Succeeding in the ACGME's NAS:

Strategies for Program Administrators and Coordinators

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Objectives for today’s session:

- Describe updated ACGME requirements, processes and activities of the NAS
- Prepare for the evolving role of the residency administrator/coordinator as part of the program team
- Develop strategies to work within your program and institution to identify opportunities for improvement and innovation.

Questions we want to answer…

- How will we prepare?
- How will resident evaluations change to report on milestones?
- How will we remain compliant over 10 years?
- What will the GME office expect from the programs?
- What will be the role of the administrator/coordinator in NAS?
- How will it be different?

"All changes, even the most longed for, have their melancholy, for what we leave behind us is a part of ourselves…"
- Anatole France

- What are we leaving behind?
  - PIFs
  - IRDs
  - Site Visits
  - Internal Reviews
  - Site Visitor Documentation Checklists
- Familiarity, comfort, the system we know…

What is changing in NAS?

- Program Accreditation:
  - ACGME data reporting
    - Milestones Assessment and Reporting
  - Program Self-Study Visits
- Institutional Accreditation:
  - Institutional Self-Study Visits
- CLER visits
  - Hospital by hospital on-site systems visits

How do we look at NAS changes?
We have to remember...(may be new)

- Resident perspective?
- Chair's perspective?
- Program director's perspective?
- Faculty perspective?
- Hospital Administration perspective?
- GME office perspective?
- Today: TPA perspective?

Where will changes come from?

- ACGME
- New ACGME webADS questions
- Milestones as they are published
- New institutional requirements
- ACGME/AOA unified accreditation

- All will be covered today…
- **Remember that we build institutional systems program by program**

Where will help come from?

- ACGME
- AHME
- Your electronic web-based residency management software system
- Each other: Central GME Office AND programs rowing in the same direction WITH hospital administration, chairs, faculty, residents and others

DIO

"When patterns are broken, new worlds emerge."
- Tuli Kupferberg

- Leaving behind the Accreditation model that we know requires ACGME to collect data annually
- Program self-study visits are made possible by this effort

Self Study & Program Improvement

- ACGME self study visits begin July 2014
- Internal reviews
  - No longer required as of July 2013, but still may be helpful
  - Don't do it for accreditation, but must do it if warranted!
- Tool for program improvement, NOT A PIF
- Regular goal setting over longer term: 3-5 years
- Includes self-reflection/self-study
- Consider SWOT (strengths/weaknesses/ opportunities and threats)/stakeholders
- Consider program outcome trends
- ANNUAL PROGRAM REVIEW WILL BE REQUIRED!
  - More on this later
  - Institutional AND program roles in APR!
  - Prepared by programs, reviewed by GMEC

Annual Data Collection?

1. Annual ADS Update – streamlined
2. Board Pass Rate
3. Clinical Experience
4. Resident Survey
5. Faculty Survey
6. Semi-Annual Resident Evaluation and Feedback
   a. Milestones
   b. Clinical Competency Committees
7. Hospital-wide CLER Visits: Patient Safety/QI

Annual Data Collection? How to prepare?

Annual ADS Update	Track locally before submission
Board Pass Rate	Track locally
Clinical Experience	Procedure log modules/ACGME
Resident Survey ^	Administer survey questions using E-system
Faculty Survey ^	Trial run using E-system
Semi-Annual Evaluation of Milestones	Evaluations – existing or reformatted give semiannual Milestones data to ACGME
CLER Visits	Data collected and prepared?

^ Very similar questions

1. ADS update: November/December 2012
Faculty & resident scholarly activity: streamlined

Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	[illegible]er [illegible]tatio[illegible]	Chapters Textbooks	Grant Leadership	Leadership or Peer-Review Role	Teaching Formal Courses
	20952683	[illegible]22	22674044	3[illegible]	7	[illegible]0	0	3	Y	Y
	22619301	22[illegible]	[illegible]13105	[illegible]	[illegible]	[illegible]	[illegible]	0	N	Y
	23130115	2217[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1	Y	N
	22588375	2239223[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	N	Y

TPA looks u[illegible]

[illegible]s/No

PHASE ONE PROGRAMS ONLY FOR NOW. OTHERS UNCHANGED...

Resident	PMID 1	PMID 2	P[illegible]	Confer[illegible] Presenta[illegible]s	Chapters Textbooks	[illegible]articipated [illegible] Research	Teaching Presentations
	21909632			1	0	Y	Y
	22325469			1	0	Y	Y
	22392230	22374151		1	0	Y	N
	22286543			0	0	N	N

1. ADS update: November/December 2012
Faculty & resident scholarly activity: streamlined

Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations ☆	Other Presentations ☆	Chapters Textbooks ☆	Grant Leadership ☆	Leadership or Peer-Review Role △	Teaching Formal Courses △
	20952683	32930122	22674044	31489960	7	10	0	3	Y	Y
	22619301	22081557			0	1	0	0	N	Y
	23130115	22172436	22145695		10	21	4	1	Y	N
	22588375	22392230	22385877	22374151	1	0	1	0	N	Y

TPA looks up PMIDs

☆ TPA reports a number

△ Yes/No

Resident	PMID 1	PMID 2	PMID 3	Conference Presentations ☆	Chapters Textbooks ☆	Participated in Research △	Teaching Presentations △
	21909632			1	0	Y	Y
	22325469			1	0	Y	Y
	22392230	22374151		1	0	Y	N
	22286543			0	0	N	N

1. ADS Update: November/December 2012

Original Accreditation Date: September 01, 1949
Accreditation Status: Continued Accreditation
Accreditation Effective Date: April 29, 2011
Accredited Length of Training: 4 years
Program Format: Standard

Total Approved Resident Positions: 48
Total Filled Resident Positions*: 45
Temporary Increase:** 2 Effective from 7/1/2009 thru 6/30/2014
Temporary Increase:** 1 Effective from 7/1/2012 thru 6/30/2013

Complement Breakdown: Approved

Years:	1	2	3	4	Total
Approved:	12.0	12.0	12.0	12.0	48.0

Additional Requirements

- Duty Hours/Learning Environment
- Overall Evaluation Methods
- Major Changes
- Board Pass Rates

Must answer these questions

- UNCHANGED from prior years:
  - Board Pass Rates
  - Major Changes including current response to citations

1. ADS update screen if no activity yet:

- **Annual Update Attention Required**
- **Date Required by:** December 07, 2012
- **Complete:** No
- **Completion Date:** *No Information Currently Present*
- **New Feature: All required sections of the annual update are listed below and are available throughout the academic year by accessing the tabs at the top of the screen.**

Program Information:

- You must have a primary teaching site.
- Update the **Duty Hour/Learning Environment section**.
- Update program address information.
- Update **responses for all current citations**.
- Update the **major changes section**.
- Update the **Overall Evaluation Methods section.**
- Enter a valid Program Director email.
- Update the Program Director certification information.
- Update the **Sites tab and complete all missing data for each institution**.
- **Upload a block diagram or confirm current block diagram still active**.
- **Resident Information**:
- Confirm all residents.
- **Faculty Information**:
- Currently 0 of Core Faculty member(s) do not have an email address listed.

1. Questions in webADS for all programs:

- DUTY HOUR, PATIENT SAFETY & LEARNING ENVIRONMENT (non-narrative)
  - Participation in patient safety programs?
  - Participate in ICQI to improve health outcomes?
  - How often needs exceeds residents' abilities?
  - Back-up systems during the day?
  - Back-up systems during the night/weekend?
  - How are hand-overs done?
  - Education on fatigue?
  - Options offered to fatigued residents?
  - Moonlighting permitted?
  - 1 day free out of 7?
  - Required rest between daily duty periods?
  - Maximum night float (consecutive)?
  - Frequency of in-house call – most demanding rotation?
  - Use outpatient settings?
  - Use EMR in primary hospital?
  - What percentage of residents use EMR to improve the health of a population?

1. Questions in webADS for all programs:

- Overall Evaluation Methods **(non-narrative)**
  - Assessment tools used for 6 competencies
    - Pre-populated with last year's selections
  - System to determine progressive authority?
  - How evaluators are educated to ensure fairness and consistency
  - How residents are informed of performance criteria
  - What percentage of faculty complete written evals within 2 weeks?

80-100%
60-79%
40-59%
20-39%
Less than 20%

  - Does the program have a Clinical Competency Committee?
  - If yes, does the CCC perform resident evals semi-annually?
  - If yes, if feedback provided to residents on a semi-annual basis?
  - If yes, if feedback documented?

2. Board Certification

- Nationally agreed upon outcome of training
- RRCs working with ABMS boards
- Subs will self-report
- Pass rate only, not individual scores
- Multi-year rolling rates for small programs

3. Clinical Experience

- Case Logs
- Review the number and mix of cases
- Correct incomplete data entry
- Need all (not just minimum) numbers
- Multi-site programs
- Tracking incomplete reporting
- For specialties not using ACGME case logs, resident survey questions may be added

4. Resident Survey

- Emphasis on themes rather than on individual questions
- High level view to minimize single resident impact
- Only significant deviation from compliance are indicators
- Trend data
- Domains: Duty hours, Faculty, Educational Content, Evaluations, Resources, Patient safety, Teamwork
- New questions about:
  - EMR
  - Patient Safety
  - Quality Improvement
  - Handoffs
  - Inter-professional Teams
  - Backup when fatigued

5. Faculty Survey

- Hours spent teaching and supervising
- Questions in similar domains as resident survey:
  - Faculty supervision
  - Faculty development
  - Educational Content including Scholarly activity
  - Program and institutional resources
  - Patient safety including Fatigue
  - Teamwork
- Only Core faculty will be surveyed
  (presumed to be more knowledgeable about program)
- Similar timing as resident survey
- Planned start in winter 2013 for Phase 1 specialties
  (2012-2013 data)

ACGME **2010-2011 US Faculty Survey**

Number of core faculty: 15

Number of core faculty responding: 6

1. Approximately how many hours per week do you devote to your professional effort, including all clinical, educational, and administrative work?

59.2	Mean hours per week

2. Time (% and mean hours) spent per week in:

%	Hours	Activity
51%	29.9	Residency program activities
8%	4.4	Administrative work (not for residency program)
8%	4.4	Research activities (not for residency program)
24%	14.3	Providing clinical care (no residents present)
6%	3.6	Preparing paperwork related to clinical care
4%	2.5	Other

3. How often do you participate in group educational activities such as morning report, grand rounds, journal clubs, case conferences, or other similarly structured presentations?

100%	Daily
0%	Weekly
0%	Monthly
0%	Every few months
0%	Once or twice per year
0%	Never

4. Which of the following best describes when you give residents documented written feedback about the rotation and / or assignment they completed under your supervision?

17%	On the last day of the rotation
67%	The week after completion of the rotation
17%	Two weeks after completion of the rotation
0%	One month after completion of the rotation
0%	Several months after completion of the rotation
0%	At the end of the academic year
0%	I do not provide written feedback

16. How often do residents participate in departmental or institutional quality improvement and / or patient safety programs?

50%	Monthly
0%	Alternate Months
0%	Quarterly
0%	Semiannually
0%	Annually
0%	Never
50%	I don't know

Question	Extremely Positive	Positive	None	Negative	Extremely Negative	1=Extremely Negative 5=Extremely Positive
5. In your opinion, what impact have the current duty hour standards had on the residents' ability to provide safe patient care?	0%	17%	0%	67%	17%	2.2
6. In your opinion, what effect have the current duty hour standards had on the residents' ability to learn?	0%	17%	0%	67%	17%	2.2

Question	Extremely	Very	Somewhat / Sometimes	A little / Rarely	Not at all / Never	I don't know	1=Not at all / Never 5=Extremely
7. How satisfied are you with the residency program's ability to deal confidentially with problems and concerns residents may have?	50%	0%	50%	0%	0%	0%	4.0
8. How satisfied are you with the education residents receive for fatigue management?	33%	33%	0%	17%	0%	17%	4.0
9. How often do you have sufficient time to adequately supervise residents?	50%	50%	0%	0%	0%		4.5
10a. Do residents recognize the limits of their authority and seek supervisory guidance while providing clinical care?	17%	67%	0%	17%	0%		3.8
10b. Do residents communicate effectively with their colleagues (including other faculty) when transferring responsibility at the end of their shifts?	33%	33%	17%	17%	0%		3.8
11. How often does the sponsoring institution and program provide adequate provisions to ensure safe patient care is provided by the residents?	33%	50%	17%	0%	0%		4.2
12. How successful is the residency program in preventing excessive reliance on the residents to maximize the number of patients seen?	50%	33%	17%	0%	0%	0%	4.3
13. How often is the residents' workload appropriate for their level of expertise to the clinical needs of the patients?	50%	17%	17%	0%	17%	0%	3.8
14. How often is the residents' work in the hospital or clinics directly related to their education?	50%	50%	0%	0%	0%	0%	4.5
15. How often do residents, faculty, and other clinical support personnel (e.g., nurses, pharmacists, case workers or dieticians) participate in teams to provide clinical and patient care?	17%	50%	33%	0%	0%	0%	3.8

17. Have you personally worked this academic year with any of the current residents on a scholarly project?

100%	Yes
0%	No

Note: Question and option wordings may be slightly different than in the actual survey, and are modified to make the report easier to read.

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6a. Milestone Development: Charge to joint ACGME and NBMS committees:

- Develop a specialty-specific system of competency based learning and assessment
- Formulate precise definitions of the subcomponents of the six core competencies and levels of performance expected of each trainee at key points along the continuum of their education (Milestones).
- Identify the assessment tools for evaluation of resident learning and performance.

6a. Milestones…

- Track what is important – outcomes
- Begin using existing assessment tools
- Clinical Competency Committees, made up of program core faculty, will be responsible for reporting UNIDENTIFIED individuals' progress to RRC
- Will be specialty-specific with expected individual norms
- Will permit (may require?) development of specialty-specific evaluation tools and techniques
- Clinical Competency Committees will need to form by 1/1/13 to do this work for Phase I cores
- Subspecialty fellowships will lag behind core residency programs ~6 months for milestones, etc.

6a. Milestones example: Patient Care

History: Obtains a comprehensive medical history				
Elicits chief complaint & takes basic history using a template format	Obtains a comprehensive and accurate history and seeks appropriate data from secondary sources.	Consistently obtains a comprehensive and accurate history in an efficient, customized, prioritized, and hypothesis-driven fashion.	Consistently identifies the clinical patterns present in the historical data gathered.	Serves as role model and educator in the gathering of sophisticated history based upon specialty.
Assessment Methods / Tools: Direct Observation (Mini-CEX), Standardized Patient, Simulation				

Emergency Medicine Milestones

- Published on ACGME website 10/9/12
- Each of 23 Milestones:
  - Attributed to 1 of the 6 competencies
  - Has 5 defined levels of performance AND
  - 9 choices along the continuum of 5 levels
- Suggested Evaluation Methods Listed for each Milestone (from our old friend, the Toolbox)

- CONFUSED?

An actual sample…

2. Performance of Focused History and Physical Exam (PC2)

Abstracts current findings in a patient with multiple chronic medical problems and, when appropriate, compares with a prior medical record and identifies significant differences between the current presentation and past presentations				
Level 1	Level 2	Level 3	Level 4	Level 5
Performs and communicates a reliable, comprehensive history and physical exam	Performs and communicates a focused history and physical exam which effectively addresses the chief complaint and urgent patient issues	Prioritizes essential components of a history given a limited or dynamic circumstance Prioritizes essential components of a physical examination given a limited or dynamic circumstance	Synthesizes essential data necessary for the correct management of patients using all potential sources of data	Identifies obscure, occult or rare patient conditions based solely on historical and physical exam findings

Comments:

9 choices

Suggested Evaluation Methods: Global ratings of live performance, checklist assessments of live performance , SDOT, oral boards, simulation

Emergency Medicine Milestones

- Patient Care
  - 14 milestones (eg, H&P, diagnosis, multi-tasking, dx studies)
- Medical Knowledge:
  - 1 milestone (inservice exam)
- Interpersonal and Communications Skills
  - 2 Milestones (team management)
- Professionalism:
  - 2 Milestones (professional values example shown)
- Practice-Based Learning and Improvement:
  - 1 Milestone (performance improvement example shown)
- Systems-Based Practice:
  - 3 Milestones (patient safety example shown)

Professionalism: 2 milestones

16. Professional values (PROF1)

Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates behavior that conveys caring, honesty, genuine interest and tolerance when interacting with a diverse population of patients and families	Demonstrates an understanding of the importance of compassion, integrity, respect, sensitivity and responsiveness and exhibits these attitudes consistently in common / uncomplicated situations and with diverse populations	Recognizes how own personal beliefs and values impact medical care; consistently manages own values and beliefs to optimize relationships and medical care Develops alternate care plans when patients' personal decisions/beliefs preclude the use of commonly accepted practices	Develops and applies a consistent and appropriate approach to evaluating appropriate care, possible barriers and strategies to intervene that consistently prioritizes the patient's best interest in all relationships and situations Effectively analyzes and manages ethical issues in complicated and challenging clinical situations	Develops institutional and organizational strategies to protect and maintain professional and bioethical principles
○ ○	○ ○	○ ○	○ ○	○
Comments:				

Suggested Evaluation Methods: Direct observation, SDOT, portfolio, simulation, oral board, multi-source feedback, global ratings

Systems-Based Practice: 3 milestones

21. Patient Safety (SBP1)

Participates in performance improvement to optimize patient safety.				
Level 1	Level 2	Level 3	Level 4	Level 5
Adheres to standards for maintenance of a safe working environment Describes medical errors and adverse events	Routinely uses basic patient safety practices, such as time-outs and 'calls for help'	Describes patient safety concepts Employs processes (e.g. checklists, SBAR), personnel, and technologies that optimizes patient safety *SBAR = Situation – Background – Assessment - Recommendation Appropriately uses system resources to improve both patient care and medical knowledge	Participates in an institutional process improvement plan to optimize ED practice and patient safety Leads team reflection such as code debriefings, root cause analysis, or M&M to improve ED performance Identifies situations when the breakdown in teamwork or communication may contribute to medical error	Uses analytical tools to assess healthcare quality and safety and reassess quality improvement programs for effectiveness for patients and for populations Develops and evaluates measures of professional performance and process improvement and implements them to improve departmental practice
○ ○	○ ○	○ ○	○ ○	○
Comments:				

Suggested Evaluation Methods: SDOT, simulation, global ratings, multi-source feedback, portfolio work products, including a QI project

Practice-Based Learning/Improvement: 1 milestone

20. Practice-based Performance Improvement (PBLI)

Participates in performance improvement to optimize ED function, self-learning, and patient care				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes basic principles of evidence-based medicine	Performs patient follow-up	Performs self-assessment to identify areas for continued self-improvement and implements learning plans Continually assesses performance by evaluating feedback and assessment Demonstrates the ability to critically appraise scientific literature and apply evidence-based medicine to improve one's individual performance	Applies performance improvement methodologies Demonstrates evidenced-based clinical practice and information retrieval mastery Participates in a process improvement plan to optimize ED practice	Independently teaches evidenced-based medicine and information mastery techniques
○ ○	○ ○	○ ○	○ ○	○
Comments:				

Suggested Evaluation Methods: SDOT, simulation, global ratings, checklist or ratings of portfolio work products, including a literature review, Vanderbilt matrix evaluation of a clinical issue, critical appraisal

Orthopaedic Surgery

- Chose a different approach
- Orthopaedic faculty wanted to get back to the REAL QUESTION: is the resident a COMPETENT SURGEON???
- For 16 specific clinical areas of Orthopaedics, medical knowledge and patient care are clearly defined

1. ACL injury	9. Elbow fracture (adult)
2. Ankle arthritis	10. Hip and knee osteoarthritis
3. Ankle fracture	11. Hip fracture
4. Carpal tunnel	12. Meniscal tear
5. Degenerative spinal conditions	13. Metastatic bone lesion
6. Diabetic foot	14. Rotator cuff injury
7. Diaphyseal femur and tibia fracture (adult)	15. Supracondylar humerus fracture (pediatric)
8. Distal radius fracture	16. Septic arthritis hip (pediatric)

- Then, other 4 competencies are treated more generically

Medical Knowledge: Distal Radius Fracture

Level 1	Level 2	Level 3	Level 4	Level 5
•Demonstrates knowledge of anatomy •Understands basic imaging	•Demonstrates knowledge of fracture description and soft tissue injury: angulation, displacement, shortening, comminution, shear pattern, articular parts •Understands mechanism of injury •Understands biology of fracture healing •Understands advanced imaging •Understands surgical approaches and fixation tech: percutaneous pinning, volar plating, external fixation, dorsal plating, fragment specific, combinations	•Demonstrates knowledge of current literature, fracture classifications and therapeutic alternatives •Demonstrates knowledge of associated injuries: median nerve injury, scaphoid fracture; SL ligament injury, TFCC injury, elbow injuries •Understands natural history of distal radius fracture •Understands biomechanics and implant choices: understand the advantage and disadvantages of different fixation techniques	•Understands controversies within field: fixation techniques and fracture pattern, correlation between radiographic and functional outcomes in elderly patient	•Participates in research in the field with publication

Level 1 Level 2 Level 3 Level 4 Level 5

Skill level 1-5
- Entrance level 1
- Graduating resident 4
- Advanced/Fellowship 5

Patient Care: Distal Radius Fracture

Level 1

- Obtains history and performs basic physical exam
- Orders/ interprets basic imaging studies
- Splints fracture appropriately
- Provides basic post-op management and rehab
- Lists potential complications: infections, hardware failure tendon injury, CRPS, carpal tunnel syndrome, malreduction

Level 2

- Obtains focused history and physical, recognizes implications of soft tissue injury: open fracture, median nerve dysfunction, DRUJ instability
- Orders/ interprets advanced imaging: CT for comminuted articular fractures
- Recognizes stable/ unstable fractures: metaphyseal comminution, volar/ dorsal Barton's, die-punch pattern; multiple articular parts
- Able to perform a closed reduction and splint appropriately
- Recognizes surgical indications: median nerve dysfunction, instability, articular step off/gap, dorsal angulation, radius shortening
- Performs surgical exposure
- Modifies and adjusts post-op plan when indicated
- Recognizes/ evaluates fragility fractures: orders appropriate work-up and/or consult
- Diagnoses and provides early management of complications

Level 3

- Performs pre-operative planning with appropriate instrumentation and implants
- Capable of surgical reduction and fixation of extra-articular fracture
- Interprets diagnostic studies for fragility fractures with appropriate management and/or referral

Level 4

- Capable of surgical reduction and fixation of simple intra-articular fractures: no more than 2 articular fragments
- Capable of surgically treating simple complications: infections, open carpal tunnel release

Level 5

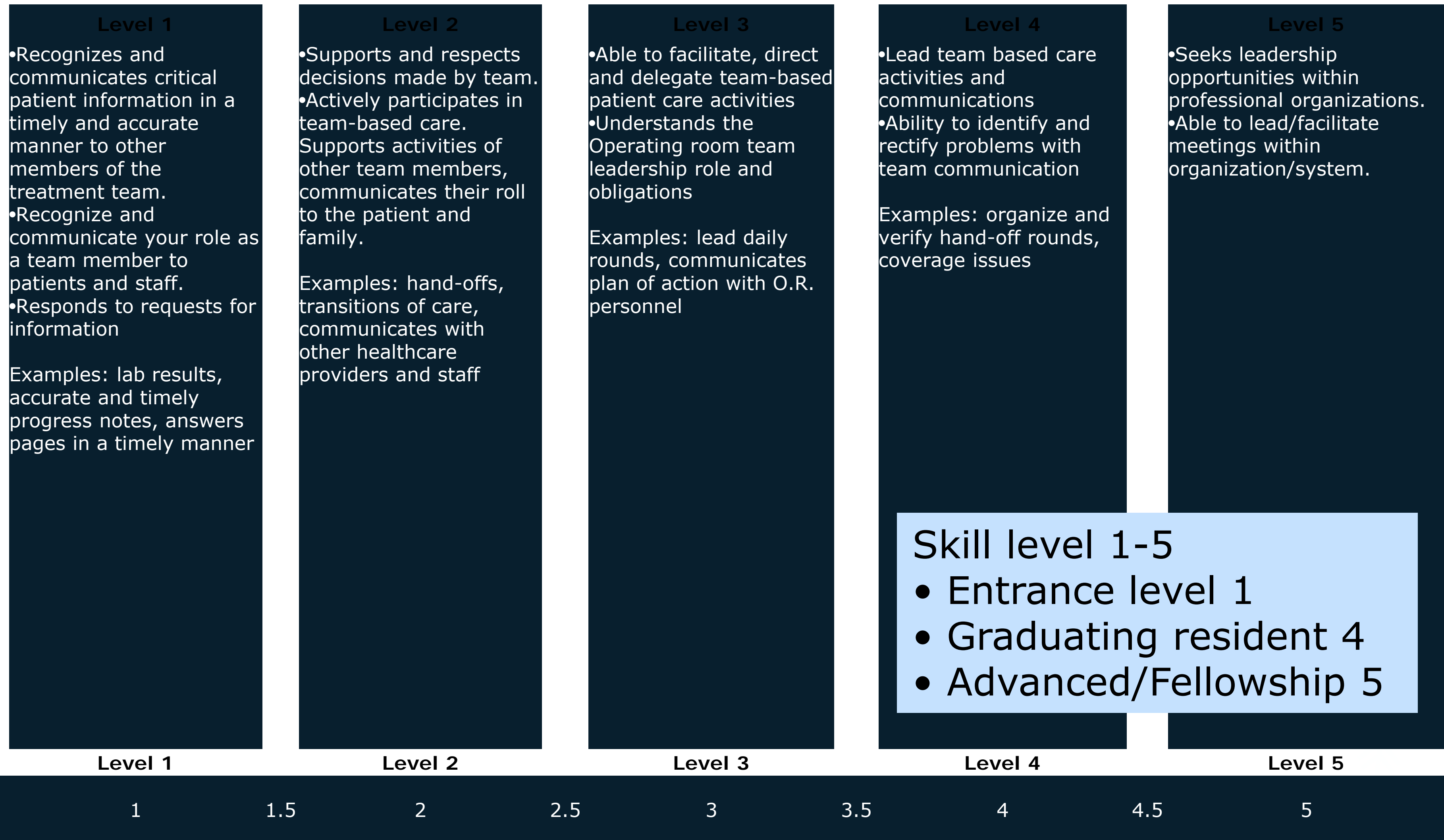
- Capable of surgical reduction and fixation of a full range of fractures and dislocations: comminuted or very distal articular fractures, dorsal and volar metaphyseal fractures, greater arc perilunate injuries, Scapholunate ligament injuries
- Capable of surgically treating complex complications: osteotomies, revision fixation

Level 1		Level 2		Level 3		Level 4		Level 5
1	1.5	2	2.5	3	3.5	4	4.5	5

Orthopaedic Surgery: remaining 4 competencies

- Professionalism:
  - 2 Milestones
- Practice-Based Learning and Improvement:
  - 2 Milestones
- Systems-Based Practice
  - 3 Milestones
- Interpersonal and Communications Skills
  - 2 Milestones: EXAMPLE: Teamwork

Interpersonal and Communication Skills: Teamwork



Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team

…ofessional…

Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients; and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

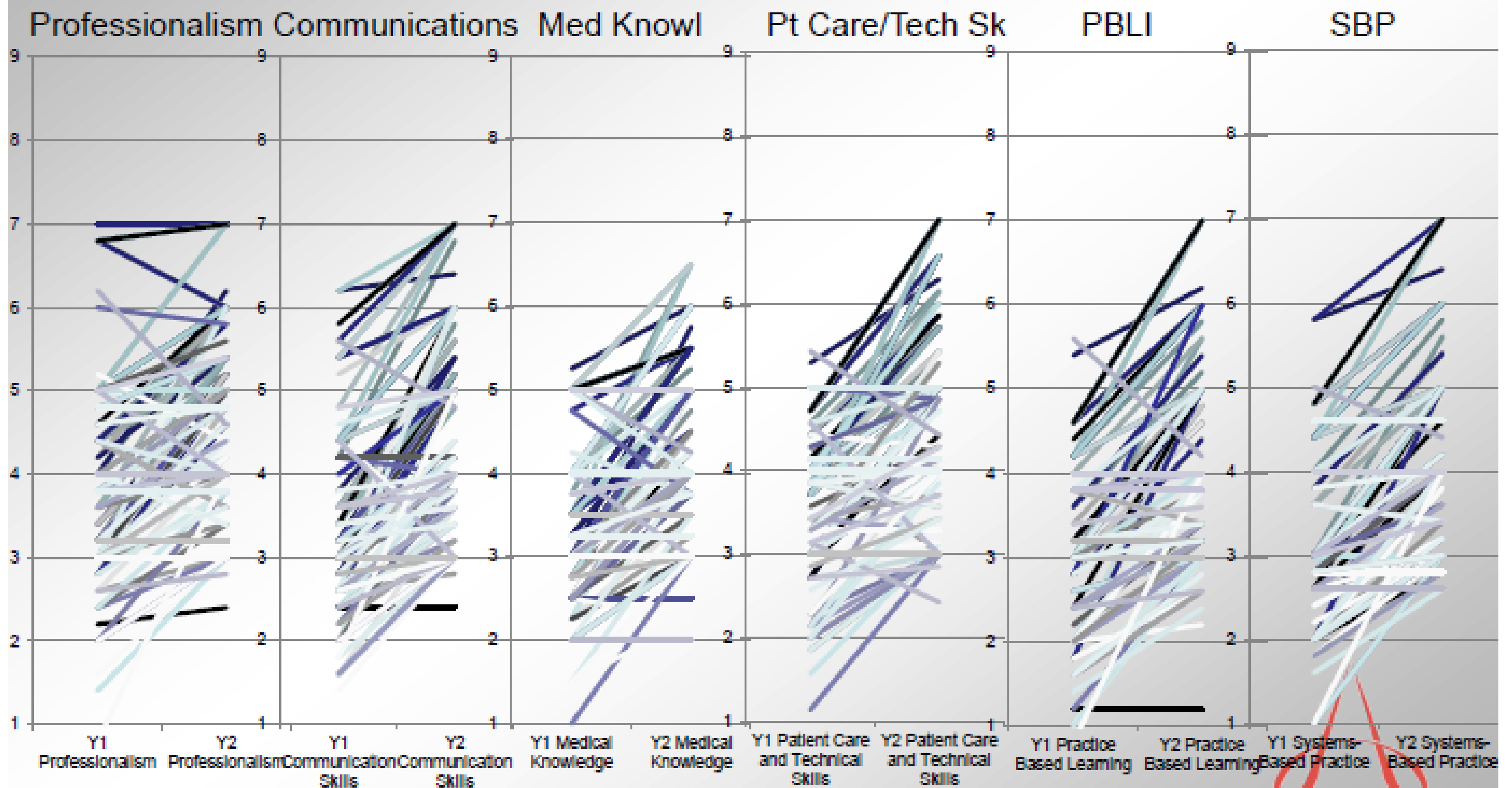
	…professional	Novice	Advanced Beginner	Competent	Profi…	Expert
a) Honesty, integrity, and ethical behavior						
b) Humanistic behaviors of respect, compassion, and empathy						
c) Responsibility and follow through on tasks						
d) Receiving and giving feedback						
e) Responsiveness to each patient's unique characteristics and needs						
f) Overall evaluation of Professionalism						

Resident demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in more complex clinical situations or settings. Occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.

From Louis Ling, MD presentation

August 14, 2012

Singapore Milestone Data, End of PGY 1 to Mid Year PGY 2
All Specialties (n=122, 100%)



ACGME

6b. Clinical Competency Committees

- Appointed by Program Director
- Composed of members of the residency faculty, who devote ≥15 hours/week
- Should have a written description of its responsibilities to the sponsoring institution and to the program director
- Actively reviews all resident evaluations by all evaluators
- Makes recommendations to the program director for resident progress, including promotion, remediation and dismissal

6b. Clinical Competency Committees

- May already be in place under a different name
- What should be reviewed:
  - Continue to look at current methods of evaluations: OSCE, simulation, 360-degree evaluations
  - Will current assessments give you milestones data?
  - Milestones, EPAs, narratives
- Issues:
  - Time constraints
  - Large residency programs
  - Small fellowship programs
- Teach the faculty the definitions
- Teach the faculty the tools
- FACULTY DEVELOPMENT IS KEY

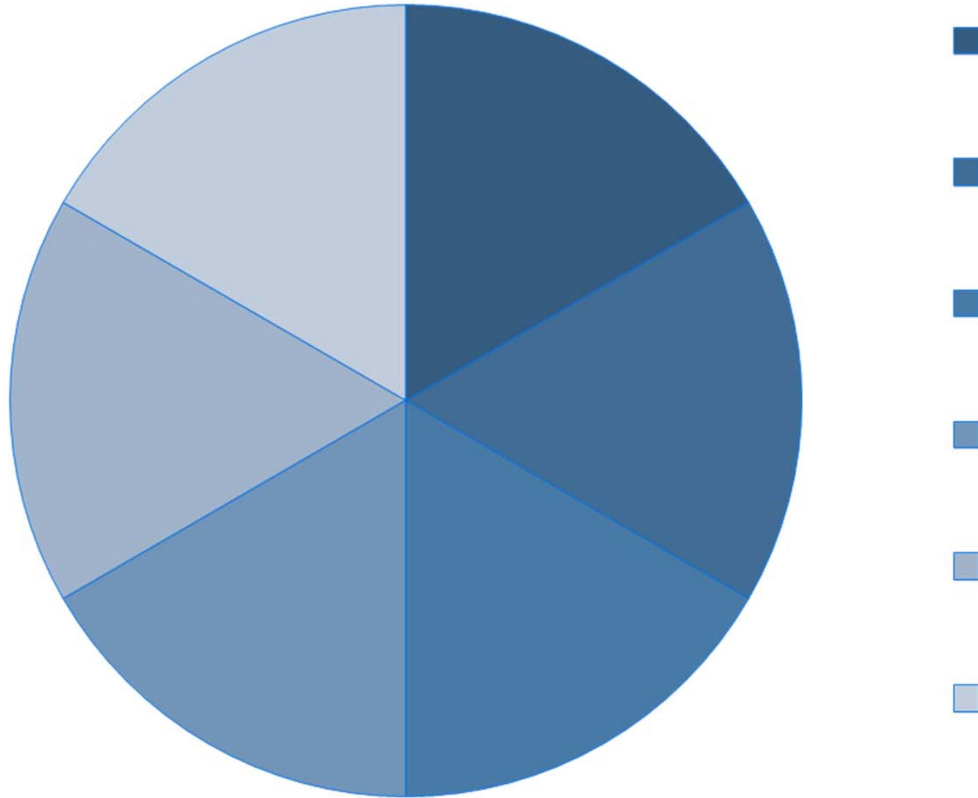
Milestones Summary

- Seek Milestones for your own specialty
- Look at your evaluation tools
  - Do the questions relate to appropriate measures?
  - Will you be able to assess milestone progress using current tools and questions?
  - Will you be able to report to ACGME using them?
- DON'T FORGET ABOUT FACULTY PREP

  just like when ACGME competencies arrived

- And what about CLER?

7. CLER assesses sponsoring institutions in six focus areas:



...by site visiting individual hospitals in your GME system

7. CLER visits…

- Will be hospital-based
- Must address these six areas
- Will be validated by site visits every 18 months
- Will not replace institutional review process

Although not punitive, alpha CLER visits have “cited”:

- Resident lack of awareness:
  - hospital reporting systems for quality, safety, professionalism concerns (before/during/after reporting)
  - How residents individually fit into system
- No standard hand-off processes in hospital and little inter-professional involvement
- Night supervision
- Lack of didactic education in professionalism

Future of CLER Visits

- They will include:
  - Chief Safety and Quality Officer(s)
  - Audience response system
  - Updated/new questions
- Up to 3 weeks' notice, will take 2-3 days
- SV teams could be 4-6 members for multiple hospital systems
- CLER evaluation committee will develop expectations for each of the 6 focus areas
- Evaluation/Quality Control component added
- Meet with 1-2 core faculty and 2 peer-selected residents from all core residency and all large fellowship programs in that hospital

Latest addition to “what’s new?”

- New Institutional Requirements: Comment period through 12/12/12!
- Not much will likely be edited from this version

- "When you're finished changing, you're finished." - Benjamin Franklin
- We are NOT finished!!!

NEW Institutional Requirements

NEW	EXAMPLE
People	SIE (Senior Institutional Executive who has authority to allocate $ for programs and GME Office)
GMEC rules	1 resident must attend each GMEC meeting
	QI/PS Officer = new GMEC member
	Annual Institutional Review
	Oversee each Annual Program Review
	Oversee Special Review Process (for programs warranting intervention)
Faculty	Professional Development
(included)	$ for supervision
	$ for quality resident/fellow education

NEW for CLER

- The Sponsoring Institution is responsible for oversight and documentation of
  within patient care and the learning and working environment.

1. PATIENT SAFETY: The Sponsoring Institution must ensure that residents/fellows

   a) errors, adverse events, unsafe conditions, and near misses that is free from reprisal; and,

   b) or other similar risk reduction teams.

2. QUALITY IMPROVEMENT: The Sponsoring Institution must ensure that residents/fellows:

   a) of care, reduce health care disparities, and improve patient outcomes; and,

   b)

   .

NEW for CLER

3. TRANSITIONS OF CARE: The Sponsoring Institution must:

   a) facilitate for faculty members and residents/fellows ; and,

   b) ensure that participating sites consistent with the setting and type of patient care.

4. SUPERVISION: The Sponsoring Institution must oversee:

   a) supervision of residents/fellows consistent with institutional and program-specific policies; and,

   b) mechanisms by which inadequate supervision in a protected manner that is .

NEW for CLER

5. DUTY HOURS, FATIGUE MANAGEMENT AND MITIGATION: The Sponsoring Institution must oversee:

   a) resident/fellow duty hours consistent with…requirements… addressing areas of non-compliance in a timely manner;

   b) systems of care and a learning and working environment that facilitate fatigue management and mitigation…,

   c) an educational program for…in fatigue management and mitigation.

6. PROFESSIONALISM: The Sponsoring Institution must provide systems to educate and monitor:

   a) residents'/fellows' and core faculty members' fulfillment of educational and

   ,

   b) …and,

   c)

New for Residents/Fellows

- Any resident/fellow from one of the Sponsoring Institution's ACGME-accredited programs must have the opportunity to

- Residents/fellows attending a meeting of the forum must have the option to meet

- The Sponsoring Institution and its ACGME-accredited must provide a learning and working environment in which residents/fellows have the opportunity to

  to the Sponsoring Institution and its respective ACGME-accredited programs

  .

Policies Affecting Residents

- Initial Appointment:

  Candidates for programs (i.e., applicants who are invited for an interview) must be informed, in writing or by electronic means, of the terms, conditions, and benefits…

- Renewal and Promotion:

  The Sponsoring Institution must have a policy for ACGME-accredited to determine the criteria for of a resident's/fellow's appointment.

- 1. The Sponsoring Institution must provide for residents/fellows and their dependents beginning on the to the Sponsoring Institution…

- 2. for residents/fellows must begin on the to the Sponsoring Institution.

Conditions of Employment

- Vacation and LOAs
- The policy must or other leaves of absence are by the resident/fellow and under which circumstances leaves of absence are
- This policy must ensure that ACGME-accredited its residents/fellows with accurate information regarding the upon the criteria for satisfactory , and upon a resident's/fellow's to participate in examinations by the relevant

Annual Program Review:

- The GMEC must demonstrate effective oversight of ACGME program accreditation **through an Annual Program Review (APR)**
- (1) Components …should include:
  - (a) the ACGME Common, specialty/subspecialty specific Program, and Institutional Requirements in effect at the time of the evaluation;
  - (b) the most recent accreditation letters of notification from previous ACGME reviews and progress reports sent to the respective Review Committees;
  - (c) the most recent APR report;
  - (d) reports from previous GMEC Special Reviews of the program;
  - (e) results from internal or external resident/fellow, faculty, and patient surveys; and,
  - (f) **annual performance data provided by the ACGME.**
- (2) **The APR protocol should outline the reporting structure and monitoring procedures after the APR is completed.**

NEW Annual Program Report

- A blend of an Annual Progress Report (APR) and the Annual Program Evaluation (APE)

- GME Central Office should:
  - Develop the template
  - Determine when and what programs submit
  - Specify the documentation (including action plans) that is required for the APR
  - Review your annual webADS data before you post it for ACGME review
  - Determine when a Special Review is warranted

Minimum Suggested APR elements

- webADS update elements
  - Board pass rates*, scholarly activity, caselogs, etc.
- Inservice exam scores/USMLE scores
- Recruitment/retention data
- Actions taken in response to ACGME Survey, Faculty Survey, Resident Satisfaction Survey *
- Faculty Development initiatives *
- Clinical Competency Committee reports on Milestones, in aggregate *
- Duty Hour Compliance Data
- CLER focus areas: program integration
- Program Letters of Agreement (PLAs) up to date
- More? Local metrics or criteria?

Special Review Process

- The GMEC must provide evidence of quality improvement efforts by maintaining a GMEC Special Review process for programs that warrant intervention beyond the APR.

What does this mean?

- ***GME(C) must assess each APR for quality***
- Conduct Special Review when warranted
- Extremely reminiscent of an Internal Review
- Will require documentation from program
- Will require evidence that oversight was provided to “programs warranting intervention”

Remember…

- NAS is built on the concept of helping programs improve their outcomes
- Identification of areas of weakness
  - in individual residents
  - in curricula
- The analysis of the collected assessments allows for clear focus on improvement opportunities

"If we don't change, we don't grow. If we don't grow, we are not really living."
- Gail Sheehy

- Some closing thoughts…

Suggested “to-do” list (not all-inclusive) FOR ALL OF US:

- Engage department (milestones) and hospital administration (CLER)
- Define and select core faculty
- Optimize annual update and board scores
- Learn as much as you can about milestones
- Create clinical competency committees
- Faculty development re: milestones
- Integrate GME and quality/safety
- Develop a self-study and strategic plan

Advice for TPAs…

- Maintain your APR as a living breathing ongoing document.
- With your PD, identify your Clinical Competency Committee and initiate a meeting schedule.
- With your PD, review your current evaluation forms for possible revision to align with milestones.
- Prepare to host the CLER visits 3 weeks from…???
  - Have a plan in place with contact numbers for all major players so that the PD can get ready to convene the group.
  - Documents to have updated for CLER: GME organizational chart, Institutional supervision and Duty Hours policies, System-wide Patient Safety protocol and Quality Strategy, DIO's most recent annual report, list of residents on committees (PS/QI)
- The most important thing is to complete the APR *ON TIME* so that GME(C) can identify program and system-wide issues.
- Keep learning as much as you can as NAS evolves.
- ONLY with advance preparation can you be ready for your role in NAS.

"If we can recognize that change and uncertainty are basic principles, we can greet the future and the transformation we are undergoing with the understanding that we do not know enough to be pessimistic."
- Hazel Henderson