After more than a year of discussion about a single accreditation system for GME, osteopathic and allopathic medical educators have reached an agreement.

On February 26, the ACGME, the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) announced their plan for establishing a single system to accredit all training programs.

Under the plan, all residency and fellowship programs would be accredited by the ACGME by 2020. Although the plan calls for dramatic changes for osteopathic training programs, which will need to be reaccredited under ACGME standards, it will also open up training opportunities for osteopathic graduates.

“Our goal is to optimize the use of every GME position in the United States for all graduates,” ACGME CEO Thomas J. Nasca, MD, MACP, said during his opening remarks at the ACGME 2014 Annual Educational Conference in National Harbor, Md., just days after the announcement. “This is not a unilateral kind of a collaboration and it really gives us the opportunity to optimize the use of scarce resources.”

Increasing opportunities

The availability of training positions for graduates of both allopathic and osteopathic medical schools has become a concern for medical educators in recent years.

Allopathic medical schools, often considered “mainstream” medical schools, increased enrollment in response to a projected physician shortage.

However, there hasn’t been an accompanying increase in Medicare funding for residency positions, which remain capped at levels set under the Balanced Budget Act of 1997. Medical educators are concerned that proposed cuts to indirect medical education payments, another major source of Medicare funding for GME, could further threaten the number of residency positions available, Nasca said during the ACGME Conference.

Colleges of osteopathic medicine, which emphasize treating the whole person and teach physicians to use their hands to make diagnoses, have rapidly added
locations since 2002. More than half of all osteopathic trainees are currently training in ACGME-accredited programs, Boyd R. Buser, DO, an AOA trustee told the organization’s House of Delegates at a July 2013 meeting.

“The problem that we have long recognized in the AOA is that we do not have the capacity to train all of our graduates and have not had that capacity for some time,” Buser said.

In late 2011, the ACGME proposed changes to its Common Program Requirements that would require applicants to some specialty and fellowship programs to have prior training in an ACGME-accredited program. The requirement would make it difficult for some osteopathic trainees to obtain fellowships without repeating training, sparking discussion between the ACGME and the AOA.

**Pathway to a single system**

In October 2012, the ACGME, the AOA, and AACOM announced they would pursue a unified accreditation system for GME.

However, the trajectory to a unified system wasn’t a straight line. In July 2013, after months of meetings with the ACGME, the AOA and AACOM’s boards of directors rejected a plan the ACGME’s board of directors proposed for the unified accreditation system.

At the time, osteopathic leaders said they remained open to discussion with the ACGME, but couldn’t accept the plan because it didn’t address all five key principles they required for a unified accreditation system:

- Negotiations would be limited to GME accreditation
- The osteopathic licensing exam, COMLEX-USA, would remain in place
- Osteopathic board certification would remain intact
- Osteopathic physicians would have an equal opportunity to participate in all training programs
- Primary care programs in community-based settings wouldn’t be jeopardized by a unified system

At a press conference in February, ACGME, AOA, and AACOM leaders didn’t reveal specifics about the progress of negotiations, but said they believed the opportunities of a unified accreditation system eventually outweighed the challenges of creating one.

“Those [opportunities] became the focus of the discussions,” said Norman E. Vinn, DO, president
of the AOA. “It was one of those things in the course of history where the time was right.”

**Changes ahead**

At the ACGME Conference, Nasca described some details of how the two accreditation systems would merge.

Under the plan, the AOA will stop accrediting training programs on or before June 30, 2020. AOA-accredited programs will be able to apply for ACGME accreditation beginning in July 2015. During this period, the ACGME will accept the credentials of faculty members certified by AOA specialty boards, Nasca said.

The ACGME will not loosen a requirement for program directors to be certified by the American Board of Medical Specialties (ABMS) or have credentials deemed acceptable to an ACGME residency review committee (RRC). However, the ACGME will allow ABMS-certified faculty members to serve as co-program directors along with osteopathic program directors who don’t meet these requirements, Nasca said.

“This is not an issue of disrespect,” he said. “This is an issue related to the ability to understand the nuances of ACGME accreditation. It is very difficult to run an ACGME-accredited program if you’ve never participated in one.”

The ACGME doesn’t plan to change its Common Program Requirements, which means rules requiring prior training in an ACGME-accredited program for entrance into some programs will go into effect in July 2016.

However, the ACGME will create an “application status” for osteopathic programs in the process of applying for ACGME accreditation. The names of these programs will be posted on the ACGME’s website and their trainees will be able to apply to ACGME programs under existing standards, rather than the more restrictive ones that go into effect in 2016, Nasca said.

“The goal of this is to provide continuity of education for those graduates during this transition period of time and not wait until the program achieves accreditation because on some programs, it may take two or even three tries for them to get accredited,” he said.

No other ACGME requirements will vary, he said.

“There is no relaxation of our standards,” he said. “Our goal, and the goal of our osteopathic colleagues, is for all programs to be treated equally in the review process and for all programs to be of the same caliber.”

**The osteopathic element**

The ACGME will make some changes to integrate the osteopathic community into its organizational structure and the accreditation process.

Under the plan, the AOA and AACOM will join the ACGME’s board of directors as member organizations. The ACGME will expand its board from 30 to 38 to include osteopathic members.

The ACGME will also appoint two new RRCs. One committee, the Osteopathic Recognition Committee, will conduct reviews for programs that wish to maintain recognition as osteopathic programs in addition to ACGME accreditation.

The ACGME will also establish a committee for neuromusculoskeletal medicine, an aspect of osteopathic medicine with no equivalent ACGME review committee.

These mechanisms will help osteopathic physicians to maintain their unique professional identity, Buser said during the February press conference.

“We are confident that programs that have an osteopathic tradition and focus will be able to continue to do so and will be recognized to do under the unified system,” he said.

Participating in a unified accreditation system will also allow osteopathic physicians to share their principles with the allopathic community, Vinn said during the press conference.

**Challenges ahead**

Although leaders were optimistic about the potential of a unified system for GME, they acknowledged the challenges of combining two different systems.

Both Vinn and Nasca said they expected communicating changes to the stakeholders to be one of the greatest challenges ahead. Perhaps demonstrating the point, an overwhelming number of member organizations dialed into a teleconference the ACGME, AOA, and AACOM held for the press in February, forcing some callers to be disconnected.

“There will need to be outreach so that we can communicate to all of our programs and sponsoring institutions in the United States the nature and the process of ACGME accreditation,” Nasca said.
Committee of champions

‘Competency champions’ help residents meet Milestones

Tim Nelson, MD, FACS, recently attended one of the most satisfying meetings in his six years as the director of the general surgery residency program at the University of New Mexico in Albuquerque.

In January, he met with his program’s clinical competency committee (CCC) to discuss the progress of a class of residents in their final year of training. The committee members felt all four residents would be prepared to graduate at the end of the academic year.

The fact that the entire class was prepared to graduate on time wasn’t simply a matter of good fortune. Since 2012, Nelson and leaders at his program have made a concerted effort to track residents’ progress and proactively address performance issues.

Along with having a CCC in general surgery, the committee is further broken down into “competency champions,” which are faculty members who specialize in one of the six core competencies.

Each month, the CCC meets to review residents’ progress. When committee members identify a struggling resident, a faculty member designated as a “competency champion” helps that resident on the aspect of his or her performance that requires improvement.

The CCC and the competency champions have helped the program to better evaluate and improve resident performance by:

- Using the ACGME’s core competencies and Milestones to assess resident performance
- Making the evaluation process manageable by routinely assessing small groups of residents
- Providing coaching for residents who aren’t meeting Milestones or performance goals
- Distributing the responsibility for helping residents with performance issues among a group

“I think that it gives you a much better sense of how your residents are progressing in the program,” says John Russell, MD, FACS, chair of the Department of Surgery at the University of New Mexico. “And it gives you the ability if they’re falling behind, if they’re slipping beneath the waves, to intervene before it becomes a crisis.”

Evaluating residents

Medical educators have long struggled to find concrete ways to evaluate residents’ performance. Test scores and logs of the numbers of procedures residents perform provide objective data about some aspects of performance, but more subjective areas, such as professionalism or communication skills, can be difficult to assess.

In the past, faculty members might sense that a resident wasn’t performing well, but struggled to specify what was wrong and how the resident might improve, Nelson says.

“We just knew some residents were good and some residents weren’t as good, and we didn’t even understand why some were good,” Nelson says. “We couldn’t give any specific direction and we’d just kind of count on them coming around.”

Often, residents did “come around,” or improve on their own over time, he says. But occasionally, a resident wouldn’t show signs of improvement and as graduation approached, faculty members would be concerned that the resident wouldn’t be ready.

In 1999, the ACGME introduced six competencies for physicians that residency programs were required to evaluate trainees under. The competencies helped to describe necessary abilities for residents, but incorporating competencies into training and assessment wasn’t necessarily intuitive.

Engaging faculty

In early 2012, Nelson designated six faculty members who had demonstrated an affinity for one of the competencies as “competency champions.” Two faculty members serve as champions for patient care and technical skills and Nelson serves as the professionalism competency champion.

At the program’s annual daylong retreat, the seven faculty members introduced themselves as competency champions, explaining their competencies and their ideas for using them in training.

Appointing competency champions engaged more faculty in a concrete way, Russell says.
“It gives them a niche area for their [educational] interests and their faculty development,” he says.

The faculty members “truly are champions” for their designated competencies, which is critical to the success of the initiative, says Erica McBride, DO, a fifth-year resident who sits on the program’s CCC. The communications competency champion is a great communicator and the medical knowledge champion is strategic and data-oriented, she says. The competency champions are also well liked and approachable, which makes residents feel more comfortable seeking their help.

The CCC

Not long after Nelson appointed competency champions, the program became a beta-testing site for the general surgery specialty Milestones, which identify measurable steps residents should take as they progress through training. Although general surgery programs won’t officially begin assessing and recording Milestone data as part of the ACGME’s Next Accreditation System (NAS) until later this year, serving as a test site gave the program the opportunity to prepare.

The program had already established a “resident competency committee,” but renamed it the “CCC,” in accordance with newly established ACGME requirements for CCCs to evaluate residents’ performance along Milestones. Each competency champion sits on the CCC, along with two resident representatives, the department chair, the director of surgical curriculum, and two at-large faculty members.

The committee meets every month, usually following a standard agenda:

- **Program director updates.**
- **Hospital service updates.** The leader of one of the hospital services where general surgery residents rotate gives a presentation about the goals of the service and how residents are evaluated.
- **Competency discussion.** A competency champion discusses methods for teaching his or her competency and provides updates about residents receiving coaching or remediation under that competency.
- **Resident updates.** Occasionally, a resident will address the committee with concerns.

### Managing Milestone evaluations

During each meeting, the committee also evaluates a class of residents’ performance along the 16 general surgery Milestones, which takes about an hour for a class of about five residents.

The committee developed an evaluation schedule to review each class of residents at effective intervals. For example, reviewing interns during the first month of the academic year didn’t make sense, but committee members didn’t want to wait too long to identify performance issues among new resident trainees, Nelson says. The group established the following evaluation schedule:

- July – PGY-5 residents
- August – PGY-4 residents
- September – PGY-3 residents
- October – PGY-1 residents
- November – PGY-2 residents
- December – Presentations from residents on research rotations
- January – PGY-5 residents
- February – PGY-4 residents
- March – PGY-3 residents
- April – PGY-1 residents
- May – PGY-2 residents
- June – Final evaluation for PGY-5 residents

**Kathleen Beard, C-TAGME,** senior surgical residency program coordinator, found that reviewing one class at a time makes the evaluation process more manageable. In the past, program leaders tried to review all residents’ performance during quarterly meetings. However, it was difficult for participants to remain focused during long meetings and sometimes the group didn’t have time to complete its discussion.

“It’s easier trying to do it one bite at a time, rather than trying to eat the entire elephant,” Beard says.

She helps to facilitate the meetings by distributing agendas, taking notes, and projecting materials committee members need to view on a large television monitor in the conference room.

Nelson describes the committee’s meetings as rambunctious but fun. Faculty member evaluations for each resident are compiled into paper files. Committee members review a file for one resident during the meeting. When the group is ready to review a resident, Beard pulls up the general surgery Milestones on the screen.
screen and the committee discusses where to rank the resident’s performance based on the levels within the Milestones. Unless their own classmates are being reviewed, the resident representatives weigh in on their experience working with residents.

Once committee members agree on the ranking, Beard records the Milestone data into a spreadsheet she developed. In July, when general surgery programs officially enter the NAS, Beard will use her program’s residency management system to record Milestone data and then will submit the data to the ACGME through its Web-based Accreditation Data System (ADS).

Coaching connection

Within about a week of the clinical competency meeting, Nelson meets with residents individually to discuss their Milestone evaluations. Residents who are struggling or whose performance is lagging behind their peers are assigned to work with an appropriate competency champion.

Initially, Nelson referred to the process as “remediation” because he wanted to convey a sense of seriousness. However, the program later began referring to the process as “coaching” at the suggestion of associate program director Erika Ketteler, MD, MA. Most residents don’t truly need “remediation,” they simply need to work with a coach to improve a certain aspect of their performance. Residents who don’t meet Milestones after being coached are placed in a formal remediation program.

Residents who require coaching typically meet with a designated competency champion individually to develop a strategy to improve the identified weakness. For example, a resident who performed poorly on an in-training exam may work with the medical knowledge champion to devise a study plan, then meet again to discuss progress.

Although residents may initially feel angry or frustrated that they need coaching, many experience a “lightbulb moment” during coaching, becoming aware of a problematic behavior or gap in their knowledge or skills, says Ketteler, who is the program’s communication competency champion.

Given the competitive nature of many residents, it can be difficult for some to acknowledge a weakness, McBride says. However, most are receptive to coaching as something designed to help them improve, she says. Some residents have actually requested coaching to improve their exam scores.

It can also be less intimidating than discussing a performance issue with the program director, which can feel like “being called into the principal’s office,” McBride says.

“It’s a little less intimidating to be able to meet with someone who’s the competency champion,” she says.

Appointing several coaches also gives the program director additional support to manage resident performance issues, Russell says.

“The program director cannot do it alone,” he says. “Developing this system of competency champions really divided it up in a way that was workable.”

Signs of success

Since the program began working with competency champions in 2012, nine residents have successfully completed coaching. Anecdotally, McBride says she’s also seen improvements in the residents she works with, observing better communication skills in residents who have undergone coaching.

Reaching Milestones, even if it requires additional coaching, gives residents a sense of accomplishment, McBride says. The Milestones also help residency programs impart what residents are expected to learn during the course of training and standards for performance.

“I think that it helps us identify the strengths and weaknesses of interns from the start and it gives them goals to accomplish during that year,” she says. “I think [residents] feel like, ‘Now I can progress, I have met these Milestones and I am ready to be a second-year resident.’”

More competencies

For more information, read “Competency Champions in the Clinical Competency Committee: A Successful Strategy to Implement Milestone Evaluations and Competency Coaching” in the January/February 2014 issue of the Journal of Surgical Education at www.jsurged.org.
Self improvement
Under the Next Accreditation System, site visits focus on improvement

More focus on improvement, less focus on checking off compliance.
That’s how Ingrid Philibert, PhD, MBA, described the ACGME’s new approach to accreditation site visits under the Next Accreditation System (NAS) at the ACGME’s 2014 Annual Education Conference held February 27–March 2 in National Harbor, Md.

During the conference, Philibert, senior vice president for the ACGME's Department of Field Activities, gave medical educators a glimpse of what accreditation and site visits will look like under the NAS.

As training programs move into the new system, the focus of accreditation will shift to improvement. The ACGME will look for evidence that programs have identified ways to improve and have followed through on those plans.

The new focus underscores concerns that residency positions are threatened by cuts to GME funding and the ACGME's position that it would rather work with struggling programs than close them.

“Our current, basic stance toward accreditation is shifting,” Philibert said during a session on the self-study site visit. “Now, more than ever, it is our stance that every program, every position is precious, and our job is to facilitate improvement.”

The new system

The NAS is a “continuous accreditation system,” in which residency review committees (RRC) will review data from programs every year. To assess whether programs are in compliance with ACGME requirements, RRCs will examine:

- Accreditation Data System (ADS) updates
- Milestone data
- Resident and faculty surveys
- Case and operative logs
- Board certification data

The committees may take one of several actions based on their review of data submitted by programs, such as:

- Issuing new citations
- Continuing previous citations
- Acknowledging the correction of previously issued citations
- Identifying opportunities for improvement
- Identifying concerning trends
- Increasing or reducing a program’s resident allowance

Based on annual review data, review committees may also call for a focused site visit, targeting specific areas identified as problematic, or a full site visit to review all applicable program requirements. Just over 1% of programs experienced a site visit during the ACGME’s testing period, Philibert said.

“Our current, basic stance toward accreditation is shifting. Now, more than ever, it is our stance that every program, every position is precious, and our job is to facilitate improvement.”

—Ingrid Philibert, PhD, MBA

Exactly how RRCs will evaluate data under the new system is still evolving, she said. The ACGME is still considering issues such as weighting certain data elements or establishing thresholds for site visits.

Self-study site visits

The ACGME will begin conducting the first self-study site visits in late 2015 for some programs in the first phase of the NAS. For programs in the second phase, self-study site visits will begin in late 2016. After programs have had an initial site visit, the self-study site visit will occur at 10-year intervals.

The ACGME is still working through some aspects of the site study visit, but there will be notable changes from previous site visits. In an ACGME Conference session, Serge Martinez, MD, JD, an ACGME accreditation field representative who helped the ACGME to test self-study site visits, described a few of
the changes:

- **Two site visitors.** ACGME site visitors will pair up to conduct most self-study site visits. Working in teams allows site visitors to interview more residents and trade perspectives on information they encounter during site visits, Martinez said. For small programs, a single site visitor will conduct the site visits.

- **Emphasis on resident interviews.** During self-study site visits, site visitors will aim to interview about 40%-50% of residents. Site visitors will use data from ACGME resident surveys to guide their interviews. Residents may be separated based on training level to allow site visitors to obtain more frank feedback. Interns tend to share more openly with interviewers when chief residents aren’t present, Martinez said.

- **Increased collaboration.** Under the self-study site visit, site visitors will take a more active role in helping programs identify and make improvements. Although site visitors can’t tell programs what to do, they may help programs to diagnose problems or suggest best practices they’ve encountered at other programs, Martinez said.

- **Ending with the program director.** Program directors get the “last word” in a self-study site visit. Program directors will have the opportunity to address or clarify the site visitors findings before they leave the site.

Program coordinators may receive more focus as part of the new accreditation process, Martinez said. Due to coordinators’ increasingly important role managing and submitting data in the NAS, “it really behooves everyone” to ensure program coordinators are receiving adequate support and training, he said.

**Preparing a self study**

About a year before the self-study site visit, programs will receive a report from the ACGME based on previously submitted annual data. After programs receive their reports, they’ll need to aggregate data from their annual evaluations and begin working on self studies.

Although the ACGME has not defined who is responsible for conducting self-studies, the following individuals may participate:

- Program leaders
- Faculty members
- Trainees
- Program coordinators

Program evaluation committees (PEC) are also an intuitive choice, Philibert said. The ACGME required programs to appoint these committees, responsible for conducting annual program evaluations, under Common Program Requirements that went into effect in July 2013. Under the requirements, the PEC must be appointed by the program director and include at least two faculty members and one resident.

The self-study is intended to be “a frank self-assessment,” Philibert said.

As part of the self-study process, programs will need to consider their specific aims and goals for graduates, she said. For example, does your program have a special focus on research? Do you want to produce graduates who work with underserved patient populations? Programs will need to identify their ultimate goals to identify areas for improvement and make progress toward their goals.

Programs will also be asked to consider:

- **Strengths.** Identifying your program’s strengths can help to ensure that you maintain what’s working, which can be especially important if resources become limited, Philibert said.

- **Areas for improvement.** Demonstrating improvement is a key element of the new accreditation model. Programs should identify areas of improvement that align with their unique aims, are important to stakeholders, and help them achieve compliance with accreditation standards, she said.

- **Opportunities.** Factors that favor a program, new curricular areas, and chances to enhance the program’s performance or relevance can be considered opportunities, Philibert said.

- **Threats.** Programs will also be asked to recognize national and local factors that could jeopardize the success of their programs, such as funding cuts or burned-out faculty members.

Programs will need to gather data to support their self-study assessments. Philibert named the following as valuable sources of data:
Residency Program Alert

- Resident and faculty surveys
- Resident files
- Goals and objectives
- Examples of resident involvement in quality improvement and patient safety efforts
- Selected data from the ACGME’s ADS
- Information about ACGME citations and how they were resolved
- Information about annual changes or changes since previous site visit
- Lists of improvements from annual program evaluations
- Duty hour data and policies
- Board certification data
- Feedback from graduates, if available

Annual program evaluations will be especially important in the self-study site visit process. The Common Program Requirements specify that PECs must track progress on the previous year’s improvement plans. Over time, this documentation will support a program’s improvement efforts. The ACGME doesn’t specify how programs should document their plans; however, a simple spreadsheet that identifies what the program wants to improve, the program’s improvement plan, who is responsible for the plan, and follow-up measures will work, Philibert said.

Although the ACGME won’t collect or review annual program evaluations, programs should use their evaluations to identify necessary improvements and devise action plans. During a self-study site visit, site visitors may ask program directors to look back at old program evaluations and discuss how the program addressed necessary improvements identified in those plans, Philibert said.

What to expect next

The ACGME envisions core specialty programs compiling their self-study findings into a five-to-seven-page summary document, Philibert said. Programs with subspecialties may need to add pages.

The ACGME will schedule a self-study site visit date with programs about four months in advance. Ten days before the visit, programs must submit their self-study summaries and finalize any data in the ADS. After this point, site visitors will not receive any changes to data, so programs should ensure all information in the system is up to date, Philibert said. If any critical changes occur within the 10 days of a visit, program representatives will need to communicate with site visitors in person.

The ACGME will continue to develop tools and processes related to self-study site visits, Philibert said. Later this year, the ACGME plans to develop a format for submitting self-study data in the ACGME’s ADS. The ACGME also hopes to release a self-study report template for programs and webinars related to self-studies and self-study site visits. 

Ten years in the making

The first self-study site visits will begin in late 2015 for selected residency programs in the first phase of the Next Accreditation System and in late 2016 for programs in the second phase.

After programs’ initial site visit, 10 years will lapse between self-study site visits. Here’s a timeline of the 10 years between self-study site visits:

- **Beginning 10 years** before a self-study site visit, programs will submit annual data to the ACGME. Residency Review Committees will review programs’ data annually and may call for focused or full site visits based on the data. Program evaluation committees conduct annual performance evaluations, tracking their programs’ improvement plans over time.
- **One year** before a self-study site visit, the ACGME sends the program an annual report based on annual data reviews. Programs begin to aggregate data from their annual performance evaluations and work on self-studies.
- **Four months** before the self-study site visit, the ACGME sets and informs the program of the final site visit date.
- **Ten days** before the visit, the program makes final updates in the ACGME’s Web-based Accreditation Data System and uploads its self-study summary to the system.
Coordinator’s corner

Ready, set, report

When the clinical competency committee (CCC) for the diagnostic radiology residency program at Cleveland Clinic met in December, committee members spent a day discussing Milestone evaluations for each of the program’s 32 residents.

Members agreed to the level that best reflected a resident’s performance under the Milestones, the developmental points residents are expected to progress along throughout training. Residency Program Coordinator Sylvia Zavatchen clicked on the corresponding radio buttons in the ACGME’s Web-based Accreditation Data System (ADS) to submit the data in real-time.

Although Zavatchen had submitted all of the Milestone data for her program in just one day, her program’s CCC had spent months preparing for the December meeting. Collecting and compiling data for the committee members to use for Milestone evaluations was a “time-intensive process,” says Zavatchen, who is also a board member for the Association of Program Coordinators in Radiology.

Under the Next Accreditation System (NAS), program coordinators play a critical role in collecting and reporting Milestone data to the ACGME. Programs often rely upon coordinators to compile the data CCCs use for Milestone evaluations, manage committee meetings, and report data through ADS.

While it’s still too early to name best practices for gathering and reporting Milestone data, Zavatchen and other program coordinators who reported Milestone data in December shared a few tips that helped them manage the process. They suggest:

- Becoming familiar with your specialty’s Milestones
- Understanding the information your CCC needs for Milestone evaluations
- Allowing adequate time to collect and compile data for your CCC
- Planning in advance to ensure Milestone evaluation meetings run smoothly

Get specialty-specific

One of Kathy Guzman’s first steps to prepare to report Milestone data was ensuring that she and the faculty members at her program were familiar with the Milestones. Guzman, who is the coordinator for the neurological surgery residency at the University of Southern California in Los Angeles, says her specialty society, the Society of Neurological Surgeons, was an invaluable resource.

“They had taken on the role of being able to provide some guidance at a national level for these Milestones,” Guzman says.

One of the society’s working groups has released useful tools, including information about how to use different evaluation systems and evaluation questions, she says. Neurological surgery coordinators also meet in conjunction with the Society’s annual meeting, which gives her the opportunity to exchange information and ideas with other neurosurgery programs. Currently, members are discussing ways to share evaluation forms and tools for CCCs so each program doesn’t have to design its own, Guzman says.

Attending professional conferences and seminars also helped Vicky Norton, C-TAGME, prepare to report Milestone data in December. Norton, the residency program and credentialing manager for the orthopaedic surgery residency program at Johns Hopkins Medicine in Baltimore, soaked up as much information about Milestones and the NAS as she could the year before her program began reporting data.

Norton is president-elect for the Association of Residency Coordinators in Orthopaedic Surgery (ARCOS). Last year, the group invited an ACGME representative to discuss the new requirements at its annual meeting. She also attended the ACGME Annual Educational Conference and listened to several webinars the ACGME organized to help coordinators prepare for the new system.

Gather your tools

For Zavatchen, gathering the data CCC members used to complete Milestone evaluations was one of the most time-consuming parts of the process. Ultimately, she spent about 100 hours preparing data for her program’s committee.
She met with her program’s four-member committee early in the academic year, which she says “laid the foundation” for the Milestone evaluation process. The committee discussed each member’s role and the data it would review to inform its Milestone assessments. To prepare for the group’s daylong Milestone evaluation meeting in December, Zavatchen needed to gather information about each resident. Some of the data she provided for her program’s CCC came from:

- Global faculty evaluations
- 360-degree evaluations
- Case log data
- Procedure summaries
- Conference attendance records
- Information from the Center for Online Medical Education and Training, a required online education module for residents in Zavatchen’s program
- Annual in-training exam scores
- Advanced Cardiovascular Life Support and Basic Life Support certification
- Resident research, meeting, and presentation information
- Resident practice-based learning and quality improvement projects

Zavatchen began compiling the data into reports in early October, before the start of the busy recruitment season. She pulled the information from several sources, including:

- Her program’s residency management system, MedHub
- In-house software systems at her institution
- Resident records
- Her program’s specialty organization, the American College of Radiology

She created a PDF for each resident, creating links to each section to help evaluators quickly access the different types of evaluation data in the report, similar to a table of contents.

Norton used a matrix in her program’s residency management system, E*Value, to provide data for her program’s CCC. The matrix linked the orthopaedic surgery Milestones with certain surgical procedures. Then, Norton matched the Milestones to the faculty members who performed those procedures and the residents those faculty members would evaluate. After all faculty members had completed their evaluations (occasionally, she needed to send reminders to ensure faculty members completed evaluations on time), she printed reports to provide to the CCC.

Over the next year, Guzman will help her program transition to a new process for collecting resident data, as her program implements a new electronic residency management system. This year, her program decided to use paper reports for Milestone evaluations, rather than establishing a new process in an electronic system it planned to phase out.

“I anticipate that over the summer, I’ll be spending lots of time creating documents or getting them from other programs,” Guzman says.

Meeting management
Organizing a final Milestone evaluation meeting for the CCC is often an important step in the Milestone

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The coordinator’s role in NAS

The Next Accreditation System (NAS) has changed the role residency coordinators play in ensuring program accreditation. Get the inside scoop from Amy Romandine, C-TAGME, HCPro’s Residency Coordinator Boot Camp™ instructor, who has successfully navigated a NAS survey. HCPro presents the webcast, The Next Accreditation System: Successful Preparation and Implementation for Coordinators, on Tuesday, April 29, 1–2:30 p.m. (EST). This webcast will prepare coordinators to play a vital role in implementing NAS.

At the end of this webcast, you will be able to:

- Take a key role in converting your program to the NAS
- Identify the key components of the NAS
- Determine who should sit on your clinical competence and program evaluation committees
- Categorize common program requirements as either core process, detailed process, or outcome and act on the freedom this gives your program
- Support others in your program working through the NAS

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data submission process. Many program coordinators are responsible for scheduling the committee’s final evaluation meeting, preparing agendas, distributing meeting materials, taking notes, and submitting Milestone evaluations through the ADS.

Zavatchen, Norton, and Guzman used these strategies to keep their programs’ final Milestone evaluation meetings running smoothly:

- **Scheduling meetings in advance.** Finding a time when all of the members of her program’s CCC were available to meet in December was challenging, Zavatchen says. This year, she’ll book a meeting date earlier. Don’t forget about other scheduling considerations, such as your program’s timing for resident performance reviews. Reporting Milestone data in December can push CCC meetings and Milestone submission into the holiday season, so it pays to plan ahead, Guzman says.

- **Staying in touch.** Even before Norton’s program met for its official Milestone evaluation meeting, she checked in with committee members informally to ensure they had the information they needed.

- **Planning breaks.** If your CCC needs to hold a longer meeting, plan breaks into your agenda. After reviewing a class of residents, the CCC at Zavatchen’s program took a short break to check emails or stretch their legs. The group also paused mid-day for a lunch break.

- **Submitting data immediately.** Zavatchen took her laptop to her committee’s meeting and submitted Milestone evaluations through the ADS in real time. Entering the data right away cut down on work she needed to do later.

- **Minimizing distractions.** It’s important to hold your meeting in a location where committee members won’t be interrupted by phone calls or assistants, Zavatchen says. If you need to submit Milestone data later, pick a time when you won’t be distracted, Norton suggests. She estimates that entering Milestone data for 15 residents took her 60–90 minutes.

- **Keeping track of the conversation.** Zavatchen took notes of discussion during the meeting and emailed a summary to committee members. Committee members said the summary helped them to remember their discussions about each resident and follow up on any actions plans.

Even after successfully submitting their first set of Milestone data, the coordinators anticipate their programs will tweak their processes as they continue working with their CCCs and Milestone data. Zavatchen hopes to find a more efficient way to compile reports for members of her program’s committee. Norton’s program may consider adding more members to its CCC to distribute the workload.

“I do think that it is still in progress and it’s going to take a little bit of time for everybody to fine-tune how to do this, so that it’s more useful and not so labor-intensive,” Guzman says.

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**Mark your calendar**

As program coordinators who reported Milestone evaluation data to the ACGME in December know, Milestone evaluations don’t really happen in a day. Here’s a timeline leading up to the day that you enter data into the Accreditation Data System (ADS):

- **At the beginning of the academic year,** or about six months before your deadline to report Milestone evaluation, meet with your program’s clinical competency committee (CCC) to determine what data you’ll need to provide the committee and when committee members need to review it.

- **Determine when you’ll gather the data for your CCC well in advance.** Based on the size of your program and the information you need to gather, the process could be time-consuming. Be sure to account for busy periods, such as recruitment season or holidays.

- **Schedule a meeting to collect and report final Milestone evaluations with your program’s CCC well in advance of the meeting date to ensure you can work with busy faculty members’ schedules.**

- **Some program coordinators suggest submitting Milestones data through the ADS “in real time” during your CCC’s final evaluation meeting.** If you can’t do so, make sure to schedule a time after the meeting when you won’t be interrupted to submit your data.