Session 2
10:45 - 12:30
Milestones

Ms. Lori Lewis Executive Director ACGME-International

Dr. Laura Edgar
Vice President
Milestones Development
ACGME-International

Dr. Latifa Al Ketbi
Chairperson of Academic Affairs Department, AHS
DIO and Family Medicine Program Director

Dr. James Arrighi
President and Chief Executive Officer
ACGME-International

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Ms. Lori Lewis Executive Director ACGME-International

Lorraine C. Lewis, EdD, is Accreditation Council for Graduate Medical Education–International (ACGME-I) Executive Director. She joined ACGME in 2011 as the Executive Director for the Review Committees for Anesthesiology, Preventive Medicine, and the Transitional Year. Before joining the ACGME, Dr. Lewis was manager of predoctoral dental education and international accreditation for the Commission on Dental Accreditation. Dr. Lewis earned an EdD in Higher Education Policy and Administration from the University of Minnesota, where she conducted research on faculty attitudes and practices related to program evaluation. She also has an MS in Allied Health and a BS in Medical Dietetics, both from the Ohio State University

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ACGME-I requirements for Milestones

Lorraine Lewis, Executive Director

Foundational Requirement

Programs must document progressive performance improvement appropriate to educational level in each milestone.

[Foundational requirement V.A.1.b).(3)]

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Foundational Requirement

Programs must provide residents'/fellows' objective performance evaluations based on the ACGME-I Competencies and regular evaluation of the Milestones.

[Foundational requirement V.B.1.]

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Foundational Requirement

The CCC must participate actively in reviewing all resident/fellow evaluations by all evaluators, Case Logs, the Milestones, incident reports, and other data semi-annually,

[*Foundational requirement V.B.3.c).(1)*]

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Foundational Requirement

The program must document formal, systematic evaluation of the curriculum at least once a year that is based on the program's stated mission and aims and monitors and tracks each of the following areas: a) resident/fellow performance, including Milestone evaluations

[*Foundational requirement V.D.1.a)*]

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Milestone data has multiple uses

For assessment of an individual learner, Milestones provide

A ‘road map’ for development and improvement

Structure for evaluation of competency

Assurance to the public, government, and certifying boards

For evaluation of a curriculum, Milestones provide

Comparative data that can be used for benchmarking

Data for evaluation of the curriculum, rotations or clinical assignments, participating sites

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Milestone data has multiple uses

For assessment of an individual learner, Milestones provide

For evaluation of a curriculum, Milestones provide

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Common questions

1. What is the difference between Milestones and EPA's

Answer: EPAs are units of professional practice, defined as tasks or responsibilities that trainees are entrusted to perform unsupervised once they have achieved sufficient competence.

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Common questions

2. How are Milestones used by the Review Committee when making an accreditation decision

Answer: Specific Milestone assessments are not considered by the review committee. The only data on milestones that is used when evaluating a program is if the milestone assessment was reported to ACGME-I by the established deadline.

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Common questions

3. Can a resident/fellow graduate if he/she has not achieved all milestones?

Answer: ACGME-I has no required minimums for Milestone reporting. The determination of an individual's readiness for graduation is at the discretion of the program director.

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Thank you

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Dr. Laura Edgar
Vice President
Milestones Development
ACGME-International

Dr. Edgar is the Vice President for Milestone Development. In her current role, she serves as an organizational and department leader. She leads volunteers and staff members through the development of Milestones and related materials for all ACGME accredited specialties. Dr. Edgar creates and manages the Milestones resources that aid program directors, learners, and Clinical Competency Committees. She serves as a liaison to the medical education community and is a frequent speaker on topics related to the Milestones, Clinical Competency Committees, assessment, education, and accreditation. She previously served as the Executive Director for Milestones Development and the Review Committees for Medical Genetics and Genomics, Pathology, and Radiation Oncology. Prior to working at ACGME, Dr. Edgar worked in the clinical laboratory for 10 years and then directed several domestic and international certification, accreditation, and scientific organizations. Dr. Edgar earned her doctorate in education, focusing on organizational leadership after obtaining a Bachelor's degree in medical laboratory sciences and a Master's degree in business administration. She is a certified medical technologist and a certified association executive

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Milestones: Return to Basics

Dr. Laura Edgar, EdD
Vice President, Milestones Development

Milestone Levels – A Brief Review

Level	Dreyfus Stage	Description (clinical reasoning example)
1	**Novice**	Rule Driven; Analytic Thinking; Little Ability to Prioritize information
2	**Advanced beginner**	Able to Sort Through Rules based on experience; Analytic and Non-Analytic for some Common problems
3	**Competent**	Embraces appropriate level of Responsibility; Dual Processing of reasoning for most Common problems; Can see Big Picture; Complex Problems default to Analytic Reasoning; Performance can be exhausting.
4	**Proficient**	More Fully Developed Non-Analytic and Dual Process Thinking; Comfortable with Evolving Situations; Able to Extrapolate; Situational discrimination; Can live with Ambiguity
5	**Expert**	Experience in Subtle Variations; Distinguishes Situations

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Milestone Levels – A Brief Review

Level	Dreyfus Stage	Description (clinical reasoning example)
1		Rule driven; analytic thinking; little ability to prioritize information
2	Advanced beginner	Able to sort through rules based on experience; analytic and non-
3	Competent	ual processing of big picture; g. Performance can
4	Proficient	cess thinking; comfortable with evolving situations; able to extrapolate; situational discrimination; can live with ambiguity
5	Expert	Experience in subtle variations; distinguishes situations

LEVEL ≠ NOT PGY

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Systems-Based Practice 1: Patient Safety				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of commonly reported patient safety events Demonstrates knowledge of how to report patient safety events	Identifies system factors that lead to patient safety events Reports patient safety events through institutional reporting systems	Participates in analysis of patient safety events Participates in disclosure of patient safety events to patients and families	Conducts analysis of patient safety events and offers error prevention strategies Discloses patient safety events to patients and families	Actively engages teams and processes to modify systems to prevent patient safety events Role models or mentors others in the disclosure of patient safety events

Comments:

Not Yet Completed Level 1

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

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What Changed?

Patient Care 2: Open Procedures				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates basic skills (e.g., positioning, knot tying, suturing)	Independently performs bedside open procedures (e.g., incision and drainage, priapism aspiration and irrigation, circumcision, removal of genital wart)	Independently performs simple open procedures (e.g., scrotal procedures, vasectomy, cystorrhaphy, mid-urethral sling)	Independently performs complex open procedures (e.g., partial nephrectomy, prosthetic replacement, cystectomy and ileal conduit, ureteral reconstruction)	Independently performs uncommon complex open procedures (e.g., retroperitoneal lymph node dissection (RPLND), nephrectomy with caval thrombus, reconstructive genital surgery)

Comments:

Not Yet Completed Level 1

Not Yet Assessable

PC5. Performs open surgical procedures.					
Has not achieved Level 1	Level 1	Level 2	Level 3	Level	
	Closes incisions for routine urologic procedures under direct supervision (as defined in the Program Requirements)	Creates and closes surgical wounds for ***routine*** urologic procedures Performs routine urologic procedures appropriate for level of education	Plans, creates, and closes surgical wounds for ***routine*** urologic procedures Manipulates, repairs, and excises (as necessary) internal structures with appropriate instrument selection and technique for ***routine urologic*** procedures	Plans, creates, surgical wound ***routine and co*** urologic proced Manipulates, re and/or excises necessary) inte structures with appropriate instrument selection for a ***majority of urologic*** procedures Demonstrates capacity to perform surgical procedures independently	
	Example: *Closure of the abdomen after a midline incision*	*Examples:* *Circumcision in an adult with phimosis* *Hydrocelectomy for a moderate sized hydrocele*	*Examples:* *Radical orchiectomy for a testicular mass* *Orchidopexy for an inguinal undescended testis* *Bladder neck/urethral sling for female stress urinary incontinence* *Opening and closing of abdominal and flank incisions*	*Examples:* *Open partial nephrectomy for a small polar renal mass* *Ileal conduit urinary diversion* *Placement of inflatable penile prosthesis*	*Examples:* *Cystectomy and orthotopic neobladder* *Radical nephrectomy for renal cancer with infrahepatic caval tumor thrombus*

Comments:

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1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1)				
Critical Deficiencies			**Ready for unsupervised practice**	**Aspirational**
Does not collect accurate historical data Does not use physical exam to confirm history Relies exclusively on documentation of others to generate own database or differential diagnosis Fails to recognize patient's central clinical problems Fails to recognize potentially life threatening problems	Inconsistently able to acquire accurate historical information in an organized fashion Does not perform an appropriately thorough physical exam or misses key physical exam findings Does not seek or is overly reliant on secondary data Inconsistently recognizes patients' central clinical problem or develops limited differential diagnoses	Consistently acquires accurate and relevant histories from patients Seeks and obtains data from secondary sources when needed Consistently performs accurate and appropriately thorough physical exams Uses collected data to define a patient's central clinical problem(s)	Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's complaints Synthesizes data to generate a prioritized differential diagnosis and problem list Effectively uses history and physical examination skills to minimize the need for further diagnostic testing	Obtains relevant historical subtleties, i information differential Identifies su physical exa Efficiently u of secondar differential Role model: effective us physical exa minimize th diagnostic t

Comments:

Patient Care 1: History				
Level 1	Level 2	Level 3	Level 4	Level 5
Elicits and reports an accurate history for common patient presentations Seeks data from secondary sources, with guidance	Elicits and concisely reports a hypothesis driven patient history for common patient presentations Independently obtains data from secondary sources	Elicits and concisely reports a hypothesis driven patient history for complex patient presentations Reconciles current data with secondary sources	Efficiently elicits and concisely reports a patient history, incorporating pertinent psychosocial and other determinants of health Utilizes history and secondary data to guide the need for further diagnostic testing	Efficiently and effectively tailors the history taking, including relevant historical subtleties, based on patient, family, and system needs Models effective use of history to guide the need for further diagnostic testing

Comments:

Not Yet Completed Level 1

Not Yet Assessable

Patient Care 2: Physical Examination				
Level 1	Level 2	Level 3	Level 4	Level 5
Performs a general physical examination while attending to patient comfort and safety Identifies common abnormal findings	Performs a hypothesis driven physical examination for a common patient presentation Interprets common abnormal findings	Performs a hypothesis driven physical examination for a complex patient presentation Identifies and interprets uncommon and complex abnormal findings	Uses advanced maneuvers to elicit subtle findings Integrates subtle physical examination findings to guide diagnosis and management	Models effective evidence-based physical examination technique Teaches the predictive values of the examination findings to guide diagnosis and management

Comments:

Not Yet Completed Level 1

Not Yet Assessable

DRAFT

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Milestones 2.0 Implementation

In effect January 2024

Map curriculum and assessments

Follow good change management processes

Include learners in the conversations

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Supplemental Guide

Internal Medicine Supplemental Guide Draft

Patient Care 1: Gathers and utilizes clinical information; Performs history	
Overall Intent: Competently interact with patients and uses all available resources to consistently obtain a comprehensive patient presentation	
Milestones	**Examples**
Level 1 *Elicits and reports an accurate history for common patient presentations* *Seeks data from secondary and collateral sources, with guidance*	• Attending observes resident taking a history from a 30-year-old patient with a red swollen joint. The resident obtains accurate patient centered history using open-ended and directed questions, but without exploring clear underlying hypotheses • Presents verbal and written report that is organized but not focused on the chief complaint • Needs prompting to seek data from outside pharmacy, outside labs, and databases for controlled substances
Level 2 *Elicits and concisely reports a hypothesis driven patient history for uncomplicated patient presentations* *Independently obtains data from secondary and collateral sources*	• A resident presents that a patient with a red swollen joint, is febrile, and has a history of gout. The resident asks the patient about recent alcohol use, diet, trauma, sexual history and other pertinent questions. Reports history limited to pertinent positive and negative facts • Without prompting, reviews and presents relevant data from previous medical records, including past labs and primary care provider notes. Proactively reviews prescription history from available databases and calls the patient's pharmacy for recent prescriptions that note allopurinol has not been refilled in months.
Level 3 *Elicits and concisely reports a hypothesis driven patient history for complex patient presentations* *Reconciles current data with secondary and collateral sources*	• A resident presents an 85 year old with a history of CHF, coronary artery disease, COPD, and diabetes presenting with several weeks of shortness of breath. The resident asks about medication and dietary adherence. Reports on the presence of angina or heart failure symptoms, recent URI, and allergen exposure. • Completes accurate medication reconciliation using multiple sources. Clarifies history based on new information as it becomes available from care givers who note recent weight gain.
Level 4 *Efficiently elicits and concisely reports a hypothesis driven patient history for complex patient presentations, incorporating pertinent psychosocial and other determinants of health* *Utilizes history and secondary and collateral data to minimize the need for further diagnostic testing*	• Same patient as in Leve[...] • Resident discovers that [...] was due to insurance la[...] • Resident determines tha[...] • Resident determines pa[...] ago and does not order[...]
Level 5 *Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis*	• Resident obtains a histo[...] test abnormalities. Resi[...] patient consumes alcoh[...]

Internal Medicine Supplemental Guide Draft

Role models effective use of history to minimize the need for further diagnostic testing	• Resident takes a history from an injured patient and realizes that the boyfriend answers all of the questions. Identifies that the patient is likely a victim of intimate partner violence based on non-verbal cues. • Resident evaluates a patient with a complaint of headache. Illustrates to the junior learners the elements of the history that preclude the need for additional testing.
Assessment Models or Tools	• Direct observation • Chart stimulated recall • Simulation Training • OSCE • Self assessment • Medical record (chart) audit
Curriculum Mapping	•
Notes or Resources	• Bickley L, Szilagyi PG. *Bares' Guide to Physical Examination and History-Taking.* 11th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2012. • Smith RC. *Patient-Centered Interviewing: An Evidence-Based Method.* 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2018. • Gottlieb LM, Tirozzi KJ, Manchanda R, Burns AR, Sandel MT. Moving electronic medical records upstream: incorporating social determinants of health. *American Journal of Preventive Medicine.* 2015;48(2):215-218. https://www.ncbi.nlm.nih.gov/pubmed/25217095. Accessed 2019. • www.acponline.org/clinical-information/high-value-care • Caringwithcompassion.org

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Supplemental Guide

Purpose is to help Better Understand the Thought Process of the Milestones Development Group

Offer Suggestions for Assessment Methods and Resources

Starting Point for creating a CCC Shared Mental Model

Not intended to “tell you what to do”

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Supplemental Guide

Review the Milestones with your CCC, Faculty, and Residents

Identify the Assessment Method in your Toolbox that will provide the best information

Determine which Rotation(s) the Milestone will be Evaluated

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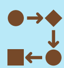
Supplemental Guide



What does YOUR Resident Need To Do/Know for the Milestone at each level

Develop a Shared Mental Model of the Meaning of the Milestone and the various Levels

What does YOUR PROGRAM Expect to see at each Level

Spend the time now, save time later!!

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Milestones Resources

Clinician Educator Milestones

Guidebooks

Faculty Development Courses

Learn at ACGME

https://acgme.org/What-We-Do/Accreditation/Milestones/Resources

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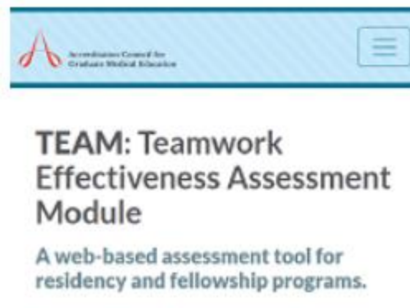
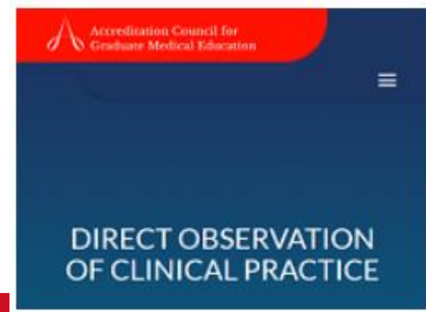
Assessment Tools

TEAM – Multisource Feedback

DOCC – Direct Observation



Available for free on Learn at ACGME



https://dl.acgme.org/pages/assessment

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April 2021
Supplement

Journal of
Graduate Medical Education

Milestones 2.0
Assessment, Implementation, and Clinical Competency Committees

https://meridian.allenpress.com/jgme/issue/13/2s

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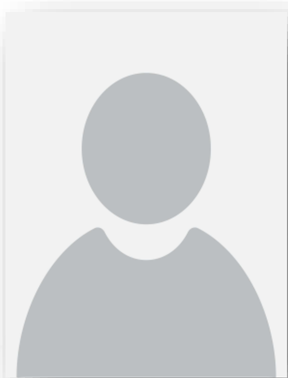

Dr. Latifa Al Ketbi
Chairperson of Academic Affairs Department, AHS
DIO and Family Medicine Program Director

Adjunct Professor UAE University, College of Medicine. Qualifications are Arab Board in Family Medicine and Ph.D. degree. A medical educator with 20 years of experience as faculty and program director of the Alain Family Medicine Program. Led the AHS through multiple accreditations in the field of medical education, Arab Board, ACGME-I, and recently NIHS Emirati Board. Researcher with publications in peer-reviewed journals. Led the AHS project in “Patients' Centered Medical Homes” from 2013 to date, aiming to implement Best Practices through unique initiatives utilizing system change, building capacity, and EMR optimization. Member of several national committees in the field of primary care

Adopting a competency-based medical education framework and ACGME-I accreditation.

The processes and educational outcomes in a Family Medicine residency program in Abu Dhabi Emirate, UAE.

Latifa AlKetbi

Ambulatory Healthcare Services

DIO and AlAin-AHS Family Medicine Program Director

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Abu Dhabi Health Services Co. P.J.S.C

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Background:

- Competency is the core outcome of residency training.
- Competency-Based Medical Education CBME is now mandated by many graduate and undergraduate accreditation standards.
- CBME organizes the educational experience around competencies, synchronizing the training of residents, as not all trainees progress at the same speed.

Background:

- Ambulatory Healthcare Services (AHS) family medicine residency program first group of residents joined on October 1st, 1994.
- Since then, it has graduated more than 160 family physicians.
- Its curriculum and process were modified to meet the ACGME-I, and it has been ACGME-I accredited since 2013 and NIHS accredited in 2022.
- Milestone was reported semi-annually since 2014
- EPA was introduced in 2018 but became fully implemented in 2021.

Objectives

- Describe the Al Ain-AHS Family Medicine Program CCC experience over the ten years of **adopting a competency-based medical education framework.**
- Highlight **the processes** in Al Ain-AHS Family Medicine residency program in adapting this framework.
- Highlight **the educational outcomes** measured.
- Discuss lessons learned.

The structure

"*A CCC is* A required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program."

- The ultimate purpose is to demonstrate accountability as medical educators to the public: that graduates will provide high-quality, safe care to patients <u>while in training</u> and be well prepared to do so <u>once in practice</u>.
- At the CCC meetings, discussions on assessment and competency are tailored to the specific specialty and program.
- Provide information on the effectiveness of individual programs' curricula.

Accreditation Council for Graduate Medical Education

Clinical Competency Committees

A Guidebook for Programs
3rd Edition

Kathryn Andolsek
Duke University

Jamie Padmore
Medstar-Georgetown

Karen E. Hauer
University of California at San Francisco

Andem Ekpenyong
Rush University Hospital

Laura Edgar
ACGME

Eric Holmboe
ACGME

This information is current as of January 2020

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Clinical Competency Committee.

- It looks at the individual residents and follows progress,
- It recommends appropriate action.
- The suggested resident’s action plan becomes the plan for the PD for each resident, the coordinator, and supervisors until the next CCC discussion.
- Send recommendations to other committees through PD when a pattern is recognized in residents’ performance (PEC, Educational program, Rotations, scholarly activities…etc).

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CCC variability in structure and function

> Acad Emerg Med. 2015 Nov;22(11):1351-4. doi: 10.1111/acem.12804. Epub 2015 Oct 16.

How Do Emergency Medicine Residency Programs Structure Their Clinical Competency Committees? A Survey

Christopher I Doty [1], Lynn P Roppolo [2], Shellie Asher [3], Jason P Seamon [4], Rahul Bhat [5],

- **Results:** A total of 116 of the 160 programs responded, giving a 73% response rate. Of responders, most (71.6%) CCCs are chaired by the associate or assistant program director, while a small number (14.7%) are chaired by a core faculty member. Program directors (PDs) chair 12.1% of CCCs. Most CCCs are attended by the PD (85.3%) and selected core faculty members (78.5%), leaving the remaining committees attended by any core faculty. Voting members of the CCC consist of the residency leadership either with the PD (53.9%) or without the PD (36.5%) as a voting member. CCCs have an average attendance of 7.4 members with a range of three to 15 members. Of respondents, 53.1% of CCCs meet quarterly while 37% meet monthly. The majority of programs (76.4%) report a system to match residents with a faculty mentor or advisor. Of respondents, 36% include the resident's faculty mentor or advisor to discuss a particular resident. Milestone summaries (determination of level for each milestone) are the primary focus of discussion (93.8%), utilizing multiple sources of information.

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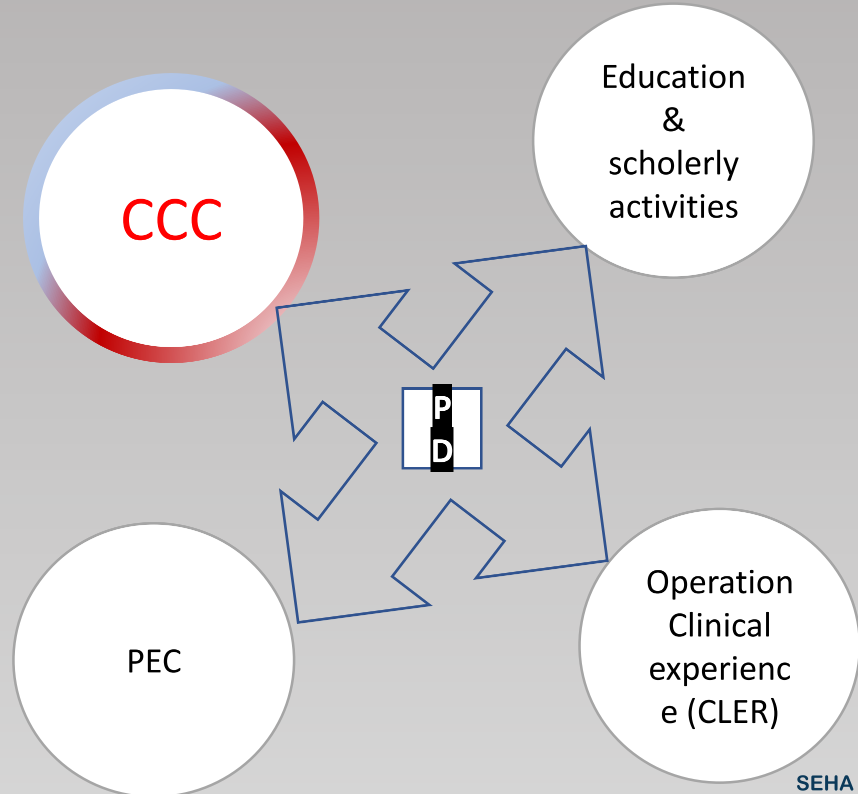
Within the program

- It meets its roles and, at the same time, provides data for other committees to improve:

- Residents’ learning,
- Residents’ performance and progress,
- Program efficiency and quality.



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The coordinator role is essential and Continuous

- From the first day of the program, data gathering is planned, and residents are aware of it.
- Following previous actions and preparing with the CCC chair for the next meeting depending on the time of the academic year (end of rotation exams, milestones, EPA completion, interim promotion criteria completion or promotion and graduation).
- Completing the residents’ files with the CCC notes (not the CCC private comments)
- Following the residents of concern or probations to prepare for the next CCC meeting
- **THE MEETING,**
- After repeating the same and sending performance data to those involved.

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Platform

- Excel dashboard
- Email and watsup reminders
- Microsoft forms

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Implemnting Milestones and EPA

- Milestones, as defined by the ACGME, are stages in the development of specific competencies.
- While EPA is an essential professional work activity or task for medical practice that requires specialized knowledge and skills and encompasses multiple competencies.

"Competencies are descriptors of physicians, and EPAs are descriptors of work"

- Milestones completed twice annually have helped programs identify individual residents who are struggling globally or in a specific area earlier in residency.
- Its importance as a standard structured tool within the program to collect data for CCC use.
- The implementation can be labor-intensive for supervisors and educators, so we needed data on the different competencies included in the milestones.
- EPA mapped to these milestones facilitates a meaningful translation of observations to these milestones.
- This made our work easier as we could SEE MORE CLEARLY the residents' performance and then make the needed action plan.

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First, the overall change…

How were we before, and how have we changed?

Al Ain Family Medicine Program before the ACGME-I accreditation (before 2011)

- No CCC
- Many assessments at different points of the program.
- Clinical and oral exams are more related to 3 main blocks, A (medicine and peds), B (Ob and Gyne and Surg), and C (family medicine).
- Annual ITE since 1996.
- OSCE and evaluations from rotations
- There is a program committee that meets to discuss all program-related matters. We had difficulty to keep with the meetings as there was no FTE.
- Every thing is discussed within the committee but the PD decides after reviewing results and has one-to-one discussions with residents about their performance. No required meetings, mainly if residents have issues or need to discuss.
- There is a lot of informal and unstructured, and undocumented discussions with core faculty supervisors and residents.
- Data is archived by residents and by categories (exams, evaluations, research,..etc)

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After the ACGME-I accreditation (after 2013)

Relating to Competency assessment:

- CCC was formed and started its meetings.
- Learning took a while to move from “ all responsibility on the PD” to a functioning committee.
- Initially, PD was the chair, which made the work less on others.
- Later the chair was a core faculty, and other members gradually accepted more authority. Now associate PD.
- One Coordinator is responsible for the CCC.
- Data on residents' performance is streamed to these meetings to facilitate the members’ judgment.

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EPA’s era started….

- In 2017 the discussion on EPA started in the CCC
- CCC structure was well established.
- We attended some faculty developments in this area (ACGME and Ottawa conference in Abu Dhabi.
- The CCC intends to implement the best tools to judge residents’ competency, not because it is required only.
- The members became more competent in using the Milestones, but it took a long time to complete the milestones to do it properly. As if something is missing. Because we need to review all data for each resident.
- So we started to work on the EPA’s

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Data sources:

1. Rotation evaluations
2. Family Medicine Center 360 evaluations
3. Family Medicine Center Preceptor evaluations
4. Resident patient panel data
5. Chart Review
6. Direct observation
7. Resident referral pattern review
8. Resident portfolio (scholarly activity)
10. Procedure evaluations
11. Practice improvement projects
12. Tele-consultation of patient encounters
13. Patient satisfaction surveys
14. American Board of Family Medicine In-training exam results
15. Journal club or evidence-based answers presentation.
16. home and nursing home visits
17. OSCE, OSTAD, FACES

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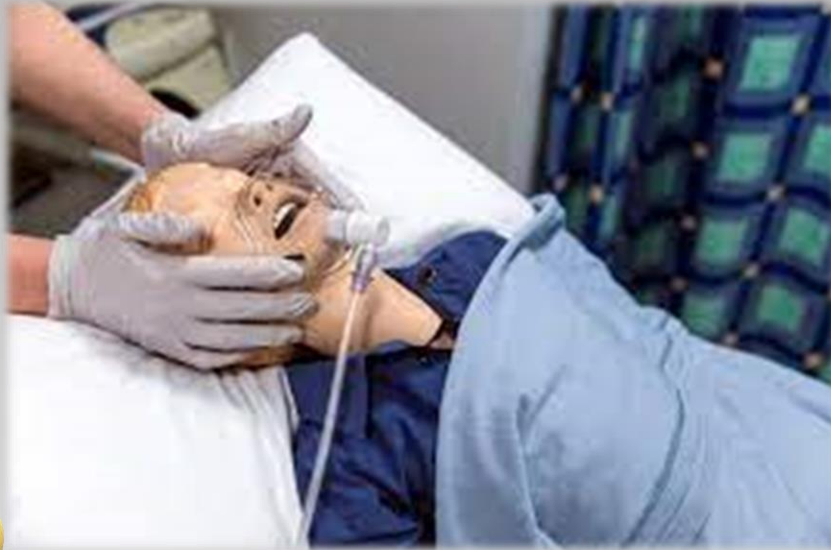
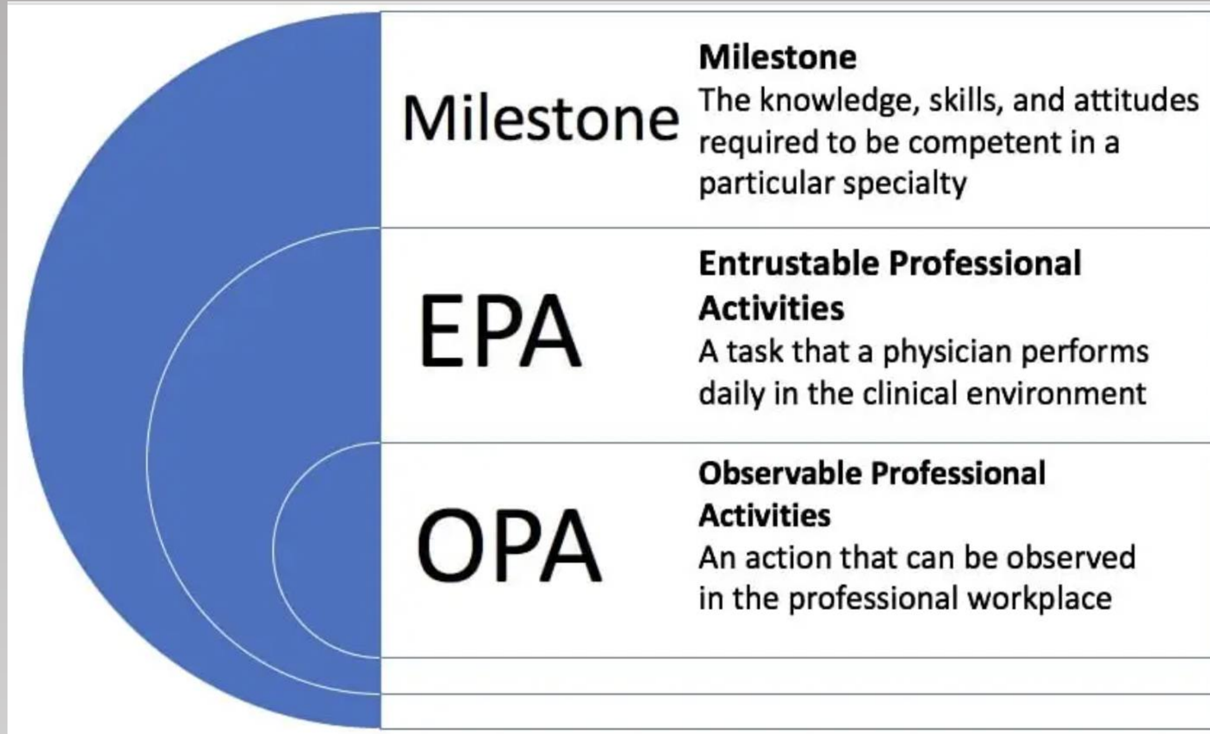
Deliberate

Observed





https://www.aliem.com/users-guide-assessment-with-epas/

Prof

IPC

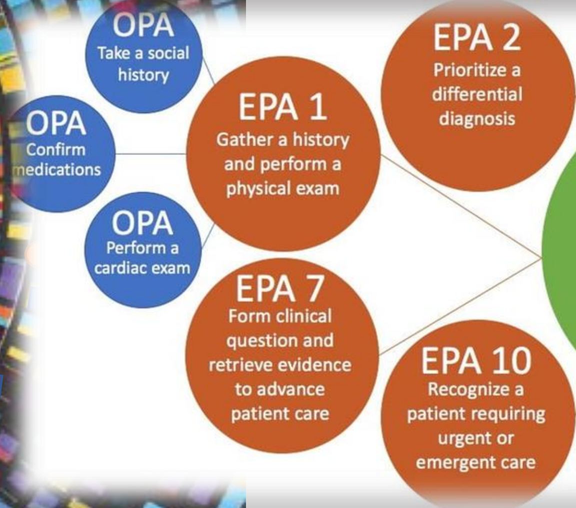
PC

clinical competencies

PBL

SBL

MK



Patient Care

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During Evaluation and Assessment of ResidentS (EARS) meetings for the EPA.

- Each center has at least two core faculties.
- They meet and complete the EPAs.
- They request information as needed from the team.
- They utilize data entered already in the resident's dashboard.

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Meetings

September	October	December	January	February	March	April	May	June	July	August

Milestones submission

Milestones submission

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Data gathering is ongoing from day 1

- The dashboard is sent to the residents and explained in the introductory course.
- Coordinators monitor data collection and send reminders.
- CCC chair requests for data to be submitted before the anticipated meetings
- For the core faculty to complete the EPAs within EARS
- Online evaluation form sent for rotation supervisors

	level 1 Need constant directions starting to do	level 2 Demonstrate Some independence but requires some directions	Level 3 Independence but unaware of risk and requires supervision for safe practice	Level 4 Complete independence, understand risk and perform safely	Level 5 Supervise others	Clear
1-Provide a usual source of comprehensive, continuous longitudinal medical care for all age groups	○	○	○	○	○	○
2-Take responsibility for the care of patients in multiple settings, including the office, home, hospital, and community	○	○	○	○	○	○
3-Provide first-contact access to care for health issues and medical problems.	○	○	○	○	○	○
4-Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness early, treatable stages.	○	○	○	○	○	○
5-Provide care that speeds recovery from						

Family Medicine for America's Health developed 20 Entrustable Professional Activities (EPAs) for family medicine.

Entrustable Professional Activities

1. Provide a usual source of comprehensive, longitudinal medical care for people of all ages.
2. Care for patients and families in multiple settings.
3. Provide first-contact access to care for health issues and medical problems.
4. Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable stages.
5. Provide care that speeds recovery from illness and improves function.
6. Evaluate and manage undifferentiated symptoms and complex conditions.
7. Diagnose and manage chronic medical conditions and multiple co-morbidities.
8. Diagnose and manage mental health conditions.
9. Diagnose and manage acute illness and injury.
10. Perform common procedures in the outpatient or inpatient setting.
11. Manage prenatal, labor, delivery and post-partum care.
12. Manage end-of-life and palliative care.
13. Manage inpatient care, discharge planning, transitions of care.
14. Manage care for patients with medical emergencies.
15. Develop trusting relationships and sustained partnerships with patients, families and communities.
16. Use data to optimize the care of individuals, families and populations.
17. In the context of culture and health beliefs of patients and families, use the best science to set mutual health goals and provide services most likely to benefit health.
18. Advocate for patients, families and communities to optimize health care equity and minimize health outcome disparities.
19. Provide leadership within interprofessional health care teams.
20. Coordinate care and evaluate specialty consultation as the condition of the patient requires.

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Examples

EPA 16

EPA #16

Use data to optimize the care of individuals, families and populations.

Interpretation

Graduates of Family Medicine residencies will access, interpret, and apply individual and population-based data using a systematic improvement process to enhance patient-oriented health outcomes.

Suggested Global Evaluation Opportunities:

1. Direct Observation
2. Practice Improvement Project
3. Journal Club or Evidence Based Answers Presentations

Family Medicine EPA	PC					MK		SBP				PBL			Prof				C				ntrusmer
	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of Sufficient Breadth and Depth to Practice	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and community health	Coordinates team based care	Evidence-Based and Informed Practice	Self Directed learning	Improves systems	Completes process of professionalizati on	Professional conduct and accountability	Demonstrates humanism	Maintain emotional, physical and mental health	Develops relationships with pts and families	Communicates effectively with pts and families	Relationships within Medicine	use techology	
	1	2	3	4	5	1	2	1	2	3	4	1	2	3	1	2	3	4	1	2		4	tools
Provide a usual source of comprehensive, continuous longitudinal medical care for all age groups	-	level 3	level 3	level 3	-			-	-	-	level 3	level 3	level 3	level 3	level 3	-	level 3	level 3	level 3	-	-	level 3	2,4,5,6,8
Take responsibility for the care of patients in multiple settings, including the office, home, hospital, and	level 3	-	level 3	-	-			level 3	level 3	-	level 3	-	-	-	level 4	-	level 4	-	level 4	-	-	level 4	1.2
Provide first-contact access to care for health issues and medical problems.	level 2	level 3	-	-	-			level 3	-	-	level 3	-	-	-	-	-	level 4	-	level 4	level 4	-	-	1,2,3
Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness	-	-	level 3	-	-	level 3	level 3	-	-	level 3	-	level 3	-	level 3	-	-	level 4	-	level 4	level 4	-	-	5.6
Provide care that speeds recovery from illness and improves function.	level 2	level 3	-	level 2	-			level 3	-	-	level 3	-	-	-	-	-	level 4	-	level 4	level 4	-	level 4	13
Evaluate and manage undifferentiated symptoms and complex conditions and patients who are highly		-	-	level 2	-	level 3		level 2	-	-	-	level 2	-	-	level 3	-	level 3	level 3	level 3	level 3	-	-	1.3
Diagnose and manage chronic medical conditions and multiple co-morbidities.	-	level 3	level 3	-	-			-	level 3	-	level 3	level 2	-	level 3	-	-	level 4	-	level 4	level 4	level 4	level4	3.16
Diagnose and manage mental health conditions.	level 2	level 2	-	level 2	-			-	-	-	level 2	-	-	-	-	level 2	level 3	-	level 3	level 3	-	-	1,2,3,9
Diagnose and manage acute illness and injury.	level 2	-	-	-	level 1			-	-	-	level 2	-	-	-	-	-	-	level 3	-	level 3	-	-	1,3,
Perform common procedures in the outpatient or inpatient setting.	-	-	-	-	level 1	level 1	level 1	-	level 1	-	-	-	-	level 1	-	-	-	-	-	-	-	level 2	3,6,10
Manage prenatal, labor, delivery and post-partum care.	level 2	-	level 2	-	level 1	level 2	Level 2	-	level 2	-	level 2	-	-	-	-	level 3	level 3	level 3	level 3	-	level 3	level 2	1,3,10,13
Manage end-of-life and palliative care.	level 2	level 1	-	-	-			-	-	-	level 1	-	-	-	level 1	-	level 1	-	level 1	level 1	-	-	1,2,3
Manage inpatient care, discharge planning, transitions of care.	level 2	-	-	-	level 1		-	level 1	level 1	-	level 1	-	-	-	level 3	level 3	level 3	-	-	level 3	level 3	level 3	1,2,3
Manage care for patients with medical emergencies	level 2	-	-	-	-	level 2		-	level 1	-	level 1	-	-	-	-	-	-	-	level 1	level 1	level 1	-	1
Develop trusting relationships and sustained partnerships with patients, families, and communities	-	level 3	level 3	level 3	-		-	-	-	-	level 3	-	-	-	level 3	level 4	-	-	level 4	level 4	-	level 4	1,2,3,7,12
Use data to optimize the care of individuals, families and populations.	-	-	level 3	-	-		-	level 3	level 3	level 3	-	-	level 3	level 3	-	-	-	-	-	-	-	level 3	2,3,11
In the context of culture and health beliefs of patients and families, use the best science to set mutual	-	level 3	level 3	-	-		-	-	-	-	-	level 3	-	-	level 3	-	level 3	-	level 3	level 3	-	-	3,6,14,15
Advocate for patients, families, and communities to optimize health care equity and minimize health outcome	-	-	level 3	-	-		-	-	-	level 3	-	-	-	-	-	-	level 3	-	-	level 3	-	-	1,2,3,6
Provide leadership within interprofessional health care teams.	-	level 3	level 3	-	-		-	-	level 3	-	level 3	-	-	-	-	level 3	-	level 3	-	-	level 3	-	1,2,9
Coordinate care and evaluate specialty consultation as the condition of the patient requires.	-	-	-	level 3	level 1		-	level 3	-	-	level 3	-	-	-	-	-	-	-	-	-	level 3	-	1,3,5,7
Perform comprehensive histories and through physical examination and identify abnormalities.	level 3	level 3	level 3	level 3		level 3	level 3						level 3		level 4	level 4	level 4	level 4	level 4	level 4			1,2,3,6,17
Knowing the Indications, contraindications of the investigation and interpretation of laboratory data	level 3	level 3	level 3	level 3		level 3	level 3	level 3	level 3	level 3		level 3	level 3				level 3			level 3		level 3	1,6,14
assists the PCP and health care team set and achieve long-term goals	level 3	level 3	level 3	level 3		level 3	level 3	level 3			level 3	level 3		level 3				level 3	level 3	level 3	level 3	level 3	3,5,6,13
Provide comprehensive medication review, reconcilation and conselling.									level 4													level 4	5
Resuscitate, stabilize, and care for unstable or critically ill patients	level 2				level 2	level 2	level 2				level 2										level 2		1,3,17,6
Demonstrate the ability to provide counselling skills and behavioural modification techniques for patient and families																	level 4	level 4	level 4	level 4			2,6,17
Incorporate considerations of cost awareness and risk benefit. Contribute to the fiscally sound and ethical management of a practice (e.g. through billing, scheduling, coding, and record keeping practices)								level 2						level 2								level 2	2,5
Able to correctly approach an ethical situation and manage it appropriately.																level 2	level 2	level 2	level 2	level 2			6,17
Apply public health principles and quality improvement methods to improve care and safety for populations, communities, and systems			level 3			level 3			level 2	level 2	level 2			level 2								level 2	11
Engage in meaningful educational activities and learning opportunities to fill knowledge/skills gaps and demonstrate deliberate practice						level 3	level 2					level 3	level 3	level 3									15
Develop a professional identify, including understanding, appreciation, and internalization of the professional role as it relates to patient, community, or specialty.											level 3				level 3	level 3	level 3	level 3	level 3	level 3	level 3		1,2
Ability to do or participate to conceptulise, plan, conduct and write a research project.							level 1					level 1	level 3	level 3									
Flexibility and maturity in adjusting to change with the capacity to alter one's own behaviors and resilience.															level 3	level 3	level 3	level 3					3.6
Provide care through differnet consultation modles; Telehealth and home visits.	level 3	level 3	level 3			level 3	level 3	level 3	level 3	level 3							level 3		level 3	level 3	level 3	level 3	12,16

	PC					MK		SBP				PBL			Prof				C			
Average																						
	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of ...	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and community ...	Coordinates team based care	Evidence Based and Informed Practice	Self Directed learning	Improves systems	Completes process of professionalizati on	Professional conduct and accountab...	Demonstrates humanism	Maintain emotional, physical and mental ...	Develops relationships with pts and families	Communicates effectively with pts and ...	Relationships within Medicine	use techology
	Cares for Acutely Ill or Injured Patients in Urgent and Emergent Situations and in All Settings	Cares for Patients with Chronic Conditions	Partners with the Patient, Family, and Community to Improve Health through Disease Prevention and Health Promotion	Partners with the Patient to Address Issues of Ongoing Signs, Symptoms, or Health Concerns that Remain over Time without Clear Diagnosis Despite Evaluation and Treatment in a ...	Performs Specialty-Appropriate Procedures to Meet the Healthcar...	...ates Medical Knowledge of Sufficient Breadth and Depth to Practice	Applies Critical Thinking Skills in Patient Care		Patient Safety and Quality Improvement	System Navigation for Patient-Centered Care	Physician Role in Health Care Systems	Evidence-Based and Informed Practice	Reflective Practice and Commitment to Personal Growth		Professional Behavior and Ethical Principles	Accountability/Conscientiousness	Self-Awareness and Help-Seeking			Patient- and Family-Centered Communication	Interprofessional and Team Communication	Communication within Health Care Systems
Final																						

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Competency	Level	
Advocate for patients, families, and communities to optimize health care equity and minimize health outcome	-	
Provide leadership within interprofessional health care teams.	-	
Coordinate care and evaluate specialty consultation as the condition of the patient requires.	-	
Perform comprehensive histories and through physical examination and identify abnormalities.	level 3	
Knowing the Indications, contraindications of the investigation and interpretation of laboratory data	level 3	
assists the PCP and health care team set and achieve long-term goals	level 3	
Provide comprehensive medication review, reconcilation and conselling.		
Resuscitate, stabilize, and care for unstable or critically ill patients	level 2	
Demonstrate the ability to provide counselling skills and behavioural modification techniques for patient and families		
Incorporate considerations of cost awareness and risk benefit. Contribute to the fiscally sound and ethical management of a practice (e.g. through billing, scheduling, coding, and record keeping practices)		
Able to correctly approach an ethical situation and manage it appropriately.		
Apply public health principles and quality improvement methods to improve care and safety for populations, communities, and systems		
Engage in meaningful educational activities and learning opportunities to fill knowledge/skills gaps and demonstrate deliberate practice		
Develop a professional identify, including understanding, appreciation, and internalization of the professional role as it relates to patient, community, or specialty.		
Ability to do or participate to conceptulise, plan, conduct and write a research project.		
Flexibility and maturity in adjusting to change with the capacity to alter one's own behaviors and resilience.		
Provide care through differnet consultation modles; Telehealth and home visits.	level 3	

	PC					MK		SBP				PBL			Prof				C				ntrusmen
	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of Sufficient Breadth and Depth to	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and community health	Coordinates team based care	Evidence-Based and Informed Practice	Self Directed learning	Improves systems	Completes process of professional izati on	Professional conduct and accountability	Demonstrates humanism	Maintain emotional, physical and mental health	Develops relationships with pts and families	Communicates effectively with pts and families	Relationships within Medicine	use techology	
	1	2	3	4	5	1	2	1	2	3	4	1	2	3	1	2	3	4	1	2		4	tools
e for all age groups	-	level 3	level 3	level 3	-			-	-	-	level 3	level 3	level 3	level 3	level 3	-	level 3	level 3	level 3	-	-	level 3	2,4,5,6,8
office, home, hospital, and	level 3	-	level 3	-	-			level 3	level 3	-	level 3	-	-	-	level 4	-	level 4	-	level 4	-	-	level 4	1.2
	level 2	level 3	-	-	-			level 3	-	-	level 3	-	-	-	-	-	level 4	-	level 4	level 4	-	-	1,2,3

Global evaluation methods

1. Rotation evaluations
2. Family Medicine Center 360 evaluations
3. Family Medicine Center Preceptor evaluations
4. Resident patient panel data
5. Chart Review
6. Direct observation
7. Resident referral pattern review
8. Resident portfolio
9. Behaviorist evaluation of residents
10. Procedure evaluations
11. Practice improvement projects
12. Tele-consultation of patient encounters
13. Patient satisfaction surveys
14. American Board of Family Medicine In-training exam results
15. Journal club or evidence based answers presentation.
16. home and nursing home visits 17. OSCE, OSTAD, FACES

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Provide care through differnet consultation modles; Telehealth and home visits.

	PC					MK		SBP				PBL			Prof				C			
Average	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and communit	Coordinates team based care	EvidenceBased and Informed Practice	Self Directed learning	Improves systems	Completes process of professionalizati on	Professional conduct and accountab	Demonstrates humanism	Maintain emotional, physical and mental	Develops relationships with pts and families	Communicates effectively with pts and	Relationships within Medicine	use techology
	Cares for Acutely Ill or Injured Patients in Urgent and Emergent Situations and in All Settings	Cares for Patients with Chronic Conditions	Partners with the Patient, Family, and Community to Improve Health through Disease Prevention and Health Promotion	Partners with the Patient to Address Issues of Ongoing Signs, Symptoms, or Health Concerns that Remain over Time without Clear Diagnosis Despite Evaluation and	Performs Specialty-Appropriate Procedures to Meet the Healthcar	ates Medical Knowledge of Sufficient Breadth and Depth to Practice	Applies Critical Thinking Skills in Patient Care		Patient Safety and Quality Improvement	System Navigation for Patient-Centered Care	Physician Role in Health Care Systems	Evidence-Based and Informed Practice	Reflective Practice and Commitment to Personal Growth		Professional Behavior and Ethical Principles	Accountability/Conscientiousness	Self-Awareness and Help-Seeking			Patient- and Family-Centered Communication	Interprofessional and Team Communication	Communication within Health Care Systems
Final																						

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Family Medicine EPA	PC					MK		SBP				PBL			Prof				C				ntrusmen
	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of Sufficient Breadth and Depth to Practice	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and community health	Coordinates team based care	Evidence-Based and Informed Practice	Self Directed learning	Improves systems	Completes process of professionalizati on	Professional conduct and accountability	Demonstrates humanism	Maintain emotional, physical and mental health	Develops relationships with pts and families	Communicates effectively with pts and families	Relationships within Medicine	use techology	
	1	2	3	4	5	1	2	1	2	3	4	1	2	3	1	2	3	4	1	2		4	tools
Provide a usual source of comprehensive, continuous longitudinal medical care for all age groups	-	level 3	level 3	level 3	-			-	-	-	level 3	level 3	level 3	level 3	level 3	-	level 3	level 3	level 3	-	-	level 3	2,4,5,6,8
Take responsibility for the care of patients in multiple settings, including the office, home, hospital, and	level 3	-	level 3	-	-			level 3	level 3	-	level 3	-	-	-	level 4	-	level 4	-	level 4	-	-	level 4	1.2
Provide first-contact access to care for health issues and medical problems.	level 2	level 3	-	-	-			level 3	-	-	level 3	-	-	-	-	-	level 4	-	level 4	level 4	-	-	1,2,3
Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness	-	-	level 3	-	-	level 3	level 3	-	-	level 3	-	level 3	-	level 3	-	-	level 4	-	level 4	level 4	-	-	5.6
Provide care that speeds recovery from illness and improves function.	level 2	level 3	-	level 2	-			level 3	-	-	level 3	-	-	-	-	-	level 4	-	level 4	level 4	-	level 4	13
Evaluate and manage undifferentiated symptoms and complex conditions and patients who are highly		-	-	level 2	-	level 3		level 2	-	-	-	level 2	-	-	level 3	-	level 3	level 3	level 3	level 3	-	-	1.3
Diagnose and manage chronic medical conditions and multiple co-morbidities.	-	level 3	level 3	-	-			-	level 3	-	level 3	level 2	-	level 3	-	-	level 4	-	level 4	level 4	level 4	level4	3.16
Diagnose and manage mental health conditions.	level 2	level 2	-	level 2	-			-	-	-	level 2	-	-	-	-	level 2	level 3	-	level 3	level 3	-	-	1,2,3,9
Diagnose and manage acute illness and injury.	level 2	-	-	-	level 1			-	-	-	level 2	-	-	-	-	-	-	level 3	-	level 3	-	-	1,3,
Perform common procedures in the outpatient or inpatient setting.	-	-	-	-	level 1	level 1	level 1	-	level 1	-	-	-	-	level 1	-	-	-	-	-	-	-	level 2	3,6,10
Manage prenatal, labor, delivery and post-partum care.	level 2	-	level 2	-	level 1	level 2	Level 2	-	level 2	-	level 2	-	-	-	-	level 3	level 3	level 3	level 3	-	level 3	level 2	1,3,10,13
Manage end-of-life and palliative care.	level 2	level 1	-	-	-			-	-	-	level 1	-	-	-	level 1	-	level 1	-	level 1	level 1	-	-	1,2,3
Manage inpatient care, discharge planning, transitions of care.	level 2	-	-	-	level 1		-	level 1	level 1	-	level 1	-	-	-	level 3	level 3	level 3	-	-	level 3	level 3	level 3	1,2,3
Manage care for patients with medical emergencies	level 2	-	-	-	-	level 2		-	level 1	-	level 1	-	-	-	-	-	-	-	level 1	level 1	level 1	-	1
Develop trusting relationships and sustained partnerships with patients, families, and communities	-	level 3	level 3	level 3	-			-	-	-	level 3	-	-	-	level 3	level 4	-	-	level 4	level 4	-	level 4	1,2,3,7,12
Use data to optimize the care of individuals, families and populations.	-	-	level 3	-	-		-	level 3	level 3	level 3	-	-	level 3	level 3	-	-	-	-	-	-	-	level 3	2,3,11
In the context of culture and health beliefs of patients and families, use the best science to set mutual	-	level 3	level 3	-	-		-	-	-	-	-	level 3	-	-	level 3	-	level 3	-	level 3	level 3	-	-	3,6,14,15
Advocate for patients, families, and communities to optimize health care equity and minimize health outcome	-	-	level 3	-	-		-	-	-	level 3	-	-	-	-	-	-	level 3	-	-	level 3	-	-	1,2,3,6
Provide leadership within interprofessional health care teams.	-	level 3	level 3	-	-		-	-	level 3	-	level 3	-	-	-	-	level 3	-	level 3	-	-	level 3	-	1,2,9
Coordinate care and evaluate specialty consultation as the condition of the patient requires.	-	-	-	level 3	level 1		-	level 3	-	-	level 3	-	-	-	-	-	-	-	-	-	level 3	-	1,3,5,7
Perform comprehensive histories and through physical examination and identify abnormalities.	level 3	level 3	level 3	level 3		level 3	level 3						level 3		level 4	level 4	level 4	level 4	level 4	level 4			1,2,3,6,17
Knowing the Indications, contraindications of the investigation and interpretation of laboratory data	level 3	level 3	level 3	level 3		level 3	level 3	level 3	level 3	level 3		level 3	level 3				level 3			level 3		level 3	1,6,14
assists the PCP and health care team set and achieve long-term goals	level 3	level 3	level 3	level 3		level 3	level 3	level 3			level 3	level 3		level 3				level 3	level 3	level 3	level 3	level 3	3,5,6,13
Provide comprehensive medication review, reconcilation and conselling.									level 4													level 4	5
Resuscitate, stabilize, and care for unstable or critically ill patients	level 2				level 2	level 2	level 2				level 2										level 2		1,3,17,6
Demonstrate the ability to provide counselling skills and behavioural modification techniques for patient and families																	level 4	level 4	level 4	level 4			2,6,17
Incorporate considerations of cost awareness and risk benefit. Contribute to the fiscally sound and ethical management of a practice (e.g. through billing, scheduling, coding, and record keeping practices)								level 2						level 2								level 2	2,5
Able to correctly approach an ethical situation and manage it appropriately.																level 2	level 2	level 2	level 2	level 2			6,17
Apply public health principles and quality improvement methods to improve care and safety for populations, communities, and systems			level 3			level 3			level 2	level 2	level 2			level 2								level 2	11
Engage in meaningful educational activities and learning opportunities to fill knowledge/skills gaps and demonstrate deliberate practice						level 3	level 2					level 3	level 3	level 3									15
Develop a professional identify, including understanding, appreciation, and internalization of the professional role as it relates to patient, community, or specialty.											level 3				level 3	level 3	level 3	level 3	level 3	level 3	level 3		1,2
Ability to do or participate to conceptulise, plan, conduct and write a research project.							level 1					level 1	level 3	level 3									
Flexibility and maturity in adjusting to change with the capacity to alter one's own behaviors and resilience.															level 3	level 3	level 3	level 3					3.6
Provide care through differnet consultation modles; Telehealth and home visits.	level 3	level 3	level 3			level 3	level 3	level 3	level 3	level 3							level 3		level 3	level 3	level 3	level 3	12,16

Average	PC					MK		SBP				PBL			Prof				C			
	Care of the Acutely Ill Patient	Care of Patients with Chronic Illness	Health Promotion and Wellness	Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns	Management of Procedural Care	Demonstrates Medical Knowledge of Sufficient...	Critical Thinking and Decision Making	Cost conscious care	Emphasizes patient safety	Advocates for individual and community health	Coordinates team based care	Evidence-Based and Informed Practice	Self Directed learning	Improves systems	Completes process of professionalization	Professional conduct and accountability	Demonstrates humanism	Maintain emotional, physical and mental health	Develops relationships with pts and families	Communicates effectively with pts and families	Relationships within Medicine	use techology
	Cares for Acutely Ill or Injured Patients in Urgent and Emergent Situations and in All Settings	Cares for Patients with Chronic Conditions	Partners with the Patient, Family, and Community to Improve Health through Disease Prevention and Health Promotion	Partners with the Patient to Address Issues of Ongoing Signs, Symptoms, or Health Concerns that Remain over Time without Clear Diagnosis Despite Evaluation and Treatment in a...	Performs Specialty-Appropriate Procedures to Meet the Healthcar...	...ates Medical Knowledge of Sufficient Breadth and Depth to Practice	Applies Critical Thinking Skills in Patient Care		Patient Safety and Quality Improvement	System Navigation for Patient-Centered Care	Physician Role in Health Care Systems	Evidence-Based and Informed Practice	Reflective Practice and Commitment to Personal Growth		Professional Behavior and Ethical Principles	Accountability/Conscientiousness	Self-Awareness and Help-Seeking			Patient- and Family-Centered Communication	Interprofessional and Team Communication	Communication within Health Care Systems
Final																						

Lessons learned.
(from others' experiences and ours)

- Decision is based on information triangulated with other data sources before a performance standard could be set at the competency level
- competency decisions have periodicity, perhaps annually, rather than being a one-time 'final' decision.
- early decision to allow remediation but higher quality decisions result from more data points
- later occurring decisions would be made with maximum information.
- integrated performances rather than the individual pieces that can be scattered with no meaning.

MEDICAL TEACHER
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PERSONAL VIEW

Three key issues for determining competence in a system of assessment

Jorie M. Colbert-Getz[a] and Judy A. Shea[b]

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Lessons learned.

	Better	Worse
Member characteristics	Heterogeneous groups perform better than homogeneous	
Group size	large groups tend to outperform small groups. large groups, members may go along with group opinion rather than think their own opinion (social loafing)	
Group understanding of its work	A shared mental model is a shared understanding of a group's work that improves group performance	
Group leader role	A leader inviting participation counteracts the tendency for members lower on the hierarchy to be passive	more senior, powerful, or confident members can dominate
Effects of time pressures	New or unshared information is more likely to emerge with longer discussions	Time pressures lead to lower-quality decisions.
Information-sharing procedures	Information-sharing procedures leads groups to better decisions Information sharing enhanced with structured discussion process that invites elaboration. Sharing written information versus just relying on group member memory increases chances of information being incorporated into group decisions. Information that all group members know (shared information) carries more weight than informatior … information). Group processes … d comments from all members.	Social pressure is minimized through structured voting and acknowledgement of diverse opinions.

Ensuring Resident Competence: A Narrative Review of the Literature on Group Decision Making to Inform the Work of Clinical Competency Committees

Karen E. Hauer, MD, PhD
Olle ten Cate, PhD
Christy K. Boscardin, PhD
William Iobst, MD
Eric S. Holmboe, MD
Benjamin Chesluk, PhD
Robert B. Baron, MD
Patricia S. O'Sullivan, EdD

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Highlight what can go wrong

- Privacy in our setting
- Time factor (no early judgment and no late decisions)
- Misleading information, therefore, team feedback through CCC meetings is essential, especially at the workplace. (especially in case one supervisor is responsible for the resident, or if supervisors are busy or inexperienced!

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What can help in having CBME framework better implemented?

- Can technology help?
- Residents' specific issues (advocate but objective judgment)
- CCC Leadership and close conversation with PD.
- Coordinators crucial support
- Faculty development
- Reflection through research
- Residents involvement. What they understand is what they do. The translation is the CCC work

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Summary tips..

- Define the committee's guiding purpose.
- Identify and collate assessment data from multiple sources
- Recruit the right members
- Conduct regular committee member training
- Develop methods for real-time sharing of assessment data during CCC meetings
- Establish ground rules for committee meetings
- Use a structured format for committee discussion
- Employ strategies for time efficient member participation before and during the meeting
- Integrate the CCC into a program of assessment
- Have standard CCC output for stakeholders (program, learner, and accrediting bodies)
- Use a standard framework to provide feedback on performance and learning planning
- Engage in continuous quality improvement of the committee

Medical Teacher

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Twelve tips to maximize the value of a clinical competency committee in postgraduate medical education

Benjamin Kinnear, Eric J. Warm & Karen E. Hauer

SEHA Abu Dhabi Health Services Co. صحة
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Outcome

- A total of 112 family medicine residents were included: 36 residents in cohort one and 76 residents in cohort two.
- The significant prediction of graduation ITE score by the early sub-competencies is an important observation as the ITE is very similar to the exit certifying exam.

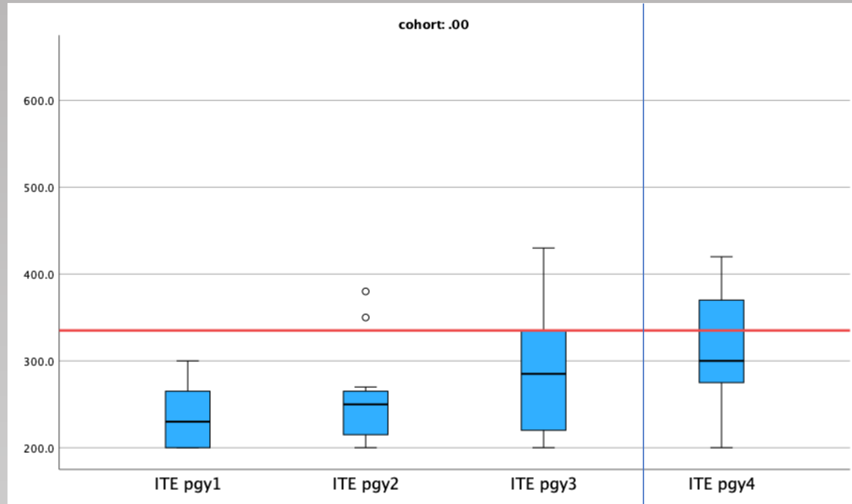
Pearson's Correlations										
	Mid All Average y1	End All Average y1	Mid All Average Y2	End All Average Y2	MD All Average Y3	End All Average Y3	MD All Average Y4	End All Average Y4	ITE y4	ITE y5
Mid All Average y1	1	.480*	.402*	.400*	.255	0.194	0.23	0.375	.321*	.646*
End All Average y1	.480*	1	.699*	.603*	.506*	.501*	.557*	.595*	.466*	.559*
Mid All Average Y2	.402*	.699*	1	.778*	.598*	.600*	.697*	.798*	.654*	.650*
End All Average Y2	.400*	.603*	.778*	1	.775*	.730*	.786*	.713*	.710*	.717*
MD All Average Y3	.255	.506*	.598*	.775*	1	.863*	.758*	.670*	.685*	.654*
End All Average Y3	0.194	.501*	.600*	.730*	.863*	1	.858*	.834*	.681*	.637*
MD All Average Y4	0.23	.557*	.697*	.786*	.758*	.858*	1	.855*	.629*	.641*
End All Average Y4	0.375	.595*	.798*	.713*	.670*	.834*	.855*	1	.680*	.705*
ITE y4	.321	.466*	.654*	.710*	.685*	.681*	.629*	.680*	1	.841*
ITE y5	.646*	.559*	.650*	.717*	.654*	.637*	.641*	.705*	.841*	1

* Significant correlations

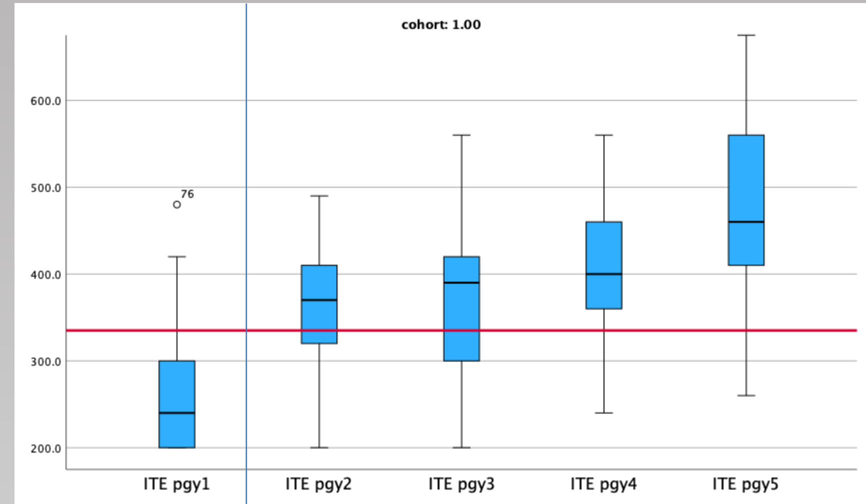
Correlation between the Milestones assessed at different training years for cohort 2, which had the milestones implemented

Outcome c

The intake from 2008 to 2012
before the ACGME accreditation



The intake from 2013 to 2019
after the ACGME accreditation



Early milestones predicted graduation ITE

- Linear regression showed a significant prediction of almost all sub-competencies with the ITE in year 4 after completion of the three ACGME-I programs' requirements.
- This was for all years' sub-competencies from PGY1 to PGY3.
- Competency development continues in years 4 and 5 in residency as residents' achievement 5 continues to improve.

Outcome

Table 4 B- Linear regression of PGY4 ITE score with early (PGY1- PGY2) milestones sub-competencies and exams in cohort Two.

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Individual average of sub-competencies					
Patient care					
Mid Patient Care Y1	32.912	30.414	0.167	1.082	0.286
End Patient Care Y1	59.359	25.888	0.337	2.293	**0.027**
Mid Patient Care Y2	68.726	20.108	0.471	3.418	**0.001**
End Patient Care Y2	92.792	22.36	0.544	4.15	**<.001**
Mid Patient Care Y3	101.82	16.713	0.689	6.092	**<.001**
End Patient Care Y3	104.44	21.588	0.603	4.838	**<.001**
Medical Knowledge					
Mid Medical Knowledge Y1	47.688	19.094	0.363	2.498	**0.017**
End Medical Knowledge Y1	79.86	25.399	0.441	3.144	**0.003**
Mid Medical Knowledge Y2	97.87	18.412	0.639	5.316	**<.001**
End Medical Knowledge Y2	81.79	23.979	0.47	3.411	**0.001**
System - Based Practice					
Mid System - Based Practice Y1	56.508	24.321	0.345	2.323	**0.025**
End System - Based Practice Y1	51.153	22.869	0.33	2.237	**0.031**
Mid System - Based Practice Y2	79.461	23.691	0.464	3.354	**0.002**
End System - Based Practice Y2	80.518	22.62	0.486	3.56	**<.001**
Practice based learning and Improvement					
Mid learning and Improvement Y1	57.034	23.803	0.35	2.396	**0.021**
End learning and Improvement Y1	60.755	18.743	0.452	3.241	**0.002**
Mid learning and Improvement Y2	66.268	17.326	0.513	3.825	**<.001**
End learning and Improvement Y2	80.85	18.52	0.563	4.366	**<.001**
Professionalism					
Mid Professionalism Y1	13.822	20.431	0.105	0.677	0.503
End Professionalism Y1	23.16	34.368	0.105	0.674	0.504
Mid Professionalism Y2	104.56	32.115	0.453	3.256	**0.002**
End Professionalism Y2	87.359	31.182	0.401	2.802	**0.008**
Interpersonal and Communication Skills					
Mid Interpersonal and Communication Skills Y1	20.483	22.076	0.143	0.928	0.359
End Interpersonal and Communication Skills Y1	-19.909	32.479	-0.095	-0.61	0.543
Mid Interpersonal and Communication Skills Y2	94.462	28.732	0.457	3.288	**0.002**
End Interpersonal and Communication Skills Y2	84.921	25.009	0.469	3.396	**0.002**
Overall milestones average of all sub-competencies					
Mid Y1 Average of All	65.673	30.282	0.321	2.169	**0.036**
End Y1 Average of All	132.41	39.243	0.466	3.374	**0.002**
Mid Y2 Average of All	140.57	25.406	0.654	5.533	**<.001**
End Y2 Average of All	162.42	25.138	0.71	6.461	**<.001**
Mid Y3 Average of All	133.76	22.214	0.685	6.021	**<.001**
End Y3 Average of All	146.7	24.655	0.681	5.95	**<.001**
Exams					
Clinical exam Y1	35.617	18.143	0.293	1.963	0.056
Oral exam Y1	54.392	16.705	0.453	3.256	**0.002**
OSCE Y1	5.351	2.292	0.363	2.335	**0.025**
OSCE Y2	4.605	2.232	0.329	2.063	**0.047**

Interpretation

- The accreditation standards required structure and processes such as Clinical Competency Committee (CCC) and Program Evaluation Committee (PEC).
- These, for example, provided a demand for time and resources for the program that supported the residents and faculty.
- Quantitative and qualitative data for both committees at different data points from different sources need to be processed by committee members to be acted upon by PD, faculty, and residents.

Interpretation

- According to Holmboe and others, milestones data offers a valid and reliable predictive tool that offers guidance for the programs to make formal decisions according to the resident's progress and needs. Also, this might even extend to provide some prediction on the level of the resident's readiness to face clinical practice.
- Local factors may have played a role such as that more supervisors were program graduates in cohort two than in cohort one. Still, as accreditation standards stress investment in faculty development, we can still attribute success to accreditation.

Conclusion

- The introduction of the ACGME-I accreditation was associated with increasing residents' achievements.
- Similar to other international studies, Milestones proved to be a promising instrument for competency acquisition in Abu Dhabi AHS family medicine program.
- The correlation between the graduation in-training exam and graduation milestones with earlier milestones suggests a possible use of early milestones in predicting outcomes.
- Processes used and work in progress with EPA can show better outcome
- Involving residents more is an area of work in the future

Thank You

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Abu Dhabi Health Services Co.
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Dr. James Arrighi
President and Chief Executive Officer
ACGME-International

Dr. James Arrighi is the President and Chief Executive Officer of ACGME-International. He completed his Bachelor of Science and Medical Doctor degrees at Brown University in Rhode Island, USA. He then completed training in internal medicine, cardiology, and nuclear medicine at Washington University in St. Louis, the National Institutes of Health, and Yale University School of Medicine. Before joining ACGME, Dr. Arrighi served as a program director for the cardiology fellowship, and as director of graduate medical education, at Brown University and Rhode Island Hospital. He is a Professor of Medicine, Diagnostic Imaging, and Medical Science at Brown, and received several faculty awards for teaching. For over two decades, he has mentored residents and fellows; he has published over 70 peer-reviewed publications and has delivered over 130 national or international invited lectures. He joined the ACGME-International in September 2021

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Introduction to Clinical Educator Milestones

Dr. James Arrighi, M.D.*
President and CEO
ACGME-International
Professor of Medicine, Brown University

*Laura Edgar, EdD**
Vice President, Milestones Development
ACGME

*Employee of ACGME, otherwise no disclosures

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The Need for Clinician-Educator Milestones

- How do you define a competent clinician-educator?
- How is this different from a competent clinician?
- How should clinician-educators be assessed?

ACGME-I has heard from you that there is a need to answer these questions!

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Clinician-Educator Milestones: Background

- CEM are designed to aid Clinician Educators in their educator professional development
- They are designed for educators across the continuum of medical education
- Can be used as a self-assessment tool to improve in specific subcompetencies or to develop skills in areas you are hoping to work (e.g., planning to become a program director)

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Milestones: Review

Level	Dreyfus Stage	Description (clinical reasoning example)
1	Novice	Rule driven; analytic thinking; little ability to prioritize information
2	Advanced beginner	Able to sort through rules based on experience; analytic and non-analytic for some common problems
3	Competent	Embraces appropriate level of responsibility; dual processing of reasoning for most common problems; can see big picture; Complex problems default to analytic reasoning. Performance can be exhausting.
4	Proficient	More fully developed non-analytic and dual process thinking; comfortable with evolving situations; able to extrapolate; situational discrimination; can live with ambiguity
5	Expert	Experience in subtle variations; distinguishes situations

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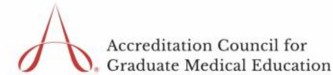
Structure of C-E Milestones

UNIVERSAL PILLARS

- Reflective Practice and Commitment to Personal Growth
- Well-Being
- Recognition and Mitigation of Bias
- Commitment to Professional Responsibilities

EDUCATIONAL THEORY AND PRACTICE

- Teaching and Faculty Learning
- Professionalism in the Learning Environment
- Learner Assessment
- Feedback
- Performance Improvement and Remediation
- Programmatic Evaluation
- Learner Professional Development
- Science of Learning
- Medical Education Scholarship
- Learning Environment
- Curriculum



What We Do | Designated Institutional Officials | Program Directors and Coordinators | Residents and Fellows | Meetings and Educational Activities

ACGME Home > What We Do > Accreditation > Milestones > Milestones Resources > Clinician Educator Milestones

Clinician Educator Milestones

Access the Clinician Educator Milestones
Access the Clinician Educator Supplemental Guide
Access the Clinician Educator Supplemental Guide Template

The Clinician Educator Milestones are a joint effort of the ACGME, the Accreditation Council for Continuing Medical Education, the Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine. This series of subcompetencies is designed to aid in the development and improvement of teaching and learning skills across the continuum of medical education.

The Clinician Educator Milestones are not an ACGME accreditation requirement and are not intended to become one in the future.

DIVERSITY, EQUITY, AND INCLUSION IN THE LEARNING ENVIRONMENT

- Diversity, Equity, and Inclusion in the Learning Environment

ADMINISTRATION

- Administration Skills
- Leadership Skills
- Change Management

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Educational Theory and Practice 3: Learner Assessment				
Level 1	Level 2	Level 3	Level 4	Level 5
Discusses the goals and principles of both formative and summative assessment	Uses appropriate methods and tools for assessment in a specific setting	Uses assessment data to identify strengths and opportunities for improvement of learners	Educates others, and when necessary, advises on selection and use of appropriate assessment methods and tools	Designs and implements evidence-based assessment methods and tools

Comments:

Not Yet Completed Level 1

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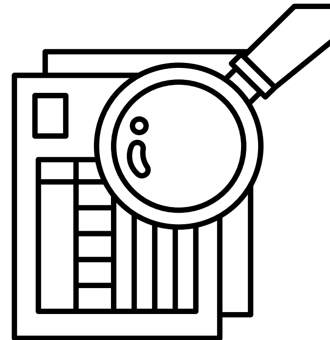
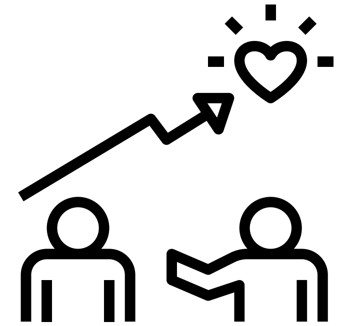
Educational Theory and Practice 3: Learner Assessment **Overall Intent:** To apply and develop principles of formative and summative assessment to improve performance	
Milestones	**Examples**
Level 1 *Discusses the goals and principles of both formative and summative assessment*	• (U/G/C): Explains the difference between summative and formative assessment to a learner • (U/G/C): Describes when a formative versus summative evaluation should be used
Level 2 *Uses appropriate methods and tools for assessment in a specific setting*	• (U/G/C): Differentiates when to use a global assessment versus more focused assessment of performance • (U/G/C): Employs pre/post-test to assess knowledge/skill/competence after an educational activity • (U/G/C): Uses daily feedback forms to provide formative assessment • (U/G/C): Provides daily verbal feedback to learners to help learners prepare for similar cases during a subspecialty rotation • (U/G/C) Ensures assessment is based on learning objectives
Level 3 *Uses assessment data to identify strengths and opportunities for improvement for the learner*	• (U/G): Utilizes training exam data and faculty evaluations from a clinical rotation and identifies areas for improvement • (G/C): Uses patient outcomes and patient experience surveys to identify areas of strength for a learner
Level 4 *Educates others on selection and use of appropriate assessment methods and tools*	• (U/G/C): Assists faculty members in selecting optimal assessment, (e.g., intent to change, knowledge tests, practice improvement measurement) • (U/G/C): Advises colleagues against using the Milestone Reporting Worksheet as an assessment tool
Level 5 *Designs and implements evidence-based assessment methods and tools*	• (U/G/C): Creates post-activity assessment tools such as intent to change and/or practice improvement measurement • (U/G/C): Develops daily feedback forms to use in a clinical setting • (U/G): Develops and guides the use of a summative rotation assessment form that collates all feedback from the rotation in a manner that lets the learner know how they performed during the entire educational experience • (G): Designs and creates evaluations or assessments with the intent of informing Milestone evaluations
Assessment Models or Tools	• Direct observation • Education portfolio • Continuing professional development/maintenance of certification activities in practice • Multisource feedback • OSTE
Notes or Resources	• Learn at ACGME https://dl.acgme.org/ • Twelve Tips for Programmatic Assessment DOI: 10.3109/0142159X.2014.973388

The Ultimate Goal: Application to Career Development





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