Implementing the Next Accreditation System for Orthopaedic Surgery Programs

J. Lawrence Marsh, MD, RRC Chair
Pamela Derstine, PhD, MHPE, RRC Executive Director

ACGME Webinar
May 23, 2013
Topics

- RRC Update (Marsh)
- Orthopaedic Surgery Milestones (Marsh)
- Next Accreditation System Basics (Derstine)
RRC Update
Membership of the RRC
(as of July 1, 2012)

**AMA**
- R. Dale Blaiser – Little Rock, AR
- Craig S. Roberts – Louisville, KY
- Lisa Taitsman – Seattle, WA*

**AAOS**
- Lynn A. Crosby – Augusta, GA
- Terry R. Light – Maywood, IL
- Vincent D. Pellegrini, Jr. – Baltimore, MD

**ABOS**
- J. Lawrence Marsh – Iowa City, IA (*Chair*)
- Terry L. Thompson – Washington, DC
- Michelle A. James – Sacramento, CA (*Vice-Chair*)
  (*Shephard R. Hurwitz – Ex-officio*)

**Resident**
- Christopher J. Dy – New York, NY*

**Executive Director**
- Pamela L. Derstine, PhD, MHPE
Membership of the RRC
(as of July 1, 2013)

AMA
R. Dale Blaiser – Little Rock, AR
Craig S. Roberts – Louisville, KY*
Theodore W. Parsons – Detroit, MI

AAOS
Lynn A. Crosby – Augusta, GA
Terry R. Light – Maywood, IL
Vincent D. Pellegrini, Jr. – Baltimore, MD*

ABOS
J. Lawrence Marsh – Iowa City, IA (Chair)
Terry L. Thompson – Washington, DC
Michelle A. James – Sacramento, CA (Vice-Chair) *
(Shephard R. Hurwitz – Ex-officio)

Resident
Jeanne M. Franzone – New York, NY

Executive Director
Pamela L. Derstine, PhD, MHPE
Accreditation Statistics AY 11/12

<table>
<thead>
<tr>
<th>Total # Accredited Programs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Core</td>
<td>154</td>
</tr>
<tr>
<td># Sub</td>
<td>248</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total # Residents/Fellows</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/Female</td>
<td>3254/506</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total # Programs Reviewed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Core</td>
<td>41</td>
</tr>
<tr>
<td># Sub</td>
<td>73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total # New Programs Accredited</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Core</td>
<td>1</td>
</tr>
<tr>
<td># Sub</td>
<td>6</td>
</tr>
</tbody>
</table>
## Other RRC Meeting Decisions (Core and Subs)

<table>
<thead>
<tr>
<th>Category</th>
<th># Requested/#Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complement increases</td>
<td>20/7</td>
</tr>
<tr>
<td>Progress/Reports</td>
<td>12/12</td>
</tr>
<tr>
<td>Duty Hour Reports</td>
<td>0/4</td>
</tr>
</tbody>
</table>
Traditional Program Review

- Program review scheduled
- PIF prepared and sent to ACGME and SV
- SV – 1-2 days
- RRC review
  - PIF and SVR
  - Board pass rates, Resident Survey, Case log data
- RRC actions
  - Initial or continued accreditation with citations
  - 1-5 year cycle
  - Progress report
  - Propose probation

SV and PIF are key portions of program review
New PGY 1 program requirements
Surgical skills training through simulation
New requirements for case log reporting
Milestones - development and implementation

Milestones - integration into NAS
NAS – other data elements
NAS – Program review and accreditation decisions

Larry Marsh - Chair RRC
Pam Derstine - Executive Director RRC
New PGY 1 program requirements
PG-1 Year Changes 2013-2014

- In 2011/2012 based on a AAOS sponsored simulation summit and a CORD survey, new ABOS certification rules for PGY 1 were developed

- ACGME/RRC accreditation rules followed from ABOS

- 6 months of orthopaedic surgery

- Basic surgical skills training through simulation

Good news – they are the same!
PGY 1 year changes (core)

The program director must be responsible for the design, implementation, and oversight of the PG-1 year. The PG-1 year must include:

IV.A.6.a).(1) a minimum of **six months of structured education on non-orthopaedic surgery** rotations designed to foster proficiency in basic surgical skills, the peri-operative care of surgical patients, musculoskeletal image interpretation, medical management of patients, and airway management skills;

IV.A.6.a).(1).(a) At least **three months must be on surgical rotations** chosen from the following: general surgery, general surgery trauma, plastic/burn surgery, surgical or medical intensive care, and vascular surgery;

IV.A.6.a).(1).(b) The **additional three months must be on rotations chosen from** the following: anesthesiology, basic surgical skills, emergency medicine, general surgery, general surgery trauma, internal medicine, medical or surgical intensive care, musculoskeletal radiology, neurological surgery, pediatric surgery, physical medicine and rehabilitation, plastic/burn surgery, rheumatology, and vascular surgery.
IV.A.6.a).(1).(c). The total time a resident is assigned to any one non-orthopaedic service must not exceed two months.

IV.A.6.a).(3) **six months of orthopaedic surgery rotations** designed to foster proficiency in basic surgical skills, the general care of orthopaedic patients both as inpatients and in the outpatient clinics, the management of orthopaedic patients in the emergency department, and the cultivation of an orthopaedic knowledge base.

IV.A.6.b) The PG-1 year must include residents’ participation in activities that will give them the opportunity to:

IV.A.6.b).(1) formulate principles and assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;

IV.A.6.b).(2) care for patients with **surgical and medical emergencies**, multiple organ system trauma, soft tissue wounds;

IV.A.6.b).(3) **care for critically-ill patients**; and,

IV.A.6.b).(4) develop an **understanding of surgical anesthesia**, including anesthetic risks and complications.
Surgical skills training through simulation
Background

- Orthopedic Surgery requires a high degree of technical skill

- Skills are acquired during residency and fellowship training through an apprenticeship model largely unchanged for over a century.
Orthopaedic Surgery Simulation Summit
– Nov 4th 2011
Goals of the Summit

- **Simulation in other surgical GME**: Review curriculum/simulations in other disciplines to learn from these experiences.
- **Current orthopedic surgical simulation**
- **Curriculum development**: Discuss the steps to develop an orthopedic resident based skills curriculum. Consider the following:
  - Which PGY years should be targeted?
  - Which orthopedic groups will be involved?
  - How will they be charged and who will they report to?
  - What is a reasonable timeline?
  - What can be patterned after existing surgical curricula and what needs to be developed for orthopedics?
- **Simulation development for orthopedics**: Discuss cost-effective simulations to train basic orthopedic surgery skills, such as arthroscopy and fluoroscopically directed navigation for trauma.
- **Validation**
- **Finances**
- **Program requirements and certification**: Once a curriculum is developed consider how it could become an educational requirement by the orthopedic RRC and the ABOS and the future potential of skills simulation as a metric for ABOS certification and maintenance of certification.
Only 50% of residency programs have a skills lab and program.

There is high interest among PD’s in a skills curriculum.

Most PD’s have little knowledge of the budget for skills training or the cost of a skills lab

Cost is a challenge to expansion of skills programs
How interested are you in a standardized simulation of surgical skills curriculum for residents?

- Very interested: 59.04%
- Somewhat interested: 22.89%
- Neutral: 14.46%
- Not interested at all: 3.61%
What is the most significant barrier to development of a formal surgical skills program at your institution? Check all that apply.

- Lack of available curriculum: 87.3%
- Lack of faculty/instructor interest: 34.2%
- Lack of dedicated space: 20.3%
- Other: 16.5%
- Lack of resident interest: 8.9%
- Other: 3.8%

Percentages may not total 100% because respondents were allowed to choose more than one answer.
The American Board of Orthopaedic Surgery (ABOS) and the Residency Review Committee (RRC) will require a laboratory based surgical skills training program beginning Academic year 2013-2014. Requirements include:

- A curriculum with goals and objectives
- Assessment metrics
- A dedicated space for the skills training.
- Training in basic skills required of residents for emergency care and to prepare residents for future participation in surgical procedures.
Here are the new Program Requirements for 2013?

IV.A.6.a).(2) **formal instruction in basic surgical skills, which may be provided longitudinally or as a dedicated rotation during either the orthopaedic or non-orthopaedic surgical rotations;** and,

IV.A.6.a).(2).(a) Basic surgical skills training must be designed to integrate with skills training in subsequent post graduate years and should prepare the PGY-1 resident to participate in orthopaedic surgery cases.

IV.A.6.a).(2).(b) The basic surgical **skills curriculum** must include:

IV.A.6.a).(2).(b).(i) **goals and objectives and assessment metrics;**

IV.A.6.a).(2).(b).(ii) skills used in the initial management of injured patients, including splinting, casting, application of traction devices, and other types of immobilization; and,

IV.A.6.a).(2).(b).(iii) basic operative skills, including soft tissue management, suturing, bone management, arthroscopy, fluoroscopy, and use of basic orthopaedic equipment.
What is a skills simulation curriculum?

ACS/APDS Phase I Curriculum Modules

- Asepsis, instruments
- Knot tying
- Suturing
- Tissue handling, wound management
- Advance tissue handling, flaps, grafts
- Catheterization
- Airway management
- Chest tubes
- Central lines
- Surgical biopsy
- Vascular anastomosis
- Laparotomy
- Bone fixation, casting
- Inguinal anatomy
- Upper endoscopy
- Colonoscopy
- Basic laparoscopic skills
- Advanced laparoscopic skills
- Hand sewn GI anastomosis
- Stapled GI anastomosis
SKILLS MODULES

Orthopaedic faculty identifies relevant ultrasound anatomy as residents inject a cadaver limb joint

The design was a modular curriculum with each module created to train residents over a half to a full day. The 16 modules were primarily developed by orthopaedic faculty.
Members of the ABOS (AOA/CORD and AAOS) Surgical Skills Task Force

- J. Lawrence Marsh, MD – Chair (ABOS)
- James E. Carpenter, MD (ABOS)
- Shepard R. Hurwitz, MD (ABOS)
- Michelle A. James, MD (ABOS)
- Joel T. Jeffries, MD (AOA/CORD)
- David F. Martin, MD (ABOS)
- Peter M. Murray, MD (ABOS)
- Bradford O. Parsons, MD (AAOS)
- Robert A. Pedowitz, MD, Ph.D. Co-Chair (AAOS)
- Brian C. Toolan, MD (AAOS)
- Ann E. Van Heest, MD (AOA/CORD)
- M. Daniel Wongworawat, MD (AAOS)
<table>
<thead>
<tr>
<th>Modules (ABOS skills taskforce modules)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sterile technique and operating room set up</td>
</tr>
<tr>
<td>2. Knot tying &amp; suturing</td>
</tr>
<tr>
<td>3. Microsurgical suturing</td>
</tr>
<tr>
<td>4. Soft tissue handling techniques</td>
</tr>
<tr>
<td>5. Casting and splinting</td>
</tr>
<tr>
<td>6. Traction</td>
</tr>
<tr>
<td>7. Compartment syndrome</td>
</tr>
<tr>
<td>8. Bone handling techniques</td>
</tr>
<tr>
<td>9. Fluoroscopy</td>
</tr>
<tr>
<td>10. K-wire techniques</td>
</tr>
<tr>
<td>11. Basic techniques in ORIF</td>
</tr>
<tr>
<td>12. Principles and techniques of fracture reduction</td>
</tr>
<tr>
<td>13. External fixation</td>
</tr>
<tr>
<td>14. Basic Arthroscopy skills</td>
</tr>
<tr>
<td>15. Basics of Arthoplasty</td>
</tr>
<tr>
<td>16. Joint injection</td>
</tr>
<tr>
<td>17. Patient Safety</td>
</tr>
</tbody>
</table>
Modules should include:

- Low cost low tech options
Modules should include:

- Instruction in accepted techniques
Modules should include:

- Deliberate Practice in Medical Education includes Assessment

1. repetitive performance of intended cognitive or psychomotor skills.

2. rigorous skills assessment

3. specific information feedback
Modules should include:
Evaluation and assessment strategies

- Guided practice until performance within time standards
- Video of performance with blinded review by expert faculty with “pass” or “needs more practice”
- OR performance ONLY after verification
January 2013

All 6 PGY 1’s

Some call on weekend no other clinical work

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Offices Closed</td>
<td>Orientation</td>
<td>Module 1</td>
<td>Module 2</td>
</tr>
<tr>
<td>7</td>
<td>Module 3</td>
<td>Module 5/6</td>
<td>Module 7</td>
<td>Module 8</td>
</tr>
<tr>
<td>14</td>
<td>Module 9</td>
<td>Module 10</td>
<td>Module 11</td>
<td>Module 13</td>
</tr>
<tr>
<td>21</td>
<td>Module 14</td>
<td>Module 15</td>
<td>Module 16</td>
<td>Module 17</td>
</tr>
<tr>
<td>University Holiday MLK Day</td>
<td>Ultrasound Guided Joint Aspiration/Injection: Hall</td>
<td>Hand Trauma/Skills: Shah/Lawler</td>
<td>Arthroplasty Hip Basic Skills: Noisieux/Willoborg</td>
<td>Arthroplasty Knee Basic Skills: Noisieux/Willoborg</td>
</tr>
<tr>
<td>28</td>
<td>Module 18</td>
<td>Module 19/AOA</td>
<td>Module 19/AOA</td>
<td>Debriefing</td>
</tr>
<tr>
<td>External Fixation: Femino</td>
<td>Research Methods: Anderson</td>
<td>Research Methods: Anderson</td>
<td>Survey/Questionnaire</td>
<td></td>
</tr>
</tbody>
</table>
Module 8: Basic Techniques in ORIF

Module Description and Template: (patterned from ACS/APDS)

I. Objectives
   - Learn to use a drill
   - Learn to use a depth gauge
   - Learn to use a tap
   - Drill, measure and place screws
   - Drill and place screws accurately
   - Increase difficulty as the module progresses

II. Assumptions

III. Background Info and Knowledge

IV. Suggested Readings

V. Description of Laboratory Module

VI. Description of Techniques
   1. Drilling, depth gauge, tap and screw
   2. Unicortical vs bicortical drilling
   3. Directional drilling
   4. PVC Pipe with soft tissue surrogate
   5. Cadaver exercises

VII. Common Errors and Preventions
   1. Plunging drill
   2. Floundering with depth gauge
   3. Incomplete tapping of far cortex
   4. Inappropriate angle with tap and screw
   5. Eccentric motion when placing the screw
   6. Inability to accomplish tasks with limited visualization
   7. Inability to drill and place screws on oblique surfaces
   8. Inability to accomplish tasks when guided by fluoro

VIII. Expert Performance and Videos

IX. Recommendations for Practice

X. Supplies and Station Setup

XI. Assessment Metric

XII. Estimated Costs of Module ($700)

XIII. Suggested Time Length (7 hours)
PERFORMANCE ASSESSMENT

- Assessment Measures
  - Objective Structured Assessment of Technical Skills (OSATS)
  - Baseline and post course skill assessment
  - Performance Checklists
  - Pre-module & Post-module questionnaires
  - Time To Completion

- Detailed Research Modules
  - ORIF Module
    - Measurement of articular step-off
    - Hand motion capture
  - Guide Wire Navigation
    - Number of fluoro shots
    - # of attempts to redirect wire

PGY-1 resident completing post-test questionnaire.

Preliminary Outcomes

ORIF Module:
- Residents performed task of placing a distal tibia periarticular screw, syndesmosis screw, and/or medial malleolar screw on a cadaver.

<table>
<thead>
<tr>
<th></th>
<th>Pre-module OSATS</th>
<th>Post-module OSATS</th>
<th>Pre-module Pass Rate</th>
<th>Post-module Pass Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Avg.</td>
<td>55%</td>
<td>78%</td>
<td>50% Pass</td>
<td>100% Pass</td>
</tr>
</tbody>
</table>
## RESIDENT SURVEYS

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Survey Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>71.4%</td>
<td>Do you feel you had Just the Right amount of faculty instruction?</td>
</tr>
<tr>
<td>83.3%</td>
<td>How do you feel about the amount of assessment that you received? Just Right?</td>
</tr>
<tr>
<td>83.3%</td>
<td>How do you feel about the # of modules, was the number Just Right?</td>
</tr>
<tr>
<td>100%</td>
<td>For the program as a whole, where the modules generally Just the Right level?</td>
</tr>
<tr>
<td>100%</td>
<td>Did you have Just the Right amount of practice time?</td>
</tr>
</tbody>
</table>

**“Overall excellent month for many reasons!”**

**“The opportunity to spend the month with my co-interns and develop these skills as a group was an excellent experience.”**

**“Great Month!”**

**“Learned a lot of necessary skills I will use in later years.”**

**“Awesome month.”**

**“I felt my surgical skills were enhanced over the month.”**

**“Would highly recommend continuing it.”**

---

### Surgical Skills Resident Survey Outcomes:

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>5</td>
</tr>
<tr>
<td>Module format</td>
<td>5</td>
</tr>
<tr>
<td>Did it help your surgical skill set?</td>
<td>4.5</td>
</tr>
<tr>
<td>Did you feel like it enhanced your Orthopaedic training program?</td>
<td>5</td>
</tr>
<tr>
<td>Did you feel it will enhance safety in the OR?</td>
<td>4.33</td>
</tr>
<tr>
<td>Do you feel this should be a permanent part of surgical education?</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note: 1=Worst, 5=Best, Overall Satisfaction: 96.2%*
COST

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Surrogate</td>
<td>$8,000</td>
</tr>
<tr>
<td>Cadaver Costs</td>
<td>$10,000</td>
</tr>
<tr>
<td>Fluoroscopy Time</td>
<td>$300</td>
</tr>
<tr>
<td>Equipment Costs</td>
<td>$1,000</td>
</tr>
<tr>
<td>Animal Models</td>
<td>$700</td>
</tr>
<tr>
<td>Vid/Org. Assistant</td>
<td>$1,000</td>
</tr>
<tr>
<td>Lab Assistant</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$22,500</strong></td>
</tr>
</tbody>
</table>

TIME ALLOCATED

<table>
<thead>
<tr>
<th>Role</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Assistant</td>
<td>120 hrs</td>
</tr>
<tr>
<td>Video/Organizational Assistant</td>
<td>60 hrs</td>
</tr>
<tr>
<td>Faculty Time Per Module</td>
<td>6-8 Hrs/Day for 1-2 Staff</td>
</tr>
<tr>
<td>Total Faculty Time</td>
<td>102 hrs</td>
</tr>
</tbody>
</table>
Summary and Conclusions

- Considerable time invested in the planning and execution but faculty members were engaged and eager to contribute.

- The greatest expense was for cadaveric specimens. With better planning and with different and more cost-effective simulations, this expense could be reduced.

- The video content produced should allow residents to learn more independently, and decrease the faculty time commitment. Video will be available through the parallel project created by the ABOS/AAOS/AOA/CORD project.
Summary and Conclusions

- Resident satisfaction was high.

- Next year we will develop better assessment metrics and assess the relative value of each of the modules.

- This experience suggests a dedicated month of surgical simulation has potential to change the paradigm of skills training for junior residents.
New requirements for case log reporting
Case Logs

Have been of gradually increasing importance to the RRC and will be a critical element of NAS data analysis. We plan on several improvements in case log reporting rules.
Case logs - more important in NAS

- Program data report – not just 1000-3000 total codes
  - Summary statistics at the program level, broken out by patient type (adult, pediatric, all)
  - Program percentiles ranked vs national norms in anatomic areas
  - Procedural minimums (13 operations, & peds & oncology cases)

What should you be doing now???
# Case Logs: Minimum Numbers

<table>
<thead>
<tr>
<th>Defined Case Category</th>
<th>Min #</th>
<th>Defined Case Category</th>
<th>Min #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee Arthroscopy</td>
<td>30</td>
<td>Ankle Fracture Fixation</td>
<td>15</td>
</tr>
<tr>
<td>Shoulder Arthroscopy</td>
<td>20</td>
<td>Closed Reduction Forearm/wrist</td>
<td>20</td>
</tr>
<tr>
<td>ACL Reconstruction</td>
<td>10</td>
<td>Ankle/Hind/Mid Foot Arthroscopy</td>
<td>5</td>
</tr>
<tr>
<td>THA</td>
<td>30</td>
<td>Supracondylar Humerus Perc</td>
<td>5</td>
</tr>
<tr>
<td>TKA</td>
<td>30</td>
<td>Femur/Tibia Intramedullary Fixation</td>
<td>25</td>
</tr>
<tr>
<td>Hip Fractures</td>
<td>30</td>
<td>All Pediatric Procedures</td>
<td>200</td>
</tr>
<tr>
<td>Carpal Tunnel Release</td>
<td>10</td>
<td>All Oncology Procedures</td>
<td>10</td>
</tr>
<tr>
<td>Spine Decompression/Posterior Spine Fusion</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defined Categories</td>
<td>Prog AVE</td>
<td>Min Req</td>
<td>Num of Res Bel Min</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------</td>
<td>---------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>116.7</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Shoulder Arthroscopy</td>
<td>126.2</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>ACL Reconstruction</td>
<td>34.3</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>THA</td>
<td>107.0</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>TKA</td>
<td>114.0</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Hip Fractures</td>
<td>39.2</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Carpal Tunnel Release</td>
<td>52.0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Spine Decompression/Fusion</td>
<td>55.2</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Ankle Fracture Fixation</td>
<td>48.8</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Closed Reduction Forearm/Wrist</td>
<td>9.3</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Ankle/Hind/Mid Foot Arthro</td>
<td>12.7</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Supracondular Humerus Perc</td>
<td>11.7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Femur/Tibia Intramedullary Fixation</td>
<td>31.8</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>Oncology Procedures</td>
<td>39.7</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Procedures</td>
<td>386.5</td>
<td>200</td>
<td>0</td>
</tr>
</tbody>
</table>
Case Logs

- Case Log program reports for all 2011-2012 graduates were reviewed and minimum number discrepancies noted (NOT CITED)

- Residents graduating 2012-2013 and beyond are expected to demonstrate compliance with the minimum numbers
Upcoming developments (approved but pending):

- Residents should enter as many codes as applicable for each case but must identify the primary code.
- Multiple index procedures done during a single patient operation will be entered as separate cases.
- 2 residents participating in a bilateral case should separately enter their participation.

What should we be doing now???
Case Logs: Resident Surgeon Definitions

• **Level 1** - Primary or Supervising resident surgeon – The resident is scrubbed on the case and participates in preoperative assessment and planning.

  Primary – the resident performs key portions of the procedure.
  Supervising – the resident surgeon guides another resident through key portions of the procedure.

  When a resident acts as a supervising surgeon and another resident is the primary surgeon both of the residents may log the case as Level 1.

• **Level 2** – Assisting resident surgeon – The resident is scrubbed on the case and participates in preoperative assessment and planning and assists a more senior surgeon in the key portions and may participate in opening or closing or other non-key portions.
Residents should log procedural experiences as either **Level 1** or **Level 2**. They should not log the procedure if they participate at less than these levels. All procedures at both levels require appropriate faculty supervision and participation in the case.

To count for procedural minimums the resident must have **Level 1** involvement in the case.
Case Logs: FAQs

• CPT code list for each DCC:
  http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramResources/260_ORS_Case_Log_Minimum_Numbers.pdf

• Case Log FAQs (see orthopaedic surgery FAQs):
  http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/260_Orthopaedic_Surgery_FAQs.pdf
Milestones - development and implementation
Milestones

5 level assessments of resident knowledge, skills, attitudes, and other attributes of performance in the six competencies in a developmental framework from less to more advanced. They are designed to demonstrate program outcomes by assessing resident progress through the competencies measured in the milestone framework!
Milestones: Medical Knowledge & Patient Care

- ACL
- Ankle Arthritis
- Ankle Fracture
- Carpal Tunnel
- Degenerative Spine
- Diabetic Foot
- Diaphyseal Femur & Tibia Fracture
- Distal Radius Fracture
- Adult Elbow Fracture
- Hip & Knee Osteoarthritis
- Hip Fracture
- Metastatic Bone Lesion
- Meniscal Tear
- Pediatric Septic Hip
- Rotator Cuff Injury
- Pediatric Supracondylar Humerus Fracture

Small slices of clinical care – a biopsy of resident performance!
Orthopaedic Surgery Milestones

• General
  – Professionalism (2)
  – Interpersonal Skills & Communication (2)
  – Practice-based learning (2)
  – Systems-based practice (3)

• See all milestones at:
  http://www.acgme-nas.org/assets/pdf/Milestones/OrthopaedicSurgeryMilestones.pdf
## Milestones: Medical knowledge (example)

### Milestone Description: Pediatric Septic Hip – Medical Knowledge

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrates knowledge of common presentation of hip septic arthritis</td>
<td>• Demonstrates knowledge of pathophysiology of joint damage related to septic arthritis</td>
<td>• Demonstrates knowledge of the vascular supply in the skeletally immature hip</td>
<td>• Demonstrates knowledge of options and anatomy for surgical approaches</td>
<td>• Author/presenter in published work</td>
</tr>
<tr>
<td>• Demonstrates knowledge of basic hip anatomy</td>
<td>• Demonstrates knowledge of basic surgical approach</td>
<td>• Demonstrates knowledge of microbiology and antibiotic choices</td>
<td>• Demonstrates knowledge of atypical infecting organisms and management options</td>
<td></td>
</tr>
<tr>
<td>• Demonstrates knowledge of basic imaging studies</td>
<td>• Demonstrates knowledge of the differential diagnosis of the irritable hip</td>
<td>• Demonstrates knowledge of potential complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrates knowledge of appropriate laboratory studies</td>
<td>• Understands natural history and the effects of intervention</td>
<td>• Demonstrates knowledge of clinical and laboratory data relevant to differential diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstrates knowledge of advanced imaging studies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains history and performs basic physical exam</td>
<td>Obtains focused history and performs focused exam</td>
<td>Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</td>
<td>Capable of performing alternative surgical approaches to the hip and knee arthritis</td>
<td>Competently performs two or more approaches to the hip and knee</td>
</tr>
<tr>
<td>Appropriately orders basic imaging studies</td>
<td>Appropriately interprets basic imaging studies</td>
<td>Appropriately recommends surgical intervention</td>
<td>Capable of performing primary THR and TKR</td>
<td>Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)</td>
</tr>
<tr>
<td>Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</td>
<td>Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</td>
<td>Completes comprehensive pre-operative planning with alternatives</td>
<td>Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</td>
<td>Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</td>
</tr>
<tr>
<td>Provides basic peri-operative management (e.g., pre- and post-operative assessment)</td>
<td>Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</td>
<td>Modifies and adjusts post-operative treatment plan as needed</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
</tr>
<tr>
<td>Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise)</td>
<td>Capable of performing one basic surgical approach to the hip and knee</td>
<td>Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capable of diagnosis and early management of complications (e.g., infections, dislocations)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assesses for risk of thromboembolic disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Not yet rotated
**Hip and Knee Osteo Arthritis (OA) – Patient Care**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains history and performs basic physical exam</td>
<td>Obtains focused history and performs focused exam</td>
<td>Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</td>
<td>Capable of performing alternative surgical approaches to the hip and knee arthritis</td>
<td>Competently performs two or more approaches to the hip and knee</td>
</tr>
<tr>
<td>Appropriately orders basic imaging studies</td>
<td>Appropriately interprets basic imaging studies</td>
<td>Appropriately recommends surgical intervention</td>
<td>Capable of performing primary THR and TKR</td>
<td>Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip prostheses, valgus knee, loose components, uniarthroplasty)</td>
</tr>
<tr>
<td>Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</td>
<td>Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</td>
<td>Completes comprehensive pre-operative planning with alternatives</td>
<td>Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</td>
<td>Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</td>
</tr>
<tr>
<td>Provides basic peri-operative management (e.g., pre- and post-operative assessment)</td>
<td>Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</td>
<td>Modifies and adjusts post-operative treatment plan as needed</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
</tr>
<tr>
<td>Lists potential complications (e.g., infections, dislocations, thromboembolic disease, periprosthetic fracture, neurovascular compromise)</td>
<td>Capable of performing one basic surgical approach to the hip and knee</td>
<td>Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capable of diagnosis and early management of complications (e.g., infections, dislocations)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assesses for risk of thromboembolic disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

Not yet rotated □
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains history and performs basic physical exam</td>
<td>Obtains focused history and performs focused exam</td>
<td>Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</td>
<td>Capable of performing alternative surgical approaches to the hip and knee arthritis</td>
<td>Competently performs two or more approaches to the hip and knee</td>
</tr>
<tr>
<td>Appropriately orders basic imaging studies</td>
<td>Appropriately interprets basic imaging studies</td>
<td>Appropriately recommends surgical intervention</td>
<td>Capable of performing primary THR and TKR</td>
<td>Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)</td>
</tr>
<tr>
<td>Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</td>
<td>Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</td>
<td>Completes comprehensive pre-operative planning with alternatives</td>
<td>Capable of treating complications both intra-and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</td>
<td>Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</td>
</tr>
<tr>
<td>Provides basic peri-operative management (e.g., pre- and post-operative assessment)</td>
<td>Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</td>
<td>Modifies and adjusts post-operative treatment plan as needed</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
<td></td>
</tr>
<tr>
<td>Lists potential complications (e.g., infections, dislocations, thromboembolic disease, periprosthetic fracture, neurovascular compromise)</td>
<td>Capable of performing one basic surgical approach to the hip and knee</td>
<td>Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Capable of diagnosis and early management of complications (e.g., infections, dislocations)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assesses for risk of thromboembolic disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Not yet rotated ☐
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obtains history and performs basic physical exam</strong>&lt;br&gt;<strong>Appropriately orders basic imaging studies</strong>&lt;br&gt;<strong>Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</strong>&lt;br&gt;<strong>Provides basic peri-operative management (e.g., pre- and post-operative assessment)</strong>&lt;br&gt;<strong>Lists potential complications (e.g., infections, dislocations, thromboembolic disease, periprosthetic fracture, neurovascular compromise)</strong></td>
<td><strong>Obtains focused history and performs focused exam</strong>&lt;br&gt;<strong>Appropriately interprets basic imaging studies</strong>&lt;br&gt;<strong>Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</strong>&lt;br&gt;<strong>Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</strong>&lt;br&gt;<strong>Capable of performing one basic surgical approach to the hip and knee</strong>&lt;br&gt;<strong>Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</strong>&lt;br&gt;<strong>Capable of diagnosis and early management of complications (e.g., infections, dislocations)</strong>&lt;br&gt;<strong>Assesses for risk of thromboembolic disease</strong></td>
<td><strong>Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</strong>&lt;br&gt;<strong>Appropriately recommends surgical intervention</strong>&lt;br&gt;<strong>Completes comprehensive pre-operative planning with alternatives</strong>&lt;br&gt;<strong>Modifies and adjusts post-operative treatment plan as needed</strong>&lt;br&gt;<strong>Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</strong>&lt;br&gt;<strong>Provides prophylaxis and manages thromboembolic disease</strong></td>
<td><strong>Capable of performing alternative surgical approaches to the hip and knee arthritis</strong>&lt;br&gt;<strong>Capable of performing primary THR and TKR</strong>&lt;br&gt;<strong>Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</strong></td>
<td><strong>Competently performs two or more approaches to the hip and knee</strong>&lt;br&gt;<strong>Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)</strong>&lt;br&gt;<strong>Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</strong>&lt;br&gt;<strong>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</strong></td>
</tr>
</tbody>
</table>

Comments: Not yet rotated
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains history and performs basic physical exam</td>
<td>Obtains focused history and performs focused exam</td>
<td>Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</td>
<td>Capable of performing alternative surgical approaches to the hip and knee arthritis</td>
<td>Competently performs two or more approaches to the hip and knee arthritis</td>
</tr>
<tr>
<td>Appropriately orders basic imaging studies</td>
<td>Appropriately interprets basic imaging studies</td>
<td>Appropriately recommends surgical intervention</td>
<td>Capable of performing primary THR and TKR</td>
<td>Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)</td>
</tr>
<tr>
<td>Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</td>
<td>Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</td>
<td>Completes comprehensive pre-operative planning with alternatives</td>
<td>Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</td>
<td>Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</td>
</tr>
<tr>
<td>Provides basic peri-operative management (e.g., pre- and post-operative assessment)</td>
<td>Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</td>
<td>Modifies and adjusts post-operative treatment plan as needed</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
<td>Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
</tr>
<tr>
<td>Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise)</td>
<td>Capable of performing one basic surgical approach to the hip and knee</td>
<td>Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</td>
<td>Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Obtains history and performs basic physical exam</td>
<td>• Obtains focused history and performs focused exam</td>
<td>• Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views)</td>
<td>• Capable of performing alternative surgical approaches to the hip and knee arthritis</td>
<td>• Competently performs two or more approaches to the hip and knee arthritis</td>
</tr>
<tr>
<td>• Appropriately orders basic imaging studies</td>
<td>• Appropriately interprets basic imaging studies</td>
<td>• Appropriately recommends surgical intervention</td>
<td>• Capable of performing primary THR and TKR</td>
<td>• Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty)</td>
</tr>
<tr>
<td>• Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices)</td>
<td>• Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections)</td>
<td>• Completes comprehensive pre-operative planning with alternatives</td>
<td>• Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability)</td>
<td>• Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise)</td>
</tr>
<tr>
<td>• Provides basic peri-operative management (e.g., pre- and post-operative assessment)</td>
<td>• Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed)</td>
<td>• Modifies and adjusts post-operative treatment plan as needed</td>
<td></td>
<td>• Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)</td>
</tr>
<tr>
<td>• Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise)</td>
<td>• Capable of performing one basic surgical approach to the hip and knee</td>
<td>• Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</td>
<td>• Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization)</td>
<td>• Provides prophylaxis and manages thromboembolic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Capable of diagnosis and early management of complications (e.g., infections, dislocations)</td>
<td>• Assesses for risk of thromboembolic disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: [ ]

Not yet rotated [ ]
Milestones: Other competencies

• Practice-based learning & improvement: locates, appraises & assimilates evidence from scientific studies to improve patient care

• Systems-based practice: cost-effective practice
  • Systems-based practice: interprofessional teamwork
  • Systems-based practice: uses technology to accomplish safe health care delivery

• Interpersonal and communications skills: communication
  • Interpersonal and communications skills: teamwork

• Professionalism: compassion, integrity, respect for others; adherence to ethical principles of medicine; putting patients above self-interest
  • Professionalism: accountability & personal responsibility
Pertinent Milestones Information

- **Required** beginning fall 2013

- **NOT** going to be used for actual program review until normative data is collected (2015 at the earliest)

- **NOT** intended to be added on to other evaluations for resident competency
  - Intended to replace these

- **NOT** the key to competency-based education
  - Reaching milestones won’t shorten education; failing to reach them won’t lengthen it
Clinical Competency Committee

- New proposed Common Program Requirements for Clinical Competency Committee (V.A.1)
  - Program director must appoint Clinical Competency Committee (CCC)
  - CCC members: at least 3 program faculty; additional eligible members include non-physician members of the health care team, residents in their final year
  - CCC reviews all resident evaluations by all evaluators semi-annually, prepares and ensures semi-annual milestone reports to ACGME, recommends to PD resident progress decisions (promotion, remediation, dismissal)
Clinical Competency Committee

- Clinical Competency Committee
  - May include Program Director, Chair
  - Represents core subspecialties
  - Meets every six months to review assessments (in resident portfolio) and determine milestone levels
  - Works by *consensus*
Milestones Important Timeline

• **Now**: Form a CCC and prepare for milestone evaluations

• **July – December 2013**: First evaluation period

• **December**: First milestone evaluations submitted to ACGME (via web)
Milestones Timeline: Core Programs

- January – June 2014: second evaluation period
- June 2014: Second milestone evaluations submitted to ACGME (via web)
- January 2015: RRC review of AY 2013/2014 milestone data
Milestones Timeline: Subspecialty Programs

• Spring 2014: Form a CCC and prepare for milestone evaluations
• July – December 2014: First evaluation period
• December 2014: First milestone evaluations submitted to ACGME (via web)
Milestones Timeline: Subspeciality Programs

• January – June 2015: second evaluation period
• June 2015: Second milestone evaluations submitted to ACGME (via web)
• January 2016: RRC review of AY 2014/2015 milestone data
Next Accreditation System Basics
Next Accreditation System Goals

- Help produce physicians for 21st century
- Accredit programs based on outcomes
- Reduce administrative burden of accreditation
- Free good programs to innovate
- Assist underperforming programs to improve
- Provide public accountability for outcomes
Next Accreditation System
Key Features

- Continuous accreditation model
- No PIF’s or cycle lengths
- Annual program review of core program data
- Scheduled (self-study) visits every ten years
- Focused site visits only for issues

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core Process
Detail Process
Outcomes

Continued Accreditation

Outcomes
Core Process
Detail Process

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core Process
Detail Process
Outcomes

Core Process
Detail Process
Outcomes

Accreditation with Warning

Continued Accreditation

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core Process
Detail Process
Outcomes

Probationary Accreditation

Continued Accreditation

Outcomes
Core Process
Detail Process

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core Process
Detail Process
Outcomes

Accreditation with Warning

Probationary Accreditation

Continued Accreditation

Withdrawal of Accreditation

Outcomes
Core Process
Detail Process

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program

STANDARDS
Core Process
Detail Process
Outcomes

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core Process
Detail Process
Outcomes

Application for New Program

Initial Accreditation

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program → Initial Accreditation → Continued Accreditation

STANDARDS
Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process
Outcomes
Core Process
Detail Process
Outcomes
Core Process
Detail Process

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program

STANDARDS
Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process

Withhold Accreditation

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Conceptual Model of Standards Implementation Across the Continuum of Programs in Neurosurgery

**STANDARDS**
- Core Process
- Detail Process
- Outcomes

**Outcomes**
- Core Process
- Detail Process

**Application for New Program**

- Core Process: 1-2%
- Detail Process: 5-10%
- Outcomes: 90-95%

**Accreditation**
- Core Process: <1%
- Detail Process: <1%

**Continued Accreditation**

**Withdrawal of Accreditation**

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Annual 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 average
✓ Resident Survey – Common and specialty elements
✓ Clinical Experience – Case logs
✓ Semi-Annual Resident Evaluation and Feedback
  ➢ Milestones
  ➢ Faculty Survey

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Streamlined ADS Annual Update

- 33 questions removed
- 14 questions simplified
- *Very* few essay questions
- Self-reported board pass rate removed
- Faculty CVs removed
- 11 MCQ or Y/N questions added
Current PIF Faculty CV

| First Name | John |
| Last Name  | Smith |
| Present Position | Department Chairman |
| Medical School Name | North Univ, Roesly, CA |
| Degree Awarded | MD |
| Graduate Medical Education Program Name | Year Completed: 1993 |

<table>
<thead>
<tr>
<th>Specialty: Urology</th>
<th>Certification Information</th>
<th>Current Licensure Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification Year</td>
<td>Certification Status</td>
<td>Date From</td>
</tr>
<tr>
<td>Specialty</td>
<td>2001</td>
<td>Original Certification Valid</td>
</tr>
</tbody>
</table>

<p>| Academic Appointments - List the past ten years, beginning with your current position. |</p>
<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Description of Position(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2009</td>
<td>Present</td>
<td>State Program</td>
</tr>
<tr>
<td>7/1999</td>
<td>Present</td>
<td>State Program</td>
</tr>
<tr>
<td>1/2002</td>
<td>6/2009</td>
<td>State Program</td>
</tr>
</tbody>
</table>

Consider Summary of Role in Programs:
Fellowship trained in female urology and urodynamics. Dr. Smith brings an expertise that is vital to resident training in urology. Along with Dr. Janus, he coordinates all resident research activities. He is an active participant at all urology conferences.

Current Professional Activities / Committees (Limit of 10):
- [2009 - Present] Chairman, Department of Urology, Medical Center
- [2009 - Present] Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery, Department of Urology, City Hospital
- [2009 - Present] President, Urological Society
- [2009 - Present] Co-Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery, Medical Center
- [1999 - Present] President, American Urogynecologic Society
- [1999 - Present] Member, International Continence Society
- [1999 - Present] Member, Section of the American Urogynecologic Association
- [1999 - Present] Member, Urologic Society

Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (Limit of 10):
- Names, Two popular treatment options for neurogenic bladder. Therapy 2009 6,2: 133-134
- Names, Selective review articles, Chapters and/or Textbooks from the last 5 years (limit of 10):
  - The Accidental Sisterhood: Take control of your bladder and your life. Names. Pelvic Floor Health, City, State, 2006

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
# Scholarly Activity Template

## Scholarly Activity as Performance Indicator

### Templates for Scholarly Activity

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
<th>Leadership or Peer-Review Role</th>
<th>Teaching Formal Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>324311</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident Scholarly Activity</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>Conference Presentations</th>
<th>Chapters / Textbooks</th>
<th>Participated in Research</th>
<th>Other Scholarly</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

### Definitions:
- **Faculty Scholarly Activity:**
  - Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012.
  - Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012.
  - Number of chapters or textbooks published between 7/1/2011 and 6/30/2012.
  - Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012.
  - Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants’ performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows, and other health professionals. This does not include single presentations such as individual lectures or conferences.

### Resident Scholarly Activity:
- PubMed IDs (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 3.
- Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012.
- Number of chapters or textbooks published between 7/1/2011 and 6/30/2012.
- Participated in funded or unfunded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012.

### Categories for points:
- Peer Review Publication
- Other Scholarly
- Grantsmanship
- Leadership / Peer Review
- Education
Faculty Scholarly Activity

Enter Pub Med ID #'s

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conf/Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Faculty Scholarly Activity

### Number of Abstracts, Posters, and Presentations

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

**Enter a number**

---

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Other Presentations Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012:

Other Presentations Count: 1
# Faculty Scholarly Activity

## Number of chapters or textbooks published between 7/1/2011 and 6/30/2012

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Enter a number

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Faculty Scholarly Activity

**Number of grants for which faculty member had a leadership role (Pl, Co-Pl, or site director) between 7/1/2011 and 6/30/2012**

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

**Grant Leadership**

3

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Faculty Scholarly Activity

Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012.

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Leadership or Peer-Review Role: Y

Answer: Yes or No
Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants’ performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.

**Answer**

Yes or No
Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
</tr>
</tbody>
</table>

Teaching Formal Courses

N
# Scholarly Activity as Performance Indicator

## For Scholarly Activity

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
<th>Leadership or Peer-Review Role</th>
<th>Teaching Formal Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

## For Resident Scholarly Activity

<table>
<thead>
<tr>
<th>Resident</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>Conference Presentations</th>
<th>Chapters / Textbooks</th>
<th>Participated in research</th>
<th>Teaching # Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>June Smith</td>
<td>12433</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
## Scholarly Activity as Performance Indicator

### Templates for Scholarly Activity

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
<th>Leadership or Peer-Review Role</th>
<th>Teaching / Formal Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>PMID 1</td>
<td>PMID 2</td>
<td>PMID 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Resident Scholarly Activity**

- **Mouse-over definitions:** Pub Med Ids (assigned by Pub Med) for articles published between 7/1/2011 and 6/30/2012. List up to 3.
- **Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012.** List up to 3.
- **Number of other presentations given (grand rounds, invited professorships, materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012.**
- **Number of chapters or textbooks published between 7/1/2011 and 6/30/2012.**
- **Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012.
- **Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012.**
- **Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants’ performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.**

**Teaching / Presentations**

- **Lecture, or presentation (such as grand rounds, or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012.**
- **Teaching / Presentations**
# Scholarly Activity as Performance Indicator

## Templates for Scholarly Activity

**Faculty Scholarly Activity**

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PUB Med ID 1</th>
<th>PUB Med ID 2</th>
<th>PUB Med ID 3</th>
<th>PUB Med ID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Resident Scholarly Activity**

<table>
<thead>
<tr>
<th>Resident</th>
<th>PUB Med ID 1</th>
<th>PUB Med ID 2</th>
<th>PUB Med ID 3</th>
<th>Conference Presentations</th>
<th>Chapters / Textbooks</th>
<th>Participated in research</th>
<th>Teaching / Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>June Smith</td>
<td>12433</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>0</td>
<td>Y</td>
</tr>
</tbody>
</table>

Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012.

Teaching / Presentations: ☑
## NAS: Annual Data Submission

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
## NAS: Annual Data Submission

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Case Logs

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yr 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yr 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## NAS: Annual Data Submission

### Year 1

<table>
<thead>
<tr>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Sep</th>
</tr>
</thead>
</table>

### ADS Update

Yr 1

### Case Logs

Yr 0

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
# NAS: Annual Data Submission

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Survey</td>
<td>Yr 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADS Update</td>
<td>Yr 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Logs</td>
<td>Yr 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
### NAS: Annual Data Submission

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td></td>
</tr>
<tr>
<td>Apr</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td></td>
</tr>
</tbody>
</table>

- **Faculty Survey**
  - **Yr 1**
- **Resident Survey**
  - **Yr 1**
- **ADS Update**
  - **Yr 1**
- **Case Logs**
  - **Yr 0**
  - **Yr 1**
  - **Yr 2**

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
## NAS: Annual Data Submission

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Faculty Survey</th>
<th>Resident Survey</th>
<th>ADS Update</th>
<th>Case Logs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 0</strong></td>
<td></td>
<td></td>
<td><strong>Yr 1</strong></td>
<td><strong>Yr 0</strong></td>
</tr>
<tr>
<td><strong>Yr 1</strong></td>
<td><strong>Yr 1</strong></td>
<td><strong>Yr 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yr 1</strong></td>
<td></td>
<td></td>
<td><strong>Yr 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Yr 1</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Yr 1</strong></td>
</tr>
</tbody>
</table>

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
NAS Program Activities

- Annual data submission
- Annual Program Evaluation
- Self-study visit every ten years
- Other possible RRC requests:
  - Progress reports for potential problems
  - Focused site visit
  - Full site visit
  - Site visit for potential egregious violations

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
New proposed Common Program Requirements for Annual Program Evaluation (V.C.1)

- Program director must appoint Program Evaluation Committee (PEC)
- PEC members: at least 3 program faculty; representation from residents
- Written description of PEC responsibilities
- PEC plans, develops implements evaluates program activities, develops competency-based goals and objectives, conducts annual program review, ensures areas of non-compliance are corrected
New proposed Common Program Requirements for Annual Program Evaluation (V.C.2)

- The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a full, written annual program evaluation (APE).
NAS: RRC Accreditation Activities

- **RRC spring meeting**: annual data review for all programs
  - ADS update
  - Resident and faculty survey
  - Milestone reports
  - Case log reports
  - Board pass rate data (aggregated rolling average)
- **RRC spring meeting**: follow-up reports and focused site visits from previous meeting
- **RRC spring meeting**: smaller number of self-study visit reports
NAS: RRC Accreditation Activities

• RRC fall meeting: larger number of self-study visit reports
• RRC fall meeting: follow-up reports and focused site visits from previous meeting
NAS Site Visits: Self-Study

- *Not* fully developed
- Scheduled every ten years
- Conducted by a team of visitors
- Minimal document preparation
- Interview residents, faculty, leadership
- Self-study visit program begins July 2015
- Core and subspecialty programs with the same sponsoring institution will be visited together
NAS Site Visits: Self-Study

- Examine annual program evaluations
  - Response to citations
  - Faculty development
- Focus: Continuous improvement in program
- Learn future goals of program
- *May* verify compliance with Core requirements
NAS Site Visits: Self-Study

Self-Study Process

Yr 0
Yr 1
Yr 2
Yr 3
Yr 4
Yr 5
Yr 6
Yr 7
Yr 8
Yr 9
Yr 10

APE
APE
APE
APE
APE
APE
APE
APE
APE
APE

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
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
NAS Site Visits: Focused

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

- 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
- More information on site visits: http://www.acgme.org/acgmeweb/GraduateMedicalEducation/SiteVisitandFieldStaff/SiteVisitFAQ.aspx
Accreditation Cycle: Next

• Begin July 1, 2013
• First Milestone reports: December 2013
• First annual program data review (no milestones): January 2014
• First annual program data review with milestones: January 2015
• Self-study visits begin July 2015
• First RRC review of program self study: January 2016
NAS: Policies and Procedures

• Policies and Procedures: 7/1/2013
  http://www.acgme-nas.org/assets/pdf/FinalMasterNASPolicyProcedures.pdf

  ➢ NO proposed adverse actions
  ➢ Potential Actions (if currently accredited): progress report; focused site visit; continued accreditation; accreditation with warning; probation; complement reduction

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
• Policies and Procedures: 7/1/2013

- Effective 7/1/2013, the ACGME will not accredit new independent subspecialty programs.

- Effective 7/1/2015, currently accredited independent subspecialty programs sponsored by an ACGME-accredited institution with a core must operate as a dependent subspecialty to the core program.

- Dependent subspecialty programs are affiliated with an ACGME-accredited specialty program and are under the governance of that specialty program’s sponsoring institution.
Currently accredited independent subspecialty programs that are also single-program sponsoring institutions must comply with one of the following by 7/1/2015:

1. Become an ACGME-accredited sponsoring institution under the oversight of the ACGME Institutional Review Committee OR

2. Change sponsorship to a geographically proximate institution that is currently ACGME-accredited under the oversight of the ACGME Institutional Review Committee
THANK YOU!