

SUBSPECIALTY INTERNAL MEDICINE FELLOWSHIP PROGRAMS

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

Abbreviations Used

PR = Program Requirement

PD = Program Director

Sub = Internal Medicine subspecialty program

Sub-sub = Subspecialty requiring completion of training in a parent subspecialty (i.e., clinical cardiac electrophysiology, interventional cardiology, transplant hepatology)

RRC-IM = Residency Review Committee for Internal Medicine

ACGME = Accreditation Council of Graduate Medical Education

DIO = Designated Institutional Official (usually serves as chair of GMEC)

GMEC = Graduate Medical Education Committee, as required by the IRC

IRC = Institutional Review Committee

PIF = Program Information Form

KCF = Key Clinical Faculty

Section I. Introduction, Duration, Scope of Education

Non-ACGME Trained Fellows

Question:

“Does the RRC limit the number of graduates of non-US medical schools in subspecialty fellowship programs?”

Program Requirements:

When averaged over any 5-year period, a minimum of 75% of fellows in each subspecialty training program must be graduates of a training program in internal medicine which is accredited by the Accreditation Council for Graduate Medical Education (ACGME); (Introduction, Definition and Scope of Specialty, Section I.A.2., CAAR-101, CIT:3.B;)

Fellows not trained in a program accredited by the ACGME must have at least 3 years of internal medicine training prior to beginning a fellowship. The program director must inform non-ACGME trained applicants before their appointment in writing of the American Board of Internal Medicine (ABIM) policies and procedures that may affect their eligibility for ABIM certification. (N.B.: Fellows in the subspecialty of geriatric medicine may be graduates of an ACGME-accredited family medicine training program.) (Introduction, Definition and Scope of Specialty, Section I.A.2., CAAR-102, CIT:4.D;)

Answer:

- The RRC-IM does not limit the number of international medical graduates appointed to a fellowship program.

- The RRC-IM does regulate the percentage of fellows who enter fellowship without having completed an ACGME accredited residency in internal medicine.
- The RRC-IM requires fellowship programs to maintain a rolling 5-year average of at least 75% of its current and former fellows having been graduates of an ACGME-accredited internal medicine residency program.
- Thus, up to 25% of fellows in the past 5 years may have completed internal medicine residency in osteopathic, international, or other non-ACGME-accredited internal medicine residency programs
- For these appointees, the program must ensure that:
 - All appointees have at least 3 years of internal medicine training (e.g., in osteopathic or international internal medicine residency) prior to appointment.
 - To ensure adequate competency in internal medicine because these fellows will be eligible to supervise internal medicine residents
 - All appointees are notified in writing that they will not be eligible for ABIM certification without repeating residency training at an ACGME-accredited IM residency program.
 - To prevent fellows from accepting an appointment under the mistaken impression that they will be able to obtain ABIM certification in the subspecialty at the completion of training.
- See IC/ CCEP PRs #1103: “All applicants entering IC/CCEP must have completed a cardiovascular disease program accredited by the ACGME. (N.B.: For exceptions see Program Requirements for fellowship Education in the Subspecialties of Internal Medicine.)”
 - The Nota Bene refers to General PR #102.
 - Therefore, 75% of IC/CCEP fellows must have completed all three years of cardiology prior to starting the Sub-Sub.
 - Non-ACGME-trained fellows are acceptable (up to 25%) but these fellows must have equivalent cardiology training prior to entering the Sub-Sub.

Integration with Core IM

Question:

“We have recently developed an affiliation with another institution that will provide salary support for additional fellows. Can our fellowship program develop a “track” for some of our fellows to spend most or all of their training at this site?”

Program Requirement:

To be eligible for accreditation, a subspecialty program must function as an integral part of an accredited residency program in internal medicine. (Introduction, Duration and Scope of Education, Section I.B.1., CAAR-104, CIT:3.B;)

Answer:

- No, stand-alone fellowship “tracks” [i.e., a subset of fellows spend the majority of their training at a separate site] are not allowed.
- Institutions may only sponsor fellowship training as a dependent subspecialty of the core internal medicine residency program.
- The major site of fellowship training must be at the same institution that sponsors the internal medicine residency program, or at a participating institution where there is a continuous presence of the sponsoring institution’s core residents and faculty.
- The fellowship program may develop affiliations and rotations at other participating institutions, as long as the fellow’s continuity experience is not interrupted for more than one month per year.

Program Director Reporting Relationship

Question:

“Why does the RRC-IM require that there be a “reporting relationship” to the core program?”

“We meet periodically to discuss the relationship of fellows and residents in the hospital. Does that fulfill this requirement?”

Program Requirement:

To ensure compliance with the ACGME accreditation standards, there must be a reporting relationship from the program director of the subspecialty program to the program director of the parent internal medicine residency program. (N.B.: The term subspecialty is used throughout this document for both types of training programs. (Introduction, Duration and Scope of Education, Section I.B.2., CAAR-105, CIT:3.B;)

Answer:

- The RRC-IM requires that each subspecialty PD reports to the core PD. The purpose of this requirement is to ensure that the subspecialty PD use the experience and oversight of the core PD to:
 - Understands and complies with PRs
 - Understands and implements competency-based educational program, QI projects, etc.
 - Ensure that the subspecialty and core PD coordinate changes in the residency or fellowship that may have an impact on either program.
- The RRC-IM expects the core PD to provide oversight of subspecialty programs. Oversight may be accomplished in a variety of ways (joint participation in departmental fellowship committee, joint meeting with the DIO, periodic meetings between core and sub PD, etc.). The RRC-IM will examine carefully for the presence of core PD oversight of each fellowship program.
 - Simply meeting to discuss interface of fellows and core residents, core resident rotations, etc. is insufficient.
- The Sub PD will cited for lack of reporting relationship
- The Core PD will cited when multiple subs have similar citations (e.g., curriculum, evaluation, continuity clinic) suggesting lack of oversight for compliance with Sub PRs.
- The RRC-IM expects the parent Sub PR to provide oversight of the Sub-Sub. The oversight can be through the parent Sub PD (i.e., core → cardiology → IC) or simultaneous (i.e., core → cardiology and IC) but the effect must be the same.

Section II. Institutions

Adequate Salary Support

Question:

“Ours is a small (3 fellow) program. What portion of my salary as a Sub PD should be provided by the institution?”

Program Requirement:

The sponsoring institution must assure that adequate salary support is provided to the program director for the administrative activities of the internal medicine subspecialty program. The program director must not be required to generate clinical or other income to provide this administrative support. It is suggested that this support be 25-50% of the program director’s salary, depending upon the size of the program. (See Section III.A.4.f) (Institutions, Sponsoring Institution, Section II.A.4., CAAR-204, CIT:1.B;)

Answer:

There are multiple administrative responsibilities and expectations for the subspecialty PD, including: developing and implementing the curriculum, planning and coordinating didactic conferences, evaluating the fellows/ faculty/ program, giving feedback to fellows and faculty, selecting faculty for teaching assignments, conducting semi-annual reviews, preparing the PIF, implementing the competencies, etc.

- The RRC-IM requires that each Sub PD be provided with “adequate” time to fulfill these administrative responsibilities.

- Programs will be cited if:
 - The PD judges that the salary support is inadequate to cover the time spent carrying out the administrative responsibilities of fellowship
 - The PD is required to generate clinical income to cover the cost of this administrative time.
- Note that “25-50% of the program director’s salary” is a suggested range to account for the different time commitment between small and large fellowships.

Institutional Affiliation Agreements and Program Letters of Agreement

Question:

“What is the difference between master affiliation agreements and program letters of agreement?”

Program Requirement:

Assignment to a participating institution requires a letter of agreement with the sponsoring institution. (Institutions, Participating Institution, Section II.B.2., CAAR-211, CIT:1.A;)

Current institutional agreements (i.e., master affiliation agreements) must exist between the Sponsoring Institution and all of its major participating institutions. (Institutional Review Committee Section II.B.2.)

The Sponsoring Institution must assure that each of its ACGME-accredited programs has established program letters of agreement (or memoranda of understanding) with its participating institutions in compliance with the specialty's Program Requirements. (Institutional Review Committee Section II.B.3.)

Answer:

- Master affiliation agreements (also referred to as institutional agreements) are agreements between a sponsoring institution and all major participating institutions involved in residency and fellowship education (Institutional Requirements, II.B.2). These are developed and maintained by the sponsoring institution.
- Each accredited program must develop and maintain program letters of agreement (or memoranda of understanding - MOU) with institutions/entities involved in educating residents/ fellows (Institutional Requirements, II.B.3).
- Program letters of agreement provide RRC members details on the educational rationale for designated assignments and include information on supervision, evaluation, educational content, length of assignment and policy and procedures for each off-site assignment. The primary purposes of these documents are to ‘protect’ the residents/ fellows and ensure an appropriate educational experience. So, unlike master affiliation agreements, which tend to be complex legal documents, program letters of agreement are intended to be short, less formal documents (approximately one-two pages in length) that specify, as simply as possible, the points noted above.
- In contrast to master affiliation agreements, program letters of agreement originate at the program (instead of the institutional) level, and are required for all rotations to institutions, not just those identified as major participating institutions.
- The RRC-IM requires program letters of agreement (MOU) for all routine rotations where residents/ fellows rotate, even if less than 1 month duration. The MOU must be current (within past 5 years), and signed by the Sub PD and the individual responsible for GME administration or resident/ fellow supervision at the site of the rotation (e.g., the local site director or the medical director).
 - Although the requirements do not specify that the program letters of agreement include the signature of the Designated Institutional Official (DIO), institutions may find it prudent to include this signature. The program director and DIO and, as needed, the governing body of the sponsoring institution should make this decision.
- Agreements should be updated whenever there are changes in program director or site director, resident/ fellow assignments, or revisions to the items specified in the PRs.

- The RRC-IM does not require a MOU for one-time electives.
- A program letter of agreement is not be required for a rotation within an integrated (i.e., same health center with shared faculty) institution.
 - Example: A residency program sponsored by a University Hospital that requires a month rotation at the Children’s Hospital would need a program letter of agreement if the two entities are operated by two different governing bodies (e.g., Board of Directors). However, if the two institutions operate essentially as one entity, that is, they are governed by a one governing body (e.g. Board of Directors), neither a master affiliation agreement nor a program letter of agreement would be necessary. This reasoning applies to all closely associated institutions, not only those between University and Children’s Hospitals.
 - A program letter of agreement would not be required for a rotation to an integrated institution if the written document that is required between the sponsor and the integrated institution incorporates the elements of the program letters of agreement (see below). Including all the required elements in the integration agreement will eliminate the need for a separate program letter of agreement and integration agreement.
- The following elements must be present in each MOU:
 - The faculty who will assume both educational and supervisory responsibilities for fellows
 - The faculty’s responsibilities for teaching, supervision, and formal evaluation of fellows
 - The duration and content of the educational experience at the participating institution
 - The financial agreements, and the details for insurance and benefits
 - The policies and procedures that will govern fellow education during the assignment

RRC-IM Notification and Approval for Participating Institutions

Question:

“Does our program need to notify the RRC-IM of a new rotation if we have adequate affiliation agreements?”

Program Requirement:

The Residency Review Committee (RRC) must give prior approval for participation by any institution that provides 3 months or more of training in a 12 or 24 month program; or 6 months or more of training in a 36 months (Institutions, Participating Institutions, Section II.B.3., CAAR-216, CIT:3.B;)

Answer:

RRC-IM notification and approval depends upon the total duration of the assignment.

- Program must notify RRC-IM and receive approval for institutions where fellows rotate routinely for 3 months or 6 months (depending on length of the accredited training program).
 - For 12- month programs (e.g., geriatrics), RRC-IM approval is required for rotations where fellows will spend 3 months or more of training.
 - For 24- month programs (e.g., endocrinology), RRC-IM approval is required for rotations where fellows will spend 3 months or more of training.
 - For 36-month programs (e.g., cardiology, pulm-cc), RRC-IM approval is required for rotations where fellows will spend 6 months or more of training
- These same criteria will be used to determine which institutions are listed as “Participating Institutions” in WebADS.

Section III. Program Personnel and Resources

Co-Program Director

Question:

“Are Co-Program Directors allowed?”

Program Requirement:

There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. (Program Personnel and Resources, Program Director, Section III.A.1., CAAR-300, CIT:1.B;)

Answer:

“Co-directors” are not accepted by the RRC-IM, except for Medicine-Pediatrics programs.

- Program may have one Associate PD (e.g., the PD of the future) who participates heavily in the operations of the program under the direction of the PD, but this individual must have sufficient administrative time and resources.
- At all times, the single PD must have at least 20 hours/ week dedicated to the residency program.

PD Responsibilities

Question:

“Can the RRC-IM clarify the extent or limitations of the PDs responsibilities for the subspecialty fellowship?”

Program Requirement:

The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership. (Program Personnel and Resources, Program Director, Section III.A.2., CAAR-302, CIT:1.B;)

[Responsibilities of the program director are as follows:] The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate fellows supervision at all participating institutions. (Program Personnel and Resources, Program Director, Section III.A.4.a), CAAR-307, CIT:1.B;)

Answer:

The RRC-IM expects that the program director will have full responsibility and full authority for all aspects of the training program. This includes:

- The PD must monitor fellow experiences and exercise the PD authority when the need arises (e.g., fellows complain about a faculty member, the PD determines a rotation has insufficient educational value, etc.).
- The PD must have the authority to make all fellow assignments.
- The PD must have the authority to revise clinical rotations as necessary to maintain fellow education.
- The PD must have the authority to remove fellows from services judged by the PD to have insufficient educational value.
- The PD must have the authority to deny admitting privileges to the inpatient subspecialty teaching service for selected physicians who fail to support the educational program.
- The PD must have the authority to remove selected faculty from teaching assignments based on fellow evaluations or issues of faculty competence/ expertise.
- Authority may be shared (e.g., with the division chef), if same effect can be demonstrated
 - Resolution of problem faculty, educationally marginal rotations, etc.

Program Director Qualifications

Question:

“Does the RRC-IM grant waivers for ABIM certification of the PD, if we can demonstrate ‘equivalent credentials’?”

Program Requirement:

[Qualifications of the program director are as follows:] The program director must be certified in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC-IM. (Program Personnel and Resources, Program Director, Section III.A.3.b), CAAR-304, CIT:3.A.)

Answer:

- Only ABIM certification is acceptable; no other credentials are accepted.
- The RRC-IM does not grant waivers for the ABIM-certification PR (for PDs or KCF).
 - Rationale: The RRC-IM uses ABIM certification as one of its major outcome measures. Furthermore, the ABIM publicly publishes program pass rates, and individual certification status. A major goal and outcome of each IM subspecialty training program has been the training of ABIM-certified graduates. ABIM-certified PD (and KCF) 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.
- 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 Sub IM program director must be ABIM-certified, and must maintain certification in the internal medicine subspecialty.
 - i.e., The Sub PD may allow core certification to lapse, but must maintain certification in subspecialty.
 - In combined fellowships (hematology-oncology, pulmonary-critical care) the PD must maintain certification in at least one subspecialty.
 - In Sub-Subs, the PD must maintain primary subspecialty certification
 - CCEP: cardiology and CCEP certification
 - IC: cardiology and IC certification
 - Transplant Hepatology (after 2010): gastroenterology and transplant
 - In IM-Geriatrics: the PD must maintain core IM and geriatrics

Exceptions to PD Certification Requirements:

Sleep:

Sleep PD may be ABMS certified in Neurology, Psychiatry, Pediatrics, ENT IF:

- The PD maintains Sleep Certification
- There is another ABIM-certified KCF who is also sleep certified

Geriatrics:

Geriatrics PD may be ABFM certified IF:

- Trained in an ACGME-accredited Internal Medicine Geriatrics fellowship, or in a Family-Medicine Geriatrics fellowship.
- Maintain current ABFM Geriatrics CAQ
- 5 years or more experience as a geriatrics faculty member in an internal medicine residency or in an internal medicine IM-Geriatrics fellowship.
- Demonstrate the ability to establish and maintain an environment of inquiry and scholarship to the same degree as required for IM-Subspecialty KCF.
 - Actively engaged in the Scholarship of Discovery or Dissemination (See III.B.4) as evidenced by at least three (3) products of scholarship in any of the following categories in the past three years: peer-review manuscripts, peer-review grants, book chapters, review articles in peer-review publications, or editorials in peer-review publications.
 - Abstracts and presentations alone will not meet this requirement.
- Recommended by the Core IM residency director for outstanding teaching and administrative ability

Question:

“Does the RRC-IM-IM grant waivers for the 5-year faculty requirement for program director qualifications?”

Program Requirement:

[Qualifications of the program director are as follows:] The program director must have at least 5 years of participation as an active faculty member in an internal medicine subspecialty fellowship program accredited by the ACGME. (Program Personnel and Resources, Program Director, Section III.A.3.d), CAAR-306, CIT:3.A;)

Answer:

The Committee feels strongly that five years as IM subspecialty faculty in an ACGME-accredited fellowship program is an important prerequisite for the responsibilities of the PD in order to have adequate subspecialty and GME expertise, and sufficient institutional creditability to direct a training program and to ensure compliance with the PRs.

- Waivers for the 5-year faculty experience PR are not granted.
- The RRC-IM requires the program director of an internal medicine subspecialty program to have at least 5 years experience as a subspecialty faculty in a teaching hospital.
- This experience does not include time spent in fellowship training.

However, the rules for PD qualifications are different for new subspecialty programs.

- Instead of requiring the PD of a new subspecialty program to have been a KCF in a subspecialty fellowship, the RRC-IM requires at least 5 years functioning as a faculty subspecialist either in a subspecialty fellowship, in a core residency program, or a combination thereof. This allows institutions to start new fellowship programs with existing faculty, rather than recruiting the PD from outside of the institution.

RRC-IM Notification/ Approval Required

Question:

“What changes in the program require notification of (or approval by) the RRC?”

Program Requirement:

[Responsibilities of the program director are as follows:] The program director must seek prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the fellows. Such changes, for example, include: the addition or deletion of a participating institution. [On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.] (Program Personnel and Resources, Program Director, Section III.A.4.d)(1), CAAR-310, CIT:3.B;)

[Responsibilities of the program director are as follows:] The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the fellows. Such changes, for example, include: a change in the format of the educational program. [On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.] (Program Personnel and Resources, Program Director, Section III.A.4.d)(2), CAAR-311, CIT:3.B;)

[Responsibilities of the program director are as follows:] The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the fellows. Such changes, for example, include: a change in the approved fellow complement i.e., any temporary or permanent increase in the total number of enrolled fellows). [On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.] (Program Personnel and Resources, Program Director, Section III.A.4.d)(3), CAAR-312, CIT:3.B;)

The RRC will approve the number of fellows based upon established written criteria that include the adequacy of resources for fellows education (e.g., the quality and volume of patients and related clinical material available for education), faculty-fellow ratio, institutional funding, and the quality of faculty teaching. (Fellow Appointment, Number of Fellows, Section IV.B., CAAR-401, CIT:2.A;)

Answer:

The following changes require RRC-IM notification and/ or approval:

- Major disruptions in the institutional affiliation, governance, stability, etc. require immediate RRC-IM notification via Web ADS.
- A major loss of program faculty (i.e., the program no longer meets the minimum number of KCF required in the program requirements) requires immediate RRC-IM notification via Web ADS.
- Programs must request approval for all complement increases, even temporary increases (e.g., maternity leave extends fellow's training by 3 months; when the fellow returns the program is 1 over the limit). Rationale: to avoid discrepancies with the WebADS data base. Complement changes are very easily accomplished using WebADS on-line.
- A complement increase requires documentation of adequate patient population, staff, facilities, faculty, research opportunities, and an educational rationale for increase.
- RRC-IM approval is required for
 - 1) Tracks that include interrupted training (e.g., MPH sandwiched between accredited training years)
 - 2) Adding a track (a program structure available to a subset of fellows in the program) or major alterations in program structure requires RRC-IM notification and prior approval.
 - 3) Training that results in interruption of continuity clinic for 6 or more weeks (e.g., an overseas rotation) RRC-IM notification and approval should occur through WebADS via the expedited review process. The RRC-IM reviews all such tracks (and other variances) at each subsequent accreditation review.
- RRC-IM approval is not required for:
 - 1) Individual variations in training (e.g., parental leave, medical LOA)
 - 2) Individual interruptions in training that are not part of an established track (e.g., an individual fellow obtaining an MPH or PhD between years 1 and 3)
 - 3) Fellows in additional non-accredited years of training (e.g., extra year of research) do not count against complement.
 - 4) A program that is under its approved complement, unless the reduction will be permanent.
- The RRC-IM will not grant a permanent increase in fellow complement under the following circumstances:
 - If the program's last accreditation status included a warning.
 - In the interval between the time of the site visit and posting on WebADS of the Letter of Notification (typically ~ 60 days following the RRC-IM Committee meeting).

Monitor Stress

Question:

“How should the PD monitor fellow stress?”

Program Requirement:

The program director is responsible for monitoring fellow stress (including mental or emotional conditions inhibiting performance or learning) and drug- or alcohol-related dysfunction. (Program Personnel and Resources, Program Director, Section III.A.4.e)

Answer:

The RRC-IM expects that the PD will monitor the well being of fellows in the program through a variety of sources: faculty evaluations, peer and other 360 evaluations, semiannual reviews, administrative meetings with the fellows, reports from KCF, and day-to-day observations. Fellows should feel comfortable discussing concerns and problems with the faculty and program director. The program director should make appropriate interventions (e.g., referral to employee assistance program) as needed.

Educational Faculty CME

Question:

“What is required for PD and KCF Educational CME?”

Program Requirement:

The program director must participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills. (Program Personnel and Resources, Program Director, Section III.A.4.g), CAAR-317, CIT:3.B;)

The program director must implement a program of continuous quality improvement in medical education for the faculty, especially as it pertains to the teaching and evaluation of the ACGME Competencies (as outlined in Section V.D. of this document). (Program Personnel and Resources, Program Director, Section III.A.4.h), CAAR-318, CIT:1.B;)

Answer:

- **PD:** The program must demonstrate CME to improve both education (teaching, specialty expertise) and administrative (GME) skills of the program director. Examples: APDIM or AAIM meetings, ACGME conferences, subspecialty PD meetings, etc.
- **KCF:** The PD and/or DIO must organize CME for faculty regarding fellowship education and competencies.
 - This faculty development can occur in a variety of ways (e.g., faculty meetings, web-based faculty curricula, assigned readings, e-mail updates, focused instruction, etc.) that promote continuous improvement of the faculty.
 - Locally organized meetings are acceptable (and encouraged).
 - Faculty attendance at specialty meetings alone is insufficient, unless special sessions on fellowship education and competencies are included in the sessions attended.

KCF ABIM Certification and Responsibilities

Question:

“How can we obtain an exception to the KCF certification requirements?”

Program Requirement:

[Qualifications of the physician faculty are as follows:] The physician faculty must be certified in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC. (Program Personnel and Resources, Faculty, Section III.B.3.b), CAAR-324, CIT:3.C;)

[Qualifications of the key clinical faculty are as follows:] Key Clinical Faculty must be certified in the subspecialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable. (Program Personnel and Resources, Faculty, Section III.B.6.a)(2), CAAR-340, CIT:3.C;)

[Responsibilities for the key clinical faculty are as follows:] In addition to the responsibilities of all individual faculty, the key clinical faculty, together with the program director, are responsible for the planning, implementation, monitoring and evaluation of the fellow’s clinical and research training. (Program Personnel and Resources, Faculty, Section III.B.6.b), CAAR-341, CIT:3.D;)

Answer:

The RRC-IM applies faculty certification requirement only to the PD (#304) and KCF (#324 and #340).

- The minimum required number of KCF (the minimum number varies by specialty and by the number of fellows approved) must be ABIM certified and maintain certification in the subspecialty (see Appendix 1)
- KCF may allow core certification to lapse
 - Geriatrics KCF must maintain core IM and IM-Geriatrics (or core FM and FM-Geriatrics) certification
 - Cardiology Sub-Sub KCF (CCEP, IC) must maintain both cardiology and sub-sub certification
 - After 2010, Transplant Hepatology KCF must maintain both GI and Transplant certification
- Extra KCF (over minimum number required) do not need ABIM certification
 - But, these additional KCF may contribute to KCF scholarship productivity if they meet all other KCF criteria.
 - Non-KCF other faculty do not need ABIM certification, but they may not contribute to the KCF scholarship productivity count.

KCF responsibilities are 10 hours/ week (average) devoted to the program, and:

- Supervision
- Teaching (Including conferences)
- Scholarship
- Specialty expertise
- Mentorship
- Commitment (to the fellows, the Competencies, the program, etc.)

KCF Scholarship and Productivity

Question:

“Can you please explain how many publications are required of the Key Clinical Faculty. Can we count abstracts and presentations at specialty meetings?”

Program Requirements:

The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. (Program Personnel and Resources, Faculty, Section III.B.4., CAAR-328, CIT:3.D;)

[Scholarship is defined as the following:] the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal; (Program Personnel and Resources, Faculty, Section III.B.4.a), CAAR-329)

[Scholarship is defined as the following:] the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks; (Program Personnel and Resources, Faculty, Section III.B.4.b), CAAR-330)

The majority of key clinical faculty must demonstrate evidence of productivity in the scholarship of discovery or dissemination as defined in III B 4 a) or b) above. (Program Personnel and Resources, Faculty, Section III.B.4.e), CAAR-334, CIT:4.I;)

Answer:

- The RRC-IM requires that all fellows train in an environment of inquiry, scholarship, and research productivity
- The RRC-IM requires KCF scholarship Participation and Productivity in scholarship of discovery (329) and dissemination (330). (**See Appendix 1**)
 - Participation standard: 51% of certified, minimum required number KCF must demonstrate at least 1 “Publication” past three years. (See definition of acceptable publication below)

- Productivity standard: Total “Publications” for all KCF (including non-certified) must = at least 1 publication / year x 3 years x the majority-of-minimum required KCF.

The RRC-IM defines the scholarship of discovery or dissemination – to meet KCF scholarship requirements – as follows:

- Publication of original research in a peer-reviewed journal
- Publication of a review article in a peer-reviewed journal
- Publication of an editorial in a peer-reviewed journal
 - The RRC-IM defines a peer-review publication as a journal indexed in Pub Med (or MEDLINE). For publications not listed by either indexing service, the program must demonstrate evidence that the journal is indexed by an abstracting and indexing resource with a documented process for selection (see list below).
 - For peer-reviewed publications NOT indexed in PubMed (or MEDLINE), the program director will be expected to submit the following information at the time of submission of the PIF: Evidence that the journal is indexed in one of the following: EMBASE, BIOSIS, Current Contents/Web of Science, CINAHL, PsychINFO, Google Scholar, Scirus, Biomed Net, Scopus, or Chemical Abstracts.
- Chapters published in textbooks (full citation required including publisher and date)
 - This includes chapters published in specialty society review texts, such as MKSAP, NephSAP, ACCSAP, and the Geriatrics Review Syllabus.
- Peer-review funding such as NIH, NCI, VA, AHRQ or other funding organizations external to the sponsoring institution such as research foundations (e.g., Robert Wood Johnson or Hartford Foundations), subspecialty societies (e.g., American Society of Nephrology), or health organizations (e.g., American Diabetes Association, American Heart Association).
 - In press or accepted for publication counts.
 - Submitted or in preparation does not count.
 - Multi-author papers may be counted for only one KCF
 - The RRC will count the last three calendar years prior to PIF submission.
Example: If site visit is in September 2005, count publications from 2002, 2003, and 2004 as well as 2005.

The following will not fulfill requirements for KCF scholarship:

- Abstracts
- Case reports
- Presentations
- Non peer-reviewed publications
- Publications in journals not indexed in PubMed (or MEDLINE), unless the program provides evidence that the journal is indexed by an abstracting and indexing resource with a documented process for selection
- Non-peer review funding, such as industry funding, or internal institutional funding.

Summary/ Example: for a 6-fellow Endo, Heme, ID, Neph, Onc, Pulm, or Rheum program, 4 KCF (including PD) are required.

- Three of these 4 must have at least one publication (as defined) in the three calendar years preceding submission of the PIF.
- ALL KCF (the minimum number plus any additional KCF) must have produced at least nine (9) such publications in the past three years.

See summary of KCF minimum numbers and research productivity in **Appendix I**

Gender and Age Diversity

Question:

“How can subspecialty programs meet the 25% gender requirement?”

Program Requirement:

There must be patients of both sexes, with a broad age range, including geriatric patients. (Program Personnel and Resources, Resources, Section III.D.5.b), CAAR-353, CIT:4.F;)

Over the course of accredited training, each fellow's panel of patients must include at least 25% of patients from each gender. (Program Curriculum, Clinical, Section V.F.2.c), CAAR-537, CIT:1.E;)

Answer:

- For subspecialties (but not for core residency programs) the gender rule can be averaged over the duration of the program. Over the duration of accredited training, the patient population must consist of at least 25% from each gender.
- In Subs, the 25% gender mix rule is applied primarily to continuity clinics.
 - However, if the inpatient experience is exclusively (or nearly so) male or female, the program will be cited for gender inadequacies.
 - If the inpatient or outpatient experience lacks exposure to geriatric patients, the program will be cited for geriatric inadequacies.
- Therefore, programs can use VA clinics in 6 months blocks combined with non-VA clinics, as long as the gender mix over the duration of the accredited program (i.e., 1-year, 2-year, 3-year) is at least 25% averaged across each fellow's continuity clinics.

Section IV. Fellowship Appointment

Prior Approval – Maximum Number of Fellows

Please see discussion under Section III “RRC-IM Notification/ Approval Required” above.

Written Lines of Responsibility

Question:

“What does the RRC require in the written lines of responsibility?”

Program Requirement:

Fellows must have clearly defined written lines of responsibility for all clinical experiences. (Fellow Appointment, Fellows Responsibilities and Professional Relationships, Section IV.E., CAAR-404, CIT:2.A;)

Answer:

Written Lines of Responsibility (LOR) must spell out reporting relationships and supervisory responsibilities between all learners and supervisors on all teaching services
e.g., on an MICU rotation, the patient care responsibilities, supervisory responsibilities, and reporting relationships must be stipulated (for interns, residents, fellows, and attendings) in writing and available to all learners and supervisors.

Section V. Program Curriculum

Program Design Approval

Question:

“Our Endocrinology program is three years in length in order to add an additional year of research. Can we stretch out the required clinical training over the three years?”

Program Requirement:

The program design and sequencing of educational experiences will be approved by the RRC as part of the accreditation process. (Program Curriculum, Program Design, Section V.A.1., CAAR-500, CIT:4.B;)

Answer:

No

All required training must be completed within the accredited years of training.

Additional year(s) of training (i.e., for research) may be required, or offered, by the program, but the required training, must be completed during the accredited years of training – during the accredited one year (IC, CCEP, Geriatrics, 1-year Critical Care, Sleep, Transplant Hepatology), three years (Cardiology, GI, Heme-Onc, Pulm-CC) or two years (all other fellowships).

Some programs encourage additional continuity clinic and additional clinical experiences during the additional (unaccredited) year, but these must be over and above the required training, which must be completed during the accredited training years.

Modifications of training for combined training (e.g., Critical Care – Infectious Diseases), or extended training for MPH, are reviewed case-by-case by the RRC and requires prior approval by the RRC – based on educational rationale, individual accommodation versus proposed routine program element, interrupted training (clinical and didactic), etc. These also require prior approval from the sponsor’s GMEC/DIO and or ABIM.

Autopsies and Death Review

Question:

“What is meant by a Death Review?”

“If autopsy reports are posted on the electronic laboratory information system, will that meet the requirements for autopsy reports?”

Program Requirement:

All deaths of patients who received care by fellows must be reviewed and autopsies performed whenever possible. (Program Personnel and Resources, Resources, Section III.D.6.a), CAAR-355, CIT:4.E;)

Fellows must receive autopsy reports after autopsies are completed on their patients. (Program Personnel and Resources, Resources, Section III.D.6.b), CAAR-356, CIT:4.E;)

Answer:

- There must be a quality assurance mechanism through which the program, the department, or the institution reviews deaths of patients cared for by fellows (and residents). This review provides assurance that all trainees were properly supervised and that care was appropriate.
- There must be a mechanism for obtaining autopsies, even if the autopsy rate is low.
- The fellow must receive autopsy reports on all patients for whom the fellow had primary responsibility.
 - If patient was cared for by residents with fellow supervising (or consulting), then only primary resident need receive autopsy report.
- Report availability alone is insufficient; the fellow must be sent the report either paper or electronically, or must be notified when the autopsy report has been posted.

Rationale: final autopsy reports are sometimes not available for 1-3 months after completion of the initial post mortem examination because of the need for special studies/ preparation/ stains/ etc. (especially the brain and microbiologic studies). The educational experience cannot hinge on the fellow’s motivation and persistence to repeatedly look up the autopsy result until the final result is available.

Curriculum

Question:

“Our program has posted the written curriculum on the Web. Why were we cited for failure to review the goals and objectives at the start of each rotation?”

Program Requirement:

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of fellows for each major assignment and for each level of the program. (Program Curriculum, Program Design, Section V.A.2., CAAR-501, CIT:4.B;)

This [written] statement must be distributed to fellows and faculty.... (Program Curriculum, Program Design, Section V.A.2., CAAR-502, CIT:3.B;)

[This [written] statement...] must be reviewed with fellows prior to their assignments. (Program Curriculum, Program Design, Section V.A.2., CAAR-503, CIT:3.B;)

[For each rotation or major learning experience, the written goals and objectives:] should include the educational purpose; teaching methods; the mix of diseases, patient characteristics, and types of clinical encounters, procedures, and services; reading lists, pathological material, and other educational resources to be used; and a method of evaluation of fellow competence; (Program Curriculum, Program Design, Section V.A.2.a), CAAR-504, CIT:4.B;)

[For each rotation or major learning experience, the written goals and objectives:] must define the level of fellows' supervision by faculty members in all patient-care activities; (Program Curriculum, Program Design, Section V.A.2.b), CAAR-505, CIT:4.B; CIT:4.J;)

[For each rotation or major learning experience, the written goals and objectives:] should be reviewed and revised at least every 3 years by faculty members and fellows to keep it current and relevant. (Program Curriculum, Program Design, Section V.A.2.c), CAAR-506, CIT:4.B;)

Answer:

The program must prepare a written curriculum for all rotations, learning experiences, and continuity clinic.

- The written curriculum must be rotation specific, and PGY-level specific.
- The written curriculum must be distributed to fellows and faculty.
- The goals and objectives of the rotation or learning experience (not the entire written curriculum) must be discussed by faculty with fellows at the start of each rotation. However, for repeat rotations within the same year, the goals and objectives need to be reviewed only prior to the first such rotation.
The following are insufficient, if the only “review:”
 - Curriculum distributed at start of academic year for all rotations, but no review at start of each rotation.
 - The curriculum is “available on the web” or e-mailed to faculty and fellows at start of assignment. However, the fellows and faculty do not review the goals, objectives, and expectations together.
 - A brief orientation to the mechanics of the service occurs at the start of the assignment without a true review of the educational goals and objectives.
- The written curriculum must contain all the elements called for in V.A.2.a.-b.
- There must be a written curriculum for each rotation and for continuity clinic.
- The written curriculum must be reviewed and revised at least every three years, by a team including the PD, KCF, and at least one fellow representative.

Fellow Research

Question:

“What are the research requirements for fellows?”

Program Requirement:

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities. (Program Curriculum, Fellows Scholarly Activities, Section V.C.1., CAAR-508, CIT:4.I;)

Participation in an active research program is an essential component for fellows enrolled in subspecialty fellowship training programs of 24 months or greater duration. (Program Curriculum, Fellows Scholarly Activities, Section V.C.2., CAAR-509, CIT:4.I;)

The program must ensure a meaningful, supervised research experience with appropriate protected time for each fellow--either in blocks or concurrent with clinical rotations-- while maintaining the essential clinical experience. (Program Curriculum, Fellows Scholarly Activities, Section V.C.2.a), CAAR-510, CIT:4.I;)

Fellows must be advised and supervised by qualified faculty members in the conduct of research. (Program Curriculum, Fellows Scholarly Activities, Section V.C.2.b), CAAR-511, CIT:4.I;)

Fellows must learn the standards of ethical conduct of research, design and interpretation of research studies, responsible use of informed consent, research methodology, and interpretation of data. (Program Curriculum, Fellows Scholarly Activities, Section V.C.2.c), CAAR-512, CIT:4.I;)

The majority of fellows must demonstrate evidence of recent research productivity through publication (manuscripts or abstracts) in peer-reviewed journals, or through abstracts presented at national specialty meetings. (N.B.: Training programs in critical care medicine, internal medicine-geriatric medicine, and internal medicine-sports medicine are exempt from this requirement.) (Program Curriculum, Fellows Scholarly Activities, Section V.C.2.d) (1) and (2), CAAR-513, CIT:4.I;)

Answer:

- All fellows must train in an environment of scholarship, inquiry and research.
- At a minimum, the RRC-IM expects all fellows to have:
 - A research mentor
 - At least one research project to be completed during training
 - Sufficient protected time – either in blocks or time concurrent with clinical rotations – to complete the project.
 - Exceptions:
 - No fellow research is required for geriatrics or for 1-year critical care programs (2-year critical care programs must meet the fellow research requirements).
 - Fellows in CCEP, IC, Transplant, and Sleep must participate in scholarly activity (i.e., research projects, enrollment of patients in clinical trials, or QI/ performance improvement projects).

The RRC-IM also expects fellows to demonstrate evidence of productivity in scholarship.

- This productivity can be scholarship of discovery or dissemination (the KCF standard) or scholarship of application such as abstracts and presentations.
- The productivity must reflect research/ scholarship completed during fellowship, although the publication/ presentation may occur after the fellow completes the program.
- At the time of the PIF submission, 51% of the fellows in the previous three graduating classes must demonstrate:
 - Manuscript(s) published
 - Or Case Reports published

- Or Abstract(s) published
 - In journal, or specialty abstract book
- Or Abstract(s) presented
 - At national specialty society meeting
- 1-year programs are exempt from the fellow research productivity requirement.

Competencies

Question:

“What are the minimum requirements for compliance with the competency requirements?”

Program Requirement:

The fellowship program must require its fellows to obtain competence in the six areas listed below to the level expected of a new practitioner. (Program Curriculum, ACGME Competencies, Section V.D., CAAR-514, CIT:4.D;)

Patient Care: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] patient care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health. (Program Curriculum, ACGME Competencies, Section V.D.1., CAAR-515, CIT:4.D;)

Medical Knowledge: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care. (Program Curriculum, ACGME Competencies, Section V.D.2., CAAR-516, CIT:4.D;)

Practice-Based Learning and Improvement: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care. (Program Curriculum, ACGME Competencies, Section V.D.3., CAAR-517, CIT:4.D;)

Interpersonal and Communication Skills: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals. (Program Curriculum, ACGME Competencies, Section V.D.4., CAAR-518, CIT:4.D;)

Professionalism: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. (Program Curriculum, ACGME Competencies, Section V.D.5., CAAR-519, CIT:4.D;)

Systems-Based Practice: [Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate:] systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Program Curriculum, ACGME Competencies, Section V.D.6., CAAR-520, CIT:4.D;)

Answer:

- The RRC-IM will examine fellowship programs carefully at the time of each accreditation review for evidence of the following:
 - A competency-based written curriculum
 - Awareness and understanding of the competencies and outcomes by all fellows
 - Awareness and understanding of the competencies and outcomes by faculty
 - Competency-based Semi-Annual Reviews by the PD
 - Competency-based Global Ratings by faculty
 - Competency-based Advancement Criteria
 - The use of Direct Observation and Reflection Exercises to assess competency i.e., Mini-CEX, OSCE, Checklists, Simulators, etc.
 - The use of Problem Based Learning and Improvement Exercises to assess competency i.e., Chart Audit, Portfolios, Vignettes, Chart Stimulated Recall, etc.
 - A system to log procedural competency with Procedure Logs (**See Appendix II**)
 - The use of 360 Evaluations to assess competency i.e., Patients, Peers, Nurses, etc.
 - The use of competency-based Summative Evaluations
 - At least one active competency-based Performance Improvement Project at all times

Conference Requirements

Question:

“The core conference requirements seem to have changed. Does the RRC still require a basic science conference or an M&M conference for fellows? What does the RRC mean by a core curriculum conference series?”

Program Requirement:

Conferences must be conducted regularly as scheduled and must be attended by faculty and fellows. At a minimum, these must include at least one clinical conference weekly; one literature review conference (journal club) monthly; one research conference monthly; and at least one core curriculum conference weekly, when averaged over 1 year. (Program Curriculum, Didactics, Section V.E.2.a)(1) - (4), CAAR-523, CIT:4.E;)

The core curriculum conference series must include the basic sciences relevant to the subspecialty. (Program Curriculum, Didactics, Section V.E.2.a)(4)(a), CAAR-524, CIT:4.E;)

The core curriculum conference series must cover the major clinical topics in the subspecialty. (Program Curriculum, Didactics, Section V.E.2.a)(4)(b), CAAR-525, CIT:4.E;)

The core curriculum conference series must be repeated frequently enough, or be made available for review on tape or electronically, to afford each fellow an opportunity to attend or review most of the core conference topics. (Program Curriculum, Didactics, Section V.E.2.a)(4)(c), CAAR-526, CIT:4.E;)

Fellows must participate in formal review of gross and microscopic pathological material from patients who have been under their care. (Program Curriculum, Didactics, Section V.E.2.b), CAAR-527, CIT:4.E;)

Fellows must participate in planning and in conducting conferences. (Program Curriculum, Didactics, Section V.E.2.c), CAAR-528, CIT:4.E;)

Fellows should become proficient in the critical assessment of medical literature, medical informatics, clinical epidemiology, and biostatistics. (Program Curriculum, Didactics, Section V.E.3.a), CAAR-529, CIT:4.E;)

Educational experiences should include instruction in clinical ethics, medical genetics, quality assessment, quality improvement, patient safety, risk management, preventive medicine, pain management, end-of-life care, and, physician impairment. (Program Curriculum, Didactics, Section V.E.3.b)(1) - (10), CAAR-530, CIT:4.E;)

Faculty and fellows must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects. (Fellow Duty Hours and the Work Environment, Supervision of Fellows, Section VI.A.3., CAAR-603, CIT:4.K.8:)

Answer:

The RRC-IM requires the program to provide at least 10 conferences per month attended by fellows and faculty:

- Four (once weekly, averaged over 1 year) core curriculum conferences
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.
 - The core curriculum is a planned course in the subspecialty.
 - It must cover the major topics in the subspecialty
 - It must incorporate the multidisciplinary topics listed in V.E.3.b)(1), as well as education in the recognition and effects of sleep deprivation.
 - Programs need not produce separate conferences on each topic, but each interdisciplinary topic must be included in core conference series, or discussion at case conferences, research conferences, and/or journal clubs.
 - It is distinct from a case conference, though it may be case based.
 - Basic science conference no longer required for Subs. Instead basic sciences should be covered at core curriculum and case conferences.
- Four (once weekly) clinical case conferences
 - Include review of pathologic material.
 - A separate M&M or CPC is not required for Subs. But pathological material must be reviewed at the required fellow case conferences.
 - Basic science conference no longer required for Subs. Instead basic sciences should be covered at core curriculum and case conferences.
- One (once monthly) journal club
- 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.
- There must be a mechanism for fellows who miss a core curriculum conference (day off, post-call, vacation, off-campus rotation, etc.) to recoup or make up the missed educational experience. The Committee accepts a variety of solutions, as long as fellows have the opportunity to experience missed core curriculum conferences. The solutions to this issue are all local, and depend partially on why fellows miss conference (post-call, day-off, away rotation). Note that the standard applies to core curriculum conferences. A variety of solutions are acceptable, including but not limited to:
 - Videotaping
 - Web casting
 - Making slides available on the web
 - Repeating conferences
 - A parallel conference series at the off-site location

Faculty Supervision in Clinic

Question:

“Does the faculty supervising fellows in clinic need to be present, on-site, during the fellow’s clinical encounter with the patient?”

Program Requirement:

There must be on-site faculty whose primary responsibilities include the supervision and teaching of fellows. (Program Curriculum, Clinical, Ambulatory Medicine, Section V.F.1.a), CAAR-531, CIT:3.D; CIT:4.E;)

Answer:

The RRC-IM expects that the ultimate supervision of fellows will be from a physician faculty member.

- That supervision must be on-site (i.e., not by telephone) and concurrent (i.e., in outpatient settings, the fellow must present the case to the physician faculty prior to the patient leaving clinic).
 - “Remote control” supervision (e.g., attending available by phone) is not acceptable in outpatient settings

Rationale: The attending must have the opportunity to interview/ examine all patients at the time he/ she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary.

Faculty assigned to clinic must have resident/ fellow teaching and supervision as their primary mission.

- Faculty must not be expected to see their own patients simultaneously IF this negatively impacts their supervisory and teaching responsibilities.

Continuity Clinic

Question:

“What are the new regulations regarding continuity clinic in subspecialty programs?”

Program Requirement:

Fellows must have a continuity ambulatory clinic experience 1/2-day each week to develop a continuous healing relationship with patients for whom they provide subspecialty care. (Program Curriculum, Clinical, Section V.F.2.a), CAAR-534, CIT:1.E;)

This continuity experience should expose fellows to the breadth and depth of the subspecialty. (N.B.: This continuity requirement may vary by subspecialty.) This may be accomplished by either: a single continuity clinic for the length of the accredited fellowship, or blocks of at least 6 months in duration for the length of the accredited fellowship. (Program Curriculum, Clinical, Section V.F.2.a)(1) & (2), CAAR-535, CIT:1.E;)

Each fellow should, on average, be responsible for four to eight patients during each 1/2-day session. (Program Curriculum, Clinical, Section V.F.2.b), CAAR-536, CIT:1.E;)

Over the course of accredited training, each fellow’s panel of patients must include at least 25% of patients from each gender. (Program Curriculum, Clinical, Section V.F.2.c), CAAR-537, CIT:1.E;)

Each fellow’s clinical experiences with ambulatory patients must provide an opportunity to observe and to learn the course of disease. (Program Curriculum, Clinical, Section V.F.2.d), CAAR-538, CIT:1.E;)

The continuing patient-care experience should not be interrupted by more than 1 month, excluding a fellow's vacation. . (Program Curriculum, Clinical, Section V.F.2.e), CAAR-539, CIT:1.E;)

During the continuity experience, arrangements should be made to minimize interruptions of the experience by fellows' duties on inpatient and consultation services. (Program Curriculum, Clinical, Section V.F.2.f), CAAR-540, CIT:1.E;)

Answer:

Subspecialty fellowship programs may organize their continuity clinics in either the traditional weekly clinic over the duration of the program, or in blocks of weekly clinics no shorter than 6 months duration. This allows fellows to be exposed “...to the breadth and depth of the subspecialty... to observe and to learn the course of disease and...

to develop a continuous healing relationship with patients for whom they provide subspecialty care....”

- The Committee requires fellows to attend a continuity clinic at least one half-day each week, except that the PD may excuse fellows from clinic up to 4 weeks/ year in addition to vacation.
- The continuity clinic must occur throughout accredited training, including research.
- Time spent in continuity clinic cannot be “deducted” from required clinical training.
 - e.g., a 36-month Heme-Onc program requires at least 18 months clinical, PLUS 18 additional months of continuity clinic during research.
- Continuity clinic blocks may be no shorter than 6 months, but may be longer.
- If the program uses alternating clinics (i.e., alternating continuity clinics every other week), then the minimum block is 12 months.
- The Committee no longer requires tracking of new and return patients.
 - 4-8 is averaged over the year, and applies only to continuity clinic (not to other ambulatory experiences).
- There is no rule in the Subs specifying the minimum number of weekly clinics per fellow (i.e., the “108 rule” in core IM programs.). Therefore:
 - The PD may excuse fellows from up to 4 weeks of continuity clinic per year (not counting vacation).
 - Each fellow’s continuity clinic must therefore occur 48 weeks (52 minus 4) per year, not counting vacation, unless RRC grants a variance (i.e., for away rotations).
 - Pulmonary and Critical Care Medicine fellows are excused from continuity clinic during intensive care rotations.

Required Procedures

Question:

“What Procedures must be tracked in the fellow’s procedure log?”

Program Requirement:

Fellows must develop a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline. (Program Curriculum, Clinical, Section V.F.3.a), CAAR-542, CIT:4.G;)

Fellows must acquire knowledge of and skill in educating patients about the rationale, technique, and complications of procedures, and in obtaining procedure-specific informed consent. (Program Curriculum, Clinical, Section V.F.3.b), CAAR-543, CIT:4.G;)

Faculty must supervise the procedures performed by each fellow until proficiency has been acquired and documented by the program director. (Program Curriculum, Clinical, Section V.F.3.c), CAAR-544, CIT:4.G;)

Each program must identify key procedures. (Program Curriculum, Clinical, Section V.F.3.d)(1), CAAR-545, CIT:4.G;)

Each program must define a standard for procedural proficiency. (Program Curriculum, Clinical, Section V.F.3.d)(2), CAAR-546, CIT:4.G;)

Each program must assure that fellows log all key procedures performed. (Program Curriculum, Clinical, Section V.F.3.d)(4), CAAR-548, CIT:4.G;)

The record of evaluation should document that records were maintained by documentation logbook or by an equivalent method to demonstrate that fellows have achieved competence in the performance of invasive procedures. (Evaluation, Fellow, Section VII.A.1.c)(2), CAAR-706, CIT:4.G;)

Answer:

Each Specialty has developed a list of required procedures for which fellows must develop:

- "...a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline...."
- "...knowledge of and skill in educating patients about the rationale, technique, and complications of procedures, and in obtaining procedure-specific informed consent...."
- Competency in performance and interpretation.

See **Appendix II** below for the list of procedures which must be tracked for each specialty.

Section VI. Fellow Duty Hours and the Work Environment

Duty Hours Monitoring

Question:

"What the RRC-IM will accept as documentation of compliance with the new work hours rules? Will fellow self report be sufficient, if supported by clearly structured, written schedule plans? Or will the RRC-IM-IM insist on objective documentation of time in/out (i.e., time card system)?"

Program Requirement:

Providing fellows with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and fellows' well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of fellows' time and energy. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients. (Fellow Duty Hours and the Work Environment, Section VI., CAAR-600, CIT:4.H;)

Answer:

- The RRC-IM-IM defers to programs and institutions the specifics of documentation of compliance with duty hours requirements.
- The RRC-IM will rely on fellow reporting (i.e., the Fellow Questionnaire, the ACGME Resident Survey, and the Fellow Interview at the site visit) and review of fellow schedules in its accreditation decision regarding duty hours compliance.
- The RRC-IM will consider additional information collected by the program (e.g., duty hour logs, periodic surveys, etc.) in its determination of compliance.
- Programs may be asked to respond to concerns identified in the ACGME Resident Survey between site visits, and the RRC expects the program to be able to document substantial compliance.

Faculty Supervision

Question:

"What is adequate availability of the faculty for supervision in the hospital? What is adequate faculty availability in the clinic?"

"One of our attendings sees private patients in his office 1 block from the resident's clinic and reviews the cases with the PGY-3 residents at the end of the half-day. Residents can call him with questions at any time."

Program Requirement:

All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty. (Fellow Duty Hours and the Work Environment, Supervision of Fellows, Section VI.A.1., CAAR-601, CIT:4.J;)

Faculty schedules must be structured to provide fellows with continuous supervision and consultation. (Fellow Duty Hours and the Work Environment, Supervision of Fellows, Section VI.A.2., CAAR-602, CIT:4.J.)

Answer:

- Fellows must be supervised in all settings, and the supervision must be on site.
- In inpatient settings, supervision need not be continuous or on site. Fellows may supervise interns and residents with faculty availability. In inpatient settings, supervision can occur at specified times such as teaching rounds, with immediate availability at all other times.
- In outpatient settings, supervision must be continuously available and on-site. Appropriate supervision cannot occur after the patient has left the clinic. Off site supervision (e.g., attending available by phone if fellow has questions) is not acceptable in outpatient settings. Rationale: The attending must have the opportunity to interview/ examine all patients at the time he/ she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary.

80-Hour Week

Question:

“Some programs have interpreted the standard for averaging the 80-hour weekly limit, call frequency and days off as allowing a constantly rolling 4-week average. Does the use of a “rolling average” comply with the common duty hour standards?”

Program Requirement:

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. (Fellow Duty Hours and the Work Environment, Duty Hours, Section VI.B.2., CAAR-605, CIT:4.K.1.)

Answer:

Averaging must be done by individual clinical rotation or by four-week (or five-week on 5-week “months”) block. Nowhere do the standards call for a “rolling” average.

- Rationale: A rolling average is not acceptable, because it may make it possible to average across high and low duty hour rotations to hide a compliance problem.
- Essentially, because the duty hour requirements are minimum standards, the rotations with the greatest hours and frequency of call must comply with the common duty hour standards.
- In addition, call frequency should be averaged for periods with call, e.g., it is not appropriate to include call rotations and ambulatory rotations that do not include call together in the numerator or the denominator to calculate on-call frequency.
- If a fellow is on vacation for one week in a four-week month, the hours for that rotation should be averaged over the remaining three weeks.

The following do not count against the 80-hour work week:

- Travel between home and work
- Home call (unless called in) or pager call
- Reading and study away from clinic/ hospital
- Time spent in the library that is not part of assigned duty
- Time spent on the phone during home call
- Personal activities
- Research outside of research rotations
- External moonlighting

Subversion of Duty Hours

Question:

“What if residents voluntarily choose to work more than 80 hours per week?”

Answer:

Programs and institutions must develop systems to insure that residents are neither required, nor permitted, to violate this or other duty-hour standards.

One Day Off Per Week

Question:

“How does the RRC define a day off?”

Program Requirement:

Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. (Fellow Duty Hours and the Work Environment, Duty Hours, Section VI.B.3., CAAR-606, CIT:4.K.2;)

Answer:

- Each fellow must receive 24 consecutive hours off duty (no beeper call) four days per (4-week) month.
 - In a 5-week month, fellows must have 5 days off.
- The RRC does not allow schedules that prohibit one day off for 2+ weeks because they are paired with “bookend” ambulatory rotations with weekends off.
 - See rolling average standard described in the 80-hour work week..
- Most programs have a 30-36 hour period of scheduled time off each week. In circumstances where the scheduled day-off is exactly 24 hours, (and no more), the RRC-IM would examine closely at the time of the site visit:
 - 1) The actual amount of time off, to be sure that it actually is not less than 24 hours.
 - 2) Compliance with the 80-hour work week

10-Hour Break

Question:

“Does the 10-hour break apply to home call?”

Program Requirement:

Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call. (Fellow Duty Hours and the Work Environment, Duty Hours, Section VI.B.4., CAAR-607, CIT:4.K.3;)

Answer:

- The RRC-IM expects full compliance with the 10-hour break rule. Because the standard is a “Should” PR, the RRC-IM will consider a variance on specifically defined rotations and when justified by a strong educational rationale and with prior approval by the RRC-IM.
 - In such cases, the break must never be less than eight hours.
 - As with all variances, it must be renewed at the time of each accreditation review.
- The 10-hour break rule is not applied to home call or moonlighting.
 - e.g., a fellow on home call who is called into the hospital from 1:00 – 2:00 AM may return for regular duties at 7:00 AM. Note that the time spent in the hospital “counts” against the 80-hour work week.

Home Call

Question:

“Which standards apply to time in the hospital after being called in from home call?”

“Is it permissible for resident to take call from home for extended periods, such as a month?”

Program Requirement:

At-home call (or pager call) is defined as a call taken from outside the assigned institution. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.) The frequency of at-home call is not subject to the every-third- night limitation. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.a) CAAR-612)

At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each fellow. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.a), CAAR-613, CIT:4.K.6;)

Fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.a), CAAR-614, CIT:4.K.2;)

When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.b), CAAR-615, CIT:4.K.1;)

The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. (Fellow Duty Hours and the Work Environment, On-Call Activities, Section VI.C.4.c), CAAR-616, CIT:4.K.8;)

Answer:

- For call taken from home (pager call), the time the fellow spends in the hospital after being called in is counted toward the weekly duty hour limit. The only other numeric duty hour standard that applies is that one day in seven must be free of all patient care responsibilities, which includes home call.
- The ACGME also requires that programs monitor the intensity and workload resulting from home call, through periodic assessment of the frequency of being called into the hospital and the length and intensity of the in-house activities.
- The requirement that one day in seven must be free of patient care responsibilities would prohibit a fellow from being assigned home call for an entire month.
- Home Call is not subject to the following Duty Hours requirements:
 - 10-hour break
 - 24+6 continuous duty
 - 1-in-3 call frequency
- When Home Call becomes de-facto in house call (because of service load), programs will be cited for excessive service.
- While on home call or pager call, fellows must have one 24-hour period per week completely free of all clinical and educational responsibilities. The pager must be turned off and signed out so that the fellow is unavailable for clinical responsibilities.
- If programs schedule a week of home call, one of those days must be completely free of any beeper responsibility. This means giving the pager to the attending, OR getting another fellow (i.e., on research) to cover it. It would also be acceptable for a program to schedule the day off on a home call schedule after seven days of home call, i.e., if a program gave the fellow the eighth day off completely (home call Monday – Sunday, then Monday completely off), that would also be acceptable.

Moonlighting

Question:

“Why does the ACGME distinguish between in-house/ internal moonlighting, which is counted under the weekly duty hour limit, and external moonlighting, which is not included?”

Program Requirement:

Any hours a fellow works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80 hour weekly limit on duty hours. This refers to the practice of internal moonlighting. (Fellow Duty Hours and the Work Environment, Moonlighting, Section VI.D.3., CAAR-619)

Answer:

The ACGME has three reasons for counting in-house moonlighting toward the weekly duty hours.

- The first is to apply the same standard to all hours fellows spend in teaching institutions, whether they are part of the required educational program or are spent moonlighting in-house.
- The second reason is to prevent institutions from inappropriately using in-house moonlighting to replace clinical service activities that fellows covered previously as part of the educational program.
- The third reason is that the ACGME's purview extends to teaching programs and sponsoring institutions, but not fellow activities outside of their educational program. Many perceive the ACGME does not have the right to curtail moonlighting or place all moonlighting hours under a weekly duty hour limit. In contrast, individual programs and institutions have the authority to prohibit or limit fellow moonlighting, and may do so formally via the fellow contract.

Section VII. Evaluation

Semiannual Evaluations

Question:

“Do the semi-annual evaluations of fellow performance need to be done by the PD, or can these be delegated to another KCF?”

Program Requirement:

Assessment should include the regular and timely performance feedback to fellows that includes at least semiannual written evaluations, and a formal evaluations of knowledge, skills, and professional growth of fellows and required counseling by the program director. (Evaluation, Fellow, Section VII.A.1.b), CAAR-702, CIT:5.A.;

Answer:

- The Subspecialty PD must perform all semiannual reviews personally.
 - Note difference from Core PRs where the core PD may designate semi-annual review to an APD or other designate.

Evaluation and Counseling Records

Question:

“We have an electronic evaluation system. Do we need to maintain paper records as well?”

Program Requirement:

Permanent records of both of the evaluation and counseling sessions (and any others that occur) for each fellow must be maintained in the fellow's file and must be accessible to the fellow and other authorized personnel. (Evaluation, Fellow, Section VII.A.1.c), CAAR-704, CIT:5.A.;

Answer:

- Electronic records are sufficient and need not be archived in print format as long as they are securely maintained, backed up, and accessible for use by the resident, program, and institution.
- Per ACGME: “If the program uses an electronic system, it should always maintain a paper record of the final evaluation at completion of training. For residents with academic or other performance problems, there should be additional hard-copy records, because the electronic evaluation parameters may not be appropriate or sufficient in cases where remediation, probation, non-renewal or dismissal needs to be documented.”

Feedback

Question:

“Why were we cited for inadequate faculty feedback; our faculty return rate on evaluations is over 90%”

Program Requirement:

The record of evaluation should document that fellows were evaluated in writing and their performance reviewed with them verbally on completion of each rotation period (and at least quarterly for longitudinal assignments). (Evaluation, Fellow, Section VII.A.1.c)(3), CAAR-708, CIT:5.A;)

Answer:

This requirement stipulates that the attending complete and return a written or electronic evaluation form and provide the fellow with verbal face-to-face feedback at completion of the rotation.

Final Summative Evaluation

Question:

“What are the requirements for a final summative fellow evaluation?”

Program Requirement:

The program director must provide a final evaluation for each fellow who completes the program. The evaluation must include a review of the fellow’s performance during the final period of education and should verify that the fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the fellow’s permanent record maintained by the institution. (Evaluation, Fellow, Section VII.A.2., CAAR-711, CIT:5.A;)

Answer:

- Use of the ABIM Tracking Form alone does not fulfill the requirement for a final summative evaluation.
- Programs must prepare a final evaluation for each fellow.
 - That review must summarize performance during the final period of residency.
 - It should include verification about the fellow’s professional competency to enter the practice of medicine
 - While the final summary statement does not need to use the exact words “demonstrated sufficient professional ability to practice competently and independently,” the final verification must contain an equivalent statement that attests to the fellow’s professional competency to begin practice in that specialty.
 - The final evaluation must be maintained for future credentialing, privileging, and letters of evaluation

Fellow Evaluation of Faculty

Question:

“What are the requirements for faculty evaluations?”

Program Requirement:

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. (Evaluation, Faculty, Section VII.B.1., CAAR-712, CIT:5.B;)

The [faculty] evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. (Evaluation, Faculty, Section VII.B.1., CAAR-713, CIT:5.B;)

The [faculty] evaluation must include annual written confidential evaluations by fellows. (Evaluation, Faculty, Section VII.B.1., CAAR-714, CIT:5.B;)

Provision must be made for fellows to confidentially provide written evaluations of each teaching attending at the end of a rotation, and for the evaluations to be reviewed with faculty annually. (Evaluation, Faculty, Section VII.B.1., CAAR-715, CIT:5.B;)

Answer:

- Each fellow must have the opportunity to evaluate each faculty member with whom they work, at the end of each rotation period.
- Evaluations must be confidential
 - The faculty evaluation does not need to be anonymous.
 - Confidentiality means that the faculty members being evaluated are blinded to the identity of the fellow completing the faculty evaluation.
 - Signed faculty evaluation forms potentially violate fellow confidentiality, and are therefore prohibited.
 - The program may track returns of the evaluations (e.g., tracking of electronic evaluations, signing of the return envelope) as long as the program takes special precautions to assure that the names are used only to track returns, and are never available to the faculty member being evaluated.
- The fellows' evaluations of the faculty must be reviewed with the faculty annually
 - And maintain fellow confidentiality in review process
- The program must use the fellow evaluations for selection of faculty for teaching assignments.

Annual Program Evaluation

Question:

“What are the requirements for program evaluation?”

Program Requirement:

Representative program personnel (i.e., at least the program director, representative faculty, and one fellow) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. (Evaluation, Program, Section VII.C.1., CAAR-718, CIT:5.C;)

In the evaluation process, the group of representative program personnel must take into consideration written comments from the faculty, the most recent report of the GMCC of the sponsoring institution, and the fellows' annual confidential written evaluations. (Evaluation, Program, Section VII.C.1., CAAR-719, CIT:5.C;)

If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting. (Evaluation, Program, Section VII.C.1., CAAR-720, CIT:5.C;)

In addition, the fellows must annually evaluate in writing the effectiveness of the program in achieving of the goals and objectives identified in the curriculum. The evaluation should include the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the effectiveness of inpatient and ambulatory teaching, the performance of faculty members, and the quality of supervision of fellows. (Evaluation, Program, Section VII.C.1.a), CAAR-721, CIT:5.C;)

Answer:

- Each fellow must have the opportunity to evaluate the program confidentially and in writing at least annually.
- Programs must have a process in place for an annual program internal review of the faculty, curriculum, facilities, etc. (defined in VII.C.1).
- This process is separate and distinct from the GMEC internal reviews that are required mid-cycle by the IRC.
 - In other words, the program conducts annual internal reviews.
 - These annual reviews are rolled up to the institutional GMEC review.
- The review panel must include at least one fellow and at least one faculty (may include more than one fellow or KCF).
- The results of the review must be documented by minutes and a summary report
- Internal review process must include documented review of
 - Faculty evaluations of the program
 - Fellow evaluations of program and faculty
 - The elements stipulated in VII.C.1.a.
 - utilization of the resources available to the program
 - contribution of each institution participating in the program
 - financial and administrative support of the program
 - volume and variety of patients available to the program for educational purposes
 - effectiveness of inpatient and ambulatory teaching
 - performance of faculty members
 - quality of supervision of fellows

If a program has a process to perform this function monthly – say by means of a standing committee of PD/ KCF/ fellow representatives – then this may meet the RRC standards. However, the evaluation of the program is more than just the summary of all end of rotation evaluations. It must include the evaluation of the total didactic and clinical program (curriculum, faculty, conferences, etc.). Therefore, with a monthly process consisting of shorter meetings to look at pieces of the program throughout the year (i.e., the faculty and rotation evaluations of the past month), there is the potential that the group might miss the “big” (summative) picture that one gets by looking at all evaluations in toto.

Appendix I

RRC-IM Calculation of Minimum KCF and KCF Scholarship Participation/ Productivity				
Endocrinology, Hematology, Infectious Diseases, Nephrology, Oncology, Pulmonary Diseases, and Rheumatology Minimum 3 KCF or 1:1.5 faculty-fellow ratio				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
2	3	2	2	6
3	3	2	2	6
4	3	2	2	6
5	4	3	3	9
6	4	3	3	9
7	5	3	3	9
8	6	4	4	12
9	6	4	4	12
10	7	4	4	12
11	8	5	5	15
12	8	5	5	15
13	9	5	5	15
14	10	6	6	18
15	10	6	6	18
16	11	6	6	18
17	12	7	7	21
18	12	7	7	21
19	13	7	7	21
20	14	8	8	24
21	14	8	8	24
22	15	8	8	24
23	16	9	9	27
24	16	9	9	27
25	17	9	9	27

Cardiology, Gastroenterology
Minimum 4 KCF* or 1:1.5 faculty-fellow ratio

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
3	4	3	3	9
4	4	3	3	9
5	4	3	3	9
6	4	3	3	9
7	5	3	3	9
8	6	4	4	12
9	6	4	4	12
10	7	4	4	12
11	8	5	5	15
12	8	5	5	15
13	9	5	5	15
14	10	6	6	18
15	10	6	6	18
16	11	6	6	18
17	12	7	7	21
18	12	7	7	21
19	13	7	7	21
20	14	8	8	24
21	14	8	8	24
22	15	8	8	24
23	16	9	9	27
24	16	9	9	27
25	17	9	9	27

* Gastroenterology Requires: 1 KCF = Advanced Endoscopy
1 KCF = Hepatology

**Hematology-Oncology, Pulmonary-Critical Care
Minimum 6 KCF or 1:1.5 faculty-fellow ratio**

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION KCF</u> with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
3	6	4	4	12
4	6	4	4	12
5	6	4	4	12
6	6	4	4	12
7	6	4	4	12
8	6	4	4	12
9	6	4	4	12
10	7	4	4	12
11	8	5	5	15
12	8	5	5	15
13	9	5	5	15
14	10	6	6	18
15	10	6	6	18
16	11	6	6	18
17	12	7	7	21
18	12	7	7	21
19	13	7	7	21
20	14	8	8	24
21	14	8	8	24
22	15	8	8	24
23	16	9	9	27
24	16	9	9	27
25	17	9	9	27

Heme-Onc: 3 Heme KCF, 3 Onc KCF
Pulm-CC: 3 Pulm KCF, 3 CC KCF or at least 50% Pulm 50% CC

Critical Care Minimum 3 KCF or 1:1 faculty-fellow ratio				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
2	3	2	2	6
3	3	2	2	6
4	4	3	3	9
5	5	3	3	9
6	6	4	4	12
7	7	4	4	12
8	8	5	5	15
9	9	5	5	15
10	10	6	6	18
11	11	6	6	18
12	12	7	7	21
13	13	7	7	21
14	14	8	8	24
15	15	8	8	24
16	16	9	9	27
17	17	9	9	27
18	18	10	10	30
19	19	10	10	30
20	20	11	11	33

Interventional Cardiology, Geriatrics, Transplant Hepatology Minimum 2 KCF or 1:1.5 faculty-fellow ratio				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
1	2	2	2	6
2	2	2	2	6
3	2	2	2	6
4	3	2	2	6
5	4	3	3	9
6	4	3	3	9
7	5	3	3	9
8	6	4	4	12
9	6	4	4	12
10	7	4	4	12
11	8	5	5	15
12	8	5	5	15

Clinical Cardiac Electrophysiology Minimum 2 KCF or 1:1 faculty-fellow ratio				
Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF(51%)	<u>PARTICIPATION</u> KCF with at Least 1 Pub Past 3 Years	<u>PRODUCTIVITY</u> Pubs All KCF Past 3 Years (1/yr x 3 yrs)
1	2	2	2	6
2	2	2	2	6
3	3	2	2	6
4	4	3	3	9
5	5	3	3	9
6	6	4	4	12
7	7	4	4	12
8	8	5	5	15
9	9	5	5	15
10	10	6	6	18
11	11	6	6	18
12	12	7	7	21

Sleep Medicine
Minimum 2 KCF or 1:2 faculty-fellow ratio

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority Minimum KCF (51%)	<u>PARTICIPATION KCF</u> <u>with at Least 1 Pub Past</u> <u>3 Years</u>	<u>PRODUCTIVITY</u> <u>Pubs All KCF Past 3 Years</u> <u>(1/yr x 3 yrs)</u>
2	2	2	2	6
3	2	2	2	6
4	2	2	2	6
5	3	2	2	6
6	3	2	2	6
7	4	3	3	9
8	4	3	3	9
9	5	3	3	9

Appendix II

RRC-IM Required Procedure Log Documentation for Internal Medicine Subspecialties

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

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

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

Critical Care	<ol style="list-style-type: none"> 1. Chest tube insertion 2. Endotracheal intubation 3. Arterial Line insertion 4. Central venous line insertion 5. Pulmonary artery catheter insertion 6. Thoracentesis 7. Therapeutic bronchoscopy
Endocrinology	Thyroid aspiration biopsy
Gastroenterology	<ol style="list-style-type: none"> 1. Flexible sigmoidoscopy (colonoscopy may be substituted) 2. Diagnostic upper gastrointestinal endoscopy (EGD) 3. Colonoscopy, including biopsy and polypectomy 4. Esophageal dilation 5. Percutaneous gastrostomy 6. Therapeutic upper and lower gastrointestinal endoscopy, including variceal and non-variceal hemorrhage (The variceal and non-variceal could be separated out to make it 5 categories) 7. Liver biopsy.
Geriatrics	No required procedures
Hematology	<ol style="list-style-type: none"> 1. Bone Marrow aspirate and biopsy
Hematology-Oncology	<ol style="list-style-type: none"> 1. Bone Marrow aspirate and biopsy
Oncology	<ol style="list-style-type: none"> 1. Bone Marrow aspirate and biopsy
Infectious Diseases	No required procedures
Nephrology	<ol style="list-style-type: none"> 1. Placement of temporary vascular access for hemodialysis and related procedures. 2. Percutaneous biopsy of autologous and native transplants.
Pulmonary	<ol style="list-style-type: none"> 1. Fiberoptic bronchoscopy procedures including those with <ul style="list-style-type: none"> - transbronchial biopsies - bronchoalveolar lavage - transbronchial needle aspiration - bronchial biopsies 2. Chest tube insertion 3. Endotracheal intubation 4. Arterial Line insertion 5. Central venous line insertion 6. Pulmonary artery catheter insertion 7. Thoracentesis 8. Cardiopulmonary exercise testing
Pulmonary-Critical Care	<ol style="list-style-type: none"> 1. Fiberoptic bronchoscopy procedures including those with <ul style="list-style-type: none"> - transbronchial biopsies - bronchoalveolar lavage - transbronchial needle aspiration - bronchial biopsies 2. Chest tube insertion

	<ol style="list-style-type: none"> 3. Endotracheal intubation 4. Arterial Line insertion 5. Central venous line insertion 6. Pulmonary artery catheter insertion 7. Thoracentesis 8. Cardiopulmonary exercise testing
Sleep	No required procedures
Rheumatology	<ol style="list-style-type: none"> 1. Diagnostic aspiration and/ or therapeutic injection of bursae, joints, entheses and tendon sheaths. 2. Analysis by light and compensated polarized light microscopy of synovial fluid.

Faculty Qualifications Judged Acceptable by the RRC-IM

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

- Core IM Residency Programs
- IM Subspecialty Fellowship Programs

The Program Requirements for Residency Education in Internal Medicine state:

III.A.3.b) The program director must be certified in General Internal Medicine by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.

III.C.1.a)(2) [Qualifications of the Associate Program Directors are as follows:] Associate Program Directors must be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable;

III.C.3.a)(1) [Qualifications of the Subspecialty Education Coordinators are as follows:] The Subspecialty Education Coordinator must be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable.

III.C.2.a)(2) [Qualifications of the Key Clinical Faculty are as follows:] Key Clinical Faculty must be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable.

The General Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine state:

III.A.3.b. The program director must be certified in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.”

III.B.6.a.2 [Qualifications of the Key Clinical Faculty are as follows:] Key Clinical Faculty must be certified in the subspecialty by the American Board of Internal Medicine or possess qualifications judged by the RRC-IM to be acceptable.

RRC-IM Policy:

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

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

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

Sleep Medicine Key Clinical Faculty

- IM-Sleep Medicine Fellowship Programs

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

Sleep Medicine Program Director

- IM-Sleep Medicine Fellowship Programs

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

Geriatrics Key Clinical Faculty and Geriatric Educational Coordinator

- IM-Geriatrics Fellowship Programs

- Core IM Residency Programs

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

Such faculty must meet the following conditions:

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

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

Geriatrics Program Director

- IM - IM-Geriatrics Fellowship Programs

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

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

1. The PD candidate must have 5 years or more experience as a geriatrics faculty member in an internal medicine residency or in an internal medicine IM-Geriatrics fellowship.
2. The PD candidate must demonstrate the ability to establish and maintain an environment of inquiry and scholarship to the same degree as required for IM-Subspecialty KCF.
 - o The candidate must be actively engaged in the Scholarship of Discovery or Dissemination (See III.B.4) as evidenced by at least three (3) products of scholarship in any of the following

categories in the past three years: peer-review manuscripts, peer-review grants, book chapters, review articles in peer-review publications, or editorials in peer-review publications.

- Abstracts and presentations alone will not meet this requirement.
3. The PD candidate must be recommended by the Core IM residency director for outstanding teaching and administrative ability.
 4. The candidate must be approved by the RRC-IM (see procedure below)

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

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

Procedure

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

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