ACGME Program Requirements for Graduate Medical Education
in Geriatric Medicine
Summary and Impact of Major Requirement Revisions

Requirement #: I.B.5.

Requirement Revision (significant change only):

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

Subspecialty-Specific Background and Intent: The Review Committee considers a participating site to be geographically distant if the distance between the site and the primary clinical site exceeds 60 miles. The Review Committee acknowledges that programs may need to use geographically distant sites to provide fellows with specific required educational experiences not available at the primary clinical site or other participating sites. It also notes that such rotations can be disruptive to fellow well-being, adversely impact faculty member/fellow team interactions and cohesion, diminish participation in educational experiences (e.g., conference attendance/participation, scholarly activity, and continuity of care), and be burdensome for fellows. Programs will need to consider these issues when using geographically distant sites and implement actions to mitigate them. Providing travel and/or housing reimbursement for fellows rotating at a required geographically distant site is one way the program can offset the potential adverse impact on fellow well-being. Programs will need to be transparent and inform fellows that geographically distant sites are used.

1. Describe the Review Committee's rationale for this revision:
   The Review Committee acknowledges that programs may need to use geographically distant sites for education but created this new requirement so that programs are mindful of potential burden associated with such experiences. The Subspecialty-Specific Background and Intent provides suggestions for ensuring compliance with this requirement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This should improve fellow education and fellow well-being.

3. How will the proposed requirement or revision impact continuity of patient care?
   This should improve continuity of care because programs will be more mindful of the number of geographically distant sites being used for fellow education. Fewer distant sites should positively impact continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This may necessitate additional institutional resources for programs that use geographically distant sites.

5. How will the proposed revision impact other accredited programs?
   N/A

Requirement #: I.D.1.a)

Requirement Revision (significant change only):

I.D.1.a) The program, in partnership with its Sponsoring Institution, must:

I.D.1.a).(1) ~~There must be~~ space available, including ~~and equipment for the program, including~~ meeting rooms, examination rooms, computers, visual and other educational aids, and ~~work/study~~office space. (Core)

I.D.1.a).(2) ensure that appropriate in-person or remote/virtual consultations, including those done using telecommunication technology, are available in settings in which fellows work; (Core)

I.D.1.a).(3) provide access to an electronic health record (EHR); and, (Core)

Subspecialty-Specific Background and Intent: An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to include every element of patient care information. However, a system that simply reports laboratory or imaging results does not meet the definition of an EHR.

1. Describe the Review Committee's rationale for this revision:

   In-person or remote/virtual consultations: The Review Committee believes that with advances in technology, the patient-doctor relationship of the future will require virtual consultations in addition to in-person visits. Programs, in partnership with the Sponsoring Institution, will need to ensure that virtual and telecommunication technology is available to address this need.

   Electronic Health Record (EHR): The Review Committee revised this requirement to make clear that programs must have access to an EHR. The Review Committee believes that most programs and institutions have implemented or are in the process of implementing an EHR to more efficiently store and access patient health information and to be in compliance with other regulating entities, such as the Centers for Medicare and Medicaid Services (CMS). The new Background and Intent provides further guidance on how to meet this requirement, including clarifying that an EHR does not have to be present at all participating sites, and does not have to include every element of patient care information.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   These changes will improve fellow education and patient care because it will ensure the fellows are able to deliver care in a variety of settings and have ready access to vital patient care information.

3. How will the proposed requirement or revision impact continuity of patient care?
   These changes will continue to improve fellow education and patient care because fellows and other health care practitioners in the health care system will be able to deliver care in variety of settings and have ready access to vital patient care information.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
This may necessitate additional institutional resources depending on where programs and institutions are with regard to the use of virtual technology and in implementing an EHR.

5. How will the proposed revision impact other accredited programs?
N/A

Program Requirement II.B.4.b-c)

Requirement Revision (significant change only):

II.B.4.b) In addition to the program director, programs must have the minimum number of core faculty members who are ~~there must be at least one faculty member~~ certified in geriatric medicine by the ABIM, ABFM, AOBIM, or AOBFP based on the number of approved fellow positions, as follows:~~.~~ (Core)

Number of Approved Positions	Minimum Number of Certified Core Faculty
1-3	1
4-6	3
7-9	4
10-12	6
13-15	8
16-18	10

II.B.4.c) ~~At a minimum, T~~the required core faculty members~~, in aggregate and excluding program leadership,~~ must be provided with support equal to an ~~average dedicated~~ aggregate minimum of ~~.1 FTE~~ 10 percent/FTE for educational and administrative responsibilities that do not involve direct patient care. Additional support must be provided based on the program size as follows: (Core)

Number of Approved Positions	Minimum Aggregate Support Required (FTE)
<7	0.10
7-9	0.15
10-12	0.15
13-15	0.20
16-18	0.20

Subspecialty-Specific Background and Intent: ~~The Review Committee specified the minimum required number of core faculty members but did not specify how the aggregate FTE support should be distributed to allow programs, in partnership with their sponsoring institution, to allocate the support as they see fit.~~

~~Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For~~

~~example, if one core faculty member is named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE.~~

The Review Committee created the table below to summarize the total minimum FTE for program director, associate program director(s), and core faculty members needed based on approved complement. The table also clarifies the minimum number of core faculty members necessary based on program size. Two examples are provided.

• A two-fellow program needs a program director and a minimum of one total minimum FTE of 30 percent. This total minimum FTE is a sum of the minimum of 20 percent for the program director and an aggregate of 10 percent for the associate program director/other core faculty member.

• An eight-fellow program needs a program director and a minimum of four ABIM, ABFM, AOBIM, or AOBFP subspecialty-certified core faculty members (at least one being the associate program director) and a total minimum FTE of 58 percent. The total minimum FTE is a sum of the minimum of 25 percent/FTE for the program director, an aggregate of 13 percent/FTE for the associate program director(s), and an aggregate of 20 percent/FTE for the remaining core faculty members.

As long as the program meets the requirements for the minimum FTE for the program director, the minimum number of ABIM-, ABFM-, AOBIM-, or AOBFP-certified core faculty members, and the aggregate FTE for core faculty members and associate program director(s), programs may exercise flexibility in how the aggregate FTE for core faculty members and associate program director(s) is distributed. For instance, in the two-fellow program example, the program can allocate the aggregate 10 percent FTE in whatever manner the program and institutional leadership feel works best.

Number of Approved Fellow Positions	Minimum Number of Subspecialty-Certified Core Faculty Members (One Being the Associate Program Director)	Minimum Support Required (FTE) for Program Director	Minimum Aggregate FTE for Associate Program Director(s)	Minimum Aggregate FTE for Core Faculty	Total Minimum FTE for Program Director, Associate Program Director(s), and Core Faculty
1-3	1	0.20	0.10		0.30
4-6	3	0.20	0.20		0.40
7-9	4	0.25	0.13	0.20	0.58
10-12	6	0.30	0.14	0.20	0.64
13-15	8	0.35	0.15	0.20	0.70
16-18	10	0.40	0.16	0.20	0.76
19-21	12	0.45	0.17	0.25	0.87

22-24	14	0.50	0.18	0.25	0.93
25-27	16	0.50	0.24	0.25	0.99

Background and Intent: Provision of support for the time required for the core faculty members' responsibilities related to resident education and/or administration of the program, as well as flexibility regarding how this support is provided, are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

It is important to remember that the dedicated time and support requirement is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the core faculty members, is also addressed in Institutional Requirement II.B.2. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/ subspecialty-specific Program Requirements.

1. Describe the Review Committee's rationale for this revision:
The Review Committees are proposing revisions to the program director, associate program director, and core faculty full-time equivalent (FTE) requirements to address (1) feedback received regarding the 2022 requirement related to FTE support in the subspecialties, and (2) to establish symmetry between the multidisciplinary subspecialties and the recently approved revision to the internal medicine subspecialty Program Requirements.

The Review Committee for Internal Medicine received much input from thought leaders and organizations within the internal medicine subspecialty communities with concerns regarding potential unintended consequences resulting from the 2022 FTE faculty requirements. The input raised important questions that hadn't surfaced during the review and comment period when this program requirement was vetted in 2021. As a result, the Review Committee revisited the FTE requirements for core faculty and included Background and Intent language with an example to clarify expectations with the revised language. Despite some dissent, there was general agreement and support for the revised requirement and support for the Review Committee to consider increasing the minimum aggregate FTE for smaller-sized programs, particularly from the subspecialty societies/communities.

In addition, the Review Committee included a summary table in the Background and Intent that contains the total minimum FTE required for program director, associate program director, and core faculty to clearly stipulate FTE expectations for multiple program personnel in one central table within the Program Requirements.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The ultimate outcome of graduate medical education is excellence in resident/fellow education and patient care. The Common and specialty-/subspecialty-specific Program Requirements related to non-clinical teaching and administrative time and support are intended to ensure that the required core faculty members are able to devote a sufficient portion of their professional effort to didactics and administration of the program to ensure an effective and high-quality educational program.

3. How will the proposed requirement or revision impact continuity of patient care?
N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
It is important to highlight that these requirements define the required minimum dedicated time for core faculty members' non-clinical teaching and administrative responsibilities. Programs for which the requirements for non-clinical teaching administrative time and support have increased will need, in partnership with their Sponsoring Institution, to provide additional support for administrative time as specified in the requirements.

Both provision of support for the time required for administrative responsibilities and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institution, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties. Those who are new to their role may need to devote additional time to program administrative responsibilities initially as they learn and become proficient in that role.

5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: III.A.1.b).(1)
Requirement Revision (significant change only):

Fellows who did not complete a family medicine or internal medicine program that satisfies the requirements in III.A.1. must have completed at least three years of family medicine or internal medicine education prior to starting the fellowship as well as met all of the fellow eligibility exception criteria outlined in III.A.1.c)-III.A.1.c).(2). (Core)

1. Describe the Review Committee's rationale for this revision:
The Review Committee included the specialty-specific requirement to provide clarity regarding the expectations for Sponsoring Institutions about the "eligibility exceptions" for fellows who did not complete family medicine or internal medicine education and training in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
N/A

3. How will the proposed requirement or revision impact continuity of patient care?
N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A

5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: IV.B.1.c).(1).(q)
Requirement Revision (significant change only):

[Fellows must demonstrate sufficient knowledge in the following content areas:]

the basic assessment of capacity and related documentation requirements (guardianship paperwork, medical holds, etc.); (Core)

1. Describe the Review Committee's rationale for this revision:
The inclusion of the Medical Knowledge competency related to fellows' knowledge of the basic assessment of capacity and related documents reflects an essential curricular component defined by the subspecialty community.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
This area falls within the scope of a geriatric medicine specialist. Requiring fellows to demonstrate sufficient knowledge in this established area will ensure they have the standard minimum knowledge and level of competence required to provide quality patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A

5. How will the proposed revision impact other accredited programs?
N/A