AAIM Response to ACGME IM Subspecialty Program Requirements
Submitted: February 25, 2023

The Alliance for Academic Internal Medicine (AAIM) represents residency and fellowship program directors, clerkship directors, UME and GME administrators, and chairs of medicine. Our comments articulate our collective perspective as educators, researchers, and administrators and do not reflect specific views on any particular internal medicine subspecialty. Rather, the comments relate to the general requirements that apply to all internal medicine subspecialties.

PROGRAM REQUIREMENT: Required Rotations on Geographically Distant Sites
I.B.5

AAIM appreciates that the purpose of the requirement change is to promote fellow wellness and improve education; however, we are also concerned that geographically distant sites are necessary in some cases to complete the required curriculum. AAIM requests that ACGME acknowledge this necessity.

PROGRAM REQUIREMENT:
Analysis and Interpretation of Practice Data, Data Management Science
II.B.1.a

AAIM recognizes the importance of training physicians to prepare for the impending complexities of health system navigation for patient-centered care and does not dispute that it requires familiarity with the use of practice data for quality improvement and to demonstrate the achievement of population health outcomes. Currently, few faculty across the country have expertise in these areas. In contrast, most health systems have some staff or consultant who provides such data to the organization. Requiring faculty with this expertise is especially burdensome for smaller or community-based programs. AAIM requests that this requirement be altered to reflect that trainees be required to receive training on the use of practice data for quality improvement and to demonstrate population health outcomes without specifying the need for expert faculty in this area.

PROGRAM REQUIREMENT: Minimum Aggregate Support and Minimum Number of Core Faculty
II.B.4.b-d

AAIM concurs with the minimum aggregate support required, as defined in section II.B.4.d. AAIM deeply appreciates ACGME's collaboration and effort to revise the minimum aggregate support required. The tasks and roles required to meet the educational needs of fellowship training programs require time that is best measured in protected FTE.

In contrast, the minimum *number* of core faculty (II.B.4.b) is overly prescriptive. Given the heterogeneity of training programs, the number of core faculty and how best to utilize their skills should be left to the program's discretion. AAIM requests further clarification about the roles and responsibilities of internal medicine subspecialty core faculty. The discrepancy between the number of core faculty required for internal medicine subspecialties v. internal medicine remains a source of confusion for the community, particularly because many subspecialty faculty serve as internal medicine core faculty.

Furthermore, the requirement for minimum *number* of core faculty would be particularly burdensome for smaller institutions and may disadvantage community-based programs, which tend to have fewer faculty, and discourage them from creating new fellowship programs. AAIM recommends that either the minimum *number* of core faculty be removed from the requirements (giving programs the autonomy to apply the FTE requirements as they fit within their program's settings), or the minimum *number* of core faculty in II.B.4.b be better aligned with the minimum aggregate support required as follows:

Number of Approved Positions	Minimum Aggregate Support Required	Minimum Number of ABIM or AOBIM Certified Core Faculty
<7	0.10 FTE	2
7-12	0.15 FTE	3
13-18	0.20 FTE	4
19-24	0.25 FTE	5
25+	0.30 FTE	6

Since this segment of the program requirements impacts training, compensation, and research, AAIM requests that ACGME consider adding an FAQ that would define fellowship program core faculty and their role since their functions vary among institutions and their teaching and administrative time are accounted for in numerous and diverse ways. Furthermore, such high requirements for core faculty may disadvantage smaller or community-based programs with fewer faculty and resources from adding fellowship programs.

AAIM would like to emphasize that within the bracket of small programs, there is wide variability – some programs may need more aggregate support for core faculty than the "Minimum Aggregate Support Required." AAIM requests that ACGME consider language to emphasize that the "Minimum Aggregate Support Required" is, in fact, the minimum and that some programs may require more support based on the program's complexities and local needs.

AAIM also recommends that empirical data be the basis for future requirements, insofar as possible. AAIM welcomes discussion of the data needed and is open to assisting ACGME acquire data or in structuring a process to acquire specifics.

AAIM deeply appreciates its strong relationship with ACGME. We welcome future conversations and collaboration when ACGME prepares to conduct its next cycle of internal medicine and subspecialties program requirements review.

PROGRAM REQUIREMENT: Novel or Non-Traditional Settings
IV.B.1.b) (1). (b). (i)

With the diversification of the patient population and the emergence of modern technologies, innovative means of patient care and novel educational experiences are surfacing. Though there are and will be programs that have access to non-traditional educational/clinical settings, not all programs may be able to fulfill this requirement due to resource limitations. AAIM proposes that the final language be modified so that the decision to implement non-traditional educational/clinical settings is determined and managed by individual programs.

PROGRAM REQUIREMENT: Telemedicine
IV.B.1.b). (1). (b). (ii)

ACGME specifies that the proposed requirement for telemedicine training "should not necessitate additional institutional resources." AAIM would like to emphasize that there is wide variability in how telemedicine is practiced. The impending end of the *Emergency Declaration* related to the SARS-CoV-2 pandemic will further impact the provision of telemedicine-based care. Further, implementation of telemedicine varies by geography (e.g., programs that straddle multiple states) as well as by institutional policies and approaches to telemedicine. While it is reasonable to conclude that most, if not all, institutions have some infrastructure related to telemedicine, AAIM expects there to be significant

variations in practice and the ability of programs to institute this as a core practice will fluctuate. Therefore, acknowledgement should be made that this requirement will be based on current institutional infrastructure and may have variable financial impacts on programs.

PROGRAM REQUIREMENT: Population Data Interpretation
IV.B.1.b) (1). (b). (iii)

AAIM recognizes the importance of training physicians to navigate the health system of the future and does not dispute that it requires familiarity with interpreting population data to understand population health within the context of prevention. Currently, few faculty across the country have expertise in this area. In contrast, most health systems have some staff or personnel who provide such data to the organization. Requiring faculty with this expertise is especially burdensome for smaller or community-based programs. We request that this requirement be altered to reflect that trainees be required to receive training on the use of population health data, experience with data registry interpretation, and analysis of epidemics and social determinants of health without specifying the need for expert faculty in these areas.

PROGRAM REQUIREMENT: Utilization of Critical Thinking and Evidence-Based Tools
IV.B.1.b). (1). (b). (iv)

AAIM recognizes the importance of training physicians to navigate the health system of the future and does not dispute that it requires fellows to critically analyze and evaluate literature and health care protocols. Currently, few faculty across the country have expertise in this area. In contrast, most health systems have some staff or personnel who have some level of knowledge in analyzing and interpreting practice data, data management science, and clinical decision support systems. Requiring faculty with this expertise is especially burdensome for smaller or community-based programs. We request that this requirement be altered to reflect that trainees be required to receive training on critical analysis and finding/understanding evidence-based tools without specifying the need for expert faculty in these areas.