



# New Program Requirements Present Challenges and Inspire Innovations in Med-Peds Programs

Sara E. Gardner, MD; Alda Maria Gonzaga, MD, MS; Russ C. Kolarik, MD

From the Department of Internal Medicine—Pediatrics, University of Missouri—Kansas City, Kansas City, Mo  
The authors declare that they have no conflict of interest.

Address correspondence to Sara E. Gardner, MD, Department of Internal Medicine—Pediatrics, University of Missouri—Kansas City, 3101 Broadway, Kansas City, MO 64411 (e-mail: [segardner@cmh.edu](mailto:segardner@cmh.edu)).

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SINCE ITS INCEPTION in 1967, medicine-pediatrics (med-peds) residency training has required a delicate balance of innovation, standardization, cooperation, and compromise.<sup>1</sup> Med-peds training programs became independently accredited by the Accreditation Council on Graduate Medical Education (ACGME) in 2007, and all programs must now adapt to the changes of the Next Accreditation System,<sup>2</sup> which emphasizes competency-based assessment and improvement in patient safety and quality outcomes. At the same time, the Pediatric Review Committee of the ACGME has issued new guidelines for Pediatrics and med-peds training.<sup>3,4</sup> With so much change, it has never been more important to collaborate with our colleagues in categorical medicine and pediatric programs. Here we identify 4 specific challenges to med-peds programs presented by the Next Accreditation System and recent changes to the ACGME program requirements. In addition, we share our experiences attempting to meet these challenges and identify opportunities to build on the rich tradition of innovation within med-peds programs.

## MILESTONE ASSESSMENT

A critical characteristic of med-peds training is the concept that combined trained physicians have equal competence to their categorical peers.<sup>5</sup> Members of the ACGME, the American Board of Internal Medicine (ABIM), the American Board of Pediatrics (ABP), and the Med Peds Program Directors Association (MPPDA) unanimously agreed that the best way to ensure equivalent competence in internal medicine and pediatrics was to use the milestones of both disciplines. For med-peds trainees, this means that they must progress along and ultimately achieve the same milestone level in the same competencies as their categorical peers in medicine and pediatrics despite a shorter duration of training in each specialty. For med-peds programs, this means that programs must assess and monitor the progress of trainees along 2 different sets of milestones in 2 different training environments.

## ASSESSMENT AND REPORTING OF 2 SETS OF MILESTONES

The ACGME requires that programs report med-peds resident milestone assessment on an annual basis, rather than the every-6-month basis required for categorical residents. Although this simplifies reporting requirements, the complexity of combined training creates a number of unique challenges for the assessment of med-peds residents. For example, med-peds residents train in 2 different categorical programs with 2 related but different sets of milestones. It is not clear how the progression of med-peds residents along the milestones of each specialty might be the same or different from categorical residents. In addition, each program has its own assessment methods and collection systems that can make tracking and oversight of progress more challenging. Furthermore, because med-peds residents spend less time than categorical residents in each specialty, the total number of assessments of med-peds residents in each specialty will likely be significantly fewer. Therefore, decisions about milestone rating and progression across key transition points in each specialty may need to be made with less assessment information than categorical residents.

One way to address these issues is to identify the milestones that are common between pediatrics and internal medicine and clearly distinguish those that are unique to each discipline. For example, a trainee's ability to obtain a clear and concise history could relate to both disciplines, while specific knowledge of pediatric and/or adult disease is confined to the specialty. The reconciled milestones can be mapped in the background of the med-peds resident's evaluations in most programs' education management systems. The net result could be that many assessments obtained in one specialty could be used to help inform milestone ratings in the other specialty and vice versa. Experience gained with this approach could also help inform the assessment of trainees in categorical and other combined programs.

## MED-PEDS CLINICAL COMPETENCY COMMITTEE

In the same way as categorical programs, the milestone assessment and monitoring process for med-peds programs

must be informed by a clinical competency committee (CCC). However, there is no ACGME requirement for a med-peds-specific clinical competency committee. Instead, med-peds programs have the flexibility to form their own independent med-peds CCC or use the CCCs of the core pediatrics and medicine programs. Either way, the CCC responsible for med-peds residents must collaborate locally with categorical program leadership to ensure transparent, consistent reporting of milestones and to align promotion standards. In addition, programs must ensure that the assessment tools used in the evaluation of med-peds residents are appropriate and valid measures of the performance and development expected in each categorical program while accounting for the unique trajectory of med-peds residents. This is particularly important when the stakes are high, such as determining promotion to supervisory roles and independent practice.

Regardless of the approach to forming the CCC, it is critical that individuals with knowledge of the combined program have a voice in the CCC that reviews med-peds trainees. If programs choose to use the 2 core program CCCs, then faculty members with extensive knowledge of the unique aspects of med-peds training should be a part of these committees. If programs choose to use an independent combined CCC, then representatives from the categorical programs should be included. Members of the CCC must develop expertise in the milestones of both specialties as well as the unique aspects of the progression and development of med-peds residents. The goal should be to interpret a resident's holistic progression, rather than simply looking at their progression across each set of specialty competencies in isolation. To facilitate this process, we recommend that med-peds residents undergo review of their progress toward achieving the expected milestone levels of each specialty specific competency every 6 months, despite the fact that it is not required by the ACGME. Through more frequent review, it should be possible for members of the CCC to share perspectives, gain an understanding of the typical progression for combined residents, facilitate comparison to the benchmark of the categorical resident, and promote the development of assessment tools to measure comparable milestones within each specialty.

### **QUALITY IMPROVEMENT CURRICULUM**

To improve patient safety and promote high-quality care, the 2013 ACGME Common Program Requirements mandate resident experience in quality improvement, including the opportunity to evaluate individual performance.<sup>6</sup> On the basis of the aggregate data from the responses med-peds residents to the 2013–2014 ACGME Resident Survey, programs were compliant 88% of the time in quality improvement (QI) but only 55% of the time providing “data on practice habits.”<sup>7</sup> Although most GME training programs (58%) struggle to provide meaningful performance data to trainees, med-peds programs have a number of unique barriers to these requirements, such as: 1) frequent transition between institutions, 2)

lack of communication between hospital quality departments and electronic medical records, and 3) fewer numbers of rotations in each specialty.

Innovative approaches are required to overcome these barriers. For example, one program implemented a QI curriculum within their med-peds continuity clinic.<sup>8</sup> The goal of this curriculum was to teach the plan–do–check–act (PDCA) QI method through 4 preclinic conferences scheduled throughout the year, one for each PDCA phase. The program's QI director facilitated the conferences, and the residents (PGY1–4) learned and applied QI through deliberate practice, implementing patient-, physician-, and system-directed solutions with their own patient panels.<sup>9</sup> This approach could be used by any program, whether large or small, and the outcomes from these resident QI projects could generate useful data for individual resident performance and to improve resident education and patient care delivery. Although there are potentially many other ways to accomplish this, regardless of the approach, programs should focus on individual performance data that relate to skills that have comparable importance for both adult and pediatric care. For example, compliance with medication reconciliation, vaccination rates, and procedural safety measures could apply to inpatient and ambulatory care for both disciplines while providing meaningful performance data to a med-peds resident.

### **HANDOFF CURRICULUM**

An important feature of safe, high-quality care is the structured handoff of patients, particularly in large academic medical centers.<sup>10</sup> The 2013 revision to the Common Program Requirements requires programs to minimize the number of handoffs for each patient and ensure that residents develop competence in the handoff process.<sup>6</sup> Historically, med-peds residents have participated in whatever handoff curricula of the categorical programs used. However, med-peds residents are in a unique position to offer feedback on the strengths and potential weaknesses of the different handoff systems they experience on the pediatric and internal medicine wards. With this perspective, we encourage med-peds program directors and faculty to share the use of best practices in handoff curricula and scheduling systems between categorical programs.

The transition of young adults with chronic conditions of childhood to adult care represents an important handoff practice and the inherent nature of med-peds training has led our colleagues to become national leaders in this transition. The requirement for structured handoff curriculum provides the opportunity for collaboration between institutions to offer structured education and practice in transitioning to adult providers. This should include development of specific tools to foster safe and effective care transitions between providers and health care systems.

### **INDIVIDUALIZED TRAINING**

The 2013 revised Pediatric Program Requirements introduced the concept of the individualized educational unit,

which provides the opportunity for programs to ensure individualized, mentored educational experiences for each resident. Med-peds residents are required to have at least 2 of these experiences within their 24-month pediatric curriculum.<sup>3,4</sup> This requirement adds to the challenge for med-peds program directors to ensure appropriate core pediatric knowledge and experience in an already truncated training program. On the other hand, it provides an opportunity for clinical enrichment through design of combined experiences, including such things as transition care, hospitalist electives, and subspecialty care.

Most graduates from med-peds residencies enter primary care practices. However, there are growing numbers of combined residents seeking subspecialty training. Med-peds graduates also are more likely than their pediatric peers to practice in a rural setting.<sup>11</sup> Therefore, individualized training for med-peds resident planning these types of careers should be used to ensure appropriate experience for the advanced primary care physician. For example, in our training program, we have used this opportunity to provide procedural training (eg, certification in placement of peripherally inserted central catheters, trauma management, critical care) for those residents who plan careers with emergency medicine or inpatient care responsibilities.

### CONCLUSIONS

Throughout its history, med-peds programs have had a strong foundation of collaborative practice.

As med-peds program leaders construct and implement creative strategies to meet the newest standards in graduate medical education, it is imperative that we seek opportunities to collaborate not only with our categorical peers but also with the larger graduate medical education community. All combined training programs (ie, emergency medicine/internal medicine, pediatrics/neurology) will be attempting to meet these new requirements, thus facing many of the same challenges faced in med-peds. As the largest combined training program, we must advocate for and deliver assessment tools that are no longer isolated to single specialties but rather contain the ability to broadly assess combined trainees. We can achieve this through

participation in CCCs, sharing feedback on different curricular innovations between programs, and establishing best practices for the transition of care from pediatrics into adult care settings. Through collaboration and innovation, med-peds, pediatrics, and internal medicine programs can meet the challenges of the next accreditation system together and provide safe, high-quality patient care and produce highly competent physicians for the next generation.

### REFERENCES

1. Greganti MA, Schuster BL. Two combined residency programs in internal medicine and pediatrics. *Med Educ.* 1986;61:883–892.
2. Nasca TJ, Philbert I, Brigham T, Flynn TC. The next GME accreditation system—rationale and benefits. *N Engl J Med.* 2012;366:1051–1056.
3. Accreditation Council for Graduate Medical Education. ACGME program requirements. Available at: [http://www.acgme.org/acgmeweb/Portals/0/PFAssets/2013-PR-FAQPIF/700\\_med\\_peds\\_07012013.pdf](http://www.acgme.org/acgmeweb/Portals/0/PFAssets/2013-PR-FAQPIF/700_med_peds_07012013.pdf). Accessed September 20, 2013
4. Accreditation Council for Graduate Medical Education. ACGME program requirements. Available at: [http://www.acgme.org/acgmeweb/Portals/0/PFAssets/2013-PR-FAQ-PIF/320\\_pediatrics\\_07012013.pdf](http://www.acgme.org/acgmeweb/Portals/0/PFAssets/2013-PR-FAQ-PIF/320_pediatrics_07012013.pdf). Accessed October 4, 2013.
5. Chamberlain JK, Frintner MP, Melgar TA, et al. Correlates and trends in training satisfaction of internal medicine-pediatrics residency: a 5-year study. *J Pediatr.* 2012;160:690–696.
6. Accreditation Council for Graduate Medical Education. Common Program Requirements. Available at: <http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf>. Accessed October 1, 2013
7. Accreditation Council for Graduate Medical Education 2013–2014 ACGME Resident Survey. Available at: <https://www.acgme.org/ads/File/DownloadSurveyReport/81038>. Accessed July 24, 2014.
8. Moen R, Norman C. Evolution of the PDCA cycle. Available at: <http://pkpinc.com/files/NA01MoenNormanFullpaper.pdf>. Accessed September 5, 2012.
9. Simak DM, Brooks RC, Gonzaga AMR, et al. Implementation and evaluation of a longitudinal quality improvement curriculum in continuity clinic for resident. *Acad Intern Med Insight.* 2013;11:10–12.
10. Philibert I. Use of strategies from high-reliability organizations to the patient hand-off by resident physicians: practical implications. *Qual Saf Health Care.* 2009;18:261–266.
11. Chamberlain JK, Cull WL, Melgar T, et al. The effect of dual training in internal medicine and pediatrics on the career path and job search experience of pediatric graduates. *J Pediatr.* 2007;151:419–424.