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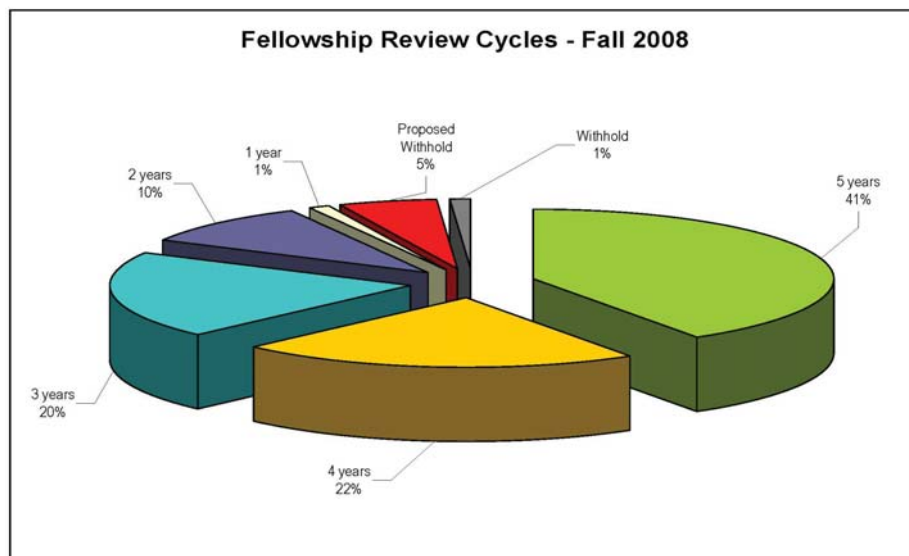
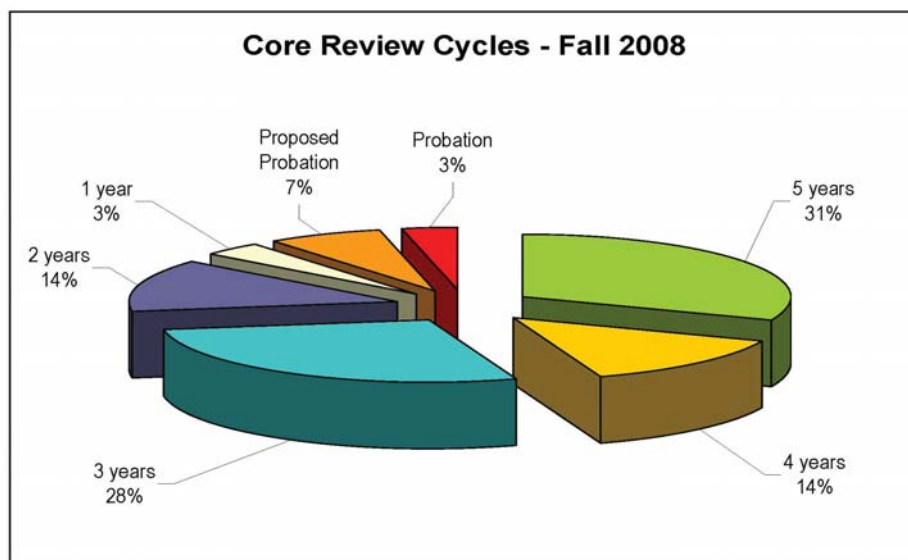
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RRC NEWS IS A BIENNIAL PUBLICATION THAT PROVIDES REVIEW COMMITTEE AND ACGME UPDATES. PLEASE CONTACT THE EDITOR FOR SUGGESTIONS OR COMMENTS ABOUT THIS NEWSLETTER: [KREINHOLD@ACGME.ORG](mailto:KREINHOLD@ACGME.ORG).

### Summary of Actions Taken at October 2008 Meeting

The Committee reviewed 28 core, 94 fellowship, and 2 med-peds programs. The pie charts below provide a summary of the actions taken at the meeting.



## Practice-based Learning and Improvement (PBLI) and Systems-based Practice (SBP)

The Review Committee appreciates the hard work of Drs. Edwin Zalneraitis and Joseph Gilhooly who developed the following document to clarify expectations for two of the more malleable and hard to grasp competencies, PBLI and SBP. The following explanation will be added to the Review Committee's Companion Document located at the following address: [http://www.acgme.org/acWebsite/RRC\\_320/320\\_prIndex.asp](http://www.acgme.org/acWebsite/RRC_320/320_prIndex.asp).

### PBLI

Question: The requirements state that residents and fellows must: systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. (IV.A.5.c.4) Does this mean that residents/fellows are expected to participate in a quality improvement project?

Answer: The program needs to document that residents/fellows (working alone or in a practice group) actively participate in an exercise in which they can examine some aspect of their practice to identify an area in need of improvement, and then implement a plan to bring about improvement. An exercise that examines some aspect of their educational activities can be used to meet this requirement if it is related to patient care. Residents/fellows will need to be provided instruction in quality improvement methods. This process is learned best when residents/fellows are able to work with those skilled in quality improvement.

Here are several examples of clinically-based quality improvement projects.

o PBLI Example 1: A group of residents has decided to work on improving how growth in patients in the continuity clinic can be better tracked. First, they document their current tracking percentage; they look at 100 charts. Then, they introduce a reminder system to improve such data. Several months after the change has been implemented, residents/fellows check another 100 charts to see if the change has resulted in improved tracking.

o PBLI Example 2: A fellow has decided to work on reducing infection rates for a particular procedure. He thinks his rates exceed those of other fellows for the procedure. He decides to work on compliance with techniques known to reduce infections associated with the procedure. The fellow then introduces a new system of doing the procedure that increases the

chance of completing the procedure in the expected way without infection. Then, the fellow tracks the technique used and the rate of infection in the future related to the procedure.

Here are two examples of educational-based quality improvement projects.

o PBLI Example 3: A resident has studied her sign-outs on the inpatient service and noticed that the information she often provides has omissions and errors. At the urging of a faculty mentor, she decides to examine her own performance along with that of her colleagues. With the help of the quality improvement department at the hospital, the resident gathers a sample of morning, evening, and weekend sign-outs. The sessions are analyzed for omissions and errors. An SBAR format is implemented and the sign-out template is revised. Residents are trained to use the new format and then omissions and errors are reviewed again two months later. The resident documents improvement in her own performance, as well as reduced errors for all involved in the new approach. Data are used to further modify the sign-out template. Interestingly, this project can be seen as an example of a PBLI or an SBP project. Since the project enhanced and improved individual practice, it was framed as a PBLI example; but since it also had a positive affect on the overall system the resident works within, it can also be seen and presented as an example of an SBP project. In order to demonstrate the broad range of training provided in the program, the same quality improvement project should not be provided as answers for PBLI and SBP competency questions in the PIF.

o PBLI Example 4: A resident feels that her shift assignments in the ED are too long. She is convinced that after 8 hours, she works slower and is more likely to make errors. She works with the faculty member in the ED to identify ways to track the patients seen by resident providers. All medication errors are tracked through the EMR. After obtaining IRB approval, the resident and faculty work to randomly assign residents to either 8-hour shifts or 10-hour shifts. The resident reviews and compares her own performance relative to performance errors, and reports are generated across all residents. Results are presented at the annual program evaluation and an action plan is determined. This example can also be seen from either a PBLI or SBP perspective. Because this was conceived of and implemented by an individual resident to improve her work, it is a PBLI example. However, because the project had an impact on the

overall system it is also an example of a SBP project. As noted with the earlier example, the same quality improvement project should not be listed in the PIF as the quality improvement project used to develop skills for both the PBLI and SBP competencies.

## **SBP**

Question: The requirements state that residents and fellows must: participate in identifying systems errors and implementing potential systems solutions. (IV.A.5.f.6). What are residents/fellows expected to do to meet this requirement?

Answer: The program needs to document that residents/fellows have actively participated in identifying systems issues that increase the risk or occurrence of errors and implemented a plan to correct these issues. This can be accomplished by an individual resident or by a group of residents/fellows and healthcare team members.

Here are two examples.

o SBP Example 1: Residents notice that the wrong size bag and mask is at the bedside when they are called to provide care to an infant in respiratory distress. The residents work with other healthcare team providers and those skilled in evaluating and addressing systems problems to analyze how often errors occur. An intervention is implemented to reduce such errors. The residents monitor error incidence rates after the intervention has been made.

o SBP Example 2: A fellow is concerned with the lack of proper patient monitoring after undergoing a procedure. Working with those skilled in evaluating and addressing systems problems, she determines the frequency and consequences of this problem, and tries to compare it to rates of occurrence elsewhere. She studies possible interventions and implements one. She then tracks the frequency of improper monitoring and/or its consequences as a result of the intervention.

Question: What is the difference between a PBLI quality improvement project and an SBP project?

Answer: The PBLI improvement project involves residents/fellows on ways to improve their own individual practice outcomes. The systems-based practice project is one aimed at identifying systems issues that increase the occurrence of errors. The goal of a systems-based practice project is to create changes

to improve all providers' work environment. However, as noted in several of the examples above, a project can be seen as either a PBLI or SBP project, depending on how it is planned, implemented, and presented.

The Committee would also like to draw attention to a recent paper written by Ingrid Philibert, PhD, on resident involvement in quality improvement that was recently posted on the ACGME's webpage: [http://www.acgme.org/acWebsite/ci/90DayProjectReportDFA\\_PA\\_09\\_15\\_08.pdf](http://www.acgme.org/acWebsite/ci/90DayProjectReportDFA_PA_09_15_08.pdf). This document also discusses the competencies further.

## **Points of Clarification**

Question: What is necessary for documentation of continuity experience?

Answer: The Committee discontinued the mandatory use of the ACGME case log system for tracking continuity in 2006. Program directors were told that they will need to have documentation that shows they are in compliance with the continuity requirements (for number of weeks of continuity clinic and for number of patients per resident per session), but they have much flexibility in terms of which system they can use to document compliance. Several program directors have asked whether the "unique patients" variable that is available on the ACGME website needs to be in the report that documents compliance with the continuity requirements. The answer is no, it does not. The "unique patients" was never a required data field. It was inserted into the ACGME report as a helpful tool for program directors interested in using it to get further information on their residents' continuity experience and track panel size.

## **Accreditation and Innovation**

Program directors interested in having the RRC review an experimental or innovative proposal are encouraged to complete the ACGME's form for such proposals, and submit it to the Executive Director for review by the Committee. The form can be found at the following location on the ACGME's website: [http://www.acgme.org/acWebsite/navpages/nav\\_program\\_experimentation.asp](http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp)

Program directors may have heard about innovation under the banner of the Residency Review and Redesign (R3P) project. The Review Committee has partnered with the subcommittee of the American Board of Pediatrics, known as the R3P Committee, to encourage programs to seek transformative change in pediatric graduate medical education. Proposals for this initiative should address one of three primary

goals: (1) Pediatricians should be prepared for diverse careers in the care of children, adolescents, and young adults; (2) Pediatric education must provide a continuum of learning that begins in medical school; (3) Pediatricians must be committed to closing the gap between current and optimal health care outcomes for children, adolescents, and young adults. Programs interested in pursuing an innovative proposal to meet one of these three goals, will need to submit a proposal for consideration. A request-for-proposal will be made available very soon by the R3P Committee. The RRC will provide input on proposals that request waivers of requirements. The Review Committee appreciates the hard work RRC members Stephen Ludwig, MD, Joseph Gilhooly, MD, Edwin Zalneraitis, MD, and Meredith Riebschleger, MD have devoted to this project.

### **2009 ACGME Educational Conference** *March 5-8, 2009 in Grapevine, Texas*

Each year, the ACGME Annual Educational Conference provides a venue for graduate medical educators to learn more about the accreditation process and ways to enhance residency program quality related to ACGME initiatives, such as general competencies, educational outcome assessment, and duty hours. The 2008 conference theme "Building Community, Improving Quality" emphasized how better education and better patient care can occur when individuals in diverse roles work together toward shared goals. The 2009 conference theme, "Shaping the Future," will offer more than 80 sessions clearly focused on the topics of education, assessment, the learning environment, and accreditation. The Conference will begin with an international pre-conference titled "Promoting Good Learning and Safe, Effective Care: A Five-Year Review of the ACGME's Common Duty Hour Standards," as well as an introductory pre-course for new program directors and coordinators. Attendees and speakers can register here: [http://www.acgme.org/acWebsite/meetings/me\\_EducConf\\_09\\_Speakers.asp](http://www.acgme.org/acWebsite/meetings/me_EducConf_09_Speakers.asp)

### **Program Evaluation by Fellows: Keeping Responses Confidential When There is Only One Fellow**

The ACGME requirement that fellows provide confidential evaluations of the program can be a challenge for programs with fewer than two fellows. Across specialties, program directors have arrived at creative methods that manage to maintain confidentiality of fellows. Fellow evaluations may be collected over a period of a few years and grouped data are then reported every two to three years. The program director's

challenge is to balance the program's need for feedback in order to make necessary adjustments towards program improvements versus fellow confidentiality that can result in delays of valuable feedback and program improvements. Additionally, the coordinator or DIO, (not directly involved in fellow education), may solicit feedback from the fellows and residents who rotate on the service, and collate and report general findings to the program director.

### **Congratulations to Dr. Yolanda Wimberly**

Committee member Yolanda Wimberly, MD was presented the Humanism in Medicine Award at the recent AAMC meeting, <http://www.aamc.org/newsroom/awards/wimberly.htm>. This award honors a medical school faculty physician who is a caring and compassionate mentor and a practitioner of patient-centered care. The Committee congratulates Dr. Wimberly on this award and is proud to learn of her dedication to teaching future medical providers effectively, openly, and compassionately.

### **Voluntary Withdrawal Requests**

Programs must now enter requests to voluntarily withdraw accreditation (VW) using ADS only. Programs initiate the request by answering a series of questions, including the proposed effective date, which should coincide with the end of an academic year, the reason for program closure, and a plan to place any active residents in other programs. After submitting in ADS, the request is automatically emailed to the DIO for approval. After the DIO/GMEC approves the request in ADS, the system informs the RRC staff designee. The RRC considers the request at its next meeting and notifies the program director via an official letter that the accreditation status is changed to VW.

### **"Red Flags" Help Programs Recognize Potential Issues**

In the [February 2008](#) issue of the ACGME e-Bulletin, an article entitled "Nine 'Red Flags' in Accreditation Site Visits and Reviews" by members of the ACGME Field Staff provides observations that may raise questions about program quality and compliance with program and institutional requirements. This may be of particular interest to programs preparing for upcoming site visits.

## **New Zip Code for ACGME**

ACGME's zip code changed on July 1, 2008. Anything mailed or sent by Fed-Ex must now reference zip code 60654. Please note that our PO Box zip code, 60610, has not changed.

### Mailing Address:

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## **RRC Meeting and Agenda Closing Date**

In order to ensure an orderly and efficient RRC meeting, we must establish cut-off dates for requested agenda items. Please note these deadlines if you have submissions for future RRC meetings. The dates and deadlines are as follows:

Meeting: March 29-April 1, 2009  
Agenda Closing: February 2, 2009

Meeting: July 27-28, 2009  
Agenda Closing: June 1, 2009

Meeting: October 25-28, 2009  
Agenda Closing: September 1, 2009

We understand that emergencies occur and we will be sensitive to your needs in these situations. However, routine agenda items will be held for the next meeting after these cut-off dates.

## **Feedback**

We welcome your comments and suggestions about this newsletter: [dbraun@acgme.org](mailto:dbraun@acgme.org).