methods used to assess each competency, and ensuring they provide meaningful information by which the Clinical Competency Committee can judge resident performance on the Milestones
• Leading the program’s efforts related to resident and faculty member well-being

Each core faculty member does not need to participate in every listed educational responsibility.

The program must have a minimum number of ABIM- or AOBIM-certified core faculty members who devote significant time to teaching, supervising, and advising residents, and working closely with the program director and APDs. One way the core internist faculty members can demonstrate they are devoting a significant portion of their effort to resident education is by dedicating an average of 15 hours per week to the program.

1. Describe the Review Committee’s rationale for this revision:

   This section has undergone significant change. In the current requirements, the minimum required number of core internist faculty members for programs with fewer than 60 approved positions is four. In the proposed revision, the Committee has increased the minimum number of core internist faculty members for medium-sized and larger programs (defined as programs with 40 or more approved positions) and decreased it for smaller programs (programs with approved complements under 30, which comprise approximately 40 percent of all accredited internal medicine programs. If the proposals are approved, programs under 30 will need three core internist faculty (in addition to the program director and the associate program director), and programs with 60 approved positions will need seven.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will directly improve resident education (and indirectly improve patient safety and patient care quality) by ensuring there are an appropriate number of core internist faculty members to teach and supervise internal medicine residents.

3. How will the proposed requirement or revision impact continuity of patient care?

   This change should improve continuity of patient care because there will be an appropriate number of core internist faculty members available to oversee and supervise resident education.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
This will require some programs and institutions to identify additional core internist faculty members than they currently have allocated. It will also require allocating a minimum FTE for non-clinical duties associated for these faculty members.

5. How will the proposed revision impact other accredited programs?

This should not affect other accredited programs.

Requirement: II.C.2.

Requirement Revision (significant change only):

II.C.2. At a minimum, the program coordinator must be supported at 50% FTE for the administration of the program. Additional support must be provided based on the program size as follows:

<table>
<thead>
<tr>
<th>Number of Approved Resident Positions</th>
<th>Minimum FTE Required for Coordinator Support</th>
<th>Additional Aggregate FTE Required for Administration of the Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 24</td>
<td>1.0</td>
<td>0.0</td>
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<tr>
<td>24-39</td>
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<td>1.0</td>
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<tr>
<td>40-79</td>
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<tr>
<td>80-119</td>
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<td>160-199</td>
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<tr>
<td>&gt;200</td>
<td>1.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Specialty-Specific Background and Intent: All internal medicine residency programs are required to have a program coordinator who is supported at 1.0 FTE for the administration of the program. Additional support is required as the size of the program increases. Additional support can be shared among several individuals, at the discretion of the program director. For example, a program approved for 45 residents is required to have a program coordinator supported at 1.0 FTE and at least two or more individuals who will share an aggregate of 2.0 FTE salary support for their administrative contributions to the program.

To provide clarity on the expectations for salary support for program personnel, the Review Committee created the table below that summarizes FTE and salary support for all program personnel.

<table>
<thead>
<tr>
<th>Approved Residents</th>
<th>Program Director</th>
<th>ABIM or AOBIM certified Core Faculty Members**</th>
<th>Associate Program Directors</th>
<th>Program Coordinator</th>
<th>Additional Aggregate FTE Salary Support for Administration of the Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;24</td>
<td>1 PD</td>
<td>0.5</td>
<td>3</td>
<td>0.0</td>
<td>1.0</td>
</tr>
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</table>
For example, a program with an approved complement of 45 residents will require the following:

- One program director at .5 FTE
- One program coordinator at 1.0 FTE
- At least two associate program directors with at least 1.0 aggregate FTE
- At least five core faculty members with FTE to be determined *
- At least 2.0 aggregate FTE (in addition to the program coordinator) to support the administration/coordination of the program

**NOTE: As noted above under II.B.4.c), the ACGME Board is having discussions about core faculty support. The Review Committee will develop and propose language for core faculty support after the Board provides guidance on this issue.**

1. Describe the Review Committee’s rationale for this revision:
This new requirement stipulates that program coordinator support is required and must increase as the size of the program increases. It was derived with significant input from both the Alliance for Academic Internal Medicine (AAIM) leadership and the Association of Program Directors in Internal Medicine (APDIM) administrators’ group. These proposed changes mark a transition from no requirements related to coordinator support, to the much-needed specificity for this critical role in residency programs. Based on the data provided by AAIM and the APDIM administrator’s group, most accredited internal medicine programs have some degree of FTE of coordinator support; however, these new requirements will set the floor for all programs and will likely require some programs and institutions to allocate more funds in order to be in compliance. This may be challenging for some programs and their Sponsoring Institutions with the COVID-19 pandemic pushing Sponsoring Institutions toward their financial breaking point. However, the Review Committee firmly believes this change is necessary, and, if approved, will ask that the ACGME Board consider an effective date of July 1, 2023 to allow programs and institutions to come into compliance.

In addition, the Committee felt that it was important to include a summary table in the requirements (see above) so there is complete clarity regarding expectations for FTE and salary support for the program director (II.C.), the associate program director(s) (II.B.5.), core internist faculty members (II.B.4. – to be determined in the future), the program coordinator, and additional administrative support staff members (II.C.).

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This will not affect resident education, patient safety, and/or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Descriptive data provided by AAIM and the APDIM administrator’s group confirms that most accredited programs have program coordinator support. However, that data also confirmed that there is wide variability in that support among programs. The Committee expects that some programs will need to increase the FTE for coordinator support to be in compliance with this new requirement.

5. How will the proposed revision impact other accredited programs?

This will not affect other accredited programs.

Requirement: III.B.1.a); III.B.1.a).(1).
Requirement Revision (significant change only):

III.B.1.a) There must be a sufficient number of residents to allow peer-to-peer interaction and learning. (Core)

III.B.1.a).(1) The program should offer a minimum of nine positions. (Detail)

III.B.1.b) A program must have a minimum of 15 residents enrolled and participating in the training program at all times. (Detail)

1. Describe the Review Committee’s rationale for this revision:

The Review Committee revised this requirement and reduced the minimum number of residents for a program from 15 to nine. The requirement remains categorized as “Detail” to provide programs flexibility. The Committee also added a new “Core” requirement to clearly articulate that the reason for having a minimum required number of residents is to ensure that resident education is not compromised by having too few residents in the program, and that there will be appropriate and sufficient peer-to-peer interaction and learning.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The revision should not affect any currently accredited programs. However, as noted in the Background and Intent box, lowering the minimum required number of residents while still keeping the requirement categorized as “Detail” may promote and allow for the establishment of programs in rural and medically underserved areas and populations, which should improve and enhance both resident education and patient care/care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

This will not affect other accredited programs.

Requirement: IV.B.1.a).(1).(a).(v)

Requirement Revision (significant change only):

[Residents must demonstrate the ability to manage the care of patients:] for whom they have limited or no physical contact through the use of telemedicine; (Core)

1. Describe the Review Committee’s rationale for this revision:
The Review Committee believes that with advances in technology, the patient-doctor relationship of the future will be more virtual than actual and will require residents to learn and develop new communication competencies. In addition to technology, the ubiquity of medical information readily available electronically, and easy access to non-physician care at retail outlets and clinics will all contribute to limiting the face-to-face interactions physicians will have with patients, particularly those with routine needs. In addition, recent experience for faculty members, residents, and others providing health care for patients during the COVID-19 pandemic has shown the emerging need for all health care providers to develop experience and skills in caring for patients who are not in the same physical space as those providing the care.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will require programs to educate residents in both physical and virtual health care settings. As such, residents will have a broader set of skills across settings.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will improve continuity of patient care because residents will be better prepared to communicate with their patients who were not able to make physical continuity or office clinic visits.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   As a result of the need to flexibly provide care in various ways during the COVID-19 pandemic, programs and institutions have already invested in technologies to facilitate education and training in this area.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

Requirement: IV.B.1.a).(1).a).(vii)

Requirement Revision (significant change only):

[Residents must demonstrate the ability to manage the care of patients:]

   using population-based data; *(Core)*

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee believes that understanding population health within the context of prevention is an important area of competence for the physician practicing medicine in the future. Residents will need experience with the use of population health data, including with data registry interpretation, analysis of epidemics or pandemics, and social determinants of health when making health care or preventive care decisions.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   
   This will improve resident education and patient care because it will ensure that residents are provided a broader understanding of population health when making health and preventive care decisions.

3. How will the proposed requirement or revision impact continuity of patient care?
   
   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This may necessitate additional institutional resources for programs to identify individuals with expertise in population health who can teach residents in this area.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

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Requirement: IV.B.1.a).(1).(a).(vii)

Requirement Revision (significant change only):

[Residents must demonstrate the ability to manage the care of patients:]

using clinical decision support systems; *(Core)*

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1. Describe the Review Committee’s rationale for this revision:

   The Review Committee believes that advances in information and knowledge networks will redefine patient care. Programs will need to ensure residents develop expertise in using clinical decision support systems, can critically evaluate the validity of the decisions from such systems, identify those decisions that are incorrect or misleading, and integrate the systems-derived decisions deemed accurate and appropriate into the team-based clinical care protocols. The ability to critically evaluate and implement algorithm-derived protocols from such clinical decision support systems will be a key lifelong skill to develop improved protocols.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will improve resident education because it will ensure that residents have access to clinical decision support systems, and that they will be able to critically interpret and evaluate the information derived from such systems.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

**Requirement:** IV.B.1.b).(2).(a).(i)

**Requirement Revision (significant change only):**

[Residents must demonstrate the ability to:]

use and/or perform point-of-care laboratory, diagnostic, and/or imaging studies relevant to the care of the patient using the laboratory and imaging techniques appropriately;

(Core)

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee intentionally did not identify specific laboratory, diagnostic, and/or imaging studies that residents must perform because it believes that scientific advances will be constant and ongoing, and whatever is codified in the requirements quickly becomes outdated. Additionally, the decision to not specifically denote studies in the requirements aligns with the Committee’s overall position that residents should perform and develop expertise with those procedures appropriate to their future practice needs, as noted in the requirement below. However, the Committee acknowledges that offering point-of-care ultrasonography to residents who believe this will be relevant for their future career practice may be one way to meet the requirement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This will directly improve resident education, patient safety, and patient care because residents will gain competence with the relevant and most up to date laboratory, diagnostic, and imaging studies relevant to the patient.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.
Requirement: IV.B.1.c).(1).(b)

Requirement Revision (significant change only):

[Residents must are expected to demonstrate a level of expertise in the knowledge of the broad spectrum of clinical disorders seen by an internist, including those areas appropriate for an internal medicine specialist, specifically: (Core)]

the core content of general internal medicine, which includes the internal medicine subspecialties, the multidisciplinary subspecialties of geriatric medicine, hospice and palliative medicine and addiction medicine, and neurology non-internal medicine specialties, and relevant non-clinical topics at a level sufficient to practice internal medicine. (Core)

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee revised this requirement to include educational experiences in addiction medicine and hospice and palliative medicine because these experiences were felt to be relevant and necessary for all practicing internists. Although the requirement now explicitly states that residents are expected to have experiences and knowledge of clinical disorders seen by internists in geriatric medicine and neurology, those expectations are not new. They are longstanding and had appeared elsewhere in the requirements document but had not been clearly articulated in this particular section.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   Experience in these clinical areas will improve resident education because the requirement now clearly specifies the areas in which residents must demonstrate they have knowledge.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.
<table>
<thead>
<tr>
<th>Section</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>IV.C.3.a).(1)</td>
<td>at least 10 months of clinical experiences in the outpatient setting.</td>
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<tr>
<td>Specialty-Specific Background and Intent: Clinical experiences in the following outpatient settings areas can be used to fulfill this requirement: general internal medicine continuity clinics; internal medicine subspecialty clinics (e.g., HIV clinic); non-medicine clinics (e.g., dermatology or physical medicine and rehabilitation clinic); walk-in clinics; neighborhood health clinics; home care visit programs; and ambulatory block rotations.</td>
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<tr>
<td>IV.C.3.a).(2)</td>
<td>at least 10 months of clinical experiences in the inpatient and critical care settings;</td>
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<tr>
<td>Specialty-Specific Background and Intent: Critical care experiences must be a minimum of two months and a maximum of six months and must not occur solely in the PGY-1 year.</td>
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<tr>
<td>IV.C.3.a).(3)</td>
<td>structured clinical experiences in each of the internal medicine subspecialties.</td>
</tr>
<tr>
<td>Specialty-Specific Background and Intent: Clinical experiences in the each of the subspecialties can be used to fulfill either the minimum required number of months in the inpatient or outpatient setting, depending on the setting the experience is provided. For instance, a month rotation on a hematology-oncology service would count towards meeting the inpatient minimums whereas a month in an oncology clinic would count towards outpatient.</td>
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<tr>
<td>IV.C.3.a).(4)</td>
<td>structured clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, and neurology.</td>
</tr>
<tr>
<td>IV.C.3.b)</td>
<td>at least six months of individualized educational experiences to participate in opportunities relevant to their future practice or attain further skill/competency development.</td>
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<tr>
<td>Specialty-Specific Background and Intent: In addition to the requirement that programs provide residents with broad foundational educational experiences in ambulatory and hospital-based internal medicine, programs must ensure that at least six months are devoted to educational experiences that are relevant to the residents’ future practice needs. Such experiences will be provided once the Clinical Competency Committee (CCC) and the program director, using the Milestones system, determine that residents have achieved competence, or appear to be on a trajectory to achieve competence, in the foundational educational areas noted above. The Committee acknowledges that residents progress and learn at different paces and trajectories. Although six months can be devoted to individualized experiences, some residents may require more time to attain competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some residents may need to devote the entirety of residency to achieve competence in the foundational areas. The converse may be possible. Programs may have the opportunity to allocate six to 12 months of individualized educational opportunities for those residents who have achieved, or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient...</td>
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setting after residency, more inpatient experiences if they are interested in hospitalist
careers, or more experiences in a subspecialty if they are interested in
subspecializing.

The need for education to be competency-based was a central theme that emerged from
the scenario-based strategic planning workshops that took place prior to the writing of
these requirements. While true competency-based education is often conflated with time-
variable education, these requirements are more about acknowledging that residents
achieve competence at different rates and require different educational experiences, and
less about residents graduating prior to completing 36 months of residency.

The Review Committee is interested in exploring pilot projects testing whether residents
who have successfully achieved competence in the broad areas of internal medicine can
pursue a one-year fellowship (such as in geriatric medicine, hospice and palliative
medicine, or addiction medicine) or start a multi-year fellowship during residency. The pilot
projects will test the feasibility of combining or “double counting” educational experiences
and the possibility of completing residency and fellowship, in the case of combining
residency with a one-year fellowships, in three years rather than four. Current models exist
for such combined experiences, including accredited combined education in internal
medicine and pediatrics and a number of other unaccredited combined experiences where
internal medicine is combined with other specialties and subspecialties. The pilot projects
will need to be conceived and implemented in partnership with professional societies and
certifying boards, and will use the ACGME’s Advancing Innovations In Residency
Evaluation (AIRE) pilot mechanism to ensure rigorous and intentional curricular design and
thorough review of program effectiveness. For additional information on the AIRE pilot
process, visit https://www.acgme.org/What-We-Do/Accreditation/Advancing-Innovation-in-
Residency-Education-AIRE.

It is clear that major changes to internal medicine residency will be needed to achieve true
competency-based medical education, as highlighted in many of the insights in the
executive summary and the description of the internist in the preamble at the beginning of
these requirements. These changes must occur, but cannot be immediate or systematically
disruptive. In addition, current program leaders may not have the systems, resources,
context of education and training, or the faculty members needed to support such changes.
Therefore, changes will require careful evaluation to determine efficacy of any plan and any
untended consequences. To accomplish the goals of the future, the strengths of the
internal medicine education community must be used to their fullest extent. Studies must
be designed to chart the path forward, learn from them, and redefine and refine educational
programs to produce the physicians required for the future. The AIRE pilots will forge the
way into the future and guide the next iteration of the Program Requirements in a
measured, systematic, and deliberate manner.

Residency training is primarily an educational experience in patient-centered care.
The educational efforts of faculty and residents should enhance the quality of patient
care, and the education of the residents. At least 1/3 of the residency training must
occur in the ambulatory setting and at least 1/3 must occur in the inpatient setting. (Core)
[Previously IV.C.3.]

1. Describe the Review Committee’s rationale for this revision:
This section has undergone significant revision to specify that residents must be provided “foundational educational experiences in internal medicine” (IV.C.3.a)(1)-(4), as well as “individualized educational experiences (IV.C.3.b)) that will allow residents to explore opportunities relevant to their future practice or to gain further skill/competency development.

The explanatory language in the Background and Intent box is longer by design because it provides the overarching guiding principles for the revision and explains how these are truly competency-based requirements. The Committee acknowledges that residents progress and learn at different paces and trajectories, and although it has specified that six months can be devoted to individualized experiences, some residents may require more time to achieve competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some residents may need to devote the entirety of residency to achieve competence in the foundational areas. Conversely, programs may have the opportunity to allocate six to 12 months of individualized educational opportunities for those residents who have achieved or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences if they are interested in hospitalist medicine careers, or more experiences in a subspecialty if they are interested in subspecializing. While true competency-based education is often conflated with time-variable education, these requirements are more about acknowledging that residents achieve competence at different rates and require different educational experiences, and less about residents graduating prior to completing 36 months of residency.

Additionally, the Background and Intent box provides insight into what direction the Committee, in partnership with the relevant stakeholders in the internal medicine community, is interested in pursuing in subsequent revisions.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change will improve resident education because it will allow for greater individualization of resident experiences.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   There is the possibility that other programs, particularly in the department of medicine, are impacted if AIRE proposals are pursued that test the feasibility of combining or “double counting” educational experiences and the possibility of
completing residency and fellowship, in the case of combining residency with a one-year fellowship, in three rather than four years.

Requirement: IV.C.3.a).(4)
Requirement Revision (significant change only):

[The educational program for all residents must include foundational experience in internal medicine, including:]

structured clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, and neurology. (Core)

Experience must include at least four weeks dedicated to geriatric medicine. (Core)

[Previously IV.C.3.j]]

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee revised the requirement to provide programs greater flexibility. Programs are still required to provide residents a geriatric medicine experience, but there is no longer a requirement that the experience be four weeks in duration.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change should not affect resident education, patient safety, or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

Requirement: IV.C.3.b)
Requirement Revision (significant change only):

[The educational program for all residents must include:]

at least six months of individualized educational experiences to participate in opportunities relevant to their future practice or attain further skill/competency development. (Core)
Experience must include opportunities for experience in psychiatry, allergy/immunology, dermatology, medical ophthalmology, office gynecology, otolaryngology, nonoperative orthopedics, palliative medicine, sleep medicine, and rehabilitation medicine.  

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee removed this requirement because it is no longer necessary, now that there is a new requirement for “individualized educational experiences” (IV.C.3.b).

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change should improve resident education in that only those interested in pursuing career paths in a particular specialty area after residency will pursue such experiences during residency.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

<table>
<thead>
<tr>
<th>Requirement: IV.C.4.g)-o)</th>
<th>Requirement Revision (significant change only):</th>
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<tr>
<td></td>
<td>[While on inpatient rotations:]</td>
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<tr>
<td>IV.C.4.g) PGY-1 residents a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services; and, (Core) [Previously IV.C.3.g).(1)]</td>
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<tr>
<td>IV.C.4.h) PGY-2 residents must not be assigned more than 10 new patients per admitting day. (Core)</td>
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<tr>
<td>IV.C.4.i) a first-year resident must not be assigned more than eight new patients in a 48 hour period; (Core) [Previously IV.C.3.g).(2)]</td>
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<tr>
<td>IV.C.4.j) a first-year resident must not be responsible for the ongoing care of more than 10 patients; (Core) [Previously IV.C.3.g).(3)]</td>
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<tr>
<td>IV.C.4.k) when supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48 hour period. (Core) [Previously IV.C.3.g).(4)]</td>
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IV.C.4.i) when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; [Previously IV.C.3.g).(5)]

IV.C.4.m) when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients; [Previously IV.C.3.g).(6)]

IV.C.4.n) second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents; [Previously IV.C.3.g).(8)]

IV.C.4.o) total required transplant rotations in dedicated units should not exceed one month in three years. [Previously IV.C.3.g).(10)]

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee significantly revised these requirements because it cannot prescriptively and explicitly assign patient census limits for every possible educational scenario or circumstance given the variability in settings and the complexity and acuity of the patients. Instead, the Committee asks the program and institutional leadership team to proactively and regularly monitor the census, complexity, and acuity of patients assigned to the health care teams, and the structure and composition of the team, particularly the knowledge, skills, and abilities of individual team members, to determine the appropriate-sized patient panel for the situation. Although the Committee has limited the number of new patients second-year residents can be assigned per admitting day (IV.C.4.g), programs may also need to apply this limit to third-year residents based on the aforementioned considerations and input from residents. The leadership team will need to carefully review institutional patient safety outcome data when determining patient census team limits. The census limits noted above apply to all inpatient experiences during the 36 months of supervised graduate medical education regardless of whether an inpatient rotation is part of the foundational educational experiences in internal medicine or part of the individualized experiences.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change should not affect resident education, patient safety, or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?
This will not affect other accredited programs.

Requirement: IV.C.5.b) – IV.C.5.b).(9).(b)

Requirement Revision (significant change only):

[While on outpatient rotations:]

IV.C.5.b) Experiences must include residents must have a longitudinal team-based continuity experience for the duration of the educational program through in which they residents develop a continuous, long-term therapeutic relationship with a panel of general internal medicine patients. (Core) Previously IV.C.3.n]

IV.C.5.b).(1) Each resident's longitudinal continuity experience: [Previously IV.C.3.n).(1)]

IV.C.5.b).(2) must include the Residents must serve serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients. (Core) [Previously IV.C.3.n).(1).(a)]

IV.C.5.b).(3) must include resident participation Residents must participate in the coordination of care of patients across health care settings. Residents should be accessible to participate in the management of their continuity panel of patients and between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available; (Core) [Previously IV.C.3.n).(1).(e)]

IV.C.5.b).(4) must include supervision Residents must be supervised and taught by faculty members with whom they have who developed a longitudinal relationship with residents throughout the duration of their continuity experience. (Core) [Previously IV.C.3.n).(1).(f)]

IV.C.5.b).(5) should not be interrupted by more than a month, not inclusive of vacation; (Detail) [Previously IV.C.3.n).(1).(b)]

IV.C.5.b).(6) must include a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period, devoted to longitudinal care of the residents' panel of patients; (Detail) [Previously IV.C.3.n).(1).(c)]

IV.C.5.b).(7) must include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year; (Detail) [Previously IV.C.3.n).(1).(d)]

IV.C.5.b).(8) must maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1; (Detail) [Previously IV.C.3.n).(1).(g)]
IV.C.5.b).(9) must have sufficient supervision and teaching; [Previously IV.C.3.n).(1).(h)]

IV.C.5.b).(9).(a) Faculty must not have other patient care duties while supervising more than two residents or other learners, and [Previously IV.C.3.n).(1).(h).(i)]

IV.C.5.b).(9).(b) Other faculty responsibilities must not detract from the supervision and teaching of residents. [Previously IV.C.3.n).(1).(h).(ii)]

1. Describe the Review Committee’s rationale for this revision:

   Although programs will still be required to ensure that residents have a longitudinal team-based continuity experience in which they develop a continuous, long-term therapeutic relationship with a panel of patients (IV.C.5.b)), the Review Committee removed the more prescriptive requirements related to “how” the continuity experiences should be structured. “Team-based” was added because the Review Committee believes such care is the cornerstone of care all internists will provide during and after residency. The Committee made this change to provide both new and established programs with flexibility in how to structure and operationalize the continuity experience.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change should not affect resident education, patient safety, or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

   The change is not expected to affect continuity of patient care because most programs have been taking advantage of the fact that this requirement was categorized as “Detail” since 2013 and have implemented schedules that do not adhere to some of the more restrictive requirements that have been deleted above, specifically, the minimum number of clinics and the minimum time between interruptions to this experience.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

Requirement: IV.C.7.a); IV.C.13.a)-c)

Requirement Revision (significant change only):

IV.C.7.a) Emergency medicine may count for no more than two weeks toward the required 1/3 ambulatory time. [Previously IV.C.3.a)]
IV.C.13. Internal medicine residents must be assigned to emergency medicine. *(Core)*

[Previously IV.C.3.o)]

- IV.C.13.a) Emergency medicine experience must comprise at least four weeks of direct experience in blocks of not less than two weeks. *(Detail)* [Previously IV.C.3.o).(1)]

- IV.C.13.b) Total required emergency medicine experience must not exceed two months in three years of training. *(Detail)* [Previously IV.C.3.o).(2)]

- IV.C.13.c) Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable. *(Detail)* [Previously IV.C.3.o).(3)]

1. Describe the Review Committee’s rationale for this revision:

The Review Committee removed the requirement that all residents must have educational experiences in emergency medicine. If some residents are interested in having emergency medicine experiences because of future practice interests, programs can assign them such experiences. These experiences will be considered “individualized educational experiences” for interested residents (IV.C.3.b). The Review Committee made this decision to provide programs greater flexibility in developing required educational experiences for all residents.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This change should improve resident education in that only those interested in pursuing career paths that include emergency medicine after residency will be assigned such experiences during residency.

3. How will the proposed requirement or revision impact continuity of patient care?

This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

This will not affect other accredited programs.

Requirement: VI.E.2.a)-b)

Requirement Revision (significant change only):
VI.E.2.a) At least one non-physician core faculty member must participate in resident and programmatic evaluations. (Core)

VI.E.2.b) The program must provide educational experiences that allow residents to interact with and learn from other health care professionals, including physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, in order to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee added these requirements to ensure that residents will have access to the appropriate health care personnel (physicians and non-physicians, core and non-core faculty members) as defined by the circumstances, and that interdisciplinary, interprofessional teams will be constituted as appropriate and as needed. The Committee has added similar language emphasizing the need for interdisciplinary and interprofessional teams in other sections of the requirements, including requesting that the program director and core internist faculty members have experience with such forms of team-based care.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   This change should not improve resident education, patient safety, or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

   This will also have a positive impact on continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

   This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

   This will not affect other accredited programs.

Requirement: VI.F.7.a)

Requirement Revision (significant change only):

   Internal Medicine fellowships must not average in-house call over a four-week period. (Core)

1. Describe the Review Committee’s rationale for this revision:

   The Review Committee removed this longstanding requirement that prohibited averaging in-house call over a four-week period to allow programs greater flexibility when creating schedules. Furthermore, having this requirement in
place does not seem to ensure that programs will comply with the 80-hour weekly work limit, averaged over a four-week period.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This change should not affect resident education, patient safety, or patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?

This will not affect continuity of patient care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

This will not necessitate additional institutional resources.

5. How will the proposed revision impact other accredited programs?

This will not affect other accredited programs.