The Next Accreditation System

Fellowship Program Directors
Pediatric Academic Societies
May 3, 2013

Mary W. Lieh-Lai, MD, FAAP, FCCP
Senior Vice President for Medical Accreditation
Princess Lieh Lai
Disclosures

- Full time employee of the ACGME
- A recovering:
  - Residency (1y) and Critical Care Medicine Fellowship (14y) Program Director
  - DIO (7y)
  - Pediatric Intensivist
- Slides: R&D (*Rip off and Duplicate*)
Aims of NAS

- Enhance the ability of the peer-review system to prepare physicians for practice in the 21st century
- To accelerate the movement of the ACGME toward accreditation on the basis of educational outcomes
- Reduce the burden associated with the current structure and process-based approach
  - Note: this may not be evident right away
Competencies/Milestones
Mid-late this past decade

- Competency evaluation stalls at individual programmatic definitions
- MedPac, IOM, and others question
  - the process of accreditation
  - preparation of graduates for the “future” health care delivery system
- House of Representatives codifies “New Physician Competencies”
- MedPac recommends modulation of IME payments based on competency outcomes
- Macy issues 2 reports (2011)
- IOM 2012-2013
How is Burden Reduced?

- Most data elements are in place (more on this later)
- Standards revised every 10 years
- No PIFs
- Scheduled (self-study) visits every 10 years
- Focused site visits only for “issues”
- Internal Reviews no longer required
Instead of biopsies, annual data collection
- Trends in annual data
- Milestones, Residents, fellows and faculty survey
- Scholarly activity template
- Operative & case log data
- Board pass rates

PIF replaced by self-study

High-quality programs will be freed to innovate: requirements have been re-categorized
(core, detail, outcome)
The Conceptual Change
From…

The Current Accreditation System

Rules

Corresponding Questions

“Correct or Incorrect”

Answer

Citations and Accreditation Decision

“Do this or else…..”
The Conceptual Change
To...

The “Next Accreditation System”

“Continuous”
Observations

Assure that the Program
Fixes the Problem

Number of Potential
Problems

Promote
Innovation

Diagnose
the Problem
(If there is one)
The Next Accreditation System
July 1\textsuperscript{st}, 2013
NAS Timeline

Phase I specialties
- Diagnostic Radiology
- Emergency Medicine
- Internal Medicine
- Neurological Surgery
- Orthopaedic surgery
- Pediatrics
- Urology

JGME 2012; 4:399
# Key Dates for Phase I specialties under NAS

ACGME News and Reviews, J Grad Med Educ, 2012; 4(3): 399

<table>
<thead>
<tr>
<th>Month &amp; Year</th>
<th>ACGME Activities</th>
<th>Program and Institutional Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring 2012</td>
<td>CPR &amp; PR for Phase I specialties categorized into core, detail &amp; outcomes</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>SV for Phase I programs with cycle length 3,4,5y moved to NAS</td>
<td>Completed</td>
</tr>
<tr>
<td>7/1/12-6/30/13</td>
<td>Phase I programs provide data including the annual ADS update, resident survey, faculty survey, case log data, and data on scholarly activities</td>
<td>Ongoing</td>
</tr>
<tr>
<td>July &amp; Aug 2012</td>
<td>Alpha testing of CLER process</td>
<td>Completed</td>
</tr>
<tr>
<td>September 2012</td>
<td>Beta testing of CLER visits</td>
<td>Ongoing</td>
</tr>
<tr>
<td>December 2012</td>
<td>Milestones published for all core specialties</td>
<td>Completed</td>
</tr>
<tr>
<td>February 2013</td>
<td></td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
# Key Dates for Phase I specialties under NAS

ACGME News and Reviews, J Grad Med Educ, 2012; 4(3): 399
http://www.acgme-nas.org/assets/pdf/KeyDatesPhase1Specialties.pdf

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<th>Month &amp; Year</th>
<th>ACGME Activities</th>
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<tbody>
<tr>
<td>March 2013</td>
<td>Final SVs in current accreditation system are completed for Phase I programs with a short cycle length</td>
<td>Identify and train CCC members</td>
</tr>
<tr>
<td>June 2013</td>
<td></td>
<td>Phase I programs form CCC and faculty members prepare to assess milestones</td>
</tr>
<tr>
<td>July 2013</td>
<td><strong>NAS GO LIVE</strong></td>
<td></td>
</tr>
<tr>
<td>7/1/13-6/30/14</td>
<td></td>
<td>Phase I milestones assessments begin for core programs</td>
</tr>
<tr>
<td>Fall 2013</td>
<td>RRC in Phase I specialties review annual data from Academic year 2012-2013 (without milestone data)</td>
<td></td>
</tr>
<tr>
<td>December 2013</td>
<td></td>
<td>Core Programs submit the first set of Phase I milestones assessments to ACGME</td>
</tr>
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<th>Program and Institutional Activities</th>
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<td>June 2014</td>
<td></td>
<td>Programs submit the second set of Phase I milestones assessment to ACGME</td>
</tr>
<tr>
<td>Fall 2014</td>
<td>RRCs in Phase I specialties review annual data from AY 2013-2014 (with milestones)</td>
<td></td>
</tr>
<tr>
<td>2015 - 2016</td>
<td>First self-study SVs for Phase I Programs</td>
<td></td>
</tr>
</tbody>
</table>
Subspecialties under NAS

<table>
<thead>
<tr>
<th>Month &amp; Year</th>
<th>ACGME Activities</th>
<th>Program and Institutional Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013 – June 2014</td>
<td>Help convene milestones working groups</td>
<td>Milestones developed for subspecialty programs</td>
</tr>
<tr>
<td>December 2014??</td>
<td></td>
<td>First milestones reporting for subspecialty programs??</td>
</tr>
<tr>
<td>???</td>
<td>Milestones for Multidisciplinary Subspecialties: Sleep, HPM, PEM</td>
<td></td>
</tr>
</tbody>
</table>

Note: Subspecialties might not need a full year to develop Milestones – work will focus on medical knowledge and patient care
Decisions on Program Standing in NAS

Application for New Program → Initial Accreditation → Continued Accreditation

STANDARDS
- Outcomes
- Core Process
- Detail Process

Outcomes
- Core Process
- Detail Process

Outcomes
- Core Process
- Detail Process

Outcomes
- Core Process
- Detail Process

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Decisions on Program Standing in NAS

Application for New Program

STANDARDS
Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Withhold Accreditation

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Decisions on Program Standing in NAS

- Accreditation
- With Warning
- Continued Accreditation

STANDARDS
- Outcomes
- Core Process
- Detail Process

Outcomes
- Core Process
- Detail Process

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Decisions on Program Standing in NAS

STANDARDS

Outcomes
Core Process
Detail Process

Probationary Accreditation

Continued Accreditation

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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Decisions on Program Standing in NAS

Application for New Program: 2-4%
Accreditation with Warning: 10-15%
Continued Accreditation: 75-80%

Withdrawal of Accreditation: <1%

STANDARDS
Outcomes
Core Process
Detail Process

NAS: No Cycle Lengths
How Can Programs Innovate?

- Program Requirements classified:
  - Outcome
  - Core
  - Detail

- Programs in good standing*:
  - May freely innovate in detail standards

* “Green Bucket”
Data Collection in the Next Accreditation System
Annual Data Review Elements

Where did they come from?

Modeling: What data predicted short cycles or adverse actions?

History: What data did RRC’s consider important?
Annual Data Review Elements
A Mix of “Old” and “New”

Annual review of the following indicators:

1) Program Attrition
2) Program Changes
3) Scholarly Activity
4) Board Pass Rate
5) Clinical Experience
6) Resident Survey
7) Faculty Survey
8) Milestones
9) CLER visit data

- Collected now as part of the program’s annual ADS update.
- ADS streamlined this year: 33 fewer questions & more multiple choice or Y/N
- Some Boards provide annually
- Collected now as part of annual administration of survey
RC Use of Annual Data

- Similar across specialties
- RC assigns weights
  - From minimally important to very important
- RC controls trigger points for “human” review
- Spotfire: Visualization of Data
- Training:
  - Phase I RCs: Jan-May 2013
  - Phase II RRCs (intro): July 15, 2013
Streamlined ADS Annual Update

- 33 questions removed
- 14 questions simplified
- Very few essay questions
- Self-reported board pass rate removed
- Faculty CVs removed
- 11 MCQ or Y/N questions added
Examples of turnover – one or more of the following leave the program:

- Residents
- Core faculty
- Program director
- Chair
- CEO

*Caveat: Turnover can sometimes be a good thing*
Board certification - Sample of requirement

- V.C.1.c).(1) At least 80% of those completing their training in the program for the most recently defined 3-year period must have taken the exam.
- V.C.1.c).(2) A program’s graduates must achieve a pass rate on the certifying exam of at least 80% for first time takers in the most recently defined three-year period.
- Threshold for per cent first-time takers and pass rate set by RC – mindful of programs with few fellows.
Except for PD
Faculty CVs will no
longer be collected
# Scholarly Activity as Performance Indicator

## Scholarly Activity Template

### Faculty Scholarly Activity

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
<th>Leadership or Peer-Review Role</th>
<th>Teaching Formal Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Resident Scholarly Activity

<table>
<thead>
<tr>
<th>Resident</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>Conference Presentations</th>
<th>Chapters / Textbooks</th>
<th>Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012</th>
<th>Teaching / Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>June Smith</td>
<td>12433</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

### Categories for points:

- Peer Review Publication
- Other Scholarly
- Grantsmanship
- Leadership / Peer Review
- Education
Faculty Scholarly Activity


Enter Pub Med ID #'s

<table>
<thead>
<tr>
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Faculty Scholarly Activity

Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012

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Enter a number

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## Faculty Scholarly Activity

### Other Presentations

Enter a number

<table>
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<td></td>
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</table>

Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012

Other Presentations

1
### Faculty Scholarly Activity

<table>
<thead>
<tr>
<th>Faculty Name</th>
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<th>PMID 2</th>
<th>PMID 3</th>
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<td>3</td>
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</table>

#### Number of chapters or textbooks published between 7/1/2011 and 6/30/2012

**Chapters / Textbooks**

Enter a number

1
## Faculty Scholarly Activity

**Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012**

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**Grant Leadership**

Enter a number

3
Faculty Scholarly Activity

Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012

Leadership or Peer-Review Role

Answer
Yes or No

Y
Faculty Scholarly Activity

Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.

Teaching Formal Courses

N
Clinical Experience Data (Specialty)

- Specialties with case logs
- Specialties without case logs:
  - Composite variable on residents’ perceptions of clinical preparedness based on the specialty specific section of the resident survey.
  - **How measured:** 3rd year residents’ responses to RS

- Examples:
  - Adequacy of clinical and didactic experience
  - Variety of clinical problems/stages of disease?
  - Do you have experience w patients of both genders and a broad age range?
  - Continuity experience sufficient to allow development of a continuous therapeutic relationship with panel of patients
  - Ability to manage patients in the prevention, counseling, detection, diagnosis and treatment of diseases appropriate to your specialty?
Clinical Experience Data (Subspecialties)

- Composite variable on fellows’ perceptions of clinical preparedness based on the specialty specific section of the fellow survey
- Brief fellow-specific survey is being developed
- Initially, questions will be identical across all subspecialties
- Subsequently:
  - Specialty-specific questions
  - Case logs or equivalent clinical information
What Happens at My Program?

- Annual data submission
- Annual Program Evaluation (PR V.C.)
  - Program Evaluation Committee
- Self-study visit every ten years
- Possible actions following RRC Review:
  - Progress reports for potential problems
  - Focused site visit
  - Full site visit
  - Site visit for potential egregious violations

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What Happens at My Program?

- Core and subspecialty programs **together**
- Independent subspecialty programs subject to:
  - Program Requirements and program review
  - Institutional Requirements and institutional review
  - CLER visits
- No new independent subspecialty programs allowed after 7/2013
What is a Self-Study Visit?

- Format – under development
- Scheduled every ten years
- Conducted by a team of visitors
- Minimal document preparation
- Interview residents/fellows, program directors, faculty, leadership
What is a Self-Study Visit?

- Examine annual program evaluations (APE)
  - Response to citations
  - Faculty development
  - Strengths/Weaknesses/Opportunities/Threats (SWOT)
- Focus: Continuous improvement in program
- Learn future goals of program
- *May* verify compliance with Core requirements
Human Nature:

“Why do today what you can put off until tomorrow?”
Ten Year Self-Study Visit

Yr 0: APE
Yr 1: APE
Yr 2: APE
Yr 3: APE
Yr 4: APE
Yr 5: APE
Yr 6: APE
Yr 7: APE
Yr 8: APE
Yr 9: APE
Yr 10: APE
What is a Focused Site Visit?

› Assesses *selected* aspects of a program and may be used:

› to address *potential* problems identified during review of annually submitted data

› to diagnose factors underlying deterioration in a program’s performance

› to evaluate a complaint against a program
What is a Focused Site Visit?

- Minimal notification given
- Minimal document preparation expected
- Team of site visitors
- Specific program area(s) investigated as instructed by the RRC
When do Full Site Visits Occur?

- Application for new program
- At the end of the initial accreditation period
- RRC identifies broad issues/concerns
- Other serious conditions or situations identified by the RRC
When Is My Program Reviewed?

- Each program reviewed at least annually
- NAS is a continuous accreditation process
  - Review of annually submitted data
  - Supplemented by:
    - Reports of self-study visits every ten years
    - Progress reports (when requested)
    - Reports of site visits (as necessary)
When Is My Program Reviewed?

“Cycle Lengths” will not be used

Programs will receive feedback from RRC each time they are reviewed

Status:

- Continued Accreditation
- Accreditation with Warning
- Probationary Accreditation
- Withdrawal of Accreditation
Competence
Competence

- RM Epstein: “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities being served

- 6 domains:
  - Medical knowledge
  - Patient care
  - Professionalism
  - Communication and interpersonal skills
  - Practice-based learning and improvement
  - Systems-based practice

Epstein RM: Assessment in Medical Education. N Engl J Med, 2007; 356:387-96. Departments of Family Medicine, Psychiatry, and Oncology and the Rochester Center to Improve Communication in Health Care, University of Rochester School of Medicine and Dentistry
Not an achievement, but a habit of lifelong learning

Assessment of competence should provide insight into actual performance and capacity to adapt to change, find and generate new knowledge and improve overall performance

Contextual: relationship between abilities, setting and particular situation

Developmental
Competence: Olle ten Cate and Fedde Scheele

- Competency is a personal quality, not an action
- Oxford Dictionary: the ability to do something successfully
- Competencies and EPAs
  - Separate but relevant
  - Not one or the other but both
  - “we can only fully trust someone to carry out a critical *activity* once they have attained all the *competencies* that are needed to adequately complete this activity”

Viewpoint: Competency-Based Postgraduate Training: Can we Bridge the Gap between Theory and Clinical Practice. Academic Medicine, 2007; 82:542-547
Competency

δ Observable ability of a health professional related to a specific activity
δ Integrates: knowledge, skills, values and attitudes
δ Observable – therefore can be:
  δ Measured
  δ Assessed
δ Activities can be assembled like building blocks
The Goal of the Continuum of Clinical Professional Development

- Master
- Expert
- Proficient
- Competent
- Advanced
- Beginner
- Novice

Undergraduate Medical Education → Graduate Medical Education → Clinical Practice
The Continuum of Clinical Professional Development
Authority and Decision Making versus Supervision

High

Physical Diagnosis

Clerkship

Sub-Internship

Internship

Residency

Fellowship

Attending

Low

Low

Authority and Decision Making

“Graded or Progressive Responsibility”
When do you hand over the car keys to your teenager?
Competence: Teenagers and Driving

Competence: Teenagers and Driving

High

Supervision

Low

Appropriate Age

Passes Written Exam

Practicing in a parking lot/city streets

Supervised Freeway driving

Passes Driver’s Exam

Unsupervised Driving

Supervised Freeway driving

Unsupervised Driving in Difficult Conditions

“Graded or Progressive Responsibility”

Low

Authority and Decision Making

High

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Milestones

- Observable developmental steps moving from Novice to Expert/Master
- “Intuitively” known by experienced medical educators
- Organized under the rubric of the six domains of clinical competency
  - Trajectory of progress: neophyte → independent practice
  - Articulate shared understanding of expectations
  - Set aspirational goals of excellence
  - Framework & language for discussions across the continuum
Milestones

- Created by each specialty
- Organized under 6 domains of competency
- Observable steps on continuum of increasing ability
- Describes the track of a fellow learner
- Provide framework and language to describe progress
- Articulates shared understanding of expectations
Milestones

- Milestones: **not an assessment tool**
  - You do not have to assess all 46 milestones for each fellow at the end of each rotation

- Do not discard all the assessment methods you use now:
  - End of the month rotation evaluations
  - OSCE
  - Simulation
  - 360° evaluations

- Use the assessment methods you have to "inform" the milestones levels by the CCC
Competency

Operative Performance Rating Scales
Mock Orals
End of Rotation Evaluations
ITE
Self Evaluations
Sim Lab
Case Logs
Unsolicited Comments
Student Evaluations
Clinic Work Place Evaluations
Patient / Family Evaluations
Assessment of Milestones

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Milestones Assessment
“You Cannot Assess What you Don’t See”
Milestones and Competency

❖ Direct Observation is key!
Be clear in setting expectations

Pull out Betty, pull out, You’ve hit an artery!

“I said put the catheter in the vein!!!”
Direct Observation is Key:

Specimen Description:
Alveolar Lavage

Special Requests:
Bronchial Left Upper Lung Bacterial Culture

Gram Stain:
Gram stain results indicate normal vaginal flora
Procedure note:

Lumbar puncture attempted by three pricks (Drs. Theodorou, Anderson and Engel). 3rd prick successful, 3 tubes of CSF sent to lab.
Language and Communication Skills
Check those orders

• Attending on rounds: “Order TED hose for the patient with head injury”

• The resident wrote the order: “Tadpoles to both legs”
Language and Communication Skills
Be specific and check those orders

- Attending on rounds: “Order a pentobarbital drip for the patient in status”. She meant *status epilepticus*

- The resident wrote an order for pentobarbital drip for a patient in *status asthmaticus*
Clinical Competency Committee

- May already be in place under a different name
- Start thinking about this and decide on composition, procedure, data elements
- What should be reviewed:
  - Continue to look at current methods of evaluations: OSCE, simulation, 360-degree evaluations
  - Milestones, Entrustable Professional Activities, narratives
- Issues:
  - Time constraints
  - Large residency programs
  - Small fellowship programs
CCC: How many members?

- Ideally five (or more) for broad consensus
- Recognize small programs may have fewer
- May have to pre-review evaluations before group discussion
CCC: Who should be on it?

- Decision for PD

- Consider:
  - Representation from each major site
  - Subspecialty representation
  - Dedication to education
CCC: How does it work?

- Understand the milestones & their use
- Leave personal bias at the door
- Review all evaluations for each resident
- “Consider the source(s)”
- For each resident, decide for each milestone the narrative that best fits that resident
Milestones and Competencies: No need to freak out

- Implications of terms - high stakes/low stakes
  - Neither – milestones are important
- Do it and do it well
- It does not have to be perfect

“Do or do not, there is no try”
Lake Wobegon

"Well, that's the news from Lake Wobegon, where all the women are strong, all the men are good looking, and all the residents are above average."

a fictional town in the U.S. state of Minnesota, said to have been the boyhood home of Garrison Keillor, who reports the News from Lake Wobegon on the radio show A Prairie Home Companion.
Lake Wobegon Residency Program
Overall Rating of Six Competencies across All Specialties

- Expert
- Proficient
- Competent
- Advanced Beginner
- Novice

The Actual Expected Trajectory

Professionalism
Communications
Medical Knowledge
Patient Care
PBLI
SBP

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In closing………

“Fear is the path to the dark side. Fear leads to anger. Anger leads to hate. Hate leads to suffering”
Milestones and Competencies:
Bears repeating: No need to freak out

❖ Do it and do it well
❖ It does not have to be perfect

“Do or do not, there is no try”
“All great changes are preceded by chaos”

Deepak Chopra
“Train yourself to let go of everything you fear to lose – like the PIF”
Educational Sessions - Webinars

- Completed/posted: CLER, NAS Milestones/CCC
- Future ACGME webinars
  - Phase 1 specialties
  - Self-study
- Previous webinars available for review at: http://www.acgme-nas.org/index.html under “ACGME Webinars”.

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Thank You!