AAFP PDW and RPS Residency Education Symposium
March 25, 2018

ACGME Update

Stacy Potts, M.D., M.Ed., Chair, Review Committee for Family Medicine
Eileen Anthony, RC Executive Director
Baretta R. Casey, MD, MPH, FAAFP, Regional Vice President, CLER Program
Mary Lieh-Lai, MD, FAAP, FCCP, Senior Vice President, Medical Section

Disclosures

- Recovering:
  - Pediatric Intensivist
- Fully Recovered:
  - Program Director

- No conflicts to report

Outline

- CPR Sections I-V: Major Changes
- The ACGME Wellness Initiative

CPR Sections I-V: Major Changes

- Almost all CPRs categorized as “core”
- New preamble
- Philosophy, Background, Intent added throughout
- RC may/must further specify where indicated
- New Fellowship CPRs
  - *Current* One-year CPRs will be discontinued

Section I

- Elimination of required elements for PLAs
  - recommended elements to be included in the PD Guide
- PLAs must be approved by the DIO
- Mission-driven, ongoing systematic recruitment and retention of diverse workforce
- Addition of PRs that mirror the IRs: access to food, sleep and rest facilities; security and safety measures; new PR addressing lactation facilities
- New PR for Fellowships: Fellows should contribute to the education of residents in core programs, if present

Section II: Program Director

- Minimum 20% FTE (8h/per week) salary support for administration of the program *(RC may specify) - (resident version only)*
- For fellowships: PD must be provided with support adequate for program administration based on program size and configuration (*RC must specify*)
- PD qualifications:
  - must include at least 3 years of educational and/or administrative experience, or qualifications acceptable to RC (not included in the fellowship CPRs)
  - AOA certification acceptable
  - must include ongoing clinical activity (not included in the fellowship CPRs)

Section II: Program Director

- Program Director responsibilities:
  - Role model of professionalism
  - Design and conduct program consistent with community needs and mission(s) of the program and SI
  - Develop and oversee process for evaluation of candidates for program faculty prior to appointment and annually thereafter
  - Have authority to appoint and remove faculty at all sites
    - NOTE: this does not mean firing someone – but "removing" them from educational/teaching activities
  - Have authority to remove residents from supervising interactions that do not meet program standards

Section II: Faculty

- Faculty responsibilities:
  - Demonstrate commitment to safe, quality, cost-effective, patient-centered care
  - Pursue faculty development at least annually
- Faculty Qualifications:
  - AOA certification acceptable
  - Any non-physician faculty member must be designated by the program director

Section II: Faculty

- Core faculty
  - Definition now based on role in resident education and supervision – not number of hours devoted
- Includes, at a minimum, CCC and PEC members
- Must complete annual ACGME Faculty Survey
- Non-physician faculty members may be appointed as core faculty
- Scholarly activity now assessed for the program as a whole, not individual core faculty (allows core faculty selection based on educational contributions)

Section II: Program Coordinator

- There must be a program coordinator
- Support for the coordinator must be at least 50% FTE (at least 20 hours per week) for administrative time (*RC may further specify*)
- Fellowship CPRs do not specify minimum level of support for the coordinator – (*RCs may specify*)

Section III: Eligibility

- Eligibility criteria from Institutional Requirements now mirrored in CPRs
- ACGME-I Advanced Specialty accreditation acceptable for prerequisite clinical education
- Fellowship CPRs provide 2 options - RC to decide on prerequisite education accredited by:
  - Option 1: ACGME or AOA only
  - Option 2: ACGME, AOA, RCPSC, CFPC or ACGME-I Advanced Specialty accreditation

Section IV: Competencies

- Competency requirements re-categorized from “outcome” to “core”
- Fellowship version: subcompetencies for Professionalism, PBLI, Interpersonal and Communication Skills, and Systems-based Practice have been deleted
- Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals.

Section IV: Scholarship

- New scholarship section replaces previous faculty and resident scholarly activity sections
- New requirements focus on scholarly activity for the program as a whole
- Scholarly activity must be consistent with the mission of the program

Scholarly Activity

- Residents must participate in scholarship. Each graduating resident should have a scholarly activity that is disseminated as further described in IV.D.2.b).(1) or IV.D.2.b).(2).(Core)

Mary's Thoughts on Scholarly Activity

The Purpose of Requiring Scholarship: The intention was not to turn you into bean counters

Do not lose sight of the forest for the trees

Unspoken Rationale

- Having an environment of scholarship:
  - Leads to the creation of new knowledge
  - Encourages life-long learning
    - Scholarship creates a mindset of inquiry
      - Might reduce "jumping on any bandwagon that comes along"
      - Mindful practice: for example – antibiotic stewardship, infection control and careful consideration of new (and expensive) drugs before use

$30.00/case of 24
+ shipping
Really?????

Rationale

- Scholarly activity is used by RCs as a *proxy* to:
  - demonstrate that faculty have the skills to analyze and utilize new knowledge
  - demonstrate that the program has the ability to teach those skills to residents
  - demonstrate that an environment of scholarship exists

Boyer's Models of Scholarship

- Discovery
- Application
- Integration
- Teaching

"Education must prepare students to be independent, self-reliant human beings. But education, at its best, also must help students go beyond their private interests, gain a more integrative view of knowledge, and relate their learning to the realities of life."

Ernest Boyer

Scholarly Activity

- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

Section IV: Independent Practice

New PR for Fellowship version only:

- *Fellowship programs may assign fellows to engage in the independent practice of their core specialty during their fellowship.*
- If programs permit their fellows to utilize the independent practice option, it must not exceed 20 percent of their time per week or 10 weeks of an academic year. (Core)

- [*The Review Committee may further specify*. This section will be deleted for those Review Committees that choose not to further specify.]

Section V: Resident Evaluation

- PD or designee, with input from CCC, must:
  - Meet with and review with each resident documented semi-annual evaluation, including Milestones progress
  - Assist residents in developing individualized learning plans
  - Develop plans for residents failing to progress

- Provide summative evaluation of resident's readiness to progress to the next year of the program

Section V: Program Evaluation

- Addition of list of required elements to be addressed in the Annual Program Evaluation
- PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats
- Annual review, including action plan, must be
  - Distributed to and discussed with faculty and residents
  - Reviewed by the GMEC
- Program must complete a Self-Study prior to 10-year accreditation site visit

Section V: Board Certification

- PD should encourage graduates to take applicable ABMS or AOA certification examination –*replaces all existing specialty specific take rate requirements*
- Pass rate (address both written and oral exams):
- Aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile
- Based on three years of data for specialty using an annual exam and six years of data for specialties using a biennial exam

The ACGME Wellness Initiative

- http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf
- Common Program Requirements VI.C. Well-being
- Components of the plan:
  - Ensuring the emergency contact list is updated yearly
  - Confirming the death of a resident and how to do so
  - Developing a Crisis Response Team
  - Communicating with emergency contact/family
  - Notifying residents and faculty
  - Creating face-to-face, phone and written notifications
  - Planning a memorial service
  - Supporting well-being of all
- Distribute the plan and maintain awareness

Family Medicine & Wellness

- Way ahead of everyone
- Balint Group in practice for decades:
  - *www.stfm.org/FamilyMedicine/Vol47Issue5/Diaz367*
  - Diaz VA, Chessman A, Johnson AH, Brock CD and Gavin JK: Balint Groups in Family Medicine Residency Programs: A Fllow-Up Study from 1990-2010

The CLER Site Visit
The Next Journey

AAFP PDW and RPS Residency Education Symposium
March 25, 2018

Baretta R Casey, MD, MPH, FAAFP
Regional Vice President
ACGME CLER Program

Disclosure

- Dr. Casey: No conflicts of interest to report

CLER Program

- Site Visits Update
- Lessons Learned
- The Next Journey

CLER Site Visits

Protocol 2.0

- Second set of visits to sponsoring institutions (SIs) with 3 or more core programs completed in June 2017
- First set of visits to SIs with 1-2 core programs 95% complete-completion in May 2018

Input for continual program development

- Focus groups/conversations at national meetings
- Internal metrics
- Retrospective surveys
- Exit surveys
- Optional responses

The CLER National Report of Findings 2016

www.jgme.org

Overarching Themes

1. Clinical Learning Environments (CLEs) vary in approaches to patient safety and health care quality and the degree of engagement of residents and fellows in addressing those areas.

2. CLEs vary in the approach of implementing GME within the organization.

3. CLEs vary in the investment of teaching and engaging faculty and program directors on system-based initiatives

4. CLEs vary in the degree of coordination of educational resources across professions.

www.acgme.org/cler

What's New in Protocol 3.0?

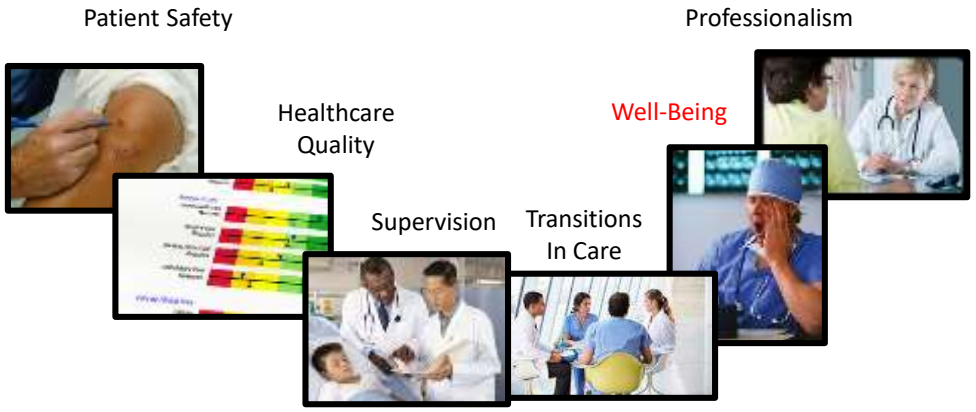
- Senior Leadership Interview
- Well-being Focus Area
  - Well-being Representative Interview
  - Inclusion of the Clinical Care Team
- Shorter Faculty Group Interview

CLER Site Visits

Protocol 3.0

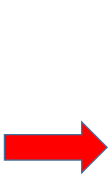
- Field testing June-Aug, launched Sept 2017 for larger sponsoring institutions
- Changes based on inputs and evolution of focus area
- 2018 will begin synchronizing cycle lengths to 18-24 months for all SIs

CLER Six Focus Areas



Pathways Version 1.1

- Well Being
- (selected topics)
  - Fatigue
  - Burnout
  - Work/life balance
  - At risk for self harm



Webinar and release May 2017

Senior Leadership Interview

- Fewer questions; more discussion-focused
- GME integration into institutional strategy and planning
- Review of overall challenges, progress, and opportunities
- Discussion of use of educational resources for interprofessional learning

Well Being Focus Area

- CLE perspective
  - Emphasis on systematic and institutional strategies and processes to cultivate and sustain well being of patients and clinical care team

41

Well-being: 6 major pathways

WB Pathway 1: Clinical learning environment promotes well-being across the clinical care team to ensure safe and high quality patient care

WB Pathway 2: Clinical learning environment demonstrates specific efforts to promote the well-being of residents, fellows, and faculty members

Well-being: 6 major pathways

WB Pathway 3: Clinical learning environment promotes an environment where residents, fellows, and faculty members can maintain their personal well-being while fulfilling their professional obligations

WB Pathway 4: Clinical learning environment demonstrates system-based actions for preventing, eliminating, or mitigating impediments to the well-being of residents, fellows, and faculty members

Well-being: 6 major pathways

WB Pathway 5: Clinical learning environment demonstrates mechanisms for identification, early intervention, and ongoing support of residents, fellows, and faculty members who are at risk of or demonstrating self-harm

WB Pathway 6: Clinical learning environment monitors its effectiveness at achieving the well-being of the clinical care team

Well Being Focus Area

- Protocol 3.0
  - Assessed in group discussions and on walking rounds
  - Group discussions to include new meeting with “well being” leadership at the CLE

Well-being Focus Area

- Selected Topics
  - Fatigue
  - Burnout
  - Work/life balance
  - At risk of or demonstrating self-harm

Well-being

- Group interviews inclusive of Well-being representatives
  - Well-being representatives - individuals formally or informally designated by senior leadership to address the well-being of the clinical care team at the clinical site
- Walking Rounds

Questions?

Review Committee for Family Medicine Update

Stacy Potts, M.D., M.Ed., Chair, Review Committee for Family Medicine
Eileen Anthony, RC Executive Director

Disclosures

Dr. Potts and Ms. Anthony have nothing to disclose.

Discussion of Topics

- RRC-Family Medicine Who We Are and What We Do
- NAS – Annual Data Review/Accreditation Decisions
- Single GME Accreditation System
- Milestones
- Self-Study and 10-Year Accreditation Site Visit

RRC-Family Medicine Team

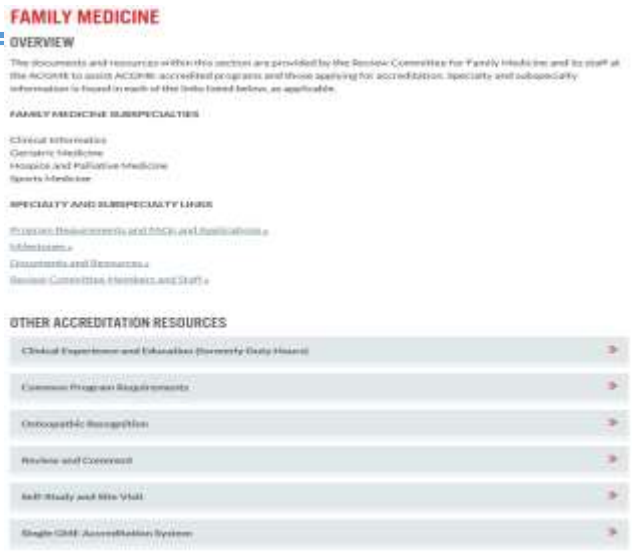
- Eileen Anthony, Executive Director; 312.755.5047; eanthony@acgme.org
- Sandra Benitez, Associate Executive Director; 312.755.5035; sbenitez@acgme.org
- Luz Barrera, Accreditation Assistant; 312.755.5077; lbarrera@acgme.org

www.acgme.org

RRC-Family Medicine Webpage

The Review Committee meets *three times* a year

Meeting and agenda closing dates on webpage



RRC-Family Medicine Composition

- 4 appointing organizations – AAFP, ABFM, AMA *and* AOA
- One public member
- 14 voting members
- Ex-officio member from AAFP and ABFM (non-voting)
- 6 year terms - except resident (2 years)
- Program Directors, Chairs, Faculty, and Public Representation
- Geographic Distribution
  - AZ, CA, GA, IL, KS, MA, MO, NJ, NY, NC, PA, VA

Review Committee Members

- John R. Bucholtz, DO
- Gary Buckholz, MD (HPM)
- Paul Callaway, MD - *Vice Chair*
- Colleen Cagno, MD
- Robert Danoff, DO
- Grant Hoekzema, MD
- Sam Jones, MD
- Martha Lansing, MD
- Harald Lausen, DO
- Joseph Mazzola, DO
- Timothy Munzing, MD
- Stacy Potts, MD, M.Ed - *Chair*
- Amanda Ashcraft Pannu, MD - *Resident*
- Allison Smith, MPH, BA, BSN, RN - *Public member*

The Work of Your RRC

- Reviews programs with regards to Common and specialty Program Requirements
- Determines accreditation status for programs
- Proposes revisions to Program Requirements
- Discusses matters of policy, issues relevant to the specialty
- Recommends changes in policy, procedures and requirements to the ACGME Council of Review Committee Chairs

ADS Annual Updates

- Each year, programs are required to enter data into ADS such as:
  - Faculty information
  - Resident/Fellow information
  - Block diagrams/curricular information
  - Scholarly activity (PD, Faculty, Residents) information
  - Participating site information
  - Responses to previous citations
  - Duty Hour, Patient Safety and Learning Environment information
  - Evaluation information
  - Reporting of major changes in the program

ADS Annual Updates *cont.*

Data elements for Annual Review, but not entered directly by the program include:

- Resident Survey
- Faculty Survey
- Milestone data
- Certification examination performance (*provided by respective Certifying Boards*)

ADS Annual Updates *cont.*

- "Traditionally" coordinator's job
  - Now speaks directly to the Review Committee
- Program Director
  - Responsible for information entered
  - Should assure entries are timely, accurate, complete

Common Mistakes in Annual Data Collection

- Inaccurate scholarly activity (*e.g., not listing ALL physician specialty faculty and only the FM physician faculty*)
- Program director responsibility for accurate and complete data (*if not there, the Committee cannot determine compliance and may cite the program*)
- Inaccurate physician faculty credentials (*MOC, AOA-boarded, etc.*)
- Identification of **core FM** faculty (*per FM PR II.B.6.a).1*)

Role of the RRC in the Accreditation Process

- **Determine** accreditation status based on data review that involves:
  - Reviewing the program's responses to PREVIOUS citations to determine if issues are corrected
  - Reviewing program data to determine substantial compliance with the requirements

Program Requirements – Focused Revision

Requirement #: IV.A.6.a).(5)

Proposed Requirement Language:

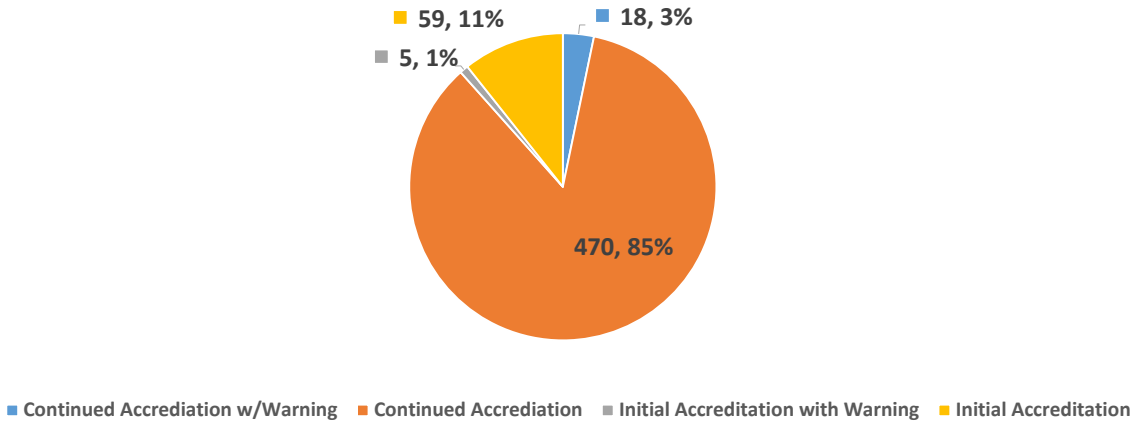
Residents must provide care for a minimum of 1650 in-person FMP patient encounters in the ~~FMP site.~~ outpatient setting, including FMP sites, nursing home, and home visits. (Core)

The proposed revision more clearly demonstrates the intent of the requirement. Specifically, the intent was that the minimum outpatient numeric requirement (1650) could include meaningful encounters with patients from the Family Medicine Practice (as a whole) in various settings (such as nursing home and home visits). As currently written, "…FMP site…" implies a location and, as is, could be read as inconsistent with the PRs that follow.

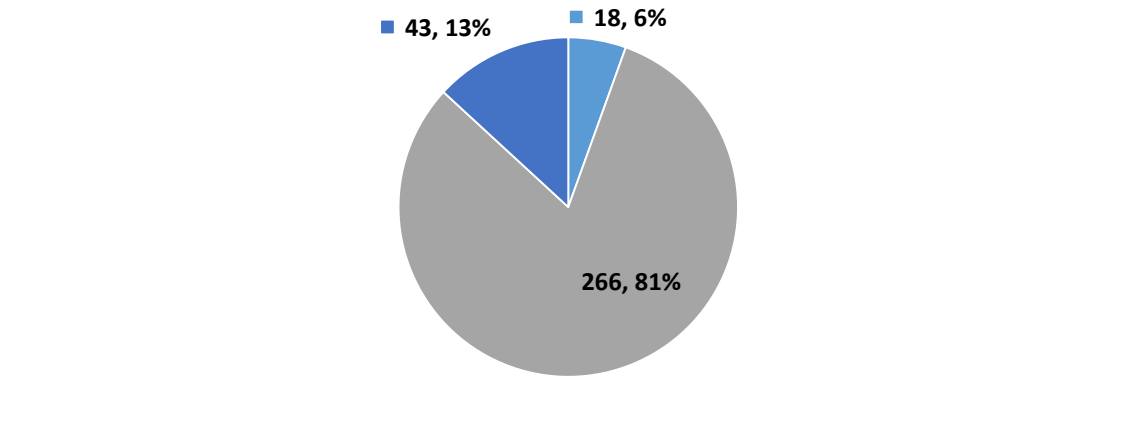
Family Medicine Program Statuses (as of January 2018)

Status	FM Core (552)	HPM (132)	Sports Med (131)	Geriatric Med (46)
Initial Accreditation	59	25	13	5
Initial Accreditation w/Warning	5	0	1	0
Continued Accreditation	470	107	118	41
Continued Accreditation w/Warning	18	0	0	0
Probation	0	0	0	0

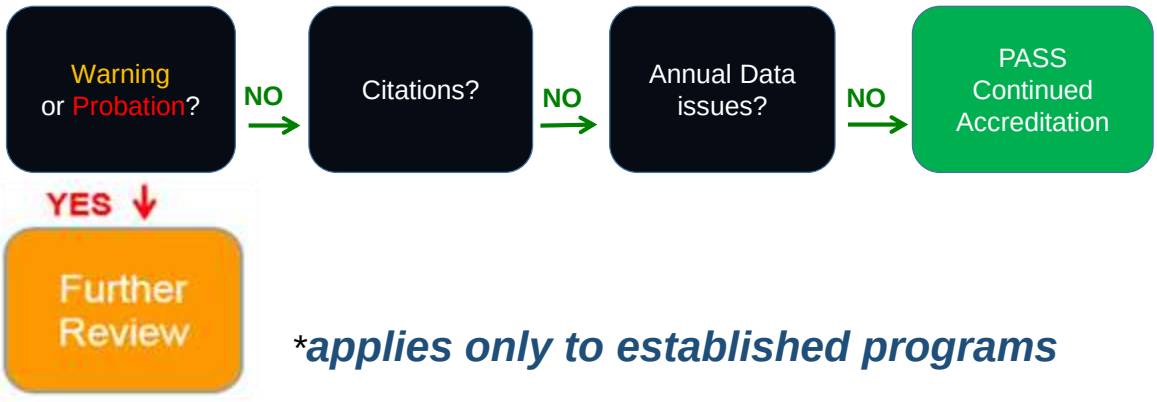
Family Medicine Program Statuses - CORE (as of January 2018)



Family Medicine Program Statuses - SUBS (GM, SM, HPM Combined) - as of January 2018



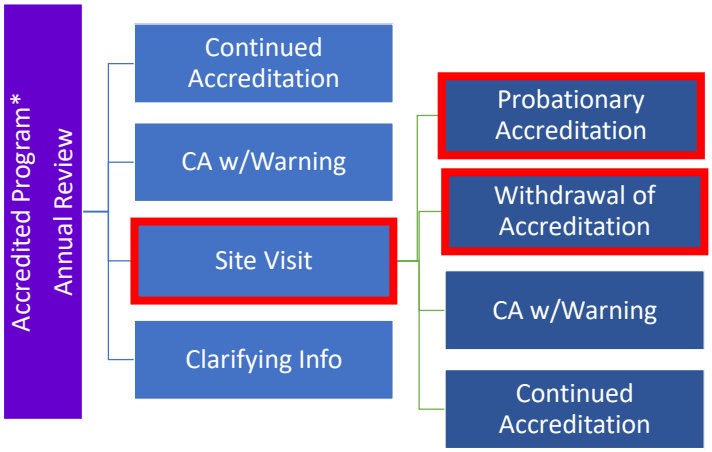
Annual Program* Review



applies only to established programs

Accreditation Status Options

Annual Program Data Review



Site Visit – Data Prompted: Focused

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

Site Visit – Data Prompted: Focused

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

Site Visit – Data Prompted Example:
Resident Survey Results

Site Visit – FULL

- Application for new core program
- At end of initial accreditation period (1-2 years)
- RC identifies broad issues/concerns
- Other serious conditions or situations identified by the RC
- 30-day notification given
- Minimal document preparation
- Team of site visitors

Practical Tips…

Supply a Block Diagram and NOT the resident schedule (BELOW) as evidence of compliance with curricular requirements

	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	UM DERM NOT AVAILABLE	INTERVIEWS	INTERVIEWS	INTERVIEWS	
PGY3	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8
AY17	Fri July 1 - Sun July 31	Mon 8/1 - Sun. 8/28	Mon 8/29 - Sun 9/25	Mon 9/26 - Sun 10/23	Mon 10/24 - Sun 11/20	Mon 11/21 - Sun 12/18	Mon 12/19 - Sun 1/15/16	Mon 1/16 - Sun 2/12
BFHC		ALSO 8/4 & 8/5	Sept 21-23 in ORL for CHIEFS		ITE Oct 24, 25, 26, 27 and 28			ALL RETREAT 1/24/2017
NAME	DERM VIDERS V4	LOA 4 weeks	LOA 4 weeks	NB Elec - Sat HC Call 10/10 WK	URGENT PEDIATRICS	PROFESSOR CHIEF 11/26 HC Call?	ELEC V2 don't move this HOL WK OFF	HEALTH CNTR CHIEF
NAME	ELEC Off 7/15-18 in Wedd (7/28-30 AAFP) Call 7/4	ORTHO Off 8/22 Bday Cov FMIS 8/4 & 8/5	ELEC + CC 9/21-9/24 FLA	Elec/VOB Fellowship	URGENT PED CONF 11/18 & 19	HEALTH CNTR CHIEF	DERM UMASS (Don't Move) VIHOL Wkoff	FMIS (8-2)
NAME	MC 2021	HEALTH CNTR CHIEF	ORTHOV2 9/5-9/9(Cov for NL CC 9/21-9/23)& NW 9/24	FAMILY MED IN PT (ADULT MED SELECTIVE)	HEALTH CNTR CHIEF	Elec	ELEC V2 MED REV 1/7-1/15	URGENT PEDIATRICS
NAME	HEALTH CNTR CHIEF off JULY 16/17	PROFESSOR CHIEF Cov FMIS 8/4 & 8/5	MATERNAL CHILD HEALTH SELECTIVE	HEALTH CNTR CHIEF	Elec Off Wedd 10/28-11/4	ORTHO w/No Vac Off 11/25	HEALTH CNTR CHIEF	ElecV3

Practical Tips…

Supply a Block Diagram and NOT the resident schedule as evidence of compliance with curricular requirements

Block Diagram Sample

Block Rotations – 1st Year													
Experience of Rotations	4 weeks Fam Med Ofc FHC	4 weeks Fam Med Inpt Svc	4 weeks Fam Med Inpt Svc	4 weeks Int Med #1	4 weeks Int Med #1	4 weeks Peds Inpt #1	4 weeks Peds Outpt #1	4 weeks OB #1	4 weeks OB #1	4 weeks Peripartum #1	4 weeks ER Dept	4 wks Critical Care #1	4 wks Dermatology #1
FMC Sessions (per week)	8	2	2	2	2	2	4	2	2	2	2	2	4
Location	FHC	MCDG	MCDG	MCDG	MCDG	MCDG	MCDG/PED SCHC/PRI Office	MCDG OB	MCDG OB	MCDG NBN	MCDG/ EC	MCDG ICM	Private Derm Office FHC Wound care
Duty Hours	45/10/3x	65/10/3x	65/10/3x	65/12/2x	65/12/2x	65/10/3x	45/9/6x	70/12/5x	70/12/5x	45/10/6x	38/12/3x	60/11/2x	45/9/6x

Continuity of Care Patients

Graduates are required to have 1,650 outpatient visits…not a high bar! The average per graduate (*3389 graduates total*) in *AY 2017 was…

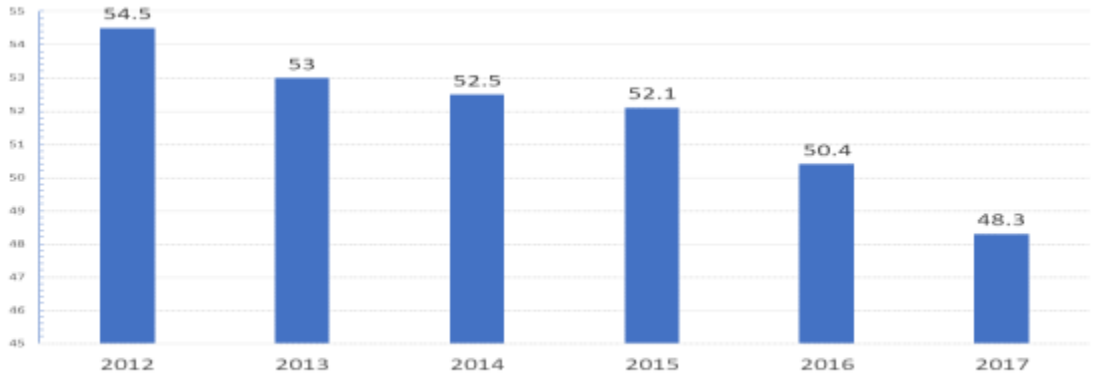
1821.00

**AY 2016 = 1,814 with 3342 graduates*

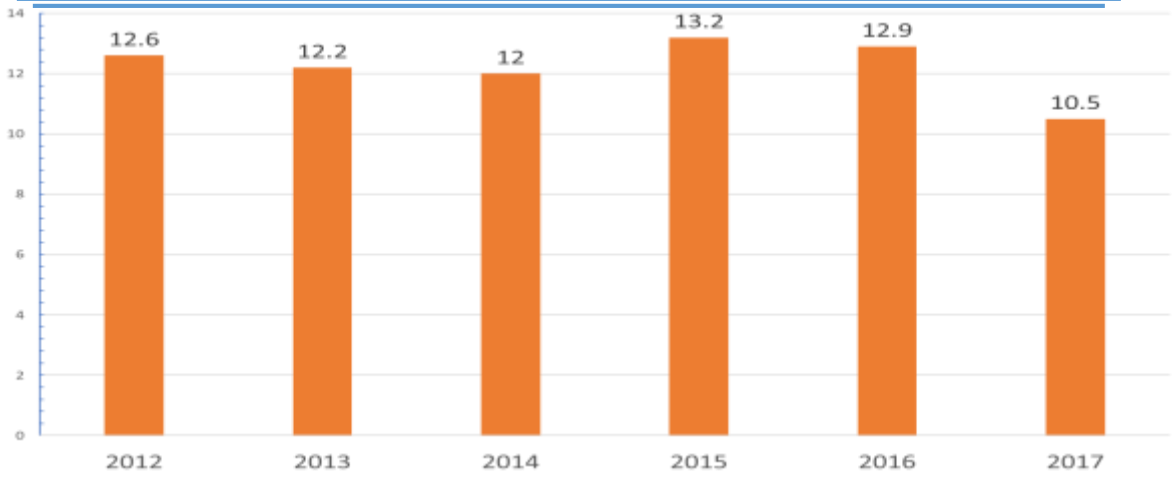
Continuity of Care Patients

PGY	Sessions (per wk)	Patients (per session)	Weeks	Patient visit
1	1	4	40	160
2	3	5	40	600
3	4	6	40	960
			TOTAL	**1,720**

Vaginal Deliveries - Mean



Continuity Deliveries - Mean



Citations (Extended and New)

- Must be linked to a program requirement
- Program **must** respond in ADS
- Responses reviewed annually by the RC
- Remains active until corrected

Areas for Improvement (AFIs)

- General concern before it's a problem
- Written program response **NOT** required or requested!
- Will be tracked by RC

Most Common Citations

- PD Responsibilities – Accurate Data
- Pediatric patient population (<10)
- Faculty role-modeling inpatient care
  (maternity, pediatric, adult)
- 1,650 in-person patient encounters in the FMP

Most Common AFIs

- Faculty scholarship
- Resident and Faculty Survey
  (*attention to areas that are trending downward*)
- Board passage rate
  (*attention to downward trends*)

Communicating Accreditation Decisions – Letter of Notification (LON)

- Within 5 business days following the RC meeting
  - Email notifications are sent to the PD(s), DIO, and PC containing accreditation status decisions

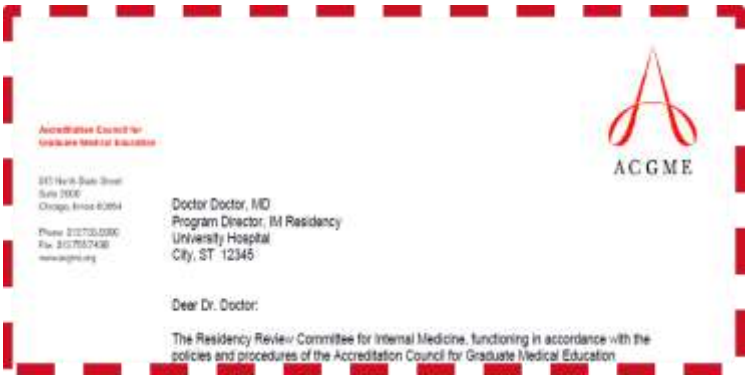
5 Days

- Up to 60 days following the RC meeting
  - Letters of Notification (LONs) are posted to ADS
  - PD(s), DIO, and PC are notified via email that LON is available
  - LONs attached to email notifications for all programs

60 Days

Communicating Accreditation Decisions – Letter of Notification (LON)

- ✓ Core always receives LON
- ✓ Sub always copied/listed on core's LON
- ✓ **NEW:** Sub will now receive individual LON



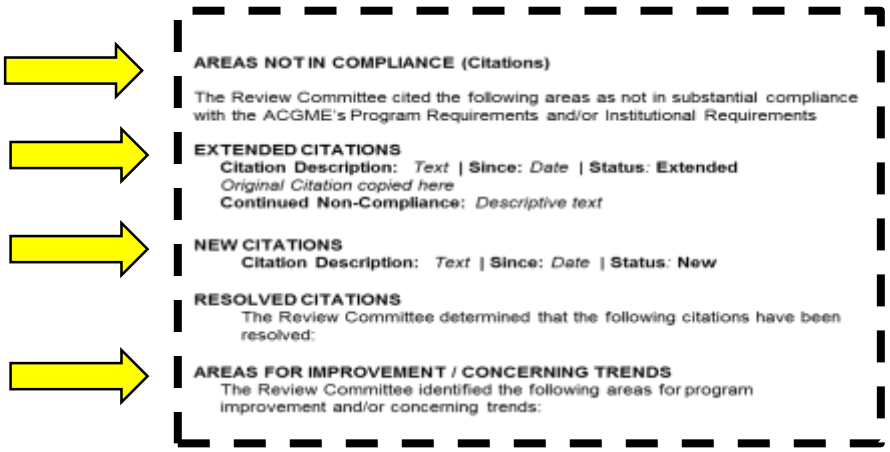
ACGME

Doctor Doctor, MD
Program Director, IM Residency
University Hospital
City, ST 12345

Dear Dr. Doctor:

The Residency Review Committee for Internal Medicine, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education

Communicating Accreditation Decisions – Letter of Notification (LON)



AREAS NOT IN COMPLIANCE (Citations)

The Review Committee cited the following areas as not in substantial compliance with the ACGME's Program Requirements and/or Institutional Requirements

EXTENDED CITATIONS
Citation Description: *Text* | **Since:** *Date* | **Status**: **Extended**
Original Citation copied here
Continued Non-Compliance: *Descriptive text*

NEW CITATIONS
Citation Description: *Text* | **Since:** *Date* | **Status**: **New**

RESOLVED CITATIONS
The Review Committee determined that the following citations have been resolved:

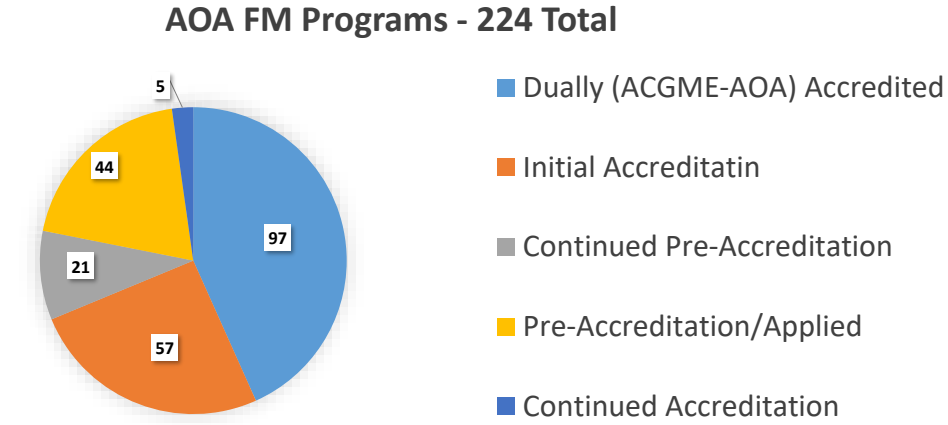
AREAS FOR IMPROVEMENT / CONCERNING TRENDS
The Review Committee identified the following areas for program improvement and/or concerning trends:

In addition to an accreditation decision, the Review Committee may…

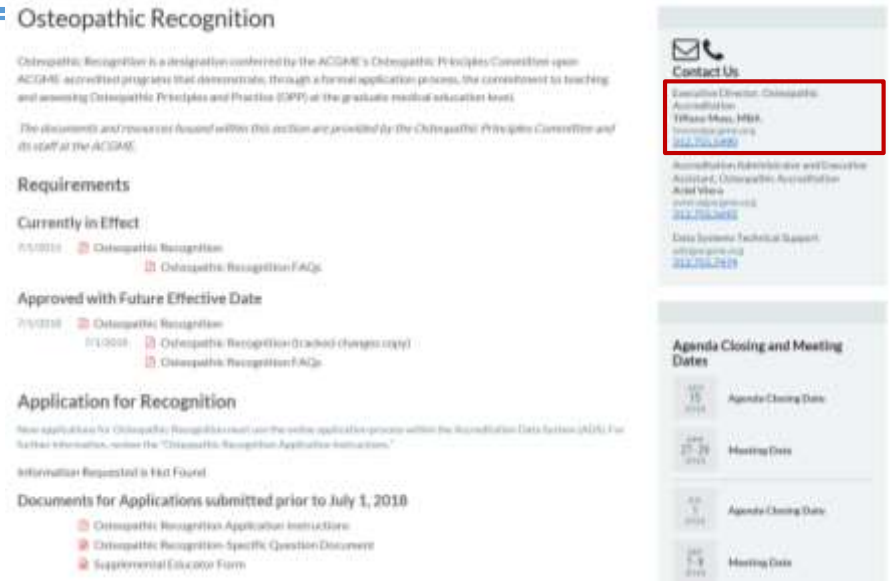
- commend exemplary performance or innovations
- identify areas for improvement (AFIs)
- identify concerning trends
- issue citations or "Extend" existing citations
- "Resolve" previous citations
- increase or reduce resident complement
- request a progress report

Single GME Accreditation System

Single GME Accreditation System

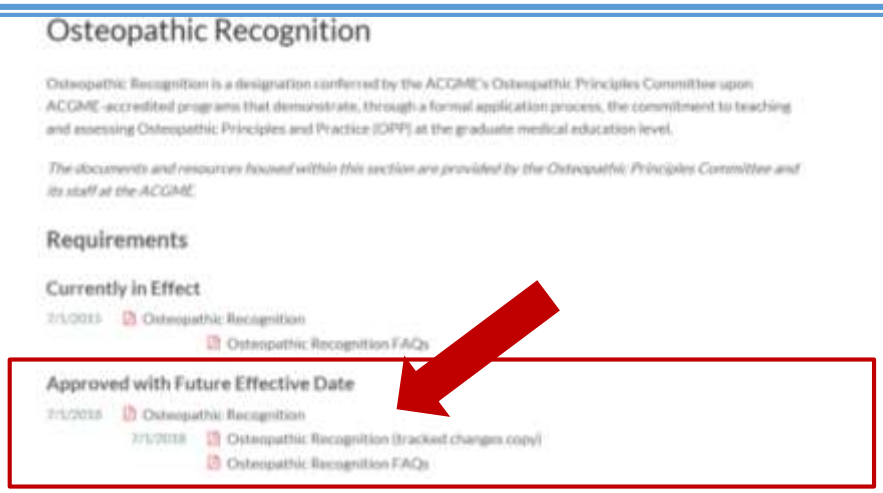


Single GME - Osteopathic Recognition
www.acgme.org/osteopathicrecognition



018 ACGME

Revised OR Requirements Effective July 1, 2018



Updated OR Application – Coming Soon!

Application for Recognition

New applications for Osteopathic Recognition must use the online application process within the Accreditation Data System (ADS). For further information, review the "Osteopathic Recognition Application Instructions."

Documents for Applications submitted prior to July 1, 2018

- Osteopathic Recognition Application Instructions
- Osteopathic Recognition-Specific Question Document
- Supplemental Educator Form

Documents for Applications submitted on or after July 1, 2018

New Osteopathic Recognition-Specific Question Document coming soon!

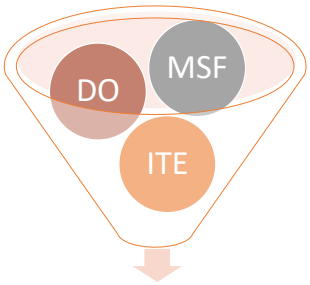
Milestones Reporting

Practical Tips for Milestones

- ✓ Share and discuss the pertinent Milestones set with residents and fellows at the beginning of the program. This helps them to gain a shared understanding of the goals of the program and Milestones.
- ✓ Have residents and fellows complete individualized learning plans, using the Milestones as an important guide.
- ✓ Consider having residents and fellows complete a self-assessment of their Milestones that they can compare and contrast, with a trusted advisor, to the Milestone judgments of the CCC every six months.
- ✓ Enable residents and fellows to seek out assessment (i.e., self-directed assessment seeking), especially direct observation, from faculty members.

Why Can't Milestones Be Used for Regular Evaluations?

- Milestones were designed to be formative
- A repository for other assessments
- Not every Milestone can or should be evaluated on every rotation
- Not everything that should be evaluated is included in the Milestones



Milestone Evaluation

Milestone Resources

Milestone Webpage
http://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview

Milestone FAQs
http://www.acgme.org/Portals/0/MilestonesFAQ.pdf

Milestone Resources

Clinical Competency Committee Guidebook **UPDATED!**
http://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf

Milestones Guidebook
http://www.acgme.org/Portals/0/MilestonesGuidebook.pdf

Milestone Guidebook for Residents and Fellows **NEW!!**
http://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesGuidebookforResidentsFellows.pdf

Milestones Annual Report 2017
http://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesAnnualReport2017.pdf?ver=2017-10-26-092443-267

The Program Self-Study and the 10-Year Accreditation Site Visit

To-date, 78 Family Medicine Core Programs have been notified to begin the process.

The Elements of the Self-Study

- Program Description
- Program Aims
- What does the program strive to "produce?"
- Activities in Furtherance of the Aims
- SWOT Analysis
- An assessment of strengths, areas for improvement, opportunities, threats
- Action Plans
- 5-Year Look Back and 5-Year Look Forward
- Summary of Self-Study Approach
- *"What will take this program to the next level?"*

The Self-Study Summary

- **Uploaded through ADS after completing the Self-Study**
- **Summary Template: 2300 words (~4-5 pages) for core program, less for small subspecialty programs**
- **Sections: Key Self-Study dimensions**
  - Aims
  - Opportunities and Threats
  - Self-study process
  - "What will take this program to the next level?"
  - Learning from the Self-Study
- **Omitted by design: Information on strengths and areas for improvement**

The 10-year Site Visit

- A full site visit with review of all applicable program requirements
- An added review of the Self-Study Summary and the improvement described in the Summary of Achievements
- 18 to 24 months after the self-study to allow the program to make improvements
  - A self-study without a concurrent site visit allows for a frank and forthright review of the program
- Discussion of, and provision of verbal feedback on the improvement process

Bridging the Self-Study and the 10-Year Site visit: The Summary of Achievements

Uploaded via ADS shortly before the 10-year site visit

- **Program Strengths**
  - How they relate to aims and context
- **Achievements in Areas for Improvement**
  - How they relate to aims and context
- **Process for Improvement**
  - Metrics
  - Useful, actionable feedback
- **Lessons Learned**
  - "Best Practices" for sharing

The 10-Year Site Visit: Format And Reporting

- A team site visit for most core program, and for more core and subspecialty sequences
- Site visit opens with the review of the self-study to provide the context for other sections of the site visit
  - Site Visit will include a formative assesses of the maturity of the program improvement effort using the developmental assessment tool
- Verbal feedback, including feedback on the improvement process at the conclusion of the site visit
- The site visitors prepare a two-part report, with the "accreditation section" followed by a review of the self-study

Thank You!