

Accreditation Council for Graduate Medical Education

Updates on the Next Accreditation System Drs. Palestro, Fig, and Ling

Nuclear Medicine March 24, 2014

Goals of The “Next Accreditation System”

- To begin the realization of the promise of Outcomes
- To free good programs to innovate
- To assist poor programs to improve
- To reduce the burden of accreditation
- To provide accountability for outcomes (in tandem with ABMS) to the Public

Where are we going?

The Next Accreditation System

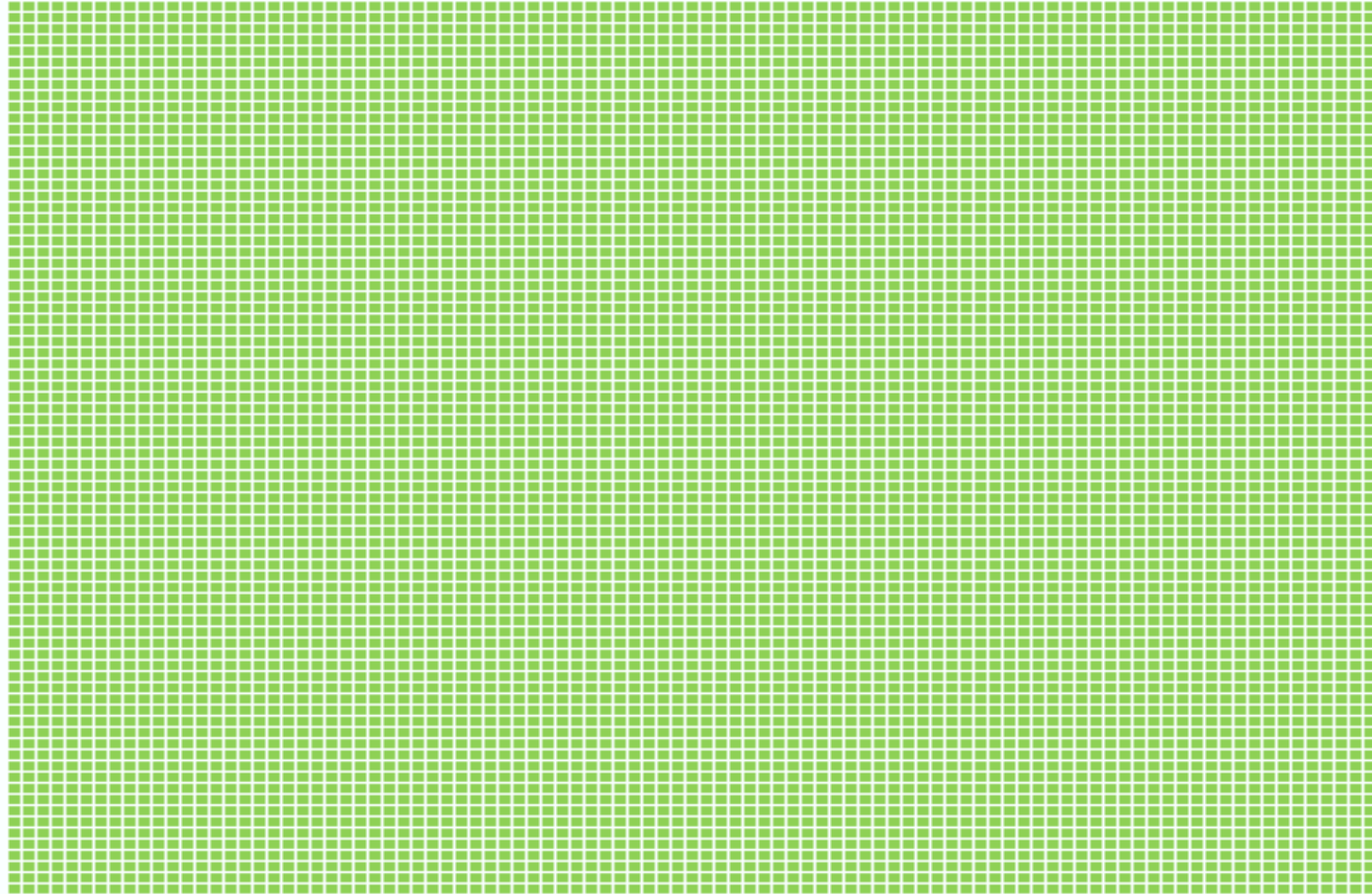
- Continuous Accreditation Model
- Review programs every 10 years with self-study
- Leave Good Programs alone
- Good Programs can innovate detailed standards
- Identify weak programs earlier
- Site visit or progress report from weak programs
- Weak programs held to detailed standards

Where did we come from?

- 2002 Six Core competencies in PR
- 2012 work done so far
 - Core and Detailed Process
 - Outcome in Requirements
 - New policies and procedures
 - ADS rebuilt to prepare for NAS
 - Annual update: free text replaced by data
 - Scholarly activity replaces CVs
 - 2012 Milestones 1.0 developed

Decisions in the *NAS*

All 9,022 ACGME Pre-NAS Accredited Residency and Fellowship Programs 2013*



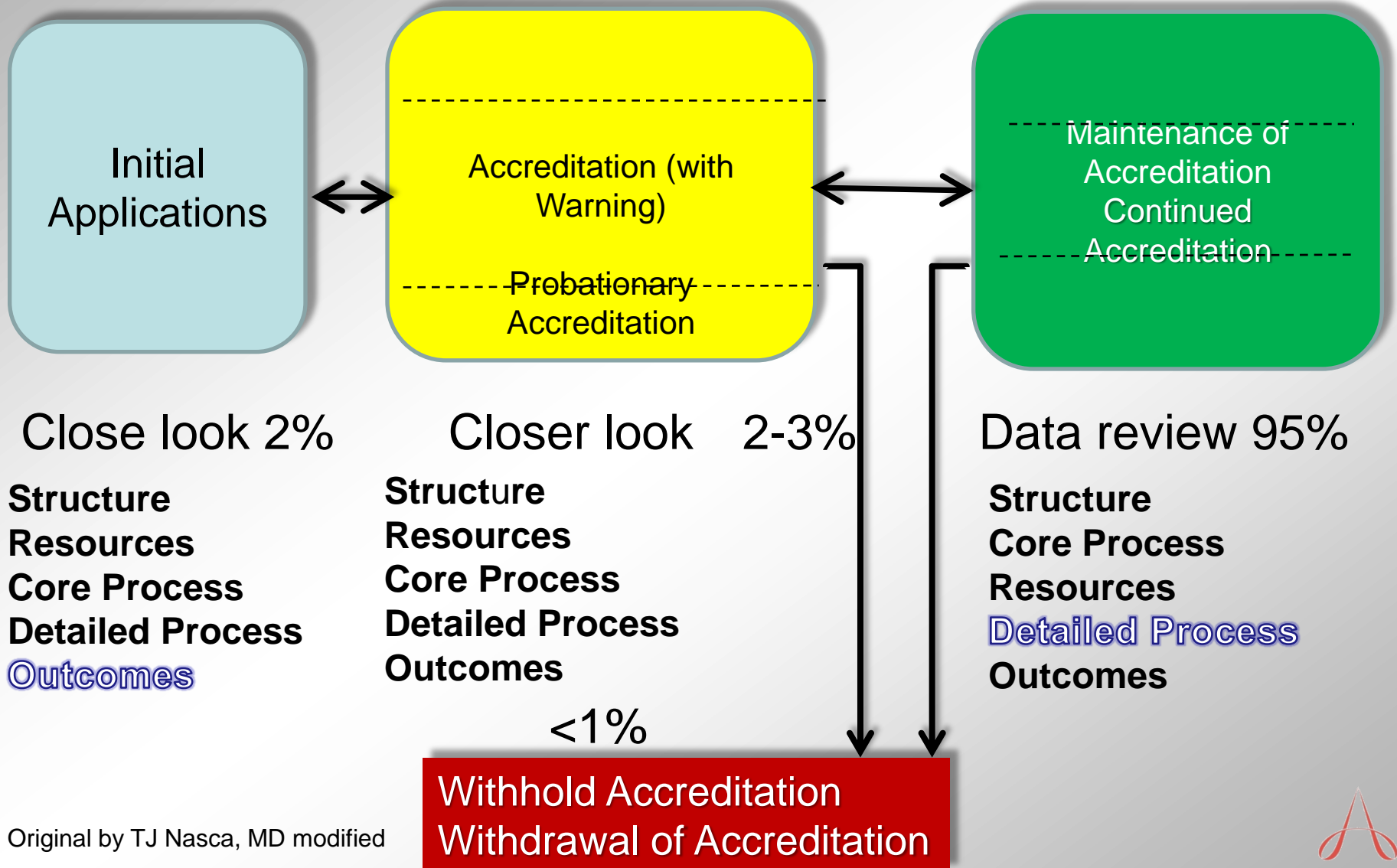
* *Excludes programs with Initial Accreditation*

All 9,022 ACGME Pre-NAS Accredited Residency and Fellowship Programs 2013*



* Excludes programs with Initial Accreditation

Program Review in the NAS 2013



The Next Accreditation System

- Screening based on annually submitted data
 - ADS annual update
 - Resident Survey
 - Faculty Survey (new for core faculty)
 - Milestones Data (new, will be phased in)
 - Procedure or Case Logs
 - Boards Pass Rate Data
 - Scholarly Activity (new format replaces CVs)
- RRC review programs based on RRC set performance indicators and thresholds
 - High performing programs moved to consent agenda
 - Programs with potential problems require more information with a progress report or site visit

Review Process in the Next Accreditation System

1. RRC screens programs using annual outcome data – high level screening
 1. No review comparing to requirements
 2. Identify some programs for closer look
 3. Decide what information to gather
2. For some programs, RRC reviews additional information or site visit and may compare to requirements
3. Every program will get an accreditation letter every year

RRC Decisions for the Green Box

1. Continued Accreditation (likely)
 1. No cycle length any more
 2. May note areas for improvement
 3. May note trends
 4. May issue citations (unlikely)
2. RRCs wants more information
 1. Clarification or progress report from PD
 2. Focused site visit for specific concern
 3. Full site visit for general concern

From the Green to the Yellow Box

1. Continued Accreditation with Warning

1. Analogous to old 1-2 year cycle
2. RRC data review next year

2. Probation*

1. Requires a site visit before going on probation
2. Site visits will have short notice and no PIF
3. Requires a site visit before going off probation

*No programs on probation

Decisions for the Yellow Box

1. Continued Accreditation (green box)
Probation can only be lifted after a site visit
2. Continued Accreditation with Warning
3. Probation (max 2 years)
4. Withdraw Accreditation (red box)
5. Request additional information
 1. Progress report
 2. Site visit, focused or full

Proposed Adverse Actions Gone

- No longer proposed adverse actions
- Can go directly to warning from any status
- Can go directly to probation from any status (site visit required)

- Faster to get off an adverse action after a site visit

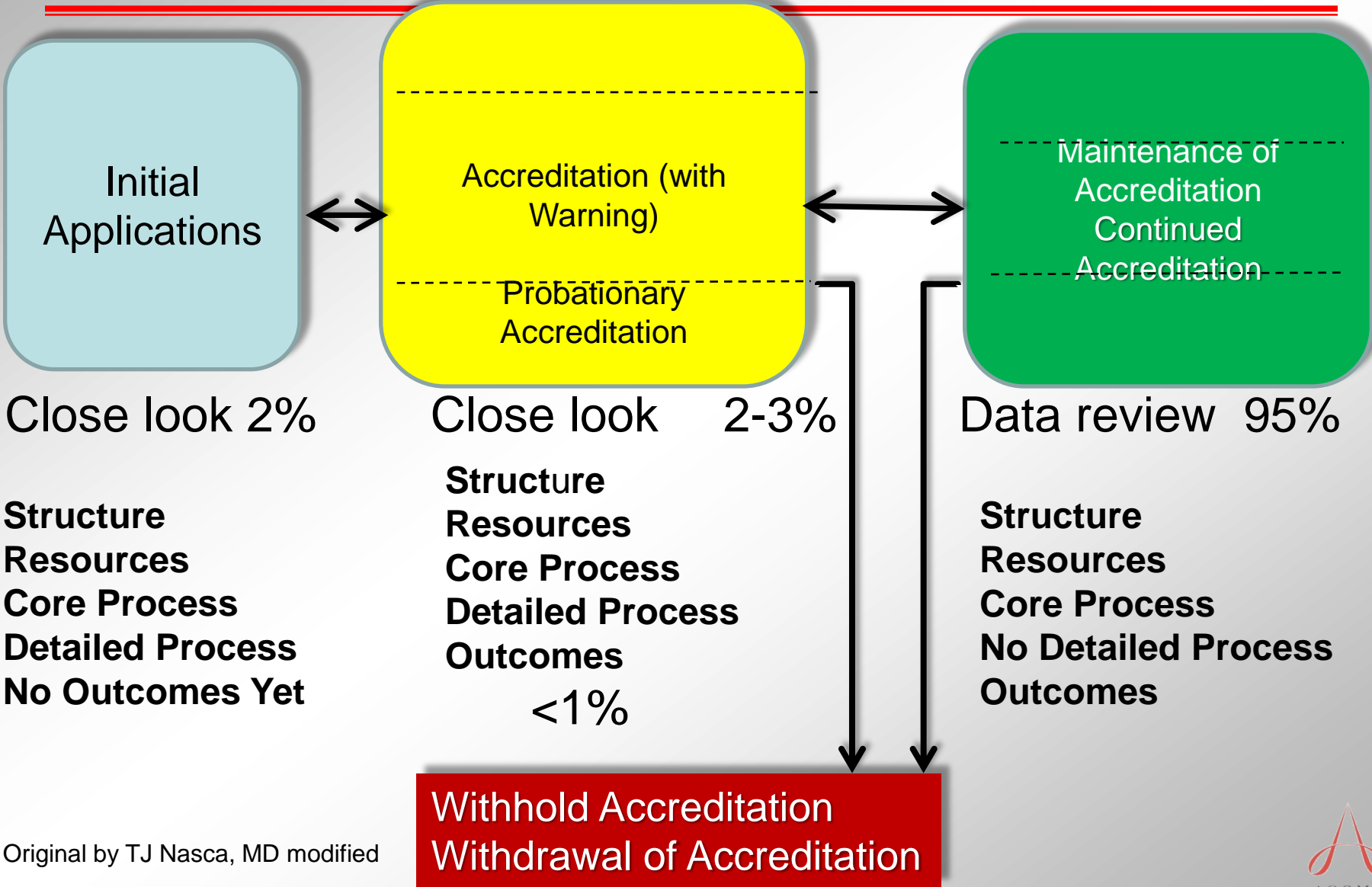
Decisions for Applications

1. Withhold Accreditation
2. Initial Accreditation
 - Subspecialties based on application only
 - Core programs require an application and a site visit

Decisions for Initial Accreditation

- Requires a full site visit within 2 years
 1. Continued Accreditation (green box)
 2. Initial Accreditation with Warning
(for one more year)
 3. Withdrawal Accreditation (red box)
 4. No probation (either up or out)

Program Review in the NAS



Original by TJ Nasca, MD modified

Next Accreditation System

What Happens at *My* Program?



What Happens at *My* Program?

- Annual data submission
- Annual program evaluation
- Self-study visits (SSV) every ten years
- Other possible actions prior/between SSVs:
 - Progress reports
 - Clarifying reports
 - Focused site visit
 - Full site visit



When Is My Program Reviewed?

- NAS is a continuous accreditation process
- *Each* program reviewed *at least* annually
 - RRC review of annually submitted data
 - Two RRC Meetings
 - February 13-14, 2015
 - May 29-30, 2015



NAS and ADS Annual Updates

- Each year, programs' data will be required to be entered in ADS such as:
 - Faculty information
 - Resident information
 - Block diagrams/curriculum information
 - Scholarly activity for residents and faculty
 - Participating site information
 - Responses to previous citations
 - Duty Hour, Patient Safety and Learning Environment information
 - Evaluation information
 - Major changes in the program

Some Data Reviewed by RRC

Most already in place

- ✓ Annual ADS Update
 - ✓ Program Characteristics – Structure and resources
 - ✓ Program Changes – PD / core faculty / residents
 - Scholarly Activity – Faculty and residents
 - Omission of data
- ✓ Board Pass Rate – 5 year rolling averages
- ✓ Resident Survey
- ✓ Faculty Survey
- ✓ Clinical Experience – Case logs
- ✓ Milestones/Semi-Annual Resident Evaluation and Feedback
 - 10-year Self-Study



Data Elements used for **NAS** annual screening of programs

(1) Program Attrition

- The attrition indicator is tracked when there are changes in any of the following:
 - *Program Director*
 - *Core faculty*
 - *Residents withdraw/transfer/dismitted*
 - *Department chair*
 - *DIO*
 - *CEO*

(2) Program Changes

- The program changes indicator is tracked when changes occur in any of the following categories in the most recent academic year:
 - *Participating site*
 - *Permanent complement*
 - *Sponsoring institution*

(3 & 4) Resident and Faculty Scholarly Activity

Templates for Scholarly Activity

Faculty Scholarly Activity

Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4.				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012	Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012	Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012	Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.
Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Chapters / Textbooks	Grant Leadership	Leadership or Peer-Review Role	Teaching Formal Courses
John Smith	12433	32411			3	1	1	3	Y	N

Resident Scholarly Activity

Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 3.			Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012		Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012		Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012
Resident	PMID 1	PMID 2	PMID 3	Conference Presentations		Chapters / Textbooks	Participated in research		Teaching / Presentations
June Smith	12433			1		0	N		Y

Categories for points:

Peer Review Publication	Other Scholarly	Grantsmanship	Leadership / Peer Review	Education
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(4) Board Pass Rate

- (2014) V.C.2.c).(1).(c)

At least 75 percent of a program's graduates taking the ABNM certifying examination for the first time should pass.

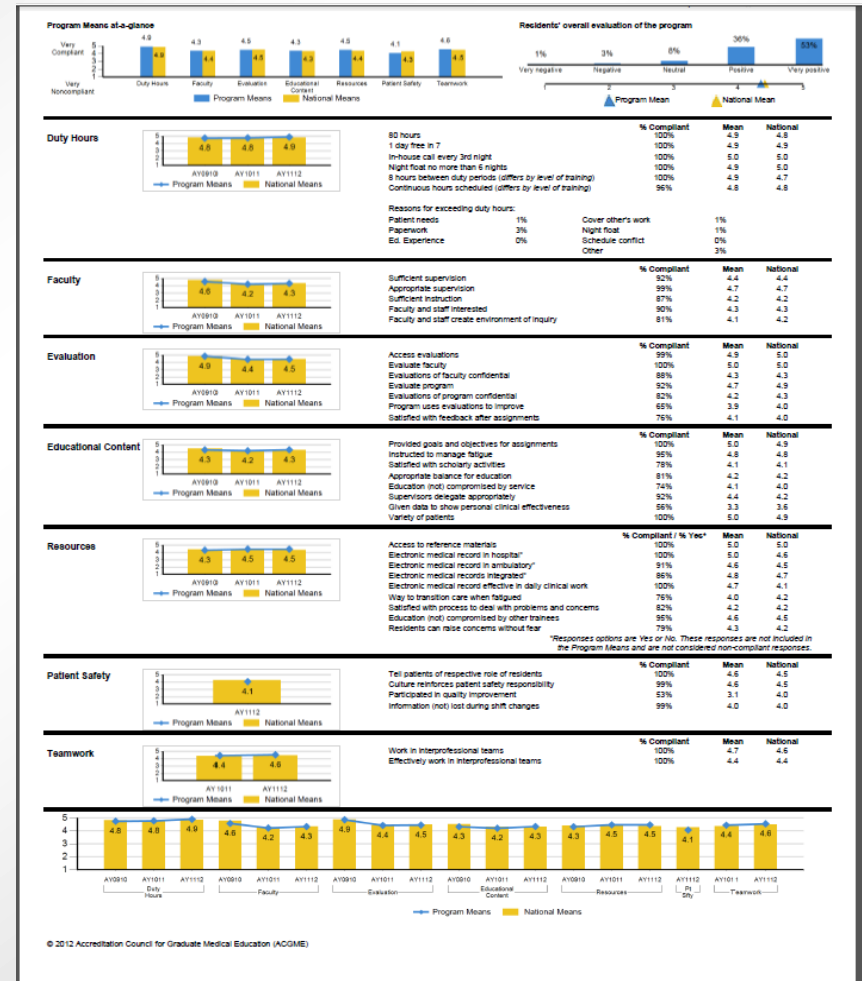
(5) Clinical Experience

- Case Log Data

Category	Type
Parenteral therapy	Parenteral therapy
Radioiodine therapy	3 - Less than or equal to 33 millicuries (mCi) I-131
	3 - Greater than 33 millicuries (mCi) I-131
	malignant/benign
Cardiac Stress Test (Pharmacologic or Exercise)	Cardiac stress test
Pediatric Procedures	Pediatric

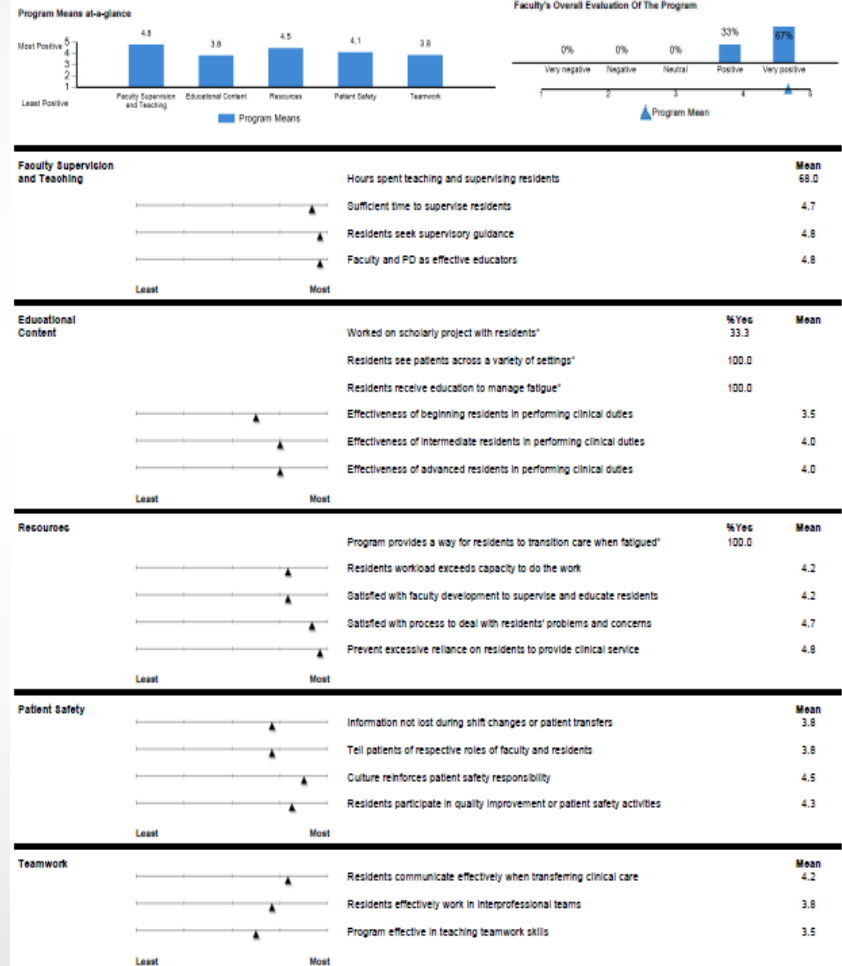
(6) Resident Survey

- Potential Non-Compliance is triggered when:
 - Duty hours exceeds the annual review threshold OR at least 3 other areas exceed the annual review thresholds
 - OR when 20% or more of residents had an overall negative opinion of the program.



(7) Faculty Survey

- Content areas align with Resident Survey
- All “core” physician faculty in ADS should complete the survey
- Non-compliance is triggered when 2 or more areas exceed the annual review thresholds



(8) Data Omission

- The data omission indicator is tracked when:
 - Annual ADS update not completed
 - Failure to identify any core faculty in ADS
 - Faculty Survey response <60%
 - Resident Survey response <70%
 - Failure to list faculty certification information for more than 20% of core faculty.

(9) Milestones

- Review Committee for Nuclear Medicine (RC-NM) will use aggregate data for program evaluation
- Will not be used right away
- Need at least one year of data collection

PD Responsibility: Accurate Data

- Program Director:
 - Must provide complete and accurate information
 - Review all information before “hitting” the submit button
 - ***DIO should also review before submission***
 - Common Data Omissions:
 - *Faculty credentials (degree, certification, re-cert)*
 - *Participating sites*
 - *Complete scholarly activity*
 - *Updated response to citation(s)*
 - *Complete block diagram*

- Recommend printing Program Summary

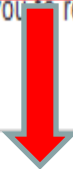
Approximate Date of Next Site Visit: *No Information Currently Present*

Self Study Date: September 01, 2015

Program Summary

Use the "Edit Program Information" [View](#) Summary" and "Print Summary PDF" options will allow you to review or print your Program Summary in HTML or PDF formats respectively.

Print a copy of the program summary for your records.



Edit Program Information

View Summary

Print Summary PDF

[back to top](#)

Important Dates

Annual Update Status:
August 01, 2013 - September 07, 2013

Next Site Visit :
NOT SCHEDULED

Self Study Date (APPROX) :
September 01, 2015

Resident Survey Status:
Apr 28, 2014 - Jun 01, 2014

Site Visit Results

Current Citations

Site Visit Evaluation

Case Logs

Resident Case Logs

All Nuclear Medicine programs are now required to use the ACGME Case Log System

- Letter sent December 2012

Resident procedure logs make it possible to:

- Track individual resident learning experiences
- Identify individual/program deficiencies
- Establish future training requirement benchmarks

Resident Case Logs

- Residents should enter all specified procedures performed during their residency education into the ACGME case log system
 - RC-NM Case Log message on 12/18/13

Program directors are expected to ensure that:

- Residents understand how to use the system
- Entries are accurate and complete
- Resident case logs are reviewed with residents during semi-annual evaluations

NM Case Log Changes

- Removal of the “Attending” field - **pending
- “Case ID” field not required
- Required procedures to be tracked:
 - Parenteral therapy
 - Radioiodine therapy
 - ~~PET/CT~~
 - Cardiac Stress Test (Pharmacologic or Exercise)
 - Pediatric Procedures
- Several “Other” CPT codes in the system grouped under “Non-Required Additional Procedures”

Required Key Index Areas

CPT Codes

- Parenteral Therapy (79101, 79445)
- Radioiodine Therapy (79005): Type Descriptions of:
 - Less than or equal to 33 millicuries (mCi) I-131
 - Greater than 33 millicuries (mCi) I-131
- Cardiac Stress Test: Pharmacologic or Exercise (93015)

Required Key Index Areas

CPT Codes

- **Pediatric (0-18 years of age):** There are no specified CPT codes and would result in a frequency count only.
- All Peds cases logged using generic code **78999**
- Residents may enter the specific name of the procedure/therapy in the comment box.
- If needed for credentialing, residents may perform a search and enter an actual CPT code and enter the data a second time in the ACGME case log system using the actual CPT code or use another system to track those procedures.

Milestones

Milestones

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

RRC's initially will use aggregate resident performance on the milestones to identify aspects of educational programs needing improvement

Specialty Specific Milestones

Patient Care & Medical Knowledge

Working Group

Educators and leaders from the Review Committee (including resident member and executive director), American Board of Nuclear Medicine, and the Society of Nuclear Medicine & Molecular Imaging(SNMMI)

Advisory Group

Specialty leaders (from Nuclear Medicine and ACGME)

Assist with establishing support for the Milestones
Provide feedback to the Working Group

Nuclear Medicine Milestones Working Group

- Lorraine M. Fig, MD, MPH - **Chair**
- Joanna R. Fair, MD,
- Erin Grady, MD
- Darlene F. Metter, MD FACR
- Lynne Meyer, PhD, MPH
- Janis P. O'Malley, MD
- Christopher J. Palestro, MD
- Henry D. Royal, MD
- David K. Shelton, MD

Milestones

- ✿ Observable developmental steps moving from Novice to Expert/Master (Level 1: entrance to Level 4: residency graduation or even Level 5: expert or mastery level)
- ✿ “Intuitively” known by experienced medical educators in each specialty
- ✿ Organized under the rubric of the six domains of clinical competency
 - ✿ Trajectory of progress: neophyte → independent practice
 - ✿ Articulate shared understanding of expectations
 - ✿ Set aspirational goals of excellence
 - ✿ Framework & language for discussions across the continuum

ACGME Goal for Milestones - Permits fruition of the promise of “Outcomes Based Accreditation”

- ✿ Specialty specific normative data and common expectations for progress of individual residents
- ✿ Tracks what is important – Outcomes
- ✿ Begins using *existing tools and observations of the faculty*
- ✿ Clinical Competency Committee triangulates progress of each resident

NM Milestones: Development

- Reference documents (ACGME, ABNM, literature)
- Challenges:
 - *NM Program varies from 1-3 years*
 - *Balance between broad/generalized vs. specific measures*
 - *Appropriateness of level 4 milestones*
- Several drafts with emphasis on important skills
- Pilot testing by working group and 6 field PDs

NM Milestones

- Patient Care – 5
- Medical Knowledge – 7
- Systems-Based Practice – 2
- Practice-Based Learning and Improvement – 2
- Professionalism – 1
- Interpersonal and Communication Skills – 2

- Total number of NM Milestones = 19

NM Milestones

- Patient Care
 - Diagnostic: General nuclear medicine, cardiovascular and molecular Imaging
 - Nuclear medicine stress testing
 - Therapy: Benign thyroid disease
 - Therapy: Thyroid malignancy
 - Therapy: Parenteral

NM Milestones

- Medical Knowledge
 - Physiology and pathophysiology
 - Anatomic imaging
 - Instrumentation
 - Radiopharmaceuticals and molecular agents
 - Medical physics, mathematics, radiation biology
 - Regulatory requirements
 - Radiation protection, patient safety, procedural safety

NM Milestones

- Practice based Learning and Improvement
 - Self-directed learning, scientific studies
 - Quality improvement project
- Interpersonal and Communications Skills
 - Patient communications
 - Health care teams
- Professionalism
 - Professional ethics and accountability
- Systems-Based Practice
 - Computer systems
 - Economics

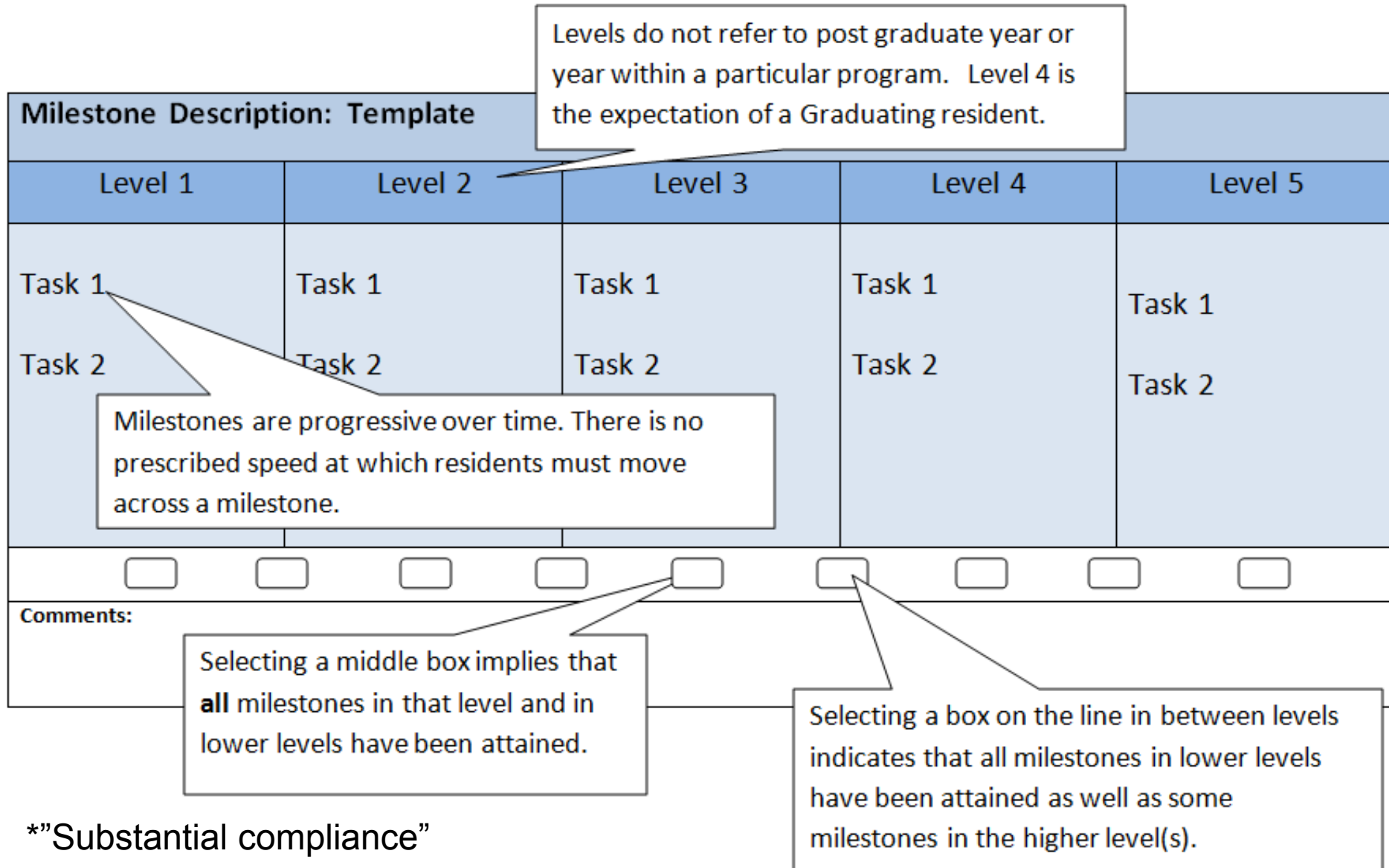
Radiation Protection, Patient Safety, and Procedural Safety – Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> • Knows basic radiation protection concepts and basic procedural safety in nuclear medicine • Understands universal precautions, including hand washing and sterile injection technique • Aware of the importance of fall prevention 	<ul style="list-style-type: none"> • Understands radiation protection concepts in nuclear medicine and correlative imaging • Understands appropriate use of “time-out” procedure • Knows how to ensure that the right patient has the right study at the right time in the right setting 	<ul style="list-style-type: none"> • Uniformly practices ALARA principles for patients, family, staff, and public • Knows more complex concepts of procedural safety and contraindications 	<ul style="list-style-type: none"> • Understands prevention of procedural complications for nuclear medicine and correlative imaging studies • Knows how to manage procedural complications 	<ul style="list-style-type: none"> • Demonstrates excellent understanding of radiation protection and/or procedural safety • Implements new safety procedures and quality control measures impacting patient care

Comments:

Not yet rotated

Milestone Template



Radiation Protection, Patient Safety, and Procedural Safety — Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> Knows basic radiation protection concepts and basic procedural safety in nuclear medicine Understands universal precautions, including hand washing and sterile injection technique Aware of the importance of fall prevention 	<ul style="list-style-type: none"> Understands radiation protection concepts in nuclear medicine and correlative imaging Understands appropriate use of "time-out" procedure Knows how to ensure that the right patient has the right study at the right time in the right setting 	<ul style="list-style-type: none"> Uniformly practices ALARA principles for patients, family, staff, and public Knows more complex concepts of procedural safety and contraindications 	<ul style="list-style-type: none"> Understands prevention of procedural complications for nuclear medicine and correlative imaging studies Knows how to manage procedural complications 	<ul style="list-style-type: none"> Demonstrates excellent understanding of radiation protection and/or procedural safety Implements new safety procedures and quality control measures impacting patient care

Example:				
<p>Knows basic radiation protection concepts (e.g., As Low As Reasonable Achievable [ALARA] principle and reducing exposure with time, distance, and shielding).</p> <p>Knows the basic considerations for imaging women of childbearing age, and pregnant/breast feeding women.</p>	<p>Understands how radiation dose impacts potential risk to patients in nuclear medicine and correlative imaging procedures.</p>	<p>Knows and practices ALARA principles.</p> <p>Balances radiation risks against study benefits and can implement strategies for imaging pregnant or breast-feeding women.</p> <p>Knows concepts of procedural safety (e.g., decreasing Tc-99m macroaggregated albumin [MAA] particles in pulmonary hypertension and right-to-left shunt).</p>	<p>Knows contraindications and treatment of complications for radiolabeled antibodies.</p> <p>Knows magnetic resonance (MR) and computed tomography (CT) safety precautions (e.g., magnetic fields, CT dose delivery, intravenous contrast reactions, gadolinium) and contraindications for their use.</p> <p>Is capable of managing procedural complications (e.g., hypersensitivity to agents, extravasation, iodinated contrast reactions, hypotension from captopril, etc.).</p>	<p>Studies the literature and proposes changes within the department to lower radiation dose to patients or technologists.</p> <p>Participates in a radiation safety audit or root cause analysis.</p> <p>Designs new protocol to maximize procedural safety.</p>

Comments:

Not yet rotated

Milestone Questions

- **Does each resident have to reach at least “Level 4” for every milestone in order to graduate?**
 - No, they do not. However, it will still remain the program director’s responsibility to verify and determine whether each resident has demonstrated sufficient competence to enter practice without direct supervision.
- **Must a resident succeed at all milestones at a certain level before being promoted to the next?**
 - No. Residents will not reach all milestones at the same time. Promotion from level to level remains a PD decision.

Reporting Milestones

- De-identified, aggregate (program) data will gradually be used as one element of accreditation decisions
- Individual reports by trainee will be provided to PD
- Semiannual reporting remains a foundation of NAS
- First NM Milestones reporting Nov-Dec 2014



1407800000 - Example Program

Internal medicine

Annual Update

Complete

Faculty Survey

0% Complete

Warning: Completion Rate is less than 60 %

Current Scheduled: Dec 05, 2012 - Jan 11, 2013

[View](#)

Current Survey Completion Rate: 0.00% - [0 of 22]

Last Faculty Survey Administration: *No Information Currently Present*

Resident Survey

0% Complete

Warning: Completion Rate is less than 70 %

Current Scheduled: Dec 19, 2012 - Jan 31, 2013

[View](#)

Current Survey Completion Rate: 0.00% - [0 of 25]

Last Resident Survey Administration: Jan 13, 2011 - Feb 13, 2011

Milestone Evaluations

Scheduled Dec 03, 2012 - Jan 05, 2013



[View](#)





1407800000 - Example Program

Internal medicine - Qatar

[Back To Program Overview](#)

Milestone Evaluations

[Click here to view Evaluation Narratives](#)

Academic Year:

2012-2013

Schedule Window:

2012-2013 ACGME-I Mid-Year Resident Evaluations

Submit

Resident	Year In Program	Position Type	Resident Status	Schedule Window	
Resident, Example	1	Categorical	Active Full time	2012-2013 ACGME-I Mid-Year Resident Evaluations	Evaluate Resident
Resident, Example	1	Categorical	Active Full time	2012-2013 ACGME-I Mid-Year Resident Evaluations	Evaluate Resident
Resident, Example	1	Categorical	Active Full time	2012-2013 ACGME-I Mid-Year Resident Evaluations	Evaluate Resident
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Resident, Example	1	Categorical	Active Full time	2012-2013 ACGME-I Mid-Year Resident Evaluations	Evaluate Resident
Resident, Example	1	Categorical	Active Full time	2012-2013 ACGME-I Mid-Year Resident Evaluations	Review Evaluation



Resident Evaluation: Current Summary

Program:
Resident: ;
Resident Year in Program: 1

Date Completed: **May 21, 2013 (End of Year)**

This form documents resident attainment of the milestones within each of the competencies as formally observed. Evaluation of the resident's developmental progression is based on numerous formative evaluations and the overall judgement of the resident's performance by the Clinical Competency Committee.

Competency	Subcompetency	Developmental Milestone Narrative
1) Professionalism	a) Honesty, integrity, and ethical behavior	Dr. Christie is truthful in all circumstances; usually acknowledges personal errors to his/her supervisor; and in most situations applies the concepts of putting the needs of patients above her/his own interests.
	b) Humanistic behaviors of respect, compassion, and empathy	Dr. Christie demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in some more complex clinical situations and settings and occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.
	c) Responsibility and follow through on tasks	Dr. Christie routinely completes most assigned tasks in a timely manner in accordance with local practice and/or policy, but still requires guidance in more complex clinical situations and unfamiliar circumstances.
	d) Receiving and giving feedback	Dr. Christie accepts feedback constructively and rarely demonstrates resistance to feedback and modifies practice in response to feedback. Dr. Christie occasionally gives constructive feedback to more junior learners, but rarely gives feedback to peers or other members of the healthcare team.
	e) Responsiveness to each patient's unique characteristics and needs	Dr. Christie demonstrates an awareness and appreciation of differences related to culture, ethnic, gender, racial, age, and religion dynamics in the patient/family encounter in routine situations, but still requires guidance in more complex clinical situations and unfamiliar circumstances.
2) Communication Skills	a) Communication and rapport with patients and families	Dr. Christie demonstrates the communication skills necessary to build rapport with patients and/or families in routine and non-stressful patient/family encounters; occasionally demonstrates recognition of non-verbal cues from patients and occasionally uses non-verbal skills to convey care and concern; but requires guidance in time-pressed, complex and stressful situations.
	b) Delivery of difficult or bad news	Dr. Christie usually recognizes the circumstances related to delivery of difficult or bad news to patients and/or families and begins to effectively communicate difficult or bad news in routine clinical situations, but still requires guidance in more complex clinical situations and unusual circumstances.
	c) Inter-professional respect, communication, and care coordination	Dr. Christie communicates in ways that convey an appreciation of the importance of the other members of the health care team in many situations; usually is effective in communicating with nursing and other health care team members; and usually communicates in ways that demonstrate respect for the skills and contributions of other professionals.
	d) Team and leadership skills	Dr. Christie demonstrates when appropriate emerging leadership skills in relationship to members of the health care team, including more junior learners, nurses, and other professional and staff members of the team; effectively coordinates efforts with other members of team in routine situations; and in most other situations knows when and how to defer to the expertise of the other members of the health care team.
	e) Communication and consultation with other physicians	Dr. Christie usually effectively communicates change in patient status to supervising residents/faculty in routine situations; usually obtains consultation, and communicates with supervisors and consultants in the care of patients; but needs guidance in complex and nuanced circumstances.

Individual Resident Milestones Narrative Report

[Overview](#)

[Program](#)

[Faculty](#)

[Residents](#)

[Sites](#)

[Case Logs](#)

[Summary](#)

[Reports](#)



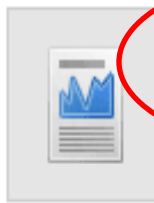
Survey
Aggregate program, national, and specialty-specific reports (if applicable)



Download My Data
Download Data for the Program



Resident Detail
Resident Detail information for a program.



Milestone Evaluations
Resident Evaluations



Emergency Medicine
Procedures, resuscitations, patient population statistics

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To access individual resident narrative reports click here

Importa

- [Ann](#)
Aug
07, 2013
- [Nex](#)
- [NOT](#)
- [Self](#)
- [Sep](#)
- [Resident](#)
Apr

[Refer](#)

[Journa](#)

New Program Requirements

Clinical Competency Committee

Program Evaluation Committee

New Program Requirements

- Clinical Competency Committee (CCC) and Program Evaluation Committee (PEC)
- Approved June 9, 2013
- Effective July 1, 2013 for Phase 1
- Effective July 1, 2014 for Phase 2

New CCC Program Requirement

- Program director appoints a CCC
- Must be at least three faculty members
 - Can include non-physician faculty
 - Subs can include faculty from cores
 - Can include program director
 - PD role is undefined, but consider conflicts
- Optional members in addition
 - Other physicians and non-physicians
 - No residents

New CCC Program Requirement

Written description of responsibilities

1. CCC reviews all resident evaluations

Semi-annually

2. Assure semi-annual reporting to ACGME

3. Advise the Program Director

1. Promotion

2. Remediation

3. Dismissal

New CCC Program Requirement

- General concept: many is better than one
- Program size and structure varies widely
- Program Requirement is broad on purpose
- Each Program will have to decide what works best
- E.g. subcommittees, individual reviewers, multiple meetings and other innovative formats are allowed

New PEC Program Requirement

- Program Evaluation Committee
- Can be same or different or overlap with CCC or Education Committee, APDs
- Adds structure to current requirement for annual review so should it not be new process

New PEC Program Requirement

- Appointed by program director
- Must be at least 2 members of the faculty and can include PD
- PD role is undefined
- Should include at least one resident
 - (recognizes sometimes no resident/fellow)
- Should meet even if no residents
- Written description of responsibilities
- Prepare written plan of action

New PEC Program Requirement

Active participation (deliberately broad):

1. Plans, develops, implements and evaluates program activities
2. Recommend Goals and Objectives revisions
3. Annual review of the program
4. Address (not fix) non-compliant areas

New PEC Program Requirement

- Produce annual program evaluation (APE)
- Written (not necessarily long)
- Systematic review of the curriculum
- Use faculty and resident feedback
- Document action plan to improve
- Monitor improvement

(Program responsibility, not GMEC or DIO)

Eligibility for Fellowship Programs

III.A.2. All required clinical education for entry into ACGME-accredited fellowship programs must be completed

- in an ACGME-accredited residency program,
- or in an RCPSC-accredited residency program
- or a CFPC-accredited residency program

(College of Family Physicians Canada)

Common Program Requirements
Adopted 28 September 2013
Effective 1 July 2016

Eligibility for Fellowship Programs

III.A.2.b)

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant*, who does not satisfy the eligibility requirements listed in III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions:

Common Program Requirements
Adopted 28 September 2013
Effective 1 July 2016

Fellowship Eligibility Exceptions in 2016

RCs permitting exceptions:

- Allergy and Immunology
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Nuclear Medicine**
- Ophthalmology
- Orthopaedic Surgery
- Pathology
- Pediatrics
- Preventive Medicine

RCs not permitting exceptions:

- Anesthesiology
- Medical Genetics
- Neurological Surgery
- Neurology
- Obstetrics and Gynecology
- Otolaryngology
- PM&R
- Plastic Surgery
- Psychiatry
- Radiation Oncology
- Surgery
- Thoracic Surgery
- Urology

2016 NM Eligibility Changes

- Nuclear Medicine will be allowed to apply fellowship “exceptional candidate” option
 - Applies to candidates appointed at the **NM2** and **NM3** levels
 - Outlined in ACGME’s Resident/Fellow Eligibility FAQs
- This option is not available in 2014 version of NM requirements
- To bridge the gap until 2016, [RC-NM will allow programs to exercise eligibility options outlined in pre-2014 requirements](#)
 - *See 2014 NM FAQs*

Summary

Submit Questions on the bottom of the screen
Reviewed and returned by e-mail

Thank-you