ACGME

# ACGME Requirements
# Review and Comment Form

| Title of Requirements | Internal Medicine Proposed Requirements |
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Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

| **Select [X] only one** | |
|---|---|
| Organization (consensus opinion of membership) | |
| Organization (compilation of individual comments) | X |
| Review Committee | |
| Designated Institutional Official | |
| Program Director in the Specialty | |
| Resident/Fellow | |
| Other (specify): | |

| Name | Marianna Drootin, MPA |
|---|---|
| Title | Director, ADGAP & Special Projects |
| Organization | American Geriatrics Society |

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

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The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

| | **Line Number(s)** | **Requirement Number** | **Comment(s)/Rationale** |
|---|---|---|---|
| **1** | 79 | Int. B. Definition of Specialty | We feel that the new description of an internist thoughtfully and comprehensively depicts the evolving roles and responsibilities in a changing health care climate. |
| **2** | 177-179 | I.D.1a).(3) | Recommend minor change in the wording to “including those done using telecommunication technology if not available in person.” |
| **3** | 331-333 | II.A.3.e | Experience in working with interdisciplinary, interprofessional teams is a crucial skill set for a program’s leadership to undertake. As it is a new |

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|  | Line Number(s) | Requirement Number | Comment(s)/Rationale |
|---|---|---|---|
|  |  |  | requirement, it may necessitate restructuring inpatient teams, schedules, and workflows – to include nurse managers, pharmacists, and social workers. Line 333 could be further revised to read …promotes high quality collaborative care, patient safety… |
| **4** | 493-495 | II.B.2.h) | The concept of a SEC is important as that faculty member will be in the position to improve the quality of sub-specialty education in each discipline and influence the curricular decisions made by the program director and PEC. The SEC's time commitment to the residency may be significant enough to justify a statement that those individuals' must be provided with sufficient time to fulfill their responsibilities. |
| **5** | 532-535 | II.B.2.i | AGS agrees with the idea that residents should learn about data and how to access these data sets. However, AGS has concerns that it is not feasible to require that a faculty member provide this type of expertise. In many institutions, either the quality and compliance staff or data analysts could serve as the expert. Smaller programs may be challenged to find such expertise among their educators. Hence, AGS recommends omitting the requirement that a faculty member serve in this capacity and include language that an institution's expert in this area work with residents to learn how to use data to drive clinical improvement. |
| **6** | 538-540 | II.B.2.j | AGS supports enhancing the role of team care and supports this addition to the IM PR. The statement, "significant experience working in interdisciplinary, interprofessional team-based health care delivery" needs further clarification. Due to the subjective nature of this statement, perhaps defining the objective timeframe of such experience or providing a healthcare delivery example of the interdisciplinary, interprofessional delivery teams would help clarify matters. |
| **7** | 597 | II.B.4.c) | We support efforts to increase the number of core faculty in IM programs. |
| **8** | 620-621 | II.B.4.c) | This is an excellent description of core faculty responsibilities. With respect to "Designing and implementing simulation and standardized patients for teaching and assessment," AGS considers the expectation of both broadly defined simulation <u>and</u> standardized patients to be potentially burdensome, particularly for smaller programs. Therefore, AGS recommends revising the statement to "simulation <u>and/or</u> standardized patients". |
| **9** | 664 | II.C.2 | AGS is appreciative of the ACGME's position that programs should have a 1.0 FTE for a program coordinator. Given the importance of this role for training program effectiveness and quality, we might |

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| | | | suggest more specific language to match that found in the APD section:<br><br>Programs, in partnership with their Sponsoring institutions, should encourage and sponsor the professional development of program coordinators. *Program coordinators should participate in academic societies and/or in educational programs designed to enhance their educational and administrative skills, and career development..* |
| **10** | 810 | IV.B.1.a) | Professionalism—360 degree evaluation is a very useful method about residents behavior with other team members including nurses, secretaries, medical assistants etc. We would propose changing “360 degree evaluation” to “multisource feedback”. In addition, peers and patients should be added to the list. We also propose changing “secretaries” to “administrative assistants”. |
| **11** | 817 | IV.B.1.a).(1).(a) | AGS feels that competence in compassion, integrity and respect for others is important and would like to see stronger statements regarding sensitivity towards implicit bias, cultural/ race responsivity and eliminating racism in health care. As such, we recommend that the ACGME incorporate implicit bias and anti-racism trainings to its requirements. Residents, faculty, and program leadership should be taught and coached to practice self-awareness, employ best practices to overcome these negativities, and to recognize and mitigate healthcare inequalities. Training in these spheres, and their implications for both academic medicine and medical research, should be included as core components for all internists. |
| **12** | 945-958 | IV.B.1.c)(1) | Residents must demonstrate more than a level of expertise in the knowledge of the clinical disorders seen by the subspecialties noted, they must also demonstrate an ability to diagnose conditions using appropriate, evidence-based screening/diagnostic tools and initiate management plans that reflect the principles aligned to each subspecialty practice. This distinction is important to highlight to prevent the clinical experiences from becoming largely observational or book learning activities.<br>Accepting that access to geriatrics expertise can be difficult in some health systems, methods that link residents to off-site experts or remote learning programs via telecommunication should be encouraged. |
| **13** | 1063 | IV.B.1.f) | System based learning—peer- review of documentation very helpful in improving documentation of trainees. |
| **14** | 1135 | IV.C.1.c) | Rotations must be structured, but time it is not |

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| | | | specified. It might create some confusion so the AGS asks for more clarity in this statement. |
| **15** | 1164-1166 | IV.C.3.a) (4) | We support explicitly stated “structured clinical experience” in geriatric medicine, hospice, palliative care and addiction medicine.<br><br>The use of the term “structured clinical” experiences is an improvement over the previously used term “experience”. The training expectations become clearer and allow for flexibility in creating the curriculum. |
| **16** | 1188 | IV.C.4.c) | AGS disagrees with this recommendation. Certain inpatient rotations might include hospice units or Acute Care for Elders teams. The statement that “non-physician faculty members must not supervise IM residents” is problematic for these experiences. Non-physician team members can play a pivotal role in these experiences and can be uniquely poised to supervise and evaluate residents in these settings. |
| **17** | 1253 | IV.C.5. | Outpatient experience, good to include transition of care visits, since it is more and more prevalent |
| **18** | 1670 | VC | Program evaluation—along with year-end review of residents’ feedback, if residents (mainly PG Y 3 or 4) attend Q6 months in education meeting with PD or Associate PD, we find it useful for their feed on curriculum structure and. |
| **19** | 2304-2313 | VI. E.2.b) | The AGS praises ACGME for promoting non-physician team members in the evaluation of learners and programs, and for the requirement for enhanced experiences in interdisciplinary team-based care. |

General Comments:

The proposed requirements for internal medicine are timely and reflect the changing practice of medicine in the past five years as a result of advances in informatics and technology, and the impact of the COVID-19 pandemic. The flexibility that has been included in some of the revised requirements is essential to allow program directors discretion in creating and delivering curricular elements across the entire program and for individual trainees.

The requirements are easier to read, with no repetitions, and offer clear descriptions of specific requirements. Interesting AIRE ideas.

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