## II. Personnel

II.B.1.a) Faculty members with credentials appropriate to the care setting must supervise all clinical experiences. (Core)

II.B.1.a).(1) There must be physicians with certification in internal medicine by the ABIM or AOBIM to teach and supervise internal medicine residents while they are on internal medicine inpatient and outpatient rotations. (Core)

**PDQ: [Paraphrasing from the PR's Background and Intent (B&I) box] "There are circumstances when a non-internist who has been approved by the PD would be an appropriate supervisor." Does this mean an IM resident could do an outpatient rotation with a FM doctor without a board-certified internist on site if PD approved?**

**RC-IM Response:**

**Yes, that's what it means. That's the specific example the RC included later in the B&I box, copied below.**

*Specialty-Specific Background and Intent: The Review Committee believes the best role models for internal medicine residents are internal medicine physicians with certification in internal medicine from the ABIM or AOBIM. Providing such faculty members ensures specialty-specific educators with significant experience managing and providing comprehensive patient care to complex patients. However, the Review Committee recognizes there are circumstances and clinical settings in which a non-internist who has been approved by the program director would be an appropriate supervisor. Examples include but are not limited to the following:*

- *On outpatient medicine rotations/experiences, it is appropriate for a non-internist with documented expertise (e.g., a family medicine physician with extensive outpatient/ambulatory experience or procedural proficiency) to teach and supervise internal medicine residents provided the non-internist is approved by the site director and the program director.*

II.B.3.b) Physician faculty members must:

II.B.3.b).(1) have current certification in the specialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)

**PDQ: Do all teaching faculty have to be board certified/eligible? What if certification lapses?**

**RC-IM Response:**

**A program needs to document that it has the minimum required number of core faculty for its approved complement.**

*II.B.4.c) In addition to the program director and associate program director(s), programs must have the minimum number of ABIM- or AOBIM-certified core faculty members based on the number of approved resident positions…(Core)*

**If a program has met this expectation, there is no issue if it lists faculty members who are board-eligible or do not have current ABIM/AOBIM certification.**

| | |
|---|---|
| II.B.4.c) | In addition to the program director and associate program director(s), programs must have the minimum number of ABIM- or AOBIM-certified core faculty members based on the number of approved resident positions…(Core)<br><br>*Note: Consideration of requirements related to dedicated time for core faculty members has been deferred pending guidance to the Review Committees from the ACGME Committee on Requirements. Additional information will be shared as it becomes available.* |

**PDQ: Any updates to dedicated time for core faculty?**

**RC-IM Response:**

**The proposed revisions to the program requirements for FTE, including support for core internist faculty, were posted for public review and comment on September 2.**

| | |
|---|---|
| II.A.2.a) | At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core) |
| II.A.2.b) | Additional salary support must be provided for an associate program director(s) to devote non-clinical time to the administration of the program… (Core) |
| II.C.2.a) | At a minimum, the program coordinator must be supported at 50 percent FTE for the administration of the program. (Core) |

Note: The proposed requirements related to non-clinical time for program administration will be reassessed based on guidance that the ACGME Committee on Requirements will provide to Review Committees in the coming months. The currently-in-effect requirements remain in effect in the meantime. Additional information will be shared as it becomes available.

**PDQ: Any updates for non-clinical time for program administration?**

**RC-IM Response:**

**The proposed revisions to the program requirements for FTE, including support for program coordinators, were posted for public review and comment on September 2.**

## III. Resident Appointments

| | |
|---|---|
| ~~III.C.1.~~ | ~~A resident who has satisfactorily completed a preliminary training year should not be appointed to additional years as a preliminary resident.~~ (Detail) |

**PDQ: Can a resident now be appointed to additional years as a prelim resident?**

**RC-IM Response:**

**A trainee who has satisfactorily completed a preliminary training year cannot be appointed to additional years as a preliminary resident. The requirement was removed because it seemed unnecessary.**

## IV. Educational Program

| | |
|---|---|
| IV.C.3.c) | [The educational program for all residents must include] foundational experience in internal medicine, including:<br><br>IV.C.3.c).(1) at least 10 months of clinical experiences in the outpatient setting. (Core) |

**PDQ: What counts towards the 10 months of outpatient (outpatient didactics, management of patients, home visits, urgent care, EM)?**

**PDQ: Is EM counted as ambulatory time?**

**RC-IM Response:**

**The first paragraph in the B&I box above addresses what "counts" towards the 10 months of outpatient experience:**

---

*Specialty-Specific Background and Intent: Clinical experiences in the following settings may be used to fulfill this requirement: general internal medicine continuity clinics; internal medicine subspecialty clinics (e.g., HIV clinic); non-medicine clinics (e.g., dermatology or physical medicine and rehabilitation clinic); walk-in clinics; neighborhood health clinics; home care visit programs; urgent care clinics; and ambulatory block rotations.*

*Time devoted to the longitudinal continuity experience can count towards the minimum required 10 months of foundational experiences in the outpatient setting. For the purposes of this calculation, a month is equivalent to four weeks, 20 days, or 40 half-days. For example, 40 half-day continuity clinic sessions would equal one month of outpatient experience.*

---

**In short, all things listed except EM can be used to fulfill the outpatient requirement. Additionally, in June, at the request of the APDIM leadership, the RC provided further clarification for the ten months of outpatient. The clarification below was made available on the listserv by the APDIM leadership.**

*Issue 1: What counts towards the 10 months of clinical experiences in the outpatient setting? Specifically, if a program uses an X+Y schedule, does the program director need to parse out the continuity clinic experiences and only count the clinic time towards the 10 months (Program Requirements IV.C.3.c.1)?*

*Explanation/clarification for issue 1:*
*The Review Committee does not wish to make the process for what counts towards meeting the outpatient requirement more challenging, complicated, or burdensome for program directors. In fact, the new requirements were intentionally developed and written to be more flexible than the current requirements in practically all ways.*

*Regarding the outpatient and continuity program requirements, programs should keep in mind that continuity clinic activities count towards the outpatient minimum time requirement but are not anticipated to be the sole component of a resident's time spent in outpatient activities. Some examples would be:*

- *A program that has residents spending two weeks on a rheumatology office/outpatient rotation would have those two weeks counted towards the minimum outpatient requirement.*
- *A program that has residents on rotations that involve both inpatient and outpatient experiences will need to make an assessment of what portion of the residents' time is spent in each of these areas, much like they do currently in completing the block diagram.*
- *A program that has residents performing subspecialty or continuity or non-continuity clinic visits using telemedicine can count that time towards the minimum outpatient requirement.*
- *For a program using X + Y scheduling, if the residents' activities during the Y weeks ("ambulatory block rotations" in the relevant Background and Intent box below) are outpatient related, then the entire time should count towards the outpatient requirement. Specifically, all patient management activities and didactics related to outpatient topics during such ambulatory block rotations count towards the minimum.*

*Program Directors do not need to parse out and count only continuity clinic time towards meeting the minimum in this area.*

**PDQ: How is one month defined?**

**RC-IM Response:**

**As noted in the B&I box above, a month is equivalent to four weeks, 20 days, or 40 half-days.**

**PDQ: Can this be accomplished all in a subspecialty clinic?**

**RC-IM Response:**

**The RC developed the following B&I box in the program requirements document to address this issue.**

*Specialty-Specific Background and Intent: The Review Committee believes that residents can only achieve a long-term therapeutic relationship with a panel of patients if the continuity clinic experience takes place for the entirety of the educational program. This will allow patients to understand that the resident is "their" primary care doctor, and residents to see the continuity clinic patients as "their" patients. While new patients will be added to the panel (and others will leave) throughout the course of the program, the Review Committee suggests that residents will remain in the same clinic throughout the 36 months to maintain continuity of care for their patient panel.*

*The committee believes this requirement can be best met through assigning residents to a general internal medicine clinic. However, to allow for residents to pursue post-residency interests during residency, programs may assign residents to subspecialty or specialized continuity clinics (e.g., an HIV clinic) if these assignments achieve the desired outcome noted in the requirement: that residents develop a long-term therapeutic relationship with a panel of patients.*

**In June, in addition to providing a clarification for the 10 months of outpatient experience, the RC-IM provided the APDIM leadership the following response to whether programs can assign all residents to a subspecialty continuity clinic to fulfill the continuity clinic requirements (PR IV.C.3.b; IV.C.5.a-b). Similar to the 10-month experience clarification, the APDIM leadership made the clarification below available to everyone on the listserv.**

*Issue 2: Can all continuity experiences for all residents be done longitudinally in a subspecialty continuity clinic (Program Requirements IV.C.3.b; IV.C.5.a-b)?*

*Explanation/Clarification for Issue 2:*
*The Review Committee does not support such an arrangement. This requirement cannot be met by assigning all residents to a longitudinal subspecialty continuity clinic. The Background and Intent box (below) clarifies that the best way to provide a longitudinal, team-based, continuity experience for the duration of the educational program is through the use of a general internal medicine clinic. However, it also specifies that programs can offer some residents the opportunity to fulfill this experience using specialized (e.g., HIV, bariatrics, or transition clinics) or subspecialty clinics (if there is interest in pursuing subspecialty interests or training post-residency), assuming that these clinics allow residents to achieve a continuity relationship with a panel of patients (Program Requirement IV.C.5.b) where they can serve as their patients' primary care provider and are responsible for chronic disease management, management of acute health problems, and preventive care (Program Requirement IV.C.5.b.1) in a coordinated manner across settings and between outpatient visits (Program Requirement IV.C.5.b.2).*

IV.C.3.c) [The educational program for all residents must include] foundational experience in internal medicine, including:

IV.C.3.c).(3) clinical experiences in each of the internal medicine subspecialties; and, (Core)

IV.C.3.c).(4) clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, emergency medicine, and neurology. (Core)

**PDQ: Is a dedicated rotation in each of the subspecialties required for the foundational IM experience?**

**RC-IM Response:**

**As part of the foundational IM experience, for each subspecialty and for geriatric medicine, there must be a curriculum (goals and objectives, teaching methods, and assessment tools), a subspecialty education coordinator, and sufficient clinical exposure. The Review Committee does not place a minimum on these experiences.**

**For hospice and palliative medicine, addiction medicine, emergency medicine, and neurology, there must be a curriculum and sufficient clinical exposure. The Review Committee does not place a minimum on these experiences.**

**PDQ: No longer a 4 week requirement dedicated to geriatrics. Could an experience be satisfied by taking care of geriatric patients on the general medicine wards/clinic?**

**RC-IM Response:**

**Yes, provided there is a Subspecialty Education Coordinator, a curriculum, and sufficient clinical exposure.**

**PDQ: How would an experience in addiction medicine be defined? Could this include taking care of patients with SUD on the general med service or does the experience need to more focused?**

**RC-IM Response:**

**Yes, provided there is a curriculum and sufficient clinical exposure.**

**PDQ: No longer a minimum EM experience. Can the requirement be satisfied by the experience admitting patients from the ED while on inpatient medicine services?**

**RC-IM Response:**

**Yes, provided there is a curriculum and sufficient clinical exposure.**

IV.C.3.d) [The educational program for all residents must include at least six months of individualized educational experiences to participate in opportunities relevant to their future practice or to further skill/competency development in the foundational areas. (Core)

**PDQ: How can the 6 months of individualized learning experiences be accomplished?**

**RC-IM Response:**

**The following is copied from the related B&I:**

*The requirements acknowledge that in addition to providing residents with broad foundational educational experiences in ambulatory and hospital-based internal medicine, programs must ensure residents have educational experiences that take into account their future plans and the different paces and trajectories at and on which residents will learn and demonstrate competence in the foundational areas.*

*Individualized educational experiences will be determined by the program director and take into account demonstrated competence in the foundational areas noted above, resources, program aims, and the residents' future practice plans. Although six months can be devoted to individualized experiences, some residents may require more time to achieve competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some residents may need to devote the entirety of residency to achieve competence in the foundational areas. The converse may be possible. Programs may have the opportunity to allocate more than six months of individualized educational opportunities for residents who have achieved or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences for those interested in hospitalist medicine careers, or more experiences in a subspecialty for those interested in subspecializing. Individualized educational experiences may be integrated throughout the 36 months of the educational program and do no need to be consecutive.*

IV.C.5.b) residents must have a longitudinal, team-based, continuity experience for the duration of the educational program through which they develop a long-term therapeutic relationship with a panel of patients. (Core)

**PDQ: How is "team-based" defined?**

**RC-IM Response:**

***"Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care."***

***-National Academy of Medicine***
***"Core Principles & Values of Effective Team-Based Health Care"***
***October 2, 2012 Discussion Paper by Pamela Mitchell, Matthew Wynia, Robyn Golden, Bob McNellis, Sally Okun, C. Edwin Webb, Valerie Rohrbach, Isabelle Von Kohorn***

**PDQ: Could a resident accomplish a continuity experience solely in a subspecialty clinic?**

**RC-IM Response:**

**The RC developed the following B&I box in the program requirements document to address this issue.**

*Specialty-Specific Background and Intent: The Review Committee believes that residents can only achieve a long-term therapeutic relationship with a panel of patients if the continuity clinic experience takes place for the entirety of the educational program. This will allow patients to understand that the resident is "their" primary care doctor, and residents to see the continuity clinic patients as "their" patients. While new patients will be added to the panel (and others will leave) throughout the course of the program, the Review Committee suggests that residents will remain in the same clinic throughout the 36 months to maintain continuity of care for their patient panel.*

*The committee believes this requirement can be best met through assigning residents to a general internal medicine clinic. However, to allow for residents to pursue post-residency interests during residency, programs may assign residents to subspecialty or specialized continuity clinics (e.g., an HIV clinic) if these assignments achieve the desired outcome noted in the requirement: that residents develop a long-term therapeutic relationship with a panel of patients.*

**In June, in addition to providing a clarification for the 10 months of outpatient experience, the RC-IM provided the APDIM leadership the following response to whether programs can assign all residents to a subspecialty continuity clinic to fulfill the continuity clinic requirements (PR IV.C.3.b; IV.C.5.a-b). Similar to the 10-month experience clarification, the APDIM leadership made the clarification below available to everyone on the listserv.**

*Issue 2: Can all continuity experiences for all residents be done longitudinally in a subspecialty continuity clinic (Program Requirements IV.C.3.b; IV.C.5.a-b)?*

*Explanation/Clarification for Issue 2:*
*The Review Committee does not support such an arrangement. This requirement cannot be met by assigning all residents to a longitudinal subspecialty continuity clinic. The Background and Intent box (below) clarifies that the best way to provide a longitudinal, team-based, continuity experience for the duration of the educational program is through the use of a general internal medicine clinic. However, it also specifies that programs can offer some residents the opportunity to fulfill this experience using specialized (e.g., HIV, bariatrics, or transition clinics) or subspecialty clinics (if there is interest in pursuing subspecialty interests or training post-residency), assuming that these clinics allow residents to achieve a continuity relationship with a panel of patients (Program Requirement IV.C.5.b) where they can serve as their patients' primary care provider and are responsible for chronic disease management, management of acute health problems, and preventive care (Program Requirement IV.C.5.b.1) in a coordinated manner across settings and between outpatient visits (Program Requirement IV.C.5.b.2).*

~~IV.C.3.n).(1).(b) [Each resident's longitudinal continuity experience] should not be interrupted by more than a month, not inclusive of vacation;~~ ~~(Detail)~~

**PDQ: Is there any maximum time allowed "away from clinic?"**

**RC-IM Response:**

**There is no limit *per se*, but note that residents must develop a long-term therapeutic relationship with patients, precluding a lengthy (though undefined) period away from continuity clinic.**

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

**PDQ: Is evaluation of performance data and development of an action plan no longer required?**

**RC-IM Response:**

**How resident competence in the clinic is developed and assessed is not prescribed. Note that the deleted program requirement is categorized as "detail" in the still currently in-effect requirements.**

~~IV.C.4.a).(2). Residents must have the opportunity to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences, all of which must involve faculty.~~ ~~(Detail)~~

**PDQ: Are grand rounds, journal club, M&M conference no longer required?**

**RC-IM Response:**

**While resident participation in conferences with those labels is not specifically mentioned in the requirements, residents must demonstrate sufficient knowledge in the application of technology appropriate for the clinical context, including evolving techniques (PR IV.B.1.c.2.f), didactic sessions/conferences must include those devoted to quality improvement (PR IV.C.6.a.1) and sessions in which residents interact with other residents and faculty members (PR IV.C.6.a.3), and residents must be provided a patient or case-based approach to clinical teaching (PR IV.C.6.a.4). Further, because faculty are still required to regularly participate in organized journal clubs (PR II.B.2.f), the expectation is that those journal clubs include the residents.**