

Pediatrics FAQ Document	
Pediatrics Applications	
Question	Answer
What is the timetable for submission of an application for a new Pediatrics Program?	<p>The process for an application takes approximately 12 months from the time the application is received in the RRC office until the RRC evaluates the application. Take this into consideration when planning the start date. Consult the MATCH and ERAS for their deadlines, as well.</p> <p>A site visit will be scheduled. When the report of the site visitor is received, the file will be prepared for review by the RRC.</p> <p>Residents should not be appointed prior to accreditation of the program.</p> <p>Additional details can be found on our website http://www.acgme.org/acWebsite/home/accreditation_application_process.asp</p>
What is the timetable for submission of an application for a new Pediatric Subspecialty Program?	<p>The RRC will review an initial application without a prior site visit. If upon review of the application at one of its regular meetings the RRC judges that it cannot conclude its evaluation without a site visit, one will be scheduled.</p> <p>Contact the RRC Administrator for the deadline related to a specific RRC meeting.</p> <p>NOTE: A Pediatric Subspecialty program must function in conjunction with and be an integral part of a fully accredited program in Pediatrics.</p> <p>Additional details can be found on our website http://www.acgme.org/acWebsite/home/accreditation_application_process.asp</p>
Sponsorship Changes and Mergers	
Question	Answer
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"> 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. 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.
How do we move an accredited program to another hospital?	<p>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 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.</p>

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Sponsorship Changes and Mergers	
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Our Core Pediatrics program would like to transfer sponsorship to another institution. What is required for this type of change?	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. Upon transfer of sponsorship, the name of the program changes to that of the new sponsor in all ACGME records.
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.
Program Changes	
Question	Answer
How do I report a change in program leadership?	A change in program director must be reported electronically through the ACGME Accreditation Data System (ADS), using the login ID and password for the program. Be sure to provide all of the information requested.
What type of change in the program is considered major and requires RRC approval?	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 required rotations one month or longer must be reported in ADS. This change should be initiated by your DIO. Revising the curriculum or shifting experiences among the three years of training does NOT require RRC notification.
PIF Preparation	
Question	Answer
What if we don't have the same fonts as specified on the forms?	Comparable fonts and point sizes may be used as long as they are easy to read.
Resident Complement	
Question	Answer
<i>The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.(Program Requirements (III.B))</i>	
Is RRC permission required for increasing the resident complement?	Changes in resident complement must be reported 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. The RRC does not approve the number of residents, as such. When it evaluates a program it judges the adequacy of the resources in relation to the proposed resident complement. If you have reason to appoint an extra resident, or to make a modest increase in each year, you are free to do so without prior approval if you have determined that adequate resources exist. Of particular concern are the inpatient and outpatient populations and the number of faculty. At the time of the next review of the program you will have the opportunity to report the number of residents in training and the RRC will judge whether adequate resources are available. It is unwise to increase the complement in the absence of adequate resources. Refer to the requirements regarding uneven numbers in the three levels of the program.
Pediatrics Faculty	
Question	Answer
<i>The physician faculty must have current certification in the specialty by the American Board of Pediatrics, or possess qualifications acceptable to the Review Committee. (Program Requirements (II.B.2.))</i>	
What is the interpretation of "posses qualifications judged to be acceptable to the RRC?"	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 phrase "board eligible." The onus of documenting alternate qualifications is on the program director.

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Pediatrics Faculty	
Question	Answer
<i>Since the faculty is expected to be role models for residents, they should demonstrate the knowledge, skills, and attitudes needed to provide an environment in which the competencies become habits of practice. To accomplish this there must be a structured program for faculty development that addresses clinical, teaching, research, and leadership skills. Teaching and evaluation of competencies must be included as part of this program. (Program Requirements (II.B.9))</i>	
What constitutes a "structured program for faculty development?"	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.
Program Curriculum	
Question	Answer
What type of change in the program's curriculum is considered major and requires RRC approval?	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.
Program Director Support	
Question	Answer
<i>Each residency should have a minimum of one FTE designated for administrative support. For programs of 31-60 residents, this support should be 1.5 FTE; for programs of 61-90 residents, two FTEs; and for programs of more than 90 residents, three FTEs. These positions should be financially supported by the sponsoring and/or participating sites. (Program Requirements (II.C.2))</i>	
Can chief residents' time spent providing support in the administration and operation of the program count towards the minimum FTE?	The Review Committee judged that chief and assistant chief residents' time to the program, must not used to meet this requirement.
Elective NICU Experience	
Question	Answer
<i>To provide additional experience for those who may need it for future practice, one additional elective block month in critical care may be allowed. As is the case with any block month, it may include call. For a program that trains pediatricians to practice in non-urban areas that require the primary care pediatrician to resuscitate critically-ill infants and children, the program may petition the Review Committee for approval to offer additional critical care experience, providing appropriate justification. (Program Requirements (IV.A.5.b).(1).(f).(vi).(c))</i>	
May a program allow residents an elective NICU experience beyond the maximum ICU time permitted, i.e., 6 months?	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.
Continuity Clinic Documentation	
Question	Answer
What is necessary for documentation of continuity experience?	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.
PICU Numbers	
Question	Answer
<i>The intensive care experiences must provide the opportunity for residents to deal with the special needs of critically-ill patients and their families. The intensive care experience must be for a minimum of five and a maximum of six months. (Program Requirements (IV.A.5.b).(1).(f).(vi).(a))</i>	
What is the expected number of patients for which residents should provide care while on the PICU?	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.

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Practice-Based Learning and Improvement (PBLI)	
Question	Answer
<i>Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:...systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Program Requirements (IV.A.5.c.4))</i>	
Are residents/fellows expected to participate in a quality improvement project?	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.
Practice-Based Learning and Improvement (PBLI)	
Examples of Clinically-Based Quality Improvement Projects	
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.
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.
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.
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.

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Systems-Based Practice (SBP) Projects	
Question	Answer
<i>Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to...participate in identifying system errors and implementing potential systems solutions. (Program Requirements (IV.A.5.f.6))</i>	
What is the expectation for residents/fellows to meet this requirement?	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.
What is the difference between a PBLI quality improvement project and an SBP project?	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 . This document also discusses the competencies further.
Systems-Based Practice (SBP) Projects	
Examples of Clinically-Based Quality Improvement Projects	
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 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.
Evaluation	
Question	Answer
<i>The program must use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff). (Program Requirements (V.A.1.b).(2))</i>	
Our program uses global evaluations to assess residents'/fellow's abilities with the competencies, but our program was cited at the last review.	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/fellows with the competencies. Multiple evaluation methods provide more comprehensive and accurate assessment of skills.
Are proprietary patient satisfaction surveys to assess residents'/fellows' abilities with the competencies an acceptable evaluation method?	Proprietary surveys generally do not provide feedback specific to a particular resident/fellow. 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/fellow-specific.
Should patients and their families be included as evaluators?	The RRC expects that families and patients are involved in assessing residents'/fellows' professionalism and interpersonal and communication skills. Inclusion of these individuals provides more comprehensive and meaningful feedback since their interactions with residents/fellows are different from those of the faculty. It also documents that programs are complying with the requirement for multiple evaluation methods to assess competence.

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Fellow Scholarly Activity	
Question	Answer
<i>Each fellow must design and conduct a scholarly project in his or her subspecialty area with the guidance of the fellowship director and a designated mentor. The program must provide a scholarship oversight committee for each fellow to evaluate the fellow's progress as related to scholarly activity. The scholarly experience must begin in the first year and continue for the entire period of training. Time must be adequate to allow for the development of requisite skills, project completion, and presentation of results to a local scholarship oversight committee established for this review. Where applicable, the process of establishing fellow scholarship oversight committees should be a collaborative effort involving other pediatric subspecialty programs in the institution. (Program Requirement for the Subspecialties of Pediatrics (IV.B.2.a))</i>	
How often should an SOC meet with fellows during the educational program?	The requirements state that the scholarly experience must begin in the first year and continue for the entire period of education. As such, the Review Committee expects that each SOC will meet with each fellow at least once during the first year and at least twice during the second and third years. The Review Committee will also review fellows' scholarly productivity to determine the adequacy of the oversight provided by the SOC.
How much time should be devoted to research and scholarly activities during any of the three year subspecialties?	As noted in the requirements, the scholarly experience must begin in the first year and continue for the entire period of training. The Committee recommends that programs provide fellows approximately 12 months for research and scholarly activity. The Committee will use evidence of scholarly products by fellows in assessing the adequacy of the amount of time devoted to research.
How much time should be devoted to the clinical activity in any of the three year subspecialties?	The Committee expects that the program will provide fellows at least 12 months of clinical experience.