Milestone/CCCs
Lessons Learned from a First-Phase Program

Andrew J. White, MD
Program Director, Pediatrics
Washington University
February 7th, 2014
Our Program

• Pediatrics
• 3 years of training
• 96 residents
• 4 APD, 3 CR
• 51 Milestones
Intro to Milestones
Milestones

• Observable developmental steps moving from novice physician to expert/master
• Analogous to Developmental Stages
  – Crawls, cruises, walks, runs, wins Olympic Gold
• Organized under the domains of Competency
• We must report our residents’ milestones to the ACGME every 6 months
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 psychiatric history including medical, functional, and psychosocial elements</td>
<td>Acquires a comprehensive psychiatric 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>
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<td></td>
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<td>Seeks and obtains data from secondary sources when needed</td>
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<td>Rapidly focuses on presenting problem, and elicits key information in a prioritized fashion</td>
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<td>Elicits subtleties and information that may not be readily volunteered by the patient</td>
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<td>Models the gathering of subtle and difficult information from the patient</td>
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Milestone
Typical Faculty Response

Dear Andy,

I just had my first experience with the new resident evaluations. I do understand the desire to try something novel and apply different response options. But seriously?

For instance, Accurate information is gathered and precise diagnoses reached with ease. Ease, other than standing next to the resident, how do I assess a his or her effort? Intuitively handles all difficult communication scenarios with grace and humility. How do I measure grace, and if so, is there a grace threshold? Analyzes one’s own data on a continuous basis. What if there is a 5 minute lapse in analyzing one’s own data? What if the resident takes a shower? Able to perform QI projects. On a 4-week clinical rotation?

Because I cannot truthfully choose many of the response options means that my response for every item defaults to the middle for every resident. Or I do not respond at all. Not a particularly good discriminator of performance. Maybe I am getting old and grumpy, but can we try something else?

Thanks,

Tom
My Response to Faculty Response

“Concerned”

Won’t do it
Won’t do it correctly

Choice:
Educate them, coerce/reward them or modify the evaluations/milestones

We modified our evals and mapped them to milestones
Practice Modifying Milestones for use in an evaluation
### Patient Care

<table>
<thead>
<tr>
<th>a) Gather essential and accurate information about the patient (PC1)</th>
<th>Not yet assessable</th>
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<td>b) Organize and prioritize responsibilities to provide patient care that is safe, effective and efficient (PC2)</td>
<td>Not yet assessable</td>
<td>Level 1</td>
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<tr>
<td>c) Provide transfer of care that ensures seamless transitions (PC3)</td>
<td>Not yet assessable</td>
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<tr>
<td>d) Make informed diagnostic and therapeutic decisions that result in optimal clinical judgement (PC4)</td>
<td>Not yet assessable</td>
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<tr>
<td>e) Develop and carry out management plans (PC5)</td>
<td>Not yet assessable</td>
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**Level 1**
Either gathers too little information or exhaustively gathers information following a template regardless of the patient’s chief complaint, with each piece of information gathered seeming as important as the next. Recalls clinical information in the order elicited, with the ability to gather, filter, prioritize, and connect pieces of information being limited by and dependent upon analytic reasoning through basic pathophysiology alone.

### Medical Knowledge

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**Level 2**
Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. Still relies primarily on analytic reasoning through basic pathophysiology to gather information, but has the ability to link current findings to prior clinical encounters. Allows information to be filtered, prioritized, and synthesized into pertinent positives and negatives, as well as broad diagnostic categories.
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**Level 3**
Demonstrates an advanced development of pattern recognition that leads to the creation of illness scripts, which allow information to be gathered while simultaneously filtered, prioritized, and synthesized into specific diagnostic considerations. Data gathering is driven by real-time development of a differential diagnosis early in the information-gathering process.

**Level 4**
Creates well-developed illness scripts that allow essential and accurate information to be gathered and precise diagnoses to be reached with ease and efficiency when presented with most pediatric problems, but still relies on analytic reasoning through basic pathophysiology to gather information when presented with complex or uncommon problems.

**Level 5**
Creates robust illness scripts and instance scripts (where the specific features of individual patients are remembered and used in future clinical reasoning) that lead to unconscious gathering of essential and accurate information in a targeted and efficient manner when presented with all but the most complex or rare clinical problems. These illness and instance scripts are robust enough to enable discrimination among diagnoses with subtle distinguishing features.
Modified Milestones PC1

1.
2.
3.
4.
5.
How reliable are these modified tools?
How do we use the tools to help the CCC?
CCC

- What
- Who
- How
ACGME Requirements

The CCC should:

1. Review all resident evaluations semi-annually

2. Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME.

3. Advise the program director of resident progress, including promotion, remediation and dismissal.
ACGME Requirements

The requirements regarding the CCC do not preclude or limit a program director’s participation on the CCC. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider:

• its program director’s other roles as resident advocate, advisor, and confidante;
• the impact of the program director’s presence on the other CCC members’ discussions and decisions;
• the size of the program faculty;
• and other program-relevant factors.

The program director has final responsibility for the program's evaluation and promotion decisions.
Members of the Clinical Competency Committees (CCCs) are chosen by the Program Director in conjunction with the Chairman, with particular attention to the following:

- Amount of exposure to residents (wards, rotations, ED, etc)
- Interest in medical education
- Buy-in from faculty member regarding Milestones
- Involvement in fellowship programs

Each CCC will be chaired by an APD, and will be comprised of an APD, a chief resident, and three additional faculty members.
Our CCC Structure

• 3 Clinical Competency Committees

• PL1 Associate PD and Chief Resident
  – +3 Faculty Members

• PL2 Associate PD and Chief Resident
  – +3 Faculty Members

• PL3 Associate PD and Chief Resident
  – +3 Faculty Members
How does the CCC tell the PD their recommendations?
Round 1
Round 2
Round 3
Lessons

• Ordinary evaluations are as good as Milestone evaluations
• Mapping evaluation questions to Milestones takes work and consensus
• Gathering all necessary data is difficult
• Reviewing all data is time consuming
• The most useful data comes from comments
Lessons

• Milestones are most useful for:
  – Teaching faculty what we expect residents to be able to do
  – Teaching residents what we expect them to be able to do

• Resident File needs to be re-structured

• Inter-Class – Inter-CCC variation occurs
  – We may have to use only 1 CCC
Tips

• Get all evals in the same format
• Make cheat sheets of Milestones
• Avoid CCCs getting bogged down
How do we know the CCCs are judging accurately and appropriately?

- The ACGME will closely study and monitor the Milestone data. Using various statistical models we will monitor overall progression of milestones in a given specialty, as well as within individual programs. We encourage every CCC to accurately report the Milestone evaluations as the data will also be used to identify individual milestones that need to be edited or removed.
The End

• Thanks to my Program Coordinator, Pat Jacobi

• Questions?