Internal Medicine – Emergency Medicine -Critical Care Medicine (Combined) programs must annually report on each set of milestones.

The Internal Medicine Milestone Project

A Jaint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Internal Medicine



The Emergency Medicine Milestone Project

A Jaint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Emergency Medicine



July 2015

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The Internal Medicine Subspecialty **Milestones** Project

A Jaint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Internal Medicine





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A Joint Initiative of

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The Internal Medicine Milestone Project

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

Internal Medicine Milestone Group

Chair: William lobst, MD Eva Aagaard, MD Hasan Bazari, MD Timothy Brigham, MDiv, PhD Roger W. Bush, MD Kelly Caverzagie, MD Davoren Chick, MD Michael Green, MD Kevin Hinchey, MD Eric Holmboe, MD Sarah Hood, MS Gregory Kane, MD Lynne Kirk, MD Lauren Meade, MD Cynthia Smith, MD Susan Swing, PhD

Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies that describe the development of competence from an early learner up to and beyond that expected for unsupervised practice. In the initial years of implementation, the Review Committee will examine milestone performance data for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

The internal medicine milestones are arranged in columns of progressive stages of competence that do not correspond with post-graduate year of education. For each reporting period, programs will need to review the milestones and identify those milestones that best describe a resident's current performance and ultimately select a box that best represents the summary performance for that sub-competency (See the figure on page v.). Selecting a response box in the middle of a column implies that the resident has substantially demonstrated those milestones, as well as those in previous columns. Selecting a response box on a line in between columns indicates that milestones in the lower columns have been substantially demonstrated, as well as some milestones in the higher column.

A general interpretation of each column for internal medicine is as follows:

Critical Deficiencies: These learner behaviors are not within the spectrum of developing competence. Instead they indicate significant deficiencies in a resident's performance.

Column 2: Describes behaviors of an early learner.

Column 3: Describes behaviors of a resident who is advancing and demonstrating improvement in performance related to milestones.

Ready for Unsupervised Practice: Describes behaviors of a resident who substantially demonstrates the milestones identified for a physician who is ready for unsupervised practice. This column is designed as the graduation target, but the resident may display these milestones at any point during residency.

Aspirational: Describes behaviors of a resident who has advanced beyond those milestones that describe unsupervised practice. These milestones reflect the competence of an expert or role model and can be used by programs to facilitate further professional growth. It is expected that only a few exceptional residents will demonstrate these milestones behaviors.

For each ACGME competency domain, programs will also be asked to provide a summative evaluation of each resident's learning trajectory.

Additional Notes

The "Ready for Unsupervised Practice" milestones are designed as the graduation *target* but *do not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the residency program director (See the Milestones FAQ for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?"). Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether the "Ready for Unsupervised Practice" milestones and all other milestones are in the appropriate stage within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Answers to Frequently Asked Questions about Milestones are available on the Milestones web page: <u>http://www.acgme.org/acgmeweb/Portals/0/MilestonesFAQ.pdf</u>.

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

• selecting the column of milestones that best describes that resident's performance

<u>or</u>

• selecting the "Critical Deficiencies" response box

11. Transitions patien	ts effectively within and across	health delivery systems. (SE	BP4)	
Critical Deficiencies			Ready for unsupervised practice	Aspirational
Disregards need for communication at time of transition	Inconsistently utilizes available resources to coordinate and ensure safe and effective patient care	Recognizes the importance communication during time of transition		Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency and ensure
Does not respond to requests of caregivers in other	within and across delivery systems	Communication with future caregivers is present but wi lapses in pertinent or time!	e delivery systems ith	high quality patient outcomes Anticipates needs of patient,
delivery systems	Written and verbal care plans during times of transition are incomplete or absent Inefficient transitions of care lead to unnecessary expense or risk to a patient (e.g. duplication of tests readmission)	information	, past and future care givers to ensure continuity of care	caregivers and future care providers and takes appropriate steps to address those needs Role models and teaches effective transitions of care
Comments:				
column implies	onse box in the middle of a milestones in that column previous columns have be monstrated.	as co en be	electing a response box on the lin olumns indicates that milestones een substantially demonstrated a ilestones in the higher columns(s	in lower levels have s well as some

INTERNAL MEDICINE MILESTONES

ACGME Report Worksheet

Critical Deficiencies											Ready	for unsu	pervised pra	ctice		Aspi	rational	
Does not collect accurate historical data	a ii	nconsistent cquire accunformation ashion	urate histo	orical	and		•	•	es accura ies from	ate	from priorit	oatients i	ate historie n an efficie I hypothesi	nt,	subtle inform	eties, inc	int histor luding se nat inforr agnosis	nsitive
Does not use					See	ks an	d obt	tains d	lata fron	n								
physical exam to confirm history	a	Does not pe oppropriate ohysical exa	ly thorou	-	seco nee	ondar		urces			exams		rate physica targeted to laints				le or unu findings	isual
Relies exclusively on documentation of others to generate own database or		ohysical exa Does not se eliant on se	ek or is ov	verly	ассі	urate	and	•••	ms priately exams		priorit		ta to gener erential dia		of sec	•	zes all so lata to ir agnosis	
differential diagnosis	1	chunt on st	condury	uutu	Use	s coll	ected	d data	to defin	e		obieini	51		Role r	nodels a	nd teach	es the
		nconsistent	tlv recogn	izes					linical	C	Effecti	velv use:	s history an	d			of history	
Fails to recognize patient's central clinical problems	p Ii	oatients' ce problem or imited diffe liagnoses	ntral clinio develops			olem					physic minim	al exami	nation skills eed for furt	to	physio minim	cal exam	ination s need for	kills to
Fails to recognize potentially life threatening problems																		
	Ц			l r			Γ							Г				
L Comments:																		

Critical Deficiencies									Read	/ for unsu	pervised p	ractice		Aspir	ational	
Care plans are consistently inappropriate or	Inconsistently of appropriate ca	•			stently priate o		•		based	on patie	nodifies ca nt's clinica , and patie	l course,		nodels ar ex and p		
inaccurate	Inconsistently sadditional guid		ı	-	gnizes si ring urg			rgent	prefer	ences	-		Devel	ops custo	omized,	
Does not react to situations that	needed			care					•	nizes dise tations t	ease hat deviat	e from	most	ized care complex	patient	5,
require urgent or emergent care				and/c	additio or consu opriate	-	-	ce		•	rns and re on- making	•	uncer	orating o tainty an iveness p	d cost	
Does not seek additional guidance when needed									-	es comp c disease	lex acute s	and				

Critical Deficiencies			Ready for unsupervised practice	Aspirational
Cannot advance	Requires direct supervision	Requires indirect supervision	Independently manages patients	Manages unusual, rare, or
beyond the need for	to ensure patient safety	to ensure patient safety and	across inpatient and ambulatory	complex disorders
direct supervision in	and quality care	quality care	clinical settings who have a	
the delivery of			broad spectrum of clinical	
patient care	Inconsistently manages	Provides appropriate	disorders including	
	simple ambulatory	preventive care and chronic	undifferentiated syndromes	
Cannot manage	complaints or common	disease management in the		
patients who	chronic diseases	ambulatory setting	Seeks additional guidance	
require urgent or			and/or consultation as	
emergent care	Inconsistently provides	Provides comprehensive care	appropriate	
	preventive care in the	for single or multiple		
Does not assume	ambulatory setting	diagnoses in the inpatient	Appropriately manages	
responsibility for		setting	situations requiring urgent or	
patient	Inconsistently manages		emergent care	
management	patients with	Under supervision, provides		
decisions	straightforward diagnoses	appropriate care in the	Effectively supervises the	
	in the inpatient setting	intensive care unit	management decisions of the team	
	Unable to manage complex	Initiates management plans		
	inpatients or patients	for urgent or emergent care		
	requiring intensive care			
		Cannot independently		
		supervise care provided by		
		junior members of the		
		physician-led team		
Comments:				

Critical Deficiencies							Ready	for unsu	pervised pra	actice		Aspirat	tional	
Attempts to perform procedures without sufficient technical skill or	tecl con	sesses ins hnical skil hpletion c cedures	l for safe	for th	e comp	sic techr letion of cedures	succes	sfully per lures requ	ical skill ar formed all uired for		and s	nizes patie afety wher dures		
supervision Unwilling to perform procedures when qualified and necessary for patient care											perfo (beyc certif antici Teach	to indepe rm additio nd those r ication) tha pated for f	nal proce equired fo at are uture pra pervises th	or Ictice he
								[_			rmance of [•] members		

Critical Deficiencies			Ready for unsupervised practice	Aspirational
ls unresponsive to questions or concerns of others when acting as a	Inconsistently manages patients as a consultant to other physicians/health care teams	Provides consultation services for patients with clinical problems requiring basic risk assessment	Provides consultation services for patients with basic and complex clinical problems requiring detailed risk	Switches between the role of consultant and primary physician with ease
consultant or utilizing consultant services	Inconsistently applies risk assessment principles to patients while acting as a	Asks meaningful clinical questions that guide the input of consultants	Appropriately weighs recommendations from	Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment
Unwilling to utilize consultant services when appropriate for patient care	consultant Inconsistently formulates a clinical question for a consultant to address		consultants in order to effectively manage patient care	Manages discordant recommendations from multiple consultants

Patient Care

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

Yes _____ No _____ Conditional on Improvement

Critical Deficiencies										Read	y for unsupe	ervised pra	actice		Aspira	tional	
Lacks the scientific, socioeconomic or behavioral knowledge required to provide patient care	sc ar re co co	ossesses in ientific, so id behavio quired to p immon me inditions a eventive c	cioeconc ral know provide c dical nd basic	omic ledge are foi	socio knov prov medi	esses the econom rledge re de care cal cond entive ca	nic a equi for ditio	ind beh ired to commo	avioral on	socioe knowle care fo condit	sses the scie conomic ar edge requir or complex ions and co ntive care	nd behavi red to pro medical	ovide	socio know succe treat	esses the s economic ledge requ ssfully dia medically guous and tions	and beha uired to gnose and uncomm	d on,

knowledge to apply diagnostic testing and procedures to patient carebasic diagnostic tests accuratelydiagnostic tests accuratelytests accuratelypitfalls and biases when interpreting diagnostic tests and procedures to understand the pre-test probability and testpitfalls and biases when interpreting diagnostic testsknowledge to apply diagnostic testing and procedures to patient carebasic diagnostic tests accuratelytests accuratelypitfalls and biases when interpreting diagnostic tests and proceduresDoes not understand the concepts of pre-testnuderstand the concepts of pre-test probability and testpre-test probability and testPursues knowledge of new	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	knowledge to apply diagnostic testing and procedures to	basic diagnostic tests accurately Does not understand the concepts of pre-test probability and test performance characteristics Minimally understands the rationale and risks associated with common	diagnostic tests accurately Needs assistance to understand the concepts of pre-test probability and test performance characteristics Fully understands the rationale and risks associated	tests accurately Understands the concepts of pre-test probability and test performance characteristics Teaches the rationale and risks associated with common procedures and anticipates potential complications when	interpreting diagnostic tests and procedures Pursues knowledge of new and emerging diagnostic test

Medical Knowledge

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

_____Yes _____No _____ Conditional on Improvement

Critical Deficiencies											Rea	dy for un	uper	vised pra	ctice		As	piratio	nal	
Refuses to recognize the contributions of other interprofessional team members	tea not util	ntifies ro m meml recogni ize them quently	pers but ze how, n as reso	does /when ources		respo meml ineffe	nsibiliti	es o t use	roles a of all tea es them eam	ım	resp effe men	erstands onsibiliti ctively pa nbers of t vely enga	es of Irtne the t	and rs with, eam		tean such maxi	rates a into tl that ea mize th of the	ne care ach is a neir ski	of pat ble to lls in th	tient
Frustrates team members with inefficiency and errors	ren cor res	ninders f nplete p ponsibili nily, ente	rom tea hysiciar ties (e.g	am to 1 g. talk t	0	discus does i	sions w not acti	vher ively	n requir v seek ir memb	nput	mee	tings and sion-mak	coll		e	activ men View men	ently c ities of bers to ed by o bers as ery of l	other optim other to s a lead	team lize car eam ler in t	the
																		Г		

Critical DeficienciesConstructionReady for unsupervised practiceAspirationalIgnores a risk for error within the system that may impact the care of a patientDoes not recognize the potential for system errorRecognizes the potential for error within the systemIdentifies systemic causes of medical error and navigates them to provide safe patient careAdvocates for system leadership to formally engage in quality assurance and quality improvement activitiesIgnores feedback and is unwilling to change behavior in order to reduce the risk for errorNakes decisions that could lead to error which are otherwise cause harmIdentifies obvious or critical causes of error and notifies supervisor accordinglyIdentifies obvious or critical causes of error and notifies systemsAdvocates for safe patient careViewed as a leader in identifying and advocating for the prevention of medical errorIgnores feedback and is unwilling to change behavior in order to reduce the risk for errorResistant to feedback about decisions that may lead to error or otherwise cause harmRecognizes the potential risk system and takes necessary steps to mitigate that riskAdvocates for system resources to investigate and mitigate real or potential medical errorTeaches others regarding the importance of recognizing and mitigating system errorWilling to receive feedback about decisions that may lead to error or otherwise cause harmWilling to receive feedback about decisions that may lead to error or otherwise cause harmReflects upon and learns from own critical incidents that may lead to medical errorMakes decisions tha	9. Recognizes system	n error	and ac	dvocates	s for sys	stem in	nprove	eme	nt. (SE	8P2)										
error within the system that may impact the care of a patient Ignores feedback and is unwilling to change behavior in order to reduce the risk for error Within the system error Wakes decisions that could lead to error which are otherwise corrected by the system or supervision Resistant to feedback about for error or otherwise cause harm Willing to receive feedback about decisions that may lead to error or otherwise cause harm Willing to receive feedback about decisions that may lead to error or otherwise cause harm Willing to receive feedback about decisions that may lead to error or otherwise cause harm Potential for system error Provide safe patient care and optimal patient care systems Viewed as a leader in identifying and advocating for systems Viewed as a leader in identifying and advocating for the prevention of medical error Teaches others regarding the importance of recognizing and medical error Reflects upon and learns from own critical incidents that may	Critical Deficiencies										Ready	/ for unsu	uper	vised pra	actice		Aspi	iration	al	
Ignores feedback and is unwilling to change behavior in order to reduce the risk for errorotherwise corrected by the system or supervisionsupervisor accordinglyAdvocates for safe patient care and optimal patient care systemsViewed as a leader in identifying and advocating for the prevention of medical errorrisk for errorResistant to feedback about decisions that may lead to error or otherwise cause harmFeecognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that riskActivates formal system resources to investigate and mitigate real or potential medical errorTeaches others regarding the importance of recognizing and mitigating system error	error within the system that may impact the care of a	pote Mak	ential for es decis	system	error could	error Identi	within t fies obv	the s	system s or crit	tical	medica them t	al error a	and	navigate	es	leade in qua	rship to ality assu	forma urance	ally er e and	
risk for error risk for error harm error or otherwise cause harm barm harm harm steps to mitigate that risk willing to receive feedback about decisions that may lead to error or otherwise cause harm harm barm to error or otherwise cause harm barm barm to error or otherwise cause harm barm to error or otherwise cause harm to error to error or otherwise cause to error or otherwise cause to error to error	Ignores feedback and is unwilling to change behavior in	othe syste Resis	erwise co em or su stant to	orrected ipervision feedbacl	by the n k about	super Recog for er	visor ac gnizes th ror in th	ccoro he p he in	dingly otentia nmedia	l risk ite	and op system	timal pa Is	itier	nt care	care	ident the p	ifying an	d adv	ocatiı	-
harm own critical incidents that may	risk for error	erro	r or oth	•		steps Willin about	to mitig ng to rea t decisio	gate ceive ons t	that ris e feedb that ma	sk ack ay lead	resour mitigat medica	ces to in ce real or al error	r po	tigate ar tential		impo	rtance o	f reco	gnizir	-
											own cr	itical inc	cider	nts that						
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effort to overcome barriers to cost- effective carecare and the role that external stakeholders (e.g. providers, suppliers, financers, purchasers) haveMinimizes unnecessary diagnostic and therapeutic testsutilization of resources (i.e. emergency department visits, hospital readmissions)utilization of resourcesActively participates in initiatives and care delivery	Critical Deficiencies			Ready for unsupervised practice	Aspirational
careeconomic, cultural, literacy, insurance status) thatutilization of health care and may act as barriers to cost- effective careeffective careeffective carerecognize and address common barriers to cost- effective care and appropriat utilization of resources (i.e. emergency department visits, hospital readmissions)recognize and address effective care and appropriat utilization of resources (i.e. emergency department visits, hospital readmissions)recognize and address effective care and appropriat utilization of resources (i.e. emergency department visits, hospital readmissions)Demonstrates no effort to overcome barriers to cost- effective careMinimizes unnecessary diagnostic and therapeutic testsAdvocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)effective care and appropriat utilization of resourcesDoes not consider limited health care resources when ordering diagnostic orPossesses an incomplete understanding of cost- awareness principles for a population of patients (e.g.Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening testseffective high quality care	Ignores cost issues	Lacks awareness of external	Recognizes that external	Consistently works to address	
Demonstrates no effort to overcome barriers to cost- effective careinsurance status) that impact the cost of health care and the role that external stakeholders (e.g. providers, suppliers, financers, purchasers) have on the cost of caremay act as barriers to cost- effective careAdvocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)common barriers to cost- effective care and appropriati utilization of resources (i.e. emergency department visits, hospital readmissions)Actively participates in initiatives and care delivery models designed to overcom or mitigate barriers to cost- effective careDoes not consider limited health care resources when ordering diagnostic orPossesses an incomplete understanding of cost- awareness principles for a population of patients (e.g.Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening testseffective care and appropriati utilization of resources (i.e. emergency department visits, hospital readmissions)Actively participates in initiatives and care delivery models designed to overcom or mitigate barriers to cost- effective high quality care	in the provision of	factors (e.g. socio-	-	patient specific barriers to cost-	healthcare team members to
Demonstrates no effort to overcome barriers to cost- effective careimpact the cost of health care and the role that external stakeholders (e.g. providers, suppliers, financers, purchasers) have on the cost of careeffective careAdvocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)effective care and appropriati utilization of resources (i.e. emergency department visits, hospital readmissions)effective care and appropriati utilization of resourcesDemonstrates no effective careMinimizes unnecessary diagnostic and therapeutic testsAdvocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions)effective care and appropriati utilization of resourcesDoes not consider limited health care resources when ordering diagnostic orPossesses an incomplete understanding of cost- awareness principles for a population of patients (e.g.Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening testseffective high quality care	care	economic, cultural, literacy,	utilization of health care and	effective care	recognize and address
effort to overcome barriers to cost- effective care		<i>insurance status)</i> that	may act as barriers to cost-		common barriers to cost-
barriers to cost- effective care external stakeholders (e.g. providers, suppliers, financers, purchasers) have on the cost of care Possesses an incomplete Does not consider limited health care resources when ordering diagnostic or poulation of patients (e.g.	Demonstrates no	impact the cost of health	effective care	Advocates for cost-conscious	effective care and appropriate
effective careproviders, suppliers, financers, purchasers) have on the cost of carediagnostic and therapeutic testshospital readmissions)Actively participates in initiatives and care delivery models designed to overcom or mitigate barriers to cost- effective high quality careDoes not consider limited health care resources when ordering diagnostic orPossesses an incomplete understanding of cost- awareness principles for a population of patients (e.g.hospital readmissions)Actively participates in initiatives and care delivery models designed to overcom or mitigate barriers to cost- effective high quality care	effort to overcome	care and the role that		utilization of resources (i.e.	utilization of resources
financers, purchasers) have on the cost of caretestsIncorporates cost-awareness principles into standard clinical judgments and decision-making, awareness principles for a ordering diagnostic orinitiatives and care delivery models designed to overcom or mitigate barriers to cost- effective high quality care	barriers to cost-	external stakeholders (e.g.	Minimizes unnecessary	emergency department visits,	
financers, purchasers) have on the cost of caretestsinitiatives and care delivery models designed to overcom principles into standard clinical judgments and decision-making, including screening testsinitiatives and care delivery models designed to overcom or mitigate barriers to cost- effective high quality care	effective care	providers, suppliers,	diagnostic and therapeutic	hospital readmissions)	Actively participates in
Image: Section of the cost of careImage: Section of the cost of t		financers, purchasers) have	tests		
Possesses an incomplete Does not consider limited health care resources when ordering diagnostic orPossesses an incomplete understanding of cost- awareness principles for a population of patients (e.g.principles into standard clinical judgments and decision-making, including screening testsor mitigate barriers to cost- effective high quality care		on the cost of care		Incorporates cost-awareness	models designed to overcome
Does not consider limited health care resources when ordering diagnostic orunderstanding of cost- awareness principles for a population of patients (e.g.judgments and decision-making, including screening testseffective high quality care			Possesses an incomplete		or mitigate barriers to cost-
health care resources when ordering diagnostic orawareness principles for a population of patients (e.g.including screening tests		Does not consider limited	•		effective high quality care
ordering diagnostic or population of patients (e.g.		health care resources when	C		
Comments:					

Critical Deficiencies										Read	y for unsu	uper	vised pra	octice		As	piratio	nal	
Disregards need for		onsistently			-	nizes tl		-			oriately u					dinates			
communication at time of transition	соо	lable resc rdinate ar effective	nd ensure	e safe		nunicati nsition	on d	uring ti	mes	and er	ces to co sures sa t care wi	fe a	nd effec	tive	to o	ss healt otimize ase eff	patien	t safe	ety,
Does not respond to requests of		nin and ac ems	ross deli	very	careg	nunicat ivers is	pres	ent but	with		y system					quality			
caregivers in other					-	s in per	tinen	t or tin	nely		ively con					cipates		•	
delivery systems		tten and v		re	inforr	nation				-	nd future		-	to		givers a			are
		is during t		lata						ensure	continu	iity (of care			iders ai			drace
		sition are bsent	incomp	lete												opriate e needs	•	to ad	aress
		DSEIIL													tilos	eneeus)		
	Inef	ficient tra	nsitions	of											Role	model	s and to	eache	sς
		e lead to u														tive tra			
		ense or ris																	
		. duplicati	•																
	read	dmission)																	
			7		7									[Γ		
Comments:						1												_	

Systems-based Practice

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

Yes No Conditional on Improvement

12. Monitors practic	e with a goal for improveme	ent. (PBLI1)		
Critical Deficiencies			Ready for unsupervised practice	Aspirational
Unwilling to self- reflect upon one's practice or performance	Unable to self-reflect upon one's practice or performance Misses opportunities for	Inconsistently self-reflects upon one's practice or performance and inconsistently acts upon those reflections	Regularly self-reflects upon one's practice or performance and consistently acts upon those reflections to improve practice	Regularly self-reflects and seeks external validation regarding this reflection to maximize practice improvement
Not concerned with opportunities for learning and self- improvement	learning and self- improvement	Inconsistently acts upon opportunities for learning and self-improvement	Recognizes sub-optimal practice or performance as an opportunity for learning and self-improvement	Actively engages in self- improvement efforts and reflects upon the experience
Comments:				

Critical Deficiencies			Ready for unsupervised practice	Aspirational
Disregards own clinical performance data	Limited awareness of or desire to analyze own clinical performance data	Analyzes own clinical performance data and identifies opportunities for improvement	Analyzes own clinical performance data and actively works to improve performance	Actively monitors clinical performance through various data sources
Demonstrates no inclination to participate in or even consider the results of quality improvement efforts	Nominally participates in a quality improvement projects Not familiar with the principles, techniques or importance of quality improvement	Effectively participates in a quality improvement project Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients	Actively engages in quality improvement initiatives Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients	Is able to lead a quality improvement project Utilizes common principles and techniques of quality improvement to continuously improve care for a panel of patients
Comments:				

Critical Deficiencies										Read	ly for unsu	per	vised pra	ctice			Aspirat	iona	l
Never solicits feedback		ely seeks ponds to				ts feedb visors	ack	only fr	om	mem	s feedbac pers of the profession	e		1	re	eflec	rmance con ets incorpor ted and uns	atio	n of
Actively resists feedback from	fee	dback in a nion			ls op feed	en to un back	soli	cited		patie	nts						back		
others	icially based	Incor feed	isistentl back	y in	corpora	ates		omes unsc stently inc ack			IDACK			to reconcile cting feedk		parate o			
Comments:																			

Critical Deficiencies									Ready	/ for unsupe	rvised pra	ctice		Aspirati	onal	
Fails to acknowledge	Π	Rarely "slows	down" t	0	Incon	sistentl	y "slo	ows down"	Routin	ely "slows	down" to		Searc	nes medica	l informa	tion
uncertainty and		reconsider an	approad	h to	to red	onsider	an a	approach to a	recons	ider an app	proach to a	a	resou	rces efficie	ntly, guid	ed
reverts to a reflexive		a problem, asl	k for hel	o, or	probl	em, ask	for h	nelp, or seek	proble	m, ask for	help, or se	ek	by the	characteri	stics of	
patterned response even when		seek new info	rmation		new i	nformat	tion		new in	formation			clinica	l questions		
inaccurate		Can translate	medical		Can t	ranslate	med	dical	Routin	ely translat	es new		Role r	nodels how	to appra	ise
		information ne	eeds int	C	inform	nation r	need	s into well-	medica	al informat	ion needs	into	clinica	l research	reports b	ased
Fails to seek or		well-formed c	linical		forme	ed clinic	al qu	lestions	well-fo	rmed clinio	al questic	ns	on acc	cepted crite	eria	
apply evidence		questions with	n assista	nce	indep	endent	ly									
when necessary									Utilizes	s informati	on techno	logy	Has a	systematic	approacl	۱to
		Unfamiliar wit	th streng	ths	Awar	e of the	stre	ngths and	with so	ophisticatic	n		track	and pursue	emergin	g
		and weakness	es of the	ć	weak	nesses o	of me	edical					clinica	l questions		
		medical literat	ture		-	nation r es inforr		irces but on		ndently ap ch reports	•	nical				
		Has limited aw	varenes	ofo	• techn	ology w	/itho	ut		ed criteria						
		ability to use i	nformat	ion	sophi	sticatio	n		-							
		technology														
					With	assistar	nce, a	appraises								
		Accepts the fir	ndings o	f	clinic	al resea	rch r	eports,								
		clinical researc	ch studi	es	based	d on acc	epte	d criteria								
		without critica	al apprai	sal		-										
												Γ				

Practice-Based Learning and Improvement

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

Yes _____ No _____ Conditional on Improvement

Version 7/2014 16. Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g., p

compassion for patients and caregiversdemonstrates empathy, compassion and respect for patients and caregiversinteractions with patients, caregivers and members of the interprofessional team, even in challenging situationscompassion and respect to patients and caregivers in all situationscompassion and respect to patients and caregivers in all situationsDisrespectful in interactions with patients, caregiversInconsistently demonstratesInconsistently demonstratesIs available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to Inconsistently considersIs available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective careCompassion and respect to patients, and caregivers in all situationsRed and caregivers in all situations	ole models compassion, mpathy and respect for atients and caregivers ole models appropriate nticipation and advocacy fo atient and caregiver needs osters collegiality that
patients and caregivers compassion and respect for patients and caregivers caregivers and members of patients and caregivers caregivers and members of patients and caregivers caregivers and members of interactions with patients, caregivers and members of the interprofessional team interprofessional team team caregivers and respect for patients and caregivers and proactively works to meet the patients, caregivers and appropriate fashion caregivers and team caregivers and respect for patients, caregivers and patients, caregivers and members of the interprofessional team to patient sand caregivers and members of the interprofessional team to patient sand caregivers and members of the interprofessional team to patient sand caregivers and patient sand caregivers and members of the interprofessional team to patient sand caregivers and patient sand caregivers and members of the interprofessional team to patient sand caregivers and patient sand caregivers and patient sand caregivers and members of the interprofessional team to patient sand caregivers and patient sand caregivers and supersedes self-interest and sand sand sand sand sand sand sand	atients and caregivers ole models appropriate nticipation and advocacy fo atient and caregiver needs
caregiverspatients and caregiversthe interprofessional team, even in challenging situationssituationsReDisrespectful in interactions with patients, caregivers and members of the interprofessional teamInconsistently demonstrates responsiveness to patients' and caregivers' needs in an appropriate fashionIs available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective caresituationsRe Anticipates, advocates for, and proactively works to meet the needs of patients and caregiversand caregivers	ole models appropriate nticipation and advocacy fo atient and caregiver needs
Disrespectful in interactions with patients, caregivers and members of the interprofessional team linconsistently considers linconsistent linconsistent linconsistent linconsistent linconsistent linconsistent linconsistent linconsistent linconsistent li	nticipation and advocacy for atient and caregiver needs
Disrespectful in interactions with patients, caregivers and members of the interprofessional team linconsistently considers linconsistent linconsistent linconsistent linconsistent linconsistent lincon	nticipation and advocacy for atient and caregiver needs
interactions with patients, caregivers and members of the interprofessional team l consistently considers l savailable and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to Inconsistently considers l savailable and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective care supersedes self-interest l and caregivers and supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and to patient needs that supersedes self-interest l and caregivers and supersed self and caregivers and supersed self and caregivers and self and caregivers and self and caregivers and self and caregivers	atient and caregiver needs
patients, caregivers and members of the interprofessional team Inconsistently considers Inconsistent Inconsi	C C
and members of the interprofessional team Inconsistently considers Inconsistent	sters collegiality that
interprofessional team appropriate fashion members of the interprofessional team to Inconsistently considers ensure safe and effective care supersedes self-interest interest	sters collegiality that
team interprofessional team to Inconsistently considers ensure safe and effective care supersedes self-interest	sters concentry that
Inconsistently considers ensure safe and effective care supersedes self-interest	romotes a high-functioning
	terprofessional team
Sacrifices patient patient privacy and Te	
	eaches others regarding
	aintaining patient privacy
	nd respecting patient
	utonomy
Blatantly disregards incorporates that input into plan	
respect for patient of care as appropriate	
privacy and	
autonomy	

17. Accepts respons	ib	ility and follows through o	n tasks. (PROF2)		
Critical Deficiencies				Ready for unsupervised practice	Aspirational
Is consistently	T	Completes most assigned	Completes administrative and	Prioritizes multiple competing	Role models prioritizing
unreliable in		tasks in a timely manner	patient care tasks in a timely	demands in order to complete	multiple competing demands
completing patient		but may need multiple	manner in accordance with	tasks and responsibilities in a	in order to complete tasks and
care responsibilities		reminders or other support	local practice and/or policy	timely and effective manner	responsibilities in a timely and
or assigned					effective manner
administrative tasks		Accepts professional	Completes assigned	Willingness to assume	
		responsibility only when	professional responsibilities	professional responsibility	Assists others to improve their
Shuns		assigned or mandatory	without questioning or the	regardless of the situation	ability to prioritize multiple,
responsibilities			need for reminders		competing tasks
expected of a					
physician					
professional					
	<u> </u>				
Comments:					

Critical Deficiencies										Ready	for unsu	pervised	oractice		Aspir	ational	
Is insensitive to differences related to culture, ethnicity, gender, race, age, and religion in the patient/caregiver encounter Is unwilling to modify care plan to account for a patient's unique characteristics and needs	awaren related ethnici and rel patient encour Requir modify for a p	tive to a hess of d to cultu ty, gende igion in t /caregiv ter es assista care pla atient's u ceristics a	ifferend re, er, race :he er ance to n to ac inique	es , age count	patier chara based gende prefer Modi for a chara	nt's unic cteristic upon c er, religi rence fies care patient'	que cs and culture on, ai e plan cs anc cs anc	erstand of I needs e, ethnio nd perso n to acco que d needs	city, onal ount	unique of the p Approp to acco	characte oatient/ riately n unt for a	accounts eristics ar caregiver nodifies c a patient' and need	nd needs are plan s unique	intera differ patier chara Role r respe	nodels p loctions to ences rel nt's uniqu cteristics nodels co ct for pat cteristics	negotia ated to a ie or need onsistent ient's ur	te a s t
Comments:																	

19. Exhibits integrity	/ and	l ethica	l beł	navior	in pro	fess	ion	al con	duc	t. (PRO	OF4)										
Critical Deficiencies												Read	y for uns	uper	rvised pra	octice		А	spirati	onal	
Dishonest in clinical		onest in	-	cal						nright ii	ו		nstrates					sts oth			ing to
interactions,		teractio						linter					ty, and a			y to		cal prir	•		
documentation,		ocument									ch, and		nts, socie	ty a	nd the					-	egrity,
research, or	ar	id schola	arly a	ctivity		SC	hola	rly act	ivity	,		profes	ssion				hon	esty, ai	nd pro	fessio	nal
scholarly activity	Re	equires c	overs	ight fo	r												resp	onsibil	ity		
	pr	ofessior	nal ac	tions		De	emo	nstrate	es ac	counta	bility	Active	ly mana	ges	challeng	ing					
Refuses to be						fo	r the	e care	of pa	atients		ethica	l dilemm	nas a	and conf	licts of	Role	mode	ls inte	grity,	
accountable for	Ha	as a basi	c uno	dersta	nding							intere	st				hon	esty, ad	ccount	ability	/ and
personal actions	of	ethical	princ	iples, t	formal	Ac	lher	es to e	ethic	al prino	ciples						prof	ession	al cono	duct ir	n all
	ро	licies ar	nd pr	ocedu	res,	fo	r do	cumer	ntati	on, foll	ows	Identi	fies and	resp	onds		aspe	ects of	profes	sional	life
Does not adhere to	ar	id does i	not ir	ntentio	onally	fo	rma	l polici	ies a	nd		appro	priately ⁻	to la	pses of						
basic ethical	di	sregard	them	۱		pr	oce	dures,	ackr	nowled	ges	profes	sional co	ondu	uct amor	ng	Reg	ularly r	eflects	s on pe	ersonal
principles						an	nd lir	nits co	onflic	ct of int	erest,	peer g	group				prof	ession	al cono	duct	
						an	nd up	oholds	ethi	ical											
Blatantly disregards						ex	pec	tations	s of r	researc	h and										
formal policies or						sc	hola	rly act	ivity	,											
procedures.																					
Comments:														·							
commentar																					

Professionalism

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

_____ Yes _____ No _____ Conditional on Improvement

Critical Deficiencies				Ready for un	supervised practice		Aspirational
Ignores patient	Engages patients in	Engages pa	atients in shared	Identifies and	l incorporates	Role r	models effective
preferences for plan	discussions of care plans	decision m	iaking in	patient prefe	rence in shared	comm	nunication and
of care	and respects patient	uncomplic	ated conversations	decision mak	ing across a wide	devel	opment of therapeutic
	preferences when offere	d		variety of pat	ient care	relatio	onships in both routine
Makes no attempt	by the patient, but does	not Requires a	ssistance facilitating	conversation	S	and c	hallenging situations
to engage patient in	actively solicit preference	es. discussion	s in difficult or				
shared decision-		ambiguou	s conversations	Quickly estab	olishes a	Mode	els cross-cultural
making	Attempts to develop			therapeutic r	elationship with	comm	nunication and
	therapeutic relationships	6 Requires g	guidance or	patients and	caregivers,	estab	lishes therapeutic
Routinely engages	with patients and	assistance	to engage in	including per	sons of different	relatio	onships with persons of
in antagonistic or	caregivers but is often	communio	ation with persons		ic and cultural		se socioeconomic
counter-therapeutic	unsuccessful	of differer	nt socioeconomic	backgrounds		backg	grounds
relationships with		and cultur	al backgrounds				
patients and	Defers difficult or			Incorporates	patient-specific		
caregivers	ambiguous conversation	S		preferences i	nto plan of care		
	to others						
				<u> </u>		<u> </u>	
Comments:					<u>.</u>		

Critical Deficiencies									Read	y for unsu	pervised pr	actice		Aspir	ational	
Utilizes	Uses unidire	ectional		Incon	sistently	y enga	ages in		Consis	tently an	d actively		Role r	nodels ai	nd teac	nes
communication	communica	tion that fai	ls to	collab	orative	comr	nunicat	tion	engage	es in colla	borative		collab	orative c	ommur	nicatior
strategies that	utilize the v	isdom of th	e	with a	appropr	iate m	nembei	rs of	comm	unication	with all		with t	he team	to enha	nce
hamper	team			the te					memb	ers of the	e team		patier	nt care, e	ven in	
collaboration and														enging set		nd with
teamwork	Resists offe	rs of		Incon	sistently	vemn	novs ve	rhal	Verhal	non-ver	bal and wr	itten		cting tea	-	
	collaborativ				erbal, a	• •		i bui,		-	consisten		opinio	-		
Verbal and/or non-	conaborativ	emput			nunicati			that			aboration	•	opinit	5115		
verbal behaviors					ate colla		-									
				Tachin		aDOLG	tive car	e		am to em	nance patie	ent				
disrupt effective									care							
collaboration with																
team members																
									_				<u> </u>			
Comments:																

22. Appropriate utili	zation and	completio	n of he	alth re	cords.	(ICS3)											
Critical Deficiencies									Ready	y for unsu	pervised p	oractice			Aspirati	ional	
Health records are absent or missing significant portions of important clinical data		ecords are nized and te		and a super	h record ccurate ficial ar l to com ning	but are nd miss	e key (data	accura effectiv reason Health	te, comp vely com ing records	are orgar rehensive municate are succii atient spe	e, and clinical nct,	imj acc hea	portan curate alth ree	ce of or and cor cords th	teaches ganized npreher nat are ient spe	l, nsive
Comments:																	

Interpersonal and Communications Skills

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

_____ Yes _____ No _____ Conditional on Improvement

Overall Clinical Competence

This rating represents the assessment of the resident's development of overall clinical competence during this year of training:

- _____ Superior: Far exceeds the expected level of development for this year of training
- _____ Satisfactory: Always meets and occasionally exceeds the expected level of development for this year of training
- ____ Conditional on Improvement: Meets some developmental milestones but occasionally falls short of the expected level of development for this year of training. An improvement plan is in place to facilitate achievement of competence appropriate to the level of training.
- _____ Unsatisfactory: Consistently falls short of the expected level of development for this year of training.

The Emergency Medicine Milestone Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education and The American Board of Emergency Medicine



July 2015

The Emergency Medicine Milestone Project

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

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Emergency Medicine Milestones

Working Group

Chair: Michael Beeson, MD

Theodore Christopher, MD

Jonathan Heidt, MD

James Jones, MD

Susan Promes, MD

Lynne Meyer, PhD, MPH

Kevin Rodgers, MD

Philip Shayne, MD

Susan Swing, PhD

Mary Jo Wagner, MD

Advisory Group

Timothy Brigham, MDiv, PhD Wallace Carter, MD Earl Reisdorff, MD

Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each reporting period, review and reporting will involve selecting the level of milestones that best describes a resident's current performance level in relation to milestones, using evidence from multiple methods, such as direct observation, multi-source feedback, tests, and record reviews, etc. Milestones are arranged into numbered levels. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (See the diagram on page v). A general interpretation of levels for emergency medicine is below:

- Level 1: The resident demonstrates milestones expected of an incoming resident.
- Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.
- Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.
- Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.
- **Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

Additional Notes

Level 4 is designed as the graduation *target* but does *not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the residency program director (See the Milestones FAQ for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?"). Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether milestone data are of sufficient quality to be used for high stakes decisions.

Answers to Frequently Asked Questions about Milestones are available on the Milestones web page: <u>http://www.acqme.org/acqmeweb/Portals/0/MilestonesFAQ.pdf</u>.

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes the resident's performance in relation to the milestones
- <u>or</u>
- selecting the "Has not Achieved Level 1" response option

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.

Has not Achieved Level 1	Level 1			Lev	el 2			Le	vel 3			L	evel 4				Leve	15	
	Performs and communica reliable, comprehensive h and physical exam		comm histor which the ch	ms and iunicate y and pl effectiv ief com t patien	s a focu iysical e iely add plaint a	exam resses nd	comp given circun Priorit comp exami limite	a limite nstance tizes es onents	of a hist ed or dyr sential of a phy given a namic	amic	neces: manag	sary fo gemen all pot	essenti or the c nt of pa tential s	orrect tients	or i bas	rare p sed so	is obsci patient plely or sical ex	condi n histo	tions
		Ľ		Ĺ							7								
Comments:																			
										7	7								
le ii	electing a response b evel implies that mile n lower levels have be lemonstrated.	stones	s in th	at lev		1		indi sub	ecting a cates t stantia ne high	hat m lly de	ilesto monst	nes	in low	er lev	els h	ave	been		

EMERGENCY MEDICINE MILESTONES

ACGME REPORT WORKSHEET

1. Emergency Stabilization (PC1) Prioritizes critical initial stabilization action and mobilizes hospital support services in the resuscitation of a critically ill or injured patient and reassesses after stabilizing intervention.

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Recognizes abnormal vital signs	Recognizes when a patient is unstable requiring immediate intervention	Manages and prioritizes critically ill or injured patients	Recognizes in a timely fashion when further clinical intervention is futile	Develops policies and protocols for the management and/or transfer of critically ill or
		Performs a primary assessment on a critically ill or injured patient Discerns relevant data to formulate a diagnostic impression and plan	Prioritizes critical initial stabilization actions in the resuscitation of a critically ill or injured patient Reassesses after implementing a stabilizing intervention	Integrates hospital support services into a management strategy for a problematic stabilization situation	injured patients
			Evaluates the validity of a DNR order		
Comments:					

Suggested Evaluation Methods: SDOT, observed resuscitations, simulation, checklist, videotape review

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.

	and communicates a omprehensive history cal exam	commu	ms and unicates and ph		sed		itizes es	sential		Synthe	esizes (essent	tial dat	ta	Identifi	es obsc	ure, o	cult
			effective ef comp patient	ely add plaint a	resses nd	given circut Priori comp exam limite	ponents n a limite imstance ritizes es ponents nination ed or dy imstance	sential of a phy given a namic	namic ysical	necess manag using a of dat	gemen all pote	t of pa	atients	S	or rare based s and ph	olely or	n histo	tions rical
Comments:							[<u> [</u>							

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

Has not Achieved Level 1	L	evel 1			Lev	vel 2	2			L	evel	3				Le	evel	4				Level	5	
	Determines th diagnostic stu	•	of	Orders diagno Perfor bedsic and pr	ostic sto ms app le diag	udie prop nost	s oriate	In dia re ris as ap Re co alt	terp agno cogr sks, s sista pprop eviev eviev	rets r ostic s nizing seekir nce v priate ws risl indic	esult itudy limi ng int wher wher s to a	enefit s, and tation terpre	es and etive	b p tl r r m P O s t U ir p	Jses d lased robak he like esults nanag ractic orderin tudies Jnders ositiv ost-te	on th pility of alter emer es cong of stand stand stand	e pr of di od o ing nt st e diag s the d ne	e-tes isease f test ffectiv nosti e false egativ	t e and ve	subt diag cont pres	rimina de and nostic text of sentati	/or co resul the p	onflic ts in t	ting the
omments:]									[]						

Suggested Evaluation Methods: SDOT, oral boards, standardized exams, chart review, simulation

Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Constructs a list of potential diagnoses based on chief complaint and initial assessment	Constructs a list of potential diagnoses, based on the greatest likelihood of occurrence Constructs a list of potential diagnoses with the greatest potential for morbidity or mortality	Uses all available medical information to develop a list of ranked differential diagnoses including those with the greatest potential for morbidity or mortality Correctly identifies "sick versus not sick" patients Revises a differential diagnosis in response to changes in a patient's course over time	Synthesizes all of the available data and narrows and prioritizes the list of weighted differential diagnoses to determine appropriate management	Uses pattern recognition to identify discriminating features between similar patients and avoids premature closure

4. Diagnosis (PC4) Based on all of the available data, narrows and prioritizes the list of weighted differential diagnoses to determine

Suggested Evaluation Methods: SDOT as baseline, global ratings, simulation, oral boards, chart review

5. Pharmacotherapy (PC5) Selects and prescribes, appropriate pharmaceutical agents based upon relevant considerations such as mechanism of action, intended effect, financial considerations, possible adverse effects, patient preferences, allergies, potential drug-food and drug-drug interactions, institutional policies, and clinical guidelines; and effectively combines agents and monitors and intervenes in the advent of adverse effects in the ED.

nows the different assifications of pharmacologic	Applies medical knowledge	o (.)		
	for selection of	Considers array of drug therapy for treatment.	Selects the appropriate agent based on mechanism	Participates in developing institutional policies on
gents and their mechanism of	appropriate agent for		of action, intended effect,	pharmacy and therapeutics
tion.	therapeutic intervention	based on mechanism of	possible adverse effects,	
onsistently asks patients for	Considers potential			ļ
rug allergies	adverse effects of	adverse side effects	food and drug-drug	
	pharmacotherapy	Considers and recognizes		
		potential drug to drug	institutional policies, and	ļ
		interactions	clinical guidelines,	
			modifying factors	
t D	tion. nsistently asks patients for	tion. therapeutic intervention sistently asks patients for Considers potential	tion. therapeutic intervention based on mechanism of action, intended effect, and anticipates potential adverse effects of pharmacotherapy Considers and recognizes potential drug to drug	tion. therapeutic intervention therapeutic intervention based on mechanism of action, intended effect, and anticipates potential adverse effects of pharmacotherapy considers and recognizes potential drug to drug interactions i

Suggested Evaluation Methods: SDOT, portfolio, simulation, oral boards, global ratings, medical knowledge examinations

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Recognizes the need for patient re-evaluation	Monitors that necessary therapeutic interventions are performed during a patient's ED stay	Identifies which patients will require observation in the ED Evaluates effectiveness of therapies and treatments provided during observation Monitors a patient's clinical status at timely intervals during their stay in the ED	Considers additional diagnoses and therapies for a patient who is under observation and changes treatment plan accordingly Identifies and complies with federal and other regulatory requirements, including billing, which must be met for a patient who is under observation	Develops protocols to avoid potential complications of interventions and therapies

Suggested Evaluation Methods: SDOT, multi-source feedback, oral boards, simulation

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes basic resources available for care of the emergency department patient	Formulates a specific follow-up plan for common ED complaints with appropriate resource utilization	Formulates and provides patient education regarding diagnosis, treatment plan, medication review and PCP/consultant appointments for complicated patients Involves appropriate resources (e.g., PCP, consultants, social work, PT/OT, financial aid, care coordinators) in a timely manner Makes correct decision regarding admission or discharge of patients Correctly assigns admitted patients to an appropriate level of care (ICU/Telemetry/Floor/ Observation Unit)	Formulates sufficient admission plans or discharge instructions including future diagnostic/therapeutic interventions for ED patients Engages patient or surrogate to effectively implement a discharge plan	Works within the institution to develop hospital systems that enhance safe patient disposition and maximizes resource utilization

Suggested Evaluation Methods: SDOT, shift evaluations, simulation cases / Objective Structure Clinical Exam (OSCE), multi-source feedback, chart review

Level 1			Level 2					Level 3					Level 4					Level 5			
Manages a single patient amidst distractions			Task switches between different patients				Employs task switching in an efficient and timely manner in order to manage multiple patients					Employs task switching in an efficient and timely manner in order to manage the ED				in	Employs task switching in an efficient and timely manner in order to manage the ED under high volume or surge situations				

Suggested Evaluation Methods: Simulation, SDOT, mock oral examination, multi-source feedback

9. General Approach to Procedures (PC9) Performs the indicated procedure on all appropriate patients (including those who are uncooperative, at the extremes of age, hemodynamically unstable and those who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, sedation requirement), takes steps to avoid potential complications, and recognizes the outcome and/or complications resulting from the procedure.

Has not Achieved Level 1	Level 1	Level 2		Level	3	Level 4	Level 5
	Identifies pertinent anatomy and physiology for a specific procedure Uses appropriate Universal Precautions	Performs patient assessment, obtains informed consent and ensures monitoring equipment in place in accordance with patient safety standards Knows indications, contraindications, anatomic landmarks, equipment, anesthe and procedural technique, and potential complications for common ED procedures Performs the indicated commo procedure on a patient with moderate urgency who has identifiable landmarks and a low moderate risk for complications Performs post-procedural assessment and identifies any	is st uu Cu re pi tic	Determines a ba trategy if initial o perform a pro insuccessful Correctly interpr esults of a diagn procedure	attempts cedure are ets the	Performs indicated procedures on any patients with challenging features (e.g., poorly identifiable landmarks, at extremes of age or with co-morbid conditions) Performs the indicated procedure, takes steps to avoid potential complications, and recognizes the outcome and/or complications resulting from the procedure	Teaches procedural competency and corrects mistakes
		potential complications					
Comments:							

Suggested Evaluation Methods: Procedural competency forms, checklist assessment of procedure and simulation lab performance, global ratings

10. Airway Management (PC10) Performs airway management on all appropriate patients (including those who are uncooperative, at the extremes of age, hemodynamically unstable and those who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, sedation requirement), takes steps to avoid potential complications, and recognize the outcome and/or complications resulting from the procedure.

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes upper airway anatomy Performs basic airway maneuvers or adjuncts (jaw thrust/chin lift/oral airway/nasopharyngeal airway) and ventilates/oxygenates patient using BVM	Describes elements of airway assessment and indications impacting the airway management Describes the pharmacology of agents used for rapid sequence intubation including specific indications and contraindications Performs rapid sequence intubation in patients without adjuncts Confirms proper endotracheal tube placement using multiple modalities	Uses airway algorithms in decision making for complicated patients employing airway adjuncts as indicated Performs rapid sequence intubation in patients using airway adjuncts Implements post- intubation management Employs appropriate methods of mechanical ventilation based on specific patient physiology	Performs airway management in any circumstance taking steps to avoid potential complications, and recognizes the outcome and/or complications resulting from the procedure Performs a minimum of 35 intubations Demonstrates the ability to perform a cricothyrotomy Uses advanced airway modalities in complicated	Teaches airway management skills to health care providers
Comments:				patients	

Suggested Evaluation Methods: Airway Management Competency Assessment Tool (CORD), Airway Management Assessment Cards, SDOT checklist, procedure log, and simulation

Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Discusses with the patient indications, contraindications and possible complications of local anesthesia Performs local anesthesia using appropriate doses of local anesthetic and appropriate technique to provide skin to sub-dermal anesthesia for procedures	Knows the indications, contraindications, potential complications and appropriate doses of analgesic/sedative medications Knows the anatomic landmarks, indications, contraindications, potential complications and appropriate doses of local anesthetics used for regional anesthesia	 Knows the indications, contraindications, potential complications and appropriate doses of medications used for procedural sedation Performs patient assessment and discusses with the patient the most appropriate analgesic/sedative medication and administers in the most appropriate dose and route Performs pre-sedation assessment, obtains informed consent and orders appropriate choice and dose of medications for procedural sedation Obtains informed consent and correctly performs regional anesthesia Ensures appropriate monitoring of patients during procedural sedation 	Performs procedural sedation providing effective sedation with the least risk of complications and minimal recovery time through selective dosing, route and choice of medications	Develops pain management protocols/care plan

11 A sector of A sector Data Management (DC11) Describes as for .. . بلا مرجا المحار ومراجع المسيران ومرجع مسرير المرير

Suggested Evaluation Methods: Procedural competency forms, checklist assessment of procedure and simulation lab performance, global ratings, patient survey, chart review

12. Other Diagnostic and Therapeutic Procedures: Goal-directed Focused Ultrasound (Diagnostic/Procedural) (PC12) Uses goal-directed focused Ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance.

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes the indications for emergency ultrasound	Explains how to optimize ultrasound images and Identifies the proper probe for each of the focused ultrasound applications Performs an eFAST	Performs goal-directed focused ultrasound exams Correctly interprets acquired images	Performs a minimum of 150 focused ultrasound examinations	Expands ultrasonography skills to include: advanced echo, TEE, bowel, adnexal and testicular pathology, and transcranial Doppler
Comments:					

Suggested Evaluation Methods: OSCE, SDOT, videotape review, written examination, checklist

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Prepares a simple wound for	Uses medical terminology	Performs complex wound	Achieves hemostasis in a	Performs advanced woun
	suturing (identify appropriate	to clearly describe/classify	repairs (deep sutures,	bleeding wound using	repairs, such as tendon
	suture material, anesthetize	a wound (e.g., stellate,	layered repair, corner	advanced techniques such	repairs and skin flaps
	wound and irrigate)	abrasion, avulsion,	stitch)	as: cautery, ligation, deep	
		laceration, deep vs		suture, injection, topical	
	Demonstrates sterile technique	superficial)	Manages a severe burn	hemostatic agents, and	
	Places a simple interrupted	Classifies burns with	Determines which wounds	tourniquet	
	suture	respect to depth and body	should not be closed	Repairs wounds that are	
	suture	surface area	primarily	high risk for cosmetic	
			printarity	complications (such as	
		Compares and contrasts	Demonstrates appropriate	eyelid margin, nose, ear)	
		modes of wound	use of consultants	-,,	
		management (adhesives,		Describes the indications	
		steri-strips, hair apposition,	Identifies wounds that may	for and steps to perform	
		staples)	be high risk and require more extensive evaluation	an escharotomy	
		Identifies wounds that	(example: x-ray,		
		require antibiotics or	ultrasound, and/or		
		tetanus prophylaxis	exploration)		
		Educates nationts on			
		Educates patients on appropriate outpatient			
		management of their			
		wound			
		wound			

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Suggested Evaluation Methods: Direct observation, procedure checklist, medical knowledge quiz, portfolio, global ratings, procedure log

				Level 5
Performs a venipuncture Places a peripheral intravenous line Performs an arterial puncture	Describes the indications, contraindications, anticipated undesirable outcomes and complications for the various vascular access modalitiesInserts an arterial catheterAssesses the indications in conjunction with the patient anatomy/pathophysiology and select the optimal site for a central venous catheterInserts a central venous catheter using ultrasound and universal precautionsConfirms appropriate placement of central venous catheterPerforms intraosseous access	Inserts a central venous catheter without ultrasound when appropriate Places an ultrasound guided deep vein catheter (e.g., basilic, brachial, and cephalic veins)	Successfully performs 20 central venous lines Routinely gains venous access in patients with difficult vascular access	Teaches advanced vascular access techniques

14. Other Diagnostic and Therapeutic Procedures: Vascular Access (PC14) Successfully obtains vascular access in patients of all ages

Suggested Evaluation Methods: Knowledge assessment using MCQ, checklist driven task analysis, procedure log

Passes initial national licensing examinations	Resident develops and	Demonstrates		
(e.g., USMLE Step 1 and Step 2 or COMLEX Level 1 and Level 2)	completes a self-assessment plan based on the in-training examination results Completes objective residency training program examinations and/or assessments at an acceptable score for specific rotations	improvement of the percentage correct on the in-training examination or maintain an acceptable percentile ranking	Obtains a score on the annual in-training examination that indicates a high likelihood of passing the national qualifying examinations Successfully completes all objective residency training program examinations and/or assessments Passes final national licensing examination (e.g., USMLE Step 3 or COMLEX Level 3)	Passes ABEM certifying examinations Meets all the requirement for the ABEM Maintenant of Certification programt set forth by national certifying agency

Suggested Evaluation Methods: National licensing examinations (USMLE, COMLEX), national in-training examination (developed by ABEM & AOA), CORD Question & Answer Bank tests, MedChallenger, local residency examinations

Has not Achieved Level 1	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 optimize 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

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

-		2) Participates in strategies t	· · · · · · · · · · · · · · · · · · ·	livery and flow. Demons	trates an awareness of
and responsiv	veness to the larger cont	ext and system of health car	е.		
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes members of ED team (e.g., nurses, technicians, and security)	Mobilizes institutional resources to assist in patient care Participates in patient satisfaction initiatives	Practices cost-effective care Demonstrates the ability to call effectively on other resources in the system to provide optimal health care	Participates in processes and logistics to improve patient flow and decrease turnaround times (e.g., rapid triage, bedside registration, Fast Tracks, bedside testing, rapid treatment units, standard protocols, and observation units) Recommends strategies by which patients' access to care can be improved Coordinates system resources to optimize a patient's care for complicated medical situations	Creates departmental flow metric from benchmarks, best practices, and dash boards Develops internal and external departmental solutions to process and operational problems Addresses the differing customer needs of patients, hospital medical staff, EMS, and the community
Comments:					

Suggested Evaluation Methods: Direct observation-SDOT, chart review, global ratings, billing records, simulation, multi-source feedback, and outcome data including throughput numbers and patients per hour

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5					
	Uses the Electronic Health Record (EHR) to order tests, medications and document notes, and respond to alerts Reviews medications for patients	Ensures that medical records are complete, with attention to preventing confusion and error Effectively and ethically uses technology for patient care, medical communication and learning	Recognizes the risk of computer shortcuts and reliance upon computer information on accurate patient care and documentation	Uses decision support systems in EHR (as applicable in institution)	Recommends systems re design for improved computerized processes					
Comments:										

Suggested Evaluation Methods: Direct observation-SDOT, chart review, global ratings, billing records, simulation, multi-source feedback

Has not Achieved Level 1	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 evidence- based clinical practice and information retrieval mastery Participates in a process improvement plan to optimize ED practice	Independently teaches evidence-based medicine and information mastery techniques

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

	nal values (PROF1) Demo ne practice of medicine.	nstrates compassion, integri	ty, and respect for other	s as well as adherence to	the ethical principles
Has not Achieved Level 1	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

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	 Demonstrates basic professional responsibilities such as timely reporting for duty, appropriate dress/grooming, rested and ready to work, delivery of patient care as a functional physician Maintains patient confidentially Uses social media ethically and responsibly Adheres to professional responsibilities, such as conference attendance, timely chart completion, duty hour reporting, procedure reporting 	Identifies basic principles of physician wellness, including sleep hygiene Consistently recognizes limits of knowledge in common and frequent clinical situations and asks for assistance Demonstrates knowledge of alertness management and fatigue mitigation principles	Consistently recognizes limits of knowledge in uncommon and complicated clinical situations; develops and implements plans for the best possible patient care Recognizes and avoids inappropriate influences of marketing and advertizing	Can form a plan to address impairment in one's self or a colleague, in a professional and confidential manner Manages medical errors according to principles of responsibility and accountability in accordance with institutional policy	Develops institutional and organizational strategies t improve physician insight into and management of professional responsibilities Trains physicians and educators regarding responsibility, wellness, fatigue, and physician impairment

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

Has not Achieved Level 1	L	evel 1			Le	evel 2	2			L	evel	3				Leve	4			Level	5	
	Establishes and demor toward pat families Listens effe patients an	nstrate en cients and ectively to	mpathy d their o	seekin expect Negot	patients g health tations f iates and t/family	n care rom d ma	e and the ED nages s	visit imple	of the in the comm that in for st misur Effec with popu	ress, o nderst tively vulner lation nts at	no re nd us ize th confli andi comi rable s, incl	ceive ses meth ne pot ct, an ng munic	care ods cential d ates ; both	com and the c reso chall seek deliv unex med	adjust linica ve sp enges ing be ering pecte ical er refusa	cation is the l situa ecific s, such havio bad n ed out rors,	m bas ation ED n as d or, news, ccome and h	rug es,	and co skills Particip counse	s commu nflict ma pates in r l of colle unication ncies	nager eview agues	nent v and
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Suggested Evaluation Methods: Direct observation, SDOT, simulation, multi-source feedback, OSCE, global ratings, oral boards

22. Team Management (ICC2) Leads actions contained ages to

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Participates as a member of a patient care team	Communicates pertinent information to emergency physicians and other healthcare colleagues	Develops working relationships across specialties and with ancillary staff Ensures transitions of care are accurately and efficiently communicated Ensures clear communication and respect among team members	Recommends changes in team performance as necessary for optimal efficiency Uses flexible communication strategies to resolve specific ED challenges such as difficulties with consultants and other health care providers Communicates with out-of- hospital and nonmedical personnel, such as police, media, and hospital administrators	Participates in and leads interdepartmental groups in the patient setting and in collaborative meetings outside of the patient car setting Designs patient care team and evaluates their performance Seeks leadership opportunities within professional organizations

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

The Internal Medicine Subspecialty Milestones Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education and The American Board of Internal Medicine



In Collaboration with





July 2015

Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of fellow performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies that describe the development of competence from an early subspecialty learner up to and beyond that expected for unsupervised practice. In the initial years of implementation, the Review Committee will examine Milestone performance data for each program's fellows as one element in the Next Accreditation System (NAS) to determine whether fellows overall are progressing.

The Subspecialty Milestones are arranged in columns of progressive stages of competence that do not correspond with post-graduate year of education. For each reporting period, programs will need to review the Milestones, identify those that best describe a fellow's current performance, and ultimately select a box that best represents the summary performance for that sub-competency (see the figure on page v). Selecting a response box in the middle of a column implies that the fellow has substantially demonstrated those milestones, as well as those in previous columns. Selecting a response box on a line in between columns indicates that milestones in the lower columns have been substantially demonstrated, as well as some milestones in the higher column.

A general interpretation of each column for subspecialty medicine is as follows:

Not Yet Assessable: This option should be used only when a fellow has not yet had a learning experience in the sub-competency.

Critical Deficiencies: These learner behaviors are not within the spectrum of developing competence. Instead they indicate significant deficiencies in a fellow's performance.

Column 2: Describes behaviors of an early learner.

Column 3: Describes behaviors of a fellow who is advancing and demonstrating improvement in performance related to milestones.

Ready for Unsupervised Practice: Describes behaviors of a fellow who substantially demonstrates the milestones identified for a physician who is ready for unsupervised practice. This column is designed as the graduation target, but the fellow may display these milestones at any point during fellowship.

Aspirational: Describes behaviors of a fellow who has advanced beyond those milestones that describe unsupervised practice. These milestones reflect the competence of an expert or role model and can be used by programs to facilitate further professional growth. It is expected that only a few exceptional fellows will demonstrate these milestones behaviors.

For each ACGME competency domain, programs will also be asked to provide a summative evaluation of each fellow's learning trajectory.

Additional Notes

The "Ready for Unsupervised Practice" milestones are designed as the graduation *target* but *do not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the residency program director (See the Milestones FAQ for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?"). Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether the "Ready for Unsupervised Practice" milestones and all other milestones are in the appropriate stage within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Answers to Frequently Asked Questions about Milestones are available on the Milestones web page: <u>http://www.acqme.org/acqmeweb/Portals/0/MilestonesFAQ.pdf</u>.

Listed below are the societies and members who have participated in the development of the Internal Medicine Subspecialty Reporting Milestones.

Chairs: Scott Gitlin, MD and John Flaherty, MD

Accreditation Council of Graduate Medical Education: James Arrighi, MD; Susan Swing, PhD; Jerry Vasilias, PhD Alliance for Academic Internal Medicine: D. Craig Brater, MD; Margaret Breida; Kelly Caverzagie, MD; Gregory C. Kane, MD; Consuelo Nelson Grier; Polly Parsons, MD; Bergitta Smith American Academy of Hospice and Palliative Care Medicine: Laura Morrison, MD; Steven Radwany, MD; Timothy Quill, MD American Academy of Sleep Medicine: Vishesh Kapur, MD; Becky Roberts; Michael Silber, MB ChB American Association for the Study of Liver Diseases: Adrian Di Bisceglie, MD; Oren Fix, MD; Ayman Koteish, MD American Association of Clinical Endocrinologists: Pasquale Palumbo, MD; Dace Trence, MD American Board of Internal Medicine: Lee Berkowitz, MD; Eric Holmboe, MD; Sarah Hood; William lobst, MD; Sharon Levin, MD; Sandra Yaich American College of Cardiology: Jill Foster; Marcia Jackson, PhD; Jeff Kuvin, MD; Eric Williams, MD American College of Chest Physicians: Doreen Addrizzo-Harris, MD; John Buckley, MD; Paul Markowski, CAE; Curtis Sessler, MD; Kenneth Torrington, MD American College of Gastroenterology: Seth Richter, MD; Ronald Szyjkowski, MD American College of Physicians: Patrick Alguire, MD; Molly Cooke, MD American College of Rheumatology: Marcy Bolster, MD; Calvin Brown, MD American Gastroenterological Association: Tamara Jones; Lori Marks, PhD; Darrell Pardi, MD; Suzanne Rose, MD; Brijen Shah, MD American Geriatrics Society: Jan Busby-Whitehead, MD; Lisa Granville, MD; Rosanne Leipzig, MD American Society of Clinical Oncology: Frances Collichio, MD; Marilyn Raymond, MD; Jamie Von Roenn, MD American Society of Gastrointestinal Endoscopy: Diane Alberson; Walter Coyle, MD; Robert Sedlack, MD American Society of Hematology: Linda Burns, MD; Charles Clayton; Karen Kayoumi; Elaine Muchmore, MD American Society of Nephrology: Nancy Adams, MD; Raymond Harris, MD; Tod Ibrahim; Ryan Russell American Society of Nuclear Cardiology: Brian Abbott, MD; James Arrighi, MD American Thoracic Society: Henry Fessler, MD Association of Program Directors in Endocrinology, Diabetes and Metabolism: Ashok Balasubramanyan, MD; Ann Danoff, MD; Geetha Gopalakrishnan, MD Association of Pulmonary and Critical Care Medicine Program Directors: Craig Piquette, MD; David Schulman, MD Association of Specialty Professors: John Flaherty, MD; Mark Geraci, MD; Scott Gitlin, MD; Don Rockey, MD; Joshua Safer, MD Infectious Diseases Society of America: Wendy Armstrong, MD; Daniel Havlichek, Jr, MD Society of Cardiac Angiography and Interventions: Tarek Helmy, MD; Daniel Kolansky, MD Society of Critical Care Medicine: Stephen Pastores, MD; Antoinette Spevetz, MD The Endocrine Society: Beverly Biller, MD; Ailene Cantelmi

The diagram below presents an example set of milestones for one sub-competency in the same format as the ACGME Report Worksheet. For each reporting period, a fellow's performance on the milestones for each sub-competency will be indicated by:

- selecting the column of milestones that best describes that fellow's performance
- or,
- selecting the "Critical Deficiencies" response box

inconsistently able to collect accurate historical dataaccurate and relevant historieshistories in an efficient, prioritized, and hypothesis-driven fashionsubtleties, including sensitive information that informs the differential diagnosisthe effect and physis skills to m for furthe testingDoes not perform or use an appropriately thorough physical exam, or misses key physical exam findingsaccurate and appropriately thorough physical examsPerforms accurate physical exams that are targeted to the patient's problemsIdentifies subtle or unusual physical exam findingsIdentifies subtle or unusual physical exam to furthe testingRelies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary dataInconsistently recognizes patient's central clinical problem or develops limited differential diagnosis and problem listUses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem listEfficiently utilizes all sources of secondary data to inform differential diagnosisFails to recognize patient's central clinical problemsFails to recognizeImited inferential diagnosis and problem listEffectively uses history and physical examination skills to minimize the need for further diagnostic testingFails to recognizeFails to recognizeImited inferential diagnosizeImited inferential diagnosis and problem listFails to recognizeFails to recognizeImited inferential conditional problems </th <th></th> <th>Does not or is</th> <th></th> <th></th> <th></th> <th>practice</th> <th>Aspirational</th>		Does not or is				practice	Aspirational
		inconsistently able to collect accurate historical data Does not perform or use an appropriately thorough physical exam, or misses key physical exam findings Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data Fails to recognize patient's central clinical problems Fails to recognize potentially life	accurate and relevant histories Consistently performs accurate and appropriately thorough physical exams Inconsistently recognizes patient's central clinical problem or develops limited differential	histories in an ef prioritized, and hypothesis-drive fashion Performs accura physical exams t targeted to the p problems Uses and synthe collected data to patient's central problem(s) to ge prioritized differ diagnosis and pr	fficient, en ate that are patient's esizes o define a I clinical enerate a rential	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Effectively uses history and physical examination skills to minimize the need for further diagnostic	Role-models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic
hents: Selecting a response box in the middle of a olumn implies milestones in that column as vell as those in previous columns have been ubstantially demonstrated. The fellow is in	electin olumn vell as t	ng a response box implies milestone those in previous	es in that column a column have bee	as en	colum been s	ins indicates that substantially dem	milestones in low onstrated as well

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	 Does not or is inconsistently able to collect accurate historical data Does not perform or use an appropriately thorough physical exam, or misses key physical exam findings Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data Fails to recognize patient's central clinical problems Fails to recognize potentially life threatening problems 	Consistently acquires accurate and relevant histories Consistently performs accurate and appropriately thorough physical exams Inconsistently recognizes patient's central clinical problem or develops limited differential diagnoses	Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's problems Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Effectively uses history and physical examination skills to minimize the need for further diagnostic testing	Role-models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing
	01				

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Care plans are	Inconsistently develops	Consistently develops	Appropriately modifies	Role-models and teaches
	consistently	an appropriate care plan	appropriate care plan	care plans based on	complex and patient-
	inappropriate or			patient's clinical course,	centered care
	inaccurate	Inconsistently seeks	Recognizes situations	additional data, patient	
		additional guidance when	requiring urgent or	preferences, and cost-	Develops customized,
	Does not react to	needed	emergency care	effectiveness principles	prioritized care plans for
	situations that require		Cooke edditional avidence		the most complex
	urgent or emergency		Seeks additional guidance and/or consultation as	Recognizes disease	patients, incorporating
	care		appropriate	presentations that deviate from common patterns	diagnostic uncertainty and cost-effectiveness
	Does not seek additional		appropriate	and require complex	principles
	guidance when needed			decision-making,	principles
				incorporating diagnostic	
				uncertainty	
				,	
				Manages complex acute	
				and chronic conditions	
Comments:	·				

Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Cannot advance beyond the need for direct supervision in the delivery of patient care Cannot manage patients who require urgent or emergency care Does not assume responsibility for patient management decisions	 Requires direct supervision to ensure patient safety and quality care Requires direct supervision to manage problems or common chronic diseases in all appropriate clinical settings Inconsistently provides preventive care in all appropriate clinical settings Requires direct supervision to manage patients with straightforward diagnoses in all appropriate clinical settings Unable to manage complex inpatients or patients requiring intensive care Cannot independently supervise care provided by other members of the 	Requires indirect supervision to ensure patient safety and quality care Provides appropriate preventive care and chronic disease management in all appropriate clinical settings Provides comprehensive care for single or multiple diagnoses in all appropriate clinical settings Under supervision, provides appropriate care in the intensive care unit Initiates management plans for urgent or emergency care	Independently manages patients across applicable inpatient, outpatient, and ambulatory clinical settings who have a broad spectrum of clinical disorders, including undifferentiated syndromes Seeks additional guidance and/or consultation as appropriate Appropriately manages situations requiring urgent or emergency care Effectively supervises the management decisions of the team in all appropriate clinical settings	Effectively manages unusual, rare, or complex disorders in all appropriate clinical settings
		physician-led team			

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Attempts to perform	Possesses insufficient	Possesses basic technical	Consistently demonstrates	Demonstrates skill to
	invasive procedures	technical skill for safe	skill for the completion and	technical skill to	independently perform and
	without sufficient	completion of common	interpretation of some	successfully and safely	interpret complex invasive
	technical skill or	invasive procedures with	common invasive	perform and interpret	procedures that are
	supervision	appropriate supervision	procedures with appropriate supervision	invasive procedures	anticipated for future practice
	Fails to recognize cases in	Inattentive to patient		Maximizes patient comfort	
	which invasive	safety and comfort when	Inconsistently manages	and safety when	Demonstrates expertise to
	procedures are	performing invasive	patient safety and comfort	performing invasive	teach and supervise others
	unwarranted or unsafe	procedures	when performing invasive procedures	procedures	in the performance of invasive procedures
	Does not recognize the	Applies the ethical		Consistently recognizes	
	need to discuss	principles of informed	Inconsistently recognizes	appropriate patients,	Designs consent instrumen
	procedure indications,	consent	appropriate patients,	indications, and associated	for a human subject
	processes, or potential		indications, and associated	risks in the performance of	research study; files an
	risks with patients	Recognizes the need to obtain informed consent	risks in the performance of invasive procedures	invasive procedures	Institution Review Board (IRB) application
	Fails to engage the	for procedures, but		Effectively obtains and	
	patient in the informed	ineffectively obtains it	Obtains and documents	documents informed	
	consent process, and/or		informed consent	consent in challenging	
	does not effectively	Understands and		circumstances (e.g.,	
	describe risks and	communicates ethical		language or cultural	
	benefits of procedures	principles of informed		barriers)	
		consent		Quantifies evidence for	
				risk-benefit analysis during	
				obtainment of informed	
				consent for complex	
				procedures or therapies	
nments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Does not recognize	Possesses insufficient skill	Inconsistently recognizes	Consistently recognizes	Demonstrates skill to
	patients for whom non-	to safely perform and	appropriate patients,	appropriate patients,	independently perform
	invasive procedures	interpret non-invasive	indications, and	indications, limitations,	and interpret complex
	and/or testing is not	procedures and/or	associated risks in the	and associated risks in	non-invasive procedure
	warranted or is unsafe	testing with appropriate	utilization of non-invasive	utilization of non-invasive	and/or testing
		supervision	procedures and/or testing	procedures and/or testing	
	Attempts to perform or				Demonstrates expertis
	interpret non-invasive	Inattentive to patient	Inconsistently integrates	Integrates procedures	teach and supervise
	procedures and/or	safety and comfort when	procedures and/or testing	and/or testing results with	others in the performa
	testing without sufficient	performing non-invasive	results with clinical	clinical findings in the	of advanced non-invas
	skill or supervision	procedures and/or	features in the evaluation	evaluation and	procedures and/or test
		testing procedures	and management of	management of patients	
	Does not recognize the		patients		Designs consent
	need to discuss	Applies the ethical		Recognizes procedures	instrument for a huma
	procedure indications,	principles of informed	Can safely perform and	and/or testing results that	subject research study
	processes, or potential	consent	interpret selected non-	indicate high-risk state or	files an Institution Rev
	risks with patients		invasive procedures	adverse prognosis	Board (IRB) applicatior
		Recognizes need to	and/or testing procedures		
	Fails to engage the	obtain informed consent	with minimal supervision	Recognizes artifacts and	
	patient in the informed	for procedures but		normal variants	
	consent process and/or	ineffectively obtains it	Inconsistently recognizes		
	does not effectively		high-risk findings and	Consistently performs and	
	describe risks and	Understands and	artifacts/normal variants	interprets non-invasive	
	benefits of procedures	communicates ethical		procedures and/or testing	
		principles of informed	Obtains and documents	in a safe and effective	
		consent	informed consent	manner	
				Effectively obtains and	
				, documents informed	
				consent in challenging	
				circumstances (e.g.,	
				language or cultural	
				barriers)	

		Quantifies evidence for risk-benefit analysis during obtainment of informed consent for complex procedures and/or tests	
Comments:			
Not Applicable			

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Is unresponsive to questions or concerns of others when acting as a consultant or utilizing consultant services Unwilling to utilize consultant services when appropriate for patient care	Inconsistently manages patients as a consultant to other physicians/health care teams Inconsistently applies risk assessment principles to patients while acting as a consultant Inconsistently formulates a clinical question for a consultant to address	Provides consultation services for patients with clinical problems requiring basic risk assessment Asks meaningful clinical questions that guide the input of consultants	Provides consultation services for patients with basic and complex clinical problems requiring detailed risk assessment Appropriately integrates recommendations from other consultants in order to effectively manage patient care	Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment Models management of discordant recommendations from multiple consultants
Comments:					

Patient Care

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the training program. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

_____ Yes _____ No _____ Conditional on Improvement

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Lacks the scientific, socioeconomic, or behavioral knowledge required to provide patient care	Possesses insufficient scientific, socioeconomic, and behavioral knowledge required to provide care for common medical conditions and basic preventive care	Possesses the scientific, socioeconomic, and behavioral knowledge required to provide care for common medical conditions and basic preventive care	Possesses the scientific, socioeconomic, and behavioral knowledge required to provide care for complex medical conditions and comprehensive preventive care	Possesses the scientific, socioeconomic, and behavioral knowledge required to successfully diagnose and treat medically uncommon, ambiguous, and compley conditions
omments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Lacks foundational knowledge to apply diagnostic testing and procedures to patient care	 Inconsistently interprets basic diagnostic tests accurately Does not understand the concepts of pre-test probability and test performance characteristics Minimally understands the rationale and risks associated with common procedures 	Consistently interprets basic diagnostic tests accurately Needs assistance to understand the concepts of pre-test probability and test performance characteristics Fully understands the rationale and risks associated with common procedures	Interprets complex diagnostic tests accurately while accounting for limitations and biases Knows the indications for, and limitations of, diagnostic testing and procedures Understands the concepts of pre-test probability and test performance characteristics Teaches the rationale and risks associated with common procedures and anticipates potential complications of procedures	Anticipates and accounts for subtle nuances of interpreting diagnostic tests and procedures Pursues knowledge of new and emerging diagnostic tests and procedures

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Foundation Unaware of or uninterested in scientific inquiry or scholarly productivity	Interested in scholarly activity, but does not initiate or follow through	Identifies areas worthy of scholarly investigation and formulates a plan under supervision of a mentor	Formulates ideas worthy of scholarly investigation	Independently formulates novel and important ideas worthy of scholarly investigation
	Investigation Unwilling to perform scholarly investigation in the specialty	Performs a literature search using relevant scholarly sources to identify pertinent articles	Critically reads scientific literature and identifies major methodological flaws and inconsistencies within or between publications	Collaborates with other investigators to design and complete a project related to clinical practice, quality improvement, patient safety, education, or research	Leads a scholarly project advancing clinical practice, quality improvement, patient safety, education, or research Obtains independent research funding
	Analysis Fails to engage in critical thinking regarding clinical practice, quality improvement, patient safety, education, or research	Aware of basic statistical concepts, but has incomplete understanding of their application; inconsistently identifies methodological flaws	Understands and is able to apply basic statistical concepts, and can identify potential analytic methods for data or problem assessment	Critiques specialized scientific literature effectively Dissects a problem into its many component parts and identifies strategies for solving	Critiques specialized scientific literature at a level consistent with participation in peer review Employs optimal statistical techniques
		Communicates		Uses analytical methods of the field effectively	Teaches analytic methods in chosen field to peers and others
	Dissemination Unable or unwilling to effectively communicate and/or disseminate knowledge	rudimentary details of scientific work, including his or her own scholarly work; needs to improve	Effectively presents at journal club, quality improvement meetings, clinical conferences, and/or is able to	Presents scholarly activity at local or regional meetings, and/or submits an abstract summarizing scholarly work to	Effectively presents scholarly work at national and international meetings

		ability to present in small groups	effectively describe and discuss his or her own scholarly work or research	regional/state/ national meetings, and/or publishes non-peer- reviewed manuscript(s) (reviews, book chapters)	Publishes peer-reviewed manuscript(s) containing scholarly work (clinical practice, quality improvement, patient safety, education, or research)
Comments:					

Medical Knowledge

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the training program. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

Yes No Conditional on Improvement

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Refuses to recognize the	Identifies roles of other	Understands the roles and	Understands the roles and	Develops, trains, and
	contributions of other	team members, but does	responsibilities of all team	responsibilities of, and	inspires the team
	interprofessional team	not recognize how/when	members, but uses them	effectively partners with,	regarding unexpected
	members	to utilize them as	ineffectively	all members of the team	events or new patient
		resources			management strategie
	Frustrates team		Actively engages in team	Efficiently coordinates	
	members with	Participates in team	meetings and	activities of other team	Viewed by other team
	inefficiency and errors	discussions when required, but does not	collaborative decision- making	members to optimize care	members as a leader i the delivery of high-
	Frequently requires	actively seek input from			quality care
	reminders from team to	other team members			. ,
	complete physician				
	responsibilities (e.g., talk				
	to family, enter orders)				
nments:					

Not Yet Assessable	Critical	Deficien	cies											Read	-	uns acti	-	vised		Aspirat	ional	
	Ignores a r within the			Does no potentia		-			-	nizes th or with	•		al	Identi of me	-			auses		ates for s ship to for	-	
	may affect	the car	e of a	-				S	yster	n				navig	ates tł	nem	to p	rovide	engag	e in qual	ity	
	patient			Makes o										safe p	atient	t cai	re			nce and	•	•
				could le						fies obv		-		A . I					•	vement a	activit	ies
	Ignores fee unwilling t			are othe by the s			ected			l causes es super			and	care a			-	atient		d as a lea	ador ir	n
	behavior ir	-		 supervis		101				ingly	VISU			care s	•		ai µa	uent		fying and		
	reduce the			Supervis				ľ	ccort	1.9.1				cures	ysten	15				e prevent		
				Resistar	nt to f	eedb	ack	R	ecog	nizes th	ie po	tenti	al	Activa	ates fo	orma	al sys	tem		al error		
				about d						r error	-	-		resou								
				lead to		or otl	herwise			diate sy				and m	-					es others	-	rdi
				cause h	arm					necessa	•	eps t	0	poter	itial m	edi	cal er	ror		portance		
								I	ntiga	te that	risk			Refle	ts un	on a	nd lo	arne	•	nizing an n error	a miti	ga
								v	Villin	g to rec	eive				•			cidents		i choi		
										ack abc			ons	that n								
								t	hat n	nay lead	d to e	error	or	error								
						_		0	ther	wise ca	use ł	narm		_	1	_			<u> </u>			

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Ignores cost issues in the provision of care Demonstrates no effort to overcome barriers to cost-effective care	Lacks awareness of external factors (e.g., socio-economic, cultural, literacy, insurance status) that impact the cost of health care, and the role that external stakeholders (e.g., providers, suppliers, financers, purchasers) have on the cost of care Does not consider limited health care resources when ordering diagnostic or therapeutic interventions	Recognizes that external factors influence a patient's utilization of health care and may act as barriers to cost-effective care Minimizes unnecessary diagnostic and therapeutic tests Possesses an incomplete understanding of cost- awareness principles for a population of patients (e.g., use of screening tests)	Consistently works to address patient-specific barriers to cost-effective care Advocates for cost- conscious utilization of resources such as emergency department visits and hospital readmissions Incorporates cost- awareness principles into standard clinical judgments and decision- making, including use of screening tests	Teaches patients and health care team members to recognize and address common barriers to cost-effective care and appropriate utilization of resources Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective, high-quality care
Comments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Disregards need for	Inconsistently utilizes	Recognizes the	Appropriately utilizes	Coordinates care within
	communication at time	available resources to	importance of	available resources to	and across health delive
	of transition	coordinate and ensure	communication during	coordinate care and	systems to optimize
		safe and effective patient	times of transition	manage conflicts to	patient safety, increase
	Does not respond to	care within and across		ensure safe and effective	efficiency, and ensure
	requests of caregivers in	delivery systems	Communicates with future	patient care within and	high-quality patient
	other delivery systems		caregivers, but	across delivery systems	outcomes
		Provides incomplete	demonstrates lapses in		
	Written and verbal care	written and verbal care	provision of pertinent or	Actively communicates	Role-models and teach
	plans during times of	plans during times of	timely information	with past and future	effective transitions of
	transition are absent	transition		caregivers to ensure	care
				continuity of care	
		Provides inefficient			
		transitions of care that		Anticipates needs of	
		lead to unnecessary		patient, caregivers, and	
		expense or risk to a		future care providers and	
		patient (e.g., duplication		takes appropriate steps to	
		of tests, readmission)		address those needs	
mments:					

Systems-based Practice

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the training program. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

Yes _____ No _____ Conditional on Improvement

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Unwilling to self-reflect upon one's practice or performance Not concerned with opportunities for learning and self- improvement	Unable to self-reflect upon practice or performance Misses opportunities for learning and self- improvement	Inconsistently self-reflects upon practice or performance, and inconsistently acts upon those reflections Inconsistently acts upon opportunities for learning and self-improvement	Regularly self-reflects upon one's practice or performance, and consistently acts upon those reflections to improve practice Recognizes sub-optimal practice or performance as an opportunity for learning and self- improvement	Regularly seeks external validation regarding self- reflection to maximize practice improvement Actively and independently engages i self-improvement efforts and reflects upon the experience
omments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Disregards own clinical performance data Demonstrates no	Limited ability to analyze own clinical performance data	Analyzes own clinical performance gaps and identifies opportunities for improvement	Analyzes own clinical performance data and actively works to improve performance	Actively monitors clinica performance through various data sources
	inclination to participate in or even consider the results of quality- improvement efforts	Nominally engaged in opportunities to achieve focused education and performance improvement	Participates in opportunities to achieve focused education and performance	Actively engages in opportunities to achieve focused education and performance	Able to lead projects aimed at education and performance improvement
Not familiar with the principles, techniques, or importance of quality improvement		improvement Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients	improvement Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients	Utilizes common principles and technique of quality improvement continuously improve ca for a panel of patients	

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Never solicits feedback Actively resists feedback from others	Rarely seeks and does not incorporate feedback Responds to unsolicited feedback in a defensive fashion Temporarily or superficially adjusts performance based on feedback	Solicits feedback only from supervisors and inconsistently incorporates feedback Is open to unsolicited feedback Inconsistently incorporates feedback	Solicits feedback from all members of the interprofessional team and patients Welcomes unsolicited feedback Consistently incorporates feedback Able to reconcile disparate or conflicting feedback	Performance continuously reflects incorporation of solicited and unsolicited feedback Role-models ability to reconcile disparate or conflicting feedback
Comments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Fails to acknowledge	Rarely reconsiders an	Inconsistently reconsiders	Routinely reconsiders an	Role-models how to
	uncertainty and reverts to	approach to a problem,	an approach to a problem,	approach to a problem,	appraise clinical research
	a reflexive patterned	asks for help, or seeks new	asks for help, or seeks new	asks for help, or seeks new	reports based on accept
	response even when inaccurate	information	information	information	criteria
		Can translate medical	Can translate medical	Routinely translates new	Has a systematic approa
	Fails to seek or apply	information needs into	information needs into	medical information needs	to track and pursue
	evidence when necessary	well-formed clinical	well-formed clinical	into well-formed clinical	emerging clinical
		questions with assistance	questions independently	questions	questions
		Unfamiliar with strengths	Aware of the strengths and	Guided by the	
		and weaknesses of the	weaknesses of medical	characteristics of clinical	
		medical literature	information resources, but	questions, efficiently	
			utilizes information	searches medical	
		Has limited awareness of,	technology without	information resources,	
		or ability to use,	sophistication	including decision support	
		information technology or decision support tools and	With assistance, appraises	tools and guidelines	
		guidelines	clinical research reports	Independently appraises	
		guidennes	based on accepted criteria	clinical research reports	
		Accepts the findings of		based on accepted criteria	
		clinical research studies			
		without critical appraisal			
mments:					

Practice-Based Learning and Improvement

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the training program. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

_____Yes _____No _____Conditional on Improvement

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Disrespectful in	Inconsistently	Consistently respectful in	Demonstrates empathy,	Role-models compassio
	interactions with	demonstrates empathy,	interactions with patients,	compassion, and respect	empathy, and respect for
	patients, caregivers, and	compassion, and respect	caregivers, and members	to patients and caregivers	patients and caregivers
	members of the	for patients and	of the interprofessional	in all situations	
	interprofessional team	caregivers	team, even in challenging		Role-models appropriation
			situations	Anticipates, advocates for,	anticipation and
	Sacrifices patient needs	Inconsistently		and actively works to	advocacy for patient ar
	in favor of self-interest	demonstrates	Is available and responsive	meet the needs of	caregiver needs
		responsiveness to	to needs and concerns of	patients and caregivers	
	Does not demonstrate	patients' and caregivers'	patients, caregivers, and		Fosters collegiality that
	empathy, compassion,	needs in an appropriate	members of the	Demonstrates a	promotes a high-
	and respect for patients	fashion	interprofessional team to	responsiveness to patient	functioning
	and caregivers		ensure safe and effective	needs that supersedes	interprofessional team
		Inconsistently considers	patient care	self-interest	
	Does not demonstrate	patient privacy and			Teaches others regardi
	responsiveness to	autonomy	Emphasizes patient	Positively acknowledges	maintaining patient
	patients' and caregivers'		privacy and autonomy in	input of members of the	privacy and respecting
	needs in an appropriate	Inconsistently aware of	all interactions	interprofessional team	patient autonomy
	fashion	physician and colleague		and incorporates that	
		self-care and wellness	Consistently aware of	input into plan of care, as	Role-models personal
	Does not consider		physician and colleague	appropriate	self-care practice for
	patient privacy and		self-care and wellness		others and promotes
	autonomy			Regularly reflects on,	programs for colleague
				assesses, and	wellness
	Unaware of physician			recommends physician	
	and colleague self-care			and colleague self-care	
	and wellness			and wellness	

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Is consistently unreliable in completing patient care responsibilities or assigned administrative tasks Shuns responsibilities expected of a physician professional	Completes most assigned tasks in a timely manner but may need reminders or other support Accepts professional responsibility only when assigned or mandatory	Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy Completes assigned professional responsibilities without questioning or the need for reminders	Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner Willingly assumes professional responsibility regardless of the situation	Role-models prioritizing many competing demands in order to complete tasks and responsibilities in a timely and effective manner Assists others to improve their ability to prioritize many competing tasks
Comments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Is insensitive to differences related to personal characteristics and needs in the patient/caregiver encounter Is unwilling to modify care plan to account for a patient's unique characteristics and needs	Is sensitive to and has basic awareness of differences related to personal characteristics and needs in the patient/caregiver encounter Requires assistance to modify care plan to account for a patient's unique characteristics and needs	Seeks to fully understand each patient's personal characteristics and needs Modifies care plan to account for a patient's unique characteristics and needs with partial success	Recognizes and accounts for the personal characteristics and needs of each patient Appropriately modifies care plan to account for a patient's unique characteristics and needs	Role-models profession interactions to navigate and negotiate difference related to a patient's unique characteristics o needs Role-models consistent respect for patient's unique characteristics and needs
mments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Dishonest in clinical interactions, documentation, research, or scholarly activity	Honest in clinical interactions, documentation, research, and scholarly activity	Honest and forthright in clinical interactions, documentation, research, and scholarly activity	Demonstrates integrity, honesty, and accountability to patients, society, and the profession	Assists others in adherir to ethical principles and behaviors, including integrity, honesty, and professional responsibil
	Refuses to be accountable for personal actions	Requires oversight for professional actions related to the subspecialty	Demonstrates accountability for the care of patients	Actively manages challenging ethical dilemmas and conflicts of interest	Role-models integrity, honesty, accountability, and professional conduc
	Does not adhere to basic ethical principles	Has a basic understanding of ethical principles, formal policies, and procedures	Adheres to ethical principles for documentation, follows	Identifies and responds appropriately to lapses of	in all aspects of professional life
	Blatantly disregards formal policies or procedures	and does not intentionally disregard them	formal policies and procedures, acknowledges and limits conflict of	professional conduct among peer group	Identifies and responds appropriately to lapses professional conduct
	Fails to recognize conflicts of interest	Recognizes potential conflicts of interest	interest, and upholds ethical expectations of research and scholarly activity	Regularly reflects on personal professional conduct Identifies and manages	within the system in which he or she works
			Consistently attempts to recognize and manage conflicts of interest	conflicts of interest	

Professionalism

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the trainingprogram. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

____ Yes _____ No _____ Conditional on Improvement

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Ignores patient preferences for plan of	Engages patients in discussions of care plans	Engages patients in shared decision-making in	Identifies and incorporates patient	Role-models effective communication and
	care	and respects patient	uncomplicated	preference in shared	development of
		preferences when	conversations	decision-making in	therapeutic relationship
	Makes no attempt to	offered by the patient,		complex patient care	in both routine and
	engage patient in shared	but does not actively	Requires assistance	conversations and the	challenging situations
	decision-making	solicit preferences	facilitating discussions in	plan of care	
			difficult or ambiguous	Quickly actablishes a	Models cross-cultural
	Routinely engages in antagonistic or counter-	Attempts to develop therapeutic relationships	conversations	Quickly establishes a therapeutic relationship	communication and establishes therapeutic
	therapeutic	with patients and	Requires guidance or	with patients and	relationships with
	relationships with	caregivers but is	assistance to engage in	caregivers, including	persons of diverse
	patients and caregivers	inconsistently successful	communication with	persons of different	socioeconomic and
			persons of different	socioeconomic and	cultural backgrounds
		Defers difficult or	socioeconomic and	cultural backgrounds	
		ambiguous conversations	cultural backgrounds		Assists others with
		to others			effective communication
					and development of therapeutic relationship
mments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Utilizes communication strategies that hamper collaboration and teamwork Verbal and/or non- verbal behaviors disrupt effective collaboration with team members	Uses unidirectional communication that fails to utilize the wisdom of team members Resists offers of collaborative input	Inconsistently engages in collaborative communication with appropriate members of the team Inconsistently employs verbal, non-verbal, and written communication strategies that facilitate collaborative care	Consistently and actively engages in collaborative communication with all members of the team Verbal, non-verbal, and written communication consistently acts to facilitate collaboration with team members to enhance patient care	Role models and teaches collaborative communication with the team to enhance patient care, even in challenging settings and with conflicting team member opinions
Comments:					

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Provides health records	Health records are	Health records are	Patient-specific health	Role-models and teache
	that are missing	disorganized and	organized and accurate,	records are organized,	importance of organize
	significant portions of	inaccurate	but are superficial and	timely, accurate,	accurate, and
	important clinical data		miss key data or fail to	comprehensive, and	comprehensive health
		Inconsistently enters	communicate clinical	effectively communicate	records that are succinc
	Does not enter medical information and test	medical information and test results/	reasoning	clinical reasoning	and patient-specific
	results/interpretations	interpretations into	Consistently enters	Provides effective and	
	into health record	health record	medical information and	prompt medical	
			test results/	information and test	
			interpretations into	results/ interpretations to	
			health records	physicians and patients	
mments:					

Interpersonal and Communications Skills

The fellow is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in the training program. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

Yes No Conditional on Improvement

Overall Clinical Competence

This rating represents the assessment of the fellow's development of overall clinical competence during this year of training:

- _____ Superior: Far exceeds the expected level of development for this year of training
- _____ Satisfactory: Always meets and occasionally exceeds the expected level of development for this year of training
- Conditional on Improvement: Meets some developmental milestones but occasionally falls short of the expected level of development for this year of training. An improvement plan is in place to facilitate achievement of competence appropriate to the level of training.
- _____ Unsatisfactory: Consistently falls short of the expected level of development for this year of training.