

Implementing the Next Accreditation System for Orthopaedic Surgery Programs

J. Lawrence Marsh, MD, RRC Chair

Pamela Derstine, PhD, MHPE, RRC Executive Director

ACGME Webinar

May 23, 2013



Topics

- RRC Update (Marsh)
- Orthopaedic Surgery Milestones (Marsh)
- Next Accreditation System Basics (Derstine)

RRC Update

Membership of the RRC

(as of July 1, 2012)

AMA

R. Dale Blaiser – Little Rock, AR

Craig S. Roberts – Louisville, KY

Lisa Taitsman – Seattle, WA*

AAOS

Lynn A. Crosby – Augusta, GA

Terry R. Light – Maywood, IL

Vincent D. Pellegrini, Jr. – Baltimore, MD

ABOS

J. Lawrence Marsh – Iowa City, IA (*Chair*)

Terry L. Thompson – Washington, DC

Michelle A. James – Sacramento, CA (*Vice-Chair*)

(*Shephard R. Hurwitz – Ex-officio*)

Resident

Christopher J. Dy – New York, NY*

Executive Director

Pamela L. Derstine, PhD, MHPE

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Theodore W. Parsons – Detroit, MI

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Resident

Jeanne M. Franzone – New York, NY

Executive Director

Pamela L. Derstine, PhD, MHPE

Accreditation Statistics AY 11/12

Total # Accredited Programs	
# Core	154
# Sub	248
Total # Residents/Fellows	
Male/Female	3254/506
Total # Programs Reviewed	
# Core	41
# Sub	73
Total # New Programs Accredited	
# Core	1
# Sub	6

Accreditation Statistics AY 11/12

Other RRC Meeting Decisions (Core and Subs)

Complement increases

Requested/#Approved 20/7

Progress/Reports

Requested/#Reviewed 12/12

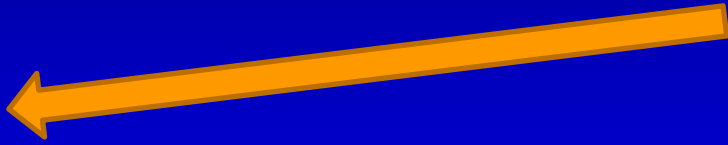
Duty Hour Reports

Requested/#Reviewed 0/4

Traditional Program Review

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

SV and PIF are
key portions of
program review



Program outline

- ❑ **New PGY 1 program requirements**
 - ❑ **Surgical skills training through simulation**
 - ❑ **New requirements for case log reporting**
 - ❑ **Milestones - development and implementation**
 - ❑ **Milestones - integration into NAS**
 - ❑ **NAS – other data elements**
 - ❑ **NAS – Program review and accreditation decisions**
- ❑ **Larry Marsh - Chair RRC**
- ❑ **Pam Derstine - Executive Director RRC**

**New PGY 1
program
requirements**

PG-1 Year Changes 2013-2014

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

Good news
– they are
the same!

- ❑ 6 months of orthopaedic surgery
- ❑ Basic surgical skills training through simulation

PGY 1 year changes (core)

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

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

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

IV.A.6.a).(1).(b) The **additional three months must be on rotations chosen from** the following: anesthesiology, basic surgical skills, emergency medicine, general surgery, general surgery trauma, internal medicine, medical or surgical intensive care, musculoskeletal radiology, neurological surgery, pediatric surgery, physical medicine and rehabilitation, plastic/burn surgery, rheumatology, and vascular surgery

PGY 1 year changes (core) - continued

IV.A.6.a.)(1).(c). The total time a resident is assigned to any one non-orthopaedic service must not exceed two months.

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

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

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

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

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

IV.A.6.b).(4) develop an **understanding of surgical anesthesia**, including anesthetic risks and complications.

**Surgical skills
training through
simulation**

Background

- ❑ Orthopedic Surgery requires a high degree of technical skill
- ❑ Skills are acquired during residency and fellowship training through an apprenticeship model largely unchanged for over a century.



Orthopaedic Surgery Simulation Summit – Nov 4th 2011



Goals of the Summit

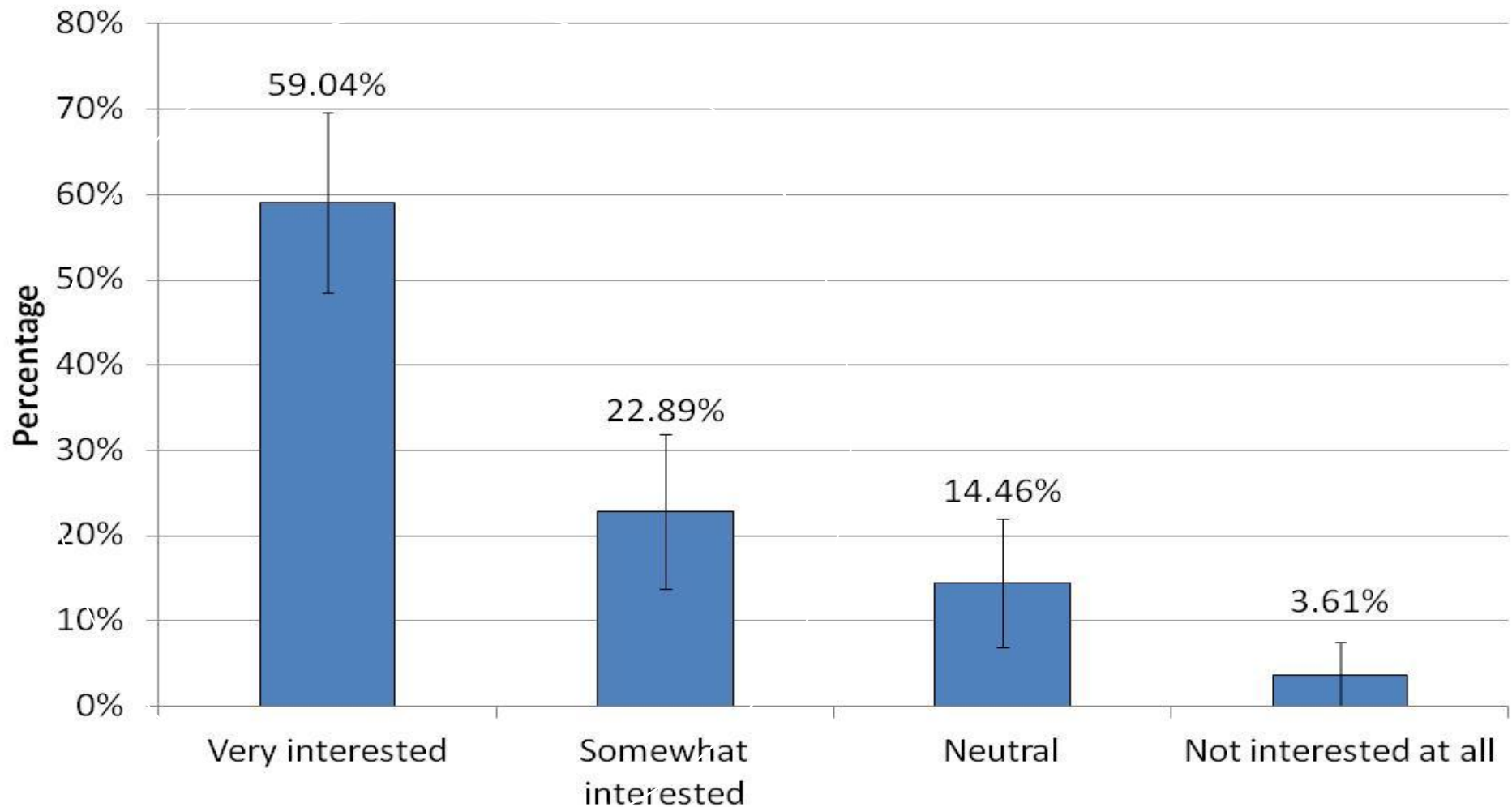
- **Simulation in other surgical GME:** Review curriculum/simulations in other disciplines to learn from these experiences.
- **Current orthopedic surgical simulation**
- **Curriculum development:** Discuss the steps to develop an orthopedic resident based skills curriculum. Consider the following:
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

Results of a 2011 National Orthopaedic Program Director and Resident Survey – *Karam and Marsh JBJS 2012*

- ❑ Only 50% of residency programs have a skills lab and program.
- ❑ There is high interest among PD's in a skills curriculum.
- ❑ Most PD's have little knowledge of the budget for skills training or the cost of a skills lab
- ❑ Cost is a challenge to expansion of skills programs

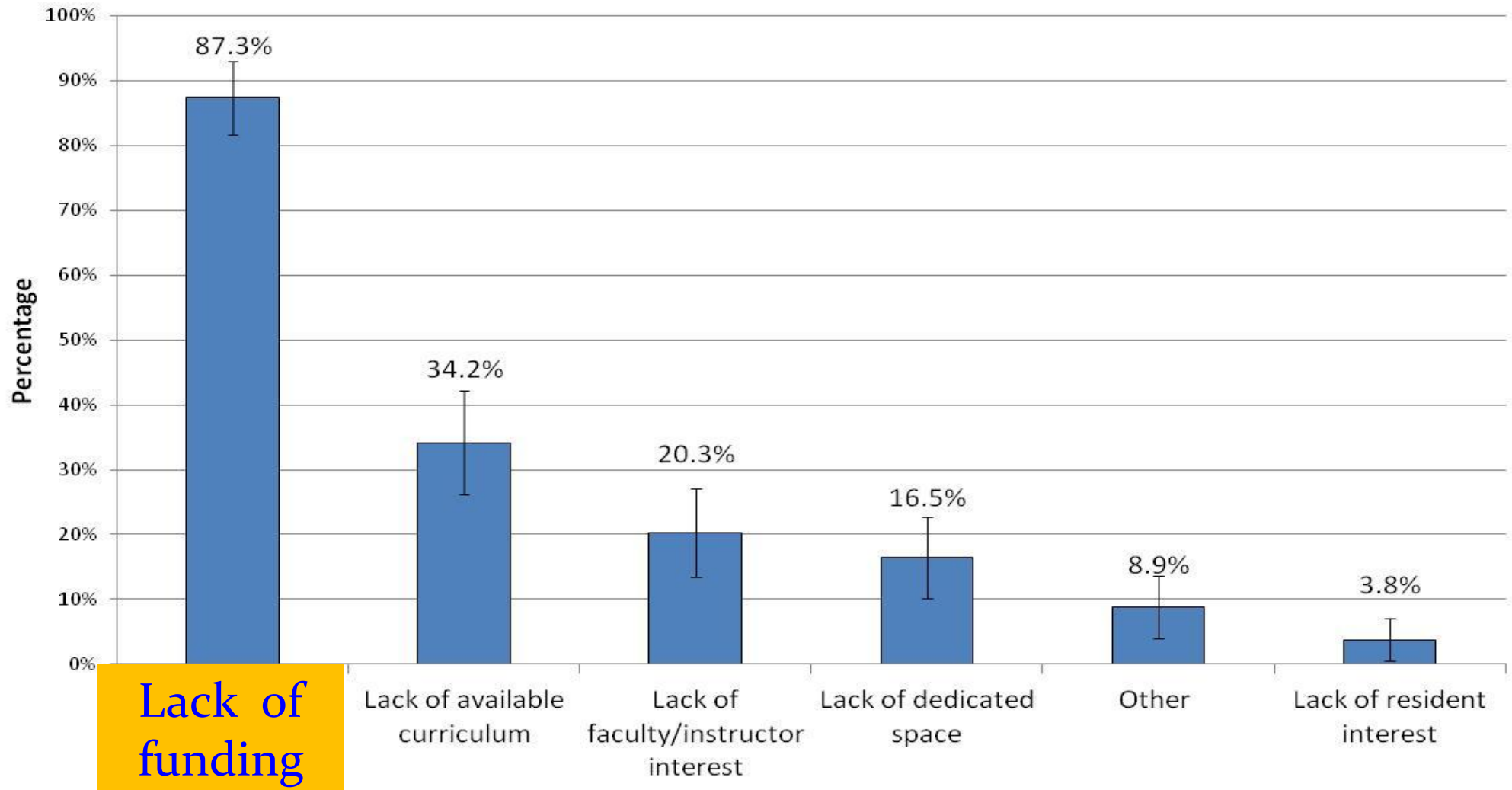
Interest in a curriculum?

How interested are you in a standardized simulation of surgical skills curriculum for residents?



Barrier to skills program

What is the most significant barrier to development of a formal surgical skills program at your institution? Check all that apply.



The American Board of Orthopaedic Surgery (ABOS) and the Residency Review Committee (RRC) will require a laboratory based surgical skills training program beginning Academic year 2013-2014. Requirements include:

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

Here are the new Program Requirements for 2013?

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

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

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

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

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

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

What is a skills simulation curriculum?

ACS/APDS Phase I Curriculum Modules

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

SKILLS MODULES



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

The design was a modular curriculum with each module created to train residents over a half to a full day. The 16 modules were primarily developed by orthopaedic faculty.

Members of the ABOS (AOA/CORD and AAOS) Surgical Skills Task Force

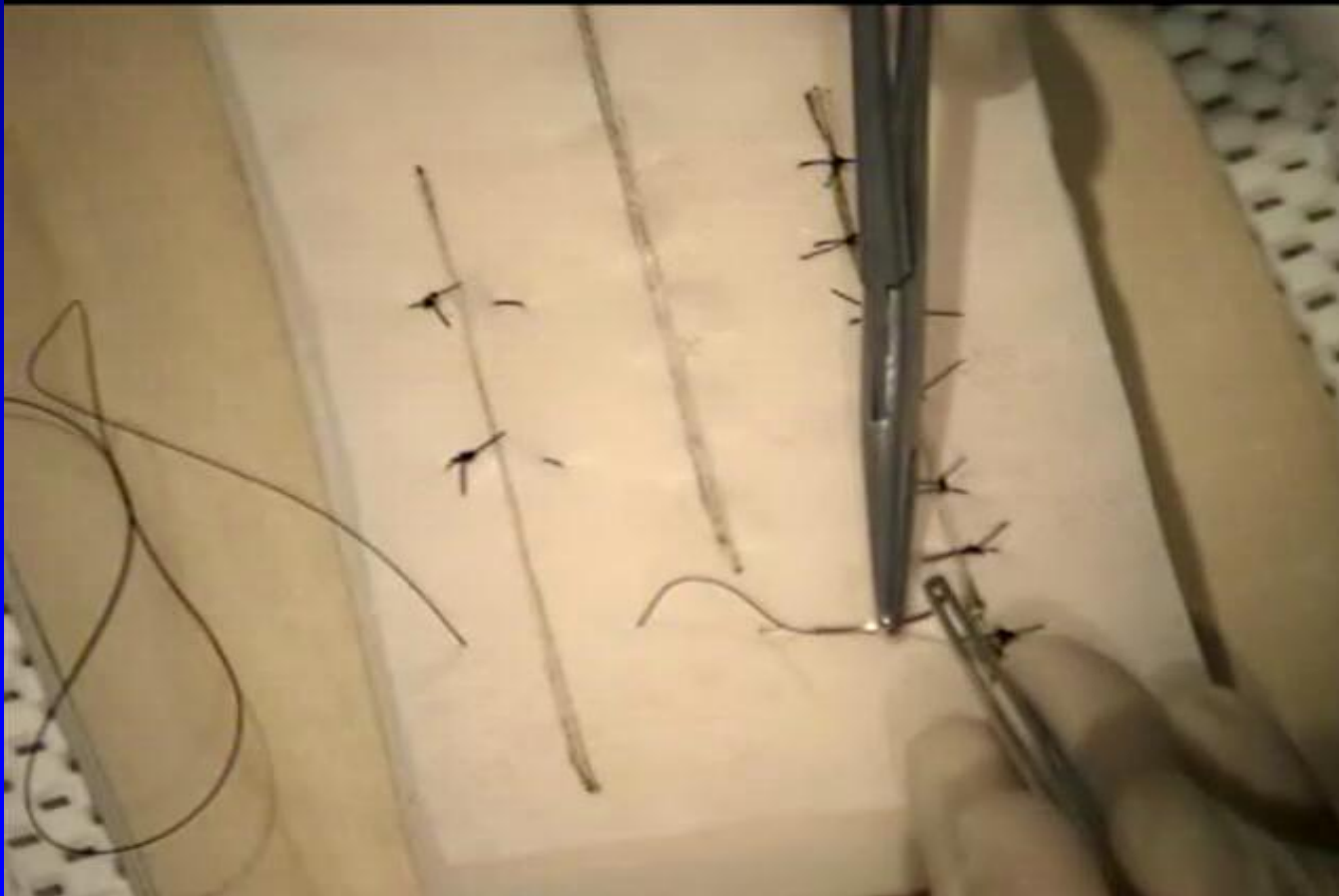
- *J. Lawrence Marsh, MD – Chair (ABOS)*
- *James E. Carpenter, MD (ABOS)*
- *Shepard R. Hurwitz, MD (ABOS)*
- *Michelle A. James, MD (ABOS)*
- *Joel T. Jeffries, MD (AOA/CORD)*
- *David F. Martin, MD (ABOS)*
- *Peter M. Murray, MD (ABOS)*
- *Bradford O. Parsons, MD (AAOS)*
- *Robert A. Pedowitz, MD, Ph.D. Co-Chair (AAOS)*
- *Brian C. Toolan, MD (AAOS)*
- *Ann E. Van Heest, MD (AOA/CORD)*
- *M. Daniel Wongworawat, MD (AAOS)*

Modules (ABOS skills taskforce modules)

1. Sterile technique and operating room set up
2. Knot tying & suturing
3. Microsurgical suturing
4. Soft tissue handling techniques
5. Casting and splinting
6. Traction
7. Compartment syndrome
8. Bone handling techniques
9. Fluoroscopy
10. K-wire techniques
11. Basic techniques in ORIF
12. Principles and techniques of fracture reduction
13. External fixation
14. Basic Arthroscopy skills
15. Basics of Arthroplasty
16. Joint injection
17. Patient Safety

Modules should include:

- Low cost low tech options



Modules should include:

- Instruction in accepted techniques



Modules should include:

❑ Deliberate Practice in Medical Education includes Assessment

1. repetitive performance of intended cognitive or psychomotor skills.
2. rigorous skills assessment
3. specific information feedback

Modules should include: Evaluation and assessment strategies

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



Calendar of the 16 Skills Modules

Monday	Tuesday	Wednesday	Thursday	Friday
	1	2	3	4
	Offices Closed	Orientation	<u>Module 1</u>	<u>Module 2</u>
			Sterile Technique/OR Setup: Noiseux/Wolf	Fluoroscopy/ Radiology: Marsh/Karam
7	8	9	10	11
<u>Module 3</u>	<u>Module 4</u>	<u>Module 5/6</u>	<u>Module 7</u>	<u>Module 8</u>
Knot Tying & Suturing: Femino/Shah	Soft-Tissue Handling Techniques: Lawler/Miller	Compartment Syndrome: Karam/Ilgenfritz Traction: Dietz	Casting/Splinting - Ilgenfritz: Morcuende	Basic Techniques in ORIF: Karam/Marsh
14	15	16	17	18
<u>Module 9</u>	<u>Module 10</u>	<u>Module 11</u>	<u>Module 12</u>	<u>Module 13</u>
Bone Handling Techniques: Phisitkul	Principles and Techniques of Fracture Reduction: Karam/Marsh	Basic LE Arthroscopy Skills: Wolf	Basic UE Arthroscopy Skills: Wolf	Basic Spine Surgical Skill: Mendoza
21	22	23	24	25
University Holiday MLK Day	<u>Module 14</u>	<u>Module 15</u>	<u>Module 16</u>	<u>Module 17</u>
	Ultrasound Guided Joint Aspiration/ Injection: Hall	Hand Trauma/Skills: Shah/Lawler	Arthroplasty Hip Basic Skills: Noiseux/ Willenborg	Arthroplasty Knee Basic Skills: Noiseux/ Willenborg
28	29	30	31	
<u>Module 18</u>	<u>Module 19/AOA</u>	<u>Module 19/AOA</u>	<u>Debriefing</u>	
External Fixation: Femino	Research Methods: Anderson	Research Methods: Anderson	Survey/ Questionnaire	

January
2013

All 6
PGY 1's

Some call
on
weekend
no other
clinical
work

Module 8: Basic Techniques in ORIF



Equipment utilized in the ORIF Module



Faculty instructing residents on techniques used in the ORIF module

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

I. Objectives

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

II. Assumptions

III. Background Info and Knowledge

IV. Suggested Readings

V. Description of Laboratory Module

VI. Description of Techniques

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

VII. Common Errors and Preventions

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

VIII. Expert Performance and Videos

IX. Recommendations for Practice

X. Supplies and Station Setup

XI. Assessment Metric

XII. Estimated Costs of Module (\$700)

XIII. Suggested Time Length (7 hours)

PERFORMANCE ASSESSMENT

▪ Assessment Measures

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

▪ Detailed Research Modules

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



PGY-1 resident completing post-test questionnaire.

Preliminary Outcomes

ORIF Module:

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

	Pre-module OSATS	Post-module OSATS	Pre-module Pass Rate	Post-module Pass Rate
Resident Avg.	55%	78%	50% Pass	100% Pass

RESIDENT SURVEYS

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

“Overall excellent month for many reasons!”

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

“Great Month!”

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

“Awesome month.”

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

“Would highly recommend continuing it.”



Faculty demonstrating soft tissue handling techniques

Surgical Skills Resident Survey Outcomes:

Overall satisfaction	5
Module format	5
Did it help your surgical skill set?	4.5
Did you feel like it enhanced your Orthopaedic training program?	5
Did you feel it will enhance safety in the OR?	4.33
Do you feel this should be a permanent part of surgical education?	5
1= Worst 5=Best	<i>Overall Satisfaction: 96.2%</i>
	4.81

COST



Faculty observes a resident perform an osteotomy on a surrogate bone model

Bone Surrogate :	\$ 8,000
Cadaver Costs:	\$ 10,000
Fluoroscopy Time	\$ 300
Equipment Costs:	\$ 1,000
Animal Models:	\$ 700
Vid/Org. Assistant	\$ 1,000
Lab Assistant	\$ 1,500
Total:	\$22,500

TIME ALLOCATED

Lab Assistant:	120 hrs
Video/Organizational Assistant	60 hrs
Faculty Time Per Module	6-8 Hrs/Day for 1-2 Staff
Total Faculty Time	102 hrs

Summary and Conclusions

- ❑ Considerable time invested in the planning and execution but faculty members were engaged and eager to contribute.
- ❑ The greatest expense was for cadaveric specimens. With better planning and with different and more cost effective simulations, this expense could be reduced.
- ❑ The video content produced should allow residents to learn more independently, and decrease the faculty time commitment. Video will be available through the parallel project created by the ABOS/AAOS/AOA/CORD project.



Summary and Conclusions

- ❑ Resident satisfaction was high.
- ❑ Next year we will develop better assessment metrics and assess the relative value of each of the modules
- ❑ This experience suggests a dedicated month of surgical simulation has potential to change the paradigm of skills training for junior residents.



New requirements for case log reporting

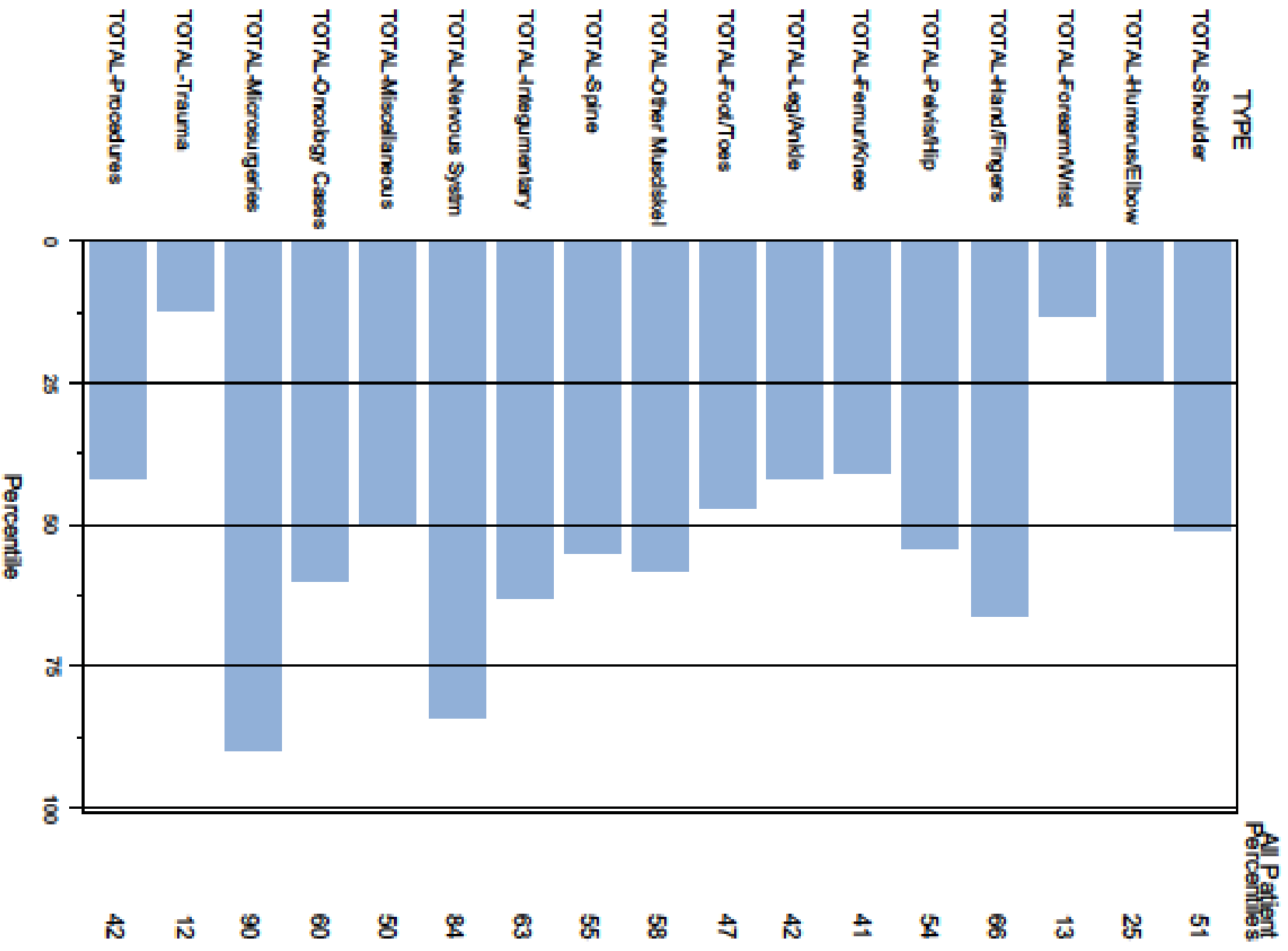
Case Logs

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

Case logs - more important in NAS

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

What should you be doing now???



Case Logs: Minimum Numbers

Defined Case Category	Min #	Defined Case Category	Min #
Knee Arthroscopy	30	Ankle Fracture Fixation	15
Shoulder Arthroscopy	20	Closed Reduction Forearm/wrist	20
ACL Reconstruction	10	Ankle/Hind/Mid Foot Arthroscopy	5
THA	30	Supracondylar Humerus Perc	5
TKA	30	Femur/Tibia Intramedullary Fixation	25
Hip Fractures	30	All Pediatric Procedures	200
Carpal Tunnel Release	10	All Oncology Procedures	10
Spine Decompression/Posterior Spine Fusion	15		

[PART 1]	Programs in the Nation: 149	Residents in the Nation: 675	Residents in this Program: 6	
	Prog AVE	Min Req	Num of Res Bel Min	Natl Prog AVE
Defined Categories				
<i>Knee Arthroscopy</i>	116.7	30	0	164
<i>Shoulder Arthroscopy</i>	126.2	20	0	131
<i>ACL Reconstruction</i>	34.3	10	0	31
<i>THA</i>	107.0	30	0	85
<i>TKA</i>	114.0	30	0	118
<i>Hip Fractures</i>	39.2	30	1	52
<i>Carpal Tunnel Release</i>	52.0	10	0	35
<i>Spine Decompression/Fusion</i>	55.2	15	0	51
<i>Ankle Fracture Fixation</i>	48.8	15	0	64
<i>Closed Reduction Forearm/Wrist</i>	9.3	20	6	38
<i>Ankle/Hind/Mid Foot Arthro</i>	12.7	5	0	13
<i>Supracondular Humerus Perc</i>	11.7	5	1	14
<i>Femur/Tibia Intra-medullary Fixation</i>	31.8	25	1	46
<i>Oncology Procedures</i>	39.7	10	0	41
<i>Pediatric Procedures</i>	386.5	200	0	538

Case Logs

- Case Log program reports for all 2011-2012 graduates were reviewed and minimum number discrepancies noted (NOT CITED)
- Residents graduating 2012-2013 and beyond are expected to demonstrate compliance with the minimum numbers

Case logs – Make the data better!

- Upcoming developments (approved but pending):
 - ❖ Residents should enter as many codes as applicable for each case but must identify the **primary code**
 - ❖ Multiple index procedures done during a single patient operation will be entered as separate cases
 - ❖ 2 residents participating in a bilateral case should separately enter their participation
 - ❖ **Level of involvement definitions**

What should we be doing now???

Case Logs: Resident Surgeon Definitions

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

Primary – the resident performs key portions of the procedure.

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

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

- **Level 2 - Assisting resident surgeon** – The resident is scrubbed on the case and participates in preoperative assessment and planning and assists a more senior surgeon in the key portions and may participate in opening or closing or other non-key portions.

Case Logs: Surgeon Definitions

- Residents should log procedural experiences as either **Level 1** or **Level 2**. They should not log the procedure if they participate at less than these levels. All procedures at both levels require appropriate faculty supervision and participation in the case.
- To count for procedural minimums the resident must have **Level 1** involvement in the case

Case Logs: FAQs

- CPT code list for each DCC:

http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramResources/260_OR_S_Case_Log_Minimum_Numbers.pdf

- Case Log FAQs (see orthopaedic surgery FAQs):

http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/260_Orthopaedic_Surgery_FAQs.pdf

Milestones - development and implementation

Milestones

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

Milestones: Medical Knowledge & Patient Care

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

Small slices of clinical care – a biopsy of resident performance!

Orthopaedic Surgery Milestones

- General
 - Professionalism (2)
 - Interpersonal Skills & Communication (2)
 - Practice-based learning (2)
 - Systems-based practice (3)
- See all milestones at:
<http://www.acgme-nas.org/assets/pdf/Milestones/OrthopaedicSurgeryMilestones.pdf>

Milestones: Medical knowledge (example)

Milestone Description: Pediatric Septic Hip – Medical Knowledge				
Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> • Demonstrates knowledge of common presentation of hip septic arthritis • Demonstrates knowledge of basic hip anatomy • Demonstrates knowledge of basic imaging studies • Demonstrates knowledge of appropriate laboratory studies 	<ul style="list-style-type: none"> • Demonstrates knowledge of pathophysiology of joint damage related to septic arthritis • Demonstrates knowledge of basic surgical approach • Demonstrates knowledge of the differential diagnosis of the irritable hip • Understands natural history and the effects of intervention • Demonstrates knowledge of advanced imaging studies 	<ul style="list-style-type: none"> • Demonstrates knowledge of the vascular supply in the skeletally immature hip • Demonstrates knowledge of microbiology and antibiotic choices • Demonstrates knowledge of potential complications • Demonstrates knowledge of clinical and laboratory data relevant to differential diagnosis 	<ul style="list-style-type: none"> • Demonstrates knowledge of options and anatomy for surgical approaches • Demonstrates knowledge of atypical infecting organisms and management options 	<ul style="list-style-type: none"> • Author/presenter in published work
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:				

Hip and Knee Osteo Arthritis (OA) – Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> Obtains history and performs basic physical exam Appropriately orders basic imaging studies Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices) Provides basic peri-operative management (e.g., pre- and post-operative assessment) Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise) 	<ul style="list-style-type: none"> Obtains focused history and performs focused exam Appropriately interprets basic imaging studies Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections) Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed) Capable of performing one basic surgical approach to the hip and knee Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization) Capable of diagnosis and early management of complications (e.g., infections, dislocations) Assesses for risk of thromboembolic disease 	<ul style="list-style-type: none"> Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views) Appropriately recommends surgical intervention Completes comprehensive pre-operative planning with alternatives Modifies and adjusts post-operative treatment plan as needed Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement) Provides prophylaxis and manages thromboembolic disease 	<ul style="list-style-type: none"> Capable of performing alternative surgical approaches to the hip and knee arthritis Capable of performing primary THR and TKR Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability) 	<ul style="list-style-type: none"> Competently performs two or more approaches to the hip and knee Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty) Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise) Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)

Comments:

Not yet rotated

Hip and Knee Osteo Arthritis (OA) – Patient Care				
Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> Obtains history and performs basic physical exam Appropriately orders basic imaging studies Prescribes non-operative treatments (e.g., NSAIDs, physical therapy, assistive devices) Provides basic peri-operative management (e.g., pre- and post-operative assessment) Lists potential complications (e.g., infections, dislocations, thromboembolic disease, peri-prosthetic fracture, neurovascular compromise) 	<ul style="list-style-type: none"> Obtains focused history and performs focused exam Appropriately interprets basic imaging studies Manages non-operative treatment (e.g., NSAIDs, physical therapy, assistive devices, injections) Completes pre-operative planning with instrumentation and implants (e.g., implant templating, instruments needed) Capable of performing one basic surgical approach to the hip and knee Provides post-operative management and rehabilitation (e.g., orders appropriate peri-operative medications and mobilization) Capable of diagnosis and early management of complications (e.g., infections, dislocations) Assesses for risk of thromboembolic disease 	<ul style="list-style-type: none"> Appropriately orders and interprets advanced imaging studies (e.g., MRI, CT, nuclear medicine imaging, and advanced radiographs views) Appropriately recommends surgical intervention Completes comprehensive pre-operative planning with alternatives Modifies and adjusts post-operative treatment plan as needed Capable of surgically treating simple complications (e.g., closed reduction, irrigation, and debridement) Provides prophylaxis and manages thromboembolic disease 	<ul style="list-style-type: none"> Capable of performing alternative surgical approaches to the hip and knee arthritis Capable of performing primary THR and TKR Capable of treating complications both intra- and post-operatively (e.g., peri-prosthetic fractures, infections, instability) 	<ul style="list-style-type: none"> Competently performs two or more approaches to the hip and knee Capable of performing complex primary and simple revision THR and TKR (e.g., hip dysplasia, hip protrusio, valgus knee, loose components, uniarthroplasty) Develops unique, complex post-operative management plans (e.g., infections, dislocations, neurovascular compromise) Surgically treats complex complications (e.g., peri-prosthetic fractures, knee instability)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;">Not yet rotated <input type="checkbox"/></div>				

Hip and Knee Osteo Arthritis (OA) – Patient Care				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:				
Not yet rotated <input type="checkbox"/>				

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments:

Not yet rotated

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Comments:

Not yet rotated

Milestones: Other competencies

- Practice-based learning & improvement: locates, appraises & assimilates evidence from scientific studies to improve patient care
- Systems-based practice: cost-effective practice
- Systems-based practice: interprofessional teamwork
- Systems-based practice: uses technology to accomplish safe health care delivery
- Interpersonal and communications skills: communication
- Interpersonal and communications skills: teamwork
- Professionalism: compassion, integrity, respect for others; adherence to ethical principles of medicine; putting patients above self-interest
- Professionalism: accountability & personal responsibility

Pertinent Milestones Information

- **Required** beginning fall 2013
- **NOT** going to be used for actual program review until normative data is collected (2015 at the earliest)
- **NOT** intended to be added on to other evaluations for resident competency
 - Intended to replace these
- **NOT** the key to competency-based education
 - Reaching milestones won't shorten education; failing to reach them won't lengthen it

Clinical Competency Committee

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

Clinical Competency Committee

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

Milestones Important Timeline

- **Now:** Form a CCC and prepare for milestone evaluations
- **July – December 2013:** First evaluation period
- **December:** First milestone evaluations submitted to ACGME (via web)

Milestones Timeline: Core Programs

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

Milestones Timeline: Subspecialty Programs

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

Milestones Timeline: Subspecialty Programs

- January – June 2015: second evaluation period
- June 2015: Second milestone evaluations submitted to ACGME (via web)
- January 2016: RRC review of AY 2014/2015 milestone data

Next Accreditation System Basics

Next Accreditation System Goals

- Help produce physicians for 21st century
- Accredite programs based on outcomes
- Reduce administrative burden of accreditation
- Free good programs to innovate
- Assist underperforming programs to improve
- Provide public accountability for outcomes



ACGME

Next Accreditation System

Key Features

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



Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

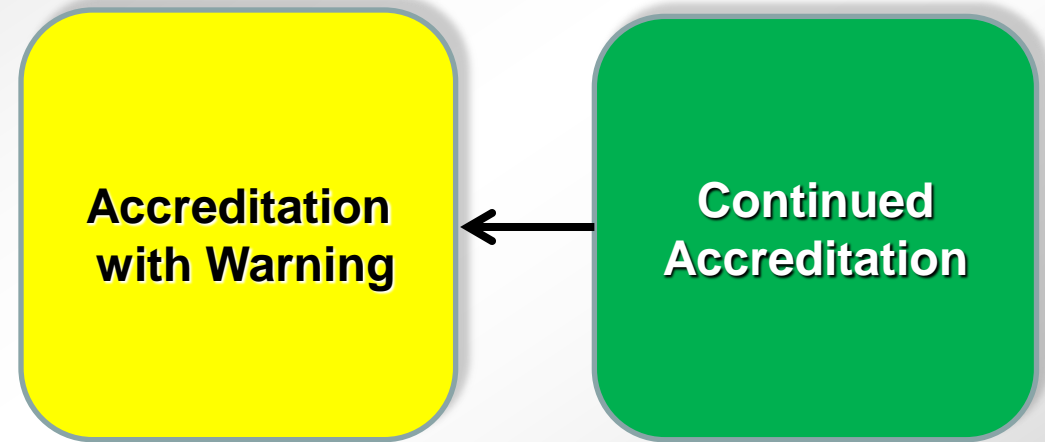
**Continued
Accreditation**

STANDARDS

**Core Process
Detail Process
Outcomes**

**Outcomes
Core Process
Detail Process**

Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



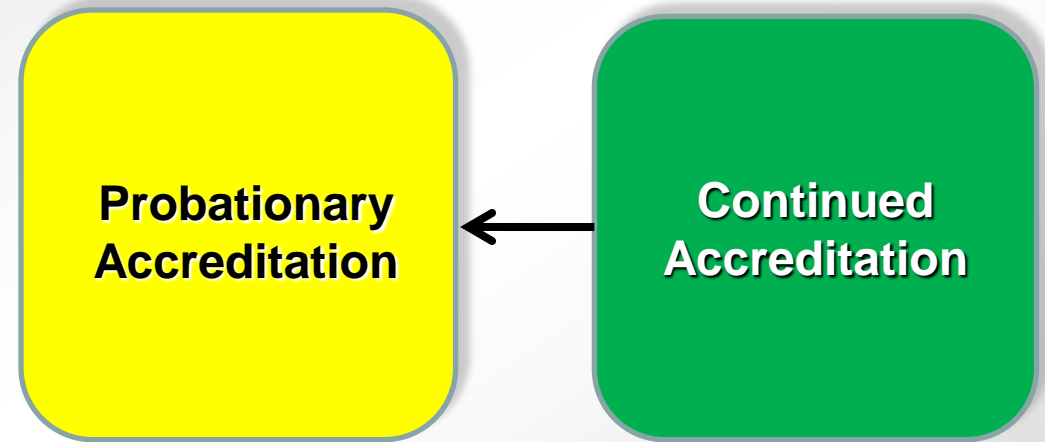
STANDARDS

Core Process
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Outcomes
Core Process
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Outcomes
Core Process
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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



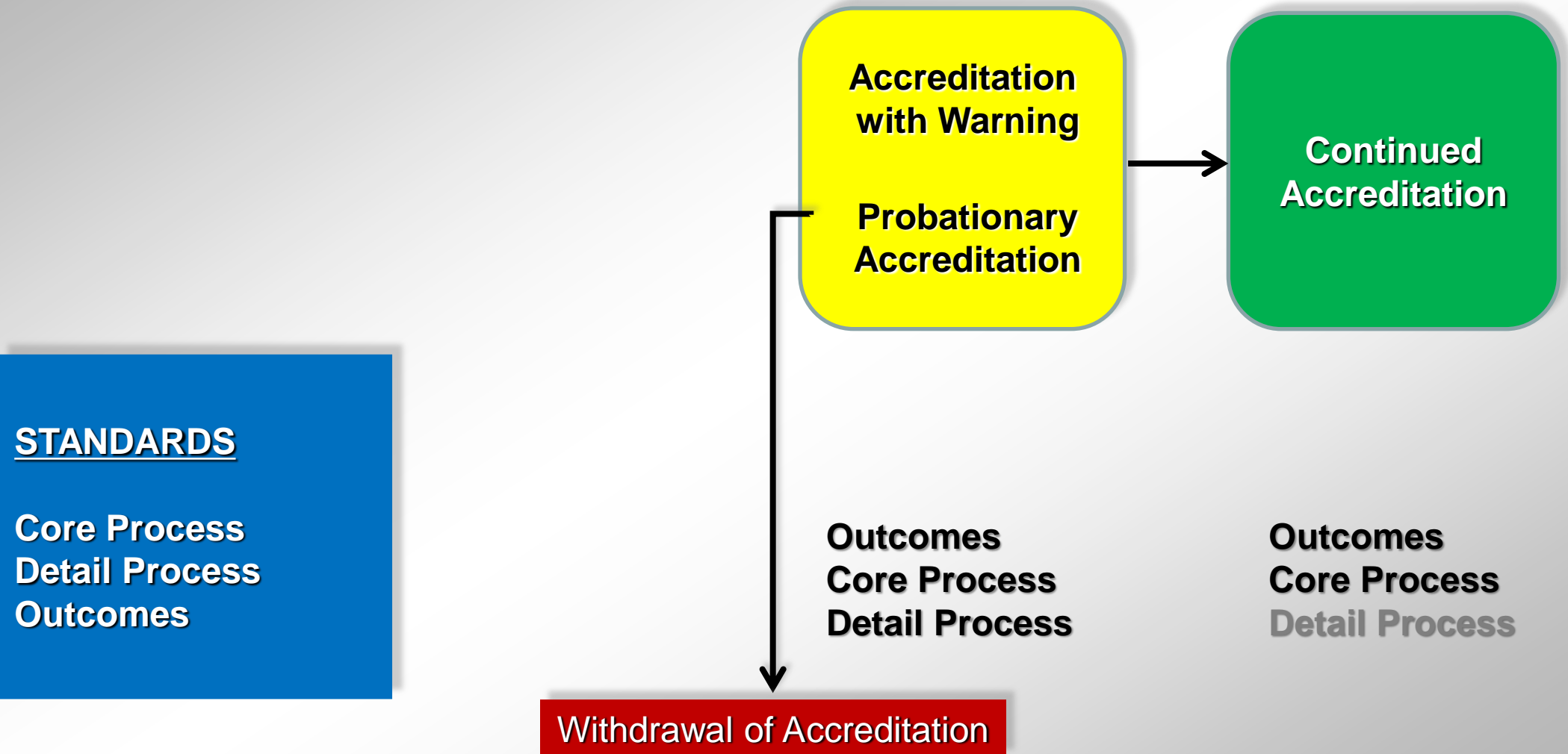
STANDARDS

Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process

Outcomes
Core Process
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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

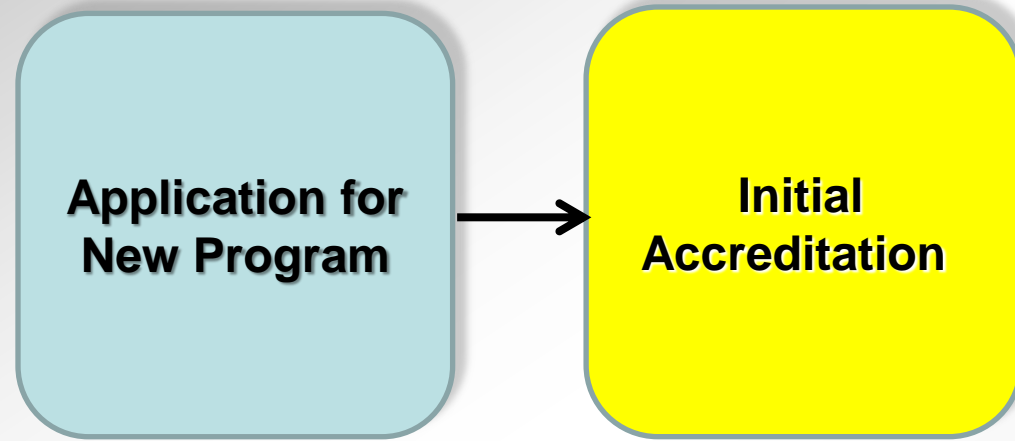
**Application for
New Program**

STANDARDS

**Core Process
Detail Process
Outcomes**

**Outcomes
Core Process
Detail Process**

Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

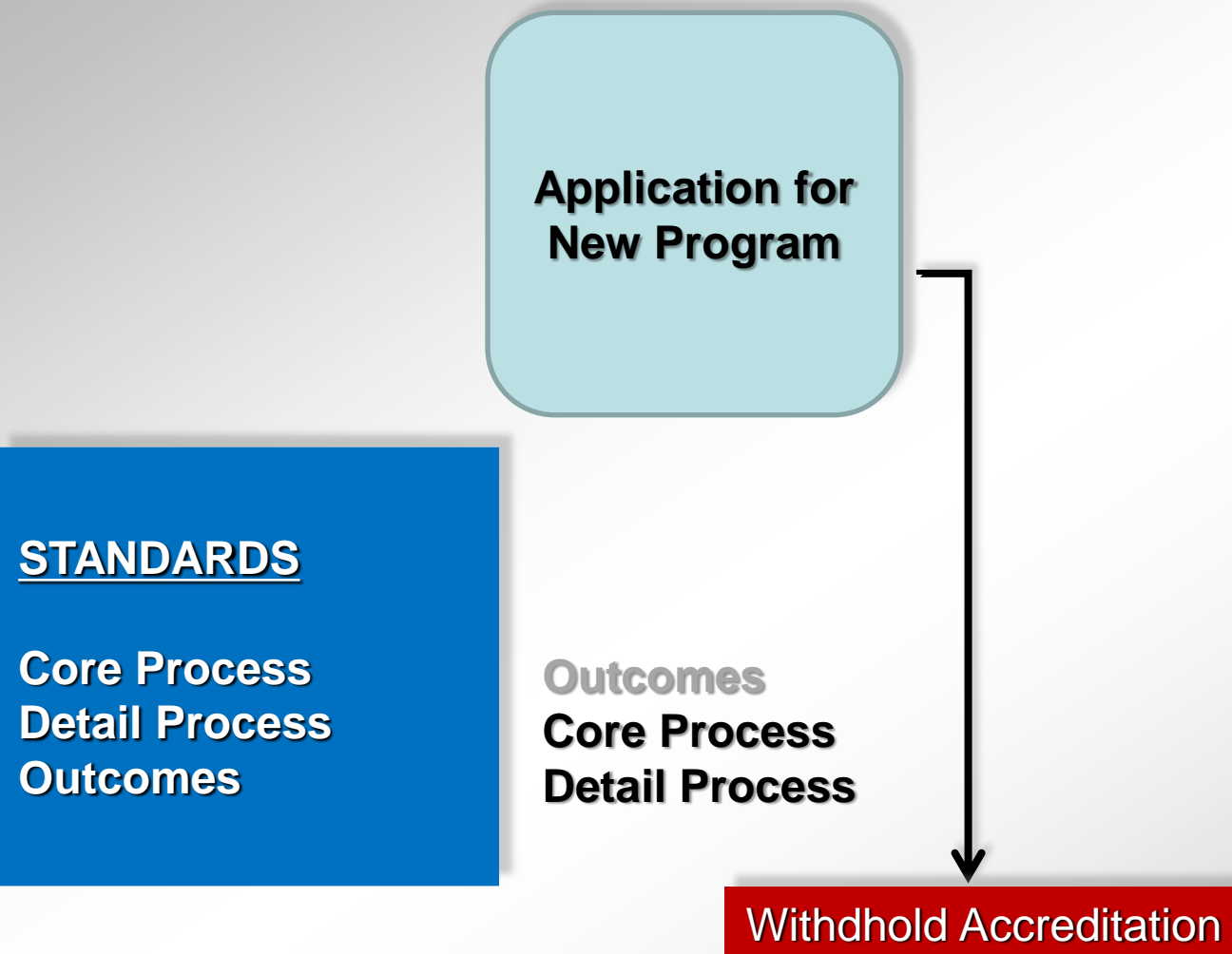
Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



Conceptual Model of Standards Implementation Across the Continuum of Programs in Neurosurgery



1-2%



5-10%



90-95%

STANDARDS

Core Process
Detail Process
Outcomes

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Withdrawal of Accreditation

<1%

Annual Data Reviewed by RRC

Most already in place

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



ACGME

Streamlined ADS Annual Update

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



Current PIF Faculty CV

First Name: John		MI: A	Last Name: Smith		
Present Position: Department Chairman					
Medical School Name: North Univ, Roots, CA					
Degree Awarded: MD			Year Completed: 1993		
Graduate Medical Education Program Name: State Program					
Specialty/Field: Urology				Date From: 7/1993	Date To: 6/1998
Certification Information			Current Licensure Data		
Specialty	Certification Year	Certification Status	Re-Cert Year	State	Date of Expiration
Urology	2001	Original Certification Valid		CA	1/2014
Academic Appointments - List the past ten years, beginning with your current position.					
Start Date	End Date	Description of Position(s)			
7/2009	Present	State Program			
7/1999	Present	State Program			
3/2002	6/2009	State Program			
Concise Summary of Role in Program:					
Fellowship-trained in female urology and urodynamics. Dr. Smith brings an expertise that is vital to resident training in urology. Along with Dr. James, he coordinates all resident research activities. He is an active participant at all urology conferences.					
Current Professional Activities / Committees (limit of 10):					
<ul style="list-style-type: none"> [2009 - Present] Chairman, Department of Urology; Medical Center [2009 - Present] Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery, Department of Urology; City Hospital [2009 - Present] President, Urological Society [2009 - Present] Co-Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery; Medical Center [1999 - Present] Member, Society for Urodynamics and Female Urology [1999 - Present] Member, American Urogynecologic Society [1999 - Present] Member, International Continence Society [1999 - Present] Member, Section of the American Urological Association [1999 - Present] Member, Urologic Society [1998 - Present] Member, American Urological Association 					
Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):					
<ul style="list-style-type: none"> Names. Historical perspective and outcomes for neurogenic bladder. <i>Future Medicine</i> 6(2)165-175, 2009. Names. Application and comparison of the American Urological Association and European Association of Urology current recommendations for antibiotic prophylaxis in the urologic patient undergoing office procedures. <i>Future Medicine</i> 6(2)145-149, 2009. Names. Two popular treatment options for neurogenic bladder <i>Therapy</i> 2009 6:2, 133-134 Names. Editorial comment. Effect of pelvic floor interferential electrostimulation on urodynamic parameters and incontinency of children with myelomeningocele and detrusor overactivity. <i>Urology</i>. 					

2009 Aug;74(2):329; author reply 329-30.

- Names. Tethered cord syndrome in a 24-year-old woman presenting with urinary retention. *Int Urogynecol J Pelvic Floor Dysfunct.* 18(6) 679-81, 2007.

Selected Review Articles, Chapters and / or Textbooks from the last 5 years (limit of 10):

- The Accidental Sisterhood: Take control of your bladder and your life. Names. 3rd Edition, Pelvic Floor Health, City, State, 2009
- The Accidental Sisterhood: Take control of your bladder and your life. Names. 2nd Edition, Pelvic Floor Health, City, State, 2007
- The Accidental Sisterhood: Take control of your bladder and your life. Names. Pelvic Floor Health, City, State, 2006
- Names. Whitmore, K.E. Hypersensitivity Disorders of the Lower Urinary tract. *Urogynecology and Reconstructive Pelvic Surgery*, 3rd edition. Mosby-Year Book, City, State, 2007.

Participation in Local, Regional, and National Activities / Presentations / Abstracts / Grants from the last 5 years (limit of 10):

- Incontinence in Women: An objective look at the options. Course faculty member AUA Annual Meeting, San Francisco, CA 2010 AUA Annual Meeting, Chicago, IL 2009 AUA Annual Meeting, Orlando, FL 2008 AUA Annual Meeting, Anaheim, CA 2007
- Multi-institutional experience with sacral neuromodulation in children for dysfunctional elimination syndrome or neurogenic bladder with intcontinence. Urological Annual meeting 2010 (presented by Katherine Hubert)
- Overactive bladder and Interstim Therapy, AdvaMed-Advanced Medical Technology Association, Washington, DC. 2008
- Stress Urinary Incontinence and Prolapse, Case presentations and complications Urologic Society Annual meeting 2007.
- Acute urinary retention status post suburethral sling. Names. Urologic Society Annual meeting 2007
- Commercial Prolapse Repair "Kits" vs. Traditional Transvaginal Prolapse Repairs: A Comparison of Efficacy and Cost. Names, A. Society for Urodynamics and Female Urology (SUFU), February 22, 2007 (Poster) Southeastern Section of the AUA, March 8-11, 2007 (Poster)
- Abdominal Sacral Colpopexy with Soft Polypropylene Mesh is Safe and Effective at Three-Year Follow-Up. Names. SUMMA Postgraduate Day, 2006.
- Early Complication Rates of the Apogee/Perigee? Prolapse Repair System for Vaginal Vault Prolapse. Names. Accepted for oral presentation, SUMMA Postgraduate Day, 2006.
- The Correlation Between Valsalva Leak-Point Pressure (VLPP) and MUCP in Determining Genuine Stress Urinary Incontinence and Intrinsic Sphincter Deficiency. Names. Postgraduate Day, Locations, June 6, 2005 Section of the AUA, September 2005

If not ABMS board certified, explain equivalent qualifications for RC consideration:

Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity

Mouse-over definitions:	Pub Med Iids (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 Iids (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

Faculty 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, and presentations given at international meetings. 7/1/2011 and 6/30/2012
	Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conferences Presented
	John Smith	12433	32411			3

Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4.

active leadership such as serving on committees or governing bodies in national medical organizations or served as member or editorial board member for a peer-reviewed journal between 7/1 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.
Peer-Review Role	Teaching Formal Courses
Y	N

Enter Pub Med ID #'s

PMID 1	PMID 2	PMID 3	PMID 4
12433	32411		



ACGME

Faculty Scholarly Activity

Faculty Member	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012 List up to 4				Conference Presentations
	PMID 1	PMID 2	PMID 3	PMID 4	
John Smith	12433	32411			3

Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012

Leadership or Peer-Review Role	Teaching Formal Courses
Y	N

Enter a number

Conference Presentations
3



ACGME

Faculty Scholarly Activity

Faculty Member	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
	PMID 1	PMID 2	PMID 3	PMID 4		
John Smith	12433	32411			3	1

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

Other Presentations

1

Enter a number

Faculty Member	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
John Smith	1



ACGME

Faculty Scholarly Activity

Faculty Member	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 formal courses taught between 7/1/2011 and 6/30/2012
	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Chapters / Textbooks	Teaching Formal Courses
John Smith	12433	32411			3	1	1	N

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

Enter a number

Chapters / Textbooks

1



ACGME

Faculty 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
		PMID	IPMID	PMID	PMID	
		1	2	3	4	
Faculty Member					Conference Presentations	
John Smith	12433	32411			3	

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

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.
Leadership	Leadership or Peer-Review Role	Teaching Formal Courses
3	Y	N

Grant Leadership

3

Enter a number



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Faculty Scholarly Activity

Faculty Member	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
	PMID 1	PMID 2	PMID 3	PMID 4	
John Smith	12433	32411			3

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

Leadership or Peer-Review Role	Teaching Formal Courses
Y	N

Answer Yes or No

Leadership or Peer-Review Role
Y



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Faculty Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assign PubMed) for article published between 7/1/2011 and 6/30/2012. List up to 4.		
	Faculty Member	PMID 1	IPMID 2	PMID 3
	John Smith	12433	32411	

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.

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Teaching Formal Courses
N

Answer Yes or No

Teaching Formal Courses
N



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Faculty Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assign PubMed) for article published between 7/1/2011 and 6/30/2012. List up to 4.		
	Faculty Member	PMID 1	IPMID 2	PMID 3
	John Smith	12433	32411	

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.

view	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.
	Teaching Formal Courses
	N

Teaching Formal Courses
N



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Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity

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

Resident	PMID 1	PMID 2	PMID 3	Conference Presentations	Chapters / Textbooks	Participated in research	Teaching / Presentations
June Smith	12433			1	0	N	Y

Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity

Faculty Member	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.
	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

Resident	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
	PMID 1	PMID 2	PMID 3	Conference Presentations	Chapters / Textbooks	Participated in research	Teaching / Presentations
June Smith	12433			1	0	N	Y

Scholarly Activity Template

Scholarly Activity as Performance Indicator

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
Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Chapters / Textbooks
John Smith	12433	32411			3	1	1

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 Scholarly Activity

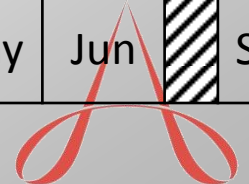
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Resident	PMID 1	PMID 2	PMID 3	Conference Presentations	Chapters / Textbooks	Participated in research	Teaching / Presentations
June Smith	12433			1	0	N	Y

Teaching / Presentations:

Y

NAS: Annual Data Submission

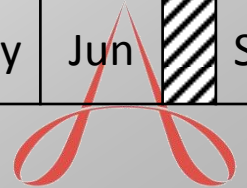
	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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NAS: Annual Data Submission

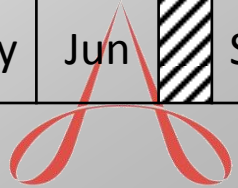
	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
Case Logs			Yr 0											Yr1
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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NAS: Annual Data Submission

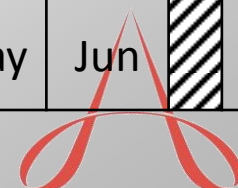
	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
ADS Update	Yr 1													Yr2
Case Logs			Yr 0											Yr1
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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NAS: Annual Data Submission

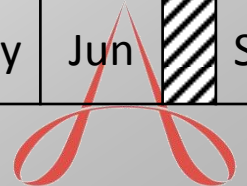
	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
Resident Survey							Yr 1							
ADS Update	Yr 1													Yr2
Case Logs			Yr 0											Yr1
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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NAS: Annual Data Submission

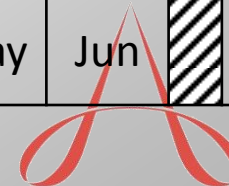
	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
Faculty Survey								Yr 1						
Resident Survey							Yr 1							
ADS Update	Yr 1													Yr2
Case Logs			Yr 0											Yr1
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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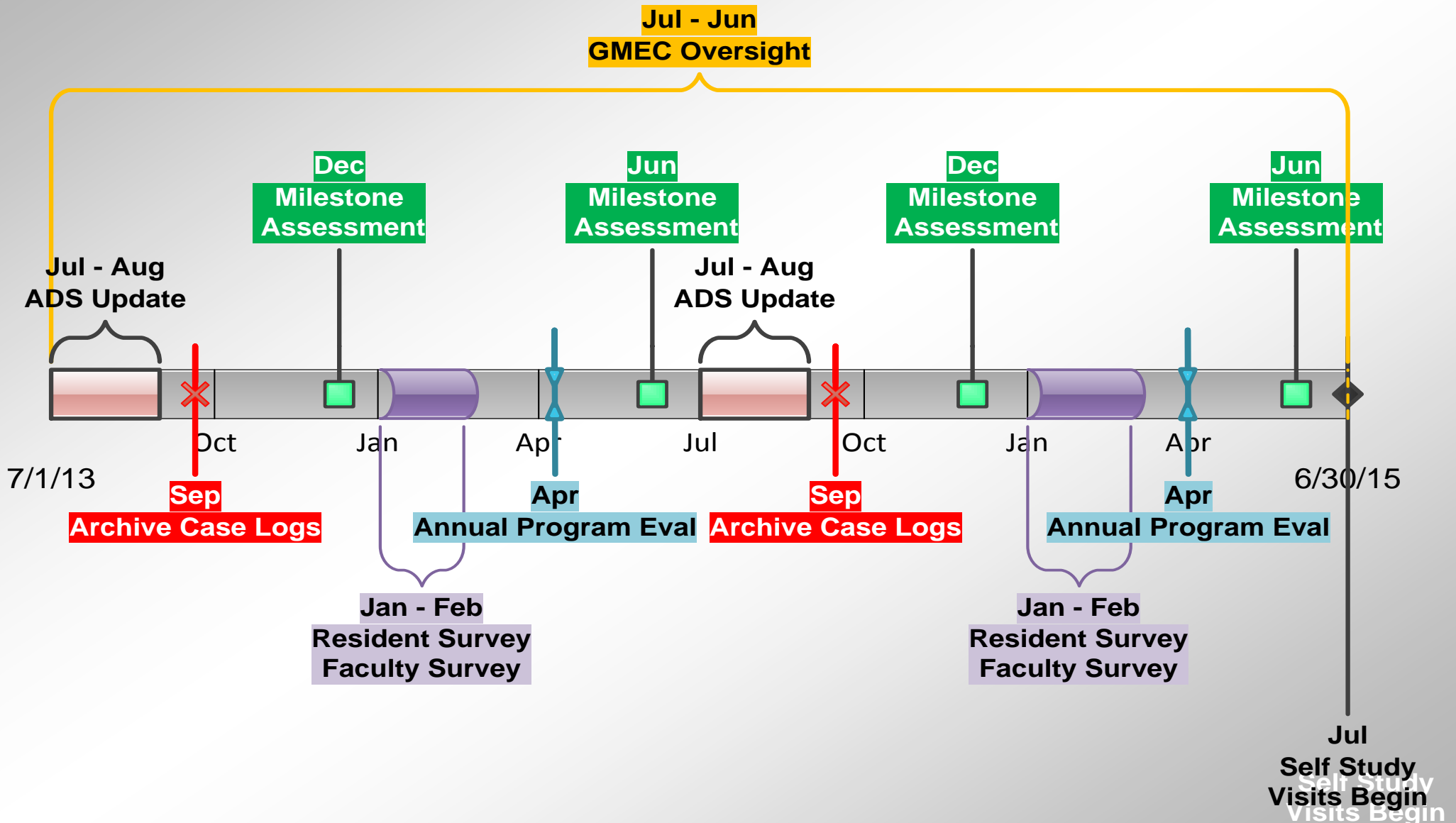
NAS: Annual Data Submission

	Year 1													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep
Milestones	Yr 0					Yr 1						Yr 1		
Faculty Survey								Yr 1						
Resident Survey							Yr 1							
ADS Update	Yr 1													Yr2
Case Logs			Yr 0											Yr1
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		Sep



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Program Activities – Next System



NAS Program Activities

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



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NAS: Annual Program Evaluation

New proposed Common Program Requirements for Annual Program Evaluation (V.C.1)

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



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NAS: Annual Program Evaluation

New proposed Common Program Requirements for Annual Program Evaluation (V.C.2)

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



NAS: RRC Accreditation Activities

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



NAS: RRC Accreditation Activities

- RRC fall meeting: larger number of **self-study visit reports**
- RRC fall meeting: follow-up reports and focused site visits from previous meeting



NAS Site Visits: Self-Study

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



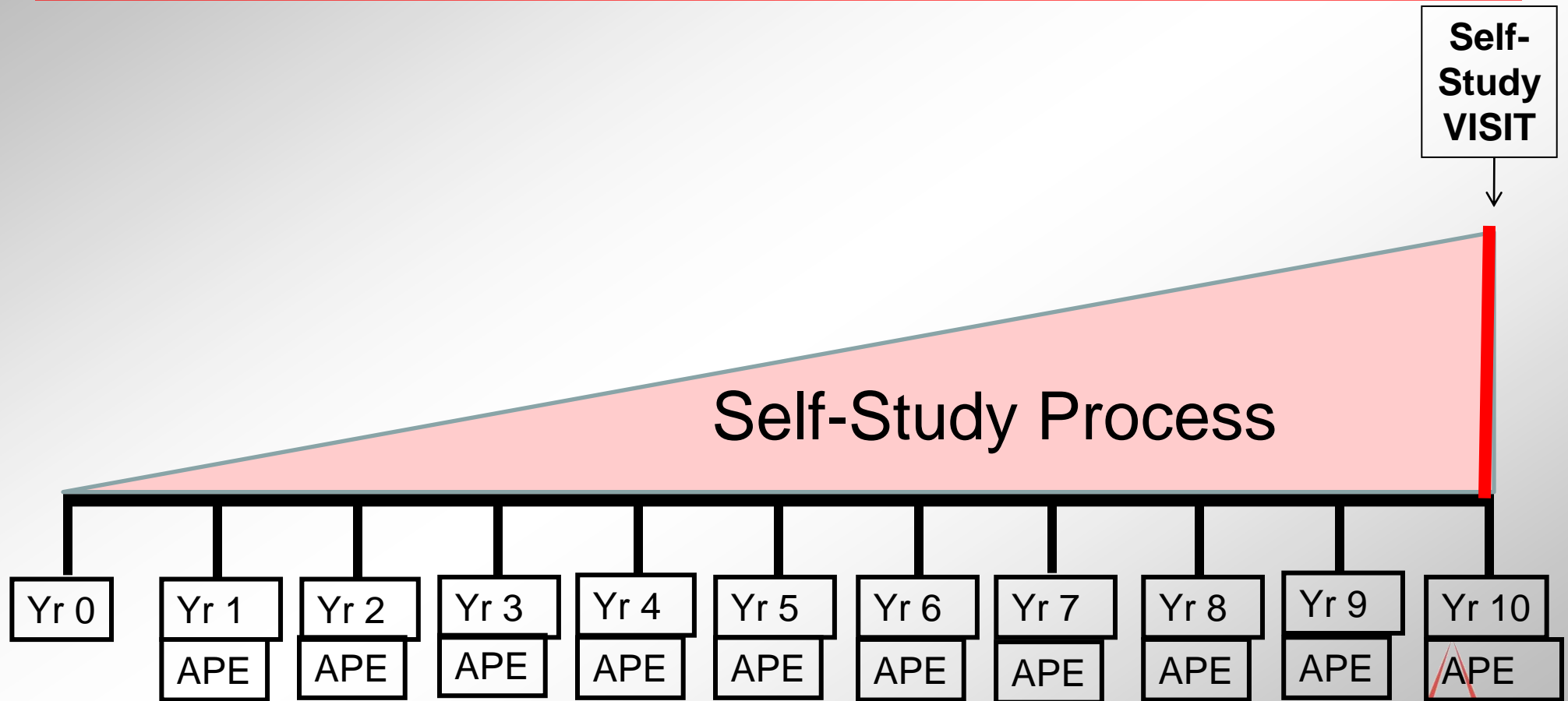
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NAS Site Visits: Self-Study

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



NAS Site Visits: Self-Study



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NAS Site Visits: Focused

- Assesses *selected* aspects of a program and may be used:
 - to address *potential* problems identified during review of annually submitted data;
 - to diagnose factors underlying deterioration in a program's performance
 - to evaluate a complaint against a program



NAS Site Visits: Focused

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



NAS Site Visits: Full

- Application for new program
- At the end of the initial accreditation period
- RRC identifies broad issues / concerns
- Other serious conditions or situations identified by the RRC
- More information on site visits:

<http://www.acgme.org/acgmeweb/GraduateMedicalEducation/SiteVisitandFieldStaff/SiteVisitFAQ.aspx>



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Accreditation Cycle: Next

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



NAS: Policies and Procedures

- Policies and Procedures: 7/1/2013
<http://www.acgme-nas.org/assets/pdf/FinalMasterNASPolicyProcedures.pdf>
 - NO proposed adverse actions
 - Potential Actions (if currently accredited):
progress report; focused site visit; continued accreditation; accreditation with warning; probation; complement reduction



NAS: Policies and Procedures

- Policies and Procedures: 7/1/2013
 - Effective 7/1/2013, the ACGME will not accredit new independent subspecialty programs.
 - Effective 7/1/2015, currently accredited independent subspecialty programs sponsored by an ACGME-accredited institution with a core must operate as a dependent subspecialty to the core program.
 - Dependent subspecialty programs are affiliated with an ACGME-accredited specialty program and are under the governance of that specialty program's sponsoring institution.



NAS: Policies and Procedures

- Policies and Procedures: 7/1/2013

Currently accredited independent subspecialty programs that are also single-program sponsoring institutions must comply with one of the following by 7/1/2015:

1. Become an ACGME-accredited sponsoring institution under the oversight of the ACGME Institutional Review Committee OR
2. Change sponsorship to a geographically proximate institution that is currently ACGME-accredited under the oversight of the ACGME Institutional Review Committee



THANK YOU!

