February 26, 2023

Jerry Vasilias, PhD
Executive Director
Review Committee for Internal Medicine
Accreditation Council for Graduate Medical Education
401 North Michigan Avenue, Suite 2000
Chicago, IL 60611

Dear Dr. Vasilias:

On behalf of the Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD), American College of Chest Physicians (CHEST), American Thoracic Society (ATS), and Society of Critical Care Medicine (SCCM), we collectively represent the breadth of Pulmonary Disease and Critical Care Medicine (PCCM), Critical Care Medicine (CCM), and Pulmonary Disease. We are responding to the recently proposed major revisions to the *ACGME Program Requirements for Graduate Medical Education in Pulmonary Disease and Critical Care Medicine, Critical Care Medicine, and Pulmonary Disease*.

The administration of postgraduate medical education programs has become more and more time-consuming as accreditation standards have standardized expectations as medical education knowledge has improved.

Many core faculty within subspecialty fellowship programs are not core faculty in the parent IM program or are not shared across the institution. Our subspecialty fellowship programs are responsible for providing necessary faculty expertise to address the specific needs of trainees within our program, including meeting the subspecialty program requirements and milestones. It is particularly burdensome for smaller programs, which have the exact requirements to train their fellows as larger programs, without the ability to leverage the infrastructure and resources that larger institutions provide. As we move toward personalized education plans for each learner, additional coaching and mentoring will be required. Further, new areas of faculty expertise are needed, such as data management, population health, quality improvement, and patient safety. The increasing complexity makes it hard for each subspecialty training program to provide efficient training.

This letter intends to clarify the impact of the revised requirements on our Pulmonary Disease, CCM, and PCCM fellowship programs. To that end, we respectfully provide feedback for the following requirements:

PCCM Requirement #: I.B.5.
CCM Requirement #: I.B.5.
Pulmonary Requirement #: I.B.5.

The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites. **(Core)**

> We recommend clarifying the intent of this requirement. We appreciate the intention of reducing the burden on fellows by limiting extended travel. The background and intent discuss using two measurements to determine extended travel; 1) time over 60 minutes each way or 2) greater than 60 miles. The use of time is an inconsistent measurement. For example, travel time depends on many variables, including traffic patterns, time of day, seasonal conditions, etc. We recommend eliminating the time measurement and only using the more objective mileage measurement.
>
> It also needs to be clarified if providing travel and housing reimbursement is required and would allow for rotations at distant sites. We recommend strengthening the requirement

to reimburse fellows for travel and housing if they must travel and reside at a remote location from their program for a required (not elective) experience.

PCCM Requirement #: I.D.1.c).(3)
CCM Requirement #: I.D.1.c).(3)
Pulmonary Requirement #: I.D.1.c).(3)

[The program, in partnership with its Sponsoring institution, must:] provide access to an electronic health record; and, (Core)

We support this revision as written.

PCCM Requirement #: II.B.1.a)
CCM Requirement #: II.B.1.a)
Pulmonary Requirement #: II.B.1.a)

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

In many smaller programs, and non-academic settings, it is not feasible to have faculty members with expertise in the analysis and interpretation of practice data, data management science, clinical decision support systems, and managing emerging health issues. Many of our subspecialties will only be able to meet this requirement, with the core IM residency program being required to provide this type of faculty expertise to the subspecialty training programs.

We request that flexibility be afforded to the subspeciality fellowship programs to provide training in these areas by allowing the subspecialty fellowship program discretion in how the training is implemented.

We recommend revising this requirement to state that… "*the program must implement a curriculum that teaches trainees how to analyze and interpret practice data, data management science, clinical decision support systems, and management of emerging health issues. (Core)"*

PCCM Requirements #: II A.2.b and II.B.4.b) and II.B.4.e)
CCM Requirement #: II A.2.b and II.B.4.b) and II.B.4.d)
Pulmonary Requirement #: II A.2.b and II.B.4.b) and II.B.4.d)

We applaud the ACGME and the Review Committee for Internal Medicine for recognizing the value of allowing fellowship programs the flexibility and discretion to allocate the minimum aggregated support among their core faculty members.

One unintended consequence of the revised requirement for core faculty support is its impact on the smaller subspecialty fellowship program's ability to support an associate program director (APD).

Per the July 2022 ACGME Program Requirements for Graduate Medical Education in the IM Subspecialties, *"Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s) (APD)…".* We support this requirement as it is essential for the stability of the subspecialty fellowship program to have an APD in place. Although without adequate support, it is difficult for programs to recruit core faculty for the APD role. This is a particular burden to smaller programs

with no dedicated support for an APD and now minimal aggregated core faculty support.

We recommend that APD support be required for subspecialty fellowship programs of all sizes and that the core faculty support be marginally increased. We propose using a clear and concise formula for all programs to implement, where APD support for programs with up to 24 fellows is 50% of the program director's (PD) support, and the aggregated core faculty support is equal to that of the PD. We have illustrated this proposed formula in the table below.

Number of Approved Fellow Positions	Minimum Support Required (FTE) for the **Program Director**	Minimum Aggregate Support Required (FTE) for the **Associate Program Director(s)**	Minimum Aggregate Support Required (FTE) for **Core Faculty**
<7	.2	~~0~~ .1	~~.10~~ .2
7-9	.25	.13	~~.15~~ .25
10-12	.3	~~.14~~ .15	~~.15~~ .3
13-15	.35	~~.15~~ .18	~~.20~~ .35
16-18	.4	~~.16~~ .2	~~.20~~ .4
19-21	.45	~~.17~~ .23	~~.25~~ .45
22-24	.5	~~.18~~ .25	~~.25~~ .5
25-27	.5	.25	~~.30~~ .5
28-30	.5	.30	.5
31-33	.5	.36	.5
34-36	.5	.42	.5
37-39	.5	.48	.5

PCCM Requirement #: IV.B.1.b).(1).(b).(i)
CCM Requirement #: IV.B.1.b).(1).(b).(i)
Pulmonary Requirement #: IV.B.1.b).(1).(b).(i)

[Fellows must demonstrate the ability to manage the care of patients:] in a variety of health care settings, including inpatient and various ambulatory settings; (Core)

We appreciate the intention of this requirement to ensure our trainees are adequately trained to provide care in settings that serve under-resourced populations. However, this requirement is difficult to implement across all the IM subspecialties. For example, providing critical care in a pop-up health clinic or on a mobile bus would be difficult. This requirement, as written, creates a need for additional faculty to train and supervise fellows in non-traditional settings.

We recommend rephrasing this requirement to state that "*the program must implement a curriculum that teaches trainees to manage the care for under-resourced populations without prescribing the setting.*

PCCM Requirement #: IV.B.1.b).(1).(b).(ii)
CCM Requirement #: IV.B.1.b).(1).(b).(ii)
Pulmonary Requirement #: IV.B.1.b).(1).(b).(ii)

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

We appreciate the rationale ACGME and the Review Committee for Internal Medicine provided. Based on feedback from the APCCMPD membership, many institutions have deemphasized telemedicine or do not have the resources to provide care through its use. Additionally, with reimbursement for telemedicine by Medicare and insurers being

in flux, telemedicine may be financially non-viable. If these clinics close, training opportunities and the need for such training will vanish.

Specification of what is considered telemedicine is needed. Our membership questioned if managing a patient locally over the telephone is considered telemedicine. Given this lack of clarity on what defines telemedicine, fellowship programs from institutions that have deemphasized telemedicine would need help meeting this requirement.

Until institutions are required to provide care using telemedicine, we recommend restating the requirement to require that fellowship programs provide training in communicating with patients who are not in the same physical space or making this a (Detail) rather than a (Core) requirement.

PCCM Requirement #: IV.B.1.b).(1).(b).(iii)
CCM Requirement #: IV.B.1.b).(1).(b).(iii)
Pulmonary Requirement #: IV.B.1.b).(1).(b).(iii)

Fellows must demonstrate the ability to manage the care of patients:] using population-based data; and, (Core)

We support this revision as written.

PCCM Requirement #: IV.B.1.b).(1).(b).(iv)
CCM Requirement #: IV.B.1.b).(1).(b).(iv)
Pulmonary Requirement #: IV.B.1.b).(1).(b).(iv)

[Fellows must demonstrate the ability to manage the care of patients:] using critical thinking and evidence-based tools. (Core)

We support this revision as written.

PCCM Requirement #: IV.B.1.c).(3)
CCM Requirement #: IV.B.1.c).(3).(a)
Pulmonary Requirement #: IV.B.1.c).(3)

Fellows must demonstrate sufficient knowledge in the clinical context, including evolving techniques. (Core)

We applaud the ACGME and the Review Committee for Internal Medicine for developing requirements that ensure our trainees have access to emerging technologies. However, without clarity around what specific evolving technologies our subspecialty trainees should demonstrate knowledge of, it's difficult to understand how subspecialty programs would be accountable for evaluating fellow knowledge.

We recommend modifying this requirement to be labeled as a (Detail) requirement rather than a (Core) requirement.

PCCM Requirement #: IV.C.10.
CCM Requirement #: IV.C.10.
Pulmonary Requirement #: IV.C.11.

The educational program must provide fellows with individualized educational experiences to allow them to participate in opportunities relevant to their future practice or to further skill/competence development in the foundational educational experiences of the subspecialty. (Core)

We support the intent of this revision. We recommend including within the "background and intent" that individualized educational experiences should be within the ability of the individual subspecialty fellowship and institution. Some individualized educational experiences may require high cost, distant sites, etc., and are not feasible.

PCCM Requirement #: VI.E.2.a)
CCM Requirement #: VI.E.2.a)
Pulmonary Requirement #: VI.E.2.a)

The program must provide educational experiences that allow fellows to interact with and learn from other healthcare professionals, such as physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)

We support this revision as written.

PCCM Requirement #: I.D.1.d).(1)
CCM Requirement #: I.D.1.e).(1)
Pulmonary Requirement #: I.D.1.(g).(1)

[The following must be available at the primary clinical site:] timely bedside imaging services, including portable chest x-ray (CXR), bedside ultrasound, and echocardiogram for patients in the critical care units; and, (Core)

We support this revision as written.

PCCM Requirement #: I.D.1.f).(1).(h)
CCM Requirement #: I.D.1.f).(6)

[The following support services must be available:] equipment, expertise, and personnel to provide both continuous and intermittent renal replacement therapy in the critical care units. (Core)

We support this revision as written.

PCCM Requirement #: IV.B.1.b).(2).(c).(xii) and IV.B.1.c).(6).(a)
CCM Requirement #: IV.B.1.b).(2).(c).(xi) and IV.B.1.c).(3).(d)
Pulmonary Requirement #: IV.B.1.b).(2).(c).(x) and IV.B.1.c).(5).(a)

IV.B.1.b).(2).(c).(xii) **[Fellows must demonstrate competence in procedural and technical skills, including: (Core)] those skills essential to critical care ultrasound, including image acquisition, image interpretation at the point of care, and use of ultrasound to**

place intravascular and intracavitary tubes and catheters; ~~**use of ultrasound techniques to perform thoracentesis and place intravascular and intracavitary tubes and catheters;**~~ **(Core)**

IV.B.1.c).(6).(a) **[Fellows must demonstrate knowledge of:] imaging techniques commonly employed in the evaluation of patients with pulmonary disease or critical illness, including the technical and procedural use of ultrasound and interpretation of ultrasound images at the point of care for medical decision-making;** (Core)

We support this revision as written. This revision establishes critical care ultrasound as a core procedure during PCCM training. We commend using "skills essential to critical care ultrasound" as appropriate as the field evolves. If the revisions were more specific to organ systems (individually naming thoracic ultrasound, cardiac ultrasound, etc.), then the requirements would likely need to be continuously updated.

As representatives of Pulmonary Disease, CCM, and PCCM, we commend the ACGME's effort toward greater fellowship program support. As individual organizations, we will provide comments using the ACGME online subspecialty program requirements comment form.

Sincerely,

Geneva Tatem, MD
President, Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD)

Doreen Addrizzo-Harris, MD, FCCP
President, American College of Chest Physicians (CHEST)

Vinay M. Nadkarni, MD, MS, FCCM
Society of Critical Care Medicine (SCCM) President

Gregory P. Downey, MD, FRCPC, ATSF, President
American Thoracic Society (ATS)

M. Patricia Rivera, MD, ATSF, President-Elect
American Thoracic Society (ATS)

Lynn M. Schnapp, MD, ATSF, Immediate Past President
American Thoracic Society (ATS)

Irina Petrache, MD, ATSF, Secretary
American Thoracic Society (ATS)

Jesse Roman, MD, ATSF, Treasurer
American Thoracic Society (ATS)