Session 102
Specialty Update – Nuclear Medicine
03/02/2013, 1:30PM – 3:00PM

Christopher Palestro, MD; RC-NM Chair
Lynne Meyer, PhD, MPH; RC-NM Executive Director
Disclosure

- No conflicts of interest to report
Session Overview

- RRC structure and membership
- 2012 overview
- Most frequent citations
- Program requirements update
- Resident complement changes
- Resident case logs
- ADS Updates
- NAS/Milestones/Clinical Competency Committees
- Questions
Nuclear Medicine

Medical specialty that uses the tracer principle, most often with radiopharmaceuticals, to evaluate molecular, metabolic, physiologic and pathologic conditions of the body for purposes of diagnosis, therapy and research.
# Nuclear Medicine

<table>
<thead>
<tr>
<th>Nuclear Medicine</th>
<th>Nuclear Radiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years</td>
<td>1 year</td>
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<tr>
<td>Nuclear Medicine RRC</td>
<td>Diagnostic Radiology RRC</td>
</tr>
<tr>
<td>ABNM certification</td>
<td>ABR certification</td>
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</tbody>
</table>
Nuclear Medicine

American Board of Nuclear Medicine
First Conjoint Board established (1971)
  American Board of Internal Medicine
  American Board of Radiology
  American Board of Pathology
Primary Certifying Board status: 1985

Nuclear Medicine Residency Programs
Initially accredited in 1973-1974
RRC Structure
Member Selection

Nominating organizations include:

- American Medical Association (2)
- American Board of Nuclear Medicine (2)
- Society of Nuclear Medicine (2)

Resident Member

- Each RC includes 1 resident member

RRC

- Votes on nominees
Term for Members

- 6 years each (two 3 year terms)
  - Resident member: one 2-year term
- Each member is evaluated by each RRC member at end of 2\textsuperscript{nd} year
- Chair and Vice Chair elected by RRC
  - Chair term is 3 years
  - Vice-Chair term is either 1 or 2 years
Membership

2012-2013 RRC Members

• Christopher J. Palestro, M.D., Chair (SNM)
• Lorraine Fig, M.D. (SNM – term ended 12/31/2012)
• Tracy Y. Brown, M.D. PhD (AMA Alternate)
• Leonie Gordon, M.D. Vice-Chair (AMA)
• Barry L. Shulkin, M.D., M.B.A (ABNM)
• Harvey Ziessman, M.D. (ABNM)
• Gauri R. Khojekar, M.D. (Resident)
• Henry Royal, M.D. (ex-officio, ABNM)
## ACGME Staff Contact List

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director</td>
<td>Lynne Meyer, PhD, MPH</td>
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<td><a href="mailto:lmeyer@acgme.org">lmeyer@acgme.org</a></td>
</tr>
<tr>
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<td>Sara Thomas</td>
<td>312-755-5044</td>
<td><a href="mailto:stthomas@acgme.org">stthomas@acgme.org</a></td>
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<tr>
<td>Accreditation Administrator</td>
<td>Lauren Johnson</td>
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</tr>
<tr>
<td>Nuclear Medicine ADS Representative</td>
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<td>312-755-7118</td>
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<td>Case Log questions</td>
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<td></td>
<td><a href="mailto:oplog@acgme.org">oplog@acgme.org</a></td>
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RRC Meetings

- Number: 2 meetings/year during May & November

- Dates: Check RRC website for agenda closing dates & meeting dates
  - May 3-4, 2013 (closing date March 8, 2013)
  - Nov 15, 2013 (closing date September 20, 2013)

- Meeting Length: 1 – 1 ½ days

- Agenda: Program reviews & Other pertinent matters
Nuclear Medicine 2012-2013

• 51 accredited programs

• 122/184 (66%) filled out of approved residents positions
Nuclear Medicine
2000-2013

Number of Programs and Filled Positions by Academic Year

- Blue line: Programs
- Pink line: Filled Positions
Actions Taken in 2012

- Initial Accreditation: 1
- Continued Accreditation: 10
- Complement Changes: 1
- Progress/Duty Hour Reports Reviewed: 2
- Progress/Duty Hour Reports Requested: 5
- Voluntary Withdrawal Requests: 4
Cycle Lengths: 2012

**Continued Accreditation Decisions by Cycle Length**

- **2 yr cycle**: 1 (Nov-12), 1 (May-12)
- **3 yr cycle**: 0 (Nov-12), 0 (May-12)
- **4 yr cycle**: 0 (Nov-12), 0 (May-12)
- **5 yr cycle**: 4 (Nov-12), 3 (May-12)

Frequency:

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
Citations

- Citation = the program has not provided evidence of compliance with the requirements, or, an area identified by the site visitor is non-compliant

Don’t Have

- Patients (# & types); required certified faculty; required experience; facilities/equipment; time/support; required program personnel

Don’t Do

- Lack of evidence that required experience is provided; no documentation of compliance with requirements

Didn’t Carefully Proof/Edit PIF

- Incomplete or inaccurate information; did not fully describe/provide sufficient details; discrepant data
Most Common Citations: 2012

Program Evaluation: 7

Program Director Responsibilities (program leadership/stability; PIFmanship): 5

Resident Evaluation: 3
Current Resident Eligibility

- Program Requirement III.A.1.a)
- One year of graduate medical education in a program accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the American Osteopathic Association (AOA). This year must include a minimum of nine months of direct patient care; or alternatively,
  - AOA may no longer be acceptable in 2015 due to revision of common program requirements

- Program Requirement III.A.1.b)
- Two or more years of graduate medical education and a passing score on the United States Medical Licensing Exam (USMLE) Step 3.
  - This PR will be eliminated due to revision of common program requirements that will be effective in 2015
Complement Increases

• **ALL** complement increases **MUST** be approved by the RRC

• Program **MUST** have
  Full accreditation
  50% 1\textsuperscript{st} time Board pass rate

• Temporary increases are for temporary situations such as:
  Off cycle residents, delayed graduation (leave, remediation), resident transfer from closed program

• All requests are entered through ADS
Resident Case Logs

Programs are now required to use the ACGME Case Log System

• Each program sent a letter in December 2012
• 79445 Radiopharmaceutical therapy, by intra-arterial particulate administration added in January 2013

Resident procedure logs make it possible to:
• Track individual resident learning experiences
• Identify individual/program deficiencies
• Establish future training requirement benchmarks
Resident Case Logs

Residents will enter all specified procedures performed during their residency education into the ACGME case log system.

Program directors are expected to ensure that:
- Residents understand how to use the system
- Entries are accurate and complete
- Review resident case logs with residents during semi-annual evaluations
Required Key Index Areas/Procedures to be documented are:

• Parenteral Therapy (79101, 79445)

• Radioiodine Therapy (79005): Type Descriptions of
  • Less than or equal to 33 millicuries (mCi) I-131
  • Greater than 33 millicuries (mCi) I-131
Required Key Index Areas/Procedures to be documented are:

- PET/CT: Type Description of
  - Oncologic/Tumor (78811, 78812, 78813, 78814, 78815 and 78816)
  - Other (Cardiac: 78459 and Neurologic: 78608)

- Cardiac Stress Test: Pharmacologic or Exercise (93015)
Required Key Index Areas/Procedures to be documented are:

- **Pediatric (0-18 years of age):** There are no specified CPT codes and would result in a frequency count only. Residents may enter the name of the procedure/therapy in the comment box. (If needed for credentialing, residents may perform a search and enter an actual CPT code and enter the data a second time in the ACGME case log system using the actual CPT code or use another system to track those procedures.)
Welcome to Resident Case Log for Nuclear Medicine

Last Updated: 9/19/2012 10:26:39 AM

System Messages

- **PROGRAM DIRECTORS & COORDINATORS: Attending & Institution Maintenance** - If your specialty utilizes Attendings for case entry, Attendings are now maintained in ADS on the Case Logs tab. You will see a list of all of your available Case Log Attendings which may include faculty. Please note when Faculty Physicians are entered via the Faculty tab they are automatically listed as a Case Log Attending. If your specialty utilizes Institutions for case entry; Institution lists for residents are now based on your Participating Sites which are listed under the Sites tab in ADS. If your residents or fellows performed procedures/cases elsewhere (not at a participating site) they have an ‘Other Institution’ option they may use.

- **RESIDENTS / PROGRAM DIRECTORS / PROGRAM COORDINATORS: Logins & Passwords** - Any new resident that is entered into ADS is now automatically sent a login and password to their email address. Residents have the ability to reset their own passwords. On the ADS login page there is a ‘Forgot your password?’ button they can click and have a new password sent to their email.

- **RESIDENTS: IF you are unable to add cases or see Add link under Case Entry menu,** - Please speak with your coordinator to re-activate your account.

Messages

Please report any problems or suggestions to the oplog@acgme.org.
Click on the Case Entry tab; click on Add to add a new procedure.

Welcome to Resident Case Log for Nuclear Medicine

Last Updated: 7/9/2012 12:13:28 PM
System Messages

- RESIDENTS: If you are unable to add cases or see Add link under Case Entry menu, please contact your program coordinator to reactivate your account.
- DIRECTORS & COORDINATORS: If residents are unable to add cases, to correct this, please go to PROGRAM SETUP > RESIDENTS > Add/Update. Click on the Edition for the resident. Check the Resident Log Resident Status box to reactivate.

Messages

Add New Case

The Case Entry screen will display. The highlighted fields must be filled out and a procedure must be selected before you can save the entry.

Case Entry

Resident
-- Select --
Resident Year
-- Select --
Resident Role
Participated/Interpret
Institution
-- Select --
Attending
-- Select --
Case ID

Procedure Date
06/30/2012
HOT TOPICS

Program Requirements

• Program requirements are being formatted for the NAS (core, detail, outcome)

• Are being revised and will be posted for public comment
What are core, detail and outcome program requirements?

**Core Requirements:** Statements that define structure, resource, or process elements *essential to every graduate medical educational program.*

**Detail Requirements:** Statements that *describe a specific structure, resource, or process, for achieving compliance with a Core Requirement.* Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

**Outcome Requirements:** Statements that specify expected *measurable or observable attributes* (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
There **must** be a formal didactic lecture schedule (**Core**)
- The didactic lecture schedule **should** indicate the specific date and time of each lecture, the topic of each lecture, the individual presenting the lecture, and the duration of the lecture (**Detail – describes how to achieve core PR**)
- Participation in regularly scheduled seminars, conferences and journal clubs **should** be documented with attendance logs. (**Detail – describes how to achieve core PR**)
Posting for Public Comment

• You will be notified via an ACGME e-Communication when the revised program requirements are posted for comment.
• You will have the ability to comment on the revisions and on how the program requirements were categorized (detail, core, outcome), if clarifying language and/or FAQs are needed.
Data Reviewed by RCs

- **Resident Survey**
  - Results aggregated into 7 areas (duty hours, faculty, evaluation, educational content, resources, patient safety, teamwork)
  - Results compared to national normative data
  - Potential RC actions: warning letter, request for progress report, advanced or expedited site visit
HOT TOPICS

Data Reviewed by RCs

• ADS Annual Update
Click on the down arrows for more information

Look for the green checkmarks or the word “complete”
Choose the type of faculty you want listed

Scholarly activity will be required to be entered in the NAS

For the NAS, only the PD has a CV, you can edit each person’s info
If these 4 boxes total 15 hours or more, then this person is considered to be a core faculty member.

Those identified as a core faculty member will be given the faculty survey and must have scholarly activity entered into ADS.
Scholarly activity for faculty and residents not required for Nuclear Medicine during 2012 annual updates, but will be in the future for NAS Phase II.
+ Add Resident
Area where programs list residents/fellows in the program or add new residents.

Edit
Area where general information can be updated for existing residents/fellows.

Resident/Fellow Quick Update
Gives a snapshot view of individual resident/fellow information and allows the user to make updates.

Scholarly Activity NEW
Area in which programs will log the scholarship by residents. Currently this function appears for Phase One NAS specialties only.

Resident/Fellow Aggregate
Block Diagram Upload

+Add Site
Section where new participating sites should be made.

Detailed on following slide
Block Diagram Upload

Block Diagram Instructions/Sample

The ACGME does not have any record of a block diagram on file for your program. Please upload a PDF diagram using the “Upload” button below.

Block Diagram Instructions/Sample NEW

Once you have expanded the section a Guide for Construction a Block Diagram will be provided. The Block Diagram is a representation of the rotation schedule for a resident.

- Block Diagrams should be uploaded in PDF format
- There are 2 typical models, the first is organized by month and the second divides the year into 13 4-week blocks
- Participating site in which the rotation takes place and the name of rotation MUST be included.
- Rotations should be grouped by venue and sites should be listed in the same order as ADS.
- When elective rotations are reflected in the diagram, available electives should be listed below the diagram.
- Clinical rotations for some specialties may also include structured outpatient time or research time.

Following the guide, several sample block diagrams are provided:

Sample Block Diagrams

(1) In this example, the year’s rotations are divided into twelve (presumably one-month) clinical rotations. Rotations may include structured research time and electives.

<table>
<thead>
<tr>
<th>Block</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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</thead>
<tbody>
<tr>
<td>Rotation Name</td>
<td>CCU</td>
<td>ICU</td>
<td>ER</td>
<td>ER</td>
<td>ICU</td>
<td>ER</td>
<td>CCU</td>
<td>ER</td>
<td>ICU</td>
<td>ER</td>
<td>CCU</td>
<td>ICU</td>
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<tr>
<td>% outpatient</td>
<td>30</td>
<td>30</td>
<td>100</td>
<td>0</td>
<td>40</td>
<td>100</td>
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<td>0</td>
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<td>30</td>
<td>0</td>
</tr>
<tr>
<td>% Research</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

(2) In this example, the year’s rotations are divided into thirteen (presumably 4-week) clinical rotations. Rotations may include structured research time and electives.

<table>
<thead>
<tr>
<th>Block</th>
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<th>12</th>
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</thead>
<tbody>
<tr>
<td>Rotation Name</td>
<td>CCU</td>
<td>Med. Onc.</td>
<td>ER</td>
<td>ER</td>
<td>ER</td>
<td>ER</td>
<td>ICU</td>
<td>ER</td>
<td>ICU</td>
<td>ER</td>
<td>CCU</td>
<td>ICU</td>
</tr>
<tr>
<td>% outpatient</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Research</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
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(3) In this example, the year’s rotations are divided into six blocks of equal duration. One of the blocks is used for an elective which can be chosen from among a list of electives and 2 vacation months.

<table>
<thead>
<tr>
<th>Block</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotation Name</td>
<td>Elective/Outpatient</td>
<td>Elective/Outpatient</td>
<td>Elective/Outpatient</td>
<td>Elective/Outpatient</td>
<td>Elective/Outpatient</td>
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<tr>
<td>% outpatient</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>% Research</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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(4) In this example for a sub-specialty program, the year’s rotations are divided into four equal blocks. Structured research time comprises 40% of the resident’s time on the specialty outpatient month. There is one three-month block devoted entirely to research.

<table>
<thead>
<tr>
<th>Block</th>
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<th>4</th>
</tr>
</thead>
<tbody>
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<td>Specialty Outpatient</td>
<td>Specialty Outpatient</td>
<td>Specialty Outpatient</td>
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<tr>
<td>% outpatient</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>% Research</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(5) In this example, there must be a formal allocation for vacation time. If not shown in the block diagram, a note section must indicate how vacation time is taken.
All three years must be submitted, even if you currently only have NM3 residents.
Current Citations
Clicking on the link to current citations allows users to view their current citations and responses if they have been entered.

Site Visit Evaluation
For programs who had a site visit, the site visitor evaluation form can be completed here.

Specialty Specific PIF
A link is provided which routes the user to the specialty specific PIF.

Program Information Form (PIF)
Programs can either print a paper copy of the Annual Report/PIF or save a PDF version by using these buttons.
**Survey**
Access to aggregate reports by program, specialty, or nationally are available:

- Program
- Faculty
- Residents
- Sites
- Site Visits
- Case Logs

**Download My Data NEW**
Programs are now able to download data entered into ADS in Excel format.

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Download</th>
<th>Field Descriptions</th>
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<td>Field Descriptions</td>
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<td>Medical school affiliations</td>
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<td>Field Descriptions</td>
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<td>Residents who have graduated in previous year</td>
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<tr>
<td>Residents who have left the program</td>
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<td>Field Descriptions</td>
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HOT TOPICS

- Next Accreditation System (NAS)
- Milestones
- Clinical Competency Committees
- Self-Studies
NAS Background

- GME is a public trust
- ACGME accountable to the public
What is the NAS and when does it start?

• The Next Accreditation System (NAS) begins July 1, 2014 for Nuclear Medicine programs

• NAS Strategic Plan:
  • Foster innovation and improvement in the learning environment
  • Increase the accreditation emphasis on educational outcomes
  • Increase efficiency and reduce burden in accreditation
  • Improve communication and collaboration with key internal and external stakeholders
The Building Blocks of The Next Accreditation System

- CLER Visits
- Continuous RRC Oversight and Accreditation Sponsor Oversight
- prn Site Visits (Program or Institution)
- Institutional Review
- Self Study

ACGME
NAS and ADS Annual Updates

- Each year, program data will be required to be entered in ADS such as:
  - Faculty information
  - Fellow information
  - Block diagrams/curricular information
  - Scholarly activity information
  - Participating site information
  - Responses to previous citations
  - Duty Hour, Patient Safety and Learning Environment information
  - Evaluation information
  - Reporting of major changes in the program
NAS

- Instead of biopsies, annual data collection
  - Trends in key performance measurements
  - Milestones, Residents, fellows and faculty survey
  - Scholarly activity template
  - Operative & case log data
  - Board pass rates
- Scheduled accreditation visits every 10 years with focused site visits if annual data trends suggest problems
- PIF replaced by self-study
NAS

- Ongoing data collection and trend analysis
- Enhance oversight to ensure high quality education and a safe and effective learning environment
- High-quality programs will be freed to innovate – detailed process standards
  - Programs with continued accreditation in good standing do not have to adhere to the “detail” program requirements as written, but are allowed to innovate
NAS and Quality Improvement…

The “Next Accreditation System”

“Continuous”
Observations

Assure that the Program
Fixes the Problem

Number of Potential
Problems

Promote
Innovation

Diagnose
the Problem
(If there is one)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS

Core and Detailed:
- Structure
- Resources
- Process
- Outcomes

Initial Accreditation
New Programs
2-4%

Accreditation with Warning
New Programs, Accredited Programs with Major Concerns
10-15%

Withhold Accreditation
Withdrawal of Accreditation
2.8%

Maintenance of Accreditation
Accredited Programs without Major Concerns
75%-80%

Probationary Accreditation
Accredited Programs with Major Concerns

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Do I have to adhere to the “detail” program requirements?

- Programs that have initial accreditation or are in trouble must demonstrate compliance with all “detail” program requirements as written.

- Programs that have continued accreditation that are in good standing will be allowed to “innovate” or use alternate ways for those program requirements that are identified as “detail”.
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 – 3-5 year rolling averages
- Resident Survey – Common and specialty elements
- Clinical Experience – Case logs or other
- Semi-Annual Resident Evaluation and Feedback
  - Milestones
  - Faculty Survey
  - Ten year self-study

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Milestones

Specific benchmarks of skills, knowledge and behaviors in the six general competency domains that residents in every specialty must achieve at certain identified points or stages during residency education.
Milestones

Joint initiative of the ACGME and specialty certification boards and with the involvement of the specialty community

RRC’s initially will use aggregate resident performance on the milestones to identify aspects of educational programs needing improvement
Specialty Specific Milestones
Patient Care & Medical Knowledge

Working Group
Educators and leaders from the Review Committee (including resident member and executive director), American Board of Nuclear Medicine, and the Society of Nuclear Medicine (SNM)
Chair: Lorraine Fig, M.D.

Advisory Group
Specialty leaders
Assist with establishing support for the Milestones
Provide feedback to the Working Group
Uses and Implications

**ACGME**
- Accreditation – continuous monitoring of programs; lengthening of site visit cycles
- Public Accountability – report at a national level on competency outcomes
- Community of practice for evaluation and research, with focus on continuous improvement

**Residency Programs**
- Guide curriculum development
- More explicit expectations of residents
- Support better assessment
- Enhanced opportunities for early identification of under-performers

**Certification Boards**
- Potential use – ascertain whether individuals have demonstrated qualifications needed to sit for Board exams

**Residents**
- Increased transparency of performance requirements
- Encourage resident self-assessment and self-directed learning
- Better feedback to residents
Building the case for milestones
J graduated with honors from a prestigious medical school. The faculty and PD were ecstatic that he matched into their residency program. During orientation, J asked for multiple “golden” weekends off to attend weddings, birthdays, etc. In the first 4 months of his residency, he shows up late during several of his rotations. He did not show up for other required experiences a couple of times. The staff complains that he is almost impossible to get a hold of and complains that he frequently disappears. His write-ups and presentations are generally acceptable. Faculty members who supervise his rotations have called the PD to let her know that J’s fund of knowledge is poor, and he is often “flippant” and appears disinterested. It is now January, and the PD and the education committee members decide that J needs some form of warning to improve his performance, without which, he will be placed on probation and remediation. In order to gather “evidence” for this action, his evaluations are reviewed.
Milestones

Observable developmental steps moving from Novice to Expert/Master (Level 1: entrance to Level 4: fellowship graduation or even Level 5: expert or mastery level)

“Intuitively” known by experienced medical educators in each specialty

Organized under the rubric of the six domains of clinical competency
  - Trajectory of progress: neophyte → independent practice
  - Articulate shared understanding of expectations
  - Set aspirational goals of excellence
  - Framework & language for discussions across the continuum
ACGME Goal for Milestones - Permits fruition of the promise of “Outcomes Based Accreditation”

- Specialty specific normative data and common expectations for progress of individual residents
- Less prescriptive ACGME program requirements, lengthened program site visits, less frequent standards revision
  - Promote curricular innovation
  - Enhance curricular and rotation design flexibility
- Development of specialty specific evaluation tools and techniques
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
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.

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.

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.
Milestone Question

• Does every resident have to reach at least “Level 4” for every milestone in order to graduate?
  • No, they do not. However, it will still remain the program director’s responsibility to verify and determine whether each resident has demonstrated sufficient competence to enter practice without direct supervision.
Clinical Competency Committee

- May already be in place under a different name
- Start thinking about this and decide on composition, procedure, data elements

What should be reviewed:
- Continue to look at current evaluations forms
- Milestones

Issues:
- Time: pilot studies
- Large residency programs
- Small fellowship programs
Clinical Competency Committees

- Learn your specialty milestones
  - (will be developed this calendar year)
- Decide how to measure milestones
- Tools to evaluate from program director associations, specialty boards, colleges
- Teach the faculty the definitions
- Teach the faculty the tools
- FACULTY DEVELOPMENT IS KEY
The Clinical Competency Committee

- A group of faculty members trained in looking at milestones
- The same set of eyes looking at other evaluations:
  - End of rotation
  - Direct Observation
  - Nurses
  - Patients and families
  - Peers
  - Others
- The same process is applied uniformly
The Clinical Competency Committee

Avoids common problematic issues:

- “I don’t like to give negative evaluations”
- “I spent little time working with this resident”
- “Herd” mentality: positive or negative
- Grade inflation
- Vague statements:
  - “I just didn’t like this resident, but I can’t put my finger on it”
  - Hearsay: I’ve heard she is lazy
Self-Study & Program Improvement

❖ ACGME self-study visits begin July 2015
  ❖ All new programs (initial accreditation) will require a site visit after approximately 2 years to gain continued accreditation before they can have their first self-study visit (SSV).
  ❖ After the first SSV, they occur every 10 years.
❖ Tool for program improvement
❖ Individualized Learning Plan (ILP) on steroids

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Tool for improvement

Regular goal setting

Longer term: 3-5 years

Includes self-reflection/self-study

Consider SWOT (strengths/weaknesses/opportunities and threats)/stakeholders

Consider program outcome trends

Don’t have to wait until ACGME announces visit
The Next Accreditation System Web Page

http://www.acgme-nas.org/
NAS Information

NAS FAQs
http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf

NAS Policies and Procedures
http://www.acgme-nas.org/assets/pdf/FinalMasterNASPolicyProcedures.pdf
NAS Webinars

• Series of 4 free webinars geared to inform DIOs and PDs about the latest information regarding new accreditation initiatives
  • 12/13/2012 – The Clinical Learning Environment Review (CLER) Program: Early Experiences
  • 1/24/2013 – Implementing the NAS

Access at: http://www.acgme-nas.org/
ACGME Website

ACGME website:
http://www.acgme.org/acgmeweb/

RRC website:
http://www.acgme.org/acgmeweb/ProgramandInstitutionalGuidelines/Hospital-BasedAccreditation/NuclearMedicine.aspx
Questions?

Thank you