

## **Companion Document (Guidelines for PIF Documentation)**

The revised Program Requirements document reflects a transition from a process orientation to one of outcomes. In order to provide assistance to program directors, this companion document includes some explanation and guidelines for the types of documentation that will be expected. The numeric designations refer to those in the Program Requirements.

### **PATIENT CARE**

For all elements of patient care, direct observation of the resident's skills is critically important.

#### **IV.A.5.a**

The history and physical examination serve as the basic foundation upon which all of clinical medicine is built. Programs must ensure that residents can perform a detailed and accurate history and physical examination appropriate for the context of the age and developmental level of the patient. In the initial stages of training, this should be demonstrated for patients with routine diagnoses. By the end of residency training, programs should document resident competence in history-taking and physical examination for any patient

To document the achievement of competence for this element of Patient Care, residents must be evaluated performing histories and physical examinations. This must be accomplished through direct faculty observation using a structured approach with different evaluators in different settings (e.g., documentation by the faculty in the adolescent clinic that the resident is capable of performing a pelvic exam). The structured approach should involve a written template that is distributed to faculty, and available for review by the site visitor, or by the RRC, if requested.

### **MEDICAL KNOWLEDGE**

#### **IV.A.5.b**

In addition to knowledge content, it is critical that residents demonstrate their ability to acquire/access new knowledge, interpret the evidence they uncover, and then apply it in the clinical setting. The program must document that residents are able to do this and that the faculty have a structured way of teaching and evaluating this element of medical knowledge. The required evidence-based exercise may take the form of a journal club, critically appraised topic, educational prescription, etc. There should be a structured template with predetermined criteria to document the achievement of competence.

## **PRACTICE-BASED LEARNING AND IMPROVEMENT**

### **IV.A.5.c**

Reflection on one's practice, by identifying strengths and limitations, is the first step in practice improvement. The learner can then build on this reflective process by developing an individualized learning plan, e.g., documented personal learning objectives and strategies to achieve them. Bridging the transition from residency to the next career step requires an individualized learning plan that extends beyond residency. The "Resident Center" of PediaLink (AAP website) provides a mechanism for the trainee to document his/her learning plan. The "Program Director Center" provides a mechanism for the mentor and/or program director to review and update the learning plan with the resident and serves as documentation that this process has occurred.

During training it is critical that programs foster self-directed learning so that this practice becomes a way of life as the resident evolves into an independent practitioner. The "Resident Center" of PediaLink also provides each resident with some self-assessment tools and the opportunity to complete PRER self-assessment questions. The "Program Director Center" provides data on number of questions completed by each resident and can be used as one measure of self-assessment.

An ethos of ongoing reflection for the purpose of improved quality of care for patients should permeate every aspect of training to reinforce the need for trainees to adopt this practice as a lifelong habit. The critical steps to achieve competency in this domain involve self-assessment, feedback from others, reflection on feedback and identification of strategies that will lead to improvement of future practice.

Mentors must guide the residents in their ability to use self-assessment techniques and analysis of events or critical incidents that exemplify particularly positive or negative behaviors to identify personal and professional strengths and weaknesses.

Ongoing feedback is critical if one expects to meet a threshold for competence. The need for, and the role of, faculty mentors in providing guidance and feedback cannot be overemphasized. Written responsibilities and/or a checklist of items to be addressed during these meetings will be helpful to mentors and ensure a comprehensive semi-annual review of performance with the resident. In addition, feedback from a variety of evaluators allows residents to gain an understanding of how their behaviors impact others with whom they interact. Residents should be encouraged to incorporate this feedback into strategies to improve future practice.

The program must document that residents also acquire the skills needed to analyze and improve the quality of clinical practice. This can be accomplished by participation in a quality improvement project or activity (e.g., membership in an institutional quality improvement committee). Projects may involve teams of residents working in any clinical setting. The Plan-Do-Study-Act (PDSA) cycle described by Berwick et al, which can be completed in a

minimum of two week cycles, provides a method for meeting this requirement. For each resident in the most recent graduated class, there must be evidence of such activity.

Programs must provide residents with excellent role models who demonstrate the value of teaching patients/families about preventive health care and educating them about disease processes. Faculty should also model the teaching skills necessary to educate residents in a variety of teaching venues, such as small group seminars, large group lectures, and clinical precepting. These activities, including evaluation of the residents' teaching skills, should be documented.

## **INTERPERSONAL AND COMMUNICATION SKILLS**

### **IV.A.5.d**

Effective written and verbal communication, including telephone triage, is critical to practicing the science of medicine; style of communication is critical to practicing the art of medicine. Both components should be addressed as part of residency training.

In the practice of pediatrics, the ability to communicate must not only extend to different cultural backgrounds and socioeconomic strata as in other disciplines, but also extend to different developmental levels. In order to be effective, the communication must target both the patient and the family. Perceptions by the patient and family of residents' level of interest and concern will affect their judgment as to the quality of care provided and their willingness to comply with recommendations. Engaging residents in interactive methods of learning such as role playing, review of videotapes, small group discussion of vignettes, etc., are particularly meaningful methods of teaching these skills.

The ability to function as part of a team is important in optimizing patient care since no one individual has all the needed expertise to attend to the medical, psychological, and social needs of patients. Teamwork during training also lays the groundwork for future collegial relationships in a primary care practice within a community or as a faculty member within a division and department of pediatrics. It is equally important to have team members (including the patient/family as part of the team) contribute to the assessment of the resident's communication skills since the resident most likely will relate to each individual in a unique way.

## **PROFESSIONALISM**

### **IV.A.5.e**

Medical ethics, including, but not limited to, the ethical principles of medical practice and the ethical aspects of the relationship of the physician to patients (e.g., initiating and discontinuing the treatment relationship, confidentiality, consent, issues of life-sustaining treatments, when to begin and stop resuscitation, legal and ethical issues in the end-of-life decision-making) and the relationship of the physician to the patients family (e.g., the interdisciplinary management of the psychosocial concerns of the patients family) the relationship of other physicians and to society (e.g., the impaired physician, peer review,

conflicts of interest, resource allocation, institutional ethics committees, and ethical issues in research) should be emphasized in the didactic curriculum and modeled by the faculty in clinical practice. Reflection on the personal and professional impact of grief and loss should likewise be emphasized. Venues for teaching may be extended beyond the traditional lecture and include small group discussions of vignettes or case studies, computer-based modules, use of and review of appropriate journal entries regarding observations of professional behaviors, etc.

The ability to demonstrate a knowledge, understanding, and acceptance of individual and cultural differences will promote greater trust on the part of the patient and a greater likelihood that the patient will reveal personal information that may be pertinent to his/her health conditions, management, and ability to comply with prescribed therapies. There should be evidence of focused teaching of cultural competence within the departmental or institutional curricula.

## **SYSTEMS-BASED PRACTICE**

### **IV.A.5.f**

In order to best serve a patient population, one must develop a familiarity with the natural history and epidemiology of major health problems in the community. A background understanding of cultural norms and health beliefs is also of crucial importance. Pediatricians should invest in the health literacy/awareness of the community served so that families can access, process, and understand health information to the extent that it allows for shared decision making about their health. This information becomes helpful in improving patient/family compliance as well.

Programs must provide a safe environment that encourages practitioners to identify weaknesses deficiencies and errors. The optimal strategy for preventing errors is through development and implementation of system strategies and processes that are not subject to human error. Morbidity and mortality conferences provides an ideal venue for a formal approach to examination of system errors and solutions for correction/prevention if the environment is safe and the interdisciplinary team that represents the system is involved. The educational leadership will need to work with faculty, to teach residents the importance of the perspective of examining the systems within which health care is delivered in order to prevent medical errors. Residents must have the opportunity to work with faculty to identify systems errors, develop and implement processes for correction, and measure the success of these efforts within a supportive environment.

## **FACULTY DEVELOPMENT**

### **II.B.9**

The shift to a competency-based system of education highlights the need to educate not only learners but to educate faculty both to teach and to assess the performance of residents in achieving the 6 ACGME domains of competence. Faculty development for the major teaching faculty must go beyond attendance at an occasional formal lecture. The key faculty should be engaged in meaningful activities, such as curriculum development and/or workshops, to determine assessment processes and criteria for judging competence. Since new tools, beyond the global form, will be needed to assess competence, faculty should be educated in how to use these new methods in order to optimize the accuracy of resident assessment. Venues such as faculty meetings, curriculum meetings, etc., can serve as effective and efficient opportunities for providing ongoing faculty development.

## Clarification of Expectations Regarding Practice-Based Learning and Improvement and Systems-Based Practice

Practice-Based Learning and Improvement (PBLI)	
Question	Answer
<p>The requirements state that residents and fellows must: <i>systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</i> (IV.A.5.c.4) Does this mean that residents/fellows are expected to participate in a quality improvement project?</p>	<p>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.</p>
<p>Examples of Clinically-Based Quality Improvement Projects</p>	<p>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.</p> <p>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.</p>
<p>Examples of Educational-Based Quality Improvement Projects</p>	<p>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 <u>same</u> quality improvement project <i>should not</i> be provided as answers for PBLI and SBP competency questions in the PIF.</p>

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Practice-Based Learning and Improvement (PBLI)	
Question	Answer
Examples of Educational-Based Quality Improvement Projects	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.
Systems-Based Practice (SBP) Projects	
Question	Answer
<p>The requirements state that residents and fellows must: <i>participate in identifying systems errors and implementing potential systems solutions.</i> (IV.A.5.f.6).</p> <p>What are residents/fellows expected to do to meet this requirement?</p>	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?	<p>The PBLI improvement project involves residents/fellows on ways to improve <i>their own individual practice outcomes</i>. The systems-based practice project is one aimed at identifying <i>systems issues</i> 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.</p> <p>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: <a href="http://www.acgme.org/acWebsite/ci/90DayProjectReportDFA_PA_09_15_08.pdf">http://www.acgme.org/acWebsite/ci/90DayProjectReportDFA_PA_09_15_08.pdf</a>. This document also discusses the competencies further.</p>

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Practice-Based Learning and Improvement and Systems-Based Practice**

<b>Systems-Based Practice (SBP) Projects</b>	
<b>Question</b>	<b>Answer</b>
Two Examples of SBP Projects	<p>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.</p> <p>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.</p>
<b>Continuity Clinic Documentation</b>	
<b>Question</b>	<b>Answer</b>
What is necessary for documentation of continuity experience?	<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 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.</p>