Substantive Changes to CPME 320

Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies
New Features

- No changes to the specific standards, only to requirements and guidelines
- Intent and Background statements to further clarify guidelines
- Addition of Milestones which may be used as part of the resident’s semi-annual assessment
Standard 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.
Standard 1.0

• Requirement 1.1: Revised to include sponsorship by healthcare systems

• Requirement 1.3: Affiliation agreement reaffirmation increased to every 10 years (from 5)

1.3 The sponsoring institution may contract with other healthcare 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 defines clearly 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 an affiliation written agreement reaffirmed at least once every five years.

This document must:

- acknowledge the affiliation and delineate financial support (including resident liability 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 must include the signatures of the program director and the site coordinator.

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 abroad 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. Residents must not participate in training at affiliated sites until the agreements are fully executed.
Standard 2.0

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

- Requirements updated to reflect digital/electronic educational resources

- Requirement 2.4: Requirement of a program coordinator rather than staff support

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

Library Educational resources should be located on-site or within close geographic proximity to the institution(s) at which the resident is afforded training. Library services 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 ready access to adequate information technologies and resources.

2.3 The sponsoring institution shall afford the resident ready access to adequate 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 support staff 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 clerical personnel. The institution must ensure that the resident does not assume the responsibilities of nurses, podiatric medical assistants, or operating room or laboratory technicians support staff.

**Intent and Background:** Each program requires a lead administrative person, 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.
Standard 3.0

The sponsoring institution formulates, publishes, and implements policies affecting the resident.
Requirement 3.3

Revised to require abiding by the rules and regulations of the matching service

3.3 The sponsoring institution shall participate in a national resident application matching service. The sponsoring institution shall not obtain a binding commitment from the prospective resident prior to the date established by the national resident matching service in which the institution participates and shall abide by the rules and regulations set forth by the matching service.

The sponsoring institution shall 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 process exists to ensure programs and applicants are not subjected to undue influence or coercion during the match process.
Requirement 3.6

- Identifies specific benefits to be provided to the residents

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 benefits

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 benefits

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.
Requirement 3.7

3.7 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall state whether the reconstructive rearfoot/ankle credential is being offered and the amount of the resident stipend. The contract or letter shall be signed and dated by the chief administrative officer of the institution or designated senior administrative officer, the program director, and the resident. The contract or letter shall state the following:

a. If the reconstructive rearfoot/ankle credential is being offered
b. The amount of the resident stipend
c. Duration of the agreement
d. Benefits provided

If a program is approved by the Council to exceed 36 months of training, the contract must state the extended program length.

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 senior administrative officer.

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 senior administrative officer of each co-sponsoring institution and the resident and be forwarded to the program director.

Programs approved by the Council to exceed 36 months of training must state the extended program length in the contract.

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.

Intent and Background: The program director has final authority over resident employment, performance improvement, and disciplinary action.
Requirement 3.8

States that the sponsoring institution will ensure that residents will not sign a non-competition guarantee or restrictive covenant with the institution or any of its affiliated training sites upon graduation.
Requirement 3.9

(Previously 3.10)

Residency manual must include clinical and educational work hours as well as information related to transition of care.
Requirement 3.9, cont’d

• Residency manual must include clinical and educational work hours as well as information related to transition of care

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.

e. Competencies specific to each rotation (refer to requirements 6.1 and 6.4)

g. Training schedule (refer to requirement 6.3)

The schedule must be for the length of the residency (36 or 48 months, if applicable), reflect the number of approved residency positions, and clearly identify the rotation, location, format, and date of each rotation. (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. Journal review schedule (refer to requirement 6.8)

j. Assessment documents (refer to requirement 7.2)

k. 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.
Requirements 3.11, 3.12

- Requirement 3.11 (previously 3.12 related to ethical conduct) further defined
- Addition of requirement 3.12: Residents may not assume the responsibility of ancillary medical staff

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, 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 must ensure that the resident does not assume the responsibility of ancillary medical staff.
Standard 4

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.
Requirement 4.2

- Expanded to include changes that require reporting to the council within 30 days

\[4.2\] 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, sponsorship, affiliated training sites, resignation or termination of the program director, appointment of a new program director, curriculum, a significant increase or decrease in faculty, and resident resignation, termination, or transfer.

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, or
- 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.
The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.
Requirement 5.2

The program director must be certified by ABPM and/or ABFAS, and must possess a minimum of three years of post-residency clinical experiences. Applicable to program directors appointed after adoption of the revised documents.

§ 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 should be certified in the specialty area(s) by the American Board of Foot and Ankle Surgery and/or the American Board of Podiatric Medicine.

The program director (appointed after the implementation date of this document) must be certified by the American Board of Foot and Ankle Surgery and/or the American Board of Podiatric Medicine, and must have a minimum of three years post-residency clinical experience.

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

In certain circumstances, the sponsoring institution may, with approval by the Residency Review Committee/Chair, appoint an interim residency director who does not meet the stated requirements. 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.
Requirement 5.5

The program director has the authority to approve/remove program faculty.
Standard 6

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.
Requirement 6.1

- Requirement 6.1: Core competencies updated to include additional components and now includes:
  - Requirements of direct participation in the management and evaluation of patients in several clinical conditions
  - New – Includes competence in manual dexterity appropriate for the level of training

4. Direct participation of the resident in the evaluation and management of patients in an inpatient/outpatient setting, including the following:
   - Formulate and implement an appropriate plan of management, including:
     - Direct participation of the resident in the evaluation and management of patients in a clinic/office setting:
       - 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. Direct participation of the resident in the evaluation and management of the surgical patient when indicated, including:
   - Evaluating, diagnosing, selecting appropriate treatment and avoiding 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. Must demonstrate competence in manual dexterity for the level of training

7. Assess the treatment plan and revise it as necessary
Requirement 6.2

- Further defines acceptable formats for web-based logging

6.2 The sponsoring institution shall require that the resident maintain web-based logs in formats approved by RRC documenting all experiences related to the residency.

- The format must be approved by and accessible for review by the Residency Review Committee.
- The format must categorize and summarize medical/surgical diversity and experiences (refer to Appendix A and B)

**Intent and Background:** Logging is intended to be a representation of the training afforded the residents, including non-podiatric experiences.
Requirement 6.3

§ 6.3 The program shall establish a formal schedule for clinical training. The schedule shall be distributed at the beginning of the training year to all individuals involved in the training program including residents, faculty, and administrative staff.

The schedule must identify the rotations and document clearly the dates, length, format, and location of each rotation provided the resident. 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 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 training.

Intent and Background: Residency training is a meaningful and protected experience that must focus on the clinical education of the resident.

Twenty percent is the maximum proportion of residency education that is acceptable to be conducted in a podiatric private practice office-based setting.
Requirement 6.4

- Behavioral science is no longer a required rotation – may be provided as one of the two required medical subspecialties
- Pathology is no longer a required rotation
- Vascular medicine has been added as a medical subspecialty
- Rotations must be at least two weeks in length.
- Emergency medicine must be a minimum of four weeks in length
- Internal Medicine/Family Medicine must be a minimum of four weeks

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. 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 two of the following rotations:
- behavioral science, burn unit, dermatology, endocrinology, geriatrics, intensive/critical care unit, neurology, pain management, pediatrics, physical medicine and rehabilitation, rheumatology, wound care, and vascular medicine.
Requirement 6.4 (cont.)

Surgical subspecialties divided into two categories and residents must be afforded a minimum of eight weeks of training in non-podiatric surgery:

- Minimum of four weeks in Group A, which now includes general surgery, trauma team/surgery, or vascular surgery

- Any rotations from Group B must be a minimum of two weeks for each rotation, which includes cardiothoracic surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, or plastic surgery, or surgical intensive care unit (SICU)

- Surgical specialties: There is a minimum requirement of 8 cumulative weeks of training in surgical specialties. Training must include at least two of the following rotations with a minimum of four weeks in Category A.
  - **Category A:** General surgery, trauma team/surgery, or vascular surgery.
  - **Category B** – Cardiothoracic surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, plastic surgery, or surgical intensive care unit (SICU).

While a typical training week involves five working days, CPME recognizes that holidays may shorten a week.
Requirement 6.7

• Residents must have protected time for didactic activities.
• Expanded to include falls prevention, resident well-being, pain management and opioid addiction, cultural humility, and workplace harassment and discrimination provided at least once during training.

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

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 during residency training:

The majority of didactic activities must include participation by faculty:

• Research methodology (e.g., web-based training, formal lectures, or a dedicated research rotation).
• Falls prevention.
• Resident well-being, (e.g., substance abuse, fatigue mitigation, suicide prevention, and physician burnout).
• Pain management 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.

Intent and Background: This instruction may be provided during resident orientation, focused activities, or through web-based programs.
The residency program shall ensure the resident is afforded appropriate clinical and educational work hours. The requirement addressed outside activities, work hours, work periods, in-house, and at-home calls.

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: Clinical and educational work periods for residents must not exceed 24 hours of continuous in-house activity. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Residents must have at least eight hours free of clinical work and education after 24 hours of continuous in-house activity.

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 prohibits resident participation in any outside activities that could adversely affect the resident’s ability to function in the training program.
Standard 7

The residency program conducts self-assessment and assessment of the resident based upon the competencies.
Requirement 7.2a

Added that assessment of the resident must be documented at least once for every three months of podiatric medicine and/or podiatric surgery service.

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 (signature and printed name) 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 remediation/ performance improvement.

Assessment must be documented at least once for every three months of podiatric medicine and/or podiatric surgery service.

**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.
Requirement 7.2b

- Expanded to include specific components to be included in the resident semi-annual assessment

- 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: extent to which the resident is achieving the competencies. Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

  - Assessment of professionalism (e.g., information from patients and/or peers having direct contact with the resident, 360 review from ancillary staff)
  - Progression in achieving the competencies (e.g., rotation assessments, competency-based assessments/milestones. See Appendix C for examples)
  - In-training examinations
  - Projected attainment of MAVs
Requirement 7.2c

• New - Final Assessment of the resident

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
- 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.
NEW – Requirement 7.3

- Requiring annual in-training exams

7.3 The program shall require that all residents take an annual in-training examination as offered by JCRSB-recognized specialty boards, and that residents take in-training examinations offered by all JCRSB-recognized specialty boards during the final year of training.

The sponsoring institution must pay any fees associated with the examinations. Examination results are used as a guide for resident performance improvement and as part of the annual self-assessment of the program.

e. In-training examinations

The program should require that the resident take in-training examinations as prescribed by JCRSB-recognized specialty boards. If the resident is required to take an in-training examination(s), the sponsoring institution must pay any fees associated with the examinations. Examination results are used as a guide for resident remediation and as part of the annual self-assessment of the program.
Appendix A

Volume and Diversity Requirements

• Eliminated Podiatric clinic/office encounter MAV of 1000 cases, replaced with Practice-based procedures (MAV of 100 Also identified as category 6)
• Surgical Case Activity for PMSR only programs identified as 250 (PMSR/RRA is 300)
• Wound Care MAV added to require 50 cases (category 11)
• Biomechanical MAVs reduced from 75 to 50

APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

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

<table>
<thead>
<tr>
<th>Case Activities</th>
<th>MAV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatric clinic/office encounter</td>
<td>1000</td>
</tr>
<tr>
<td>Pediatric Foot and ankle surgical cases (PMSR/RRA)</td>
<td>300</td>
</tr>
<tr>
<td>Foot and ankle surgical cases (PMSR only)</td>
<td>250</td>
</tr>
<tr>
<td>Trauma cases</td>
<td>50</td>
</tr>
<tr>
<td>Podopediatric cases</td>
<td>25</td>
</tr>
<tr>
<td>Practice-based procedures</td>
<td>100</td>
</tr>
<tr>
<td>Wound Care</td>
<td>50</td>
</tr>
<tr>
<td>Biomechanical cases (examinations)</td>
<td>7550</td>
</tr>
<tr>
<td>Comprehensive history and physical examinations</td>
<td>50</td>
</tr>
</tbody>
</table>

   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  |
Appendix A
Volume and Diversity Requirements

• Added definition for Wound Care

\[\text{Wound Care. Management of wounds, including debridement of ulcer or wound (e.g., neuropathic, vascular, traumatic), and/or advanced wound modalities (negative pressure wound therapy, biological dressings, total contact casting, multi-layer compression therapy/Unna boot). Does not include 6.6 repair of simple laceration or simple delayed wound closure.}\]
Appendix B

Surgical Procedure Categories and Code Numbers

- Category 6 – updated and expanded to include practice-based procedures that may be applied to meet the 100 MAV requirement

<table>
<thead>
<tr>
<th>6 Practice-Based Procedures (these procedures cannot be counted toward the minimum procedure requirements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 debridement of ulcer or wound (neuropathic, vascular, traumatic)</td>
</tr>
<tr>
<td>6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)</td>
</tr>
<tr>
<td>6.3 nail avulsion (partial or complete)</td>
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<tr>
<td>6.4 matrixectomy (partial or complete, by any means)</td>
</tr>
<tr>
<td>6.5 removal of hardware (internal or external fixation)</td>
</tr>
<tr>
<td>6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)</td>
</tr>
<tr>
<td><strong>Includes simple delayed wound closure</strong></td>
</tr>
<tr>
<td>6.7 advanced wound care modalities (negative pressure wound therapy, biological dressings, total contact casting, multi-layer compression therapy/Unna boot)</td>
</tr>
<tr>
<td>6.8 extracorporeal shock wave therapy</td>
</tr>
<tr>
<td>6.9 taping/padding/splinting/casting (limited to the foot, and ankle)</td>
</tr>
<tr>
<td>6.10 orthotics/prosthetics (limited to the foot, and ankle casting/scanning/impressions for foot and/or ankle orthosis)</td>
</tr>
<tr>
<td>6.14 percutaneous procedures, i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma, digital tenotomy</td>
</tr>
<tr>
<td>6.15 foot care (nail debridement, callus paring)</td>
</tr>
<tr>
<td>6.16 therapeutic/diagnostic injections (without sedation)</td>
</tr>
<tr>
<td>6.17 incision and drainage (performed outside of the operating room)</td>
</tr>
<tr>
<td>6.18 closed reduction of fracture or dislocation</td>
</tr>
<tr>
<td>6.19 removal of foreign body (not in the operating room)</td>
</tr>
<tr>
<td><strong>6.20 application of external fixation</strong></td>
</tr>
</tbody>
</table>
Appendix B,

Surgical Procedure Categories and Code Numbers

• Added Wound Care as Category 11

11  Wound care

11.1  debridement of ulcer or wound (neuropathic, vascular, traumatic)
11.2  advanced wound care modalities (negative pressure wound therapy, biological dressings, total contact casting, multi-layer compression therapy/Unna boot)
Milestones – May be used as part of the semi-annual resident assessment but are not mandated for use by CPME

APPENDIX C MILESTONES

The Milestones included in Appendix C are optional forms that program directors may use when conducting a semi-annual assessment of the resident (requirement 7.2 b). These Milestones are intended to help program directors detail the resident’s progression in achieving the competencies. These Milestones are included as a resource for programs and are not mandated for use by CPME.