

DEVELOPING SPECIALTY- BASED ROATIONS IN THE ACGME WORLD

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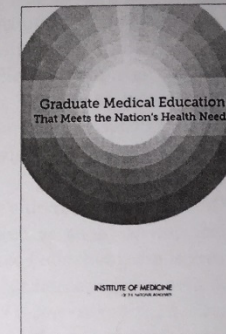
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Graduate Medical Education That Meets the Nation's Health Needs

Institute of Medicine Brief 2014

Graduate Medical Education That Meets the Nation's Health Needs



Since the creation of the Medicare and Medicaid programs in 1965, the public has provided tens of billions of dollars to fund graduate medical education (GME), the period of residency and fellowship that is provided to physicians after they receive a medical degree. Although the scale of government support for physician training far exceeds that for any other profession, there is a striking absence of transparency and accountability in the GME financing system for producing the types of physicians that the nation needs.

In 2012, the Josiah Macy Jr. Foundation asked the Institute of Medicine (IOM) to conduct an independent review of the governance and financing of the GME system. Eleven other private foundations provided additional support for the study (the ABIM [American Board of Internal Medicine] Foundation, Aetna Foundation, The California Endowment, California HealthCare Foundation, The Commonwealth Fund, East Bay Community Foundation, Jewish Healthcare Foundation, Kaiser Permanente Institute for Health Policy, Missouri Foundation for Health, Robert Wood Johnson Foundation, and UnitedHealth Group Foundation), as well as the Health Resources and Services Administration (HRSA) and Department of Veterans Affairs (VA). Eleven U.S. senators, from both sides of the aisle, encouraged the IOM to undertake the study.

The 21-member IOM committee concludes that there is an unquestionable imperative to assess and optimize the effectiveness of the public's investment in GME. In its report, *Graduate Medical Education That Meets the Nation's Health Needs*, the committee recommends significant changes to GME financing and governance to address current deficiencies and better shape the physician workforce for the future.

There is a striking absence of transparency and accountability in the GME financing system for producing the types of physicians that the nation needs.

The Next GME Accreditation System– Rationale and Benefits

The New England Journal of Medicine
February 22, 2012

SPECIAL REPORT

The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,¹ and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

Self-regulation is a fundamental professional responsibility, and the system for educating physicians answers to the public for the graduates it produces.² As the accreditor for graduate medical education (GME), the ACGME serves this public trust by setting and enforcing standards that govern the specialty education of the next generation of physicians. In this article, we discuss the NAS, including elements and attributes of interest to stakeholders (program directors, leaders of sponsoring institutions, ACGME's partner organizations, residents, and the public). The ACGME's public stakeholders have heightened expectations of physicians. No longer accepting them as independent actors, they expect physicians to function as leaders and participants in team-oriented care. Patients, payers, and the public demand information-technology literacy, sensitivity to cost-effectiveness, the ability to involve patients in their own care, and the use of health information technology to improve care for individuals and populations; they also expect that GME will help to develop practitioners who possess these skills along with the requisite clinical and professional attributes.³⁻⁷

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education⁸ and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Performance on certifying examinations has improved, residents are prepared to deal with the dramatically increasing volume and complexity of information in their specialty, and graduates and academic institutions have contributed to clinical advances and innovation that the public enjoys today.^{9,10} In addition, the role of the program director has been established as an educational career path, and the formal teaching and assessment of residents and fellows have improved substantially.

Yet success has come at a cost. Program requirements have become prescriptive, and opportunities for innovation have progressively disappeared. As administrative burdens have grown, program directors have been forced to manage programs rather than mentor residents, with a recent study reporting administrative tasks related to compliance as a factor in burn-out among directors of anesthesiology programs.¹¹ Finally, educational standards often lag behind delivery-system changes. The introduction of innovation through accreditation is limited and is often viewed as an unfunded mandate.

The NAS

- The amalgamation of the Competency Based System and the new Milestone Project

Key System Attributes

Key attributes of the new accreditation system will include:

- Specialty-specific educational milestones
- A focus on improvement and self study
- Development of national normative data
- Less prescriptive program requirements, revised less frequently
- Greater flexibility that allows educational innovation
- Reduced burden of accreditation
- Greater emphasis on institutional oversight

This system has 3 parts: Institutional Accreditation, interim visits on short notice (CLEAR), Program Accreditation.

Specialty Program Accreditation

Program site visits every 10 years, with self-study

Continuous observation of:

- Progress by residents on specialty milestones
- Board pass rates
- Attrition from program
- Resident feedback (survey)
- Faculty feedback (survey)
- Clinical experience/case logs
- Structure and resources

The NAS--Other Orthopedic Changes

- PGY I Curriculum and Resident Experiences
- Simulation Lab- 16 modules
- ACGME Review Committees will track milestone trajectories of unidentified individual residents
- Local CLINICAL COMPETENCY COMMITTEE will triangulate progress of each resident via Specialty Milestones

Accreditation Council for Graduate Medical Education

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*



**New PGY 1
program
requirements**

Program outline

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

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.

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

AOAO BASIC STANDARDS

- We are very well positioned to transition to the ACGME standards
- Need to add key components of ACGME
- Milestones, Sim lab, Clinical Competency Committee, Program Evaluation Committee

Orthopaedic Surgery Minimum Numbers
Review Committee for Orthopaedic Surgery



		<u>CPT Codes in Each Category</u>
Category	Minimum	
Knee arthroscopy	30	Knee arthroscopy (29850, 29851, 29855, 29856, 29866, 29867, 29868, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887)
Shoulder arthroscopy	20	Shoulder arthroscopy (29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828)
ACL reconstruction	10	ACL reconstruction (29888)
THA	30	THA (27130, 27132, 27134, 27137, 27138)
TKA	30	TKA (27442, 27443, 27445, 27446, 27447, 27487)
Hip fractures	30	Hip fractures (27235, 27236, 27244, 27245)
Carpal tunnel release	10	Carpal tunnel release (29848, 64721)
Spine decompression/posterior spine fusion	15	Spine decompression lumbar spine/posterior spine fusion thoracic or lumbar (22612, 22630, 22800, 22802, 22804, 63005, 63012, 63017, 63030, 63042, 63047)
Ankle fracture fixation	15	Ankle fracture fixation (27766, 27769, 27792, 27814, 27822, 27823, 27826, 27827, 27828, 27829)
Closed reduction forearm/wrist	20	Closed reduction forearm and wrist fractures (25505, 25520, 25535, 25565, 25605, 25624, 25675, 25680, 25690)
Ankle and hind and mid-foot arthro	5	Ankle and hind and mid-foot arthrodeses (27870, 27805, 27815, 27825, 27830, 27835, 27837)
Suprachondylar humerus perc	5	Supracondylar humerus percutaneous treatment (24538, 24566, 24582)
Operative treatment of femoral and tibial shaft fractures	25	Operative treatment of femoral and tibial shaft fractures (27506, 27507, 27758, 27759)
All pediatric procedures	200	
All oncology procedures	10	

Total All Cases: at least 1000 but no more than 3000

Updated 9/10/2014

So how do we show competency in a subspecialty while doing mostly General Orthopedic Rotations ?

- Joint Reconstruction
- Trauma
- Spine
- Hand
- Foot and Ankle
- Sports Medicine
- Shoulder/Upper Extremity

The NAS--Other Orthopedic Changes

- PGY I Curriculum and Resident Experiences
- Simulation Lab- 16 modules
- ACGME Review Committees will track milestone trajectories of unidentified individual residents
- **Local CLINICAL COMPETENCY COMMITTEE will triangulate progress of each resident via Specialty Milestones**

“ Specialty Rotation “

- Use the specific competency of each specialty milestone on rotation
- If on the general rotation 4 ankle fractures were done; use that competency from the specialty group
- Same for each competency total hip, total knee, etc
- No need to do for each procedure but the accumulated cases for the rotation

“ Specialty Rotation “

- Before meeting with the attending(s), the resident prepares a summary of the category cases for the attending
- The attending can complete the appropriate competencies identifying strengths and weaknesses
- The resident and attending meet prior to completion of the rotation and discuss the progress of the resident based on the competencies performed

Summary

- By the end of each year the CCC will have enough data to track the progress of each resident for each competency
- By the end of the PGY IV and PGY V year specific deficiencies of volume or performance may be addressed to correct any issues
- If most of your rotations are specialty specific, the process is much easier

Summary

- This process is more labor intensive
- I suspect this end of rotation meeting is frequently not happening- other than completing the resident evaluation which may only occur after the coordinator has sent a nasty email after 2 months or the resident is in trouble
- I firmly believe the next change will be faculty development especially in ASSESSMENT of Competency



Developing Faculty Competencies in Assessment: A Course to Help Achieve the Goals of Competency-Based Medical Education (CBME)

After a broadly successful first run in the fall of 2014, the ACGME is thrilled to announce the return of this highly interactive course designed to enhance faculty skills in competency-based assessment of residents and fellows. Assessment is essential to all of education, and graduate medical education is no exception. With the introduction of competency- or outcomes-based education nearly 15 years ago in the US, and now the launch of the ACGME's Next Accreditation System and the Milestones, the need and urgency for high quality graduate medical education programs to meet the needs of learners, programs, and the public has grown substantially.

This six-day course will be held at the ACGME headquarters in Chicago and is limited to 48 attendees. Sessions will begin on Sunday at 1:00 p.m., and continue through Friday at 12:00 p.m. The target audience is residency and fellowship program directors, associate program directors, chairs and members of Clinical Competency Committees (CCCs), and any faculty members with major responsibility for the assessment of residents/fellows.

2015 Fall Course Dates

Sunday, October 11 – Friday, October 16, 2015

Registration is now open and will close on October 2, 2015

Sunday, November 1 – Friday, November 6, 2015

Registration is now open and will close on October 23, 2015

Course Overview

The week begins with a review and exploration of key theories and concepts, and then drills deeper into more specific assessment skills and needs. Highlights of the curriculum include:

- Goals and principles of CBME
- Practical and effective application of multiple assessment methods and tools
- Highly experiential with hands-on practice
- How to create effective assessment systems
- How to effectively run your CCC
- How to use Milestones and Entrustable Professional Activities (EPAs) effectively

Course Faculty

Eric Holmboe, MD, Senior Vice President, Milestone Development and Evaluation, ACGME

Kelly Caverzagie, MD, Associate Dean for Educational Strategy and Assistant Professor, University of Nebraska College of Medicine

William Iobst, MD, Vice President for Academic and Clinical Affairs and Vice Dean, Commonwealth Medical College

DISCUSSION- QUESTIONS





**I DON'T ALWAYS
WATCH COLLEGE
FOOTBALL**

**BUT WHEN I DO ITS
TO WATCH OHIO STATE
STOMP MICHIGAN**