EXECUTIVE COUNCIL MEETING

October 12-13, 2012
Hilton Nashville Downtown
Nashville, TN

Executive Council Members and Committee Chairs in attendance: Kathy Sanders, President; Chris Varley, President-Elect; Adrienne Bentman, Secretary; Bob Boland, Program Chair; Mike Jibson, Treasurer; Rick Summers, Past-President; Sheldon Benjamin, Past-Past-President; Tami Benton (via phone); Gene Beresin (via phone); Adam Brenner; Deb Cowley; Kim-Lan Czelusta; Sandra DeJong; Chandlee Dickey; Arden Dingle; Jed Magen; Isis Marrero, Sahana Misra (via phone); Brian Palmer; Tony Rostain (via phone); Donna Sudak; Cindy Telingator; Art Walaszek; Sid Zisook. Liaison: Bruce Levy (via phone), Sandra Sexson; Lucille Meinsler
Invited Guest: Malgorzata Rajda, COPE representative

Absent Members: Bob Rohrbaugh, George Tesar

Action Item: May minutes approved with correction of Bruce Levy present.

Kathy Sanders has accepted the position of Deputy Commissioner for Mental Health, State of Massachusetts. This is the most senior psychiatrist position in the Mass DMH. Among her responsibilities will be those for all research and training in the state. She will step down as the MGH/McLean Program Director at the end of October and Felicia Smith, Director of the MGH Psychiatric ER and former associate program director will assume the PD role. Kathy has been at MGH for 24 years, 12 as PD. She will retain her Harvard academic appointment and an outpatient clinic. She will continue as the President of AADPRT and as Past and Past-Past-President, assessing annually whether that makes professional sense and serves the needs of AADPRT.

1. COPE Representative: Malgorzata Radja, Program Director, Dalhousie University/Past President, COPE

Malgorzata is the past-president of COPE, the AADPRT equivalent body in Canada. In Canada there are 17 departments of psychiatry and 17 psychiatry residency programs.
COPE representation differs in that they include resident representatives from the programs.

Active issues:

The Canadian Royal College (CRC) has recently approved 3 psychiatry subspecialties, Child/Adolescent, Forensics, and Geriatrics. It will be a significant effort for departments to develop these fellowships because of the rigorous requirements of the CRC. They are also grappling with the first year of CA training (2 years) being the final year of adult training. Residents must complete their adult training before moving on to forensic and geriatric training each 1 year long.

Program directors are struggling to meet the new (2009) CRC requirements. They are more stringent and less flexible than before. In some cases they are not practical e.g., requiring residents to be in 2 locations at the same time, inpatient and outpatient. There is a requirement for collaborative care which is not defined and for longitudinal care of patient(s) with chronic, persistent mental illness which for some programs is difficult to meet. Recruitment into psychiatry is a struggle relative to other disciplines as Psychiatry is not a top choice. IMG's have limited access to programs. Some provinces have a special entry for IMG's. Depending on the province, Americans may be treated as Canadians or as IMG's.

2. Finance Report: Mike Jibson, Treasurer

The accounting office reviewed the financial information based on the submitted Peachtree reports and submitted a report comparing the income/expenses for the past two fiscal years. All financial information will be submitted for the annual audit.

3. Academic Psychiatry-Governance Report: Bruce Levy (via phone)

The Governance Board is looking for a new publisher. I t has been reviewing a proposal from Springer. The Board will be hiring a lawyer to review the Consortium Agreement (out of date, clauses not followed, unaddressed issues) and the Springer proposal. The amended proposal will be forwarded to the Steering Committee for Review. The Consortium representatives would have to agree to hire (pay for) the lawyer.

Additional issues for the lawyer: 1) each sponsoring organization needs liability insurance. AADPRT's must be reviewed for adequate coverage. Question - will the Consortium need insurance or will each member organization need insurance? 2) What is the definition of who gets a free subscription? Bruce continues to hold the line that AADPRT "Members" ARE our "Training Institutions/Programs", not individual people, with the subscription number limited to 2 per institution plus the capacity for additional purchases. Question - who gets the journals and who gets the bill? 3) Springer draft - there will be advertising in the Journal. The Editor-in-Chief will have first-run approval with provisos so long as approval is not unreasonably withheld and there is no delay in publication. The other Consortium organizations do not have a problem with advertising. Refusal of advertising would be a complete deal breaker. This would include advertising by the pharmaceutical industry.

Discussion/clarification/questions:

- Affiliate members do receive the journal as part of their membership dues.
- Needs confirmation - if the journal with advertisements does makes money, then the consortium organizations should get a share of this profit.
- Is there a signing bonus?
- Advertisements—AADPRT has a COI policy. Art Walaszek reviewed the policy and believes that advertising should not represent a problem. Accepting monetary gifts is

different from supporting a journal that makes money from advertising. Of note, the Mass Medical Society decided not to accept pharma ads for their journals (NEJM, etc.). The current contract w/ APPI allows for advertising. Advertisements should be sequestered. Though many on EC were in agreement with advertising, others believed that it represented an ethical issue to publish both EBM articles and ads.

Vote#1: Do we approve that money spent and earned should be equally divided among the consortium organizations? Unanimous Yes.

Vote #2: Do we want to move forward with negotiations with a publisher which will include advertising? Yes—17, No—0, Abstain—3

Action Item: Follow up with Bruce at the next EC

3. Update-2013 Annual Meeting: Bob Boland, Program Chair

The title of the Annual Meeting is "Tomorrow's Psychiatrist: Training for the Future". Two plenary speakers, Kenneth Kendler and Carl Chan are confirmed. The third plenary will be a panel discussion centering on the Milestones. New this year are minor workshop submission system additions including word count limits and an "agenda" field. AADPRT will have its own online annual meeting evaluation system. The special workshops on Thursday morning will use the standard submission process for selection. Selections will be made with presidential input.

The Ft Lauderdale site visit was successful. The site is lovely. There is adequate space and excellent food. Concerns regarding competing events (Spring Break) were allayed....and we are on a waterway but not the beach.

4. Update-BRAIN Conference-2013 (former Pre-Meeting): Sid Zisook

Program Chairs - Deb Cowley, Grace Thrall, Sid Zisook. The focus will be "Treatment-Resistant Depression: Using Large and Small Groups to Teach Research Literacy" Plenary speakers - Charlie Nemeroff (neuroscience), Karen Wagner (CA), Donna Sudak (psychotherapy). During the plenaries at least one interactive and innovative teaching method used in large groups will be demonstrated (and evaluated). Both resident scholars and their program directors will present at lunch. The small group sessions will demonstrate "how to read a neuroscientific paper and conduct a journal club", will demonstrate the use of team-based learning to analyze evidence on one topic, and will demonstrate web-based training of behavioral activation.

The mentorship committee will organize a listserv for past and incoming scholars. Mentorship will continue to be offered to training directors from non-academic departments. The tracking committee will follow the number of MD/PhD's from selected academic programs and the scholarly activities of trainees from programs whose PD's attend this meeting. There have been 3 papers accepted for publication based on research conducted at this meeting.

Pre-meeting Finances: The charge of $125. worked. The Pre-meeting is in the black. Carry-over monies paid for unanticipated expenses. Information and experience from the 2012 meeting will set the fee for 2013. It was determined to keep the fee for the Pre-meeting at $125.

5. Discussion-Milestones: Kathy Sanders, AADPRT President and member of the Milestones Working Group:

Overview:
The Next Accreditation System (NAS) is coming to Psychiatry in July, 2014. The NAS movement was stimulated by the increased interest in patient safety and continuous quality improvement. It will change how programs are accredited. Each program will have a dashboard of outcome measures including board pass rates, WebADS update/responses to citations, resident and faculty surveys, resident milestones, etc. Where one's program falls with respect to preset standard deviations will determine whether there is/is not an ACGME trigger of concern. If there is no trigger the program will be granted 10 years of accreditation, thus 10 years between site visits. If there is a trigger of concern there may be a program site visit or spot check. Sponsoring institutions will be site visited every 18 months. Institutional GME offices will maintain tighter monitoring of programs in order to meet their increased responsibilities and more frequent reviews. Milestone evaluation tools will be suggested.

Programs must constitute a Competency Committee (CC) whose task will be to determine where each resident stands on each milestone twice/year. Though programs will enter data for individual residents, the ACGME will only "see" the aggregate data for all residents in a program. Individual resident and program aggregate data will not be made public. This aggregate data will be used by the ACGME/Psychiatry RC as a measure of RESIDENCY effectiveness and NOT individual resident competence. These data will not be used to compare one program against another. Residencies may use resident acquisition of milestones as a component to determine readiness for graduation. Program directors in concert with members of the CC will continue to determine whether residents are prepared for independent practice and thus graduation

Review of the Milestone Process:
The ACGME gave instructions to the Working & Advisory Groups. In addition, the ACGME constituted a multi-specialty working group to write Common Milestones for the core competencies ICS, PROF, PBLI, SBP. Each specialty will use them, making them relevant for their field.

The ACGME expected 21milestones —6/subsets per milestone. The draft version currently has 23 milestones. Each milestone has five (5) levels. Level 1 = entry into residency. Level 4 = capable of independent practice. Level 5 = a stretch competency. Levels 1 through 4 DO NOT correspond to PG-years. All residencies regardless of their duration, 3 years or more, have five levels (1 = entry, 4—independent practice, 5 = stretch).

The draft will be released to the public and stakeholders before November 1, 2012. Chris Thomas wants the EC to take a first look, advise him on the process of the rollout and its cover letter content. EC member questions will help him frame the process. Rollout will include release

of the draft, a comment/survey period, and pilots. AADPRT, through the auspices of the ACGME Liaison Committee plans an independent survey. Results will be shared with members. A letter representing AADPRT member feedback will be sent to Chris Thomas to be shared with the Working and Advisory groups. These recommendations will be considered in the revision of the draft.

The ACGME Milestone Pilot - Programs of various types (large/small, academic/community, single/multi-site) will participate in the pilot using their newly constituted CC's to discuss resident progress and determine their milestone progression and enter these data onto the ACGME site in January and July, 2013. Participants in the pilot programs will complete a survey exploring their experience of the process and the utility and appropriateness of the milestones. Results of ACGME and pilot surveys will be given to the Working and Advisory Groups who will then revise the milestones.

Milestones will be implemented in all General Adult residencies on July 1, 2014 with the first data entry in January, 2015. No timetable has been set for the writing/release of the subspecialty milestones. The CA Milestones will be 'written/released' no sooner than 2015.

See the EC questions and Chris Thomas' answers in the attached FAQ document.

6. ACGME Liaison Committee: Gene Beresin, Committee Chair (via phone)

This Committee has solidified its tasks: to develop lines of communication with stakeholders in psychiatry including Chairs, DIO's, the APA, AAP, AACAP, ABPN; to maintain communication with the Psychiatry RC and its Chair; to develop ties with potential allies in other specialties; to develop relationships with residents in psychiatry including representatives on the RC, in AA, and AACAP; to clarify plans for the Resident and Faculty Surveys in advance of their use.

Milestone surveys: a discussion took place regarding whether the Milestones survey should be a joint effort of the ACGME + AADPRT or separate surveys. Collaboration of the ACGME around the milestones process was applauded but there was consensus regarding the need for independent surveys. Discussion focused on the possibility of shared access of the ACGME Working/Advisory Group and AADPRT to the questions asked, the data, the process of interpretation, and the recommendations from the ACGME and AADPRT Surveys and the Pilot Survey. We were reminded that the process of Milestone development is different from that of RC guideline revision. There was unanimity in belief that members of the AADPRT Survey team NOT be members of the Working or Advisory Groups.

Recommendation to Chris Thomas regarding rollout of the milestone draft: provide a slideshow with one illustrative milestone followed by the full set. The overview should be very clear about how the data will be managed. There is concern about the readiness of WebADS to handle the data and about the lack of interface between the residencies and the ACGME.

Action Items:

General Psychiatry Milestones Survey of AADPRT Membership—a small task force including Adam Brenner, Kim-Lan Czelusta, Grace Thrall, Gene Beresin, Art Walaszek in consultation with Sheldon Benjamin will construct and analyze a member survey which solicits information on the milestones in general and each individual milestone. The results of the analysis and recommendations will be sent to the ACGME as our organization's response to the request for review and comment from the field.

7. Child/Adolescent Caucus: Arden Dingle, Caucus Chair

Has collected and disseminated information on CAP resident oncall systems, facilitated feedback on the AACAP Presidential Initiative "Back to the Future", will give updates at the AACAP training director luncheon, and clarified the selection process for the Child Caucus Chair. Selection of the next Caucus Chair—there has been a clear delineation of the process of Caucus Chair selection and the CA group is in the process of forming a nominating committee. There is a connection between the Caucus and the General (Adult) Milestones Working Group and the ACGME Liaison Committee via Jeff Hunt. CA recruitment will use ERAS beginning with the 2013-14 recruitment years.

PRITE Fellowships - Caucus members have requested that the American College of Psychiatrists (ACP) make their process of Fellowship selection more transparent. Program directors would appreciate the evaluation rubric and selection criteria be made public. This will allow program directors to write better letters of recommendation.

Action Item:

The CA Caucus will be involved in the rollout of the CA Milestones. AADPRT authorizes the Caucus to invite Chris Thomas to speak to the Caucus at AACAP and at the annual meeting.

8. Information Committee: Sahana Misra, Committee Chair

AADPRT CME system—the final bid for the cost of our own online evaluation system and CME granting/printing process was $4K for the first year + est. 20-25% for the second year (if needed). This was approved by the Steering Committee. It will be beta- tested and in place for the March, 2013 Annual Meeting.

Migration of all listservs to their new location took place 6/1/12. Virtual Training Office (VTO) reorganization will make task force curricula more visible. Two NIMH modules are available on the VTO, part of the NIMH Neuroscience and Psychiatry series. The Psychotherapy Committee's "tip of the month" will be available on the VTO in the next several months.

The website had —5,000 hits in July/August. The VTO was not in the top 10. The curricula on resident safety and professionalism are more prominently available, making access easier. Discussion included a

request to review the effectiveness of the ListServ's archives search function and to determine whether the old ListServ's archives are on the new platform.

9. Psychotherapy Committee: Donna Sudak and Adam Brenner, Committee Co- chairs
The Committee provides monthly "psychotherapy training tips". These will be archived and more accessible on the updated VTO. "Benchmarks for Psychotherapy Training" is now complete and will be posted on the website along with evaluation measures and hyperlinks to cited research. The Committee's work turns now to the development of a psychotherapy OSCE. This will enable a supervisor-resident pair to review a videotaped session during which the supervisor asks structured questions with clear anchor points for evaluation. The evaluation will measure how well the resident describes what is happening and reflects on the resident-patient interactions. This will offer programs concrete, user-friendly templates through which one can measure reliability and outcome. Others are working on an observer rating scale for a medication management visit.

Plan: It was recommended that these groups connect with the CSV Committee which is engaged in CSV anchor point revision based on survey feedback. The Committee will request that useful evaluation tools currently being used, be shared with them. The President will reach out to Chris Thomas regarding AADPRT's involvement in development of evaluation tools.

10. Model Curriculum Committee: Tony Rostain, Committee Chair

The deadline for new curriculum submission has been extended to 10/15112. The Committee has developed a new system for submission review. Curricula will be requested throughout the year. Milestones will guide curricula requests.

11. Recruitment Committee: Sandra DeJong, Committee Chair

An online toolkit of recruitment talking points with references targeted at specific audiences was distributed. The Committee is participating in a World Psychiatric Association initiative designed to study recruitment and the personal and training issues that affect the decision to pursue a career in psychiatry. An Executive Summary on the new NRMP All-In Policy was sent to members in August. Responses/concerns were reviewed and an update/clarification regarding PG2 slots was sent. A co-sponsored presentation (ADMSEP/AAPRT) "Bridging UME & GME: Recruiting Students into Psychiatry" will be presented at ADMSEP in June and has been submitted to AADPRT.

NRMP:

Results of the AADPRT Survey were collated and a summary sent to the NRMP. The final decision from the NRMP allows no exemptions. An executive summary from Laurie Curtin (NRMP) was posted on the AADPRT website in August. PG2 slots: We discovered that all PG1

and PG2 positions for residents beginning work after 1/31 must go through the match. NRMP decided this for Psychiatry because we are not a categorical 4-year program. Under these circumstances, applying residents will not know whether they have a PG2 position until mid-March and programs will not know whether their post-January (July) empty position has been filled until the match results are in. This makes for uncertainty on the part of applicants and programs effecting life planning, workforce and finances. An unofficial count of EC members revealed that 100% of adult program directors had had an unexpected PG2 open position in the last 2 years suggesting that this consequence of the new All-in Policy will have wide-spread effects. It was anticipated that the Chair's Group would have an interest in this issue as well.

Action Item: The President will draft a letter addressed to Chris Thomas (ACGME) and to Paul Summergrad (Chair's Group) outlining the issue and giving examples of the consequences of the NRMP decision in the hope that it will be reviewed and reversed.

12. Membership Committee (New Training Director's Symposium [NTDD: Tami Benton, Co-Chair (via phone)

NTD Symposium and Boot Camp: The Symposium will include a presentation on the nuts and bolts of the job, the role and responsibilities, and a highlighted program director. A "walk-in clinic" room will be arranged for NTD's to pose curbside questions to senior program directors. Boot Camp will be offered Wednesday evening after the BRAIN Meeting and will address 1-2 core issues. Meet Your Mentor will be continued at the 2013 meeting.

13. Membership Committee (the members): Isis Marrero, Co-Chair

The AADPRT Manual and membership guidelines have been updated. Registration continues to be made easier with links of programs and websites. The aim continues to be for up-to-date payments before the final meeting deadline.

14. Development Committee: Brian Palmer, Art Walaszek, Committee Co Chairs

There is no longer pharma funding for the meeting or for fellowships. There is an expanding effort to solicit donations for the Fellowships.

15. APA Council on Medical Education: Sandra Sexson, Chair—Council on Medical Education and Lifelong learning

Office of GME/UGME: 1) new APA Resident Recognition Awards to be presented annually to one resident or fellow from each department/institution in recognition of their compassion, leadership, community service, political action, clinical excellence. Not meant for the award-winners rather for the next best resident. 2) Bryce Templeton received the Vestermark Award.

3) Resident Census reports available 10/12. 4) APA accepting submissions for the Resident Poster Competition at the APA 2013 Annual Meeting.

Focus: eFocus redesigned as an ABPN-approved, MOC Part 2 self-assessment activity free to APA members. APA Online CME: 2012 Annual meeting On Demand website and DVD. On to IPS On Demand.

Support for MOC: 1) #5 MOC Part 4—PIP Modules now available free to APA members. 2) I n August, the first FOCUS MOC Workbook Series was published (MDD) —self-assessment, PIP Module, Practice Guideline, real-time assessment tool, patient/peer feedback forms, and detailed instructions on "How to Participate in MOC".

We continue to work out the details of the AADPRT/APA copyright agreement to sell Professionalism and the Internet. After cost we split the money and the contract is non-exclusive. There are no taxes on educational materials because it's part of our mission.

16. Regional Representatives: Chandlee Dickey

ACGME Annual Resident Survey: ACGME responded to clarify what program directors can discuss with their residents prior to the residents taking the Survey. There is a link for program director and resident guidance regarding the survey. On visiting this website, one discovers "that it is no longer available". One also cannot open any of the PDF's posted to see whether they meet PD educational needs. Neither "what programs need to do" (for coordinators & PD's) nor the FAQ's meet the request above. Through personal communication we have learned that it is fine to discuss the survey, its transparency, its use by the ACGME, and the definition of terms with one's residents and faculty before they take the survey. One CANNOT tell residents how to answer the questions.

Plan: For improved dissemination to the field we wish to obtain an official letter from the ACGME clarifying these issues for posting on our website with an accurate link to a working ACGME website.

Faculty Survey: Communication from the ACGME "it is our best guess that the first faculty survey will be fielded in late 2012/early 2013. It is not certain whether it will be sent ONLY to the 8 early-adopter NAS specialties or to everyone, the latter includes Psychiatry. Clarification expected in the summer, 2012". No information regarding this was available in the room.

Plan: Gene Beresin will contact the ACGME to find out the plan for release of the Faculty survey.

Trace (not Tracer) Method: Gene Beresin clarified use of this method during Site Visits with Ingrid Philbert of the ACGME. This clarification can be found via a search of the ACGME website (acgme.org) using search words "Tracer Method", which takes one to an e-

communication on this topic.

Plan: Disseminate this information to the members via an email and AADPRT web posting.

17. Duty Hours Task Force: Deb Cowley, Chair
Results of the program director survey will be prepared for publication. There will be a follow-up survey sent to membership this winter regarding programmatic changes that have been made in response to the new duty hour and supervision rules and the effects of these new requirements on resident education.
Plan: Sunset this Task Force

18. Fellowships: Chris Varley, Chair Selection Committee

The Awards DEADLINE for submission has been moved to 11/2/12. Common dates and times permit members to prepare nominations before recruitment starts and facilitates planning for the annual meeting. Resident nominees will be encouraged but not required to submit a poster or workshop.
Action Items:
Follow the organizational cost, the effect of these changes on the number of submissions and the workload of the committees, Confirm continued invitation of awardees to the President's Reception

19. CSV Task Force: Mike Jibson, Chair

Goals for 2012-13 include establishing a consensus rating for the new videos, preparation of training materials for the new videos, preparing report on existing surveys for publication.

Action Items:

Data analysis and draft report of existing surveys Continue collaboration with ABPN on existing surveys. Complete ratings of new website videos Select a co-chair for this task force.
Prepare a workshop for the 2013 meeting on how the CSV can be used to measure milestones and an AAP-AADPRT joint workshop at the next AAP meeting.

20. GME Task Force: Jed Magen, Chair

There are unlikely to be significant federal actions until after the election at which time the lame duck congress must address the end of the Bush tax cuts and the mandated sequestration of federal funds. At such time as things heat up, the Committee will begin to do phone conferences

and develop action items.

Plan: Reconnect with Jed after the election and inform members as firm information emerges. As the impact on GME Funding becomes clearer, solicit information from members regarding alternate means for GME funding currently being used.

21. Wrap-up: Kathy Sanders, President AADPRT

Respectfully submitted,

Adrienne Bentman, MD Secretary

Issues EC members asked for additional clarification about:

- How does one use the anchor points?
    - **Anchor points provide a frame of reference for training programs and residents in understanding the level of progress represented by the Milestones. Level 1 narratives describe the skills and abilities expected of entry level residents and can assist with identifying critical deficiencies early in training. Level 4 narratives describe the characteristics of residents ready for competent and independent practice. Level 2 and 3 narratives outline intermediate stages of progress in the Milestones. Level 5 narratives are "stretch goals" that can assist residents and programs in developing educational plans for those residents who have accomplished some or most Level 4 milestones but have not yet graduated from their program. While Levels 1 and 4 narratives are anchored by competencies generally expected at the beginning and ending of training, none of the other Levels are intended to represent fixed time points in training (i.e. Level 2 does not mean PGY2).**
- If a resident meets some anchor points in one level and some in another?
    - **This is to be expected as development in the specific Milestone competencies is not linear. Residents may master some skills quickly or exhibit them in special circumstances, but take longer to advance to the next step or in generalizing the skill to other clinical settings. In addition, some Milestones may be learned, practiced or assessed only in certain clinical settings. Reaching those Milestones will then depend on when those rotations are scheduled in training.**
- Can a resident drop a level?
    - **Yes, this might happen as noted in the previous question. Some skills might be exhibited only in certain settings and are not yet generalized to others. It might also indicate that a resident has encountered problems or developed habits that limit progress or cause regression and block the consolidation of prior learning.**
- Does ability to supervise as described in the milestones map onto the supervision requirements as defined in the duty hour requirements?
    - **Yes, they are included in appropriate Milestone narratives at Levels 1 or 2. The ACGME Specialty Specific Duty Hour Definitions include the following for permitting advancement in supervision level:**
        - ***"VI.D.5.a).(2) PGY-1 residents may progress to being supervised indirectly with direct supervision available only after demonstrating competence in: 1) the ability and willingness to ask for help when indicated; 2) gathering an appropriate history; 3) the ability to perform an emergent psychiatric assessment; and 4) presenting patient findings and data accurately to a supervisor who has not seen the patient."***

    - **Definition 1) is described in PBLI 2.1 Development and Execution of Life-Long Learning through Constant Self-Evaluation, "Recognizes limits of one's knowledge and skills and seeks supervision."**
    - **Definition 2) is described in PC 1.2 Psychiatric Evaluation, "Acquires efficient, accurate and relevant history customized to the patient's complaints."**
    - **Definition 3) is described in PC 1.2 Psychiatric Evaluation, "Assesses patient safety, including suicidal and homicidal ideation."**
    - **Definition 4) is described in PC 2.1 Psychiatric Formulation and Differential Diagnosis, "Accurately summarizes, reports, and presents to colleagues information obtained from the patient evaluation."**
- Do the levels imply timing of knowledge and skill acquisition over the course of the residency?
    - **No, while Levels 1 and 4 narratives are anchored by competencies generally expected at the beginning and ending of training, none of the other Levels are intended to represent fixed time points in training (i.e. Level 2 does not mean PGY2).**
- How does a residents' progress on the milestones affect his or her level/year in the residency and/or readiness for graduation.
    - **The Milestones are intended by the ACGME as an outcomes measure of only a program's effectiveness in training residents. Programs can use resident progress in the Milestones in their consideration of resident promotion along with other factors, such as completion of required clinical rotations, performance on exams, professionalism, etc. The decision for graduation remains the prerogative of the Program Director.**
- Can residents be evaluated and found to be at a level which would be well ahead of their PGY year?
    - **Yes, the Milestone Levels are not intended to reflect precise years of training but rather stages in progress towards overall training goals. Advancement is not expected to be linear or uniform across all the Milestone Levels.**
- Can the current assessment tools be used?
    - **Yes, the Milestones were designed to incorporate existing assessment tools such as the PRITE and the CSV Exam. The Working Group is now focused on identifying other valid and reliable assessment tools as well as gaps in available assessment measures.**
- Can one complete the entire milestones evaluation using supervisor evaluations?
    - **While that might be possible, it is important to consider the widest range of training assessment tools to support and complement supervisor evaluations.**

- How do assessments connect specifically with the milestones, e.g. are there specific assessments that must be used for specific milestones?
    - **The Working Group will provide a list of assessments that can be used by programs and specify the Milestones to which they apply, but they will not be required or the only assessments permitted.**
- Do the levels map onto educational concepts like minimal standards, proficiency and competency?
    - **No, as stated above, Level 1 narratives describe the skills and abilities expected of entry level residents and can assist with identifying critical deficiencies early in training. Level 4 narratives describe the characteristics of residents ready for competent and independent practice. Level 2 and 3 narratives outline intermediate stages of progress in the Milestones. Level 5 narratives are "stretch goals" that can assist residents and programs in developing educational plans for those residents who have accomplished some or most Level 4 milestones but have not yet graduated from their program.**
    - **While the Dreyfus model of skill acquisition was referenced in the original discussions of Milestones development, the five stages in the Dreyfus model are not the same as the five Milestone Levels.**
- How much supervision from faculty is implied for each level?
    - **That is dependent on the Milestone narratives and how the program approaches assessment. The Milestones are not intended to imply a specific level of supervision for residents but progress in the Milestones would indicate ability to handle greater autonomy in clinical duties.**
- Does a resident have to perform the activities specified in the anchor points entirely independently to meet the criterion?
    - **The narratives are intended to be descriptions of behaviors or skills that a resident would routinely exhibit. The decision on having achieved a level is the decision of the Clinical Competency Committee.**
- Is there potential legal exposure from the milestones evaluations, e.g. a PGY1 who is in a situation where he/she is asked to do level 4 activity?
    - **That will depend on the ability and capacity of the resident in question and the level of instruction and supervision provided in the situation. The ACGME is drafting a policy statement that addresses the intent of the Milestones for overall program assessment that should help with this concern.**
- What does the Milestone Project consider to be basic competent care? What is the definition of the standard?
    - **Part of the Milestone Pilot Project and public discussion and comment will be directed at determining these issues.**

- Who will complete the milestone evaluations?
    - **The assessments of resident performance will be reviewed by the Clinical Competency Committee of the training program and they will determine the resident's progress. The Program Director is responsible for entering resident progress data in the ACGME database.**
- Is there a requirement about the staffing and leadership of the evaluation committee?
    - **The ACGME will provide information about the Clinical Competency Committee.**
- How will program and institutional IT systems be able to track milestones and interface with the NAS?
    - **The ACGME will set up an on line data system for entry of a program's Milestone information.**

General concerns:

- Many of the milestones are overlapping.
    - **The Working Group was very aware of overlaps in Milestone narratives and tried to reduce them to a minimum. Where they do exist, it was thought to be important to the description of the particular Milestone (i.e. Psychotherapy has both Patient Care and Medical Knowledge aspects that are distinct but overlap). One of the tasks for the Milestone Pilot Project and the public discussion and comment is to determine how best to understand and deal with potential overlaps if they cannot be avoided.**
- The anchor points are uneven and not parallel in many cases.
    - **Many abilities and knowledge are not independent and arise from different pathways. The Milestone narratives were intended to provide the best and most concise description of this development, not an encyclopedic overview that would be impractical to use in assessment.**
- Using ability to teach as an anchor point is confusing because we ask very early residents to teach. They can be effective and knowledgeable teachers or not, and using teaching as a proxy for having sufficient knowledge to teach effectively is problematic.
    - **Teaching is integral to professional duties, not only in patient education, but educating colleagues, other professionals as well as students and other residents. While residents may enter training with teaching skills, it is critical to promote and develop those skills.**
- Some milestones are very specific and some are more general.
    - **This is a reflection of our current knowledge about any specific Milestone narrative and our ability to assess it. We hope that the Pilot Project and public comment will help refine the Milestones so they are all concise and descriptive.**

- So much here that it will take time away from clinical care to teach
    - **The Milestones do carry an implicit expectation on teaching, but we are committed to making them feasible and practical. The Pilot Project will clarify the exact burden to programs and hopefully provide insights on how use of the Milestones can be streamlined and improve both clinical care and teaching.**
- Not simple enough
    - **Any suggestions to simplify without losing descriptive clarity are greatly appreciated. We want to be able to describe the trees without losing sight of the forest.**

Specific concerns:

- The MK milestones on development struck several child psychiatrists as inconsistent with how they teach about normal development.
    - **These Milestones are for General Psychiatry and would understandably differ from the expectations for training of Child Psychiatry Fellows. The Milestones are also intended primarily as an assessment tool rather than a specific curriculum outline.**
- The psychopharmacology milestones consider activities we expect of PGY2's to be at level 4, e.g. augmentation strategies and use of multiple medications.
    - **One of the principal goals of the Pilot Project and public discussion over the coming year is to define the appropriate level of expectation for the Milestone narratives. Again, do not confuse Levels 2 and 3 with PGY2 and PGY3 respectively.**
- There is no specific mention of addiction, child psychiatry and geriatric psychiatry.
    - **The required clinical experiences will still be contained within the Program Requirements. The Milestone narratives are to describe competencies in any clinical rotation.**
- With teaching as its own milestone, why so much emphasis on teaching/supervising skill as a Level 4 and 5 accomplishment when it is something expected earlier in their training to be able to do.
    - **The expectation is that as the resident progresses he/she will be teaching more advanced learners more independently and with greater expertise in both teaching methods and knowledge of content. In addition, newly graduated residents who start as junior faculty will be expected to begin**