The Match  
Presented by:  
-Jeffrey C. Klick, MD  
-Wayne McCormick, MD  
-Stacie Levine, MD

The plan...  
• 8:30-8:40am: Logistic aspects and resources  
  Jeffrey C Klick, MD
• 8:40-9:00am: NRMP Code of Conduct  
  Wayne McCormick MD MPH
• 9:00-9:45am: Practical aspects and advice  
  Stacie Levine, MD
• 9:45-10:00am: Q/A

Disclosure  
The speakers have no relevant financial interests, directly or indirectly, related to the subject of the presentation.
MATCH PARTICIPATION DATA, TIMELINE, AND ERAS

Jeffrey C Klick, MD
Children’s Healthcare of Atlanta
Emory University School of Medicine
Jeffrey.klick@choa.org

Objectives

• Recognize how the field is participating in the NRMP Match process

• Know how to find essential resources that describe and explain ERAS and NRMP Match process

• Describe the timeline associated with ERAS and NRMP Match for fellows starting July 1st, 2016.

HPM Fellowship Training Programs
HPM Fellowships – Match Participation

as of December 18, 2014

Out of 107 programs...
– 104 approve AAHPM as official Match sponsor
– 101 will participate in Match in 2015
– 3 abstaining programs are considering future participation

94.4% of all program are participating

87% of all positions will be in the Match

Have the number of programs/positions changed?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>55</td>
<td>69</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Radiology/Oncology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total programs</strong></td>
<td>97</td>
<td>106</td>
</tr>
<tr>
<td><strong>Approved positions</strong></td>
<td>284</td>
<td>309</td>
</tr>
<tr>
<td><strong>Temporary positions</strong></td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total positions</strong></td>
<td>288</td>
<td>320</td>
</tr>
</tbody>
</table>

**Data obtained from AOA website; core programs are not identified.

Have the number of applicants changed?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of programs</td>
<td>157</td>
<td>135</td>
<td>-22</td>
</tr>
<tr>
<td>Number of approved positions</td>
<td>320</td>
<td>319</td>
<td>-1</td>
</tr>
<tr>
<td>Positions filled</td>
<td>217</td>
<td>235</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total applicants</strong></td>
<td>647</td>
<td>639</td>
<td>-8</td>
</tr>
</tbody>
</table>

*ACGME website reflects the total filled positions from the previous academic year. It does not state when annual update is completed.

*Not all core vs. non-core applicants.

**AOA data is not included in this slide as AOA programs will not be participating in the NRMP Match.

*As reported by individual programs.
HPM NRMP & ERAS Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRMP Online Program Information Update</td>
<td>1 May 2015</td>
</tr>
<tr>
<td>NRMP Open</td>
<td>19 Jul 2015</td>
</tr>
<tr>
<td>NRMP Close</td>
<td>28 Jul 2015</td>
</tr>
<tr>
<td>Rank List Open</td>
<td>9 Oct 2015</td>
</tr>
<tr>
<td>Match Change Deadline</td>
<td>28 Oct 2015</td>
</tr>
<tr>
<td>Rank List Deadline</td>
<td>11 Nov 2015</td>
</tr>
<tr>
<td>Match Day</td>
<td>2 Dec 2015</td>
</tr>
<tr>
<td>NRMP Close</td>
<td>16 Nov 2015</td>
</tr>
<tr>
<td>Fellowship Close</td>
<td>1 Jul 2016</td>
</tr>
</tbody>
</table>

Resources and Practical Information

- AAHPM Website: [http://aahpm.org/fellowships/match](http://aahpm.org/fellowships/match)
- AAHPM sponsored Match Webinar 1/22/15
  - ERAS
    - Jennifer Nelson, Fellowship Programs Specialist:
      - jnelson@aamc.org
    - ERAS HelpLine: erashelp@aamc.org or (202) 828-0413
  - Match
    - Jeanette L. Calli, Director of Match Operations:
      - jcalli@nrmp.org
      - support@nrmp.org or (866) 653-NRMP

COMMUNICATION AND CODE OF CONDUCT

Wayne McCormick, MD, MPH
University of Washington
Harborview Medical Center
Palliative & Long Term Care Services
mccorm@uwashington.edu
Objective

• Apply Match etiquette techniques during interactions among applicants, program directors, and staff

Post-Interview Communication

• Practices vary widely and are often problematic for PDs and for applicants

• If we talk through this issue and reach a common agreement about how to behave, we will be off to a good start!

• First the Rules....

Communication Code of Conduct

• Respect an applicant’s right to privacy and confidentiality (PD can express interest in a candidate, but applicant does not have to say anything about preferences, intentions, etc)

• PD accepts responsibility for the actions of the entire recruitment team (buck stops here – disseminate these rules)

• Refrain from asking illegal or coercive questions (about age, gender, etc)
• Decline to require second visits or visiting rotations

• Discourage unnecessary post-interview communication – OK to discuss particular details of the program later, but avoid disingenuous matters that might unduly influence the applicant

• [www.nrmp.org/code-of-conduct/](http://www.nrmp.org/code-of-conduct/)

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**Communication Code of Conduct – Current State of Affairs**

• Varies from no communication to statements like
  – “ranked to match”
  – “ranked highly”,
  – “we’re very interested in you”

• This can take up quite a bit of time for PD, staff

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• A quarter of students report that communications from programs regarding likelihood of matching leads them to change their rank lists.

• In another study, 20% of students felt assured they would match and did not, indicating misleading communication from PD

• Uncertainty about how to communicate is stressful to all and is especially hard on applicants
Solutions

• It is OK to communicate post-interview with applicants, but PD and staff should limit communications to factual programmatic information
• PDs should be precise and honest in communications. PD can tell an applicant they are “ranked to match” if in fact they are ranked in a position less than the total number of positions. This is a so-called “lock” position.

“Ranked to Match” or “Ranked Highly” can mean that an applicant is ranked within the point a program historically fills (which we will not know for several years!) but not a “lock”. It is better to explain this fully rather than use lingo.
• Oddly enough, NRMP does not prohibit programs from telling an applicant their rank position.
• THE PROGRAM MAY NOT SOLICIT RANK INFORMATION FROM THE APPLICANT!

• We should discourage follow up thank you notes or emails and let applicants know that these will not receive a reply. Objective questions can of course be answered (# electives, etc...).
• It is suggested that the personnel responsible for communication with applicants be limited to a few and these persons fully understand the rules.
• Second visits neither required nor encouraged.
PRACTICAL ASPECTS AND ADVICE

Stacie Levine, MD
University of Chicago
slevine@medicine.bsd.uchicago.edu

Objectives

• Discuss practice for interview preparation

• Share what a typical interview day is like

• Determine the process for ranking candidates

• Consider current interview practices and develop action plans to prepare for Match

Review of our Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERAS with early registration options</td>
<td>Spring 2015</td>
</tr>
<tr>
<td>NRMP Online Program Information Update</td>
<td>1 May 2015</td>
</tr>
<tr>
<td>NRMP Portal Open</td>
<td>1 May 2015</td>
</tr>
<tr>
<td>NRMP Portal Close</td>
<td>15 Jul 2015</td>
</tr>
<tr>
<td>Rank List Close</td>
<td>30 Jul 2015</td>
</tr>
<tr>
<td>Match Day</td>
<td>2 Nov 2015</td>
</tr>
<tr>
<td>Fellowship Start Date</td>
<td>1 Jul 2016</td>
</tr>
</tbody>
</table>
Housekeeping

- Make sure your website is up to date
- Know data about your graduates – where are they now?
- Prepare your faculty
  - Expectations, interview etiquette
  - Program history and evolution
  - Details on curriculum, electives, scholarly projects
- Detecting the “red flags” or potential problems
- Get meetings with program coordinator on the calendar

Reviewing Applications

- Decide what your criteria are
  - Does Visa status matter?
  - What makes an application stand-out?
  - What would be your “red flags”?
- Who should review the applications?

Inviting the Applicants

- Decide how many you have capacity to interview
- Some programs pre-screen via telephone
- Pick the interview dates in advance to allow people to block off their schedules
- Do you cover travel costs?
Preparing for the Interview

• How many people should interview the candidate?
• How long should the interview day take?
• Who should interview the candidate?
• How much time should be allotted per interviewer?
• How many candidates should you interview per day?

Questions you shouldn’t ask

• How serious are you about coming here?
• Do you plan on starting a family during fellowship?
• What is your ethnic background?
• Are you married/dating anyone?
• Do you practice an organized religion?
• What is your national origin?
• Where were you born?
• How old are you?
• What do your parents do for a living?
• What programs are you interviewing at?

What makes a candidate stand out?

• Has done their homework, knows details about your program
• They have a vision for themselves
• They will bring “greatness” to the field/your program
• Maturity, understand challenges
• What else?
The Rank List

• Convene meeting of core group to discuss rank list
• Interview checklist
  - may help guide ranking
• There is no limit to number of people you rank
• Do not rank anyone you have serious concerns about
• Ranking still can be subjective or “gestalt”

Group Discussion

What are your current interview practices pre-Match?

What will you be changing in preparation for the Match?

Write down three – five action plans you will take home with you

GO TO THE AAHPM WEBSITE FOR MORE INFORMATION:
http://aahpm.org/fellowships/match

Special thanks to Dawn Levreau!
# Preparation for the Match

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring 2015</td>
<td>ERAS emails registration invitations</td>
<td>✓ Update internal website</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Familiarize with ERAS functionality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Prepare for incoming 2015-2016 fellows</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Designate application review committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Designate interview committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Prepare faculty and other interviewers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Block off interview dates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Schedule meetings with program coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Schedule meetings with GME office (if need be)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Block off your summer schedule (busiest time)</td>
</tr>
<tr>
<td>May 1, 2015</td>
<td>NRMP online program information update</td>
<td>✓ Familiarize with NRMP website functionality</td>
</tr>
<tr>
<td>June 2015</td>
<td>Applicants may start working on ERAS</td>
<td></td>
</tr>
<tr>
<td>July 15, 2015</td>
<td>ERAS opens</td>
<td>✓ Review applications</td>
</tr>
<tr>
<td></td>
<td>• Applicants begin applying to July cycle programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Programs begin receiving applications</td>
<td>✓ Invite applicants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Interview applicants (August – October)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Schedule rank day with interview committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 29, 2015</td>
<td>Match opens (Noon, EST)</td>
<td></td>
</tr>
<tr>
<td>September 30, 2015</td>
<td>Rank list opens (Noon, EST)</td>
<td></td>
</tr>
<tr>
<td>October 28, 2015</td>
<td>Quota change deadline (11:59 PM, EST)</td>
<td></td>
</tr>
<tr>
<td>November 11, 2015</td>
<td>Rank list deadline (9 PM, EST)</td>
<td>✓ Finalize and submit rank list</td>
</tr>
<tr>
<td>Date</td>
<td>Event/Action</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>December 2, 2015</td>
<td>Match Day!</td>
<td>Match data available through NRMP website</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>Applicants begin their fellowship training</td>
<td></td>
</tr>
</tbody>
</table>

Additional Action Plans:

1)

2)

3)
ACGME update
Gary Buckholz, MD, FAAHPM

Objectives
• Analyze the Singapore milestone data
• Review the self-study timeline, objectives and process
• Describe changes to the common program requirements

NAS: past, present
• Formation of CCC
• Experience with and reporting of context-free milestones
• 4b, not applicable option?
NAS: present, future

- Challenges of having many primary specialty sponsors
- Unclear what data will trigger more detailed review
- CLER visits
- Self-study

The 10-year Self-Study

- A comprehensive review of the program
  - Using the Annual Program Evaluation
  - Information on how the program creates an effective learning and working environment
  - How this leads to desired educational outcomes
- Analysis of strengths, weaknesses, opportunities and threats, and ongoing plans for improvement
- Subspecialty Programs
  - Core and subspecialty programs reviewed together
The 10-year Self-Study: Scope

- Assesses current performance and ongoing improvement effort
- Covers the period between Self-Study Visits
  - Initially: the period since last accreditation review
  - Eventually, a 10-year interval
- Reviews program improvement activities, successes achieved, and areas still in need of improvement
  - Uses data from successive Annual Program Evaluations, ACGME data, other relevant information
- Conducted 1 year before the Self-Study Visit date

The 10-year Self-Study: Timeline

<table>
<thead>
<tr>
<th>Time prior to Self Study Visit</th>
<th>ACGME Actions</th>
<th>Program Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-12 months</td>
<td>1. Sends summary of actions/follow-up from Annual Data Review</td>
<td>1. Aggregates data from Annual Program Evaluations</td>
</tr>
<tr>
<td>6-11 months</td>
<td></td>
<td>1. Conducts Self Study</td>
</tr>
<tr>
<td>4 months</td>
<td>1. Sets FINAL Self-Study Visit Date and informs program</td>
<td></td>
</tr>
<tr>
<td>10 days</td>
<td></td>
<td>1. Completes ADS data update</td>
</tr>
</tbody>
</table>

Objectives of the 10-year Self-Study

- **Assess** ongoing compliance and improvement in all dimensions
- **Focus on**
  - Program Strengths
  - Program Areas for Improvement
- **Track** ongoing improvements and the success of actions taken
- **Consider**
  - Program Aims
  - The program’s external environment
    - Environmental Opportunities
    - Environmental Threats

© 2014 Accreditation Council for Graduate Medical Education
Examples of Program Aims

- Provide a comprehensive 3 year curriculum to enable residents to learn tertiary, secondary, and primary care skills in all settings.
- Educate residents to be excellent practitioners of medically directed anesthesiology in an Anesthesia care team model.
- Train individuals with expertise in population health and serving medically underserved.
- Produce excellent, independent practitioners who will be local and national leaders, and for academic careers.

Benefit of a Focus on Strengths, Areas for Improvement, Opportunities and Threats

- Facilitates assessment of the program’s performance in its local environment
- What are program strengths?
  - What should definitely be continued (important question in an environment of limited resources)
- What are areas for improvement?
  - Prioritize by relevance to program aims, compliance, importance to stakeholders
- Useful for all programs, but particularly high-performing programs: “What will take our program to the next level?”

Sample Improvement Plan

<table>
<thead>
<tr>
<th>Area for Improvement</th>
<th>Issue(s)</th>
<th>Improvement Plan</th>
<th>Group Responsible</th>
<th>Target Completion Date</th>
<th>Follow-up</th>
</tr>
</thead>
</table>
| Dissemination of Goals and Objectives | • Posted on Intranet (fails to reach)  
• Not accessible  
• Not known how this is utilized by residents and faculty | • Educate residents and faculty  
• More prominent placement on Intranet (1-4th)  
• Make accessible/visible in every setting  
• Integrate with resident formative evaluations | 2 residents and 1 faculty member (names) give them credit for work | June XXXX for implementation at start of new academic year | Quarterly survey regarding effectiveness of new approach  
• Spot check |
NAS: future

- AAHPM
  - Development of EPAs
  - Development of curricular milestones
- AAHPM / ACGME collaboration
  - Potential modification of reporting milestones

Program requirements

- Major revision process
  - Oct 2013 to Nov 2014
- Changes effective July 2015
  - Part-time training of fellows
  - Program Director support
  - Experience of PD
  - Other significant faculty, 10 hrs
  - Time in hospice

Program requirements

- Changes effective 2015, continued
  - Faculty to fellow ratio
  - Patients seen longitudinally across settings
  - “Participation” in a system improvement project
  - Chemical dependency curriculum
  - Provision of “basic” counseling
  - Ability to do HPM training after 3 years of residency training for most sponsoring specialties
Hospice & Palliative Medicine
Entrustable Professional Activities:
Who is trusting whom with what?

Lindy H. Landzaat, DO
Laura J. Morrison, MD
AAHPM HPM Curricular Milestone/EPAs Workgroup
February 25, 2015

EPA Workgroup

Physician Members
• Laura Morrison, Chair
• Lindy Landzaat, Assoc. Chair
• Michael Barnett
• Gary Buckholz
• Jillian Gustin
• Jennifer Hwang
• Stacie Levine
• Tomasz Okon
• Skip Radwany
• Holly Yang

AAHPM Support from:
• Margaret Rudnik
• Julie Bruno
• Dawn Leveau
• Steve Smith
• Academic Palliative Medicine Task Force
• Shaping the Future Campaign

EPA/Curricular Milestones Workgroup

Task: lead a consensus process to define key educational components for our field

EPAs & Curricular Milestones together will define the critical tasks, developmental progression, and assessment needs for the HPM fellow
Objectives

By the end of the session, participants will be able to:

• Define & explain the differences between Curricular Milestones, Reporting milestones, & Entrustable Professional Activities (EPAs)
• Describe the initial draft of HPM EPAs
• Consider strengths & limitations of the EPA list

Outline

o Definitions
  o Comparing and Contrasting
  o HPM EPA Development
  o Vetting the EPAs
  o Future of the EPAs

Definitions

o Reporting Milestones
o Curricular Milestones
o Entrustable Professional Activities
Reporting Milestones (RM)

- Sometimes called Educational Milestones
- “Significant point in development”
- Observable developmental steps
- Describe a trajectory of progress

ACGME Website on Milestones, www.acgme.org

Reporting Milestones (RM)

- HPM (11 primary specialties) using Internal Med Subspecialty RM
- 23 Reporting Milestones—No 4a
- Reported to ACGME every 6 months

“Of EPAs, Curricular Milestones, and Reporting Milestones, **only the **Reporting Milestones are **required** as part of the accreditation process in the NAS”

Internal Medicine Subspecialty Reporting Milestones
Frequently Asked Questions
ACGME Website
Curricular Milestones (CM)

- Sometimes called Developmental Milestones
- Granular descriptions of knowledge, skills, and attitudes
- Describe competent behavior over the training course
- Curricular milestones are specialty specific
- Assist in curricula and assessment development

Hospice & Palliative Medicine Core Competencies

- Sometimes called "companion document" by ACGME
- Describes what is expected of fellows in 6 core competencies
- New Pediatric version

HPM Competencies

Hospice and Palliative Medicine Competencies Project

http://aahpm.org/fellowships/competencies
Raising the Bar for the Care of Seriously Ill Patients: Results of a National Survey to Define Essential Palliative Care Competencies for Medical Students and Residents.

Schaefer KG, Chittenden EH, Sullivan AM, Periyakoil VS, Morrison LJ, Carey EC, Sanchez-Reilly S, Block SD. Academic Medicine, Vol. 89, No. 7 July 2014

HPM Competencies for Medical Students & Residents

EPAs in teaching settings

- Supervisors decide when & what tasks/responsibilities they entrust to trainees
- Entrustment → unsupervised execution after attaining sufficient competence
- Do you trust your student driver to...
  - Drive alone on highway?
  - Parallel Park the car himself?
Conditions of Entrustable Professional Activities

1. Are part of the essential professional work of the specialty and not general medical ability
2. Must require adequate knowledge, skill, and attitude
3. Must lead to recognized performance that is unique to a doctor
4. Should be unique to physicians in that specialty
5. Should be independently executable
6. Should be executable within a time frame
7. Should be observable and measurable in its process and outcome (well done or not well done)
8. Should reflect one or more of the ACGME competency categories

Shaughnessy, AF et al.

Conditions of Entrustable Professional Activities

1. professional work of the specialty
2. require knowledge, skill, and attitude
3. unique to a doctor
4. unique to specialty
5. independently executable
6. executable within a time frame
7. observable and measurable
8. competency based

Shaughnessy, AF et al.

AAMC’s 13 Medical Student EPAs

Core Entrustable Professional Activities for Entering Residency (CEPAER)

www.aamc.org/cepaer

1. Give a history and perform a physical examination in a patient with a cardiac condition.
2. Develop a differential diagnosis and select a final diagnosis for a patient with a common disease (example: diabetes).
3. Protect patients from harm, including self-harm, by implementing appropriate interventions (example: opioids).
4. Participate in a research study and obtain informed consent from patients (example: clinical trial).
5. Administer a drug correctly and monitor its effects (example: anticoagulant therapy).
6. Provide care for patients with a chronic condition (example: diabetes mellitus).
7. Communicate effectively with patients and families (example: management of chronic pain).
8. Manage patients with psychological disorders (example: depression).
10. Use technology to enhance patient care (example: electronic health records).
11. Manage patients with a specific disease (example: asthma).
12. Perform surgical procedures (example: skin biopsy).
13. Perform procedures related to patient care (example: phlebotomy).

www.aamc.org/cepaer
EPAs vary in granularity

**Internal Medicine**
- Identify and manage acute, emergent problems
- Admit and manage a medical inpatient with an acute exacerbation of a chronic problem on a medical floor

**Family Medicine**
- Managing the patient with neck pain
- Managing the patient at risk for diabetes
- Managing the child with a cough
- Managing the older confused patient


---

EPAs vary in granularity

**Internal Medicine**
- Identify and manage acute, emergent problems
- Admit and manage a medical inpatient with an acute exacerbation of a chronic problem on a medical floor

**Family Medicine**
- Managing the patient with neck pain
- Managing the patient at risk for diabetes
- Managing the child with a cough
- Managing the older confused patient

Shaughnessy AF, et al.

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Putting this all together
Curricular Reporting EPAs EPA Tool

Bakes a Cake

- Competent for unsupervised practice as a Baker

Baking Knowledge

Follows simple recipes but can not frost or decorate

Offers different sizes, flavors, and simple frosting decoration

Designs complex cakes incorporating customer requests

What is the learner expected to learn during training?

What are development landmarks by which we measure & report progress?

What are the expected practices of a fully trained professional in our field?

What reliable tools do we evaluate with?

Competent for unsupervised practice as a Baker

Curricular Reporting EPAs EPA Tool

Bakes a Cake

- Competent for unsupervised practice as a Baker

Baking Knowledge

• Cracks eggs without spilling eggshell into batter

• Measures flour accurately

• Uses mixer appropriately

Baking Knowledge

What is the learner expected to learn during training?

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What is the learner expected to learn during training?

What are development landmarks by which we measure & report progress?

What are the expected practices of a fully trained professional in our field?

What reliable tools do we evaluate with?

Competent for unsupervised practice as a Baker
### EPA Workgroup Process

| May 2014 | • Workgroup formed  
|          | • Education and benchmarking  
|          | • Initial EPA list drafted  
| June 2014 - January 2015 | • Working in dyads, drafted EPA  
|          | • Each drafted EPA reviewed by each member  
|          | • Each drafted EPA reviewed by committee  
| February 2015 | Vetting with colleagues at AAHPM  
| March - April 2015 | Revisions of EPA based on feedback  
| April - May 2015 | Community / Large Group Vetting  
| June 2015 | Final EPA list released  

### References

See HPM EPA Resource List  
Separate Handout
HPM EPA Resource List

AAMC’s Core Entrustable Professional Activities for Entering Residency available at
http://www.aamc.org/cepaer

ACGME “Milestones FAQ” August 2014.
www.acgme.org/acgmeweb/tabid/430/ProgramandInstitutionalAccreditation/NextAccreditationSystem/Milestones.aspx

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A Practical Guide to the ACGME Self-Study

Editor’s Note: The ACGME News and Views section of JGME includes data reports, updates, and perspectives from the ACGME and its review committees. The decision to publish the article is made by the ACGME.

On July 1, 2014, the second group of programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) entered the Next Accreditation System (NAS), and all programs are now functioning under the principles of NAS, which include continuous accreditation via annual reviews of data, lengthening the interval between scheduled accreditation visits, and a focus on educational outcomes. The aims are to reduce the burden of accreditation, contribute to ongoing program improvement, and allow high-performing programs to innovate. The focus on improvement calls for a new approach to self-assessment, and the model is a Self-Study undertaken by the program, producing a record of improvements and areas still being worked on, followed by Self-Study Visit (SSV). The SSV has 2 objectives: assess the program’s current status and compliance with the relevant requirements, and review the record of improvements made since the last scheduled accreditation review.

This practical guide to the ACGME Self-Study and the SSV is based on the deliberations of ACGME senior staff who designed elements of the NAS, and on test visits to nearly 40 accredited programs to pilot the new elements of the Self-Study and associated site visit. These visits explored the utility and value of the new dimensions of the Self-Study: use of longitudinal data from the Annual Program Evaluation to record programs’ ongoing improvements and a new focus on program aims, and opportunities and threats.

The authors would like to thank the leadership, faculty, and residents of the nearly 40 accredited programs that participated in the Self-Study test visits held between 2012 and 2014 for their willingness to take the time to participate, and for their frank discussion and feedback on the Self-Study process. We would also like to recognize the contributions of the members of the field staff who participated in the Self-Study test visits, particularly William W. Robertson Jr, MD, MBA; Serge Martinez, MD, JD; Donna Caniano, MD; John Coyle, MD; Judith Rubin, MD, MPH, and Barbara Bush, PhD, and the members of the ACGME senior leadership team who helped refine the approach.

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1. The Self-Study Committee

Given its role in the Annual Program Evaluation, the Program Evaluation Committee (PEC), or a slightly expanded group with additional faculty and residents will be ideally suited to serve as the core body for the Self-Study. The members of the PEC are already involved in planning and evaluating educational activities, reviewing and revising curricula, addressing areas of noncompliance, and conducting the Annual Program Evaluation. In addition, given the focus on educational outcomes, it may be useful to have a representative from the Clinical Competency Committee on the Self-Study Committee.

Subspecialty programs will appoint their own PEC, but it is important to note that the SSV for a subspecialty program will be coordinated with that for its core program, and there may be benefit in coordinating the Self-Study. The reason for the coordinated approach is that in NAS, the ACGME places more responsibility for the oversight of subspecialty programs on the core program, and there are dimensions such as faculty development, scholarly activity, or access to educational resources such as simulation, where the core programs and its subspecialty programs may benefit from a coordinated approach.

2. Longitudinal Annual Program Evaluation Data

The Self-Study constitutes an in-depth assessment of the program that examines longitudinal data from all annual evaluations since the program’s last scheduled accreditation review. Depending on the timing of the Self-Study, it may also incorporate the Annual Program Evaluation for the current year. For visits scheduled in 2015 and 2016, programs are expected to track improvements since the last scheduled review, generally the prior 5 to 6 years. The information collected should highlight strengths, areas where improvement has been achieved, and areas still in need of improvement. For areas for improvement, the focus should be on each year’s action plans (V.C.3 (Core)), records of progress on the previous year’s action plans (V.C.2.e (Core)), and documentation in PEC meeting minutes that relate to the action plans (V.C.3.a (Detail)). This information can be entered into a simple table or spreadsheet to create a longitudinal record of the improvements achieved.
In addition to data from the Annual Program Evaluations, the Self-Study Committee may explore what other existing data (such as information collected by the sponsoring institution) may be of value to the Self-Study.

3. Program Aims

Program aims are a new dimension for the Self-Study. They offer added context for a program’s improvement efforts by focusing on program and institutional leaders’ key expectations for the program, and are elicited through responses to the question, “What types of residents is the program educating; what are their future roles and practice settings?” Aims may focus on some or all of these dimensions: types of trainees accepted into the program, training for particular career options (clinical practice, academics, research, primary/generalist care), and added objectives, such as care for underserved patients, health policy or advocacy, population health, or generating new knowledge.

4. Strengths and Areas for Improvement

The longitudinal data from the Annual Program Evaluations will offer information on Strengths and Areas for Improvement that, at minimum, will address the 4 dimensions of program evaluation stipulated by the Common Program Requirements (V.C.2) (Core) as shown in Box 2. These dimensions can serve as the basis for the assessment of strengths and areas for improvement. In addition, programs may wish to broaden the assessment by surveying residents and faculty about strengths and areas for improvement as part of their Self-Study.

The Self-Study test visits revealed a wide range of program strengths, including faculty experience, capabilities and dedication, and resident excellence and caring. Common areas for improvement related to the need to enhance the capabilities of vendor-provided residency management suites to generate useful data for Clinical Competency Committees, and faculty development needs, particularly needs related to faculty members’ expanded role in making Milestone assessments.

5. Opportunities and Threats

A new dimension of the Self-Study is the focus on opportunities and threats. Opportunities are factors beyond the immediate control of the program that, if acted upon, contribute to enhanced success, while threats are factors that could have a negative effect. Assessing the environment for opportunities and threats could be an ongoing activity, but at minimum, the Self-Study Committee and program leaders should examine these dimensions as part of the Self-Study.

Exploring opportunities and threats is relevant to program sustainability by considering factors that may assist with, or detract from, the program succeeding and achieving its aims in the future. For example, the Self-Study test visits to several primary care programs revealed common threats for programs that depend on community settings for resident experiences. Added pressure for clinical productivity on community practitioners, and practices being assumed into delivery networks under the Affordable Care Act reduced community faculty ability and willingness to serve as preceptors for residents. A benefit of identifying potential threats is that it facilitates the development of contingency plans for dealing with them.

6. Aggregating the Self-Study Findings

The next step entails aggregating the data collected and examined during the Self-Study process. The documentation of the findings should ensure the program has considered how strengths will be maintained, has prioritized the areas for improvement, and has developed plans for what improvements will be made and how success will be tracked. The discussion should ensure that program leadership takes advantage of opportunities, and that threats are considered and addressed.

7. Discussion of the Findings by Program Leaders and Constituents

The primary aim of the Self-Study is to assist in ongoing efforts at program improvement. In this context, its value is greater when there is input from the faculty, residents and fellows, and any other constituents relevant to the program. When discussing the data from the Self-Study with these stakeholders, program leadership should ask them to reflect on program improvement and challenges that still face the
program, using the information collected during the Self-Study.

8. The Self-Study Document

In the final step, the Self-Study Committee should synthesize the information into a succinct Self-Study report that focuses on strengths, areas for improvement, opportunities and threats, and an action plan for addressing priority areas for improvement. Consistent with an improvement model, programs are expected to indicate both strengths and areas still in need of improvement in the document. An outline showing the elements of the Self-Study document is shown in Box 3.

The Self-Study document should offer insight into how prior areas for improvement were addressed, as well as any high-level information about current areas still in need of improvement. The document should not exceed 2500 words (about 7 pages of single-spaced narrative). Programs are expected to upload their final updated report through the Accreditation Data System (ADS) 10 days prior to the SSV.

**The Self-Study Site Visit**

The first group of Phase I programs is scheduled for an SSV in late spring and summer of 2015. Programs scheduled for an SSV in the last months of academic year 2014–2015 will need to initiate their Self-Study in the fall of 2014.

The ACGME will give programs 90 to 120 days of advance notice for the exact date of the SSV. Programs should upload their Self-Study document to reflect any recent improvements in high-priority areas identified during the Self-Study, and also update the narrative sections in ADS.

A survey team made up of 2 or more accreditation field representatives will visit the program, or the core program and its associated subspecialty programs. Visits for a core program will generally be a full day, while visits for a subspecialty program may involve a half-day or less for a smaller subspecialty. Prior to the visit, the team members will review the materials submitted by the program in detail. At the time of the SSV, program leaders should be able to describe action plans for addressing key areas for improvement, and might be able to provide early data on the success of these efforts.

During the visit, the survey team will develop a list of strengths, areas for improvement, and opportunities and threats based on the program’s report and information gathered during interviews and review of documentation. At the conclusion of the site visit, selected strengths and areas for improvement will be shared as verbal feedback with the program leadership. This feedback does not include any recommendations about compliance with standards or the program’s accreditation status; these decisions are the prerogative of the Review Committee.

**Conclusions**

An effective Self-Study requires participation from program leadership, residents and fellows, faculty members, and any other constituents, with a frank assessment of the program’s strengths and areas for improvement. There also is benefit in an approach that provides transparency through sharing the findings with constituents and eliciting their reaction. Finally, programs may benefit from exploring other uses of the data from their Self-Study. The effort of conducting a Self-Study can be offset by the uses and value of the information gathered for the given program.

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