ALLERGY-IMMUNOLOGY
REVIEW COMMITTEE UPDATE
7 JANUARY 2017

William K. Dolen, MD, Chair
Louise King, MS, Executive Director

Review Committee for Allergy and Immunology

DISCLOSURES

• Dr. Dolen is chair of the ACGME allergy-immunology review committee, but not an ACGME staff member
• Dr. Dolen is an ABAI Director
• Ms. King is an ACGME staff member
• These slides have been reviewed by ACGME staff
• No financial conflicts of interest to report
DISCUSSION TOPICS

- ACGME and the Professional Self-Regulatory Assessment System
- Introduction to ACGME-speak
- RC for A&I: membership, meetings, programs, and activities
  - Revision and simplification of case and procedure logs
  - Revision of FAQs
  - Update and revision of resident and faculty surveys
  - Provision for research pathways
  - Milestones and ABAI competency reporting
- Working in the NAS
  - Program requirements
  - Review committees; citations and AFIs; accreditation decisions; the ADS update; letters of notification; site visits
  - Case and procedure logs; cross training
  - Scholarly activity; patient safety and QI projects
  - Milestones, the CCC
  - Transitions of care; CLER; the Single Accreditation System (SAS)
- Online resources

LET’S MEET EACH OTHER

Please tell us:
- Who you are
- Where you’re from
- What brought you to this session

Coming up next:
- ACGME and the Professional Self-Regulatory Assessment system
- Introduction to ACGME-speak
- RC for A&I membership, meetings, programs, and activities
THE PROFESSIONAL SELF-REGULATORY ASSESSMENT SYSTEM

Assessments within Program:
• Direct observations
• Audit and performance data
• Multi-source feedback
• Simulation
• Exams

"Data" Synthesis: Committee

Milestones and EPAs as Guiding Framework and Blueprint

ACGME-SPEAK

• RC: review committee; formerly called “residency review committee” (RRC)
• NAS: Next Accreditation System (actually, the current accreditation system)
• ADS: Accreditation Data System
• PR: Program Requirements
• FAQ: Commentary on the PR, reflecting the RC’s current interpretation
• AFI: Area for improvement
• Resident vs. Fellow: In the ACGME, allergy-immunology is classified as a core residency, not as a subspecialty fellowship; A-I thus has its own RC, separate from pediatrics and internal medicine
• If you encounter unfamiliar acronyms, always ask – don’t assume
RC FOR ALLERGY AND IMMUNOLOGY MEMBERS

- William K. Dolen, MD* (Chair)
- Rohit K. Katial, MD (Vice Chair)
- Amal H. Assa’ad, MD
- Thomas Prescott Atkinson, MD
- Mary Beth Fasano, MD
- Beverly B. Huckman – Public Member
- Anne-Marie Antointe Irani, MD
- Evelyn M. Lomasney, MD – Resident Member
- Gailen D. Marshall, Jr., MD
- Stephen I. Wasserman, MD - Ex-Officio (ABAI)
- Joseph S. Yusin, MD
- Louise King, MS – Executive Director, RC for A&I

*Term ends June 30, 2017
RC members are not allowed to discuss RC activities, accreditation decisions

INCOMING RC MEMBERS

- Paul J. Dowling, Jr., MD
  – Children’s Mercy Hospital
  – Kansas City, MO

Term begins July 1, 2017
RC FOR ALLERGY AND IMMUNOLOGY STAFF

ACGME Leadership
• Mary Lieh-Lai, MD, Senior Vice President for Medical Accreditation
  (312) 755-7405 – mliehlai@acgme.org

RC Staff
• Louise King, MS, Executive Director
  (312) 755-5498 – lking@acgme.org
• Tiffany Hewitt, BFA, Accreditation Administrator
  (312) 755-7471 – thewitt@acgme.org
• Landyn Jordan, MPH, Executive Assistant/Accreditation Administrator
  (312) 755-7471 – thewitt@acgme.org

RC MEETINGS IN 2016

• January 12-13, 2017 (mostly program reviews)
  – Agenda closed November 18, 2016
• March 30-31, 2017 (mostly an advancement meeting)
  – Agenda closed January 6, 2017

Note – These are the same agenda closing dates for the submission of new applications
PROGRAM ACCREDITATION

• Academic year 2015-2016
• Total programs: 78
• Newest program: University of Colorado School of Medicine (Denver Children’s Hospital), Dr. Joe Spahn, Director

CURRENT RC ACTIVITIES

• Update and revision of FAQs
• PR revision to allow explicitly for research pathways
• Integration of milestones and ABAI competency reporting
• ACGME Common Program Requirement Revisions to Section VI
• Revision and simplification of case and procedure logs
**REVISION OF FAQS**

- The current FAQs were created at the time of the last major revision to the PR
- While still accurate, the implementation of the NAS changed the way the RC operates, and its current culture
- They have been updated to reflect these changes, as well as to provide answers to questions more recently brought up
- The document is in the final review process at ACGME

**RESEARCH PATHWAYS**

- Under certain circumstances, the ABIM (in collaboration with the Internal Medicine RC) and the ABP (in collaboration with the Pediatric RC) will allow residents to enter subspecialty training before completion of their primary residency
- The A-I PR make no provision for this:
  III.A.1. Prior to appointment in the program, residents must have successfully completed a residency program in internal medicine and/or pediatrics accredited by the ACGME or the RCPSC. (Core)
- A PR revision to enable this has passed early stages of review and is scheduled for review at the February 2017 ACGME Committee on Requirements meeting
III.A.1. Prerequisite Education
Prior to appointment in the program, residents must have successfully completed:

- III.A.1.a).(1) a residency program in internal medicine and/or pediatrics accredited by the ACGME or the RCPSC; (Core)

- III.A.1.a).(1).(b) two years of a residency program in internal medicine accredited by the ACGME or the RCPSC, and been accepted into a research pathway of the American Board of Internal Medicine (ABIM), as attested to by the ABIM and American Board of Allergy and Immunology (ABAI); or, (Core)

- III.A.1.a).(1).(c) two years of a residency program in pediatrics accredited by the ACGME or the RCPSC, and been accepted into a research pathway of the American Board of Pediatrics (ABP), as attested to by the ABP and ABAI. (Core)

MILESTONES AND THE ABAI

- ACGME and ABAI have a data-sharing agreement in place
- ACGME is willing to send milestone data to ABAI
- ABAI is considering options that would simplify the rating of competencies by PDs by use of milestone data
PROGRAM REQUIREMENTS AND CASE LOGS

Current Program Requirements
• Drafted by RC members, who are active or former program directors
• Greatly simplified from previous PR, under leadership of Bryan Martin and David Peden
• Reviewed by the College and AAAAI, ABAI, other stakeholders
• Finalized by ACGME
• Presumably, reflect the perceived needs of the a-i community
• Can be revised!

IV.A.6.b) Resident experiences in direct patient care must include...direct patient contact with pediatric and adult patients with the following diagnoses:
• anaphylaxis
• asthma
• atopic dermatitis
• contact dermatitis
• drug, vaccine, or immunomodulator allergy, or adverse drug reaction allergy to drugs and other biological agents
• food allergy
• ocular allergies
• primary and acquired immunodeficiency
• rhinitis
• sinusitis
• stinging insect allergy
• urticaria and angioedema
 PROGRAM REQUIREMENTS AND CASE LOGS

• The list was formulated to define, in part, the scope of allergy-immunology practice
• Never intended for the RC to assess an individual fellow’s competency
• In the former accreditation system, residents kept logs that were submitted to ACGME, and the PD or Program Coordinator entered data into the PIF submitted for a site visit
• Now, every program is reviewed every year, but without a PIF
• In NAS, program reviews are data-driven
• The way that this is done was presented last year, and is summarized elsewhere in this slide deck

 PROGRAM REQUIREMENTS AND CASE LOGS

• In customizing the Next Accreditation System, the a-i RC felt that resident experience in these areas should be monitored
• Indicators
  – review of patient case log data
  – review of the yearly fellow survey data
• Since the case logging system had already in place for many years, the RC opted to use this for monitoring
• So...
CASE AND PROCEDURE LOGS – STATUS QUO

• RC chairs have consistently been “on message” reminding PDs that logging is important; see the RC FAQ for details on what to log
• The RC tracks, analyzes, and scrutinizes log data closely, and assumes that reported data are complete and accurate
• The logging system is being brought into line with the current PR, and simplified
• The RC has prepared a new guide to help residents do this
• But...

CASE AND PROCEDURE LOGS – STATUS QUO

• In the past 30 years, physicians have become clerk-typists, medical transcriptionists, and data entry clerks – taking time away from patient care, education, and research
• The RC is aware that the logging process adds to this burden, and has explored other ways to obtain similar data – to no avail
• As part of its continuous improvement process, the RC is always open to finding innovative ways to go about its duties
• We need your help
CASE AND PROCEDURE LOGS – OPTIONS

1. Should the list of required diagnoses be dropped from the PR? If so, then there would be no need for monitoring.
   - This would require consensus from stakeholders, and ACGME approval
   - A long process, but doable

2. Who does the data entry for the case logs – can this be a local option?
   - FITs
   - Program faculty, or program director
   - Program coordinator
   - Other staff

3. Could the RC rely solely on yearly fellow survey data?
   - Currently, the RC cross-checks log data with fellow survey data

4. Alternatives to manual data entry
   - EHR: would IT staff compile data from EHR and transmit to ACGME in a unified format?
   - Direct transmission not possible due to interoperability issues

5. Other options?

DISCUSSION TIME!

Next up – Working in NAS, Part 1:
• Program requirements
• Review committees
• Citations and AFIs
• Accreditation decisions
• The ADS update
• Letters of notification
• Site visits
PROGRAM REQUIREMENTS

- The current A-I PR are dated 1 July 2016
- PR and FAQs are at the ACGME website
- Program directors and program faculty need to be familiar with the PR and FAQs
- Program directors should also be familiar with the institutional PR
- A PR that’s a ‘must’, must be implemented; a PR that’s a ‘should’, should be implemented
- PR currently reflect minimum standards
- The RC discourages programs from having an educational culture of only meeting the minimum requirements established for monitoring purposes.

PROGRAM REQUIREMENTS

The PR are **minimum** accreditation standards; those in your institutional ‘chain of command’ may impose additional requirements

Selected examples:
- Verification of procedural skills by Entrustable Professional Activities (EPAs)
- Additional case and procedure requirements
- A scholarly oversight committee
ROLE OF REVIEW COMMITTEE IN NAS

• Utilize data and judgment to:
  – Improve program quality
  – Concentrate efforts on improving programs with significant areas of noncompliance
  – Determine whether accreditation standards are violated and provide useful feedback for programmatic improvement
  – Determine whether these violations (citations, AFIs) rise to a level requiring alteration in accreditation status
  – Over time, understand and refine the nuances of the process
• Conduct complete review of the program every 10 years, using a “PIF-less,” team based, department wide evaluation of programs

HOW DOES IT WORK?

• Basic operational principle of NAS:
  – RC will make an accreditation action on every program annually
  – All programs will receive notice regarding accreditation status between January and July
• At January 2017 meeting, RC reviewed NAS data submitted for AY 2015-2016
  – ADS annual update information submitted in fall of 2016
  – Faculty and Resident/Fellow survey data from early spring of 2016
HOW DOES IT WORK?

• All programs with continued accreditation with warning or probation seen by reviewers
• All programs identified by NAS data as potentially noncompliant underwent further scrutiny by RC staff and members
• What data elements were triggered?
  – Not all data elements have same importance/weight
  – Board scores and resident survey have more weight
  – Are programs still getting used to data elements (e.g., scholarly activity table)?
  – Are there patterns/trends in data?

CITATIONS IN NAS

Citations are not new
• Identify areas of non-compliance
• Linked to specific requirements
• Responses required in ADS
• Citations are given and removed by RC (not by staff)

Citations received in NAS require an RC member to review annually

Citations received in the old system (given prior to July 1, 2013): went away after two cycles of continued accreditation in NAS if there were no new citations
AREAS FOR IMPROVEMENT (AFI)

- AFIs reflect “General concerns”
- May be given or removed by staff (on basis of RC decision guidelines) or RC
- May not be specifically linked to a requirement
- AFIs will be included in the Letter of Notification
- Do not require written response in ADS
- Expectation that AFIs will be monitored locally — PD and GMEC will work to resolve
- AFIs are tracked by RC

CITATIONS VS AFIS

- In OAS, the main mechanism to provide feedback was through citations
- In NAS, there are 2 methods: citations and AFIs
- Citations require annual review by a member of the RC
- It is intended that AFIs will trigger appropriate local program improvement, so that citations may be used more sparingly
- AFIs related to program requirements, if not addressed, will likely become citations
**ACCREDITATION DECISIONS - EXISTING PROGRAMS**

- Continued Accreditation
- Accreditation with Warning (no time limit)
- Probationary Accreditation (2 years)
- Withdrawal of Accreditation

**ACCREDITATION DECISIONS – NEW PROGRAMS**

Accreditation Decisions: (New Application)
- Initial Accreditation
- Withhold Accreditation

Accreditation Decisions: (Programs with Initial Accreditation)
- Initial Accreditation with Warning
- Continued Accreditation
- Withdrawal of Accreditation
ADS UPDATE PD RESPONSIBILITY: ACCURATE DATA

• Program Director:
  – Must be aware that the RC assumes that submitted data are complete and accurate
  – Review all information before “hitting” the submit button (ideally, one other person should also proofread)
  – Throughout the year, as there are changes in the program, it’s a good idea to update ADS at the time
• DIO should also review before submission
• Common omissions:
  – Faculty credentials (degree, certification, re-cert)
  – Participating sites
  – Complete scholarly activity
  – Updated response to citation(s)
  – Complete block diagram

IDENTIFYING FACULTY FOR FACULTY ROSTER

• This is a PD responsibility
• Identifying who to list in ADS:
  – Only physicians count as core faculty
  – Core Programs (including A&I): Only faculty who spend at least 15 hours or more/week on residency (including clinical, didactic, research and administration)
  – Review instructions in ADS: List minimum number for size of program
  – Core faculty members complete the scholarly activity report and the faculty survey
LETTER OF NOTIFICATION (LON)

• New LON
  – Summarizes actions
  – Includes citations and AFIs
  – Sent to core program directors, and DIO

SITE VISITS IN NAS

Three types
• Full site visits
• Focused site visits
• Ten year self-study visits
FULL SITE VISITS

• Application for a new core program
• At the end of the initial accreditation period for a new program
• If the RC identifies broad issues/concerns
• Other serious conditions or situations identified by the RC
• Notification given about 30 days in advance
• Minimal document preparation anticipated
• Team of site visitors

FOCUSED SITE VISITS

• To assess selected aspects of program:
  — Potential problems identified during annual review
  — To diagnose reason for deterioration in performance
  — To evaluate a complaint
• Minimal notification given – 30 days
• Minimal document preparation expected
• Team of site visitors
SELF-STUDY VISIT

What is it?
• Not yet fully developed – stay tuned
• Scheduled every ten years
• Conducted by a team of visitors
• Minimal document preparation expected
• Interview residents, faculty, leadership

ELEMENTS OF THE SELF-STUDY

• SVOT/SLOT Analysis: Program strengths, vulnerabilities/limitations (including areas for improvement), opportunities and
• A five-year “look back” on program changes and improvements
• A five-year “look forward” – plans/considerations of the future
  – With input from all relevant stakeholders
    (program, department, institutional leaders, other affected)
• Consideration of/answer to the question “What will take this program to the next level?”
THE 10-YEAR ACCREDITATION SITE VISIT (ALL PROGRAMS)

A full accreditation site visit – review of all applicable requirements
• 12- to 18-month period is by design, to allow programs to implement improvements
Programs submits a “Summary of Achievements” – 1500 words, describing program strengths and key improvements accomplished from the self-study
• Site Visit assesses maturity of the program improvement effort, using a developmental categorization/assessment tool currently being pilot tested by the ACGME
• Site Visit opens with the review of the self-study to provide the context for the accreditation section of the site visit
• A two-part report with a review of the self-study, followed by the “regular” section of the review and the program against the accreditation standards

DISCUSSION TIME!

Next up – Working in the NAS, Part 2:
• Case and procedure logs
• Scholarly activity
• Patient safety and QI projects
CASE AND PROCEDURE LOGS

The data entry process for the logs changed (much for the better) in January 2016

The RC has affirmed the need for logs in the first place (having examined alternatives to logging), and are reevaluating the data collected in the logging process

CASE AND PROCEDURE LOGS

• The RC uses log data to evaluate compliance with Program Requirements. The RC has not found an alternative.
• Currently, the log data are important components of the Next Accreditation System – the RC tracks, analyzes, and scrutinizes log data closely
• Log EVERY diagnosis up to 3; see the RC FAQ for details on what to log
• Log EVERY procedure; see the RC FAQ for details on what to log
• PLEASE LOG EVERYTHING – not just the bare minimum!
• A local program is free to require residents to log additional diagnoses and procedures (not reported to ACGME)
PATIENT LOG MINIMUMS

• Each resident must demonstrate adequate patient exposure by logging experience with at least 750 total diagnoses, 500 of which are principal diagnoses.
• Residents may log as many as 3 diagnoses per patient.
  – A patient with anaphylaxis due to peanut allergy can be listed as both a food allergy and anaphylaxis experience.
• Of these 750 total diagnoses, a minimum of 150 primary diagnoses should occur in patients over 18 years, and 150 should occur in patients 18 years and younger.

WHERE DID THIS COME FROM?

• The Review Committee used the 10th percentile values for total and diagnosis-specific data from the 2009-2010 National Resident Log Report as a reference norm.
• The Committee recognizes that when the 10th percentile for a required diagnosis is less than 5, there may be difficulties in reaching a minimum of five patient experiences.
• These numbers reflect bare minimum expectations.
• The RC discourages programs from having an educational culture of only meeting the minimum requirements established for monitoring purposes.
DIAGNOSES

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum (10th percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylaxis</td>
<td>15</td>
</tr>
<tr>
<td>Asthma</td>
<td>130</td>
</tr>
<tr>
<td>Atopic dermatitis</td>
<td>35</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>5</td>
</tr>
<tr>
<td>Drug reactions</td>
<td>20</td>
</tr>
<tr>
<td>Food reactions</td>
<td>50</td>
</tr>
<tr>
<td>Immunodeficiency</td>
<td>40</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>180</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum (10th percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venom hypersensitivity</td>
<td>5</td>
</tr>
<tr>
<td>Urticaria, angioedema</td>
<td>45</td>
</tr>
<tr>
<td>Pediatric diagnoses</td>
<td>150</td>
</tr>
<tr>
<td>Adult diagnoses</td>
<td>150</td>
</tr>
<tr>
<td>Total principal Dx</td>
<td>500</td>
</tr>
<tr>
<td>Total</td>
<td>750</td>
</tr>
</tbody>
</table>

If even one graduating resident is below the minimum, expect an AFI or citation. In the special case of contact dermatitis and venom hypersensitivity, make provision for alternative training in this area, and communicate this in your ADS update.

LESS THAN 5 DIAGNOSES?

- In the event that a resident will have <5 experiences for a required A/I diagnosis (for which 5 is the minimum), the PD is required to document an alternate approach to provide the required number of experiences for this diagnosis.
- This may include development of simulated cases for the resident to manage or rotations with other programs to acquire the required minimum number of experiences.
- Simulated cases may be developed within the program, provided as programming in national or regional allergy immunology meetings, or established as an online resource (such as a PIM provided for A-I MOC).
WHAT ABOUT PROCEDURES?

What is the Review Committee's expectation regarding demonstrating proficiency in each of the required procedures?

- Residents must perform and evaluate the results of each required procedure at least 5 times...to the satisfaction of the PD or delegated faculty member
- An individual resident's log should reflect the activities of that resident
- When more than one resident participates in a given procedure, each should log it, providing the criteria in the FAQ have been met

PROCEDURES

<table>
<thead>
<tr>
<th>Reported, monitored</th>
<th>Currently reported, but not monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergen immunotherapy</td>
<td>Contact or delayed hypersensitivity (anergy) testing</td>
</tr>
<tr>
<td>Drug hypersensitivity diagnosis and treatment</td>
<td>Interpretation of T cell phenotype and function</td>
</tr>
<tr>
<td>Food hypersensitivity diagnosis and treatment</td>
<td>Physical urticaria testing (reported, not monitored as a procedure)</td>
</tr>
<tr>
<td>Immediate hypersensitivity skin testing</td>
<td>Rhinoscopy (reported, not monitored)</td>
</tr>
<tr>
<td>Immunoglobulin treatment and administration [includes intravenous (IVIG) or subcutaneous (SCIG) for replacement therapy or use of other immunomodulator therapy]</td>
<td>Others, as thought locally important (not reported to ACGME)</td>
</tr>
<tr>
<td>Pulmonary function tests (PFT)</td>
<td></td>
</tr>
</tbody>
</table>
PROCEDURES - NUMBERS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Probable AFI</th>
<th>Probable citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergen IT</td>
<td>10</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Drug desens/challenge</td>
<td>10</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Food challenge</td>
<td>5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Skin testing</td>
<td>30</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Immunoglobulin</td>
<td>5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>PFT</td>
<td>30</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Others</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

CROSS TRAINING

IV.A.6.a) The program format must be as follows:
- IV.A.6.a).(1) 50% of the program (12-month equivalent) must be devoted to direct patient care activities, clinical case conferences, and record reviews; (Detail)
- IV.A.6.a).(1).(a) At least 20% of the required minimum 12-month equivalent direct patient care activity must focus on patients from birth to 18 years. (Detail)
- IV.A.6.a).(1).(b) At least 20% of the required minimum 12-month equivalent direct patient care activity must focus on patients over the age of 18 years. (Detail)
**EXPLANATION**

- The RC sees this as meaning that there should be a minimum of 20% clinical cross-training in year 1, and a minimum of 20% in year 2.
- 10% in year 1 and 10% in year 2 is seen as 10% overall, not as 20%.
- This is a detail requirement, evaluated by examination of the ADS block diagram.
- Established programs that are meeting the case volume requirements and have resident survey reports indicating satisfaction with adequacy of cross-training have some wiggle-room with this detail requirement.
- New programs do not, since there are no log data or resident survey reports.

**SCHOLARLY ACTIVITY**

- All residents must, and at least 50% of faculty members should, participate in scholarly activities, as indicated by:
  - Peer-reviewed grant funding
  - Publication of original research papers in a peer-reviewed journal
  - Published abstract
  - Oral or poster research presentation at a meeting
  - Dissemination (as evidenced by review articles or chapters in textbooks)
  - Application (see next slide)
SCHOLARLY ACTIVITY - APPLICATION

- Publication or presentation of, for example:
  - Case reports or clinical series at local, regional, or national professional and scientific society meetings
  - Other scholarly discussions (journal club, grand rounds, etc.)
- Production of educational materials
- Educational leadership
- Does peer-review of journal manuscripts
- Other leadership roles

SAFETY AND QUALITY IMPROVEMENT PROJECTS

- Each resident should do at least one patient safety project, and at least one QI project in the course of training
- This is another aspect of scholarly activity
- The program director can decide the extent to which QI is done in the program
DISCUSSION TIME!

Next up – Working in the NAS, Part 3:
• Milestones
• The Clinical Competency Committee

DREYFUS & DREYFUS DEVELOPMENT MODEL

MILESTONES (and EPAs)

Curriculum Assessment
Curriculum Assessment
Curriculum Assessment
Curriculum Assessment
Curriculum Assessment

Development is a non-linear phenomenon

Time, Practice, Experience

Dreyfus SE and Dreyfus HL. 1980
Carraccio CL et al. Acad Med 2008;83:761-7
MILESTONES

• Created by each specialty
• A combined effort of the ACGME and Specialty Boards
• The first Milestones Summit met in Chicago on 3-4 December 2015 to review work to date, and to plan for the future
  – Representatives from ACGME, the RCs, the ABMS and its boards

MILESTONES DEFINED

• General definition
  – Skill and knowledge-based developments that commonly occur by a specific time
• Milestone project definition
  – Specific behaviors, attributes, or outcomes in the general competency domains to be demonstrated by residents by a particular point during residency
• Milestones are like a roadmap, showing where you started, where you are, and where you can go
WHY MILESTONES?

• A framework of observable behaviors, created by specialty peers (not the ACGME)
• Intended to help residents learn about strengths and weaknesses, and identify a pathway for lifelong learning
• Intended to encourage resident self-assessment and self-directed learning; better feedback to residents
• Milestones can provide data about an individual’s progress to an ABMS board
• Milestones can provide program accreditation data to ACGME

MILESTONES DOCUMENT

• Template for evaluating physician performance at various career points
• Based on the 6 core competencies
  – Divided into subcompetencies
  – Each has performance language to allow categorization ranging from Level 1 (entry) through Levels 2, 3, 4 (competent to graduate), and Level 5 (aspirational)
  – For an individual, Level 4 is the recommended (but not required) graduation target
A-I MILESTONE EXAMPLE
PATIENT CARE (#3 OF 4 PC & 10 TOTAL)

Management Plan: Designs an appropriate management plan that incorporates indication, risk, benefits, and cost of therapies for allergic and immunologic disorders. (Core Competency: Patient Care)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognize basic treatments for common allergic and immunologic disorders</td>
<td>• Select and implement treatment from existing evidence based therapies or clinical trials with substantial supervision</td>
<td>• Select and implement cost effective treatment from existing evidence based therapies or clinical trials with minimal supervision</td>
<td>• Independently select and implement cost effective treatment from existing evidence based therapies or clinical trials</td>
<td>• Participate in writing or reviewing practice guidelines</td>
</tr>
<tr>
<td>• Identify outcomes associated with various treatments</td>
<td>• Formulate a plan for monitoring outcomes</td>
<td>• Monitor outcomes and appropriately adjust treatment with supervision</td>
<td>• Independently monitor outcomes and appropriately adjust treatment</td>
<td>• Identify and report previously unrecognized outcomes</td>
</tr>
<tr>
<td>• Identify potential adverse events associated with various treatments</td>
<td>• Formulate a plan for monitoring and treating adverse events with substantial supervision</td>
<td>• Monitor and treat adverse events with minimal supervision</td>
<td>• Independently monitor and treat adverse events</td>
<td>• Identify and report previously unrecognized adverse events</td>
</tr>
</tbody>
</table>

Comments:

PD QUESTION

• The overall intent of milestones is to help residents learn about strengths and weaknesses, and to identify a pathway for lifelong learning
• Milestones should be used to encourage self-assessment and self-directed learning, and for faculty to provide better feedback
• The narratives are only for local use, and can be as brief or detailed as the PD and CCC desire; they are not used by ACGME as part of the evaluation process, and do not need to be submitted
A-I MILESTONE DEVELOPMENT

Working Group
• Prescott Atkinson
• William Dolen
• Laura Edgar (ACGME)
• Mary Beth Fasano
• Anita Gewurz
• John Kelso
• Louise King (ACGME)
• Dennis Ledford
• Michael Nelson
• Stokes Peebles
• Jay Portnoy
• Nastaran Safdarian

Advisory Group
• Timothy Brigham (ACGME)
• David Peden
• Lawrence Schwartz
• Stephen Wasserman (ABAI)
• Richard Weber

ACGME MILESTONES PROJECT

Key features
• Emphasize core competencies
• Move accreditation from structure and process-based to outcomes-based
• Level 5 is aspirational; most evaluation systems only define minimal expectations
• A-I milestones are similar to information already being reported to ABAI
• Hope for future integration between ACGME and ABAI
MILESTONES DOCUMENT

- Milestones are not the only measure of competency, nor are they complete assessments of competency.
- A local program is free to develop additional milestones thought to be locally important (but not reported to ACGME).
- Not all Level 4 items are expected to be achieved by the end of training.
- Resident not required to meet EACH Level 4 item to graduate.
- Resident not assured of graduation solely on basis of Level 4 item achievement.

MILESTONES DOCUMENT

- The milestone document was not intended for use by faculty to evaluate fellow performance on a rotation.
- Certain milestones might be appropriate for a rotation.
- Chances are that the evaluation tools that you’ve been using in recent years are still appropriate for input to the CCC.
**MILESTONES DOCUMENT**

- Milestones are not used for individual summative evaluations.
- However, a resident at Level 1 or Level 2 at the end of 6 or 12 months would presumably have an “Unsatisfactory” rating on the ABAI competency report.
- With guidance from the CCC, the PD should use the same remediation procedures that have always been used in such a situation.
- ACGME only looks at aggregate data, not individual data.
- The milestone working group set Level 4 as a recommended, but not required, level for graduation.
- Milestone data are only one factor to consider in deciding whether a resident has met requirements to graduate and sit for the ABAI exam.

**MILESTONES DOCUMENT**

- Designed for use by a Clinical Competency Committee which meets every 6 months.
- The CCC reviews data from various evaluation tools, and categorizes each resident as Level 1-5 for each competency (A-I has 10 reporting items).
- Milestones are not intended to be millstones for program directors and coordinators, or residents.
- Expect fine-tuning and revisions as more data are collected and analyzed.
- Questions/comments about milestones? milestones@acgme.org
**MILESTONES DOCUMENT**

- The allergy-immunology milestones will not change in the immediate future, although there could be some minor tweaking.
- ACGME is planning “Milestones 2.0” which (in the next several years) will reevaluate all milestones in all specialties.
- You will be asked for input on this, should consider joining the working group.

---

**LEVEL 4 ATTAINMENT BY FELLOWSHIP YEAR**

- The graph shows the attainment of Level 4 in allergy and immunology from Year 1 to Year 2. It includes categories such as PC, MK, SBP, PBLI, PROF, and ICS.

Slide courtesy of Eric Holmboe, MD

© 2015 Accreditation Council for Graduate Medical Education
WKD4    Update needed
Bill Dolen, 12/14/2016
CLINICAL COMPETENCY COMMITTEE

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

- V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

- V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)

- V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

CLINICAL COMPETENCY COMMITTEE

V.A.1.b).(1) The Clinical Competency Committee should:

- V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

- V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

- V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)
CLINICAL COMPETENCY COMMITTEE

The role of the Program Director in the CCC is undefined (local option)
• “Voting” member
• Ex-officio member
• Chair
• Not a member

Clinical Competency Committee Guidebook located on the ACGME website at www.acgme.org

DISCUSSION TIME!

Next up – Working in the NAS, Part 4:
• Transitions of care
• Clinical Learning Environment Review (CLER)
• The Single Accreditation System
ACGME COMMON PROGRAM REQUIREMENT REVISION – SECTION VI

• Dr. Nasca’s November 4, 2016 Letter to the Community was posted via the ACGME e-Communication
• Proposed ACGME Common Program Requirements – Section VI – posted for 45 day Public Comment period (ended December 19, 2016).
• The proposed ACGME Common Program Requirements – Section VI were reviewed by the ACGME Committee on Requirements and Board of Directors at its February 2017 meetings with implementation targeted for the 2017-2018 academic year.
• The text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

CHANGES TO ACGME COMMON PROGRAM REQUIREMENT REVISION – SECTION VI

• The Learning and Working Environment Language changed from “Resident Duty Hours in the Learning and Working Environment” to “The Learning and Working Environment”
• Patient Safety, Supervision and Accountability
• Define the need for a culture and clinical learning environment focused on resident education and faculty development in patient safety and quality improvement
CHANGES TO ACGME COMMON PROGRAM REQUIREMENT REVISION – SECTION VI

• New requirements for resident and faculty member well-being address the emerging evidence that physicians are at risk for burnout, and perhaps depression
• The terms “clinical experience and education,” “clinical and educational work,” and “work hours” have replaced the terms “duty hours,” “duty periods,” and “duty” in the proposed revisions to emphasize that residents’ responsibility to the safe care of their patients supersedes any duty to the clock or schedule

ACGME COMMON PROGRAM REQUIREMENT REVISION – SECTION VI

Approved ACGME Common Program Requirements for Section VI and FAQs will be posted to the ACGME website at www.acgme.org
**CLER PROGRAM**

- Clinical Learning Environment Review (CLER)
- An institution-level program, not program-level
- Institutions will be visited every 18 months
- Data will not be used for program accreditation
- Programs must ensure that residents and fellows:
  - Are aware of patient safety/quality improvement efforts of the institution
  - Are actively participating in patient safety and quality improvement efforts

**SINGLE ACCREDITATION SYSTEM**
ACCREDITATION OF AOA PROGRAMS

TIMELINE FOR ACCREDITATION

• To apply, programs must be associated with ACGME-accredited sponsoring institution or institution with “Pre-Accreditation Status”

• Window for institutional accreditation open 1 April 2015 - 30 June 2020

• New institutional application process
DISCUSSION TIME!

Next up:
• Online resources

WEBINARS

• Previous webinars available for review at: http://www.acgme-nas.org/index.html under “ACGME Webinars”
• CLER
• 2013 Coordinator Webinars
• NAS Phase I and Phase II: Overview of Next Accreditation System
• Single Accreditation System – Series for AOA-Approved Programs
• Milestones, Evaluation, CCCs
• Stand-alone slide decks for GME community: NAS, CCC, PEC, Milestones, Update on Policies
• ACGME Self-Study
DISCUSSION TIME!

Thank you