SUMMARY – APPD 2012 Fall Meeting Presentations and Discussions

Key Points from the Plenary Session – American Board of Pediatrics

- The ABP has modified the end of the year evaluation and tracking forms. These now include the use of marginal status, with either promotion to the next level or repeat of training year.
- The new computer based ABP Certification Exam began in October at the Prometric Testing Centers. There will be four parts to the exam over one single testing day.
- A new scoring scale will be used for the 2012 Exam with a scale from 0 to 300. An absolute (criterion-based) score for passing will be established. The ABP will no longer provide % correct.
- The curriculum for non-standard pathways will be modified to maintain consistency with the New Pediatric Requirements.
- Time-limited eligibility for initial certification (7 years) is now the standard established by the ABP. Beginning in 2014, practitioners who have not completed certification within 7 years of completion of training will be required to take an additional year of training prior to being approved for the ABP Certification Examination. This additional training must occur in an accredited program. This is a common area for inquiry and the ABP has posted an FAQ on this topic. The link to the ABP FAQ on this topic is on the ABP webpage.
- Primary Care Boards (Peds, IM, FM) are working to strengthen residency training to support delivery of high-quality ambulatory care for 21st century health care systems. HRSA is collaborating in creating a nationwide faculty development initiative to address common needs of training programs and RFP will be distributed in November 2012.

Key Points from the Plenary Session – The ACGME Presentation

- New training program requirements will be phased in beginning with residents entering their PI-1 year of training on July, 1, 2013. Residents who will enter their second year or third year of training will not be measured against the new training requirements.
- The RC will allow for “double counting” during the curriculum established for the Six Individualized Educational Units. Up to three Educational Units of this Six
Educational Unit Curriculum can also be counted as EU’s for additional subspecialty training, as long as it aligns with the career goals of the individual resident.

- Core faculty is defined on ADS. Each Program will list its Core faculty in the ADS system. These are the faculty who will be surveyed (using the faculty survey) as part of the annual survey that the RC will review for each program. Think about what makes sense for your program. Requirements for core faculty are specified on WebADS. There is no minimum number of core faculty based on size of the residency, but it is clear that those listed as core faculty must play an important role in the education of trainees in the program.
- The new requirements are emphasizing minimum requirements and have removed any maximum requirements. The emphasis is on meeting the minimum training requirement.
- Faculty in Pediatric Emergency Medicine are now required for each residency.
- Supervision of interns can be by a licensed provider, supervisory resident, faculty member. (See FAQ for VI.D.1, and VI.F.)

**Key Points from the Plenary Session – The Pediatric RC and the Next Accreditation System (NAS)**

- The NAS has been designed to foster innovation and reward excellence. The ACGME encourages program directors to transition to a cycle of continuous accreditation and self study for programs. Program Requirements will now only change every 10 years and there will be an evolutionary change to site visitors.
- We discussed the parameters for program self-study and identified what data the ACGME be reviewing. If a program has difficulties with any of these elements, the ACGME will want more detail and will “drill down” to understand the problem and how to address it.
- Core elements include:
  - Program attrition such as resident withdrawals or dismissals
  - Key leadership changes in the hospital (PD, CEO DIO, etc)
  - Key changes to the residency, including educational innovation
  - WebADS will be used as a data system and programs will be asked to submit block diagrams, sponsorship changes, etc. to WebADS since we will no longer be submitting this as part of a PIF.
  - Scholarly activity of core faculty will need to be submitted. Thus, it is imperative to think carefully about who is listed as core faculty for each program. Examples of scholarly activity include manuscripts, review articles, chapters, workshops, etc. PubMed ID numbers will be utilized to ease the burden of data submission. Grants will also be an element that will be submitted for core faculty.
  - ACGME Resident surveys will continue to be conducted of all residents in training programs, including fellowship programs. There are two additional domains added; Patient safety and teamwork
All graduating PI-3 residents will be asked to complete additional survey questions assessing their clinical experience within the training program. Questions may include the following domains:

- Self assessment of procedural competency without supervision
- A review of their patient care activities
- Their satisfaction with patient volume and depth of clinical experience
- Question related to milestones.
- A review of their longitudinal outpatient experience
- An overall assessment of how well prepared they are for the practice of General Pediatrics

An ACGME Faculty survey continues to be developed. The format of the faculty survey is not yet finalized and the content is not specified at this time. However, it is likely to reflect questions about program curriculum, compliance with requirements, etc. Faculty survey (not yet published) will be distributed to those that you list as Core faculty on WebADS.

Milestone data will be submitted for each resident for the 21 chosen milestones. We will report in December and May of each year. Each milestone must be assessed for each trainee. Each program will need to develop a Clinical Competency Committee (CCC), which can be used to review this data. WebADS will be utilized to submit this data. A standard scale will be used for each milestone with radio buttons included to serve as a guide for resident assessment. Milestones are context independent, and thus, they can be used across the continuum. Residents are not expected to be at the highest level by the time they graduate as it is anticipated each of our training programs will have residents at different levels throughout all three years of training.

The APPD LEARN project continues to enroll sites in the Milestones Assessment Project. The current tools are being evaluated and it is anticipated that these tools will be released in the near future.

Milestones Data will be entered into WebADS.

Board Pass rates

- 80% in last five years must take boards
- 70% must pass, on average, based on most recent 5 years of first time certification examinees

Results of the CLER site visit

Programs must continuously assess their training programs using their own internal annual surveys. The RC is interested to see how programs have used data from their own internal faculty and resident surveys to develop an action plan for innovation or program changes.

Please note that several questions arose regarding the NAS Performance Indicator #4 - Board Pass Rates (see Joe & Caroline's slide #13 posted on;

https://www.appd.org/meetings/2012FallPres/NASDesignFri.pdf
(Friday October 5th session)

Joe restated that if a program had a less than 70% pass rate from the preceding 5 years for those who are taking the certifying examination for the first time, a "drill down" would take place to look into the meaning of that reported number.

Of note, the ABP cautions interpretation of this percentage for programs with fewer than 25 first time test takers in their 3 year average posted on the website

https://www.abp.org/abpwebsite/becomecert/trainingprograms/aboutgeneralpediatrics/passrateschart.htm

- Other Specific Questions that were covered:
  - If a program chooses to allow residents to use a longitudinal subspecialty experience in lieu of a third year ambulatory continuity clinic experience, this experience cannot be counted towards the subspecialty requirement.
  - If a program requires experiences in advocacy, QI or research, this time must be reported in the individual duty hours reporting for the residents.
  - A Program Director does not need to participate in an MOC for General Pediatrics if they are participating in their MOC for their subspecialty discipline.
  - Strictly speaking, the 32 half-day sessions that define an outpatient Educational Unit cannot include the residents continuity clinic towards meeting this 32 session requirement

Pearls from the Plenary Session – the CLER Visit Presentation - Mary Lieh Lai, Senior VP for Medical Accreditation

The Clinical Learning Environment (CLER)

1. The CLER Visits were established partly in response to patient safety and QI. This is an institutional visit and not a program accreditation visit. Process improvement is the focus of the review. There will be a number of areas of focus for the CLER visit, including:
   - An assessment of the degree of integration of trainees into Patient Safety and QI activities
   - Supervision
   - Transitions of Care
   - Education of fatigue and the mitigation of impact of duty hours
   - Professionalism

2. The first set of CLER visits have been conducted and have been concentrating on learning the process for conducting these visits. Some of the key questions that area asked during a CLER visit include:
   - Who is responsible for providing the structure and oversight for the area of focus (see above list)
3. Patient safety is an important component of a CLER visit. Institutions or trainees may be asked to describe the structure for involving residents in M and M Rounds, Root Cause Analysis and/or QI activities. The institution must demonstrate their involvement in patient safety and QI and how they involved the housestaff.

3. A CLER Visit will likely include the following individuals:
   - Senior Hospital Leadership (DIO CEO COO)
   - Residents
   - Core Faculty
   - Program Directors
   - There will likely be visits to clinical areas and during the presentation key areas may include the operating suites, an inpatient or critical care unit and the Emergency Department. Ambulatory clinics may also be visited.

4. Supporting documentation may be requested by the CLER Site visitors, including organizational charts, rosters, sponsoring institutions, process for transitions of care, etc.

5. At the completion of the visit a report is developed. It is reviewed by the CLER evaluation committee where it is finalized and distributed to the hospital. It is anticipated that this process may take a couple of months before the report is finalized.

6. Approximately 360 visits will occur over the next 18 months, beginning Sept 2012. Each sponsoring institution should anticipate a CLER site visit every 18 months.