ACGME Program Requirements for Graduate Medical Education in Pediatrics

Common Program Requirements are in BOLD

Proposed Effective Date: July 1, 2013

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int. B. Pediatrics encompasses the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of infants, children, adolescents and young adults during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific model of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values. Educational experiences emphasize the competencies and skills needed to practice general pediatrics of high quality in the community. Education in the fields of subspecialty pediatrics enables graduates to participate as team members in the care of patients with chronic and complex disorders.

Int. C. Duration of Education

The educational program in pediatrics must be 36 months in length.

I. Institutions

I.A. **Sponsoring Institution**

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. The sponsoring institution and the program must support additional program leadership to include associate program director(s), chief resident(s), and residency coordinator(s) to assist the program director in effective administration of the program.

I.A.1.a) The program leadership must not be required to generate clinical or other income for this support.

I.A.1.b) The minimum amount of full-time equivalent (FTE) support provided must be based on the size of the program as follows:

I.A.1.b).(1) The program director must devote a minimum of 0.5 FTE regardless of the size of the program.

I.A.1.b).(1).(a) For programs with 12-30 residents, there must be a minimum of 0.75 combined FTE program director and associate program director, 1.0 FTE chief resident, and 1.0 FTE residency coordinator.

I.A.1.b).(1).(b) For programs with 31-60 residents, there must be a minimum of 1.0 combined FTE program director and associate program director, 2.0 FTE chief residents, and 1.5 FTE residency coordinators.

I.A.1.b).(1).(c) For programs with 61-90 residents, there must be a minimum of 1.25 combined FTE program director and associate program director, 2.0 FTE chief residents, and 2.0 FTE residency coordinators.

I.A.1.b).(1).(d) For programs with 91-120 residents, there must be a minimum of 1.5 combined FTE program director and associate program director, 3.0 FTE chief residents, and 3.0 FTE residency coordinators.

I.A.1.b).(1).(e) For programs with greater than 120 residents, there must be a minimum of 1.75 combined FTE program director and associate program director, 3.0 FTE chief residents, and 3.5 FTE residency coordinators.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the

program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;**

I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

I.B.1.c) **specify the duration and content of the educational experience; and,**

I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.**

I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

I.B.3. The program must be structured to provide at least 30 months of required residency education at the primary and other participating sites.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**

II.A.3. **Qualifications of the program director must include:**

II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**

II.A.3.b) **current certification in the specialty by the American Board of** Pediatrics (ABP)**, or specialty qualifications that are acceptable to the Review Committee; and,**

II.A.3.b).(1) The program director should meet the requirements for Maintenance of Certification in Pediatrics or a Subspecialty of Pediatrics through the ABP.

II.A.3.c) current medical licensure and appropriate medical staff appointment.

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for resident education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.4.n).(1) all applications for ACGME accreditation of new programs;

II.A.4.n).(2) changes in resident complement;

II.A.4.n).(3) major changes in program structure or length of training;

II.A.4.n).(4) progress reports requested by the Review Committee;

II.A.4.n).(5) responses to all proposed adverse actions;

II.A.4.n).(6) requests for increases or any change to resident duty hours;

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;

II.A.4.n).(8) requests for appeal of an adverse action;

II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,

II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.

II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**

II.A.4.o).(1) **program citations, and/or**

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

II.B. Faculty

II.B.1. **At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

The faculty must:

II.B.1.a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

II.B.2. **The physician faculty must have current certification in the specialty by the American Board of** Pediatrics**, or possess qualifications acceptable to the Review Committee.**

II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**

II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**

II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**

II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**

II.B.5.b).(1) **peer-reviewed funding;**

II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**

II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**

II.B.5.b).(4) **participation in national committees or educational organizations.**

II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**

II.B.6. For each required educational unit, a core faculty member must be responsible for curriculum development, and ensuring orientation, supervision, teaching, and timely feedback and evaluation.

II.B.7. Faculty Development

II.B.7.a) Program leadership and core faculty members must participate at least annually in faculty or leadership development programs relevant to their roles in the program.

II.B.7.b) All faculty members should participate in programs to enhance the effectiveness of their skills as educators at least every 24 months, based on their roles in the program, and as needed according to their faculty evaluations.

II.B.8. General Pediatricians

There must be faculty members with expertise in general pediatrics who have ongoing responsibility for the care of general pediatric patients. These faculty members must participate actively in formal teaching sessions, and serve as attending physicians on inpatient and outpatient services, including the term newborn nursery.

II.B.9. Subspecialty Faculty

II.B.9.a) There must be at least one faculty member with expertise in each of the following subspecialty areas of pediatrics:

II.B.9.a).(1) adolescent medicine;

II.B.9.a).(2) developmental-behavioral pediatrics or neuro-developmental disabilities;

II.B.9.a).(3) neonatal-perinatal medicine;

II.B.9.a).(4) pediatric critical care; and,

II.B.9.a).(5) pediatric emergency medicine.

II.B.9.b) There must also be subspecialists from five other distinct pediatric medical disciplines.

II.B.9.c) Subspecialty faculty members must function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings.

II.B.10. Other Faculty

At the primary clinical site, there must be at least one physician available for clinical consultation and teaching of residents who is Board-certified in each of the following areas:

II.B.10.a) diagnostic radiology;

II.B.10.b) pathology; and,

II.B.10.c) surgery.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

II.D.1. Facilities

II.D.1.a) There must be inpatient and outpatient facilities available to the residents to achieve all of the required educational outcomes.

II.D.1.b) There must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have been transported via the Emergency Medical Services system.

II.D.1.c) Residents must have access to teaching and patient care work space, including meeting rooms, computers, and medical and electronic resources to achieve all of the required educational outcomes.

II.D.2. Patient Population

The program must provide a volume, variety, and complexity in diagnoses and age, of pediatric patients necessary for residents to achieve all of the required educational outcomes.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.B. Number of Residents

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.

III.B.1. The program must ~~should~~ offer a minimum total of 12 resident positions.

III.B.2. The number of combined positions should not exceed the number of categorical pediatrics positions.

III.B.3. Resident attrition must not have a negative impact on the stability of the educational environment.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**

IV.A.2.a) The curriculum should incorporate the competencies into the context of the major professional activities for which residents should be entrusted.

IV.A.2.b) For each educational unit, the curriculum must contain competency-based goals and objectives, educational methods, and the evaluation tools that the program will use to assess each resident's competence and achievement of entrusted professional activities.

IV.A.3. **Regularly scheduled didactic sessions;**

IV.A.3.a) The program must have planned educational experiences which include both independent study and group learning exercises necessary to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of pediatrics.

IV.A.3.a).(1) The program must establish requirements for resident participation in order to achieve competence.

IV.A.3.a).(1).(a) Participation by residents must ~~should~~ be documented.

IV.A.3.a).(1).(b) Faculty oversight, involvement, and attendance, must be documented.

IV.A.4. **Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

IV.A.4.a) Patient care discussions between residents and precepting faculty members must occur, as part of resident assignments, by qualified generalist or subspecialist faculty members.

IV.A.4.b) Residents must act in a supervisory role, under faculty guidance, for a minimum of five months during the last 24 months of education.

IV.A.5. **ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) **Patient Care**

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents

IV.A.5.a).(1) must be able to competently perform procedures used by a pediatrician in general practice. This includes 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 procedures:

IV.A.5.a).(1).(a) bag-mask ventilation;

IV.A.5.a).(1).(b) bladder catheterization;

IV.A.5.a).(1).(c) giving immunizations;

IV.A.5.a).(1).(d) incision and drainage of abscess;

IV.A.5.a).(1).(e) lumbar puncture;

IV.A.5.a).(1).(f) reduction of simple dislocation;

IV.A.5.a).(1).(g) simple laceration repair;

IV.A.5.a).(1).(h) simple removal of foreign body;

IV.A.5.a).(1).(i) temporary splinting of fracture;

IV.A.5.a).(1).(j) umbilical venous catheter placement; and,

IV.A.5.a).(1).(k) venipuncture.

IV.A.5.a).(2) must complete training and maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line, and Neonatal Resuscitation, including the simulated placement of an umbilical catheter.

IV.A.5.b) **Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

IV.A.5.b).(1) must be competent in the understanding of the indications,

contraindications, and complications for the following procedures:

IV.A.5.b).(1).(a) arterial line placement;

IV.A.5.b).(1).(b) arterial puncture;

IV.A.5.b).(1).(c) chest tube placement;

IV.A.5.b).(1).(d) circumcision;

IV.A.5.b).(1).(e) endotracheal intubation;

IV.A.5.b).(1).(f) peripheral intravenous catheter placement;

IV.A.5.b).(1).(g) thoracentesis; and,

IV.A.5.b).(1).(h) umbilical artery catheter placement.

IV.A.5.b).(2) When these procedures are important for a resident's post-residency position, residents should receive real and/or simulated training

IV.A.5.c) Practice-based Learning and Improvement

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:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

IV.A.5.c).(2) set learning and improvement goals;

IV.A.5.c).(3) identify and perform appropriate learning activities;

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

IV.A.5.c).(7) use information technology to optimize learning; and,

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.

IV.A.5.d) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.

IV.A.5.e) **Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others;

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3) respect for patient privacy and autonomy;

IV.A.5.e).(4) accountability to patients, society and the profession; and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.f) **Systems-based Practice**

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:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;**

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;**

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**

IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;**

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,**

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.**

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) The curriculum should be organized in Educational Units.

IV.A.6.a).(1) An Educational Unit should be a block (four weeks or one month) or a longitudinal experience.

IV.A.6.a).(1).(a) A longitudinal outpatient educational unit should be a minimum of 32 half-day sessions.

IV.A.6.a).(1).(b) A longitudinal inpatient educational unit should be a minimum of 200 hours.

IV.A.6.b) The overall structure of the program must include:

IV.A.6.b).(1) a minimum of six educational units of an individualized curriculum;

IV.A.6.b).(1).(a) The individualized curriculum must be determined by the learning needs and career plans of the resident and must be developed through the guidance of a faculty mentor.

IV.A.6.b).(2) a minimum of 10 educational units of inpatient care experiences, to include:

IV.A.6.b).(2).(a) two educational units of pediatric critical care;

IV.A.6.b).(2).(b) two educational units of neonatal intensive care;

IV.A.6.b).(2).(c) five educational units of inpatient pediatrics; and,

IV.A.6.b).(2).(d) one educational unit of term newborn care.

IV.A.6.b).(3) no more than 16 educational units of inpatient experiences;

IV.A.6.b).(3).(a) These additional experiences should be based on the goals of the individual resident and the program. Inpatient experiences that are part of the individualized curriculum or subspecialty educational units are not included in this limit.

IV.A.6.b).(4) a minimum of nine educational units of additional subspecialty experiences, to include:

IV.A.6.b).(4).(a) one educational unit of developmental-behavioral pediatrics;

IV.A.6.b).(4).(b) one educational unit of adolescent health;

IV.A.6.b).(4).(c) four educational units of four of the following subspecialties:

IV.A.6.b).(4).(c).(i) child abuse;

IV.A.6.b).(4).(c).(ii) medical genetics;

IV.A.6.b).(4).(c).(iii) pediatric allergy and immunology;

IV.A.6.b).(4).(c).(iv) pediatric cardiology;

IV.A.6.b).(4).(c).(v) pediatric dermatology;

IV.A.6.b).(4).(c).(vi) pediatric endocrinology;

IV.A.6.b).(4).(c).(vii) pediatric gastroenterology;

IV.A.6.b).(4).(c).(viii) pediatric hematology-oncology;

IV.A.6.b).(4).(c).(ix) pediatric infectious diseases;

IV.A.6.b).(4).(c).(x) pediatric nephrology;

IV.A.6.b).(4).(c).(xi) pediatric neurology;

IV.A.6.b).(4).(c).(xii) pediatric pulmonology; or,

IV.A.6.b).(4).(c).(xiii) pediatric rheumatology.

IV.A.6.b).(4).(d) three educational units consisting of single subspecialties or combinations of subspecialties, not already experienced, from either the list above or from the following:

IV.A.6.b).(4).(d).(i) child and adolescent psychiatry;

IV.A.6.b).(4).(d).(ii) hospice and palliative medicine;

IV.A.6.b).(4).(d).(iii) neurodevelopmental disabilities;

IV.A.6.b).(4).(d).(iv) pediatric anesthesiology;

IV.A.6.b).(4).(d).(v) pediatric dentistry;

~~IV.A.6.b).(4).(d).(vi) Pediatric Dermatology;~~

IV.A.6.b).(4).(d).(vii) pediatric ophthalmology;

IV.A.6.b).(4).(d).(viii) pediatric orthopaedic surgery;

IV.A.6.b).(4).(d).(ix) pediatric otolaryngology;

IV.A.6.b).(4).(d).(x) pediatric rehabilitation medicine;

IV.A.6.b).(4).(d).(xi) pediatric radiology;

IV.A.6.b).(4).(d).(xii) pediatric surgery;

IV.A.6.b).(4).(d).(xiii) sleep medicine; or,

IV.A.6.b).(4).(d).(xiv) sports medicine.

IV.A.6.b).(5) a minimum of five educational units of ambulatory experiences, to include:

IV.A.6.b).(5).(a) three educational units of pediatric emergency medicine (one educational unit of emergency medicine is equivalent to 160 hours);

IV.A.6.b).(5).(a).(i) Residents must have first-contact evaluation of pediatric patients in the Emergency Department.

IV.A.6.b).(5).(b) one educational unit of community health and child advocacy; and,

IV.A.6.b).(5).(c) one educational unit from the following list

(combinations suggested):

IV.A.6.b).(5).(c).(i) ambulatory general pediatrics;

IV.A.6.b).(5).(c).(ii) global/international health;

IV.A.6.b).(5).(c).(iii) adolescent health, developmental-behavioral pediatrics, or,

IV.A.6.b).(5).(c).(iv) acute illness.

IV.A.6.b).(6) a minimum of 36 half-day sessions per year, which must occur over a minimum of 26 weeks, of a longitudinal outpatient experience.

IV.A.6.b).(6).(a) 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.

IV.A.6.b).(6).(b) 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.

IV.A.6.b).(6).(c) 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.

IV.A.6.b).(6).(d) 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.

IV.A.6.b).(6).(e) 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.

IV.A.6.b).(6).(f) 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.

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic

principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. **Residents should participate in scholarly activity.**

IV.B.3. **The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

V.A.1.a).(1) Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for the following:

V.A.1.a).(1).(a) performing histories and physical examinations;

V.A.1.a).(1).(b) providing effective counseling of patients and families on the broad range of issues addressed by general pediatricians;

V.A.1.a).(1).(c) demonstrating the ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans; and,

V.A.1.a).(1).(d) providing longitudinal care for healthy and chronically-ill children of all ages.

V.A.1.b) **The program must:**

V.A.1.b).(1) **provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

V.A.1.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

V.A.1.b).(3) **document progressive resident performance improvement appropriate to educational level;**

V.A.1.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback;**

V.A.1.b).(5) administer the ABP In-Training Examination annually; and,

V.A.1.b).(6) create and document an individualized learning plan at least annually.

V.A.1.b).(6).(a) The program must provide a system to assist residents in this process, including:

V.A.1.b).(6).(a).(i) faculty mentorship to help residents create learning goals; and,

V.A.1.b).(6).(a).(ii) systems for tracking and monitoring progress toward completing the individualized learning plan.

V.A.1.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

V.A.2. **Summative Evaluation**

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) **document the resident's performance during the final period of education, and**

V.A.2.b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

V.B. **Faculty Evaluation**

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

V.B.3. **This evaluation must include at least annual written confidential evaluations by the residents.**

V.C. **Program Evaluation and Improvement**

V.C.1. **The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

V.C.1.a) **resident performance;**

V.C.1.b) **faculty development;**

V.C.1.c) **graduate performance, including performance of program graduates on the certification examination; and,**

V.C.1.c).(1) At least 80% of those who completed the program in the preceding five years should have taken the certifying examination.

V.C.1.c).(2) At least ~~60%~~ 70% of a program's graduates from the preceding five years who are taking the certifying examination for the first time should have passed.

V.C.1.d) **program quality. Specifically:**

V.C.1.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**

V.C.1.d).(2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

V.C.2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

V.C.2.a) <u>There must be regular meetings, at least six times per year, of the program leadership, including select core faculty members and residents, to review program outcomes and develop, review, and follow-through on program improvement plans.</u>

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

VI.A.2. **The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational**

environment.

VI.A.3. **The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**

VI.A.4. **The learning objectives of the program must:**

VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**

VI.A.4.b) **not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**

VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**

VI.A.5.a) **assurance of the safety and welfare of patients entrusted to their care;**

VI.A.5.b) **provision of patient- and family-centered care;**

VI.A.5.c) **assurance of their fitness for duty;**

VI.A.5.d) **management of their time before, during, and after clinical assignments;**

VI.A.5.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;**

VI.A.5.f) **attention to lifelong learning;**

VI.A.5.g) **the monitoring of their patient care performance improvement indicators; and,**

VI.A.5.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**

VI.A.6. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**

VI.B. **Transitions of Care**

VI.B.1. **Programs must design clinical assignments to minimize the number**

of transitions in patient care.

VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**

VI.B.3. **Programs must ensure that residents are competent in communicating with team members in the hand-over process.**

VI.B.4. **The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. **The program must:**

VI.C.1.a) **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**

VI.C.1.b) **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**

VI.C.1.c) **adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

VI.C.2. **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**

VI.C.3. **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**

VI.D. Supervision of Residents

VI.D.1. **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

VI.D.1.a) **This information should be available to residents, faculty members, and patients.**

VI.D.1.b) **Residents and faculty members should inform patients of their respective roles in each patient's care.**

VI.D.2. **The program must demonstrate that the appropriate level of**

supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.**

VI.D.3.b) **Indirect Supervision:**

VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**

VI.D.3.c) **Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**

VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**

VI.D.4.a) **The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the**

needs of the patient and the skills of the residents.

VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**

VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**

VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**

VI.D.5.a).(2) PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.

VI.D.6. **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities for each resident based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

VI.E.2. Residents must be responsible for an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience.

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.1.b) The Review Committee for Pediatrics will not consider requests for exceptions to the 80 hour limit to residents' work week.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use

alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) **It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**

VI.G.4.b).(2) **Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

VI.G.4.b).(3) **In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**

VI.G.4.b).(3).(a) **Under those circumstances, the resident must:**

VI.G.4.b).(3).(a).(i) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**

VI.G.4.b).(3).(a).(ii) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**

VI.G.4.b).(3).(b) **The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.**

VI.G.5. **Minimum Time Off between Scheduled Duty Periods**

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.**

PGY-2 residents are considered to be at the intermediate level.

VI.G.5.c) **Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**

PGY-3 residents are considered to be in the final years of education.

VI.G.5.c).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

VI.G.5.c).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

VI.G.5.c).(1).(b) There are no circumstances under which residents may stay on duty without eight hours off.

VI.G.6. **Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.6.a) Residents should not have more than one consecutive week of night float and not more than four total weeks of night float per year.

VI.G.7. **Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. **At-Home Call**

VI.G.8.a) **Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

VI.G.8.a).(1) **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each**

resident.

VI.G.8.b) **Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".**

VII. Innovative Projects

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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