

**ACGME Program Requirements for
Graduate Medical Education in Pediatrics
Summary and Impact of Major Requirement Revisions**

Requirement #: **Int. B.**

Requirement Revision (significant change only):

Pediatricians are physicians who provide comprehensive patient-centered preventive, acute, and chronic care for the growing and developing child from birth through the transition to adult care. They care for the whole patient, having knowledge to recognize and manage common childhood and adolescent medical, psychosocial, and behavioral issues.

Pediatrics practice is characterized by flexibility and adaptability. A good pediatrician has broad-based knowledge, strong critical thinking skills, and the flexibility to practice in a wide variety of settings and circumstances. Pediatricians have the skills to initially manage children and to recognize the need to refer to higher levels of care as appropriate. Pediatricians provide consultation to others, formulate questions for consulting subspecialists, and co-manage children with chronic or complex physical and mental health problems.

Pediatricians are advocates for children. They have a strong presence within communities, where they promote health and health equity in ways that build public trust in the profession. In their interactions with others, they exhibit cultural humility and empathy. They are grounded in principles of social justice, advocate for underserved populations, and seek to eliminate disparities in care. They are collaborative leaders who lead by example and practice interprofessional team-based care. Pediatricians communicate effectively with patients, patients' families, treatment teams, communities, and within health care systems.

As self-directed lifelong learners, pediatricians stay current with advanced and emerging technologies. They understand and collaboratively navigate the changing business aspects of medicine. Pediatricians utilize data management science to inform patient care, resulting in high-value patient-centered care, continuous quality improvement, and equitable and ethical service delivery.

Pediatricians partner and connect with colleagues, team members, and patients, optimizing both their own and their teams' well-being. They find meaning, joy, and purpose by capably caring for patients and are equipped, educated, and trained to lead and manage teams. The pediatrician's coordination of care extends beyond the end of life, including grief and bereavement management. The discipline is characterized by a collaborative, compassionate, cognitive, scholarly, and relationship-oriented approach to comprehensive patient care.

1. Describe the Review Committee's rationale for this revision:

Every 10 years, the ACGME Review Committees are required to evaluate the applicable specialty-specific Program Requirements for revision. In 2017, the ACGME re-envisioned the process by which this is done. The new process, which includes scenario-based strategic planning, called for rigorous and creative consideration about what the specialty will look like in the future prior to proposing any revisions, recognizing the future is marked with significant uncertainty.

Several themes emerged from the scenario planning efforts that provide insight into the pediatricians of the future and their practice:

1. Comprehensive Clinical Care
2. Technology Integration
3. Outcomes-Based Practice
4. Effective Communication
5. Leadership and Collaboration
6. Community and Physician Advocacy
7. Professionalism, Diversity, Equity, and Inclusion
8. Educational Process

It is recognized that the pediatrician of the future will not achieve mastery of all the competencies identified during residency alone. Residency must serve as the foundation for career-long professional development and adaptation to a changing health care system and community need. A significant number of pediatricians go on to attain further education and training in subspecialties.

The definition of a pediatrician reflects the core functions and values of pediatrics that are foundational, and that faculty members and graduates of pediatrics residency programs should possess and/or practice.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Although this is a vision statement and functions as an introduction to the Program Requirements, the Review Committee expects that the views expressed will encourage and promote program improvements and innovation in resident education, patient safety, and patient care quality.
3. How will the proposed requirement or revision impact continuity of patient care?
Continuity of patient care is an important piece comprehensive patient care and is addressed later in the document.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
There may need to be some additional resources, in that there is expansion of outpatient activities, and the addition of mental health education. Not all institutions may have the appropriate facilities, quantity of facilities, or personnel to meet the new requirements.
5. How will the proposed revision impact other accredited programs?
This will not affect other accredited programs.

Requirement #: **II.B.1.c) – II.B.1.e).(1).(f)**

Requirement Revision (significant change only):

II.B.1.c) There must be faculty members with expertise in subspecialty pediatrics who have ongoing responsibility for the care of subspecialty pediatric patients. (Core)

~~II.B.1.d) There must be faculty members with expertise in mental health. (Core)~~

~~II.B.1.e) Subspecialty Faculty~~

~~Faculty members with subspecialty board certification must function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings. (Core)~~

~~II.B.1.e).(1) This should include a faculty member in each of the following subspecialty areas of pediatrics: (Core)~~

~~II.B.1.e).(1).(a) adolescent medicine; (Core)~~

~~II.B.1.e).(1).(b) developmental behavioral pediatrics; (Core)~~

~~II.B.1.e).(1).(c) neonatal-perinatal medicine; (Core)~~

~~II.B.1.e).(1).(d) pediatric critical care; (Core)~~

~~II.B.1.e).(1).(e) pediatric emergency medicine; and, (Core)~~

~~II.B.1.e).(1).(f) subspecialists from at least five other distinct pediatric medical disciplines. (Core)~~

1. Describe the Review Committee's rationale for this revision:

The requirements were revised to allow greater flexibility in identifying appropriate faculty members and allow for faculty members who possess requisite expertise to teach residents in disciplines where there may not be sufficient board-certified physicians in certain subspecialty areas. In addition, a requirement was added for mental health faculty members, which may include psychologists, general pediatricians, adolescent medicine physicians, developmental-behavioral pediatricians, child and adolescent psychiatrists, and social workers, to ensure that appropriate faculty are available to educate residents.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

Allowing educators who are not board certified in some subspecialty areas to participate in resident education will benefit the learners by exposing them to individuals with rich clinical expertise who may not have qualified to serve as faculty members under the current requirements. Expanding the list to include mental health providers acknowledges the critical need for this training for future pediatricians.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Additional faculty members in mental health may need to be added for those institutions that do not currently have them.

5. How will the proposed revision impact other accredited programs?
There should be no impact.

Requirement #: **II.B.2.g)**

Requirement Revision (significant change only):

[Faculty members must:] maintain awareness of and respond to patient volumes and acuity as they affect the workload of the team, well-being of the residents, and safety of the patients.
(Core)

1. Describe the Review Committee's rationale for this revision:
While the Review Committee decided not to specify patient caps, it wanted to emphasize the importance of ensuring appropriate patient loads.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Ensuring appropriate patient loads will improve patient safety and care and resident well-being.
3. How will the proposed requirement or revision impact continuity of patient care?
There should be no impact.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
**There may be a need to increase other staffing to provide care for these patients.
The additional personnel could be advanced practice providers or faculty members.**
5. How will the proposed revision impact other accredited programs?
There should be no impact.

Requirement #: **II.B.4.c)**

Requirement Revision (significant change only):

At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of 0.1 FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)

1. Describe the Review Committee's rationale for this revision:
The requirement is intended to ensure that core faculty members have dedicated time and support to meet the educational and administrative responsibilities of the program as assigned by the program director.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

Providing appropriate support to the core faculty should help to ensure that faculty members have adequate time to devote to resident education.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

As there may be variability in the amount of support provided to the core faculty, additional financial support may be needed. The requirement did not specify how the aggregate FTE support should be distributed so as to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **II.D.1. – II.D.1.b).(3)**

Requirement Revision (significant change only):

~~II.D.1 The sponsoring institution and the program must support additional program leadership to include a liaison(s) to assist the program director in effective administration of the program.~~
(Core)

~~II.D.1.a) The program leadership must not be required to generate clinical or other income for this support.~~ (Core)

~~II.D.1.b) The minimum amount of full time equivalent (FTE) support provided must be based on the size of the program as follows:~~ (Detail)

~~II.D.1.b).(1) For programs with 12-30 residents, there must be a minimum of 1.0 FTE liaison.~~ (Detail)

~~II.D.1.b).(2) For programs with 31-90 residents, there must be a minimum of 2.0 FTE liaisons.~~ (Detail)

~~II.D.1.b).(3) For programs with more than 90 residents, there must be a minimum of 3.0 FTE liaisons.~~ (Detail)

1. Describe the Review Committee's rationale for this revision:

The requirements were removed, as additional program support requirements are not permitted by the ACGME beyond what is specified in the program director, program coordinator, and core faculty support requirements.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

Not applicable.

3. How will the proposed requirement or revision impact continuity of patient care?

Not applicable.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There may be a need for additional administrative staffing to support program needs.

5. How will the proposed revision impact other accredited programs?

Not applicable.

Requirement #: **IV.B.1.b).(1).(a).(iii)–(vii); IV.B.1.b).(1).(a).(x)–(xii); IV.B.1.b).(1).(a).(xv)–(xvi)**

Requirement Revision (significant change only):

IV.B.1.b).(1).(a) Residents must demonstrate the ability to provide comprehensive medical care to infants, children, and adolescents, including: ^(Core)

IV.B.1.b).(1).(a).(iii) conducting health supervision, minor sick, and acute severe illness encounters, in addition to managing complex or chronic conditions; ^(Core)

IV.B.1.b).(1).(a).(iv) assessing growth and development from birth through the transition to adult practitioners; ^(Core)

IV.B.1.b).(1).(a).(v) recognizing normal variations in growth, development, and wellness, and anticipating, preventing, and detecting disruptions in health and well-being; ^(Core)

IV.B.1.b).(1).(a).(vi) diagnosing and treating common conditions while recognizing, critically evaluating, and managing complexities; ^(Core)

IV.B.1.b).(1).(a).(vii) incorporating consideration of the positive and negative impacts of socio-economic, cultural, and environmental conditions in each patient encounter; ^(Core)

IV.B.1.b).(1).(a).(x) providing medical care that addresses concerns of patients and their families; ^(Core)

IV.B.1.b).(1).(a).(xi) providing medical care that addresses concerns of groups of patients; ^(Detail)

IV.B.1.b).(1).(a).(xii) participating in end-of-life care coordination and grief and bereavement management; ^(Detail)

IV.B.1.b).(1).(a).(xv) referring patients who require consultation, including those with surgical problems; and, ^(Core)

IV.B.1.b).(1).(a).(xvi) resuscitating, stabilizing, and triaging patients to align care with severity of illness. ^(Core)

1. Describe the Review Committee's rationale for this revision:

The essential role of the pediatrician is to provide comprehensive medical care to infants, children, and adolescents. This includes routine well-child visits, minor intercurrent sick visits, acute more severe illness encounters, and management of chronic conditions. Pediatricians are competent in assessing growth and development from birth until the transition to adult practitioners. They are experts in recognizing normal variations in growth, development, and wellness, along with detecting abnormalities that may threaten the well-being of their patients. The requirements were modified to identify the components needed to provide comprehensive clinical care.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This should have a positive effect on resident education as the requirements now clearly specify the areas in which residents must demonstrate knowledge and will improve their ability to provide comprehensive care to patients. The requirements describe a wider scope of practice, including needed attention to environmental concerns and clear expectations about the transition to adult care and end-of-life care.

3. How will the proposed requirement or revision impact continuity of patient care?

It should improve continuity with adult care physicians and improve communications between physicians.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **IV.B.1.b).(2).(a) – IV.B.1.b).(2).(a).(xiii); IV.C.8)**

Requirement Revision (significant change only):

~~IV.B.1.b).(2).(a) Residents must be able to competently perform procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post procedure care, and interpretation of applicable results. Residents must demonstrate procedural competence by performing the following:~~ ^(Core)

~~IV.B.1.b).(2).(a).(i) bag-mask ventilation;~~ ^(Core)

~~IV.B.1.b).(2).(a).(ii) bladder catheterization;~~ ^(Core)

~~IV.B.1.b).(2).(a).(iii) giving immunizations;~~ ^(Core)

IV.B.1.b).(2).(a).(iv) ~~incision and drainage of abscess;~~^(Core)

IV.B.1.b).(2).(a).(v) ~~lumbar puncture;~~^(Core)

IV.B.1.b).(2).(a).(vi) ~~neonatal endotracheal intubation;~~^(Core)

IV.B.1.b).(2).(a).(vii) ~~peripheral intravenous catheter placement;~~^(Core)

IV.B.1.b).(2).(a).(viii) ~~reduction of simple dislocation;~~^(Core)

IV.B.1.b).(2).(a).(ix) ~~simple laceration repair;~~^(Core)

IV.B.1.b).(2).(a).(x) ~~simple removal of foreign body;~~^(Core)

IV.B.1.b).(2).(a).(xi) ~~temporary splinting of fracture;~~^(Core)

IV.B.1.b).(2).(a).(xii) ~~umbilical catheter placement; and,~~^(Core)

IV.B.1.b).(2).(a).(xiii) ~~venipuncture.~~^(Core)

IV.C.8. The program must provide instruction and opportunities for residents to perform procedures, as applicable to each resident's future career plans.^(Core)

1. Describe the Review Committee's rationale for this revision:

The Review Committee is allowing flexibility for programs to determine which procedures residents must have experience in. This was done in recognition that procedures pediatricians are expected to perform may be variable and subject to change. The procedural skills a resident will need to develop will be determined by the program director or designee in collaboration with the resident, considering future career plans and the needs of the community to be served.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The proposed revision will improve resident education and patient care by allowing programs to focus on those procedures relevant to the community needs and the resident's future career.

3. How will the proposed requirement or revision impact continuity of patient care?

There may be some opportunities to teach procedures not previously taught, and to utilize the strength of the faculty locally to involve residents in new skills (e.g., point-of-care ultrasound).

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **IV.B.1.c).(4) – IV.B.1.c).(5).(m)**

Requirement Revision (significant change only):

IV.B.1.c).(4) Residents must demonstrate knowledge of central principles that drive exceptional health outcomes, high-value patient-centered care, continuous quality improvement, and equitable service delivery. ^(Core)

IV.B.1.c).(5) Residents must demonstrate knowledge of the full spectrum of inpatient and outpatient care of well and sick infants, children, and adolescents through the transition to adult care. In addition to the diagnosis and management of common presentations, this includes but is not limited to knowledge of the following: ^(Core)

IV.B.1.c).(5).(a) the indications, contraindications, and complications for procedures; ^(Core)

IV.B.1.c).(5).(b) diagnosis and initial management of behavioral/mental health issues, including attention-deficit/hyperactivity disorder, anxiety, depression, and suicidality; ^(Core)

IV.B.1.c).(5).(c) the application of information technologies and telehealth; ^(Core)

IV.B.1.c).(5).(d) the selection and interpretation of screening tools and tests; ^(Core)

IV.B.1.c).(5).(e) the components of requesting and providing patient consultation; ^(Core)

IV.B.1.c).(5).(f) the components of effective hand-over; ^(Core)

IV.B.1.c).(5).(g) the cost of lab tests, pharmaceuticals, and imaging; ^(Detail)

IV.B.1.c).(5).(h) evidence-based guidelines that inform care; ^(Core)

IV.B.1.c).(5).(i) preventive health services for children and the components of normal childhood development; ^(Core)

IV.B.1.c).(5).(j) the components of the transition of care to adult practitioners; ^(Core)

IV.B.1.c).(5).(k) the components of quality improvement and patient safety; ^(Core)

IV.B.1.c).(5).(l) medication side effects and identification of adverse events; and ^(Core)

IV.B.1.c).(5).(m) antiracism, anti-oppression, recognizing explicit and implicit biases, and health care inequities. ^(Core)

1. Describe the Review Committee's rationale for this revision:

Pediatricians must be mindful of the many dimensions of the outcomes of their care. They must monitor patient safety, patient cost, patient access, and effectiveness of treatment in single patients and in populations. Pediatricians are cognizant of their role in preventive care and health maintenance through transitioning a child's care

to an adult practitioner. The requirements were modified to identify areas in which residents should have knowledge.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This should have a positive effect on resident education as the requirements now clearly specify the areas in which residents must demonstrate knowledge and will improve their ability to provide comprehensive care to patients.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **IV.B.1.e).(2).(a) – IV.B.1.e).(2).(a).(iii)**

Requirement Revision (significant change only):

IV.B.1.e).(2).(a) This must include:

IV.B.1.e).(2).(a).(i) age-appropriate communication strategies inclusive of risk assessment and anticipatory guidance; ^(Core)

IV.B.1.e).(2).(a).(ii) effective communication strategies with patient and patients' families who hesitate to accept recommended treatment, including vaccines; and ^(Core)

IV.B.1.e).(2).(a).(iii) effective communication strategies with patients and patients' families consistent with trauma-informed care. ^(Detail)

1. Describe the Review Committee's rationale for this revision:

To better serve the needs of the whole patient, pediatricians have exemplary communication skills. They interact and build relationships with patients, patients' families, care teams, health care managers, schools, and other members of the patient's community. Communication needs to be culturally sensitive and conducted through a variety of modalities. Requirements were added to reflect these expectations.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The additional requirements should improve patient safety and patient care quality by ensuring residents have the appropriate skills to communicate effectively regarding various aspects of a patient's care.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **IV.B.1.f).(3) – (4)**

Requirement Revision (significant change only):

IV.B.1.f).(3) Residents must learn to collaborate with interprofessional colleagues. ^(Core)

IV.B.1.f).(4) Residents must learn to collaborate with community organizations including schools and/or leaders in healthcare systems, in order to improve healthcare and well-being of patients. ^(Detail)

1. Describe the Review Committee's rationale for this revision:

Pediatricians are collaborative leaders of care teams and partners in decision-making around issues of child health and well-being. The new requirements reflect the strategies to become effective team members. In addition, this requirement recognizes the role that schools and communities play in child wellness.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

Interdisciplinary collaboration and collaboration with community organizations will help to improve patient care.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

The requirements should help to improve professional relationships with other learners.

Requirement #: **IV.C.4.a)**

Requirement Revision (significant change only):

These experiences should be designed to complement and address any gaps in the clinical experience. ^(Core)

1. Describe the Review Committee's rationale for this revision:

The Review Committee recognizes that the educational experiences of the residents will not just occur in the clinical setting and will need to be supplemented with other educational methods such as didactics, simulation, etc. These additional experiences can also enhance education in areas where clinical exposures are variable or where knowledge gaps are identified by the program.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The requirement is meant to improve resident education by ensuring that additional experiences are provided as needed to supplement/complement clinical experiences.

3. How will the proposed requirement or revision impact continuity of patient care?
There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
There should be no impact.

5. How will the proposed revision impact other accredited programs?
There should be no impact.

Requirement #: **IV.C.6 – IV.C.6.f).(2)**

Requirement Revision (significant change only):

IV.C.6 The overall structure of the program must be organized as block and/or longitudinal experiences and must include: ^(Core)

IV.C.6.a) A minimum of 40 weeks of ambulatory care experiences, to include a minimum of:

IV.C.6.a).(1) 8 weeks of general ambulatory pediatric clinic; ^(Core)

IV.C.6.a).(2) 4 weeks of community advocacy; ^(Core)

IV.C.6.a).(3) 4 weeks of subspecialty outpatient experience, composed of no fewer than two subspecialties, in the first 18 months of the program; ^(Core)

IV.C.6.a).(4) 4 weeks adolescent medicine; ^(Core)

IV.C.6.a).(5) 4 weeks of mental health; ^(Core)

IV.C.6.a).(6) 4 weeks developmental-behavioral pediatrics; and, ^(Core)

IV.C.6.a).(7) 12 weeks of pediatric emergency medicine and acute illness. ^(Core)

IV.C.6.a).(7).(a) At least 8 of these weeks must be in the emergency department. ^(Core)

~~IV.C.6.b) a minimum of five educational units of ambulatory experiences, including; (Core)~~

~~IV.C.6.b).(1) ambulatory experiences to include elements of community pediatrics and child advocacy; and (Core)~~

~~IV.C.6.b).(1).(a) There must be two educational units. (Detail)~~

~~IV.C.6.b).(2) pediatric emergency medicine and acute illness. (Core)~~

~~IV.C.6.b).(2).(a) There must be three educational units of pediatric emergency medicine, at least two of which must be in the emergency department. (Detail)~~

~~IV.C.6.b).(2).(b) Residents must have first contact evaluation of pediatric patients in the emergency department. (Detail)~~

~~IV.C.6.c) A minimum of 40 weeks of inpatient care experiences, to include; (Core)~~

~~IV.C.6.c).(1) 24 weeks of inpatient medicine with a minimum of 16 weeks of general pediatrics or pediatric hospital medicine service.~~

~~IV.C.6.c).(1).(a) The remaining time must be on the general pediatrics or pediatric hospital medicine service or other subspecialty services, with no more than 4 weeks spent on a single non-pediatric hospital medicine service; (Core)~~

~~IV.C.6.c).(2) 12 weeks intensive care to include a minimum of 4 weeks of pediatric intensive care unit and 4 weeks of neonatal intensive care unit; and, (Core)~~

~~IV.C.6.c).(3) 4 weeks of newborn nursery. (Core)~~

~~IV.C.6.d) a minimum of 10 educational units of inpatient care experiences, including; (Core)~~

~~IV.C.6.d).(1) inpatient pediatrics; (Core)~~

~~IV.C.6.d).(1).(a) There must be five educational units. (Detail)~~

~~IV.C.6.d).(1).(b) No more than one of the five required educational units should be devoted to the care of patients in a single subspecialty. (Detail)~~

~~IV.C.6.d).(2) neonatal intensive care; (Core)~~

~~IV.C.6.d).(2).(a) There must be two educational units. (Detail)~~

~~IV.C.6.d).(3) pediatric critical care; and, (Core)~~

~~IV.C.6.d).(3).(a) There must be two educational units. (Detail)~~

~~IV.C.6.d).(4) term newborn care. (Core)~~

~~IV.C.6.d).(4).(a) There must be one educational unit. (Detail)~~

IV.C.6.e) A minimum of 40 weeks of an individualized curriculum. (Core)

IV.C.6.e).(1) The individualized curriculum must be determined by the learning needs and career plans of each resident and must be developed through the guidance of the program director or designee. (Core)

IV.C.6.e).(2) Experiences must be distributed across the years of training. (Core)

IV.C.6.e).(3) There must be a minimum of 20 weeks of at least 5 additional subspecialty experiences beyond those used to meet the inpatient and outpatient requirements. Each subspecialty experience must be a minimum of 1 week and a maximum of 4 weeks in duration. (Core)

~~IV.C.6.f) a minimum of six educational units of an individualized curriculum; (Core)~~

~~IV.C.6.f).(1) The individualized curriculum must be determined by the learning needs and career plans of each resident and must be developed through the guidance of a faculty mentor. (Core)~~

~~IV.C.6.f).(2) There must be a minimum of 20 weeks of elective clinical, scholarly, and/or other experiences. (Core)~~

1. Describe the Review Committee's rationale for this revision:

The education and training of a pediatrician includes the development of attributes and values, as well as knowledge and skills. The time it takes for residents to acquire competence may vary in length and experience. Some abilities, once acquired, may not be permanent, and require ongoing attention and effort by graduates throughout their careers. The shift to competency-based education needs to be incremental. The curriculum requirements were modified to allow programs the flexibility to tailor educational experiences, but still provide parameters to ensure that the minimum foundational experiences are provided for all residents.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The revised requirements will improve resident education by allowing for greater individualization of resident experiences.

3. How will the proposed requirement or revision impact continuity of patient care?

The revised requirements will allow greater flexibility for programs to offer improved continuity experiences for the residents.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **IV.C.6.g) – IV.C.6.g).(8)**

Requirement Revision (significant change only):

IV.C.6.g) A longitudinal general pediatric outpatient experience in a setting that provides a medical home for the spectrum of pediatric patients, allowing residents to develop a continuous, long-term therapeutic relationship with a panel of pediatric patients which is in addition to the other required 40 weeks of ambulatory experiences. ^(Core)

~~IV.C.6.g).(1) The sessions must not be scheduled in fewer than 26 weeks per year.~~ ^(Core)

~~IV.C.6.g).(2) There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children with special health care needs and chronic conditions.~~ ^(Core)

~~IV.C.6.g).(3) There must be a longitudinal working experience between each resident and a single or core group of faculty members with expertise in primary care pediatrics and the principles of the medical home.~~ ^(Core)

IV.C.6.g).(4) There must be a A minimum of 36 half-day sessions per year of a longitudinal outpatient experience. [moved from IV.C.6.e] ^(Core)

IV.C.6.g).(4).(a) These sessions must be distributed throughout the year. [moved from IV.C.6.e.(1)] ^(Core)

IV.C.6.g).(4).(b) The interval between these sessions should not exceed 8 weeks. ^(Core)

~~IV.C.6.g).(5) PGY-1 and PGY-2 residents must have a longitudinal general pediatric outpatient experience in a setting that provides a medical home for the spectrum of pediatric patients.~~ ^(Core)

~~IV.C.6.g).(6) PGY-3 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, sessions in the final year may take place in a longitudinal subspecialty clinic or alternate primary care site.~~ ^(Detail)

~~IV.C.6.g).(7) The medical home model of care must focus on wellness and prevention, coordination of care, longitudinal management of children with special health care needs and chronic conditions, and provide a patient- and family-centered approach to care.~~ ^(Detail)

~~IV.C.6.g).(8) Consistent with the concept of the medical home, residents must care for a panel of patients that identify the resident as their primary care provider.~~ ^(Detail)

1. Describe the Review Committee's rationale for this revision:

Continuity experience was felt to be a major component of pediatrics training. Numerous programs have joined a pilot that exempted participants from the requirement that longitudinal outpatient sessions must not be scheduled in fewer than 26 weeks per year. After reviewing the pilot reports and considering the themes

and strategies identified in the strategic planning workshops, the Review Committee agreed to allow flexibility in the scheduling of continuity sessions.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The additional flexibility should allow programs to provide comprehensive continuity care that results in improved quality of patient care.

3. How will the proposed requirement or revision impact continuity of patient care?

The revised requirements will allow greater flexibility for programs to offer improved continuity experiences for the residents.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There should be no impact.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **V.A.1.g)**

Requirement Revision (significant change only):

The evaluation process must be structured to mitigate implicit bias in resident evaluation. (Detail)

1. Describe the Review Committee's rationale for this revision:

Professionalism, Diversity, Equity, and Inclusion was a major theme identified in the scenario planning workshops. While existing requirements address professionalism in general, the Review Committee felt it was important to address this specifically in the evaluation process.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The intent is that unbiased feedback will improve the residents' education by providing them with more accurate feedback.

3. How will the proposed requirement or revision impact continuity of patient care?

There should be no impact.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

There may be a need for faculty development in this area.

5. How will the proposed revision impact other accredited programs?

There should be no impact.

Requirement #: **VI.A.2.b).(1).(a).(i).(b)**

Requirement Revision (significant change only):

After the assessment of the PGY-1 resident's performance, the program may approve the resident's ability to be supervised indirectly with direct supervision immediately available. (Core)

1. Describe the Review Committee's rationale for this revision:
The new requirement addresses when PGY-1 residents may be supervised indirectly with direct supervision immediately available.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
The requirement is intended to ensure that PGY-1 residents have appropriate supervision that ensures patient safety.
3. How will the proposed requirement or revision impact continuity of patient care?
There should be no impact.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
There should be no impact.
5. How will the proposed revision impact other accredited programs?
There should be no impact.

Requirement #: **VI.B.2.b).(1)**

Requirement Revision (significant change only):

Patient care responsibilities must be structured to support the well-being of the entire care team while supporting clinical, scholarly, personal, and professional development. (Core)

1. Describe the Review Committee's rationale for this revision:
The intent of the requirement is to provide further detail regarding patient care responsibilities and ensure that programs assess how the assignment of patient care responsibilities can affect work compression.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Well-being of the care team should result in improved patient safety and care.
3. How will the proposed requirement or revision impact continuity of patient care?
There should be no impact.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
There should be no impact.
5. How will the proposed revision impact other accredited programs?
There should be no impact.

