Governance of Residency Training and Ophthalmology Accreditation

The Accreditation Council for Graduate Medical Education/ Ophthalmology Residency Review Committee
The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits medical residency programs in the United States. The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians’ education through accreditation. The ACGME is represented on the Board of the ABMS and vice-versa. The strategic plans of both organizations are currently in alignment, with the goals of providing excellence in accreditation and certification, respectively. The 2006-2008 ACGME Strategic Plan states the organization’s overall goal is to make the ACGME an exemplary accrediting organization based on:

- Accountability: By accountability we mean processes and results that are: open and transparent; responsive to the educational community and the health of the public; reliable; valid; and consistent.
- Excellence: By excellence we mean: accreditation that is efficient and effective; outcomes-based; improvement-oriented; and innovative.
- Professionalism: By professionalism we mean: that our actions are: respectful and collaborative; responsive, ethical and fair.

The ACGME Strategic Plan indicates that Exemplary Accreditation will be characterized by:
- encouraging program flexibility and innovation;
- reinforcing quality educational outcome measures;
- efficiently gathering “real time” data;
- building and recognizing community.

Three major outcomes of the ACGME Strategic Plan, include the resident toolbox, the resident learning portfolio and the development of educational milestones.

Resident Toolbox: Series of tools and evaluations to assess competencies
- New tools will compose the “toolbox” of assessment of the ACGME competencies. Teaching and assessing the competencies requires psychometrically valid, reliable, and easy to use tools. The traditional model of residency education relied most heavily on three basic tools: 1) multiple choice question written examinations, 2) oral examinations, and 3) qualitative global ratings by rotation preceptors. These three tools alone are not sufficient to adequately measure the competencies.
- A Task Force at the University of Iowa has identified ophthalmology-specific tools.

Resident Portfolio: Personalized web portal to house residency training information
- Capture outcomes-based data for accreditation system for use in creating national standards for performance in each specialty
- Create web-based, nationally developed specialty-specific evaluation tools to meet educational Milestones
- Capture learning experience, reflect on learning experience, integrate experiences and receive formal and informal assessments
- One-stop for residents, can include CV, test scores, abstracts, procedures, didactic learning sessions

Milestones:
- Educational Milestones are expectations that each resident must meet competencies appropriate to his/her clinical discipline at key points in his/her progression toward initial specialty certification. The establishment of Milestones gives the ACGME and the educational community specialty-specific benchmarks of performance along the path to proficiency in each domain of clinical competency against which residents’ performance can be measured.
- The milestones will allow programs to be tracked and evaluated on the progress their learners demonstrate against these expectations. At appropriate points during their education, residents’ performance will be below, at, or above the expectation of the specialty for their educational level. The
ACGME would be able to look at the percentage of residents who have met or exceeded each milestone and compare that rate to a national average of all programs in the specialty. The ACGME anticipates that this information will be available to each RRC, on a twice yearly basis.

- ACGME will work with American Board of Medical Specialties to develop tools to be used in each specialty in the competencies of medical knowledge, patient care, and Practice-Based Learning and Improvement.
- Collectively, the organizations will have the ability to assure the public and our residents that we have established specialty specific educational outcomes and can demonstrate proficiency in those outcomes.

The ACGME carries out its mission through the dedicated work of its staff and volunteers. The 100-plus employees of the ACGME, 27 Board members, more than 200 Review Committee members, and thousands of program directors and designated institutional officials work together as a team. In their different positions, they all contribute to the ACGME’s mission of assessing and advancing resident physicians’ education through accreditation. On the following pages, some members of the ACGME community reflect on their roles within the ACGME.

**Ophthalmology Residency Review Committee (RRC) (a fourth of the members are ABO representatives)**

Vice-Chair, Maria M. Aaron, MD, FACS
Ex-Officio, John Clarkson, MD
Martha J. Farber, MD, Chair
Mark S. Juzych, MD
Paul Daniel Langer, MD
Andrew G. Lee, MD
Resident Member
Todd J. Mondzelewski, MD
James C. Orcutt, MD
Howard D. Pomeranz, MD, PhD
Joel S. Schuman, MD
Raymond M. Siatkowski, MD
(Anthony Arnold will begin in July 2010.)

Recently, the ACGME approved the following “focused” change to the program requirements, which becomes effective July 1, 2009. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Ophthalmology (ABO) regarding the resident performance on the certifying examination. The program should: (a) maintain a pass rate on both the written and oral examination of the American Board of Ophthalmology for first-time examinees from the program that is equal to or greater than 60% averaged over the past five years, and (b) have 80% or more of those eligible to take the examination over the past five years actually take the examination.

**Competency Assessment Methods Used by Ophthalmology Residency Programs**

There are common program requirements and ophthalmology specific program requirements. There is not a universal curriculum. Competency assessment methods being used by ophthalmology residency programs, include:

**Observed Patient Encounter and Evaluation (OCEX)**

- A one-page evaluation form which evaluates a resident’s interaction with patients. The form is designed to be completed by an attending ophthalmologist while observing a resident/new patient interaction and the resident’s case presentation afterwards. The attending assesses factors such as interview skills, the traditional eight parts of an examination, interpersonal skills, professionalism and case presentation. Once the form is filled out, he discusses the results with the resident.
- The OCEX form includes a scoring rubric that defines what each score actually means. “For example, you might wonder how someone can ‘exceed expectations’ when taking a family history.” “The rubric explains that this means ‘obtained subtle, relevant details of family history.’ ‘Meets expectations’ would be the
appropriate grade if the resident simply obtained important details. Recent studies have confirmed that the OCEX shows both reliability and validity, meeting the ACGME's criteria for an acceptable assessment tool.

**On Call Assessment Tool (OCAT)**
- The OCAT is a self-audit of consecutive resident on-call charts. The OCAT checklist tasks represent the important issues in examining the ophthalmic patient on call. The tasks for evaluation of the OCAT were selected from educational objectives and from generally accepted and previously published norms of on call practice. The specific tasks in OCAT were selected using a formal task analysis that was based in part on survey data of faculty at a single tertiary care teaching hospital (The University of Cincinnati) but agreed upon by consensus with a second teaching institution (The University of Iowa).
- A retrospective chart audit of consecutive resident on-call charts was performed at the University of Cincinnati and the University of Iowa, and resident performance was scored using the OCAT. A consensus of faculty comments established the face and content validity of the OCAT. One hundred ninety-one on-call consultations were assessed. Timeliness of consultation was the most common category receiving a borderline or unsatisfactory rating. Borderline ratings in knowledge-based categories (history, examination, assessment and plan, urgency rating) occurred more often for postgraduate year 2 (PGY2) residents than for PGY3 residents (P = 0.05, chi-square test). Incomplete differential diagnosis (n = 6) and lack of follow-up instruction (n = 5) were the most common deficiencies observed.

**Eye Surgical Skills assessment Test (ESSAT)**
- ESSAT is a laboratory-based surgical skills 'obstacle course' which was developed in response to the need for improved tools for the assessment of surgical skills during residency.
- Twenty-seven content experts (program directors and faculty members involved in resident surgical training) watched videos of junior and senior residents completing the three ESSAT stations (skin suturing, muscle recession and phacoemulsification: wound construction & suturing technique) and filled out assessment forms, task specific checklists and a global rating scale of performance.
- ESSAT demonstrated good inter-rate reliability for determining whether residents "passed" each section. In addition, at each station the senior resident was consistently rated above the pass threshold whereas the junior residents were more often rated below. It is the conclusion of the authors that ESSAT is a useful tool that should be integrated into all residency programs.

**Objective Assessment of Skills in Intraocular Surgery (OASIS)**
- OASIS is a one-page form filled out largely by the trainee, although part of the purpose of the form is to inspire interaction with the attending, who may participate in completing the form and/or use it as a basis for questioning and comments. It tracks preop information, including indication, type of cataract, axial length, intraocular pressure, size of pupil and risk factors; intraoperative events such as loss of vitreous; and postop information such as acuity, inflammation and induced astigmatism. The form is meant to be filled out after every surgery. Once completed, the data is entered into a computer database that tracks it cumulatively over time.

**Global Rating Assessment of Skills in Intraocular Surgery (GRASIS)**
- GRASIS is also one page. It monitors 10 different, more subjective attributes important to being a well-rounded surgeon. These include bedside manner, interaction with the staff, use of instruments, centration of the microscope, preop planning, knowledge of the patient's history, surgical flow, and knowledge of the surgery.
- GRASIS is usually filled out by the attending surgeon, although if the resident also fills it out, comparing the two perspectives can be very educational. GRASIS can be used after every case to show how the resident is progressing. OASIS and GRASIS are intended to be complementary.

**Question and Answer with RRC Member and ABO Board Director, Dr. Jim Orcutt:**
Q. Is the current RRC working on the toolbox for assessing the competencies in ophthalmology? If not the RRC, then who?
A. The RRC provides a background of tools (i.e. toolbox) from which program may select in order to meet the competency requirements for their program. The RRC then evaluates at the time or reaccreditation if the program is adequately meeting this goal. The RRC does not require specific tools but does require an assessment program that focuses and evaluates all the competencies.

Q. Is there a common ophthalmology-specific curriculum required for each program? i.e., like the POC. Who develops this, updates it?
A. The ACGME and RRC publish program requirements that must be taught in the program. However, these requirements are much less detailed than the POC format. For instance must learn about “uveitis” but the POC might have several specific areas within uveitis in detail.

Q. What is the relationship between the RRC and the AUPO – how do they communicate and what is the level of collaboration?
A. There is a formal relationship between the RRC and the AUPO. The RRC reports to the ACGME as you know and that group has oversight. The AUPO is a professional organization of Chairs and Program Directors, and has oversight by the members of the organization. Having such a mission difference, to some might imply a possible conflict of interest. That said however, there is a close working relationship between the organizations. For instance every year at the AUPO meeting the RRC makes a presentation of what is new in the RRC. The AUPO often supports the development of tools for assessment of competencies which the RRC may put in a “tool box”.

General Comments:
As for the Milestones project, not much has been done to my knowledge in Ophthalmology. I was just reading an article from Internal Medicine who has milestones listed for the competencies and several step-wise assessments over the times of a residency with expected time frame of meeting the goals. I have not seen this in other surgical specialties, but then I might have my head under a rock or buried in the sand so have inquired of Pat Levenberg what is out there for surgical milestones.

In some ways, milestones for residency may be easier than ongoing MOC assessments. A resident is in a learning mode, assuming starting from no knowledge to that required to graduate and be a competent and independent provider. In practice we all learn and develop, but the goals and practice are different. Setting uniform milestones for a life-long practice seems to me impossible, and the model adopted by MOC of self evaluation, finding areas that may be improved and developing an improvement process makes much more sense. Some ramblings.

Q. In your experience on the RRC, what other tools or approaches to assessing the competencies are being developed and/or used?
A. Of the list provided the majority of programs use the OCEX. This is probably because it was one of the first developed and published. The surgery and on call assessment tools are only used sporadically, and often by the program where the author developed the tool. Of those the OCAT is probably the most commonly used. Assessments in the OR are much more rare, but some sites use an immediate debriefing after surgery as a mechanism to provide input, but unfortunately, this remains poorly documented.

There are other tools which get at the assessments as well, specifically the 360 degree evaluation. This can look at systems based practice, communications, ethics, patient care and professionalism. It does not however directly assess medical knowledge or surgical ability.

The portfolio has been touted as a tool that is useful, however, to me the portfolio is just a central collection of the other assessment tools so they are all in one place and can be cross correlated.

What is still used most commonly for “surgical competence” is meeting the minimum number of cases on average per resident in a program. However, this is obviously a misuse of these requirements. The numbers are there to be sure the program has enough clinical material to provide a basic education to residents. The numbers are average across all graduating residents, and does not at all reflect on a specific resident and his/her numbers.
Number do not equal competency, and this is poorly misunderstood. Many programs feel that if each resident achieves the average number then they will be “competent”. Nothing is further from the truth.

**Examples of Other Boards Collaboration with RRC**

**Pediatrics**
The American Board of Pediatrics has done the most (available) work to align certification with both initial and lifelong education. The ABPeds has a standing “Program Directors Committee” which developed a comprehensive “General Pediatrics’ Program Director’s Guide to the ABP.” This is an excellent example of alignment of training and certification. [see attached]

The ABPed also conducted an enormous project aimed at redesigning residency training, called the “Residency Review and Redesign in Pediatrics Project.” The project has morphed into the Initiative for Innovation in Pediatric Education (IIPE). A summary of this experience can be viewed: https://www.abp.org/abpwebsite/publicat/dipnews.pdf

The ABPed also updated its mission statement to include the competencies: The American Board of Pediatrics certifies general pediatricians and pediatric subspecialists based on standards of excellence that lead to high quality health care during infancy, childhood, adolescence, and the transition into adulthood. The ABP certification provides assurance to the public that a general pediatrician or pediatric subspecialist has successfully completed accredited training and fulfills the continuous evaluation requirements that encompass the six core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The ABP’s quest for excellence is evident in its rigorous evaluation process and in new initiatives undertaken that not only continually improve the standards of its certification but also advance the science, education, study, and practice of pediatrics.

For several decades, the ABPed has assimilated workforce data using questionnaires administered in association with its various examinations and through a tracking system that provides an annual update of residents and fellows in training. These data provide critical information regarding trainees and practitioners in pediatrics and the overall workforce landscape and are made public via the ABP Web site. In addition, various research initiatives regarding the pediatric profession have been implemented. This includes:

- Comprehensive Compendium of Research Publications from 2001-2009
- Future of Pediatric Education Projects
- Literature Reviews on developing topics or topics likely to impact practice: hospitalists, transition of care, pay for performance, inactive pediatricians

**Psychiatry and Neurology**
The ABPN publishes downloadable clinical skills evaluation forms for use by residency programs. They also offer “Pre-Cert” through an online portal that helps programs build and track resident progress, including clinical skills. It also facilitates communication between Board and programs regarding requirements and examinations.

**Otolaryngology**
ABOto provides a curriculum and a set of core surgical procedures to the programs. They also provide a handbook to residents. They also worked within their medical community to develop a specialty scope of knowledge report [see attached].

**Dermatology**
The American Board of Dermatology provides a table that lists the competencies and offers the programs suggested methods for evaluation of the competencies. The suggestions are similar to those listed in the ophthalmology-specific grid of assessment methods.

**Licensure Requirements**
As of the date of application and at all times throughout certification, the candidate must hold a valid and unrestricted license(s) to practice medicine in the United States, its territories or Canadian province in which the candidate’s practice of medicine is regularly conducted and in each other place in which the person practices or has practiced medicine and has an unexpired license. A candidate must notify the ABO of any action taken by a State Medical Licensing Board within sixty (60) days of such action. The definitions of restricted licensure and the exceptions to these definitions are described in the ABO’s Rules and Regulations.