Frequently Asked Questions: Child Neurology
Review Committee for Neurology
(FAQs related to Child Neurology Program Requirements effective July 1, 2023)
ACGME

Question	Answer
Oversight	
What are the Review Committee's expectations for adequate facilities and space for the program? *[Program Requirements: I.D.1.a); IV.D.1.b)]*	The Review Committee's expectations include the following: • Conference facilities must be available to the neurology program. • Residents and faculty members will have access to study or workspace, desks, and locked storage cabinets or lockers. • Confidential dictation space will be available. • Residents will have access to research resources, including laboratory space and equipment, computer access, and statistical consultation services. • Sharing of administrative offices, study areas, or conference facilities is acceptable as long as it does not prohibit resident teaching, service, or learning. • Although not all resources need to be directly on site, access to resources will be available at each site as necessary for patient care.

What is meant by “ready access to specialty-specific and other appropriate reference material in print or electronic format . . . [including] access to electronic medical literature databases with full text capabilities”? *[Program Requirement: I.D.3.]*	Common Program Requirement I.D.3. is parallel to ACGME Institutional Requirement II.E.2. Sponsoring Institutions are expected to provide access to medical literature that supports patient care and education in compliance with ACGME requirements. Access to medical literature cannot be solely restricted to physical locations with limited hours. Access to full-text reference materials may be provided online or in print and may be supported by processes such as interlibrary loans. The availability of a computer or mobile device with internet access alone may provide access to a wide range of relevant reference material. Many Sponsoring Institutions and programs purchase subscriptions to information resources and services to supplement open access materials. As with other programmatic resources, interpretation of the requirement may depend on unique circumstances of participating sites, programs, faculty members, and residents. Residents and faculty members may provide valuable input to Sponsoring Institutions and programs regarding the adequacy of available medical literature resources.
Personnel	
Where must the program director have a staff appointment if the Sponsoring Institution is not a clinical site? *[Program Requirement: I.B.1.a)]*	If the Sponsoring Institution is a non-clinical site, such as a medical school, the program director must have a staff appointment at the primary clinical site.
What is the minimum support required for a program director and, if applicable, associate/assistant program director(s)? *[Program Requirements: II.A.2. and II.A.2.a)]*	The ACGME recognizes that dedicated time is needed to support the administration of the program, and those needs increase with the number of resident positions in the program. There must be one program director who takes overall responsibility for the management of the program. Some programs may benefit from an education leadership team that includes additional associate/assistant program directors. The program leadership team must receive full-time equivalent (FTE) support according to the table provided in Program Requirement II.A.2.a). This time encompasses all the administrative duties of the program leadership team, including, but not limited to program compliance, resident recruitment, ensuring that residents receive proper education, monitoring of the clinical learning environment, and overall oversight. It is

	important to note that the Review Committee for Neurology considers approved resident complement rather than filled resident complement when assessing program director/program leadership support for administration of the program. Further, residents who were simultaneously accepted into a preliminary program (e.g., pediatrics) and the child neurology program as part of the Match (i.e., accepted to both programs right out of medical school) and who are currently enrolled in their pediatric training are not included as part of this calculation. The protected time for administration of the program may be divided among the program director and any associate/assistant program directors. It should be noted that these reflect the minimum dedicated time and support requirements. Depending on the needs of the program and experience of the program leadership, additional support may be warranted.
Is it required for a program to have an associate/assistant program director? *[Program Requirements: II.A.2., II.A.2.a), and II.B.2.-II.B.3.b).(1).]*	The program director's role must include ongoing clinical activity, and not be solely administrative. Therefore, programs requiring 1.0 or more FTE for the program leadership team according to the table in Program Requirement II.A.2.a) must have one or more associate/assistant program directors. Programs requiring less than 1.0 FTE for the program leadership team may operate under the sole oversight of a single program director as long as that individual's duties include ongoing clinical activity. Associate/assistant program directors must have current certification in the specialty from the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Board of Neurology and Psychiatry (AOBNP).
Do residents who were simultaneously accepted into a pediatric residency and child neurology residency at the same institution count toward the complement when calculating minimum support required for the program director/program leadership team or program coordinator? *[Program Requirements: II.A.2, II.A.2.a), II.C.2., and II.C.2.a)]*	Child neurology programs are accredited for three years. Residents matriculating in these programs complete their PGY-1 and PGY-2 under the primary administrative oversight of an accredited program, either at the same program or different institution. These residents do not count toward the resident complement when calculating the minimum support for the child neurology program leadership team. The minimum program leadership and program coordinator FTE is based on the total approved resident positions listed in the Accreditation Data System (ADS), not on the total filled residents per year.

If a program does not have faculty members with expertise in particular disciplines, how should it ensure its residents have exposure to all of the areas listed in the Program Requirements? *[Program Requirement: II.B.1.a)]*	Resident exposure to all the disciplines identified in the Program Requirements may occur through several methods. Residents may learn from a child neurologist who sees a high volume of patients with a particular problem, even if that faculty member is not formally listed as an expert in this area. Residents may also work with multi-disciplinary specialists or rotate to other clinical sites to obtain exposure to all required disciplines.
What is considered regular participation in organized clinical discussions, rounds, journal clubs, and conferences? *[Program Requirement: II.B.2.f)]*	Formal didactic education activities should include experienced faculty members who provide commentary and clinical insights to augment the information being presented in organized clinical discussions, rounds, journal clubs, and conferences. All faculty members do not need to participate in all didactic sessions. However, it is inappropriate for residents to consistently lead organized didactic experiences without faculty present.
What is considered appropriate certification for subspecialty faculty members? *[Program Requirement: II.B.3.b).(1)]*	All faculty members providing subspecialty teaching in the program should be board certified in the relevant subspecialty by the ABPN or the AOBNP when an applicable certification is available. This would apply to situations in which residents rotate through subspecialty clinics or subspecialty inpatient rotations. Those faculty members supervising general patient experiences would only be required to be ABPN or AOBNP certified in neurology.

Question	Answer
What is considered adequate time for a program coordinator? *[Program Requirements: II.C.2. and II.C.2.a)]*	The Review Committee stipulates both time and funding in order to underscore the importance of administrative time for the coordinator in support of the program director's administrative responsibilities. The following list provides examples of some of the administrative and/or support functions that program coordinators may perform or with which they may assist: data collection and reporting; accreditation; resident recruitment; evaluation processes; appointment process and credentialing; preparation of teaching materials; distribution of schedules and information; resident function coordination; correspondence and other types of communication; budget; and payroll. The program coordinator must receive full-time equivalent (FTE) support according to the table provided in Program Requirement II.C.2.a). It is important to note that the Review Committee for Neurology considers approved resident complement rather than filled resident complement when assessing program coordinator support for administration of the program. Further, Residents who were simultaneously accepted into a preliminary program (e.g., pediatrics) and the child neurology program as part of the Match (i.e., accepted to both programs right out of medical school) and who are currently enrolled in their pediatric training are not included as part of this calculation.
Resident Appointments	

When should a program request a temporary increase in resident complement versus a permanent increase in resident complement? *[Program Requirement: III.B.]*	The Review Committee for Neurology defines temporary and permanent complement increases as follows: **Temporary Complement Increases** Temporary complement increases are intended to address only a few extenuating circumstances, usually involving a current resident needing to extend education and training. The circumstances could be due to resident performance concerns (e.g., resident needing remediation before graduating) or excessive time away from the program (e.g., extended medical leave during residency) that impact the achievement of competence. Temporary increases must not be multi-year requests or submitted with intent to annually renew. Temporary increases are intended to extend education and training for current residents who need to finish the program off cycle. *Temporary complement increases for a period of 90 days or less do not require a request for approval.* Requests for greater than 90 days require Committee review. Under special circumstances (e.g., a program's participation in the ACGME's Advancing Innovation in Residency Education (AIRE) program or similar initiatives), temporary increases will be reviewed and considered by the Review Committee on a case-by-case basis. **Permanent Complement Increases** Permanent complement increases should be requested when the program desires to expand the total resident complement in an ongoing manner to a total higher than currently approved (as published on the ACGME's ADS public site). A permanent increase should be requested even if the position will be filled temporarily, (i.e., funding is available temporarily). The position need not be filled each year. This type of request should occur only after the program director carefully weighs the educational impact of adding residents to the currently approved complement and obtains institutional support for the proposed complement expansion. It is imperative that programs plan well in advance for permanent complement increases. Candidates must not be matched into a program before such a request is approved by the Review Committee. Per ACGME Policies and Procedures *[19.20, 19.30, 19.60, 19.70]*, programs with statuses of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation with Warning, or Probationary Accreditation may not request a permanent increase in resident complement.

Is it permissible for a program to accept a transfer resident prior to receiving the required documentation? *[Program Requirement: III.C.]*	No, a program director must not accept a transfer resident without receiving verification of the resident's previous educational experiences and performance. A request for this documentation is not sufficient; the program must wait until all required documentation is received to accept the transfer.
When is a resident considered a transferring resident? *[Program Requirement: III.C.]*	Residents are considered transferring residents under several conditions, including: • when moving from one program to the another within the same or different Sponsoring Institution; and, • when entering a child neurology program, even if the resident was simultaneously accepted into the preliminary program (e.g., pediatrics) and the child neurology program as part of the Match (i.e., accepted to both programs right out of medical school). Before accepting a transferring resident, the "receiving" program director must obtain written or electronic verification of prior educational experiences and performance from the program from which the resident is transferring. Documentation includes evaluations, rotations completed, procedural/operative experience, Milestones reports, and a summative competency-based performance evaluation. The term "transfer resident" and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and is then accepted into a subsequent residency or fellowship.
Educational Program	

How can a program confirm that its curriculum includes all required educational components? *[Program Requirement: Section IV.A.]*	Program directors can use the checklist noted in Appendix I at the end of this FAQ document to determine if all required curricular components are included as part of the educational program.
How much time must a resident spend in the continuity clinic if the resident cannot participate due to a rotation, such as intensive care unit (ICU)? *[Program Requirement: IV.C.5.]*	The spirit of continuity clinic is that of an organized, longitudinal, and supervised clinical experience in which one's clinic patient panel is followed over a long period of time. A program may organize its continuity clinic in either the traditional weekly clinic over the duration of the program or in blocks (X + Y continuity clinic model). An outpatient clinic where the same patients cannot be followed over a long period of time will not fulfill the requirement. Scheduling of continuity clinics may be deferred during a busy inpatient month in which inpatient continuity of care is paramount (e.g., neurocritical care or night rotations). The longitudinal/continuity clinic must not be interrupted by more than five weeks. Although there may be a few gaps based on rotations such as ICU or night float, the same total number of continuity clinics (40 per year minimum) must be seen with the same patient panel in the same academic year. If weekly continuity clinics are occasionally deferred in the manner described above, then the program director must provide evidence at the time of the site visit that each resident has completed at least 40 continuity clinics per year for each of the three years during PGY-3-5.
Can continuity clinics be scheduled by clustering them into blocks of time, separate from inpatient rotations, rather than scheduling them weekly? *[Program Requirement: IV.C.5.]*	Continuity clinics may be scheduled separately from inpatient rotations as an alternative to weekly clinics as long as: 1) the clinics still adhere to the spirit of a longitudinal experience of patient care over the 36 months of residency, with resident seeing their own patients over time, rather than simply outpatients; 2) there are at least 40 total continuity clinics per year; and 3) clinic blocks are held not more than six weeks apart. A change to the weekly format of continuity clinic should be noted in the Major Changes section in the program's ADS profile, and evidence of this continuity must be provided to the Accreditation Field Representative during the accreditation site visit and/or to the Review Committee when requested.
If a resident requires leave in an academic year, can the number of required continuity clinics be prorated?	Yes; if a resident requires medical, parental, or caregiver leave in an academic year, the required number of continuity clinics can be prorated. A resident requiring leave does not need to make up continuity clinics to meet the 40 continuity clinics per year requirement.

[Program Requirement: IV.C.5.]	
What types of conferences count as national professional conferences? *[Program Requirement: IV.D.1.b).(1)]*	Each resident must attend at least one national specialty-specific conference. Appropriate conferences may include a general child neurology meeting, such as the Child Neurology Society Annual Meeting, or a subspecialty meeting in an area in which the resident has a particular interest.
How do programs demonstrate faculty scholarly activity? *[Program Requirements: IV.D.2.a)-b).(1)]*	Among their faculty scholarly activity, programs must demonstrate accomplishments in at least **three** of the following domains: • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education The program will be reviewed in aggregate. This requirement does not mean that each faculty member must have activity in three domains. Dissemination of scholarly activity by the program must be demonstrated by the following methods: Peer-reviewed publications, faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, nonpeer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor.
What are examples of acceptable resident scholarly activity? *[Program Requirement: IV.D.3.a)]*	Examples of acceptable resident scholarship include participation in research; publication and presentation at national and regional meetings; preparation and presentation of neurological topics at educational conferences and programs; organization and administration of educational programs; and activity related to professional leadership. Peer-review activities and quality of care programming, as well as presentations at departmental conferences, would also qualify.

Evaluation

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<td>How can a program provide objective assessments of resident competence?

[Program Requirement: V.A.1.c)]</td>
<td>See the table below for examples:
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<tr><th>Competency</th><th>Examples of Documentation</th></tr>
<tr><td>Patient Care and Procedural Skills</td><td>Milestones, Objective Structured Clinical Examinations (OSCEs), mini-clinical evaluation exercise (mini-CEX), direct observation, structured case discussions, role-play or simulation, chart review, etc.</td></tr>
<tr><td>Medical Knowledge</td><td>Milestones, American Academy of Neurology’s Residency In-Service Training Exam (RITE), OSCEs, global assessment, direct observation, structured case discussions, other exams, etc.</td></tr>
<tr><td>Practice-Based Learning and Improvement</td><td>Milestones, resident portfolios, global assessment, conferences presented by residents, patient education materials developed by residents, quality performance measures, chart review, etc.</td></tr>
<tr><td>Interpersonal and Communication Skills</td><td>OSCEs, Milestones, Neurology Clinical Evaluation Exercise (NEX), global assessment, direct observation, multi-source feedback, patient surveys, role-play or simulation, etc.</td></tr>
<tr><td>Professionalism</td><td>Milestones, residents portfolios, global assessment, direct observation, multi-source feedback, patient surveys, etc.</td></tr>
<tr><td>Systems-Based Practice</td><td>Milestones, resident portfolios, global assessment, multi-source feedback, quality measures, chart review, etc.</td></tr>
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Note: Milestones are meant as a tool to better understand a resident’s progress toward ACGME competencies. Milestones are not intended to be used as objectives and programs should create their own specific and measurable objectives and link them to the Milestones.</td>
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<td>Who needs to evaluate residents?

[Program Requirement: V.A.1.c).(1)]</td>
<td>Multiple evaluators should be used, including faculty members, other residents, patients, the residents themselves, and other professional staff members. In addition, each resident must be evaluated by at least one ABPN-certified child neurologist and two ABPN-certified neurologists. Refer to the ABPN website for information regarding required Neurology Clinical Skills Evaluation and clinical skills verification.</td>
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What types of goals should be considered when evaluating a program? *[Program Requirement: V.C.1.b).(2)]*	In addition to the program's goals for each rotation, longitudinal experience and didactic goals should also be reviewed for program evaluation. It is acceptable for a single set of goals to be used for a multispecialty rotation. All of these, as well as outcomes based upon these goals, should also be assessed as part of the program evaluation.
Who should annually review curriculum goals and assess whether they have been met? *[Program Requirement: V.C.1.b).(2)]*	In addition to the faculty members, at least one resident must serve on the Program Evaluation Committee (PEC), and all residents must have input into the program evaluation process. Program goals should be reviewed as part of this process.
The Learning and Working Environment	
Which licensed independent practitioners can contribute to residents' education? *[Program Requirement: VI.A.2.a).(1).(a) Background and Intent]*	Licensed practitioners include health care professionals who are licensed in the state and have appropriate credentials to provide patient care. Examples of these professionals include advanced practice providers or psychologists.
What does the Review Committee consider to be an optimal clinical workload? *[Program Requirement: VI.E.1.]*	The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of resident knowledge, skills, and abilities when determining the clinical workload for each resident.
Is there a maximum number of patients that can be cared for by a single resident, i.e., does the Review Committee mandate patient caps? *[Program Requirement: VI.E.1.a).]*	No. The Review Committee recognizes the need for flexibility in service structures across programs and does not consider it feasible to establish a universal patient cap or individual caps for all variations in service structure. The responsibility to monitor resident workload remains in the hands of the program director and should be based on patient needs, patient safety data, and the needs and abilities of individual residents. Therefore, the program director may institute patient caps.
Who should be included in the interprofessional teams? *[Program Requirement: VI.E.2.]*	Nurses; pharmacists; physician assistants; psychologists; social workers; and occupational, physical, and speech therapists are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.
Must every interprofessional team include representation from every profession listed above? *[Program Requirement: VI.E.2.]*	No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case.

Appendix I

Educational Program Checklist	Yes/No
1. Are overall educational goals for the program distributed to the residents annually? (IV.A.1)	
2. Are goals and objectives competency-based? (IV.A.2.)	
3. Are the goals and objectives specific to each rotation AND each educational level? (IV.A.2.)	
4. Are didactic sessions scheduled on a regular basis? (IV.A.4.)	
5. Do residents attend required seminars, conferences, and journal clubs? (IV.C.6.)	
6. Are all additional required topics covered during didactics? (IV.C.6.)	
7. Do residents attend at least one national professional conference during the program? (IV.D.1.b).(1))	
8. Are residents clearly informed about their patient care responsibilities? (IV.A.3.)	
9. Are residents provided progressive responsibility for patient management? (IV.C.3.b))	
10. Are residents provided supervision throughout the program? (IV.C.3.)	
11. Are residents provided a combination of patient care, teaching, and research experiences? (IV.C.3., IV.C.3.a), and IV.C.3.b))	
12. Do patient care responsibilities include inpatient experiences? (IV.C.4.a).(1))	
13. Do patient care responsibilities include outpatient experiences? (IV.A.6.a))	
14. Do patient care responsibilities include consultation experiences? (IV.C.4.g))	
15. Do the 12 FTE months of clinical adult neurology experience provide at least six months of inpatient adult neurology? (IV.C.4.a).(1))	
16. Do the 12 FTE months of clinical adult neurology experience provide at least three months of outpatient adult neurology? (IV.C.4.a).(2))	
17. Do the 12 FTE months of clinical adult neurology experience provide at least three months of elective clinical adult neurology? (IV.C.4.a).(3))	