APPD HOT TOPICS SIG DISCUSSION- MEETING NOTES
MAY 3RD, 2007 TORONTO
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* See attached slides and the appended pre-meeting survey results for additional information.

INTRODUCTION

The Hot Topics SIG is a forum which grew out of member input to address topics at the meeting in an open group forum. This session is led by 3 members of the APPD who facilitate discussion, take notes, and forward to APPD Board and website. The last few years, SIG leaders have conducted a brief survey to target common interests and priorities (see appended survey results). This year, we selected 3 main topic areas as outlined below. The R3P and ABP discussion was high on the interest list, but since other large group sessions were planned, we limited discussion of this area. The 3 main topics we covered attempted to incorporate many of the survey items as subheadings.

The SIG group does not have formal follow up or a set/defined role with the APPD Board— any questions on follow-through or next steps should be directed to the APPD leadership. All of the notes below are our individual interpretation of the discussion and should not be seen as official policy or final authority. We apologize if anyone or any topic was misinterpreted or omitted.

Thanks to all who participated. We are very interested in using this SIG forum to maximize the amount of interaction and effectiveness. If you have suggestions for future meeting planning, please send to Jerry Rushton jrushton@iupui.edu or provide to future meeting planning committees. See you in Hawaii!

A. DISCUSSION OF ACGME COLLABORATION IN ACCREDITATION [RUSHTON]

1. Background

- Jerry Rushton introduced the topic, gave an update on follow-up from last year
- Encourage group to review the article "Community discernment— getting documentation right— a first step to exemplary accreditation" by Leach, Carraccio, McGregor in Jan/Feb 2007 Ambulatory Pediatrics for additional background context
- Issues center around procedural logs, clinic logs, and future portfolios or potential documentation.
- The ACGME appears willing to listen and collaborate; thus we have an opportunity to work together on shared goals
- However, there are some likely limitations in manpower, cost, and discussion about the responsibility to administer these logs (ACGME?, program?, resident?)

2. Procedure logs and documentation

- Rob McGregor updated that he expects to have some pilot data and summary from the first 3 years by the Fall meeting. This will be important to share experiences, results, and consider how valid and useful APPD membership feels the data are
- While less vocal this year, there are still many concerns about how the data and ACGME goals are being communicated, how the data will be used
- Many recent site visits did not focus on any specifics about the procedure logs, just checked for the forms (not type of dxs, quality of data or specific numbers).
- Consensus in the discussion by APPD members was to avoid attempting to simply count numbers or to set rigid minimum standards by ACGME or ABP to individuals
- Many concerns that these logs/data are not valid, and do not equate to competency which may vary significantly among individual residents who could have the same raw number of specific procedures logged
- Discussion of diminishing opportunities for many procedures (e.g. chest tubes, umbilical lines) and challenge to the notion that we should even attempt proficiency/expertise as a realistic, achievable goal.
- Types of future practice and varying individual needs should be considered (e.g. suburban practice vs. rural) and attention on these skills such as stabilization of critically ill neonate vs. # of intubations.
- Comments that despite decreased opportunities for some neonatal procedures, the RRC has limited the number of NICU months— some goals and regs. appear in conflict and should focus on outcomes and needs of workforce and individual grads. more
- Patty Hicks and the APPD, APA will be starting a process to explore describing the key components of procedures and how to develop the content within pediatrics, neonatology, surgery, critical care, EM, etc. to develop more meaningful educational objectives and measures of procedural competency
- Still a need for supervisory sign off vs. the current “honors system” of self-report
- Frustrations continue of this as a duplicative process; many believe that we must demand import/exportability and push ACGME to provide the tech. support and solutions to make this practical
- Concerns that it took almost 12 months to even complete errors in the ICD-9 codes, overlapping age categories, etc. which create some skepticism of the ACGME IT support/capabilities of their system or potential to improve
- Discussion of how do achieve competence, when do we stop logging or signing off and some programs do this for their seniors, so some data or PGY3 summaries may look incomplete.
- Others raised the question if logs or individual data collection should continue after graduation and some continuum of logging that the individual resident kept and took ownership for that might assist with accreditation, or other recertification potentially
- Concerns that recent Med-Peds notification shows that despite the progress and dialogue of the last year, the log initiative appears to be continuing and expanding without full communication and collaboration.

3. Clinic logs

- With suspension of this requirement, there was less discussion about these logs. However, the group is still interested in the overall goals of how to document the continuity experience (a) for volume, #sessions, and PIF data and (b) for the advanced skills of chronic disease management, longitudinal care, etc. (see also Lynn Campbell's section notes)
- A few programs with recent site visits felt like the basic numbers were reviewed, but minimal to no attention was paid to details of the diagnoses, ages, etc.
- Some discussion that the ideal goal that (whatever system is used ultimately), to have residents and clinic preceptors receive summary information and use this to set goals based on needs
- Some discussion that clinic experience and logs should not be viewed in isolation. For example, if clinic logs show relatively few adolescents, can programs document this and achieve these goals on the adolescent rotation vs. addressing this in clinic numbers?
- Many clinics still use paper, cards, or their own systems. Some anecdotes that the ACGME logged data and reliance on residents or admin. assistant entry which has up to 25% error rate vs. other IDX or passively captured scheduling system logs
- Consensus was the need to develop clear aims for what should be reported that serves individual, program, PIF, and accred. needs
- We did not have much discussion or time to discuss other competency documentation, future portfolios, or other next steps in the future which may be used.
- Although the SIG is not charged with problem solving or refining next steps, there was interest in considering how to continue this as a PDSA cycle, how to communicate to the board/ACGME/RRC, and how to use our own individual and committee expertise to operationalize this partnership and develop these logs.

B. RESIDENT AUTONOMY AND OWNERSHIP OF PATIENTS [BRIAN YOUTH]

1. NOTES from open group discussion:

- Importance of recognizing the difference between "autonomy" and "independent decision making"—the real issue is are we giving residents the opportunity to make patient care decisions, regardless of attending presence.
- Attendings on-site needn't detract from independent decision making and we should promote those settings where hospitalists/intensivists/clinic preceptors are around the residents enough that they get to know who they can trust, who needs more help and guidance. This takes faculty development to teach attendings how to "hold back" and let the residents make decisions first
- We should think of attendings in the role of not interfering with medical decision making, but instead, be in the position of providing "support" to the residents as they make independent decisions.
- "We are the enemy!"— we need to model excellent patient care clinical decision making, professionalism, communication, sign out effectively etc… We should think of changing the language – "owning" patients doesn't necessarily mean no attending is around, but instead, should mean the resident owns the patient, but

has attendings who are AVAILABLE AND SUPPORTIVE, as well as GUIDING the residents who are primarily caring for the patients

- Duty hours "Shift" mentality need NOT be a barrier to autonomy. We can do more to educate our housestaff that when they receive sign out, they TAKE ON the OWNERSHIP of the patient for that period of time, and need to rise to the challenge of not moving into "babysitting mode" for the night or call shift. "When you are on, you are the doc!"—Carol Berkowitz comment : "I don't know what's going on, I'm off service and just covering"- we need to get away from that language
- Big Picture on Autonomy/Patient Ownership- we need to keep a global thought in mind- that being "what does a general pediatrician need to know" -- this may help guide our services where specialty attendings (for example) may "own" the patient more than the resident- this may be ok if it is a relatively rare disorder that does not fall into the knowledge "needs" of a given resident.
- One PICU intensivist brought up how she can effectively sign out the unit in 10 minutes and capture all the relevant information the coverage needs- we should model this for housestaff as well. This modeling can and should be part of faculty development.
- Idea of "relay team." When you hand off (sign out) patients and key information, you now are running the next leg, and when you transfer care again, you don't want to drop the baton. Again, we need to model not only the transfer of care, but the ownership as well.
- It would behoove us to consult with our med/peds colleagues who seem to "own" patients better based on their medicine experience. Why is this? What are the differences?- these are questions we should explore further.
- All of these thoughts should be considered in the context of R3P- that being that we need to view Residency Education as part of the ongoing process of medical education that starts prior to residency, and continues well past residency.

C. CONTINUITY CLINICS [CAMPBELL]

Part 1.) Background Material Presented (see slides)

Old documentation requirements

New documentation requirements

1. 36 weeks per year – PIF Table

   PIF data – # half day sessions / wk

   Range number sessions per yr

   For each level of training

   Explanation if any less than 36 per year

2. Scope of resident experience as a log with age, DX, encounter dates

   PIF Attachment – Appendix H

   Current PIF instructions say ACGME case log required

   Substitute equivalent log

   Unique patients – indicator of multiple visits?

   PIF data - # CC visits per resident per year

Unique patients
Number of days a patient was seen
Average number of patients per session

3. Progressive Numbers of patients per session (3,4,5 rule) and Continuity of resident with preceptor, team and not too many trainees per preceptor as documented via a PIF table

   PIF data - Name and location of all sites
   Ratio residents / preceptor for all sites
   Numbers of residents assigned to each location, including combined residents
   Average number of patients / resident / session for PL1 – 3
   Group or Team Practice? Y or N

4. If group or team practices required description of mechanism to ensure communication between team members –Dialogue box limited to 75 words

5. Consistency of preceptors over time required –"State the frequency with which residents change preceptors over the course of training", if varies by site must discuss all - Dialogue box limited to 75 words

Part 2.) Concerns expressed

1. Reports from recent site visits –
   a. Wanted plan to assure 36 weeks per yr
   b. Make up weeks acceptable
   c. Cudos for tracking and generating a plan to add make up clinic
   d. No diagnosis or age data reviewed if numbers OK
   e. Wanted to know system used to track # and experience
   f. One site visitor did ask to see a resident's log as produced by New Innovations
   g. One site visitor asked PDs to reflect of program changes needed if numbers not what they "should" be but not to assure that adequate experience despite inadequate numbers
2. Some confusion about "team" issue – suggested say no if resident sees own patient on regular day
3. Suggest that PIF clarify exactly what data in Appendix H – suggest similar to what produced by following directions if using Case Log
4. Suggest PIF instructions be changed to reflect option to use alternative system and to list exactly what data need be included
5. Concern expressed that this is still all process and bean counting and not at all outcomes driven – Several expressed concerns with varying degrees of intesity
6. Suggestion that site visitor do "Direct Observation" and resident interview to assess adequacy of CC experience.
7. Discussion that APA CC SIG will be focusing on unique experiences in CC that they would suggest that all resident be assured of having to include age diversity, well child and acute care and chronic care for target conditions at various stages (dx, early management, med monitoring, complications, coordination of care…..)

8. Discussion that the ACGME wants us / APA CC SIG to suggest a log format that would capture desired data and patient experiences thought essential in CC
9. Dialogue about persistent problems with Case log that were never fixed – particularly need to track entries by MR (to look at longitudinal care).
10. Concerns about data entry error rate even if taken out of hands of tired residents and done by clerical person
11. Some suggested using number data (which might otherwise be considered worthless) as part of program CQI (average experiences, compared to ideal) and individual data in ILP (you compared to peer average) for PBLI.
12. Strong push still to allow data to be presented in another format so that it can be imported into the ACGME systems for both procedures and case log so that residents can stop double entering data. Particularly problematic because procedure system does not allow verification of competence or sign off by supervisor and is an "honor system" only.
13. Concern that CC diversity panel characteristics not be so specific and to allow program to show that there is training and exposure to certain patients in other rotations (examples B&D exposure in CC not necessary if obtained in general peds clinic and on the B&D rotation and exposure to WCC as well as acute and chronic care issues in Adol clinic versus CC) – allow programs to define where residents get the training rather than insist that everything be in CC
14. Some APPD urge APA members (CC SIG) to be careful in defining what is unique and essential in CC and to avoid numbers and focus on peer review / direct observation / resident interview about appropriateness and adequacy of their experience.
15. Another push to having a site visit be less validation of the PIF and more direct observation / peer review of the experiences and education that residents are getting in the program – Let the site visitors actually visit a CC site and interview all involved to see the good thing that is actually happening instead of citation based on numbers which have nothing to do with the quality and outcome of the experience.

D. MISC- Other notes from last 10 minutes of SIG

1. Reports from recent site visit that there was careful review that programs and individual rotations goals and objective are competency and outcomes driven in language and evaluation.
2. Suggestion of card for faculty and residents that lists each competency, defines it and says where it is being taught and evaluated in your program, and lists at least one example of how it is being measured.
3. Faculty development seems harder that residents – lots of coaching sessions of key faculty.
4. Emphasis of resident and faculty interview times to discover if competency is being taught and measured. Are faculty involved in writing their rotational competency based goals and objectives and doing direct observation?
5. Warning that the PIF requires that there be documentation of faculty development including about how faculty are taught to be mentors and advisors.

APPENDIX- APPD PROGRAM DIRECTOR PRE-MEETING SURVEY RESULTS

SURVEY ITEMS (N= 128 RESPONSES) Data as of May 1st, 2007	% who selected item as a priority topic	n
COLLABORATION WITH THE ACGME to develop standards and documentation that meet all of our needs (residents, PDs, RRC)— procedures, clinic logs, competency portfolios, etc.	47.7%	61
CONTINUITY CLINIC ISSUES: Session and visit numbers and how to deal with holiday, vacation, post-call, and other absences. Balancing and doc. continuity, volume, diversity, and competence in this setting.	47.7%	61
MEASURING COMPETENCE VS. DOCUMENTING EXPERIENCE ARE THEY THE SAME? How do we move from numbers, process to real outcomes and fully individualized plans?	46.1%	59
R3P PROJECT UPDATE: Working with the ABP and other organizations to stay involved planning discussions regarding potential impact on future training and program administration	37.5%	48
NEW PIF AND SPECIFIC COMPETENCY DOCUMENTATION: sharing info from early site visits and how to share resources for these specific documentation needs and best practices.	35.2%	45
CONFERENCE STRUCTURE/DIDACTICS—attendance/interest and challenges/solutions in post duty hours era and use of alt. educational methods (self study, web, etc.)	31.2%	40
PROCEDURE LOGS: where do we go after the 3yr. pilot; and should Pediatrics consider standard core requirements like ABIM?	29.7%	38
REWARDING / VALUING EDUCATION WITHIN THE DEPT./INSTITUTION to support and promote of required / essential educational efforts (faculty time, merit, pay) beyond traditional clinical and research measures.	22.7%	29
HOSPITALISTS AND NON-RESIDENT TEAMS: Balancing these trends with resident autonomy, ownership, responsibility and program educational needs.	21.1%	27
INSTITUTIONAL SUPPORT FOR PROGRAM DIRECTOR AND ADMIN. DATA NEEDS: Getting institutions to provide salary and other financial support and resources needed in this new ERA of documentation of competence.	19.5%	25
HOW TO ADAPT SCHEDULES TO DIFFERENT INDIVIDUAL NEEDS (family-friendly, leave, part-time) and balance individual and program needs?	14.8%	19
SIMULATION- what is the role for this in pediatric education- now, future - for board recertification, for teaching of key procedures and doc. competencies.	14.8%	19
MAKING RESIDENCY INFORMATION USEFUL AFTER GRADUATION to future employers, credentialing, and resident ongoing development.	8.6%	11
RELATIONSHIPS BETWEEN RESIDENCY PROGRAMS AND FELLOWSHIP PROGRAMS: Shared challenges of documentation of the competencies and other issues at national org. and local level	6.2%	8
OTHER (please type your addl. suggestions)	5.5%	7

OTHER TEXT COMMENTS

1. Innovation and experimentation in residency program design
2. The R3P is going to impact us in many ways it seems. The plenary focuses on this. I feel getting ideas from PDs would be great at the plenary. Not complaining about the concept of change, but positively driving our residents' future should be (I think) the tine of this discussion! I would be interested in hearing from others ways they solve/deal with work-family balance issues!!
3. quality improvement projects for residents - how are programs handling this requirement?
4. Rsidency training in community settings
5. Mental Health issues in residency
6. duty hours - lmits affect education and may be too rigid
7. I think all of these are very important. I am having difficulty across the board.

SMALL PROGRAM ADDL. COMMENTS

1. new requirements that continue to come out make it more and more difficult for small programs to remain viable.
2. Organization of inpatient teams with limited numbers of residents; i.e. Mix of general vs subspecialty patients and is the subspecialists the attending or the consultant? Conference/education organization, curricula, and planning with limited faculty.

3. Conference structure continuity clinic issues
4. Continuity Clinic Issues, Institutional Support, Rewarding/Valuing Education, How to Adapt Schedules
5. The post call "no work" culture affecting professionalism, ownership of patients, commitment to care of patients.
6. Hopitalists and Non-resident teams in small programs....is it needed is it occurring? Measuring competence vs. Documenting experience. Great topic would be nice to have converstions about this. Many of the programs in this forum are of a similar set-up/size range...would make for interesting discussions.
7. CONFERENCE STRUCTURE/DIDACTICS—attendance/interest and challenges/solutions in post duty hours era and use of alt. educational methods (self study, web, etc.) R3P UPDATE: Working with the ABP and other organizations to stay involved planning discussions regarding potential impact on future training and program administration
8. what is the definition of a small program? Ours has 33 peds residents and was described by some applicants as small!
9. continuity issues hospitalist issues
10. Adapting schedules to individual needs, especially in a small program.
11. In small programs with less than optimal faculty "buy in" and participation, how are you managing to teach AND measure all of the competencies, track procedures, track continuity panels, etc.? It is getting to be a bit overwhelming for some small programs with limited resources. What sort of SBP/QI "projects" do you have your residents working on? It would be nice to share some "best practices" or pearls more realistic for small programs.
12. R3P project Rewarding education within the Dept
13. Scheduling issues with small programs Lack of faculty support within the program as small programs rely heavily on clinical income.
14. I would really like to discuss the "studentization" of residents. With more attending supervision, residents seem to be making very few decisions on their own. I worry about resident autonomy. Each day, we are treating them more and more like students. How do we address this?
15. R3P--undifferentiated and/or comprehensive generalists Procedure Logs, getting more procedures in smaller settings Seems like RRC is again Children's biased; Only 2 members from non-children's hospitals.
16. Any topic that will help me prepare for my upcoming site visit (my first) will be appreciated; I'd echo the ones checked above.
17. HOW TO ADAPT SCHEDULES TO DIFFERENT INDIVIDUAL NEEDS
18. 1. Concern that the new requirements are going to lead to more program closures / withdrawals because we don't have the resources (education specialists, dollars to purchase propietary systems and the educational programs available and staff personnel to track all this now required stuff) that big programs may have. 2. Problem solving getting through a site visit without a "critical faculty member" - What happens when your only B&D or AM specialist leaves for "greener pastures"? 3. Creative solutions (other than human cloning which George frowns upon) to the challenges of faculty development when you and only you are the EDUCATION Guru. Also interested in the issues checked above from a smaller program perspective - ie the new PIF and small program citiations, The new ACGME resident survey experience with it and the new ambiguous questions, hospitalists and non teaching services experience at smaller programs