CPME 320

STANDARDS AND REQUIREMENTS FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

COUNCIL ON PODIATRIC MEDICAL EDUCATION

DRAFT II

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INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency programs conducted under sponsorship of health-care institutions and colleges of podiatric medicine. Residencies afford these individuals structured learning experiences in patient management along with training in the diagnosis and care of podiatric pathology. The individuals involved in these training programs are referred to as "residents" and are recognized as such by the institutions sponsoring the programs.

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council's approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of graduate education, postgraduate education, certification, and continuing education. By confirming these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council has been authorized by APMA to approve institutions that sponsor residency programs that demonstrate and maintain compliance with the standards and requirements in this publication. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council.

Standards and requirements in this publication are divided into institutional standards and requirements and program standards and requirements. Standard 6.0 and the associated requirements were developed as a collaborative effort of the Council on Podiatric Medical Education, the American Board of Foot and Ankle Surgery (ABFAS), and the American Board of Podiatric Medicine (ABPM).

Under no circumstances may the standards and requirements for approval by the Council supersede federal or state law.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council's community of interest may be affected.

The Council formulates and adopts its own approval procedures. These procedures are stated in CPME 330, *Procedures for Approval of Podiatric Residencies*. This document, as well as CPME 320, may be obtained on the Council's website at www.cpme.org or by contacting the Council office.

ABOUT THIS DOCUMENT

This publication describes the standards and requirements for approval of podiatric residency programs. The standards and requirements, along with the procedures for approval, serve as the basis for evaluating the quality of the educational program offered by a sponsoring institution and holding the institution and program accountable to the educational community, podiatric medical profession, and the public.

The **standards** for approval of residency programs serve to evaluate the quality of education. These standards are broad statements that embrace areas of expected performance on the part of the sponsoring institution and the residency program. Compliance with the standards ensures proper educational practice in the field of podiatric medicine and thus enables the Council to grant or extend approval.

Related to each standard is a series of specific **requirements**. Compliance with the requirements provides an indication of whether the broader educational standard has been satisfied. During an on-site evaluation of a residency program, the evaluation team gathers detailed information about whether these requirements have been satisfied. Based upon the extent to which the requirements have been satisfied, the Council determines the compliance of the sponsoring institution and the residency program with each standard.

- The verb "shall" is used to indicate conditions that are imperative to demonstrate compliance.

The **guidelines** are explanatory materials for the requirements. Guidelines are used to indicate how the requirements either must be interpreted or may be interpreted to allow for flexibility, yet remain within a consistent framework. The following terms are used within the guidelines:

- The verbs "must" and "is" indicate how a requirement is to be interpreted, without fail. The approval status of a residency program is at risk if noncompliance with a "must" or an "is" is identified.

- The verb "should" indicates a recommended, but not mandatory, condition.

- The verb "may" is used to express freedom or liberty to follow an alternative.

Throughout this publication, the use of the terms "institution" and "program" is premised on the idea that the program exists within and is sponsored by an institution.

The terms "college" and "school" are used interchangeably throughout this document.

GLOSSARY

The Council strongly encourages sponsoring institutions and program directors to become familiar with the following definitions to ensure complete understanding of this publication.

Academic Health Center

An academic health center is the entire health enterprise at a university including health professions, education, patient care, and research. An academic health center consists of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association, one or more health profession schools or programs (such as podiatric medicine, dentistry, allied health, nursing, pharmacy, public health, graduate studies, or veterinary medicine), and one or more owned and affiliated teaching hospitals or health systems.

Accreditation

Accreditation is the recognition of institutional or program compliance with standards established by the Council on Podiatric Medical Education, based on evaluation of the institution's own stated objectives. Accreditation is a voluntary process of peer review. The Council is responsible for accrediting colleges of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

Affiliated Training Site

An affiliated training site is an institution or facility that provides a rotation(s) for residents. Examples of sites include: a college of podiatric medicine, a teaching hospital including its ambulatory clinics and related facilities, a private medical practice or group practice, a skilled nursing facility, a federally qualified health center, a public health agency, an organized health care delivery system, an outpatient surgery center, or a health maintenance organization (clinical facility).

American Board of Foot and Ankle Surgery (ABFAS)

ABFAS is the specialty board currently recognized by the Council on Podiatric Medical Education's Specialty Board Recognition Committee (SBRC) to certify in the specialty area of podiatric surgery. ABFAS maintains two certification pathways: foot surgery and reconstructive rearfoot/ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot/ankle status.

American Board of Podiatric Medicine (ABPM)

ABPM is the specialty board currently recognized by the Council on Podiatric Medical Education's Specialty Board Recognition Committee to certify in the specialty area of podiatric medicine and orthopedics. ABPM maintains one certification pathway leading to certification in podiatric orthopedics and primary podiatric medicine.

Approval

Approval is the recognition of a podiatric residency program, podiatric fellowship program, or sponsor of continuing education that has attained compliance with standards established by the Council on Podiatric Medical Education. Approval is a program-specific form of accreditation.

Behavioral Medicine

Behavioral medicine incorporates management of patients with behavioral, mental, and psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).

Centralized Application Service for Podiatric Residencies (CASPR)

CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to podiatric residency programs approved by the Council. CASPR conducts a national matching process, based on a mathematical algorithm, for the purpose of placing applicants into residency positions. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the residency application and matching process. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

Certification

Certification is a process to provide assurance to the public that a podiatric physician has successfully completed an approved residency and an evaluation, including an examination process designed to assess the knowledge, experience, and skills requisite to the provision of high-quality care in a particular specialty.

Clinical Competency Committee

A committee appointed by the program director that completes the milestones for each resident on a semi-annual basis. This committee must include three members and should be comprised of health professionals (faculty members and/or ancillary medical staff) who have extensive experience working with the residents and can comment on the progression of the residents throughout the program and identify gaps in their individual training. While the program director may be a member of this committee, the committee must be chaired by someone other than the program director. The clinical competency committee must meet prior to the residents' semi-

annual evaluations and advise the program director regarding each resident's progress.

Collaborative Residency Evaluator Committee (CREC)

CREC is an effort of ABFAS, ABPM, and the Council to improve the methods by which residency evaluators and team chairs are selected, trained, assessed, remediated, and dismissed. The composition of the Committee includes three individuals from each organization, one of whom must be the executive director or that individual's designee, who must be an employee of the organization represented.

Competencies

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. ABFAS and ABPM have identified competencies related to certification pathways.

Council of Teaching Hospitals (COTH)

COTH is a membership organization comprised of institutions sponsoring Council-approved podiatric residency programs (including programs holding provisional and probationary approval). The goals of COTH include fostering excellence in residency training, promoting a code of ethics, developing policy, and serving as a forum for the exchange of ideas on residency education. COTH is a component of the American Association of Colleges of Podiatric Medicine. The Council on Podiatric Medical Education and RRC encourage sponsoring institutions to participate in COTH.

Curriculum

The curriculum is the residency program's unique organization and utilization of its clinical and didactic training resources to assure that the resident achieves the competencies identified by the Council and is prepared to enter clinical practice upon completion of the residency.

Designated Institutional Official (DIO)

The individual with the authority or responsibility for oversight and administration of the graduate medical education program at the institution.

Due Process

Due process is a defined procedure established by the sponsoring institution that is utilized whenever any adverse action is proposed or taken against a resident. All parties in a residency program are protected when there is a written and disseminated due process policy in place.

Duplication

Duplication occurs when a resident enters the same case and procedure on the same day of surgery more than once in clinical/patient logs.

External Assessments

External assessments are standardized evaluations of residents that are monitored and/or delivered by organizations external to the residency program for the purpose of validating the resident's experiences and development. An example is an annual in-training examination conducted by a specialty board.

Faculty

Faculty refers to the entire teaching force responsible for educating residents. The term faculty does not imply or require an academic appointment or salary support.

Fragmentation

Fragmentation occurs when a specific surgical procedure in clinical/patient logs is unbundled or fragmented inappropriately into its individual component parts.

Health-care System

A health-care system is a group of hospitals or facilities that work together to deliver services to their communities.

Hospital

A hospital is an institution that provides diagnosis and treatment of a variety of medical conditions in inpatient and outpatient settings. The institution may provide training in the many special professional, technical, and economic fields essential to the discharge of its proper functions.

Internal Assessments

Internal assessments are those evaluations of residents that are conducted within the residency program by faculty, staff, peers, and patients for the purpose of validating the serial acquisition of necessary knowledge, attitudes, and skills by the residents. Knowledge, attitudes, and skills should be evaluated separately. Knowledge may be assessed with internal modular testlets. Attitudes may be assessed with an attitudinal assessment form. Skills may be assessed by utilizing a standardized technical skills assessment form and observing a particular skill set.

In-training Examination

Administered by the specialty board(s), the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification by the specialty board(s).

Specialty Board Recognition Committee (SBRC)

The SBRC is a committee established by the Council on Podiatric Medical Education on behalf of the podiatric medical profession to recognize specialty boards. The recognition of a specialty board by the SBRC serves to provide important information to the podiatric medical profession, health-care institutions, and the public about the sound operations and fair conduct of the board's certification process. The Council and the SBRC are committed to a process that assures the public that those podiatric physicians who are certified have successfully completed the requirements for certification in an area of specialization. The Council's authority for the recognition of specialty boards through the SBRC is derived solely from the House of Delegates of the American Podiatric Medical Association. The SBRC recognizes the American Board of Foot and Ankle Surgery and the American Board of Podiatric Medicine.

Milestones

Milestones are a semi-annual assessment tool, completed by a clinical competency committee, that provide a consistent framework for formative assessment of the resident. Milestones demonstrate the resident's progress toward competency throughout residency training.

Miscategorization

Miscategorization occurs when a surgical procedure or clinical encounter in patient/clinical logs is misclassified into an incorrect procedure code.

Podiatric Medicine and Surgery

Podiatric medicine and surgery is the profession and medical specialty that includes the study, prevention, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.

Residency

A residency is a postgraduate educational program conducted under the sponsorship of a hospital, college of podiatric medicine, or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges of podiatric medicine through clinical and didactic experiences.

A residency program is based on the resource-based, competency-driven, assessment-validated model of training:

- Resource-based implies that the program director constructs the residency program based upon the resources available. While the Council recognizes that available resources may differ among institutions, the program director is responsible for determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.

- Competency-driven implies the program director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the sponsoring institution as having successfully completed the residency program.

- Assessment-validated implies the serial acquisition and final achievement of the competencies are validated by assessments of the resident's knowledge, attitudes, and skills. To provide the most effective validation, assessment is conducted both internally (within the program) and externally (by outside organizations).

Residency Review Committee (RRC)

The RRC is responsible for determining eligibility of applicant institutions for initial and subsequent on-site evaluation, authorizing increases in and reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

The composition of the Residency Review Committee shall include two representatives from each specialty area in which specialty residency training occurs to be recommended by the boards, one representative from the AACPM Council of Teaching Hospitals (hereinafter referred to as "COTH") to be recommended by AACPM, at least one at-large representative to be selected by the Council, and at least two Council members. The specialty organizations and COTH each shall be requested to provide a list of names from which the Council chair shall select an appointee for the Committee. If the chair does not identify a suitable appointee, then the Council may request a second list of names. The members of the Committee are appointed by the Council chair and confirmed by the Council.

Although RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of RRC.

Training Resources

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medical

and surgical subspecialties.

Verification

Verification is the process by which the program director reviews resident clinical/patient logs to ensure resident attainment of the Minimum Activity Volume (MAV) requirements and for accuracy to ensure there is no duplication, miscategorization, and/or fragmentation of procedures or clinical encounters.

STANDARDS FOR APPROVAL OF PODIATRIC RESIDENCY PROGRAMS

The following standards pertain to all residency programs for which initial or continuing approval is sought. The standards encompass essential elements including sponsorship, administration, program development, clinical expectations, and assessment.

INSTITUTIONAL STANDARDS:

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

PROGRAM STANDARDS:

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

INSTITUTIONAL STANDARDS AND REQUIREMENTS

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

1.1 The sponsor shall be a hospital, academic health center, health care system*, or CPME-accredited college of podiatric medicine. Hospital facilities shall be provided under the auspices of the sponsoring institution or through an affiliation with an accredited institution(s) where the affiliation is specific to residency training.

A surgery center may co-sponsor a residency with a hospital, academic health center, and/or college of podiatric medicine but cannot be the sole sponsor of the program.

Institutions that co-sponsor a residency program must define their relationship to each other to delineate the extent to which financial, administrative, and teaching resources are to be shared. The document defining the relationship between the co-sponsoring institutions must describe arrangements established for the residency program and the resident in the event of dissolution of the co-sponsorship.

*The addition of health care system was included in the Draft I version (released October 2020) and approved by the Council in April 2021; it was not included in the first version of Draft II (uploaded in May 2022) but has been added back as of June 22, 2022.

1.2 The sponsoring institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission, the American Osteopathic Association, or a health-care agency approved by the Centers for Medicare and Medicaid Services. The sponsoring college of podiatric medicine shall be accredited by the Council on Podiatric Medical Education.

1.3 The sponsoring institution may contract with other health-care facilities to provide resident training. The sponsoring institution shall formalize arrangements with each training site, including private practice offices, by means of a written agreement that clearly defines the roles and responsibilities of each institution and/or facility involved.

When training is provided at an affiliated training site, the participating institutions must:

- indicate their respective training commitments through a written agreement reaffirmed at least once every ten years.

This document must:

- acknowledge the affiliation and delineate financial arrangements, liability coverage, and educational contributions of each training site;
- be signed by the chief administrative officer, designated institutional official (DIO), or designee of each participating institution or facility;
- include an effective date; and
- be forwarded to the program director.

If the program director does not participate actively at the affiliated training site, or if a significant portion of the program is conducted at the affiliated training site, a site coordinator must be designated formally to ensure appropriate conduct of the program at this training site. The site coordinator must hold a staff appointment at the affiliated site and be a faculty member involved actively in the program at the affiliated institution or facility. Written confirmation of this appointment, either within the affiliation agreement or in a separate document, must include the signatures of the program director and the site coordinator.

Residents must not participate in training at affiliated sites until the agreements are fully executed.

The expected daily commute to each sponsoring and affiliated training site must not have a detrimental effect upon the educational experience of the resident. Training provided outside of the US (and its territories) may not be counted toward the requirements of any training resource.

Intent and Background: *Agreements are meant to ensure that residents are protected with professional and general liability insurance. Institutions owned by the same corporate entity as the sponsoring institution may need affiliation agreements if they function independently.*

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

2.1 The sponsoring institution shall ensure that the physical facilities, equipment, and resources of the primary and affiliated training site(s) are sufficient to permit achievement of the stated competencies of the residency program.

The physical plant must be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources, and a health information management system must be available for resident training.

The sponsoring institution must have been in operation for at least 12 months before submitting an application for approval to assure that sufficient resources are available for the residency program.

2.2 The sponsoring institution shall afford the resident ready access to adequate educational resources, including a diverse collection of current podiatric and non-podiatric medical texts and other pertinent reference resources (i.e., journals and digital materials/instructional media).

Educational resources must include the electronic retrieval of information from medical databases that are readily available at no cost to the resident.

2.3 The sponsoring institution shall afford the resident dedicated office and/or study spaces at the institution(s) in which residency training is primarily conducted, including access to electronic resources.

2.4 The sponsoring institution shall provide a designated administrative staff member, frequently referred to as a program coordinator, to ensure efficient administration of the residency program.

The program coordinator must dedicate sufficient time to the administration of the program.

The institution must ensure that neither the program director nor the resident assumes the responsibility of ancillary medical staff.

Intent and Background: *Each program requires a lead administrative staff member, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty, and other staff members. The individual is expected to develop unique knowledge of the program requirements, policies, and procedures. Program coordinators assist the program director in compliance efforts, educational programming, and support of residents*.

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

3.1 The sponsoring institution shall utilize a residency selection committee to interview and select prospective resident(s). The committee shall include the program director and individuals who are active in the residency program.

3.2 The sponsoring institution shall conduct its process of interviewing and selecting residents equitably and in an ethical manner.

The sponsoring institution must make available to the prospective resident

information describing the selection process and conditions of appointment established for the program. Interviews must not occur prior to, or be in conflict with, interview dates established by the national resident application matching service with which the residency program participates. The sponsoring institution must make the residency curriculum available to the prospective resident.

3.3 The sponsoring institution shall participate in a national resident application matching service and shall abide by the rules and regulations set forth by the matching service.

The sponsoring institution, including the program director, faculty, and residents, must not obtain a commitment, either oral or written, from the prospective resident prior to the date established by the national resident matching service in which the institution participates

Intent and Background: *The requirement exists to ensure programs and applicants are not subjected to undue influence or coercion during the match process.*

3.4 Application fees, if required, shall be paid to the sponsoring institution and shall be used only to recover costs associated with processing the application and conducting the interview process.

The sponsoring institution must publish its policies regarding application fees (i.e., amount, due date, uses, and refunds).

3.5 The sponsoring institution shall accept only graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed all components of Parts I and II examinations of the National Board of Podiatric Medical Examiners.

3.6 The sponsoring institution shall ensure that the resident is compensated equitably with and is afforded the same benefits, rights, and privileges as other residents at the institution. The institution shall provide the following benefits:

a. Health insurance

The sponsoring institution must provide health insurance for the resident for the duration of the training program. The resident's health insurance must be at least equivalent to that afforded other professional employees at the sponsoring institution.

b. Professional, family, and sick leave

The resident's leave benefits must be at least equivalent to those afforded other professional employees at the sponsoring institution.

c. Leave of absence

The sponsoring institution must establish a policy pertaining to leave of absence or other interruption of the resident's designated training period. In accordance with applicable laws, the policy must address continuation of pay and benefits and the effect of the leave of absence on meeting the requirements for completion of the residency program.

d. Professional liability insurance coverage

The sponsoring institution must provide professional liability insurance for the resident that is effective when training commences and continues for the duration of the training program. This insurance must cover all rotations at all training sites and must provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution must provide the resident with proof of coverage upon request.

e. Other benefits if provided (e.g., meals, uniforms, vacation policy, housing provisions, payment of dues for membership in national, state, and local professional organizations, and disability insurance benefits)

If the sponsoring institution does not offer other residency programs, then the resident must be compensated equitably with other residents in the geographic area.

The sponsoring institution should disclose annually to the program director the current amounts of direct and indirect graduate medical education reimbursement received by the sponsoring institution.

3.7 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall be signed and dated by the chief administrative officer of the institution or designated institutional official (DIO) and the resident.

The contract or letter must state the following:

a. whether the program to which the resident is appointed awards the reconstructive rearfoot/ankle credential upon completion of training;
b. the amount of the resident stipend;
c. duration of the agreement;
d. benefits provided; and
e. the length of the program, if it is approved by the Council to exceed 36 months.

When a letter of appointment is utilized, a written confirmation of acceptance must

be executed by the prospective resident and forwarded to the chief administrative officer or designated institutional official (DIO).

The contract or letter of appointment must be forwarded to the program director.

The stipend offered by the institution is determined as an annual salary. The amount of resident compensation must not be contingent on the productivity of the individual resident.

In the case of a co-sponsored program, the contract or letter of appointment must be signed and dated by the chief administrative officer or designated institutional official of each co-sponsoring institution and the resident and be forwarded to the program director.

For programs in which residents sign contracts with multiple institutions, a letter of understanding between those institutions must be in place, identifying the program director as the final authority to oversee resident training at all sites.

3.8 The sponsoring institution shall ensure that the resident is not required to sign a non-competition guarantee or restrictive covenant with the institution or any of its affiliated training sites upon graduation.

3.9 The sponsoring institution shall develop the following components compiled into a residency manual (in either written or electronic format) that is distributed to and acknowledged in writing by the resident at the beginning of the program and following any revisions. The manual shall include, but not be limited to, the following:

a. The mechanism of appeal

The sponsoring institution must establish a written mechanism of appeal that ensures due process for the resident and the sponsoring institution should there be a dispute between the parties. Any individual possessing a conflict of interest related to the dispute, including the program director, must be excluded from all levels of the appeal process.

b. Performance improvement methods established to address instances of unsatisfactory resident performance

The sponsoring institution must establish and delineate performance improvement methods to address instances of unsatisfactory resident performance (academic and/or attitudinal) and identify the time frame allowed for improvement. Performance improvement methods may include, but not be limited to, requiring that the resident repeat particular training experiences, spend additional hours in a clinic, or complete additional assigned reading to facilitate achievement of the stated competencies of the curriculum. Performance improvement methods should be completed no later than three

months beyond the normal length of the residency program.

c. Resident clinical and educational work hours

d. Rules and regulations for the conduct of the resident

e. Transition of care

Programs, in partnership with their sponsoring institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

f. Curriculum, including competencies and assessment documents specific to each rotation (refer to requirements 6.1 and 6.4)

Intent and Background: *Assessment documents and competencies must correlate. They may be included in a single document.*

g. Training schedule (refer to requirement 6.3)

h. Schedule of didactic activities and critical analysis of scientific literature (refer to requirements 6.7 and 6.8)

i. Policies and programs that encourage optimal resident well-being (refer to requirement 3.13)

j. CPME 320 and CPME 330

These documents may be provided within the manual or the manual may include links to the residency section of CPME's website.

3.10 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements.

The certificate must include the following:

- The statement "Approved by the Council on Podiatric Medical Education"
- At a minimum, the certificate must be signed by the program director and the chief administrative officer or DIO. In the case of a co-sponsored program, the certificate must be signed by the chief administrative officer or DIO of each co-sponsoring institution and the program director.
- Date of completion
- Identification of the residency as a "Podiatric Medicine and Surgery Residency"
- If applicable, the certificate must identify the added credential as "with the added credential in Reconstructive Rearfoot/Ankle Surgery"

3.11 The sponsoring institution shall ensure that the residency program is established and conducted in an ethical manner.

The conduct of the residency must focus upon the educational development of the resident rather than on service responsibility to individual faculty members.

Programs, in partnership with their sponsoring institution and affiliates, must provide a professional, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of trainees, faculty, and staff.

3.12 The sponsoring institution shall ensure that the resident does not assume the responsibility of ancillary medical staff.

3.13 The sponsoring institution shall ensure that policies and programs are in place that encourage optimal resident well-being.

The institution must provide residents the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during working hours.

The institution must provide education and resources that support faculty members and residents in identifying in themselves or others the risk factors of developing or demonstrating symptoms of fatigue, burnout, depression, and substance abuse, or displaying signs of self-harm, suicidal ideation, or potential for violence.

The institution must provide access to confidential and affordable mental health care, necessary for either acute or ongoing mental health issues.

The institution must provide an environment in which the physical and mental well-being of the resident is supported, without the resident fearing retaliation of any kind.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

4.1 The sponsoring institution shall report annually to the Council office on institutional data, residents completing training, residents selected for training, changes in the curriculum, and other information requested by the Council and/or the Residency Review Committee.

4.2 The sponsoring institution shall inform the Council office in writing within 30 calendar days of substantive changes in the program.

The sponsoring institution must inform the Council of changes in areas including, but not limited to the following:

- Change in sponsorship
- Change in the chief administrative officer, DIO, or designee
- Resignation or termination of the program director, and/or appointment of a new program director
- Resident resignation, termination, or transfer
- Delay in resident starting date
- Resident extended leave of absence
- Resident extension of training

Intent and Background: *The Council must be informed of these changes to ensure continuity of communication with the institution and program director. Information related to the resident is needed for future verification of training.*

4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, and current and incoming residents informing them of adverse actions or voluntary termination of the program. Program applicants shall be notified prior to their interview.

The institution must submit either the program applicants' and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicants' and the current and incoming residents' receipt of the institution's letter. These materials must be submitted as part of the progress report that is due to CPME at a date identified by the RRC.

Adverse actions include probation, withholding of provisional approval, and withdrawal of approval.

PROGRAM STANDARDS AND REQUIREMENTS

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

5.1 The sponsoring institution shall designate one podiatric physician as program director to serve as administrator of the residency program. The program director shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.

The sponsoring institution must provide compensation to the program director. This compensation must be commensurate with that provided other residency directors at the institution. If the sponsoring institution does not offer other residency programs, then the program director must be compensated equitably with other program directors in the geographic area.

The program director must be a member of the medical staff and/or employed by the sponsoring institution, or in the case of a co-sponsorship, at one of the sponsoring institutions. The program director must be a member of the graduate medical education committee or equivalent within the institution. The program director should be a member of national, state, and/or local professional organization(s).

Because of the potential of creating confusion in the leadership and direction of the program, co-directorship is specifically prohibited; however, the program director may appoint an assistant/associate director to assist in administration of the residency program. A residency training committee also may be established to assist the program director in the administration of the residency program.

Co-sponsoring institutions must designate one program director responsible for the entire co-sponsored residency. This individual must be provided the authority and have the ability to oversee resident training at all sites.

5.2 The program director shall possess appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and achieving the stated competencies of the residency.

The program director (appointed after the implementation date of this document) must be certified by at least one board recognized by the Specialty Board Recognition Committee and must have a minimum of three years of post-residency clinical experience.

In certain circumstances, the sponsoring institution may, with approval by the RRC or its chair, appoint an interim residency director who does not meet the qualifications identified in this requirement and guideline. Institutions must specify

the anticipated length of time the interim director will serve, and this appointment may be subject to continued approval by the RRC.

Intent and Background: *Leading a program requires knowledge and skills that are established during residency and further developed subsequently. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming established professionally. The three-year period is intended for the individual's professional maturation.*

5.3 The program director shall be responsible for the administration of the residency in all participating institutions. The program director shall be able to devote sufficient time to fulfill the responsibilities required of the position. The program director shall ensure that each resident receives equitable training experiences.

The director is responsible for maintenance of records related to the educational program, communication with the RRC and Council, scheduling of rotations, instruction, supervision, review and verification of logs, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. In a co-sponsored program, the director is responsible for ensuring that the Council is provided requested information for all residents at all training sites, not just at one of the co-sponsoring sites (e.g., the institution at which the director is based).

The director must not delegate to the resident maintenance of records related to the educational program, communication with the RRC and Council, scheduling of rotations, instruction, supervision, verification of logs, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

The director must ensure resident participation in training resources and didactic experiences (e.g., lectures, journal review sessions, conferences, and seminars).

5.4 The program director shall participate at least annually in faculty development activities (i.e., administrative, organizational, teaching, and/or research skills for residency programs).

The faculty development activities and programs should be delivered by continuing education providers approved by the Council or another appropriate agency. Formal faculty development programs provided by teaching hospitals and colleges will be acceptable with appropriate documentation.

5.5 The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident.

The complement of faculty relates to the number of residents, institutional type and

size, organization, and capabilities of the services through which the resident rotates, and training experiences offered outside the sponsoring institution.

Faculty members must take an active role in the presentation of lectures, conferences, journal review sessions, and other didactic activities. Faculty members must supervise and evaluate the resident in clinical sessions and assume responsibility for the quality of care provided by the resident during the clinical sessions that they supervise. Faculty members must discuss patient evaluation, treatment planning, patient management, complications, and outcomes with the resident and review records of patients assigned to the resident to ensure the accuracy and completeness of these records.

The program director has the authority to approve and remove program faculty members from participation in the residency program at all sites.

5.6 Podiatric and non-podiatric medical faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible.

The active podiatric faculty must include sufficient representation by individuals qualified or certified by each board recognized by the Specialty Board Recognition Committee, or by individuals possessing other specialized qualifications acceptable to the RRC. Faculty members must be able to competently instruct and supervise residents.

Podiatric faculty should participate in faculty development activities to improve teaching, research, and evaluation skills.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

The resident must be afforded training in the breadth of podiatric health care. Completion of a podiatric residency currently leads to the following certification pathways: the American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM).

Completion of a podiatric residency with the added credential in reconstructive rearfoot/ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of ABFAS.

Additional educational experiences may be added to the curriculum to extend the length of the program up to 48 months. The program director must obtain the approval of the sponsoring institution and RRC prior to implementation and at each subsequent approval review of the program. Programs that extend the residency beyond 36 months must present a clear educational rationale.

The Council and RRC view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

- Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, biomechanical, and surgical means.

- Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident's competencies in the perioperative care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.

- Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

- Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.

At the beginning of the training year, all site coordinators or rotations directors must be provided the training schedule, competencies, and assessment documents for their respective rotation(s).

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the lower extremity.

1. Perform and interpret the findings of a thorough history and physical exam, including neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis as indicated.

2. Formulate an appropriate diagnosis and/or differential diagnosis.

3. Understand the indication(s) for and interpret appropriate diagnostic studies, including:

   - Medical imaging (e.g., plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging).
   - Laboratory tests (e.g., hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis).
   - Pathology (e.g., anatomic and cellular pathology).
   - Other diagnostic studies (e.g., electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies).

4. Participate directly in the evaluation and management of patients in inpatient and outpatient settings, including the following:

   - Perform biomechanical examination and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
   - Dermatologic conditions.
   - Neurological conditions.
   - Orthopedic conditions.

- Arterial and venous conditions.
- Wound care.
  - Congenital deformities (e.g., manipulation, casting, bracing of foot/ankle).
  - Trauma.
  - Office-based procedures (e.g., injections and aspirations, nail avulsion, biopsies).
  - Pharmacologic management.
  - Lower extremity health promotion and education.

5. Participate directly in the evaluation and management of the surgical patient when indicated, including the following:

   - Evaluating, diagnosing, selecting appropriate treatment, and recognizing and managing complications.
   - Progressive development of knowledge, attitudes, and skills in perioperative assessment and management in foot and ankle surgery (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).

6. Assess the treatment plan and revise it as necessary.

B. Assess and manage the patient's general medical and surgical status.

1. Perform and interpret the findings of comprehensive medical history and physical examinations through diverse podiatric and non-podiatric experiences, including (see Appendix A):

   - Comprehensive medical history.
   - Comprehensive physical examination.
     - Vital signs.
     - Physical examination (e.g., head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic examination).

2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).

3. Understand the indication(s) for and interpret the results of diagnostic studies including (see also section A.3 for diagnostic studies not repeated in this section).

   - EKG.
   - Medical imaging (e.g., plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound).
   - Laboratory studies (e.g., hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases,

microbiology, synovial fluid analysis, and urinalysis).
- Other diagnostic studies.

4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.

5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, gender, psychosocial status, and socioeconomic status.

6. Participate actively in non-podiatric surgical rotations that include surgical evaluation and management of patients including, but not limited, to:

   - Understanding management of preoperative and postoperative surgical patients
   - Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision
   - Understanding surgical procedures and principles applicable to non-podiatric surgical specialties

7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:

   - Local anesthesia.
   - General, spinal, epidural, regional, and conscious sedation anesthesia.

8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.

9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:

   - Recognizing and diagnosing common infective organisms.
   - Using appropriate antimicrobial therapy.
   - Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
   - Managing patients with local and systemic infections.

C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

2. Practice and abide by the principles of informed consent.

3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

4. Demonstrate professional humanistic qualities.

5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of health-care costs.

D. Communicate effectively and function in a multi-disciplinary setting.

1. Demonstrate effective physician-patient communication skills.

2. Demonstrate effective physician-provider communication skills.

3. Demonstrate appropriate medical record documentation.

4. Demonstrate appropriate consultation and/or referrals.

E. Manage individuals and populations in a variety of socioeconomic and health-care settings.

1. Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.

2. Demonstrate cultural humility and responsiveness to values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.

3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

F. Understand podiatric practice management in a multitude of health-care delivery settings.

1. Demonstrate familiarity with utilization management and quality improvement.

2. Understand health-care coding and reimbursement.

3. Explain contemporary health-care delivery systems.

4. Understand insurance issues including professional and general liability, disability, and Workers' Compensation.

5. Understand medical-legal considerations involving health-care delivery.

6. Demonstrate understanding of common business practices.

G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and evidence-based practice.

1. Read, interpret, and critically analyze and present medical and scientific literature.

2. Demonstrate information technology skills in learning, teaching, and clinical practice.

3. Participate in education activities.

6.2 The sponsoring institution shall require that the resident maintain web-based logs documenting clinical and didactic experiences related to the residency.

The format must be approved by and accessible for review by the RRC.

The format must categorize and summarize medical/surgical diversity and experiences (refer to Appendices A and B).

6.3 The program shall establish a formal schedule for clinical training.

The program shall provide an anticipated rotation schedule for residents throughout the entirety of their training, including rotation lengths, rotation formats (block or sequential only), and rotation locations. Specific dates need only be included for the current academic year.

The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

The residency must be continuous and uninterrupted unless extenuating circumstances are present.

The length of residency education to be conducted in a supervised podiatric private practice office-based setting must not exceed seven months or 20 percent of a 36-

month training program.

6.4 The residency program shall provide rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include podiatric medicine and surgery as well as non-podiatric rotations. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.

The program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources. In developing the curriculum, the program director must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

In addition to podiatric medicine and surgery, the following rotations and minimum lengths of training are required. Each of the rotations must be a minimum of two weeks of training unless otherwise noted:

a. Anesthesiology

b. Behavioral medicine

b. Emergency medicine (minimum of four weeks of training).

c. Medical imaging

d. Medical specialties. There is a minimum requirement of **12 cumulative weeks** of training in medical specialties.

   Training must include rotations in:
   - Internal medicine/Family Medicine (minimum 4 weeks)
   - Infectious Disease

   Training must also include at least <u>two</u> of the following rotations
   - Burn unit, dermatology, endocrinology, geriatrics, intensive/critical care unit, neurology, pain management, pediatrics, physical medicine and rehabilitation, rheumatology, wound care, and vascular medicine.

e. Surgical specialties: There is a minimum requirement of **8 cumulative weeks** of training in surgical specialties. Training must include at least <u>two</u> of the following rotations, with a minimum of two weeks in endovascular/vascular surgery.

   - Endovascular/vascular surgery (at least two weeks)

- Cardiothoracic surgery, general surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, plastic surgery, or surgical intensive care unit (SICU), trauma team/surgery.

While a typical training week involves five working days. CPME recognizes that holidays may shorten a work week.

6.5 The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of training.

Resident certification must be obtained as early as possible during the training year but no later than six months after the resident's starting date.

6.6 The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.

The program director must assure that patient records document accurately the resident's participation in patient care activities.

The resident should participate in quality improvement and utilization review activities.

6.7 Didactic activities that complement and supplement the curriculum shall be available.

Residents must be afforded protected time for weekly didactic activities. Didactic activities must be provided in a variety of formats. These formats may include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

Training in the following must be provided to the resident at least once per year of training:

- Falls prevention.
- Resident well-being (e.g., substance abuse, fatigue mitigation, suicide prevention, self-harm, and physician burnout).
- Pain management (i.e., multi-modal approach to chronic and acute pain) and opioid addiction.
- Cultural humility (e.g., training in implicit bias, diversity, inclusion, and culturally effective components particularly regarding access to care and health outcomes).
- Workplace harassment and discrimination awareness and prevention.

Training in research methodology must be provided at least once during residency

training (e.g., web-based training, formal lectures, or a dedicated research rotation).

The majority of didactic activities must include participation by at least one faculty member.

The program director may appoint a faculty member to coordinate didactic activities.

Intent and Background: *Didactic experiences provide an opportunity to expand the resident's knowledge in the breadth of podiatric medicine, including biomechanical assessment and surgical evaluation and management. The annual instruction may be provided during resident orientation, focused activities, and through web-based programs. CPME recognizes that holidays may interrupt regularly scheduled weekly didactic activities.*

6.8 The curriculum shall afford the resident instruction in the critical analysis of scientific literature.

A journal review session, with participation of faculty and residents, must be scheduled at least monthly. The resident should present current articles and analyze the content and validity of the research.

6.9 The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.

The program must define levels of resident supervision appropriate for the level of training.

6.10 The residency program shall ensure the resident is afforded appropriate clinical and educational work hours.

Work Hours: Clinical and education work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home.

Work Periods: (A) Except as provided in (B, below), clinical and educational work periods for residents must not exceed 24 hours of continuous in-house activity and must be followed by at least eight hours free of clinical work and education. (B) The 24-hour work period may be extended up to four hours of additional time for necessary patient safety, effective transitions of care, and/or resident education.

In-house Call: Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Outside Activities: The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident's ability to function in the training program.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

7.1 The program director shall review, evaluate, and verify resident logs on a monthly basis.

The program director must review the logs for accuracy to ensure that there is no duplication, miscategorization, and/or fragmentation of procedures into their component parts. Procedure notes must support the selected experience.

The program director must monitor resident logs to ensure resident attainment of the Minimum Activity Volume (MAV) and diversity requirements prior to completion of training.

7.2 The faculty and program director shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.

a. Faculty Assessment of the Resident

Assessment forms must be completed for all rotations identified in the curriculum. The document must specify the dates covered, the name of the resident, and the name of the faculty member. The assessment must be signed and/or electronically acknowledged and dated by the faculty member, the resident, and the program director. The document must assess competencies specific to each rotation including communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency must allow sufficient opportunity for performance improvement.

Assessment must be documented at least once for every three months of uninterrupted training in podiatric medicine and/or podiatric surgery service and must include assessment of resident outpatient podiatric experiences (clinic and/or private practice offices).

Intent and Background: *Podiatric medicine and surgery assessment forms may be combined or separate documents.*

Electronic or written acknowledgement of receipt and review of the assessment by the resident and program director is acceptable.

b. Program Director Semi-annual Assessment of the Resident

The program director must conduct and document a semi-annual meeting with

each resident on an individual basis. The semi-annual assessment must be signed and dated by the program director and the resident. This review must include the following:

- Review of milestones as completed by the clinical competency committee (see Appendix C)
- Review of completed rotation assessments (see requirement 7.2a)
- In-training examinations
- Projected attainment of MAVs

c. Program Director Final Assessment of the Resident

The program director must conduct a final meeting with each resident upon completion of the program. A final assessment must be provided in a written format and include the date and signatures of the program director and the resident. The final assessment must:

- become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy, and
- verify that the resident has achieved the competencies of the residency program and ensure attainment of MAVs in all categories.

Intent and Background: *The final assessment of the resident is to be conducted in lieu of the semi-annual assessment. This must be conducted within the resident's final two months of training.*

7.3 **The program shall require that all residents take an annual in-training examination as offered by SBRC-recognized specialty boards.**

The sponsoring institution must pay any fees associated with the examinations. The program must require that residents take one exam from each SBRC-recognized specialty board at least once during their time in residency training.

Examination results are used as a guide for resident performance improvement and as part of the annual self-assessment of the program.

7.4 The program director, faculty, and resident(s) shall conduct a formal, written annual self-assessment of the program's resources and curriculum. Information resulting from this review shall be used in improving the program.

The review must include the following:

a. Identification of individuals involved (e.g., program director, faculty, and residents).

b. Performance data utilized (e.g., evaluation of the program's compliance with the standards and requirements of the Council, the resident's formal evaluation of the program, the director's formal evaluation of the faculty, and the extent to which the didactic activities complement and supplement the curriculum).

c. Measures of program outcomes utilized (e.g., in-training examination results, success of previous residents in private practice and teaching environments, board certification pass rates, hospital appointments, and publications).

d. Results of the review (i.e., whether the curriculum is relevant to the competencies, the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether the resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved).

APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

A. Patient Care Activity Requirements **MAV**
(Abbreviations are defined in section B.)

Case Activities	
Foot and ankle surgical cases (PMSR/RRA)	300
Foot and ankle surgical cases (PMSR only)	250
Trauma cases	50
Podopediatric cases	25
Other podiatric procedures	100
Podiatric wound care	50
Biomechanical examinations	50
Comprehensive history and physical examinations	50
Procedure Activities	
First and second assistant procedures (total)	400
First assistant procedures, including:	
Digital	80
First Ray	60
Other Soft Tissue Foot Surgery	45
Other Osseous Foot Surgery	40
Reconstructive Rearfoot/Ankle (added credential only)	50

B. Definitions

1. Levels of Resident Activity for Each Logged Procedure

First assistant: The resident participates actively in the procedure under direct supervision of the attending.

Second assistant: The resident participates in the procedure in a limited capacity under direct supervision of the attending.

2. Minimum Activity Volume (MAV)

MAVs are patient care activity requirements that assure that the resident has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. It is incumbent upon the program director and the faculty to assure that the resident has achieved a competency, regardless of the number of repetitions.

3. Required Case Activities

A case is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

a. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.

b. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients in the acute phase of a traumatic episode. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Comprehensive history and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

   Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.

   Intent and Background: *The acute phase of trauma is defined as occurring within six weeks of the initial injury.*

c. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of foot and ankle pathology in patients who are less than 18 years of age.

d. Biomechanical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by biomechanical means. These experiences include, but are not limited to, performing lower extremity biomechanical examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders.

e. Comprehensive history and physical examinations. Admission, preoperative, and outpatient H&Ps may be used as acceptable forms of a comprehensive H&P, 25 of which must be performed during non-podiatric rotations. A problem-focused history and physical examination does not fulfill this requirement.

   The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to utilize

information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

f. Lower Extremity Wound Care. Management of lower extremity wounds, including debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal), advanced wound modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot), and/or hyperbaric oxygen therapy. Does not include 6.6, repair of simple laceration or simple delayed wound closure in Appendix B. Non-podiatric wound care should be logged as category 10.20.

4. Required Procedure Activities

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable (e.g., a bunionectomy that has been fragmented into an osseous procedure and an adjunctive soft tissue procedure, creating two separate procedures, is unacceptable).

Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies.

C. Assuring Diversity of Experience

The construct of the procedure categories assures some degree of diversity in the resident's training experience. The two paragraphs below relate to **first assistant procedures only.**

To assure proper diversity within each procedure category and subcategory, at least 33 percent of the procedure codes within each category and subcategory must be represented. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedure codes must have at least one activity.

To avoid overrepresentation of one procedure within a category and subcategory, one procedure code must not represent more than 33 percent of the minimum number of procedures required in each procedure category and subcategory.

Intent and Background: *This statement applies more to a resident just meeting the minimum procedure requirement in a procedure category than to a resident significantly exceeding the procedure requirement in a procedure category. For example, the number of partial ostectomies must not exceed 26 when the minimum of 80 required Digital procedures are logged.*

D. Multiple Residents and/or Fellows

1. Only one resident/fellow may take credit for first assistant participation on any one procedure.

2. More than one resident may take credit for second assistant participation.

3. The activity of a fellow should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

4. When multiple procedures are performed on a single patient, more than one resident/ fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

5. Individual procedures may not be fragmented to allow for multiple residents/fellow(s) to claim first assistant participation.

APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

The following categories, procedures, and codes must be used for logging surgical procedure activity:

1 Digital Surgery (lesser toe or hallux)

1.1	partial ostectomy/exostectomy
1.2	phalangectomy
1.3	arthroplasty (interphalangeal joint [IPJ])
1.4	implant (IPJ) (silastic implant or spacer)
1.5	diaphysectomy
1.6	phalangeal osteotomy
1.7	fusion (IPJ)
1.8	amputation
1.9	management of osseous tumor/neoplasm
1.10	management of bone/joint infection
1.11	open management of digital fracture/dislocation
1.12	revision/repair of surgical outcome
1.13	other osseous digital procedure not listed above

2 First Ray Surgery

Hallux Valgus Surgery

2.1.1	bunionectomy (partial ostectomy/Silver procedure), with or without capsulotendon balancing procedure
2.1.2	(procedure code number no longer used)
2.1.3	bunionectomy with phalangeal osteotomy
2.1.4	bunionectomy with distal first metatarsal osteotomy
2.1.5	bunionectomy with first metatarsal base or shaft osteotomy
2.1.6	bunionectomy with first metatarsocuneiform fusion
2.1.7	metatarsophalangeal joint (MPJ) fusion
2.1.8	MPJ implant
2.1.9	MPJ arthroplasty
2.1.10	bunionectomy with double correction with osteotomy and/or arthrodesis

Hallux Limitus Surgery

2.2.1 cheilectomy
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
2.2.3 joint salvage with distal metatarsal osteotomy
2.2.4 joint salvage with first metatarsal shaft or base osteotomy
2.2.5 joint salvage with first metatarsocuneiform fusion
2.2.6 MPJ fusion
2.2.7 MPJ implant
2.2.8 MPJ arthroplasty

Other First Ray Surgery

2.3.1 tendon transfer/lengthening/procedure
2.3.2 osteotomy (e.g., dorsiflexory)
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
2.3.4 amputation
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
2.3.6 management of bone/joint infection (with or without bone graft)
2.3.7 open management of fracture or MPJ dislocation
2.3.8 corticotomy/callus distraction
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
2.3.10 other first ray procedure not listed above

3 Other Soft Tissue Foot Surgery

3.1 excision of ossicle/sesamoid
3.2 excision of neuroma
3.3 removal of deep foreign body (excluding hardware removal)
3.4 plantar fasciotomy
3.5 lesser MPJ capsulotendon balancing
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
3.7 open management of dislocation (MPJ/tarsometatarsal)
3.8 incision and drainage/wide debridement of soft tissue infection (includes foot, ankle or leg)
3.9 plantar fasciectomy/ plantar fibroma resection
3.10 excision of soft tissue tumor/mass (without reconstructive surgery: includes foot, ankle or leg)
3.11 (procedure code number no longer used)
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
3.13 microscopic nerve/vascular repair (forefoot only)
3.14 other soft tissue procedures not listed above (limited to the foot)
3.15 (procedure code number no longer used)
3.16 external neurolysis/decompression (including tarsal tunnel)
3.17 decompression of compartment syndrome (includes foot or leg)

4 Other Osseous Foot Surgery

4.1 partial ostectomy (including the talus and calcaneus) (includes foot, ankle, or leg)
4.2 lesser MPJ arthroplasty
4.3 bunionectomy of the fifth metatarsal without osteotomy
4.4 metatarsal head resection (single or multiple)
4.5 lesser MPJ implant
4.6 central metatarsal osteotomy
4.7 bunionectomy of the fifth metatarsal with osteotomy
4.8 open management of lesser metatarsal fracture(s)
4.9 harvesting of bone graft distal to the ankle (includes foot, ankle, or leg)
4.10 amputation (lesser ray, transmetatarsal amputation)
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
4.13 open management of tarsometatarsal fracture/dislocation
4.14 multiple osteotomy management of metatarsus adductus
4.15 tarsometatarsal fusion
4.16 corticotomy/callus distraction of lesser metatarsal
4.17 revision/repair of surgical outcome in the forefoot
4.18 detachment/reattachment of Achilles tendon with partial ostectomy
4.19 other osseous procedures not listed above (distal to the tarsometatarsal joint)

5 Reconstructive Rearfoot/Ankle Surgery

Elective - Soft Tissue

5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
5.1.5 delayed primary or secondary repair of ligamentous structures
5.1.6 tendon augmentation/supplementation/restoration
5.1.7 open synovectomy of the rearfoot/ankle
5.1.8 (procedure code number no longer used)
5.1.9 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

Elective - Osseous

5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.2 (procedure code number no longer used)
5.2.3 subtalar arthroeresis
5.2.4 midfoot, rearfoot, or ankle fusion
5.2.5 midfoot, rearfoot, or tibial osteotomy
5.2.6 coalition resection
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy/arthroscopy with removal of loose body or other osteochondral debridement
5.2.9 ankle implant
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
5.2.11 other elective rearfoot reconstructive/ankle osseous surgery not listed above

Non-Elective - Soft Tissue

5.3.1 repair of acute tendon injury
5.3.2 repair of acute ligament injury
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
5.3.4 excision of soft tissue tumor/mass of the foot, ankle, or leg (with reconstructive surgery)
5.3.5 (procedure code number no longer used)
5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above
5.3.8 (procedure code number no longer used)

Non-Elective - Osseous

5.4.1 open repair of adult midfoot fracture
5.4.2 open repair of adult rearfoot fracture
5.4.3 open repair of adult ankle fracture
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
5.4.5 management of bone tumor/neoplasm (with or without bone graft)
5.4.6 management of bone/joint infection (with or without bone graft)
5.4.7 amputation proximal to the tarsometatarsal joints
5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above
5.4.9 (procedure code number no longer used)

6 Other Podiatric Procedures

6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
6.3 nail avulsion (partial or complete)
6.4 matrixectomy (partial or complete, by any means)
6.5 removal of hardware (internal or external fixation)
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement); includes simple delayed wound closure
6.8 extracorporeal shock wave therapy
6.9 taping/padding/splinting/casting (limited to the foot and ankle)
6.10 orthotics/prosthetics (limited to the foot and ankle casting/scanning/impressions for foot and/or ankle orthosis)
6.14 percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma, digital tenotomy)
6.15 foot care (nail debridement, callus paring)
6.16 therapeutic/diagnostic injections (without sedation)
6.17 incision and drainage (performed outside of the operating room)
6.18 closed reduction of fracture or dislocation
6.19 removal of foreign body (not in the operating room)
6.20 application of external fixation

7 Biomechanics

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment

8 History and Physical Examination

8.1 comprehensive history and physical examination
8.2 problem-focused history and physical examination

9 Surgery Specialties

9.1 general surgery
9.2 orthopedic surgery
9.3 plastic surgery
9.4 vascular surgery
9.5 cardiothoracic surgery
9.6 hand surgery
9.7 neurosurgery
9.8 orthopedic/surgical oncology
9.9 pediatric orthopedic surgery
9.10 surgical intensive care unit (SICU)
9.11 trauma team/surgery
9.12 other

10 Medicine and Medical Subspecialty Experiences

10.1 anesthesiology
10.2 cardiology
10.3 dermatology
10.4 emergency medicine
10.5 endocrinology
10.6 family practice
10.7 gastroenterology
10.8 hematology/oncology
10.9 imaging
10.10 infectious disease
10.11 internal medicine
10.12 neurology
10.13 pain management
10.14 pathology
10.15 pediatrics
10.16 physical medicine and rehabilitation
10.17 psychiatry/behavioral medicine
10.18 rheumatology
10.19 sports medicine
10.20 wound care (non-podiatric)
10.21 burn unit
10.22 intensive/critical care (ICU/CCU)
10.23 geriatrics
10.24 vascular medicine
10.25 other

11 Lower Extremity Wound Care

11.1 debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal)
11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot)
11.3 hyperbaric oxygen therapy

APPENDIX C: MILESTONES

Milestones are a semi-annual assessment tool, completed by a clinical competency committee, that provide a consistent framework for formative assessment of the resident. Milestones demonstrate the resident's progression towards competency throughout residency training.

The program director must appoint a clinical competency committee to complete the milestones for each resident on a semi-annual basis. This committee must include three members and should be comprised of health-care professionals (faculty members and/or ancillary medical staff) who have extensive experience working with each of the residents and can comment on the progression of each resident throughout the program and identify gaps in their individual training. While the program director may be a member of this committee, the committee must be chaired by someone other than the program director. The clinical competency committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress on the milestones.

The milestones appear on the following pages.

Scale Explanation:

The Level 1 to Level 5 scale is synonymous with moving from novice to expert. It does not correspond to a resident's year in a training program.

Level 1 = The resident demonstrates a milestone expected of an incoming resident.

Level 2 = The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level

Level 3 = The resident continues to advance and demonstrates additional milestones, consistently including the majority of milestones targeted for residency.

Level 4 = The resident has advanced so that they now substantially demonstrate the milestones targeted for residency. This level is designed as the graduation target but is not a requirement for graduation.

Level 5 = The resident has advanced beyond performance targets set for residency and their achievements in a subcompetency are greater than the expectation.

1. Practice-Based Learning and Improvement: Reflective Practice and Commitment to Personal Growth				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates how to access and use available evidence, and incorporate patient preferences and values into the care of patients with routine conditions	Articulates clinical questions and elicits patient preferences and values to guide evidence-based care	Locates and applies the best available evidence, integrated with patient preference, to the care of complex conditions	Critically appraises and applies both evidence-based medicine and personal experience in the care of patients	Coaches others to critically appraise and apply evidence for patients with complex conditions; and/or participates in the development of guidelines and learning plans
Accepts responsibility for personal and professional development by establishing goals. Identifies the strengths, deficiencies and limitations in one's own knowledge and expertise	Demonstrates openness to peer and supervisory feedback and other input to inform goals. Analyzes and reflects on the strengths, deficiencies, and limitations in one's knowledge and expertise to design a learning plan	Responds to feedback and other input with adaptability and humility. Creates and implements a learning plan to optimize educational and professional development	Uses ongoing reflection, feedback, and other input to measure the effectiveness of the learning plan and when necessary, improves it	Serves consistently as a role model, seeking feedback and other input with adaptability and humility
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

2. Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
Gathers necessary information and develops a differential diagnosis for patients in inpatient and outpatient clinical settings	Organizes and accurately summarizes information obtained from the patient evaluation to develop a clinical impression in inpatient and outpatient clinical settings	Develops a plan to manage patients with straightforward conditions in inpatient and outpatient clinical settings	Develops a plan to manage patients with complex conditions in inpatient and outpatient clinical settings	Teaches and develops a clinical pathway or guideline for the management of patients with complex conditions in inpatient and outpatient clinical settings
Performs a general physical examination while attending to patient comfort and safety	Performs a problem-focused physical examination for a common patient presentation	Performs a problem-focused physical examination for a complex patient presentation	Uses advanced maneuvers to elicit subtle findings	Teaches and develops a clinical pathway or guideline
Identifies pathologies indicating simple lower extremity surgical intervention	Proposes surgical procedures for simple lower extremity pathologies	Identifies pathologies indicating complex lower extremity surgical intervention	Proposes surgical procedures for complex lower extremity pathologies	Proposes and defends a comprehensive surgical plan for patients
Evaluates patients for simple perioperative management concerns	Evaluates patients for complex perioperative management concerns	Manages with supervision perioperative problems in patients with multiple co-morbidities	Manages post-operative problems independently in patients with complex conditions	Teaches and develops a clinical pathway or guideline for management of complex perioperative problems

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Not Yet Assessable ☐

3. Patient Care – Biomechanical Examination				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates understanding of appropriate problem-focused history and physical in patients with functional deficits of lower extremity musculoskeletal deformities	Performs an appropriate problem-focused history and physical in patients with functional deficits of lower extremity musculoskeletal deformities	Demonstrates use of differential diagnosis of lower extremity musculoskeletal deformities	Implements treatment plans based on history and physical findings in patients with functional deficits and/or deformity of lower extremity	Models and teaches appropriate problem-focused history and physical in patients with lower extremity musculoskeletal deformities and functional deficits
Demonstrates appropriate examination of functional deficits and/or deformity including manual muscle testing and gait examination	Performs appropriate examination of functional deficits and/or deformity including manual muscle testing and gait examination	Demonstrates the use of differential diagnosis in functional deficits and/or deformity including manual muscle testing and gait examination	Develops and implements treatment plans based on examination of functional deficits and/or deformity including manual muscle testing and gait examination	Models and teaches appropriate examination of functional deficits and/or deformity including manual muscle testing and gait examination
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐
Not Yet Assessable ☐

4. Patient Care – Intra-operative Technical Skills

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited surgical dexterity	Demonstrates careful surgical dexterity with directed spatial reasoning for uncomplicated procedures (e.g., forefoot procedures)	Demonstrates surgical dexterity with directed spatial reasoning for more complex procedures (e.g., reconstructive rearfoot/ankle procedures)	Demonstrates careful surgical dexterity while incorporating independent spatial reasoning for complex procedures	Develops innovative operative techniques, instrumentation, operative approaches, or significant improvement in established techniques
Demonstrates an understanding of various fixation techniques	Demonstrates usage of simple fixation techniques (e.g., k-wires, screw fixation)	Demonstrates usage of complex fixation techniques (e.g., plate fixation, static external fixation)	Demonstrates use of advanced fixation techniques (e.g., multiplanar external fixation, intermedullary nails)	Develops innovative or novel fixation techniques
Moves forward with operating room procedures only with active direction	Moves forward with operating room procedures with minimal direction	Moves fluidly through the course of the operation and anticipates next steps	Adapts to unexpected findings and events during the course of the operation	Guides or instructs more junior learners during the course of the operation
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐
Not Yet Assessable ☐

5. Patient Care - Other Procedures

Level 1	Level 2	Level 3	Level 4	Level 5
Identifies the need for wound and lower extremity care	Demonstrates basic wound and lower extremity care (e.g., at-risk foot care, casting, orthotics, ingrown toenail procedure, injections)	Demonstrates complex wound and lower extremity care (e.g., incision and drainage, repair of lacerations complex or simple)	Demonstrates advanced lower extremity care modalities (e.g., negative pressure wound therapy, closed reduction)	Instructs junior learners to perform lower extremity care
☐ ☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Not Yet Assessable ☐

6. Systems-Based Practice

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of quality improvement and patient safety	Uses institutional reporting system to report patient safety events	Participates in disclosure of patient safety events and quality improvement projects	Provides improvements to system-based patient safety concerns	Conceptualizes and initiates quality improvement and patient safety projects at the institutional or community level
Identifies key elements for safe and effective transitions of care/hand-offs	Performs safe and effective transitions of care/handoffs in routine clinical situations	Performs safe and effective transitions of care/hand-offs in complex clinical situations	Performs safe and effective transitions of care/handoffs within and across health-care delivery systems including outpatient settings	Improves quality of transitions of care within and across health-care delivery systems to optimize patient outcomes
Demonstrates knowledge of care coordination	Identifies specific population and community health needs and inequities for the local population	Uses local resources effectively to meet patient needs and coordinates care by engaging interprofessional team	Participates with the interprofessional team in changing and adapting practice to provide for the needs of specific populations	Leads innovations and advocates for populations and communities with health care inequities
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐
Not Yet Assessable ☐

7. Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates a basic scientific knowledge (e.g., physiology, biomechanics, mechanism of disease) of common presentations and conditions	Demonstrates a basic scientific knowledge of complex presentations and conditions	Integrates scientific knowledge to address comorbid conditions within the context of multisystem disease	Integrates scientific knowledge to address uncommon, atypical, or complex comorbid conditions within the context of multisystem disease	Demonstrates a detailed understanding of the scientific knowledge related to uncommon, atypical, or complex conditions
Explains the scientific basis for common pharmacologic and non-pharmacologic therapies	Explains the indications, contraindications, risks, and benefits of common therapies	Integrates knowledge of therapeutic options in patients with comorbid conditions, multisystem disease, or uncertain diagnosis	Integrates knowledge of therapeutic options within the clinical and psychosocial context of the patient to formulate treatment options	Demonstrates a detailed understanding of emerging, atypical, or complex therapeutic options
Orders and interprets results of common diagnostic modalities (e.g., physical exam, imaging)	Orders and interprets results of complex diagnostic modalities (e.g., physical exam, imaging)	Integrates complex diagnostic data accurately to reach high-probability diagnoses	Uses results of diagnostic modalities to develop a plan for managing complications	Identifies and integrates emerging diagnostic modalities and their applications

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Not Yet Assessable ☐

8. Interpersonal and Communication Skills - Patient and Family-Centered Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Communicates effectively with active listening and is attentive and respectful to patients and families/caregiver(s)	Identifies barriers to communication (e.g., language, cultural differences, cognitive disabilities, health literacy)	Identifies and uses available resources to overcome barriers to communication with patients and families/caregiver(s)	Recognizes biases and incorporates patient perspectives and beliefs to ensure effective communication	Coaches or teaches others on effective communication skills
Demonstrates ability to begin discussions to obtain informed consent	Answers questions about treatment plans with assistance	With guidance, counsels patients and family/caregiver(s) through decision-making regarding treatment plans	Independently counsels patients and family/caregiver(s) to develop a treatment plan	Coaches or teaches others on effective shared decision-making
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

9. Interpersonal and Communication Skills - Team-Centered Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes the value and role of the health-care team and respectfully interacts with all members	Demonstrates respectful and effective communication to all members of the health-care team and identifies barriers and biases to communication	Mitigates communication barriers and biases within the health-care team	Facilitates respectful communications and conflict resolution with the health-care team	Teaches effective communication and conflict management skills within the health-care team
Respectfully communicates with consultants	Responds to consultation requests in a clear, concise, and timely manner	Communicates understanding of treatment recommendations and options when providing or receiving a consultation	Effectively communicates with members of the health-care team to optimize patient care by coordinating recommendations from the primary and/or consulting team	Teaches others on skills of effective communication with consultants
Accurately records information in the patient record while safeguarding patient personal health information	Demonstrates accurate, timely, and efficient use of electronic health record to communicate with the health-care team	Concisely reports diagnostic and therapeutic management plans in the electronic health record while incorporating relevant outside data	Communicates via electronic health record to offer clear and constructive suggestions for patient care	Demonstrates expertise in electronic health record technology and uses knowledge to improve system-based health care
☐	☐	☐	☐ ☐	☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐
Not Yet Assessable ☐

10. Professionalism - Professional Behavior

Level 1	Level 2	Level 3	Level 4	Level 5
Responds to clinical activities and responsibilities in a timely manner and describes strategies for ensuring timely task completion	Performs tasks and responsibilities in a timely manner with appropriate attention to detail without reminders	In complex or stressful situations, prioritizes and performs tasks and responsibilities in a timely manner with appropriate attention to detail	Recognizes situations that will impact others' ability to perform tasks and responsibilities in a timely manner with appropriate attention to detail	Identifies and seeks to address changes to system-wide standards that enable others to perform tasks and responsibilities in a timely manner
Demonstrates professional behavior in routine situations and in how to report lapses in professional behavior	Appropriately reports lapses in professional behavior	Demonstrates professional behavior in routine situations	Demonstrates professional behavior in complex or stressful situations	Identifies and addresses system-level factors that contribute to professional problems
Recognizes limits in knowledge, skills, and abilities and seeks help when appropriate	Accepts feedback and recognizes the team's limits in knowledge, skills, and abilities and seeks help when appropriate	Uses constructive feedback to advance the knowledge base of self and team	Coaches others in receiving feedback and recognizes limits in knowledge/skills/abilities	Makes changes to system-wide standards of feedback and/or evaluation systems
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐

Not Yet Assessable ☐

11. Professionalism - Ethical Principles and Wellness

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of ethical principles of scholarly activity and patient care conditions	Demonstrates use of ethical principles during scholarly activity and routine patient care	Demonstrates use of ethical principles during scholarly activity in complex or stressful patient care situations	Uses appropriate resources for managing and resolving ethical dilemmas during scholarly activity and patient care	Identifies and addresses system-level factors that contribute to ethical problems
Recognizes, with assistance, one's personal and professional well-being	Independently recognizes one's personal and professional well-being and seeks help as appropriate	Develops a plan to optimize one's personal and professional well-being	Executes a plan to optimize one's personal and professional well-being	Coaches others in personal and professional well-being
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐
Not Yet Assessable ☐