Developing Faculty Competencies in Assessment: An ACGME Co-Sponsored Regional Pilot Program

Thomas A. Boyle, D.O., FACEP, FACOEP
Dean, Postdoctoral Education and MWU OPTI Academic Officer
Midwestern University

Ms. Lilia Wilson, MBA, MPM
Acting Designated Institutional Official (DIO)
Midwestern University OPTI
Pilot Program Origin

• ACGME conducts 4 six-day programs in Chicago annually

→ goal of instructing GME faculty and leadership in Competency-Based Medical Education (CBME), which is the foundation of the resident assessment system as contained within the Next Accreditation System (NAS)

• Approximately 170 per year can receive such training
Regional “Short” Courses

• Pilot program initiated to present the core material in a regional, shorter (3 ½ days), and less costly format ➔ first national meeting of course directors scheduled in March 2018

• Vanderbilt University presented first program 2 years ago

• UCLA is presenting their first program this year

• Penn State is likely the next site to present

• MWU OPTI is planning on presenting the program in 2018
So what does the short course teach GME faculty?

**Faculty Competencies in Resident Assessment**

→ (Emphasis on the “DOES” Category)

→ CBME
→ The Assessment Tools and How to Use Them
→ Integration of the Tools into the CCC
→ Explanation and Completion of Milestones
→ Development and Completion of EPA’s
→ Direct OBSERVATION
CBME

- Six Competencies

- Sub-competencies evaluated through semi-annual completion of Milestones

- **CBME** incorporates variable length of time for training with a defined outcome.

- “The old ways” incorporated a fixed length of training with variable outcomes.
## PC1. History (Appropriate for age and impairment)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquires a general medical history</td>
<td>Acquires a basic physiatric history including medical, functional, and psychosocial elements</td>
<td>Acquires a comprehensive physiatric history integrating medical, functional, and psychosocial elements</td>
<td>Efficiently acquires and presents a relevant history in a prioritized and hypothesis driven fashion across a wide spectrum of ages and impairments</td>
<td>Gathers and synthesizes information in a highly efficient manner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeks and obtains data from secondary sources when needed</td>
<td>Elicits subtleties and information that may not be readily volunteered by the patient</td>
<td>Rapidly focuses on presenting problem, and elicits key information in a prioritized fashion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Models the gathering of subtle and difficult information from the patient</td>
</tr>
</tbody>
</table>

**Specific Milestone**
Competency Development Model

MILESTONES

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>Curriculum</th>
<th>Curriculum</th>
<th>Curriculum</th>
<th>Curriculum</th>
</tr>
</thead>
</table>

- Competent
- Proficient
- Expert/Master
- Advanced Beginner
- Novice
- MS3
- MS4
- PGY-1
- PGY-3

Time, Practice, Experience

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

© 2013 Accreditation Council for Graduate Medical Education
Information Current as of December 2, 2013
### PC1. History (Appropriate for age and impairment)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquires a general medical history</td>
<td>Acquires a basic physiatric history including medical, functional, and psychosocial elements</td>
<td>Acquires a comprehensive physiatric history integrating medical, functional, and psychosocial elements</td>
<td>Efficiently acquires and presents a relevant history in a prioritized and hypothesis driven fashion across a wide spectrum of ages and impairments</td>
<td>Gathers and synthesizes information in a highly efficient manner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeks and obtains data from secondary sources when needed</td>
<td>Elicits subtleties and information that may not be readily volunteered by the patient</td>
<td>Rapidly focuses on presenting problem, and elicits key information in a prioritized fashion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Models the gathering of subtle and difficult information from the patient</td>
<td></td>
</tr>
</tbody>
</table>

**List of Critical Deficiencies in IM**

- Early Learner
- Learner Showing Improvement
- Ready for Unsupervised Practice
- Aspirational

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Based on Holistic Evaluation

© 2013 Accreditation Council for Graduate Medical Education (ACGME)
Why Direct Observation?

“To Provide Good Feedback”

• Why Feedback?

• Among the most frequent resident complaints → no (or meaningless) feedback from faculty

• The resident who is competent but not confident will know the s/he is meeting the standard.

• More importantly, the resident who is confident but not competent may be identified early and prior to promotion.
MWU OPTI PLAN

• The first MWU OPTI program will be open to **SAS programs in transition**

• **Purpose**: answer the “What’s Next?” question after a program has submitted an ACGME application---emphasis on community hospitals and **SAS programs**

• **Direct Observation training**: conducted in the Sim Center (1/2 day; 4-6 cases; each participant provides feedback to “**standardized residents**” after observing resident performance in a clinical scenario

• 25-35 participants per course
Thank you