NAS
The Next Accreditation System

Elisa A Crouse, MD
September 4, 2013
Disclosures

- Nothing financial
- I went to Washington University School of Medicine
  - Residency Ended in 1993
  - I worked 110 hours a week
  - I only saw faculty if there was a problem
  - I never had an evaluation
  - Nobody asked what I thought about my learning environment
- I must be absolutely crazy
- I’ve been a Program Director for 15 years
- I don’t need a job
- I love what I do but I’m not sure what it is
Most Importantly

Even though I envision I’ll have a lot more work for the next year or so......

I’m a big fan of NAS
Objectives

- To Define the Next Accreditation System
- To List the components of NAS
- To understand the benefits of NAS
- Get a few ideas for implementation of NAS
A continuous accreditation model

Annual update

Based on data submitted, data requested and program trends

Scheduled site visit replaced by 10 year self study visit
The first step to knowing where you are going is to know where you have been and where you are now.
Residency

*Began in.....at Hopkins*

*Or Cos...*
Initial approval process was for hospitals approved for internship and then residency

Program accreditation began in 1951

Changed in early 1980’s to make requirements consistent but this became proscriptive
What’s Good in the Current Accreditation System

- Increased quantity and quality of formal teaching
- Balance between service and education
- Resident evaluation and feedback
- Required support for trainees
- Residents prepared to deal with volume and complexity of information
What’s Not So Good

- No room for innovation
- Program Directors manage programs rather than mentor residents
- The large paperwork load leads to rapid burnout and turnover among Program Directors
- It’s only an episodic biopsy of the programs
  - 4-5 year cycle
  - “PIF-man-ship”
- Why do today what you can put off until tomorrow?
Six Months Prior to the Site Visit

PANIC!!!
What is NAS

- A new and improved way of accrediting residency programs
- Reduce Accreditation Burden
- Free Good Programs to Innovate
- Help Poor Programs Improve
Key Attributes

- Specialty specific educational milestones
- Focus on improvement and self study
- Development of national normative data
- Less prescriptive program requirements revised less often
- Greater flexibility to allow educational innovation
Parts of NAS

- Milestones
- Clinical Learning Environment Review
- Clinical Competency Committee
- Others??
NAS Motives

- To foster innovation and improvement in the learning environment
- To emphasize educational outcomes
- To improve communication and collaboration with internal and external stakeholders
Aims of NAS

- Enhance the ability of the peer-review system to prepare physicians for practice in the 21st century

- To accelerate the movement of the ACGME toward accreditation on the basis of educational outcomes

- Reduce the burden associated with the current structure and process-based approach

- Note: this may not be evident right away
Who Wants NAS

- Accreditation Council on Graduate Medical Education
- Congress
- The American Public
- Public Accountability for outcomes
The Institute of Medicine, our duty hours friends and others question.....

- The process of accreditation
- The preparation of graduates for the “future” health care delivery system

MedPac, the advisors to congress on Medicare issues, recommends modulation of IME payments based on competency outcomes
How Will NAS Happen

**In the Past.....**

- Programs were ‘biopsied’
- Site visits every 3-5 years
Starting NOW

- Annual data collection
- Trends in key performance measurements
Trends to Follow

- Structure and function of the program
  - Program Characteristics – Structure and Resources
  - Clinical Experience
  - Semi-Annual Resident Evaluation and Feedback
- Program Attrition
  - Residents
  - Faculty
  - Program Director
- Milestones
- Resident survey
- Faculty survey
- Scholarly activity
- Operative & case log data
- Board pass rates
- CLER results
Program Data

- *Will be consolidated into a report card*
- *Report will be publicly available*
Good News For Program Director and Coordinator

- No more PIF’s!
- More years between site visits!!
Annual Update
Simplified

- 33 questions removed
  - 11 multiple choice or Y/N questions added
  - 14 questions simplified
  - No essay questions
  - Board pass rate now obtained directly from the Board
  - Faculty CVs removed
The "Next Accreditation System"

"Continuous"
Observations

Assure that the Program
Fixes the Problem

Number of Potential
Problems

Promote
Innovation

Diagnose
the Problem
Now the Bad News

- Everything the Program Director and Coordinator do will still continue to be done
- And, now it has to be kept current every year and also entered into the Milestones Tracking Site
Which statement best describes your enthusiasm for NAS?

- This discussion is likely to affect my life so I am excited to hear about it
- If Dr. Crouse wants to talk about it, I’ll listen since I am a respectful person
- Wake me when this is over
New Things to Know

- Program Core, Detail & Outcome Requirements
- Faculty Survey
- Scholarly Activity Data Collection
- Site Visits
- Milestones
- Entrustable Professional Activities
- Clinical Competency Committee
- CLER
Program Requirements

- Now reviewed and updated every 10 years
- NAS requires categorization of common program requirements
  - Core requirements
  - Detail requirements
  - Outcome requirements
Core Requirements

- Requirements that define structure, resource, or process elements essential to every GME program
Examples of Program Requirements

“Core”

- PD salary support
- Inpatient caps
- Faculty qualifications (e.g. certification)
- Overall resources needed “for resident education”
  - Specific resources, e.g. angiography, are detail
- Continuity clinic experience inclusive of “chronic disease management, preventive health, patient counseling, and common acute ambulatory problems.”
- Major duty hours rules
Detail Requirements

- Requirements that define a specific structure, resource, or process for achieving compliance with a core requirement

- Detail requirements include specific educational approaches and learning experiences
Examples of Program Requirements

“Detail”

- Simulation
- Minimum 1/3 ambulatory, 1/3 inpatient
- Critical care min (3 mos) and max (6 mos)
- 130-session clinic rule
- Specific conference structure
- Verbal discussion of evaluation at end rotation
- Specific aspects of evaluation structure
  - Semiannual evals remain core
- 5 year rule for PD’s
Outcome Requirements

Requirements of the expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Programs in substantial compliance with the outcome requirements may utilize alternative or innovative approaches to meet core requirements.
Examples of Program Requirements

“Outcome”

- Sections listed under the 6 competencies
- 80%/80% board take/pass rule
- PR’s related to principles of professionalism
  - Safety, recognition of fatigue, commitment to LLL, honesty of reporting, etc.
- Effective hand overs
Faculty Survey

- **Core faculty only**
- **Similar domains as resident survey**
- **Similar timing as resident survey**
- **Start in Spring 2014**
Resident Survey

- Emphasis on themes
- Minimizes single resident impact
- Compared to national normative data
- Trended data
- Only significant deviations from compliance
Resident Survey
Domains

- Duty hours
- Faculty
- Educational Content
- Evaluations
- Resources
- Patient Safety
- Teamwork
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>32441</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident Scholarly Activity</th>
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</thead>
</table>

<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 funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012</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></td>
<td>N</td>
</tr>
</tbody>
</table>

### Categories for points:
- Peer Review Publication
- Other Scholarship
- Grantmanship
- Leadership / Peer Review
- Education
Program Site Visits

- Program Information Forms replaced by self-study
- Scheduled accreditation visits every 10 years
- Focused site visits if annual data trends suggest problems
“The future isn’t what it used to be.” -- Yogi Berra
RRC Interventions

- 50% of Programs
  - All indicators satisfactory
- 25% of Programs
  - 1 indicator needing attention
- 15% of Programs
  - 2 indicators needing attention
- 7% of Programs
  - 3-5 indicators needing attention
- 3% of Programs
  - 6-8 indicators needing attention
RRC Interventions

❖ Programs in first 3 groups would receive communication from RRC that encourages attention to any areas needing attention.

❖ Programs in 4th group would be reviewed by 2 members of the RRC; their analysis would identify next steps to be taken.

❖ Programs in 5th group would have site visit to ensure timely correction of problems.
Self study begins July 2014

Internal reviews are no longer required

Still may be helpful for some programs

Schedule, reviewers and format are flexible

Use as tool for improvement
Self Study

- A comprehensive self-study
  - How the program creates an effective learning & working environment
  - How this leads to desirable educational outcomes
  - Analysis of strengths, weaknesses & plans for improvement

- Site visit
  - Clarifies that self-study document verifies educational outcomes & assessment measures & how learning environment contributes to these outcomes
What Will Site Visits Look Like

- Conducted by individual ACGME field staff or by team of field staff members
- May be “announced” or “unannounced”
- Up to 3 weeks’ notice of unannounced visits.
What Site Visitors Will Use

- Information collected by ACGME
  - Board scores
  - Operative logs
  - Resident & faculty surveys
  - Resident experience data
  - Milestones
Additional data

- Program & institution accreditation history
- On-site interviews
- Document reviews & Critical Policies
  - Supervision
  - Fatigue mitigation
  - Resident Quality Improvement projects
  - Faculty and resident evaluations of program
  - Duty hour compliance
  - Post graduate feedback
- Tours of clinic and educational facilities
- Self-study reports
They Will Do What They Have Always Done

- *Site visitor or team interviews*
- *DIO*
- *Faculty members*
- *Peer-selected or all available residents*
- *Possibly other administrators or institutional representatives*
- *Site visitor or team does not make recommendations regarding program or institutional accreditation*
They May Do More

- Site visitor participation in programs or institutional activities
  - Morning reports/Handovers
  - Conferences
  - Patient safety rounds
  - Quality Improvement activities
  - Simulation-based educational and assessment activities
- May interview residents & other participants individually, small groups, or large groups
Types of Site Visits

- Focused
- Full
- Site visit for alleged egregious violations
Focused

- Assesses selected aspects of program or institution identified by a Review Committee
- Assess aspects needing attention or follow-up identified during annual review of accreditation information
- Evaluate merits of a complaint
- As diagnostic visit to explore factors underlying deterioration in selected aspects of performance
Addresses & assesses compliance with all applicable standards

To review new program application

At end of initial accreditation period

When review of continuous accreditation data identifies broad issues and/or concerns

For other serious conditions or situations at discretion of RRC

At end of 10-year accreditation period
Egregious

- ACGME may conduct site visit at any time if an alleged egregious violation is identified.
- ACGME CEO will determine
  - Size and membership of team
  - Format & scope of visit
“All great changes are preceded by chaos”

Deepak Chopra
Competency

- 6 domains
  - Medical knowledge
  - Patient care
  - Professionalism
  - Communication and interpersonal skills
  - Practice-based learning and improvement
  - Systems-based practice
Definition

- Oxford Dictionary: the ability to do something successfully

- “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities being served

Epstein RM: Assessment in Medical Education. N Engl J Med, 2007; 356:387-96. Departments of Family Medicine, Psychiatry, and Oncology and the Rochester Center to Improve Communication in Health Care, University of Rochester School of Medicine and Dentistry
Attaining Competence

- Competency is a personal quality, not an action
- Not an achievement, but a habit of lifelong learning
- Developmental

Assessment of competence should provide insight into

- Actual performance
- Capacity to adapt to change
- Capacity to find and generate new knowledge
- Capacity to improve overall performance
Competencies, Milestones, and Entrustable Professional Activities are separate but linked

All three are relevant

“we can only fully trust someone to carry out a critical activity once they have attained all the competencies that are needed to adequately complete this activity”
Milestone

Noun

1. A stone set up beside a road to mark the distance in miles to a particular place.

2. An action or event marking a significant change or stage in development.
Lebanon, Kansas

Geographic Center of the Contiguous United States
Millarium Aureum

A gilded pillar placed at the center of the Forum in ancient Rome by the Emperor Augustus

The starting point for a system of roads, all of which led to Rome.

The roads were marked every mile with a stone “millarium” or milestone.

The milestones had several purposes.

Travelers knew that they were on a Roman road, had a standardized sense of the distance between two points, and where they were in relation to the Eternal City.
Zero Milestone
Washington, DC

Intended as mile marker for ZERO from which to measure all United States roads. Only roads in the Washington, D.C. area have distances measured from it.
Today instead of marking our journey on an actual road, milestones mark significant events in our lives.

Milestones provide reference points along the road.
The Use of Milestones

- They reassure travelers that the proper path is being followed.
- They indicate both distance travelled and the remaining distance to a destination.
- They may be used to direct emergency services (remediation) to specific points where help is required.
**Specialty Milestones**

- **Milestones are specific resident performance levels associated with each of the six general competencies.**

- **ACGME Review Committees will track milestone trajectories of unidentified individual residents.**

- **Local Clinical Competency Committees will monitor progress of each resident.**
The “GME Envelope of Expectations”
AKA - Milestones

PGY 1  PGY 2  PGY 3  PGY 4  PGY 5  MOC

- Novice
- Entering PGY 1
- Advanced Beginner
- Finishing PGY 1
- Competent
- Intermediate Level Resident
- Proficient
- Graduating Resident
- Aspirational Goal
- Expert
An Example

- M completed residency training at a prestigious program.
- His recommendation letters were decent.
- During his interview for fellowship, one of the interviewers remarked that M seemed arrogant.
M’s Fellowship

In the first 6 months of his fellowship, he has been found to “make up lab data” on rounds.

He has also reported imaging tests as “normal” that were later found to have significant abnormalities.

He often forgets to perform tasks or follow up on patient care plans detailed during rounds.

His peers complain that his “sign-outs” are worthless.

The nurses complain that he talks down to them and ignores their concerns.
Faculty remark that he is technically “clumsy” and not very careful with sterile precautions.

Faculty from other services complain that he is dismissive.

His lectures and presentations to the division are superficial and contain outdated information.

The faculty mentor assigned to help him with a research project reports that he has cancelled three meetings with her.

The program director plans to discuss M’s poor performance with him at his twice-yearly evaluation meeting.
### The Not So Helpful Evaluation

<table>
<thead>
<tr>
<th>History Taking Skills</th>
<th>Not Evaluated</th>
<th>Minimal information; old charts not obtained; important details are always left out</th>
<th>Adequate history; Some details missing</th>
<th>Complete history with summary of old charts</th>
<th>Outstanding history with summary of old charts when pertinent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Examination</td>
<td>Not Evaluated</td>
<td>Incomplete exam; misses key points, eg: no percentiles for wt, hgt, head circ. Incomplete neuro exam even when indicated.</td>
<td>Adequate physical examination, but missing some details</td>
<td>Good physical examination. Follows trend of history.</td>
<td>Thorough, detailed exam. Careful attention to problems identified in history. Findings consistently accurate.</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Not Evaluated</td>
<td>Limited diagnostic ability, misses major problems, fails to monitor and follow up</td>
<td>Adequate diagnostic ability; monitors primary problem; misses on non-primary problems.</td>
<td>Recognizes most important problems; provides monitoring and follow-up.</td>
<td>Attends to all patient needs with careful monitoring and follow up throughout; Educates patients and families.</td>
</tr>
<tr>
<td>Data Synthesis</td>
<td>Not Evaluated</td>
<td>Unable to apply knowledge to patient care; orders labs and consults undiscriminatorily; does not know when to call for help.</td>
<td>Able to correlate major problems to knowledge; orders appropriate labs and consults most of the time.</td>
<td>Good correlation of knowledge to problems; synthesizes data in problem-oriented fashion.</td>
<td>Excellent correlation of knowledge to problems; consistently selects the most appropriate labs/consults; synthesizes all data into cohesive package.</td>
</tr>
<tr>
<td>Organizational Skills</td>
<td>Not Evaluated</td>
<td>Disorganized; unable to set priorities; frequently unable to complete tasks; forgets tasks and details.</td>
<td>Limited organizational skills; remembers more important tasks; occasionally able to complete tasks.</td>
<td>Organized; carries out all required tasks.</td>
<td>Very organized; manages time effectively; able to complete all tasks with time left over for reading/teaching.</td>
</tr>
<tr>
<td>Presentation Skills</td>
<td>Not Evaluated</td>
<td>Poor; missing details; no chronology, poor flow of thoughts.</td>
<td>Able to present with most important details; occasionally leaves out information.</td>
<td>Good presentations; logical; chronological; contains key info; has DDx and assessment.</td>
<td>Excellent presentation skills; has key points; chronology. DDx, assessment and plan of action.</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>Not Evaluated</td>
<td>Behavior sometimes undermines team; Dumps tasks on peers.</td>
<td>Active team member who works well with others, but does not go the extra mile.</td>
<td>Active team member who elicits the cooperation of others; helpful.</td>
<td>Exceptionally active team member whose leadership is sought by others.</td>
</tr>
<tr>
<td>Dependability and Attendance</td>
<td>Not Evaluated</td>
<td>Not dependable; frequently absent or late; provides minimal care; misrepresents patient information.</td>
<td>Present and punctual; provides adequate patient care.</td>
<td>Present and conscientious; provides complete patient care.</td>
<td>Always present and punctual; spends additional time providing optimal patient care. Very reliable.</td>
</tr>
</tbody>
</table>
We All Know Who Evaluates Like This
### Taking the Easy Way

<table>
<thead>
<tr>
<th>Category</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Knowledge</td>
<td>1</td>
</tr>
<tr>
<td>Patient Care</td>
<td>2</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>3</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>4</td>
</tr>
<tr>
<td>Professionalism</td>
<td>5</td>
</tr>
<tr>
<td>Systems Based Practice</td>
<td>5</td>
</tr>
</tbody>
</table>

- Poor: 1
- Excellent: 5

Comments (Required):

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Further Investigation of M

- Review of 4 other evaluation forms show “scores” in the good to excellent section
- Comments are few to none
  - Needs to read more
  - Needs to be more organized
- A junior faculty member wanted to give M a poor evaluation but was over-ruled by the more senior members of the division
Going it Alone

- When the PD attempts to solicit impressions of M from faculty members, one asks to see his picture.

- Some state they only worked with him briefly and cannot provide an opinion.

- With the lack of documentation, the PD is unable to implement a plan of action at this time.

- Had there been a CCC in place looking at milestones, would things have been different...........
Milestones

- Emphasize expectations not requirements
- Observable developmental steps moving from Novice to Expert/Master
- “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
A selection of observable concrete critical clinical activities allows faculty to infer the presence of multiple competencies from these observed activities.
## Milestone Example

<table>
<thead>
<tr>
<th>PC-1: Obtaining a patient history</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dreyfus Level 1 Novice</strong></td>
</tr>
<tr>
<td>1. Elicits chief complaint, take basic history using a template format.</td>
</tr>
<tr>
<td><strong>Dreyfus Level 2 Advanced Beginner</strong></td>
</tr>
<tr>
<td>1. Obtains a comprehensive and accurate history and seeks appropriate data from secondary sources.</td>
</tr>
<tr>
<td><strong>Dreyfus Level 3 Competent</strong></td>
</tr>
<tr>
<td>1. Consistently obtains a comprehensive and accurate history in an efficient, customized, prioritized, and hypothesis-driven fashion.</td>
</tr>
<tr>
<td><strong>Dreyfus Level 4 Proficient</strong></td>
</tr>
<tr>
<td>1. Consistently identifies the clinical patterns present in the historical data gathered.</td>
</tr>
<tr>
<td><strong>Dreyfus Level 5 Expert</strong></td>
</tr>
<tr>
<td>1. Serves as role model and educator in the gathering of sophisticated history based upon specialty.</td>
</tr>
</tbody>
</table>

**After medical school**

**Half way through TY year**

**TY graduate**

**Resident graduate**

**Practicing physician**
We Know It When We See It
What Will They Look Like

<table>
<thead>
<tr>
<th></th>
<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>PATIENT CARE (PC2) – Care of Patients in the Intrapartum period</td>
<td></td>
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<tr>
<td>Demonstrates basic knowledge of routine/ uncomplicated intrapartum obstetrical care including conduct of normal labor</td>
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<tr>
<td>Provides intrapartum obstetrical care for women with uncomplicated pregnancies (e.g., identification of fetal lie, interpretation of fetal heart rate monitoring and tocodynamometry)</td>
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<tr>
<td>Manages abnormal labor</td>
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<tr>
<td>Manages intrapartum complications (e.g., cord prolapse, placental abruption)</td>
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<tr>
<td>Provides care for women with complex intrapartum complications and conditions</td>
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<tr>
<td>Identifies indications for consultation, referral and/or transfer of care for patients with intrapartum complications</td>
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</tr>
<tr>
<td>Effectively supervises and educates lower level residents in intrapartum care</td>
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</tr>
<tr>
<td>Collaborates and provides consultation to other members of the health care team in intrapartum care</td>
<td></td>
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</tr>
<tr>
<td>Applies innovative approaches to complex and atypical intrapartum conditions and implements treatment plans based on emerging evidence</td>
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</tr>
</tbody>
</table>

Comments:
Obstetrics
Milestones by Competency

- **Patient Care**
  - **PC 1** - Antepartum Care and Complications of Pregnancy
  - **PC2** - Care of Patients in the Intrapartum Period
  - **PC3** - Care of Patients in the Postpartum Period
  - **PC4** - Obstetrical Technical skills
  - **PC5** - Immediate Care of the Newborn
Gynecology
Milestones by Competency

- **Medical Knowledge**
  - MK1 - Perioperative Care
  - MK2 - Abdominal/Pelvic Pain (Acute and Chronic)
  - MK3 - Abnormal Uterine Bleeding (Acute and Chronic)
  - MK4 - Pelvic Mass
  - MK5 - Pelvic Floor Disorders (Urinary Incontinence, Pelvic Prolapse, Anal Incontinence)
  - MK6 - First Trimester Bleeding
Patient Care

PC1 - Gynecology Training Skills: Laparotomy (Hysterectomy, Myomectomy, Adnexectomy)

PC2 - Gynecology Technical Skills: Vaginal Surgery (Vaginal Hysterectomy, Colporrhaphy, Mid-Urethral Sling)

PC3 - Gynecology Technical Skills: Endoscopy (Laparoscopy, Hysteroscopy, Cystoscopy)
Office Practice
Milestones by Competency

- Medical Knowledge
  - MK1 - Health Care Maintenance and Disease Prevention

- Patient Care
  - PC1 - Family Planning
  - PC2 - Ambulatory Gynecology
  - PC3 - Care of the Patient with Non-Reproductive Medical Disorders
Practice Based Learning and Improvement Milestones by Competency

- **PBLI1** - Self Directed Learning/Critical Appraisal of Medical Literature
- **PBLI2** - Quality Improvement Process
Professionalism
Milestones by Competency

- PROF1 - Compassion, Integrity, and Respect for Others
- PROF2 - Accountability and Responsiveness to the Needs of Patients, Society, and the Profession
- PROF3 - Respect for Patient Privacy, Autonomy, Patient/Physician Relationship
Interpersonal Skills and Communication Milestones by Competency

- **ICS1** - Communication with Patients and Families
- **ICS2** - Communication with Physicians and Other Health Professionals
- **ICS4** - Informed Consent
Systems Based Practice Milestones by Competency

- **SBP1** - Systems Based Practice Including Cost Effective Care and Patient Advocacy
- **SBP2** - Patient Safety and Systems Approach to Medical Errors
Move from Numbers to Narratives

- **Numerical systems produce range restriction**
- **Narratives:**
  - *Easily discerned by faculty*
  - *Shown to produce data without range restriction*

The Study

- 19 faculty members interviewed
- 57 actual resident descriptions
- 16 narrative profiles created that represented a range of resident competence
- Strong consistency in rankings
- More consistency in decisions regarding who is excellent, competent or has significant problems compared to a numeric scale
### Narratives Result for F

- **F is highly organized, efficient and energetic.**
- **F manages time well and is able to prioritize tasks effectively.**
- **F’s efficiency and ability to prioritize improved even further during the rotation.**
- **F handles demanding situations well and does not appear stressed or fatigued on busy days.**
- **Even though F is efficient, F does not appear rushed.**
- **Clinically, F has a very strong knowledge base and sound understanding of how different drugs and devices work, what their indications and contraindications are, the way in which different patients might respond to these, the side effect profile, and the expected benefits.**
More on F

- F is comprehensive in the approach to obtaining a medical history and summarizing what is wrong with the patient.
- F is also inclusive in generating a management plan.
- When reporting on patients, F expresses ideas clearly and succinctly, both verbally and in writing, and is not over inclusive but communicates the core and essential data.
- Technically, F is very competent.
- As the rotation progressed, F gained more confidence, made quicker decisions, and achieved greater finesse in judgment.
F routinely looks up relevant information and is very good at critically appraising the literature and generating discussion about it.

F often has a good sense of the applicability of the literature.

F has good relationships with other team members but can sometimes be demanding when F perceives that someone is not responding quickly enough to requests.

F describes things well but can become frustrated with juniors who don’t catch on as quickly.

F has a very strong interpersonal approach with patients, is compassionate, and practices patient-centered care as well as family centered care.
<table>
<thead>
<tr>
<th>Profile Indicator</th>
<th>Category Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding, excellent, exemplary</td>
<td>Outstanding, dream resident</td>
<td>Minimal guidance required</td>
</tr>
<tr>
<td>Solid, Safe</td>
<td>Needs fine tuning</td>
<td>Needs guidance, minor intervention</td>
</tr>
<tr>
<td>Borderline, bare minimum, acceptable</td>
<td>Motivational deficits, professional deficits</td>
<td>Lone wolf, problems in group setting</td>
</tr>
<tr>
<td>Safe Underachiever</td>
<td>No fatal flaw, could improve</td>
<td>Cruise by, fly through, remediable, just tries to get through the month</td>
</tr>
<tr>
<td>Unacceptable, unsatisfactory, fail</td>
<td>Multiple deficits, critical flaw</td>
<td>Unsafe, critical flaw, makes hour heart sink</td>
</tr>
<tr>
<td>Unsafe</td>
<td>Unsafe, requires high degree of remediation</td>
<td>Cannot trust, unprofessional, dangerous, competence lacking</td>
</tr>
</tbody>
</table>
Long Island Pilot Experience

- Six pediatrics milestones
- Two pediatrics programs
- Ward and PICU rotations/July 2012
- Replaced current questions on global assessment form with milestones

• Susan Guralnick, MD, Associate Dean/DIO Winthrop University Hospital
After one hour, PICU and ward faculty reported:

- They could “visualize” where a resident is at.
- They agreed with the interpretations.
- They could use evaluations as effective feedback tool.
- They could define what to work on.
- Favorable response to milestones.
Narratives and Milestones

- **Time:** 20 – 60 minutes per resident

- Ratings were very close between faculty members

- Residents preferred feedback using milestones
  
  - Better idea of their level of competency

  - Concrete descriptions provided them with the knowledge of where they needed to improve – made expectations clear
Let's Practice One

- T is a nice person.
- T always shows up to the OR on time and is interested in performing procedures.
- T brings completed admission materials for every case.
- T has good hands.
- T knows basic pelvic anatomy.
- T knows what the plan is for the day.
  - What Year Is T???
  - What Level is T???
### MEDICAL KNOWLEDGE (MK1) - Perioperative Care

<table>
<thead>
<tr>
<th>GYNECOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
</tr>
</tbody>
</table>

- **Demonstrates knowledge of basic abdominal and pelvic anatomy**
  - relevant surgical anatomy
  - common procedural indications
  - co-morbidities relevant to gynecologic surgery
  - prophylactic strategies to reduce postoperative complications

- **Demonstrates knowledge about the management of:**
  - medical comorbidities relevant to gynecologic surgery
  - prophylactic strategies to reduce postoperative complications
  - identifies appropriate procedural options for relevant gynecological condition

- **Demonstrates advanced knowledge necessary for management of medically complex patients:**
  - demonstrates the ability to recognize and manage perioperative complications
  - effectively supervises and educates lower level residents regarding perioperative care

- **Applies innovative approaches to complex and atypical perioperative care and implements treatment plans based on emerging evidence:**
  - collaborates and provides consultation to other members of the team regarding perioperative care
  - manages critically-ill patients requiring care in an intensive care unit

**Comments:**
Where is Z

- Z always has complex patients and does a good job with them even in the ICU
- Z chooses the appropriate antibiotic prophylaxis
- Z teaches in the OR
<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 basic abdominal and pelvic anatomy</td>
<td>Demonstrates knowledge of:</td>
<td>Demonstrates knowledge about the management of:</td>
<td>Demonstrates advanced knowledge necessary for management of medically complex patients.</td>
<td>Applies innovative approaches to complex and atypical perioperative care and implements treatment plans based on emerging evidence.</td>
</tr>
<tr>
<td></td>
<td>• relevant surgical anatomy</td>
<td>• medical comorbidities relevant to gynecologic surgery</td>
<td></td>
<td></td>
</tr>
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<td>• prophylactic strategies to reduce postoperative complications</td>
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</tbody>
</table>

The milestones are a product of the OBGYN Milestone Project, a Joint Initiative of the Accreditation Council for Graduate Medical Education, the American College of Obstetrics and Gynecology, and the American Board of Obstetrics and Gynecology.
Milestones

Assessment of an individual resident's progress

Not a new evaluation tool

Focused on selected indicators among many possible key indicators

Based in the competencies

Level of Training is Observed Behavior - NOT PGY Level

Narratives of competencies rather than numerical evaluations

Track outcomes using existing tools and faculty observation

Goal: to monitor behavior over a continuum from student to resident to practice
“Professional activities that together constitute the mass of critical elements that operationally define a profession”

A level of work that supervisors have confirmed the trainee is able to assume independent responsibility for performing

Can happen at any time

Not based on longevity in the position
Entrustable Professional Activity (EPA’s)

- Real life patient care episodes
- Usually composed of elements of most if not all “competencies”
- Benchmark of performance is the ability to be entrusted to perform care with “indirect supervision with direct supervision available”
- Progression is then the achievement of EPA’s of increasing difficulty, risk, or sophistication
- Proficiency is then the achievement of the most sophisticated EPA’s required of the resident
Trust “Levels” of EPAs

- *Has knowledge*
- *May act under full supervision*
- *May act under moderate supervision*
- *May act independently*
- *May act as a supervisor and instructor*
When is Competence Reached

- When a professional activity is mastered
- On a threshold level
- That permits trust
- To act unsupervised

Competence is one stage of a developmental continuum
# Building EPAs as Goals

<table>
<thead>
<tr>
<th>Title</th>
<th>Short description of activity on which entrustment decision is to be made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Brief general description Bulleted list of functions</td>
</tr>
<tr>
<td>Map to Competencies</td>
<td>ACGME Competencies</td>
</tr>
<tr>
<td>Select Sub-competencies Critical to Entrustment</td>
<td>Typically will have 3-7 critical components</td>
</tr>
</tbody>
</table>
| A Nonmedical EPA | \[
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EPA</td>
<td>Bake A Cake for Guests</td>
</tr>
<tr>
<td>Competency</td>
<td>Knowledge (MK) Skill (PC)</td>
</tr>
<tr>
<td>Subcompetency</td>
<td>Appropriately Interpret Recipe Competently Use Mixer Competently Use Oven</td>
</tr>
<tr>
<td>Level 1</td>
<td>Level 2</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>MK1 Interpret Recipe</td>
<td>Find a recipe book</td>
</tr>
<tr>
<td>PC1 Use Mixer</td>
<td>Knows difference between mixer and spatula</td>
</tr>
<tr>
<td>PC2 Use Oven</td>
<td>Knows the difference between oven and microwave</td>
</tr>
</tbody>
</table>
Clinical Competence Committee

- Each program expected to form Clinical Competency Committee (CCC) and begin to develop members by June 2013

- The task of this committee is to make consensus decisions on progress of each resident

- Initially, this will use the existing resident assessment data, tools and faculty observations

- Beginning in 2014, CCC assessments will use data from the Educational Milestone assessments
Clinical Competency Committee

- May already be in place under a different name
- A group of faculty members trained in looking at milestones
- The same set of eyes looking at all evaluations for all residents
- The same process is applied uniformly
Avoids Common Pitfalls

- Vague statements
  - “I don’t like to give negative evaluations”
  - “I just didn’t like this resident, but I can’t put my finger on it”
- “Herd” mentality
  - positive or negative
  - “I spent little time working with this resident”
- Grade inflation
- Hearsay
  - I’ve heard she is lazy
Who Should be on the CCC

- Engaged Faculty Members
  - Probably 5-7 people
  - Not all must be physicians
  - May include nursing or administrative representatives
  - May include sub-specialists
  - Ultimately may not include the Program Director as a voting member
What will the CCC do

- **Utilize the evaluation data (compiled by the program coordinator and director) for each resident and determine their progress along the milestones from novice to expert**

- **For residents lagging behind**
  - **Make recommendation to Program Director for corrective actions**
  - **Develop mentoring program and plan for performance improvement**
  - **ACGME recommends quarterly meetings**
What the Clinical Competency Committee Will Use
Faculty Development

- Program Director must facilitate development of faculty knowledge and skills about NAS and milestones
- CCC must have a thorough understanding of milestones and how to utilize them
Institutional Accreditation

- Accreditation site visit every six years
- CLER visit every 18 months
- Emphasis on institutional oversight through DIO and GMEC
- Regular reporting of selected performance indicators
- Effective July 1, 2014
- First CLER visit before then
CLER

- 6 focus areas
  - Patient safety
  - QI - health care quality
  - Supervision
  - Transition in care
  - Fatigue mitigation
  - Professionalism
Patient Safety Focus

- Effective reporting systems
- Feedback & communication
- Encourage reporting of near misses
- Systems issues
  - 80% of medical errors are systems issues
  - Look and sound alike
  - Abbreviations
  - Illegibility
  - Multi-tasking
5 Key Questions

- Who at hospital advances the six focus areas
- What is the GME relationship with their hospitals
- How will GME and hospitals integrate on the six focus areas
- Who at hospital determines areas of improvement
- How are residents and fellows engaged
CLER

- Every 12-18 months
- Short notice - 2 weeks
- Lasts 2-3 days

Required Participants

- CEO
- CMO
- DIO
- GMEC chair
- Residents on GMEC
- QI officer
- Hospital risk management
May be asked to provide for any program

- Organizational charts
- Organizational strategies for patient health care safety and quality
- Sponsoring institution & participating sites plans for supervision, duty hours, etc
Three Phases

- Initial meetings
  - DIO, GMEC chair, CEO, and CMO
- Resident meeting
- Core faculty meeting
- Program Director meeting
- Walk around with senior resident and/or nursing staff
- Exit meeting with first group
- Feedback is positive
2014 Key Dates

- Annual data collection has begun
- Jun 2014
  - Clinical Competency Committees start to assess Milestones
  - Begin operating under next accreditation system
  - RRC begins to review annual data from 2013-2014
    - Without milestones
- Dec 2014
  - First set of Milestones assessment summaries submitted to ACGME
2015 Key Dates

Jun 2015
- Second set of Milestones assessment summaries submitted to ACGME
- RRC begins to review annual data from 2014-2015
  - With milestones

Fall 2015
- First Self-Study visits begin for programs
  - 12 months notice
“The best way to predict the future is to invent it.”
-- Alan Kay
What is OU Doing?

- **NAS**
  - Redefining role of the GMEC
  - Moving away from Internal Reviews for high performing programs
- **Milestones**
- **Urology**
  - Turned Milestones over the Residents
- **Pediatrics**
  - Asking questions in evaluations related to personal family members care
- **EPA’s**
- **Rewriting Goals & Objectives**
- **CLER**
  - Waiting for our first visit
Program To Do List

- Define and select core faculty
- Optimize annual update
- Create Clinical Competency Committees
- Decide how to measure milestones
- Narratives
- EPAs
- Develop a self-study and strategic plan
Update Existing Rotations

For Each Rotation

- Identify functional outcomes expected - EPA’s
- Map outcomes to specific sub-competencies
- Write competence based objectives
- Develop evaluation form based on milestones for mapped sub-competencies
- Develop and implement additional assessment strategies
Faculty Development is Key

- Train faculty in use of Milestones for assessment
- Teach the faculty the definitions
- Teach the faculty the tools
“A year from now you will wish you had started today”

Karen Lamb
More Good News

Help is On Its Way
CREOG Milestones
Taskforce

- Tools
- Data Management and Work Flow
- Faculty Development
- Feedback
CREOG
Coming Soon to a Meeting Near You
Παρακαλω

Parakalo