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Accreditation Council for Graduate Medical Education (ACGME)
Pediatric RC

515 North State Street, Suite 2000
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Dear Pediatric Review Committee,

Thank you for allowing the Association of Pediatric Program Directors (APPD) to provide input for the revision of the pediatric requirements.

To engage the membership in the input process, we conducted four conference calls to discuss various areas of the Pediatric Requirements. The membership was also invited to comment on the minutes of the calls via a comment board. Each of the four calls had roughly 25 participants who "signed in". Our recommendations reflect the area of the requirements that were discussed and had substantial agreement from participants. Please see the attached document for specifics.

Please also note that the leadership and membership of the APPD would be happy to work with your committee as your process moves forward to flesh out more details, do needs assessments and/or surveys of PDs, and/or get specific input on specific questions that you may have moving forward. Again, thank you for allowing us to meaningfully participate in this process.

Sincerely,

APPD Board of Directors

Summary of APPD Input into Revision of the Pediatric Review Committee (RC) Requirements

Conceptual Considerations for Revisions

1. With increasing awareness of the need to demonstrate resident competence and program effectiveness through assessment of resident outcomes, new program requirements should focus on demonstration of outcomes, rationale and approach to instruction, and alignment of curriculum with program and ACGME goals.
 - a. Process or curricular suggestions, if offered in the new requirements, should be in the form of suggested instructional approaches, - not requirements or “must” statements unless the outcomes for those required strategies have demonstrated that they represent best practice [can define].
 - b. Numbers should not be used as evidence for minimum experience, unless there is evidence that without a minimum experience competence cannot be achieved. **Limiting clinical service** may be required as a safeguard against institutional pressure to gain additional service through disproportionate assignment to subspecialty, intensive care or patient service coverage.
2. The APPD’s suggested input for program requirements are based on the current duty hour requirements. If those change, some aspects of the requirements will need to be readdressed.
3. Programs and residents should be encouraged to individualize curricula based on educational rationale and needs to allow innovations such as in the IPE. The balance of core foundation requirements and individualized approaches is vital.

Arranged by topic area:

CONTINUITY CLINIC

Key Points: Focus on longitudinal experience with continuity of care. This may be accomplished via any number of scheduling schema. Focus on outcomes in preventive care, longitudinal relationships with families, and medical home principles the qualitative aspects are far more important than the quantitative documentation.

Specifics:

1. Shift to requiring an overall total number of sessions throughout residency training, with more flexibility to individualize scheduling. It is reasonable to expect somewhere between 120-130 sessions, much like the requirement in Internal Medicine. Residents should attend clinics regularly and not miss continuity clinic for service demands. However, some absences from clinic for brief periods with good educational rationale may be appropriate.
2. Documentation of resident session attendance, coupled with clinic site statistics can serve to demonstrate any numbers and specifics about the variety of patients seen. A specific log for tracking numbers and patient demographics should not be necessary if clinic attendance and clinic data representing patient numbers and demographics can be reported, along with the number of providers present.
3. Longitudinal care is an important concept which should be a part of continuity clinic and residency; however, this may be accomplished in different ways

beyond the “panel patient” concept. Follow up on continuity patients and chronic illness management in a medical home setting are important experiences. The PIF should focus on these outcomes instead of more limited focus on number of weekly sessions or panel patients.

ADOLESCENT MEDICINE, DEVELOPMENTAL/BEHAVIORAL PEDIATRIC ROTATIONS

Key Points: Flexibility is key. Clearly these are important to general pediatrics and should be maintained as educational requirements.

Specifics:

1. Reconsider the concept of “time” with these rotations. The RC should review concepts of how the month experience, number of weeks/sessions, and call are considered. As these are primarily outpatient experiences, call and inpatient requirements should be minimized and not interfere with the educational programming of these required rotations. .
2. Allow flexibility in the “block” structure of the experience, allowing two weeks at a time, one week at a time, or combinations of experiences during residency with proper educational rationale.

EMERGENCY MEDICINE

Key Points: No changes needed except with the PIF

Specifics: Take out the questions about number of patients per resident per shift.

PEDIATRIC INTENSIVE CARE

Key Points: Do away with Patient counting and allow educational rationale to guide the experience. Specifics:

1. Allow PDs to explain and describe the learning experience in the PIF.
2. Take out the tables requiring tables with numbers of patients per resident per shift.

NEONATAL INTENSIVE CARE UNIT

Key Points: No changes needed.

SUBSPECIALTY ROTATIONS

Key Points: General agreement on the amount of subspecialty time required. Appreciate any added flexibility.

Specifics:

1. Remove PIF question asking for the percent time inpatient vs. outpatient
2. Remove vague wording on “For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.” Overall balance of inpatient experiences and outpatient is important, but specialty practice varies greatly. Ensure residents have overall appropriate mix of inpatient care, consultations, and outpatient experiences for full range of pediatric conditions seen in different settings.

3. Remove the PIF question asking for the number of residents that have rotated on each subspecialty over the years.
4. Add pediatric toxicology and pediatric forensics to the second tier list.

INPATIENT WARD TEAMS

Key Points: Allow flexibility in the way residents can experience rounds on inpatient pediatric medicine rotations. In some programs, combination teams of general/specialty patients may count as “general teams”. Require program directors to describe the learning experience rather than fill out grids.

Specifics:

1. Delete the diagnostic categories table at the end of the PIF.
2. Delete the grid requiring specific numbers of patients/resident/shift.
3. Allow Program Directors to comment on the spectrum of patients that the residents encounter.
4. Delete the specific sentence on “3 attending rounds per week” as it does not reflect the concept of family centered rounds, which many programs use currently, and is the future of medicine. However, appropriate oversight and daily supervision is important.

CONFERENCES

Key Points: Restrictive requirements should be modified. The current requirements are not consistent with adult learning and varied learning styles. Traditional conferences may not be as effective as pod casts, modules and interactive learning experiences. In addition, changes in duty hour requirements may make it impossible to meet the current standards.

Specifics:

1. Program Directors should be required to document how their residents are receiving all educational experiences. There should be flexibility in how this is being accomplished, requiring evidence of outcomes, not process.

FULL TIME EQUIVALENT

Key Point: It is critical for programs to have appropriate support by institutions, hospitals, and departments for program leaders, assistants, and faculty with dedicated protected time.

Program Director Support

Specifics:

1. Change the “should” to a “MUST” in terms of financial support

Faculty Section

Specifics:

1. Consider the concept of “Key” faculty or “educational liaisons” as people who are in charge of or oversee required rotations. Consider naming them and being held to a standard of faculty development/involvement, similar to the internal medicine requirements.

PROGRAM ADMINISTRATION

Key Point: The concept of a cap is to assist Program Directors with allowing some leverage if patient care is being compromised by overly “high” numbers of patients per resident is important. Programs should ensure a reasonable balance of service/education, autonomy/oversight, etc. Some teams and complex patients may require additional limits on daily rounding, weekend coverage, and night call to ensure appropriate communications, patient safety, etc.

The APPD recognizes the complexity of proposing a specific number for all services and acknowledges the complexity of creating the right size team for optimal patient care. Residents have responsibilities to provide patient care as part of their duties; commitment to patient care delivery is part of the critical development of every responsible physician. Residents also need time to reflect, direct their learning and respond to increasing responsibility and challenges as they learn to provide safe care for all patients. Some patients take more time to manage than others. New admissions, patients with complex medical conditions or unanticipated patient care complications contribute to the time it takes for a resident to safely and effectively manage their work-responsibilities. Given all of these considerations, the APPD feels that new requirements should include limits on patient numbers and specification about supervision and back-up support for residents - both day and night.

In discussing the number of patients per intern on call and per supervising resident on call, there was wide variation of opinion. Some general thoughts emerged:

- 1) The number of patients per intern or supervising resident is difficult to specify unless that number considers the patient care needs for that setting. It was agreed that the number of patients that could be covered was significantly higher if the patients were stable v. a setting of far fewer patients who were in need of constant monitoring or therapeutic intervention.
- 2) The number of admissions an intern or supervising resident is responsible for also affects the number of patients that individual can cover at the same time.
- 3) The availability of back-up or support assistance allows for a higher number of patients per resident-provider.
- 4) Program Directors are most familiar with their respective institutions' patient acuity/stability and availability of patient care support as it relates to the residents' capability to safely manage a given number of patients and therefore Program Directors should be able to establish appropriate limits to patient team size.