FREQUENTLY IDENTIFIED AREAS OF POTENTIAL NONCOMPLIANCE

- The following slides identify the areas of potential noncompliance most often found by either on-site evaluation teams or the Residency Review Committee.

- Requirements as identified in CPME 320 (July 2011) and guidelines to avoid having these areas identified in the team report or the Residency Approval Profile will be discussed.

AFFILIATION AGREEMENTS (1.3)

- Exist in writing for each training site (e.g., surgery center, office, hospital).
- Define clearly the roles and responsibilities of each institution and/or facility.
- Delineate financial support (including resident liability) and educational contributions.
- Are signed and dated by the chief administrative officer or designee of each site.

DESIGNATED SUPPORT STAFF (2.5)

- Provided by the sponsoring institution to ensure efficient administration of the residency program.
- Neither the program director nor the resident(s) assumes the responsibility of clerical personnel.

RESIDENT CONTRACTS (3.8)

- Properly identify the program.
- If Podiatric Medicine and Surgery Residency with Reconstructive Rearfoot/Ankle Surgery, clearly state this information.
- Include the amount of the resident stipend.
- Signed and dated by chief administrative officer, the program director, and the resident.

RESIDENT CONTRACTS (3.9)-continued

- Include or reference the following:
  - Resident duties and hours of work
  - Duration of the agreement
  - Health insurance benefits
  - Professional, family, and sick leave benefits
  - Leave of absence policy
  - Professional liability coverage
  - Other benefits, if provided

RESIDENCY MANUAL (3.10)

- Includes, but not limited to, the following:
  - Policies and mechanisms affecting the resident
  - Rules and regulations
  - Curriculum (for the entire training period)
  - Training schedule (for the entire training period)
  - Assessments (for each rotation)
  - Schedules of didactic activities and journal review
  - CPME 320 and CPME 330

RESIDENCY MANUAL-continued

- Distributed to the resident at the beginning of the program and following any revisions.
- Distribution must be acknowledged in writing.
- Distributed to faculty and administrative staff involved in the residency at the beginning of the training year.
- Available in written or electronic format.

RESIDENT CERTIFICATE (3.11)

- Awarded only upon successful completion of all training requirements.
- Properly identifies the program.
- States actual date of completion of residency training.
- Includes a statement that the program is "Approved by the Council on Podiatric Medical Education."
- Properly identifies the Reconstructive Rearfoot/Ankle Surgery credential, if awarded.

PROGRAM ADMINISTRATION (5.3)

- Director is responsible for administration of the program in all participating institutions.
- Responsibilities include:
  - Maintaining records related to the program
  - Communicating with the Council (including Council staff) and the Residency Review Committee
  - Scheduling training experiences that facilitate each resident’s attainment of specified competencies, while ensuring that each resident receives equitable training
  - Instructing, supervising, and evaluating each resident
  - Periodically reviewing and revising the curriculum
  - Conducting an annual programmatic self-assessment

CURRICULUM (6.1, 6.4)

- Required rotations include:
  - Medical imaging
  - Pathology
  - Internal medicine or Family practice
  - Behavioral science
  - General surgery
  - Orthopedic, plastic, or vascular surgery
  - Anesthesiology
  - Emergency medicine
  - Podiatric medicine
  - Podiatric surgery

CURRICULUM-continued

- Podiatric Medicine and Surgery Residencies (PMSR) include at least two of the following medical subspecialty rotations:
  - Dermatology
  - Endocrinology
  - Neurology
  - Pain management
  - Physical medicine and rehabilitation
  - Rheumatology, or
  - Wound care

CURRICULUM-continued

- PMSR rotations also include
  - Infectious disease

- The time spent in Infectious Disease + Internal Medicine or Family Practice + at least two Medical Subspecialties = at least three full-time months of training.

CURRICULUM-continued

- Distributed at the beginning of the training year to all individuals involved in the training program.
- Provides a sufficient volume and diversity of experiences to allow the resident to achieve the competencies of the program.
- Included in the residency manual.

RESIDENT LOGS (6.2, 7.1)

- Web-based format approved by the RRC.
- Document all experiences related to the residency.
- Reviewed, evaluated, and verified by the program director on a monthly basis.
  - Ensures completion of all columns
  - Ensures no duplication of procedures
  - Ensures no miscategorization of procedures
  - Ensures no fragmentation of procedures
  - Ensures that procedure notes support the experience logged

RESIDENT ASSESSMENT (7.2)

- Resident attainment of the competencies established for each rotation conducted on an ongoing basis.
- Faculty and program director assess and validate attainment of established competencies.
- Assessments in written or electronic format.
- Reviewed with resident formally on at least a semi-annual basis.
- Timing of assessment must allow sufficient opportunity for remediation (if needed).

RESIDENT ASSESSMENT-continued

- Assessments include the following:
  - Dates covered
  - Name of faculty member
  - Name of resident
  - Signature and date signed of faculty member, resident, and program director
  - Assessment of the resident in areas such as communication skills, professional behavior, attitude, and initiative

PROGRAMMATIC SELF-ASSESSMENT (7.3)

- Conducted by program director, faculty, and residents.
- Review of program's resources and curriculum.
- Information obtained from review to be used to improve the program.

PROGRAMMATIC SELF-ASSESSMENT-continued

- Review includes:
  - Evaluation of program’s compliance with CPME 320
  - Each resident’s formal evaluation of the program
  - Program director’s evaluation of the faculty
  - Curriculum’s relevance to the competencies
  - Extent to which competencies are achieved
  - Extent to which competencies are understood by all involved
  - Determination of any changes needed in resources to ensure achievement of competencies

PROGRAMMATIC SELF-ASSESSMENT-continued

- Review includes (continued):
  - Extent to which didactic activities complement and supplement the curriculum
  - Uses performance data (resident performance on external exams, attainment of board certification and state licensure) to determine if curriculum appropriate
  - Measures of program outcomes (success of previous residents in private practice and teaching environments, hospital appointments, and publications)

APPENDIX A

- A minimum of 75 biomechanical cases are required for each resident.

- Effective July 1, 2011, biomechanical cases must include three components:
  - Diagnosis
  - Evaluation, and
  - Treatment

APPENDIX A-continued

- Evaluation component must include
  - Complete biomechanical examination on all patients
    - Includes static and dynamic examination of the area of chief complaint
    - Includes examination of any areas of potential abnormal biomechanical function
  - Gait analysis on ambulatory patients
    - May range from basic visual analysis to complex computerized analysis
    - Documentation must include
      - Reason for performance/nonperformance
      - Interpretation of gait analysis

APPENDIX A-continued

- Biomechanical examination and gait analysis must
  - Be comprehensive relative to the diagnosis and consistent with the clinical findings
  - Demonstrate an understanding of the thought process in determining a diagnosis and treatment, as related to the evaluation

APPENDIX A-continued

- A minimum of 50 comprehensive medical histories and physical examinations are required for each resident.

- Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P.