

Companion Document (Guidelines for Subspecialty PIF Documentation)

The revised Program Requirements document for the Subspecialties of Pediatrics 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 sections of the Program Requirements.

Goals and Objectives (Section V.A.2)

Written goals and objectives are required for each learning experience. These must be level specific since you would expect more expertise as learners progress through fellowship training. Goals are broad statements of what the learner is expected to accomplish over time. Objectives are specific statements about what the learner is expected to do. Learning objectives should begin with a verb. The choice of verbs is important as the verb gives an indication of the level of complexity of the task. For example, it is easier to “identify” or “explain” than it is to “apply” and “evaluate.” The verb that one chooses also needs to be one that describes a measurable behavior. So verbs like learn or understand are not useful for writing learning objectives because it is difficult for an evaluator to directly observe whether the objective has been met. Responsibilities should not be confused with learning objectives and should not be included here. For example, “respond to the arrest team pager when you are on the ICU and ED rotations” is a responsibility and not a true learning objective. The level of detail of the learning objectives should be such that an evaluator would be able to say that a goal has been reached because the requisite set of behaviors needed to reach the goal have all been witnessed. The goals and objectives for each learning experience must be distributed to and reviewed with each learner.

Collaboration Between Programs (Section V.A.3)

For departments/institutions with more than one pediatric subspecialty fellowship program, there should be evidence of a collaborative effort among the fellowship directors in: 1) the preparation and delivery of required general curricular content areas (e.g., biostatistics, critical literature review, preparation of grant applications, etc.), 2) the formation and implementation of the scholarship oversight committees such that, to the extent possible, each fellow’s committee is consistent in function, level of responsibility and expectations of fellow accountability. Written guidelines for the operation of the scholarship oversight committee should be developed as a collaborative effort among subspecialty program directors. A mechanism for fellows to document their research progress is available through the American Academy of Pediatrics (AAP) “Fellow Center” of PediaLink (www.PediaLink.org),

ACGME Competencies (Section V.D)

Practice-based Learning and Improvement (Section V.D.3)

In order for fellows to adopt this competency as a life-long habit of practice, they should be guided in the process of reflection with the intent of identifying strengths, needed areas for improvement, and plans to implement strategies that will lead to practice improvement. Fellows should be paired with a faculty mentor with whom they can develop a meaningful relationship to guide them in this process. Faculty development is necessary to ensure that mentors have the needed skills to address the full scope of their responsibilities and function as a valuable resource to fellows. Mentors should meet with mentees a minimum of twice per year along with ongoing interaction via email, phone conversations, etc., during these intervals.

The process of self-assessment is most valuable when discussed with a mentor. The mentor should guide the fellow in reviewing evaluations from health care team members and patients to understand: 1) how one's performance /behavior can impact others, and 2) how to incorporate this feedback into future practice improvement. The fellow can then build on this self-assessment and reflective process by developing an individualized learning plan (e.g., documenting a minimum of three personal learning objectives to address identified areas of needed improvement and strategies to achieve the objectives). This plan should be updated at least annually with the final plan focusing on transition to the next phase of one's career and a plan for life-long learning. The "Fellow Center" of PediaLink provides a mechanism to guide fellows through a self-assessment and reflective process that culminates in documentation of their learning plan.

In addition to knowledge content, it is critical that fellows demonstrate their ability to use technology to access scientific evidence, interpret the evidence they uncover, and then apply it to the care of their patients. The program must document that a fellow is able to perform these skills and that the faculty have a structured way of teaching and evaluating such skill. Having the fellows present at Journal Club or complete a critically-appraised topic are examples of ideal ways of teaching and assessing skills. Necessary components include faculty guidance, criteria for demonstrating competence that are transparent to both fellows and faculty, and documented achievement of competence using the established criteria.

The program must also document that fellows acquire the skills needed to analyze and improve the quality of their practice. Each fellow should engage in a quality improvement project/activity under the guidance of the faculty. The Plan-Do-Study-Act (PDSA) cycle, as described by Berwick, which can be completed in a minimum of two week cycles, provides a practical method for engaging fellows in this process. This requirement may also be met through fellow membership on a QI Committee. In this case there must be evidence of the fellow's active participation in the planning, implementation and analysis of an intervention on a practice outcome.

Programs must provide skilled teachers as role models who demonstrate the value of teaching students, residents, patients and families. Structured learning activities that address teaching skills should be incorporated into the curriculum. Fellows should have opportunities to practice these skills and in turn be evaluated in so doing so that feedback can be used to bring about ongoing improvement.

Interpersonal and Communication Skills (Section V.D.4)

Effective written and verbal communication is critical to practicing the science of medicine; style and content of communication is critical to practicing the art of medicine.

Providing fellows a structured curriculum to address the needed skills as well as engaging them in interactive methods of learning, such as role modeling, role playing, direct observation and feedback, etc., are necessary to enable them to become competent in this area. Based on the need for subspecialists to engage in the delivery of critical/complex and sometimes devastating information regarding diagnosis, process and treatment, particular attention must be given to teaching and assessing competence in conducting family meetings for these purposes. “On-the-job” training without structured teaching and feedback is not sufficient.

Effective communication is a requisite skill for optimal functioning of the health care team. The ability to function as a both a member and leader of a team are critical skills for the subspecialist who works with referring physicians and agencies, patient and families, as well as other members of the health care system.

One effective way of evaluating communication is through review of the fellow’s correspondence with other health care professionals. A structured process for review of written communication, particularly consults and letters to referring physicians is required. Ad hoc review of written communication does not meet this requirement. Timeliness of completion as well as quality of information provided should be assessed and a mechanism for delivering feedback to the fellow must be ensured. Documentation of competence should be included as part of the written evaluation process.

Professionalism (Section V.D.5)

Medical ethics and professionalism should be emphasized in the didactic curriculum and modeled by the faculty in all aspects of their practice. A structured curriculum with meaningful venues for teaching that extend beyond the traditional lecture to include interactive learning (e.g., small group discussions of vignettes or case studies, computer-based modules, role plays, etc.) will meet this requirement.

Multi-source feedback that includes patients/families and allied health professionals is critical to the professional formation of fellows. Since the fellow will relate to each individual in a unique way it is important to have team members (including the patient and family as part of the team) contribute to the assessment of a fellow’s

professionalism. The program should provide a mechanism to ensure that patients/families and representatives of the health care team assess appropriate aspects of the fellow's professionalism and that this feedback is given to the fellows, preferably as aggregate data, that preserves the anonymity of the evaluators. These evaluations should supplement the evaluations of faculty and peers. A structured mechanism for dissemination and collection of evaluations as well as delivery of feedback to the fellows is required. Timeliness of feedback is also important particularly when there has been a breach of professionalism. A structured mechanism for timely documentation, such as the use of critical incidents or instant evaluations, should be in place. In cases where remediation is needed, the steps should include immediate feedback, the development of an action plan with the fellow that specifically addresses the infraction, ongoing monitoring of behavior, and an identified consequence if improvement is not demonstrated.

Systems-Based Practice (Section V.B.6)

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 the health literacy of the community, along with knowledge of the cultural norms and health beliefs, will improve care delivery. This information becomes helpful in improving patient/family compliance as well. The program must provide a structured curriculum to address all of the elements of this competency as well as opportunities to apply this learning. Particularly relevant to subspecialty fellows is their ability to apply the elements of this competency (e.g., preventive care, resource allocation, cost-effective care, etc.) to help patients navigate the complexities of the health care delivery system. A clinical setting that particularly lends itself to experiential learning and demonstration of the requisite skills is a continuity clinic setting where the fellow has an ongoing therapeutic relationship with patients.

In addition, for three year fellowship programs, fellows must have exposure to the administrative aspects of the delivery of care appropriate to their subspecialty discipline. The required elements may be addressed by having fellows be active participants in division meetings and division conferences where these issues are discussed and solutions to identified problems developed and/or by participating with designated faculty in carrying out administrative responsibilities within the division.

Programs must provide a safe environment that encourages practitioners to identify weaknesses, deficiencies, and errors. The program must ensure that each fellow is actively engaged in activities, under the guidance of experienced faculty, to identify system problems/errors, and to develop and implement system solutions. Morbidity and mortality conference provides an ideal venue for a structured approach to the examination of system errors and the development of system solutions provided the interdisciplinary team that represents the system is involved and the fellow is an active participant in identifying and addressing the problems/errors.

Evaluation (Section VII)

An important consideration in the evaluation of competence is that multiple methods of assessment provide a more comprehensive and valid assessment of the learner. Global evaluations are helpful when used in conjunction with other methods but should not be used as the only method of assessment. The type of assessment methods/tools should be paired in a meaningful way to the tasks of real world practice to be evaluated. For example, if it is important for learners to demonstrate competence as evidence-based practitioners then they need to demonstrate competence in systematically accessing, analyzing and applying evidence which can be accomplished in activities like journal club and care delivery in the clinical setting. The former task may be assessed using direct observation of performance in delivering an evidence-based journal club while the latter may be best assessed using a global assessment of the learner by a faculty member directly interacting with the fellow over some period of time such as a block rotation or several months of a longitudinal experience. The learner and the evaluator should be clear about the criteria on which the judgment of competence will be based. Formative feedback is critical in helping the learner meet the bar that has been set to define competence. Faculty development becomes important for those who will serve as evaluators, ensuring that they understand how to use the assessment tools. Training evaluators has been shown to improve the consistency of the assessment process. Self-assessment is critical in the evaluation of competence. Multi source feedback from various stakeholders such as peers, patients, families and other health care professionals provides valuable feedback to the learner and should be used to inform the process of self-assessment.

**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>

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

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: http://www.acgme.org/acWebsite/ci/90DayProjectReportDFA_PA_09_15_08.pdf. This document also discusses the competencies further.</p>

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

Systems-Based Practice (SBP) Projects	
Question	Answer
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>
Continuity Clinic Documentation	
Question	Answer
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>