Next Accreditation System: What it Means for Surgery Programs, Residents, and GME

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Disclosures

• Fiduciary
  • Full-time employee of ACGME (Potts, Simpson)

• Financial
  • None (Potts, Hebert, Simpson)
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- John H. Armstrong, MD
- Timothy R. Billiar, MD
- Ronald Dalman, MD
- George Fuhrman, MD
- Linda M. Harris, MD
- David Herndon, MD
- G. Whit Holcomb, MD
- John J. Ricotta, MD
- Marshall Z. Schwartz, MD
- Steven Stain, MD, Vice Chair
- Danny Takanishi, MD
- Paula Termuhlen, MD
- Jennifer Tseng, MD, Resident
- Mark Malangoni, MD, Ex-Officio ABS
- Ajit Sachdeva, MD, Ex-Officio ACS
## Accredited Programs 2013-2014

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</table>
NAS & Milestones

• NAS: Background
• NAS: Goals
• NAS: Structural overview
• NAS: What’s different?
• Milestones
NAS & Milestones

• NAS: Background
• NAS: Goals
• NAS: Structural overview
• NAS: What’s different?
• Milestones
The Next GME Accreditation System — Rationale and Benefits

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession, and in 2009, it began a multiyear process of restructuring its accreditation system to be.

LIMITATIONS OF THE CURRENT SYSTEM
When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education.

NAS Background

- GME is a public trust
- ACGME accountable to the public

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NAS Background

• Patients & payers expect doctors to be:
  • Health information technology literate
  • Able to use HIT to improve care
  • Sensitive to cost-effective care
  • Involve patients in their own care
NAS Background

• ACGME created 1981

• From inception, emphasized:
  • Program structure
  • Increase in quality & quantity of formal teaching
  • Balance between service and education
  • Resident evaluation & feedback
  • Financial & benefit support for trainees
NAS Background

- Efforts rewarding by many measures

- But:
  - Program requirements increasingly prescriptive
  - Innovation squelched
  - PDs have become “Process Developers”*

*Term borrowed from Karen Horvath, M.D.
NAS & Milestones

- NAS: Background
- NAS: Goals
- NAS: Structural overview
- NAS: What’s different?
- Milestones
Next Accreditation System: Goals

- Produce physicians for 21st century
- Accredit programs based on outcomes
- Reduce administrative burden of accreditation
Next Accreditation System: Goals

• Free *good* programs to innovate
• Help *underperforming* programs improve
• Realize the promise of “Outcomes Project”
• Provide public accountability for outcomes
• Reduce the burden of accreditation
NAS & Milestones

• NAS: Background
• NAS: Goals
• NAS: Structural overview
• NAS: What’s different?
• Milestones
The “Old” Accreditation System

Rules
Corresponding Questions
“Correct or Incorrect” Answer
Citations and Accreditation Decision

Rules
Corresponding Questions
“Correct or Incorrect” Answer
Citation and Accreditation Decision

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The Next Accreditation System

Promote Innovation

Continuous Observations

Identify Opportunities for Improvement

Program Makes Improvement(s)

Assess Program Improvement(s)
NAS & Milestones

• NAS: Background
• NAS: Goals
• NAS: Structural overview
• NAS: What’s different?
• Milestones
# The Old Accreditation System

<table>
<thead>
<tr>
<th>Accreditation Status</th>
<th>Percentage of Programs</th>
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<tbody>
<tr>
<td>Five years</td>
<td>23%</td>
</tr>
<tr>
<td>Four years</td>
<td>25%</td>
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<tr>
<td>Three years</td>
<td>32%</td>
</tr>
<tr>
<td>Two years</td>
<td>17%</td>
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<tr>
<td>One Year</td>
<td>2%</td>
</tr>
<tr>
<td>Probation</td>
<td>1%</td>
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</table>

Surgery programs 30 June 2013
NAS: What’s Different?

- Continuous accreditation model
- No cycle lengths
NAS: What’s Different?

"The rumors of my death have been greatly exaggerated"
NAS: What’s Different?

HERE LIES
"PIF"
BORN: ?
DIED: 30 JUNE 2013
NAS: What’s Different?

- No PIFs
- No Internal Review
- Programs notified of status *at least* annually
- Requirements revised every ten years
NAS: What’s Different?

- Citations *can* be levied annually by RRC
- But, *could* be removed quickly based upon:
  - Progress report
  - Site visit (focused or full)
  - New annual data from program
NAS: What’s Different?

• No site visits (as we know them)

but…

• **Focused** site visits for an “issue(s)” (no PIF)

• **Full** site visit (no PIF)

• **Self-study** visits every ten years
Focused Site Visits

• Assesses *selected* aspects of a program and may be used:
  • to address *potential* problems identified during review of annually submitted data;
  • to diagnose factors underlying deterioration in a program’s performance
  • to evaluate a complaint against a program
Focused Site Visits

- Minimal notification given (30 days)
- Minimal document preparation expected
- Team of site visitors
- Specific program area(s) investigated as instructed by the RRC
Full Site Visits

- Application for new program
- At the end of the initial accreditation period
- RRC identifies broad issues / concerns
- Other serious conditions or situations identified by the RRC
Full Site Visits

- Minimal notification given (60 days)
- Minimal document preparation expected
- Team of site visitors
Ten Year Self-Study Visit

- *Not* fully developed
- *Not* a traditional site visit
- Will be implemented in 2015
Self Study
A Departmentally Coordinated Effort

• Respond to any Active Citations

• Evaluate Programmatic Performance against Goals (written plans of action)

• Review Previous 10 year “Annual Program Evaluations” (APE’s)

• Demonstrate effectiveness of modifications of the Program over time

• Establish Programmatic Goals for the future
Ten Year Self-Study Visit

• Assess a broader unit of the GME educational environment
• Will review core and any affiliated sub programs together
  • General Surgery
    • Surgical Critical Care
    • Pediatric Surgery
    • Vascular Surgery-Independent
    • Vascular Surgery-Integrated
    • Complex General Surgical Oncology
Self Study Visit (Draft)

- Team of site visitors
- Review the Self Study of the Departmental Educational Effort (Core and Subs)
- Conduct a “PIF-less” Site Visit
- Validate most recent Annual Data submitted
- Potentially serve as a vehicle for:
  - Description of Salutary Practices
  - Accumulation of Innovations in the field
Ten Year Self-Study Visit

- Review annual program evaluations (PR-V.C.)
  - Response to citations
  - Faculty development
- Judge program success at CQI
- Learn future goals of program
- *Will* verify compliance with Core and Outcome Requirements
Ten Year Self-Study Visit

Annual Program Evaluation (PR-V.C.)
- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan

Self-Study PROCESS

Self-Study VISIT

Ongoing Improvement

Yr. 0
Yr. 2
Yr. 3
Yr. 4
Yr. 5
Yr. 6
Yr. 7
Yr. 8
Yr. 9
Yr. 10

Annual Program Evaluation (PR-V.C.)
- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan

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AY 2013 Top Areas of Citation

- **Procedural Experience**: 53
- **Program Evaluation**: 40
- **Duty Hours & Work Environ.**: 33
- **PD Responsibilities**: 33
- **Faculty Qualifications**: 30
- **Continuity of Care**: 27
- **Faculty Responsibilities**: 24
- **Professional Respons Culture**: 20
- **Resident Evaluation**: 15
- **Resident Appointment**: 14
- **Scholarly Activities**: 14
- **Service /Education Imbalance**: 13
- **Performance on Board Exams**: 11
- **Curricular Development**: 12
Next Accreditation System

- Program Requirements revised every ten years

- Each standard categorized:
  - Outcome - All programs must adhere
  - Core - All programs must adhere
  - Detail - Good programs may innovate
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Outcomes
Core Process
Detail Process

Continued Accreditation

Outcomes
Core Process
Detail Process

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Outcomes
Core Process
Detail Process
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS

Outcomes
Core Process
Detail Process

Probationary Accreditation

Continued Accreditation

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty
Some Data Reviewed by RRC
Most already in place

✓ Annual ADS Update
  ✓ Program Characteristics – Structure and resources
  ✓ Program Changes – PD / core faculty / residents
    ➢ Scholarly Activity – Faculty and residents
    ➢ Omission of data
✓ Board Pass Rate – 5 year rolling averages
✓ Resident Survey – Common and specialty elements
✓ Clinical Experience – Case logs
✓ Semi-Annual Resident Evaluation and Feedback
  ➢ Milestones
  ➢ Faculty Survey
  ➢ Ten year self-study
Review of Annual Data

- Board Pass Rate
- Case Logs/Clinical Experience
- Resident Survey
- Milestone Semi Annual Reporting
- Core Faculty Survey
- ADS Annual Update
- RRC

NEW

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RRC Actions in NAS

- Programs notified of status \textit{at least} annually
- Citations \textit{may} be levied by RRC based on annual data provided
  - \textit{Could} be removed quickly based upon
    - Progress report
    - Site visit (focused or full)
    - New annual data from program
After Review of Annual Data RRC can...

- Request Progress Report
- “Resolve” Citations
  - Need to continue to respond is removed
- “Continue” Citations
  - Need to respond with updates continues
- Change Accreditation Status, e.g.:
  - Continued Accreditation with Warning → Continued Accreditation
- Require Focused or Full Site Visit
  - All Site Visits are PIFLess
After Review of Annual Data RRC will...

- Post a letter to every program
  - Confirming accreditation status
    - Self-Study Visit Dates do not change
  - Indicated which citations are continued and which citations are resolved
  - Indicated if additional information is needed
    - Via a progress report
    - Clarifying report
    - Interim Site Visit
      - Focused visit (Letter will specify areas of focus)
      - Full visit
NAS & Milestones

• NAS: Background
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• Milestones
Milestones

- Via Ignatia
- Key West, FL
- Milion of Constantinople
- Yorkshire Moors
- Portadon Ireland
- Gemas Malaysia
- Boston, MA
- County Cork
- Apian Way

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Milestones

• Why?
• What?
• Who?
• When?
Milestones

• Why?
• What?
• Who?
• When?
The Continuum of Clinical Professional Development

“Graded or Progressive Responsibility”

Clerkship
Sub-internship
PGY-1 year
Residency
Fellowship
Attending

Low Authority and Decision Making High

Supervision Independence
The Continuum of Professional Development
The Three Roles of the Physician

Clinician → Teacher → Manager of Resources


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Professional Development in the 5 year Preparation of the Surgeon

- Systems-Based Practice, OR Team Skills
- Surgery Related Technical Skills
- Patient Care, Non-Procedural

Performance Ability

PGY 1  PGY 2  PGY 3  PGY 4  PGY 5
Miller’s\textsuperscript{1} Pyramid of Clinical Competence

\textbf{Knows How}

- MCQ, Oral Examinations
- Standardized Patients
- Mini CEX

\textbf{Shows How}

- Clinical Observation, Simulation
- Teamwork Evaluation
- Operative (Procedural) Skill Evaluation

\textbf{Does}

- Clinical Observations, Multi-Source Feedback
- Teamwork Evaluation
- Operative (Procedural) Skill Evaluation
- Mini CEX

\textsuperscript{1}Miller, GE. Assessment of Clinical Skills/Competence/Performance. Academic Medicine (Supplement) 1990. 65. (S63-S67)

van der Vleuten, CPM, Schuwirth, LWT. Assessing professional competence: from Methods to Programmes. \textit{Medical Education} 2005; 39: 309–317

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Move from Numbers to Narratives

- Numerical systems produce range restriction
- Narratives:
  - easily discerned by faculty
  - shown to produce data without range restriction

1 Hodges and others

The Power of Narratives

The illustration above shows:
The illustration above shows:

A. A prolate spheroid which is 725 mm in long circumference and 550 mm in transverse circumference. It is similar to a rugby ball but slightly smaller, more rounded at the ends and more elongated. Red balls are used for day matches and yellow for night matches.
The illustration above shows:

B. This has the form of a prolate spheroid, 11 inches long axis; 28 inches long circumference; 21 inches short circumference. It is less rounded at the ends than a rugby ball and has a pebble grained leather case of natural tan color.
The illustration above shows:

C. A prolate spheroid ball which is 28 cm long, 60 cm in circumference at its widest point and 76 cm in circumference end to end.
The illustration above shows:

D. A spherical ball with a circumference of 68-70 cm, which may be white, consisting of 32 panels of leather or plastic including 12 panels that are regular pentagons and 20 panels that are hexagons.
The illustration above shows:

E. A white spherical ball which is of 25 cm diameter. The pattern of panels consists of six groups perpendicular to each other, each group being composed of two trapezoidal and one rectangular panel; 18 panels in all.
Milestones

- Why?
- What?
- Who?
- When?
Milestones

- Organized under six domains of clinical competency
- Observable steps on continuum of increasing ability
- Describe trajectory from neophyte to practitioner
- Intuitively known by experienced specialty educators
- Provide framework & language to describe progress
- Articulate shared understanding of expectations
ACGME Goals for Milestones

• Permits fruition of the promise of “Outcomes”
• Track what is important
• Uses existing tools for observations
• Clinical Competence Committee triangulates progress of each resident
  • Essential for valid and reliable clinical evaluation system
• RRCs track aggregated program data
• ABMS Board may track the identified individual
ACGME Goals for Milestones

- Specialty specific normative data
- Common expectations for individual resident progress
- Development of specialty specific evaluation tools
Uses for the Milestones

• Program Director
  • Provide feedback to residents
  • Benchmark her residents to program mean
  • Determine program strengths
  • Determine program opportunities for improvement
  • Benchmark her residents nationally
  • Benchmark her program nationally
Uses for the Milestones

• Resident
  • Get specific feedback
  • Benchmark herself against peers in program
  • Determine individual strengths
  • Determine individual opportunities for improvement
  • Benchmark herself against peers nationally
The “Envelope of Expectations”
Professionalism

1. Is punctual for conferences, rounds, pages, and operating room (OR)
2. Manages fatigue and sleep deprivation
3. Reports duty hours in a timely and accurate manner
4. Presents appropriate attire and respectful demeanor
5. Seeks patient information with reliability, industry, and confidentiality

- Assumes leadership in clinical care team
- Recognizes individual limits in clinical situations and asks for assistance when needed
- Manages personal emotional, physical, and mental health
- Seeks and accepts professional criticism
- Demonstrates personal ownership of complications and patient outcomes
- Acts as effective team leader for physicians and other health care personnel
- Leads accurate and effective discussions at morbidity and mortality conference
- Assumes leadership responsibility for clinical care team decisions and outcomes
- Mediates conflict amongst members of the health care team
- Recognizes and responds to physician impairment in self or others
- Serves as a role model for other practicing and resident physicians for standards of ethical behavior and professionalism
- Participates in or lead institutional ethics board or program, or IRB
Organization of Surgery Milestones

Practice Domains

- Care for Diseases and Conditions (CDC)
- Performance of Operations & Procedures (POP)
- Coordination of Care (CC)
- Improvement of Care (IC)
- Teaching (TCH)
- Self-directed Learning (SDL)
- Maintenance of Physical & Emotional Health (MPEH)
- Performance of Assignments and Administrative Tasks (PAT)
# Milestones: Domains Mapped to Competencies

<table>
<thead>
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<th>Domain</th>
<th>Patient Care &amp; Procedural Skills</th>
<th>Medical Knowledge</th>
<th>Practice-based Learning &amp; Improvement</th>
<th>Interpersonal &amp; Communication Skills</th>
<th>Professionalism</th>
<th>Systems-Based Practice</th>
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<td>PROF3</td>
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</table>
# Surgery Milestones PC1

| Practice Domain | Competency            | Critical Deficiencies                                                                                                                                                                                                 | LEVEL 1                                                                 | LEVEL 2                                                                                                                                                                                                                     | LEVEL 3                                                                                                                                                                                                                     | LEVEL 4                                                                                                                                                                                                                     |
|-----------------|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Care For        | PATIENT CARE (PC1)   | This resident is not able to perform an efficient and accurate initial history and physical for patients admitted to the hospital.                                                                                  | This resident performs a focused, efficient, and accurate initial history and physical for a full spectrum of patients admitted to the hospital, including critically-ill patients. | This resident accurately diagnoses most "broad" conditions in the SCORE curriculum and initiates appropriate management for some common, "broad" conditions. This resident can develop a diagnostic plan and implement initial care for patients seen in the Emergency Department (ED). | This resident accurately diagnoses most "broad" surgical conditions independently.                                                                                                                                                 | This resident can lead a team that cares for patients with common and complex conditions and delegates appropriate clinical tasks to other health care team members. This resident recognizes atypical presentations of a large number of conditions. |
| Diseases and    |                        |                                                                                                                                                                                                                      |                                                                         |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                        |
| Conditions (CDC)|                        |                                                                                                                                                                                                                      |                                                                         |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                        |

Comments:

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Milestones

• Why?
• What?
• Who?
• When?
Creation of Milestones

ABS  RRC  APDS  Residents  ACS

Milestones
GS Milestones Working Group

- Dick Bell\textsuperscript{1,5}
- Tom Cogbill\textsuperscript{1,3,5}
- Stan Ashley\textsuperscript{1,5}
- Karen Borman\textsuperscript{1,3,5}
- Jo Buyske\textsuperscript{1,5}
- Joe Cofer\textsuperscript{1,3,5}
- Adeline Deladisma\textsuperscript{6}
- Mark Friedell\textsuperscript{3,5}
- Jim Hebert\textsuperscript{2,4,,5}
- Mark Malangoni\textsuperscript{1,2}
- Paula Termuhlen\textsuperscript{3,5}
- Jim Valentine\textsuperscript{1,3,5}
- Reed Williams\textsuperscript{4}
- Charles van Way\textsuperscript{3}
- Peggy Simpson, EdD\textsuperscript{7}
- Susan Swing, PhD\textsuperscript{7}

\textsuperscript{1} American Board of Surgery
\textsuperscript{2} RRC-Surgery
\textsuperscript{3} Association of Program Directors in Surgery
\textsuperscript{4} Association for Surgical Education
\textsuperscript{5} American College of Surgeons
\textsuperscript{6} Resident
\textsuperscript{7} ACGME Staff
Evaluation of Miller’s “Does”

- Trained observers
  - Common understanding of the expectations
  - Sensitive “eye” to key elements
  - Consistent evaluation of levels of performance
- Requires certain number of observations
- Interpreter/Synthesizer Experts
  - Clinical Competency Committee (Resident Evaluation Committee)
Clinical Competence Committee

- Operative Performance Rating Scales
- Mock Orals
- End of Rotation Evaluations
- Self Evaluations
- Case Logs
- Nursing and Ancillary Personnel Evaluations
- ITE
- Sim Lab
- Student Evaluations
- Clinic Work Place Evaluations
- Patient / Family Evaluations
- OSCE
- Peer Evaluations

Assessment of Milestones
ACGME Goal for Milestones - Permits fruition of the promise of “Outcomes Based Accreditation”

- Tracks what is important - Outcomes
- Begins using *existing tools* and *observations of the faculty*
- **Clinical Competency Committee** triangulates progress of each resident
  - Essential component of a valid and reliable clinical evaluation system
  - ABMS Board has the opportunity to track the identified individual
  - ACGME Review Committee tracks unidentified individuals’ trajectories
## Sample Professionalism Milestones

<table>
<thead>
<tr>
<th>Level</th>
<th>D</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.) Honesty, integrity and ethical behavior</td>
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<td></td>
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<tr>
<td>b.) Responsibility and follow through on tasks</td>
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## Sample Professionalism Milestones

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Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team.
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Resident demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in more complex clinical situations or settings. Occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.
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Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients; and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.
Milestones

- Why?
- What?
- Who?
- When?
Milestones: When?

Publication:
General Surgery: July 2013

Implementation (data collection):
General Surgery Programs: AY 2014

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NAS & Milestones

- NAS: Background
- NAS: Goals
- NAS: Structural overview
- NAS: What’s different?
- Milestones
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