

## Frequently Asked Questions: Pediatrics

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<b>Sponsorship Changes and Mergers</b>	
How do we handle a description of a merger for the RRC?	<p>Contact the Executive Director to discuss the type of merger and how to describe it for the RRC.</p> <p>There are various types of mergers and the specific plans may determine how the proposal should be worded and what type of action is possible by the RRC. The following are the major types that have been reported involving two separately accredited programs:</p> <ol style="list-style-type: none"> <li>1. Two programs will be combined to form a new entity, a combined program. The full PIF, describing the proposed combined program, will be required. The executive director will tell you whether a site visit will be required prior to RRC review of the proposal. A request for voluntary withdrawal of accreditation, and the date of closure, will be needed from each of the currently accredited programs and should be signed by the DIO of its sponsoring entity. The newly constituted combined program will be issued a new ACGME identification number and, if accredited will receive initial accreditation.</li> <li>2. One program (#1) will absorb the other program (#2) and will usually include rotations to the latter. Program #1 will submit the proposal, explaining the extent of the change in curriculum and resident complement, and documenting that all residents in the program will participate in a minimum of 18 months in common. The executive director of the RRC will review with you the degree to which the PIF should be completed. Program #2 will submit a request for voluntary withdrawal of accreditation with the date by which current residents will complete their training in that program. This must be co-signed by the DIO of that program's sponsoring entity. The executive director of the RRC will tell you whether the changes necessitate a site visit prior to RRC review of the proposal. Unless the changes are so extensive that the RRC considers the finished product to be virtually a new program, the program (#1) will retain its current ACGME program number and accreditation status.</li> </ol>
How do we move an accredited program to another hospital?	The executive director of the RRC should be informed of the plans and will advise regarding the steps that are needed. A program is accredited as it was constituted at the time of its last review. It may not be "moved" without RRC review and approval. If a sponsoring entity

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	wants to relocate a residency program from one hospital to another, it must submit a full PIF and probably undergo a site visit. If the existing primary hospital wants to retain the program, it is suggested that the issue be resolved locally between the hospital and its sponsoring institution. The welfare of the residents who are currently in training must be considered.
Our Pediatrics program would like to transfer sponsorship to another institution. What is required for this type of change?	<p>Transfer of sponsorship requires a letter from the program's current sponsor (the DIO and the institution's senior administrative official) indicating willingness to give up sponsorship, and a letter from the proposed sponsor (the DIO and the institution's senior administrative official) indicating willingness to sponsor. The letters should be addressed to the Executive Director of the RRC, with a copy to the Director of the Department of Field Activities.</p> <p>Upon transfer of sponsorship, the name of the program changes to that of the new sponsor in all ACGME records.</p>
When the requirements mandate that all residents participate in 18 months of common training, can this involve comparable experiences at different sites?	No. Each program must demonstrate that all residents appointed to that program have 18 months of core required experiences in common, i.e., the same rotations/experiences at the same sites. The remaining 18 months may be comparable experiences or different experiences, in different sites, etc.
<b>Resident Complement</b>	
<p>Is RRC permission required for increasing the resident complement?</p> <p><i>[Program Requirement: III.B.]</i></p>	<p>Changes in resident complement must be submitted for approval electronically through the ACGME Accreditation Data System (ADS) by updating the field for resident complement. If additional information is needed, or if the change should be reviewed by the RRC, you will be notified.</p> <p>Programs must have adequate resources to accommodate the increase. Of particular concern are the inpatient and outpatient populations and the number of faculty.</p>
<b>Pediatrics Faculty</b>	
<p>What specialty qualifications are acceptable to the Review Committee if the physician faculty does not have current certification in pediatrics by the ABMS?</p> <p><i>[Program Requirements II.B.2.]</i></p>	The phrase is in the requirements for every ACGME specialty to allow those who might have achieved certification in a comparable system from another country, e.g., the Royal College, to be considered qualified. The determination of whether qualifications are equivalent to certification by an ABMS Board is a judgment call on the part of the Committee. In some instances, a significant record of publication in peer reviewed journals is considered evidence of adequate specialty qualifications. Years of practice are not an equivalent of specialty board certification and neither ABMS nor the RRC accepts the

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	phrase "board eligible." The onus of documenting alternate qualifications is on the program director.
<p>What constitutes a "structured program for faculty development?"</p> <p><i>[Program Requirements II.B9.]</i></p>	<p>A program needs to provide evidence of annual departmental, residency, and faculty needs assessments that include structured group and individual development/enhancement activities. These activities should not be limited to clinical skills development activities only. They must also address administrative, leadership, research and behavioral components of faculty performance.</p>
<b>Program Curriculum</b>	
<p>What type of change in the program's curriculum is considered major and requires RRC approval?</p>	<p>Check with the Executive Director of the RRC. Generally, use of a participating hospital that is not currently approved as part of the program for rotations of three months or more should be discussed with the Executive Director. Refer to the requirements regarding the limitation to outside rotations before planning this type of change.</p>
<b>Program Director Support</b>	
<p>Can chief residents' time spent providing support in the administration and operation of the program count towards the minimum FTE?</p> <p><i>[Program Requirement: II.C.2.]</i></p>	<p>The Review Committee judged that chief and assistant chief residents' time to the program, must not used to meet this requirement.</p>
<b>Elective NICU Experience</b>	
<p>May a program allow residents an elective NICU experience beyond the maximum ICU time permitted, i.e., 6 months?</p> <p><i>[Program Requirement: IV.A.5.b.(1).(f).(vi).(c)]</i></p>	<p>A program director may allow an individual resident to have an elective one month block NICU rotation after s/he has completed the required NICU experience in that program. As is the case with all block months, it may include call. This is permitted especially for those residents who plan to practice in rural areas where subspecialty support will be limited or non-existent. Program directors will be asked on the PIF to explain the cases in which this option was exercised.</p>
<b>Continuity Clinic Documentation</b>	
<p>What is necessary for documentation of continuity experience?</p>	<p>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</p>

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	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.
<b>PICU Numbers</b>	
<p>What is the expected number of patients for which residents should provide care while on the PICU?</p> <p><i>[Program Requirement: IV.A.5.b).(1).(f).(vi).(a)]</i></p>	<p>Core Pediatrics residents should provide care for 4 PICU patients. The Committee also reviews the list of 50 consecutive diagnoses that is submitted as an appendix to the PIF to assess the complexity and acuity of cases in the PICU. Both criteria are used to determine whether residents have sufficient experience with critically ill children.</p>
<b>Practice-Based Learning and Improvement (PBLI)</b>	
<p>Are residents expected to participate in a quality improvement project?</p> <p><i>[Program Requirement: IV.A.5.c).(4)]</i></p>	<p>The program needs to document that residents (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 will need to be provided instruction in quality improvement methods. This process is learned best when residents are able to work with those skilled in quality improvement.</p>
<b>Examples of Clinically-Based Quality Improvement Projects</b>	
PBLI Example 1	<p>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 check another 100 charts to see if the change has resulted in improved tracking.</p>
PBLI Example 2	<p>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</p>

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	<p>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.</p>
<p>PBLI Example 3</p>	<p>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.</p>
<b>Systems-Based Practice (SBP) Projects</b>	
<p>What is the expectation for residents to participate in identifying system errors and implementing potential systems solutions?</p> <p><i>[Program Requirement: IV.A.5.f).(6)]</i></p>	<p>The program needs to document that residents 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 and healthcare team members.</p>
<p>What is the difference between a PBLI quality improvement project and an SBP project?</p> <p><i>[Program Requirement: IV.A.5.f).(6)]</i></p>	<p>The PBLI improvement project involves residents 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,</p>

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	depending on how it is planned, implemented, and presented.
<b>Examples of Clinically-Based Quality Improvement Projects</b>	
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.
SBP Example 2	A resident 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.
<b>Evaluations</b>	
Our program uses global evaluations to assess residents' abilities with the competencies, but our program was cited at the last review.  <i>[Program Requirement: V.A.1.b).(2)]</i>	The use of global evaluations on their own are not acceptable. The RRC expects programs to use multiple methods and evaluators to assess the abilities of residents with the competencies. Multiple evaluation methods provide more comprehensive and accurate assessment of skills.
Are proprietary patient satisfaction surveys to assess residents' abilities with the competencies an acceptable evaluation method?  <i>[Program Requirement: V.A.1.b).(2)]</i>	Proprietary surveys generally do not provide feedback specific to a particular resident. The RRC has cited programs who use only such instruments to assess the competencies because (1) there is no documentation that multiple evaluation methods are being used; and (2) the survey data is not useful, meaningful, or actionable information because it is not resident-specific.
Should patients and their families be included as evaluators?  <i>[Program Requirement: V.A.1.b).(2)]</i>	The RRC expects that families and patients are involved in assessing residents' professionalism and interpersonal and communication skills. Inclusion of these individuals provides more comprehensive and meaningful feedback since their interactions with residents are different from those of the faculty. It also documents that programs are complying with the requirement for multiple evaluation methods to assess competence.
<b>Duty Hours</b>	
Are there situations when residents may	Physician assistants, nurse practitioners, psychologists, physical and occupational

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<p>be supervised by licensed independent practitioners?</p> <p><i>[Program Requirement: VI.D.1.]</i></p>	<p>therapists, speech and language pathologists, dietitians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e. school-based health centers, child development clinics) and inpatient (i.e. NICU) settings. Some states may have regulatory rules that won't allow LIPs to supervise residents.</p>
<p>What is an appropriate patient load for residents?</p> <p><i>[Program Requirement: VI.E.]</i></p>	<p>This depends on all the factors listed in the requirement. The program director must make an assessment of the learning environment with input from the faculty and residents. Minimum patient loads should usually be five on the general inpatient unit, and four in PICU and NICU. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors.</p>
<p>Who should be included on the interprofessional teams?</p> <p><i>[Program Requirement: VI.F.]</i></p>	<p>Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the interprofessional teams.</p>
<p>Can interns make “mommy calls”?</p> <p><i>[Program Requirements: VI.D.5.a).(1); VI.G.4.a)]</i></p>	<p>Interns may not take “mommy calls” from home. Interns may take “mommy calls” within the 16 hour duty period from the hospital or other clinical site where supervision is either direct or indirect with direct supervision immediately available.</p>
<p>What is the difference between night float, night shift, and night call?</p> <p><i>[Program Requirement: VI.G.6.]</i></p>	<p>Night Call:</p> <ul style="list-style-type: none"> <li>• <u>“Traditional” Night Call</u> is for those working in the day who will also stay at night to provide patient care</li> <li>• PGY-2 and above</li> <li>• No more frequently than every third night when averaged over a 4 week period</li> <li>• Limited to 24+4 hours</li> <li>• No additional clinical responsibilities after 24 hours</li> <li>• Strategic napping after 16 hours of duty</li> </ul> <p>Night Float:</p> <ul style="list-style-type: none"> <li>• <u>Night Float</u> involves the episodic coverage of patients just at night.</li> <li>• Residents come from another educational experience to do a series of night shifts</li> <li>• No more than 6 consecutive nights</li> <li>• Example: Resident on a one month block of Cardiology and does a series of nights</li> </ul>

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	<p>of patient coverage in the PICU</p> <ul style="list-style-type: none"> <li>• Night float is limited to 1 consecutive week and no more than 4 total weeks per year</li> </ul> <p>Night Shift:</p> <ul style="list-style-type: none"> <li>• <u>Night Shift</u> is a scheduled series of nights to provide consistent care at night that mirrors the day shift.</li> <li>• This is the new paradigm for PGY-1 residents</li> <li>• Limit of 16 hour shifts <ul style="list-style-type: none"> <li>• They should have 10 hours between shifts and must have 8 hours free between scheduled duty periods</li> </ul> </li> <li>• No more than 6 consecutive shifts</li> <li>• No limit on night shift during a block month, however: <ul style="list-style-type: none"> <li>• The balance between day and night must be appropriate</li> <li>• Education must occur for residents doing shifts</li> </ul> </li> </ul>

PD\_ED\_07\_2011