

Report of the Core Competency Task Force

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Presented to:

AOA Board of Trustees

July 2003

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Preface

The AOA Core Competency Task Force is in the process of completing a review of AOA policies and procedures in graduate medical education to address concerns of the Executive Committee of the Council on Postdoctoral Training (ECCOPT). Specifically, the ECCOPT asked the Task Force to evaluate our training and accreditation process for the profession from the standpoint of inclusion of essential core competencies necessary to enhance quality. These competencies would then be maintained into the life-long learning process and validated through certification and re-certification examination. In recent times, the issue of physician training and competency has become a public issue, often addressed in the lay media.

This report represents the work product of the AOA Core Competency Task Force. It is intended to advise the AOA Board of Trustees on the development of the seven core competencies previously approved by the Board and to promote a shift from “experience-based” education to “competency-based” education. The Task Force will recommend that the core competencies be incorporated, implemented and evaluated by specialty colleges, specialty boards and continuing medical education, as applicable.

The following individuals contributed their time and input into this report:

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Executive Summary

This document is the report of the Core Competency Task Force and its activities from inception in February 2002 through January 2003. The Core Competency Task Force was established by action of the AOA Board of Trustees in February 2002 to: (1) define the elements of each of the previously-approved seven core competencies that osteopathic trainees must demonstrate; (2) define methodologies and processes for the integration of the core competencies into each specialty and subspecialty training program, and (3) develop a list of potential outcome measures for the evaluation of each trainee’s competence, which is established and incorporated in the development of skills for future practice and development into life-long learning.¹

Definition of Professional Competence

There is a substantive amount of research on competency-based education. Ronald Epstein, M.D., and Edward M. Hundert, M.D.,² proposed the following definition: “*Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of*

1 *the individual and community being served.*” Their writing further states “Competence builds
2 on a foundation of basic clinical skills, scientific knowledge, and moral development.”
3

4 ***Chronicle of Committee Activity***

5

6 The Task Force met in four face-to-face meetings and five teleconferences between
7 February 2002 and January 2003. In an attempt to function in a cost and time efficient manner, all
8 face-to-face meetings were conducted together with ECCOPT or COPT scheduled meetings.
9 Since the board had already approved the core competencies, the Task Force focused on the
10 definitions of these competencies, the process being presented, and methodologies for monitoring
11 the competencies within the residencies. In addition there was discussion on how these
12 competencies could be included in board certification, re-certification, and continuing medical
13 education. The respective councils and bureaus will be asked for their input on how to include the
14 competencies at a later time. A broad timetable for a gradual progression to implement the
15 competencies was developed and feedback has been requested from all specialty affiliates, which
16 will ultimately be incorporated into the final report.
17

18 At the initial meeting of February 11th 2002, the Task Force agreed to accept the
19 Accreditation Council for Graduate Medical Education’s (ACGME) six core competencies and
20 added a seventh competency on the integration of Osteopathic Philosophy and Osteopathic
21 Manipulative Medicine. Teleconference meetings proved to be a valuable tool to complete tasks
22 and clarify directions, especially in the initial and final stages of project development. In
23 subsequent meetings, both teleconference and face-to-face, the Task Force decided on content,
24 process, methods, and a timeline. Progressive discussion continued with a review of the ACGME
25 *Toolbox of Assessment Methods*© (Appendix 2) and the decision to use this document as a
26 reference when creating a structure for integration. There was agreement that all core
27 competencies should include 1) a definition of the competency; 2) required elements; 3) suggested
28 methodology to achieve compliance; and 4) suggested methods of evaluation. The committee
29 assigned members to complete drafts for each competency, and then reviewed and approved the
30 drafts.
31

32 At the November 15, 2002 final meeting, a timeline for implementing the core
33 competencies was developed. The Task Force determined that two of the seven core
34 competencies--Medical Knowledge and Osteopathic Philosophy and Osteopathic Manipulative
35 Medicine--are specialty-specific. Specialty colleges would be required to develop their own
36 specific criteria and methods to incorporate these core competencies into the specialty basic
37 standards for residency training. Furthermore, the Task Force determined that the remaining five
38 competencies are general in nature and apply to all specialties.
39

40 ***Background and Statement of Problem***

41

42 The Institute of Medicine report, *To Err is Human*³ on patient-safety, in addition to public
43 pressure and payor requirements, prompted the ECCOPT to begin a discussion of the importance
44 of implementing competency-based education to improve patient-safety. It was felt that safe
45 medical practice and competencies of medical practitioners must be demonstrated through
46 measurable outcome analysis. In addition, the ACGME had already developed six core
47 competencies that would be integrated as a condition of continuing program accreditation for
48 allopathic programs.
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Approach to the Issue

The AOA Board of Trustees approved the seven core competencies in February 2002. A Task Force on Core Competencies was established to further evaluate and develop these competencies, and report back to the AOA Board in February 2003. A number of committee meetings and teleconferences were conducted, literature was reviewed, and discussion of core competencies was incorporated into various AOA educational symposia.

Recommendations to the AOA Board of Trustees

The Core Competency Task Force recommends adoption of the following points:

- 1) Incorporate the seven Board of Trustees (BOT) approved core competencies into all AOA approved Basic Standards for internship and residency training programs.
- 2) Evaluate core competency requirements at all on-site inspections and incorporate core competency criteria in the specialty affiliate survey workbooks;
- 3) Incorporate core competency testing into the board certification and re-certification process;
- 4) Incorporate core competency education in life-long learning and the continuing medical educational process;
- 5) Incorporate the core competencies into the evaluation process of all residency and intern programs and the specialty college Program Director and Residency Annual Reports;
- 6) Require all OPTIs to assist partner hospitals and programs in core competency education and evaluation initiatives; and
- 7) Require all specialty affiliates to participate in core competency initiatives by offering training programs as part of their conferences, conventions, and seminars.

Section 1 – Definition of Professional Competence

“Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served.”⁴

Section 2 – History of Competency-Based Education

As early as the 1930s, evidence of competency-based education or mastery learning has been used to train students.⁵ Benjamin Bloom fully developed the concept now known as *mastery learning* in 1968.⁶ He concluded that if aptitude could predict a learning rate, the degree of learning expected of a student could be set to some level of mastery performance. If the instructional variables were under an instructor’s control, such as the opportunity to learn and the quality of the instruction, the instructor should be able to ensure that each learner can attain a specified objective. Bloom concluded that given sufficient time and quality instruction, nearly all students could learn the given material. The theories of mastery learning resulted in a radical shift in responsibility for teachers; the blame for a student's failure would rest with the instruction not the student’s lack of ability.

1 Bloom, as described by Hershey Bell,⁷ developed the following model of mastery learning
2 incorporating the following concepts:

- 3
- 4 1. “Mastery is defined in terms of a specific set of major objectives that the student is
5 expected to exhibit by the completion of a subject of study;
- 6 2. Subject matter is broken into smaller learning units that is essential for mastery of the
7 major objectives;
- 8 3. Typical group-based instructional methods are used to teach each unit; and
- 9 4) Brief diagnostic tests (formative/interval evaluations) are given at the completion of each
10 unit.”
- 11

12 To summarize, Bloom differentiates the major features of mastery learning from other
13 teaching methods in the following way: There is “a clear definition of the competencies that must
14 be mastered for successful completion of a curriculum; a use of formative evaluation instruments
15 that help learners and teachers assess interval mastery; an allowance of enough time for learners
16 to attain mastery; and an availability of a variety of teaching strategies for those who require
17 additional instruction, so that strategies can be matched to learner styles.”

18

19 Competency-based learning encompasses not only a student’s/physician’s knowledge of
20 accepted medical standards, but also includes the practical application of those standards. This
21 concept has evolved over time whereas many years ago, students/physicians were evaluated
22 based on their textbook knowledge of a particular subject.

23

24 Over time, new learning concepts have been developed which provide a multi-level
25 approach where students/physicians were expected to show proficiency in a subject, in addition to
26 test scores, through their text knowledge, application of knowledge, level of professionalism,
27 interpersonal and communication skills and continued medical education.

28

29 Block describes “programmed instruction” as a “series of instructional frames” whereby
30 the student/physician may advance to the next “frame” only upon mastery of the content of the
31 “current frame.”⁸ Block argued that “if aptitude was predictive of the learning rate, not the
32 attainable level of mastery, then it should be possible to fix the degree of learning at some mastery
33 level and manipulate the learning environment” so that the majority of students/physicians can
34 attain a mastery of learning or competence. Patricia Callendar and Laurie Thomas define
35 programmed instruction as “a method of instruction whereby new subject matter is presented to
36 students in a graded sequence of controlled steps. Students work through the programmed
37 material by themselves at their own speed and after each step, test their comprehension by
38 answering an examination question or filling in a diagram. They are then immediately shown the
39 correct answer or given additional information. Computers and other types of teaching machines
40 are often used to present the material, although books may also be used.”⁹

41

42 Herbert and Stuart Dreyfus developed the Dreyfus Model of Skill Acquisition in 1986.¹⁰
43 David Leach, M.D., Executive Director of the Accreditation Council for Graduate Medical
44 Education,¹¹ believes this model is useful to understanding competency-based learning in medical
45 education and lifelong learning. It is Dr. Leach’s contention that acquisition of skills is an evolving
46 process. While students/physicians gain insight from training experiences, actual competence is
47 developed over time and is achieved from the trainee’s reflection of his/her experiences.
48 According to the Dreyfus Model, a *novice* relies on rules. He or she cannot use previous
49 experience to make decisions or deal with situations. Richard LeBlond¹² likens this stage to the
50 new medical student. The learner in the next stage, *advanced beginner*, is still rule-focused, but

1 the student begins to rely on previous experience. The medical student at this stage needs strong
2 guidance and support in order to perform at an acceptable level. Medical students will grow from
3 a novice to an advanced beginner during clerkship training in the last two years of medical school.
4 *Competent* performers are more organized; they have a plan and have become more efficient.
5 LeBlond believes that residents will progress from advanced beginner to competent. It is not until
6 the first years of practice, the physician will become *proficient*. A proficient physician formulates
7 plans for care, anticipates “most likely” occurrences, recognizes departures from the expected
8 course, and modifies plans accordingly. As a lifelong learner, it will be several years later before
9 a physician can progress to the *expert* or *master* stage of skill acquisition. At the *expert* stage the
10 physician anticipates the unusual, has a repertoire of skills based upon experience, has knowledge
11 not easily available in textbooks, has fluid performance and is an accomplished implementer of
12 plans. At the *master* stage, the physician publicly engages in learning from personal failures,
13 connects learning with the redesign of personal daily work, is embedded in the context of each
14 case, and not dependent on rules. These are the physicians typically engaged in medical research.
15

16 The drive for accountability and responsibility to the public has become the driving force
17 for medical education and physicians to shift to competency-based initiatives.¹³ Also known as
18 outcome-based learning, this approach to education and assessment provides clear learning
19 direction for both faculty and residents, creates accountability around the process and outcomes of
20 learning, requires relationship-based teacher/learner interaction and promotes *safety* in
21 education.¹⁴ Safety, in the realm of education, refers to the learner’s need to feel safe in asking
22 questions, risk thinking in new ways, and practice skills without fear of ridicule or disapproval. In
23 medical education, safety also includes that the learner can practice skills that will ensure patient
24 safety in the future.
25

26 Bell’s Model of Competency Based Evaluation (Appendix 1) begins with the development
27 of competencies for a given group of learners. After instruction, formative evaluation is used to
28 give learners information as they demonstrate skills and knowledge. Summative evaluation, where
29 the learner is given only a final examination of his or her achievement, is not part of competency-
30 based evaluation, as it does not contribute to learning. Teachers provide formative evaluation
31 through feedback, redirection, and encouragement to the learner. After remediation, the learner is
32 given the opportunity to demonstrate the competency again. This systems approach to evaluation
33 is continued until the learner has demonstrated competency. Though evaluation can be entirely
34 subjective as a tool in competency-based education, it can be made reliable and valid through
35 examination of accurate and complete data, definitions of competency, and thorough teaching and
36 attention to the learner.
37

38 **Section 3 - Background and Statement of the Problem**

39

40 In today’s litigious society, concerns about quality and patient safety have drawn attention
41 to the need for validation of competent physicians. Standard health care practices and patient
42 customer service has prompted review of physicians and the health care systems in which they
43 practice. Not only are patients becoming frustrated with the level of care they perceive as
44 inadequate, but physicians are expressing anxiety about practicing within complex delivery
45 systems that foster compromise of work ethics and values.
46

47 To allay the concerns of the public concerning competent medical care, healthcare
48 organizations, insurance companies and government agencies together with the American Board
49 of Medical Specialists (ABMS) in March 1998 created a Task Force on Competence. This Task

1 Force determined that the initial certification process was a good one, and that the next goal of
2 graduate medical education would be to ensure that trainees venturing into practice become
3 competent physicians. Dr. Leach teamed with the American Board of Medical Specialties
4 (ABMS) and identified the need to develop “initiatives designed to improve graduate medical
5 education by using educational outcome assessments as an accreditation tool.” Due to the
6 visibility of this issue in the public arena and the ACGME decision to develop a core competency
7 model, the COPT has concluded that there is validity to develop a similar model into osteopathic
8 programs.
9

Section 4 - Approach to the Problem

At the request of COPT, the AOA Board of Trustees adopted ACGME's six core competencies and added a seventh competency in Osteopathic Philosophy and Osteopathic Manipulative Medicine. The Core Competency Task Force broadly defined each competency as a basis for developing measurable criteria that identifies achievement of mastery learning within the osteopathic profession. The Task Force recommends that this criterion be incorporated into the requirements specific to relevant affiliates of the AOA. The Task Force charged the following constituencies with the development of core competency criteria and measurable tools for its evaluation and implementation:

1. Specialty colleges should develop measurable criteria to incorporate basic standards for residency training. It will be the responsibility of the program reviewers/inspectors, through the guidelines in inspection workbooks to validate whether training programs have incorporated and implemented methods for teaching and evaluation of these competencies;
2. Specialty boards should develop and include measurable criteria into its testing standards to evaluate the success of competency-based training for purposes of becoming board certified and for re-certification; and
3. Continuing medical education should develop competency-based educational criteria for inclusion within its life-long learning programs for required CME recognition.

Section 5 – Chronicle of Committee Activity

The initial meeting of the task force began with a conjoint meeting between the Task Force and the AOA Council on Postdoctoral Training (COPT) for purposes of gaining input from the COPT. The charge from the AOA Board of Trustees was reviewed.

Task Force Meeting of February 11, 2002

Task Force members reviewed the seven core competencies and agreed that a definition for each competency should be developed and included in all basic standards. In addition, each competency should include suggested methodology to achieve compliance and educational methods of evaluation.

Task Force Teleconference of March 14, 2002

Discussion revolved around a sample grid taken from Epstein's and Hundert's article "Defining and Assessing Professional Competence," cited earlier in this report. It was noted that this grid could be modified and used as a tool to use in the evaluation process. The Task Force determined that each specialty college should develop and define the basic criteria for evaluation of these competencies respective to its specialty, including the interjection of osteopathic principles and practice techniques.

Task Force Teleconference of March 15, 2002

The Task Force accepted the overall definition of competency as cited in the article "Defining and Assessing Professional Competence," as a starting place.

Task Force Teleconference of April 18, 2002

The Task Force members agreed that six of the seven core competencies adopted by the

1 AOA Board of Trustees are applicable to all postdoctoral training, with the seventh core
2 competency unique to the osteopathic profession. The members noted that the ACGME Toolbox
3 of Assessment Methods© is a good resource because it is generic, but noted it would require input
4 by each specialty to create its own structure. The Task Force agreed to include an osteopathic
5 component within the above definition with an explanation of the context for the use of
6 Osteopathic Manipulative Medicine. The members agreed that when using the ACGME core
7 competency model, “OPP” could replace the reference to “structure”.

8 9 ***Task Force Meeting of April 26, 2002***

10 The Task Force agreed that the ACGME Outcome Project(Appendix 3) document of
11 general core competencies would be used as a basis to develop the definitions of osteopathic core
12 competencies. When these definitions are finalized, the specialty colleges will be requested to
13 develop measurable criteria based upon these definitions.

14 15 ***Task Force Teleconference of June 7, 2002***

16 The Task Force decided that the ACGME Toolbox of Assessment Methods© and format
17 should be used with modifications to suit the uniqueness of the osteopathic profession. The
18 strategy should include the following:

- 19 1. Definition of the Competency
- 20 2. Required Elements
- 21 3. Suggested Methodology to Achieve Compliance
- 22 4. Suggested Methods of Evaluation

23
24 Task Force members were given assignments to complete the drafts.

25 26 ***Task Force Teleconference of June 27, 2002***

27 The group briefly discussed the drafts of the five general core competencies;
28 professionalism, interpersonal and communication skills, patient care, systems-based practice,
29 practice-based learning and improvement. It was decided that the Task Force members would
30 develop criteria for the general core competencies.

31 32 ***Task Force Meeting of July 25, 2002***

33 Members of the Task Force agreed that the drafts of the competencies needed to be
34 reviewed on a psychosocial and ethical basis before finalization. Final copies of the core
35 competencies will be distributed to specialty colleges in late August 2002. The Task Force
36 identified two of the seven core competencies (Medical Knowledge and Osteopathic Philosophy
37 and Osteopathic Manipulative Medicine) as specialty-specific and will request specialty colleges to
38 develop methodology specific to each specialty.

39 40 ***Events of September 25, 2002***

41 The core competencies were distributed to the specialty colleges to review. Directions
42 were given to specialty college leadership to present and discuss core competencies with
43 education and evaluation committees. Specialty Colleges should review the core competencies and
44 create methods to establish a baseline data and measure outcomes of integration into postdoctoral
45 education. Feedback from specialty colleges is due by March 15, 2003 for discussion at the April
46 ECCOPT meeting.

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6 ***Task Force Meeting of November 15, 2002***

7 The Task Force discussed a timeline to implement core competencies into residency
8 training and evaluation. The chair of the Task Force sent a letter to the Chair of the Bureau of
9 Osteopathic Specialists and the Chair of the Council on Continuing Medical Education requesting
10 that each of these entities review the competencies and the required integration of the
11 competencies into the training standards as well as to begin plans to incorporate the competencies
12 into life-long learning programs and the certification and re-certification process of each specialty
13 board.
14

15 **Section 6 – Seven Core Competencies of the Osteopathic**
16 **Profession**
17

18 **Osteopathic Philosophy and Osteopathic Manipulative Medicine**
19 **Medical Knowledge**
20 **Patient Care**
21 **Interpersonal and Communication Skills**
22 **Professionalism**
23 **Practice-Based Learning and Improvement**
24 **Systems-Based Practice**
25

26 ***Competency 1: OSTEOPATHIC PHILOSOPHY AND OSTEOPATHIC MANIPULATIVE***
27 ***MEDICINE***
28

29 **DEFINITION:**
30

31 **Residents are expected to demonstrate and apply knowledge of accepted**
32 **standards in Osteopathic Manipulative Treatment (OMT) appropriate to their**
33 **specialty. The educational goal is to train a skilled and competent osteopathic**
34 **practitioner who remains dedicated to life-long learning and to practice habits in**
35 **osteopathic philosophy and manipulative medicine.**
36

37 **REQUIRED ELEMENTS:**
38

- 39 **1. Demonstrate competency in the understanding and application of OMT**
40 **appropriate to the medical specialty.**
41

42 Suggested Methodology to Achieve Compliance
43

- 44 a. Provide opportunities for active participation for residents in hospital and
45 ambulatory sites for OMT training.
46 b. Teach residents to perform a critical appraisal of medical literature related to OMT.
47 c. Observe and credential residents in the performance of OMT by assessing their
48 diagnostic skills, medical knowledge, and problem-solving abilities.
49 d. Computer educational modules
50

Suggested Methods for Evaluation

- a. Simulations and Models
- b. Objective Structured Clinical Examination (OSCE)
- c. Record Reviews
- d. Standardized Oral Examination
- e. Competency Cards
- f. Monthly Service Rotation Evaluations

2. Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate.Suggested Methodology to Achieve Compliance

- a. Have residents assume increasing responsibility for the incorporation of osteopathic concepts in patient management.
- b. Participate in activities that provide educational programs at the student and intern levels.
- c. Participate in CME programs provided by COMS, the AAO, and specialty colleges.
- d. Computer Teaching Modules

Suggested Methods for Evaluation

- a. Simulations and Models
- b. Procedures or Case Logs
- c. Global Rating of Live or Recorded Performance
- d. Standardized Patient Examination
- e. Monthly Service Evaluations

3. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.Suggested Methodology to Achieve Compliance

- a. Utilize caring, compassionate behavior with patients.
- b. Demonstrate the treatment of people rather than symptoms.
- c. Demonstrate understanding of somato-visceral relationships and the role of the musculoskeletal system in disease.
- d. Demonstrate listening skills in interaction with patients.
- e. Demonstrate knowledge of and behavior in accordance with the Osteopathic Oath and AOA Code of Ethics.

Suggested methods for Evaluation

- a. Direct Observation
- b. Global Rating of Live or Recorded Performance
- c. 360-Degree Evaluation Instrument
- d. Standardized Patient Examination
- e. Peer Review
- f. Monthly Service Evaluations

1
2 **Competency 2: MEDICAL KNOWLEDGE**

3
4 **DEFINITION:**

5
6 **Residents are expected to demonstrate and apply knowledge of accepted**
7 **standards of clinical medicine in their respective specialty area, remain current**
8 **with new developments in medicine, and participate in life-long learning**
9 **activities, including research.**

10
11 **REQUIRED ELEMENTS:**

12
13 **1. Demonstrate competency in the understanding and application of clinical**
14 **medicine to patient care.**

15
16 Suggested Methodology to Achieve Compliance

- 17
18 a. Performance on COMLEX Part III and In-Service Examinations
19 b. Supervised observation of the clinical decision-making abilities of residents
20 c. Attendance at seminars or CME, Grand Rounds, Lectures
21 d. Participation in a directed readings program and journal club
22 e. Periodic assessment of resident critical thinking and problem-solving abilities
23

24 Suggested Methods for Evaluation

- 25
26 a. Chart Stimulated Recall Oral Examinations (CSR)
27 b. Simulations and Model
28 c. 360-Degree Evaluation Instrument
29 d. Written Examinations (i.e., in-training examination)
30 e. Month Service Evaluations
31

32 **2. Know and apply the foundations of clinical and behavioral medicine appropriate**
33 **to their discipline.**

34
35 Suggested Methodology to Achieve Compliance

- 36
37 a. Participate in research activities that critically evaluate current medical information
38 and scientific evidence.
39 b. Develop as a medical educator by having residents give presentations before peers,
40 faculty, and participate in the instruction of medical students.
41 c. Routinely assess the skill and outcomes of residents in their performance of medical
42 procedures.
43 d. Develop programmatic education in Life Long Learning
44 e. Lectures, workshops and behavioral psycho-social multi-cultural issues in medical
45 specialties as appropriate.
46

47 Suggested Methods for Evaluation

- 48
49 a. Chart Stimulated Recall Oral Examinations (CSR)
50 b. Written Examination

- c. 360-Degree Evaluation Instrument
- d. Direct Observation
- e. Simulations and Models
- f. Monthly Service Evaluations

Competency 3: PATIENT CARE

DEFINITION:

Residents must demonstrate the ability to effectively treat patients, provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine, and health promotion.

REQUIRED ELEMENTS:

- 1. Gather accurate, essential information for all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic plans and treatments.**

Suggested Methodology to Achieve Compliance

- a. Supervise the performance of medical interviewing techniques to assess the resident's skill and ability.
- b. Provide instruction on the development and implementation of effective patient management plans.
- c. Teach residents the proper methods for requesting and sequencing diagnostic tests and consultative services.
- d. Instill in residents the need to provide a caring attitude that is mindful of cultural sensitivities, patient apprehensions, and accuracy of information.
- e. Bedside teaching rounds

Suggested Methods for Evaluation

- a. Checklist Evaluation
- b. Standardized Patient Examination
- c. Objective Structured Clinical Examination (OSCE)
- d. Standardized Oral Examination
- e. Record Review
- f. 360-Degree Evaluation Instrument
- g. Month Service Evaluations

- 2. Validate competency in the performance of diagnosis, treatment and procedures**

1 **appropriate to the medical specialty.**

2
3 Suggested Methodology to Achieve Compliance

- 4
5 a. Provide instructional programs for the performance of medical procedures where
6 appropriate.
7 b. Develop a credentialing program for residents to validate their competency in the
8 performance of medical procedures where appropriate.
9 c. Instruct residents in the performance of a medical procedure, any potential
10 complications and known risks to the patient (informed consent)
11 d. Beside teaching rounds

12
13 Suggested Methods of Evaluation

- 14
15 a. Checklist Evaluation
16 b. Global Rating of Live or Recorded Performance
17 c. Simulations and Models
18 d. Procedure and Case Logs
19 e. Monthly Service Evaluations

20
21 **3. Provide health care services consistent with osteopathic philosophy, including**
22 **preventative medicine and health promotion that are based on current scientific**
23 **evidence.**

24
25 Suggested Methodology to Achieve Compliance

- 26
27 a. Counsel patients and their families on health promotion and lifestyle activities related
28 to good health maintenance.
29 b. Refer patients to non-for-profit and community service organizations that support
30 health promotion and behavioral modification programs.
31 c. Work with professionals from varied disciplines as a team to provide effective
32 medical care to patients that address their diverse healthcare needs.
33 d. Bedside teaching rounds

34
35 Suggested Methods for Evaluation

- 36
37 a. Checklist Evaluation
38 b. Global Rating of Live or Recorded Performance
39 c. Simulations and Models
40 d. Patient Surveys
41 e. Objective Structured Clinical Examination (OSCE)
42 f. Standardized Patient Examination (SP)
43 g. Procedure or Case Logs
44 h. Monthly Service Evaluations

45
46 ***Competency 4: INTERPERSONAL AND COMMUNICATION SKILLS***

47
48 **DEFINITION:**

49
50 **Residents are expected to demonstrate interpersonal and communication skills**

1 **that enable them to establish and maintain professional relationships with**
2 **patients, families, and other members of health care teams.**

3
4 **REQUIRED ELEMENTS:**

5
6 **1. Demonstrate effectiveness in developing appropriate doctor-patient**
7 **relationships.**

8
9 Suggested Methodology to Achieve Compliance

- 10
11 a. Demonstrate patient interviewing techniques.
12 b. Demonstrate ability to assess the health of non-English-speaking and deaf patients.
13 c. Involve patients and families in decision-making.
14 d. Illustrate the use of appropriate verbal and non-verbal skills when communicating with
15 patients, families and faculty
16 e. Demonstrate an understanding of cultural and religious issues and sensitivities in the
17 doctor-patient relationship
18 f. Videos, workshops, beside and clinic/office teaching

19
20 Suggested Methods for Evaluation

- 21
22 a. Checklist Evaluation
23 b. Objective Structured Clinical Examination (OSCE)
24 c. 360-Degree Evaluation
25 d. Patient Surveys
26 e. Standardized Patient Examination
27 f. Videotaping
28 g. Monthly Service Evaluation

29
30 **2. Exhibit effective listening, written and oral communication skills in professional**
31 **interactions with patients, families and other health professionals.**

32
33 Suggested Methodology to Achieve Compliance

- 34
35 a. Communicate medical problems and patient options at appropriate levels of
36 understanding.
37 b. Maintain comprehensive, timely, and legible medical records.
38 c. Demonstrate respectful interactions with health practitioners, patients, and families of
39 patients
40 d. Elicit medical information in effective ways.
41 e. Demonstrate an understanding of resources available to physicians to assist with
42 appropriate assessment of communication-impaired patients.
43 f. Work effectively with others as a member or leader of a healthcare team.
44 g. Workshops, videos, bedside and clinic/office teaching.

45
46 Suggested Methods for Evaluation

- 47
48 a. Standardized Patient Examination
49 b. Objective Structured Clinical Examination (OSCE)
50 c. 360-Degree Evaluation

- 1 d. Patient Surveys
- 2 e. Checklist Evaluation
- 3 f. Case/Chart Review
- 4 g. Monthly Service Evaluations

6 **Competency 5: PROFESSIONALISM**

8 **DEFINITION:**

10 **Residents are expected to uphold the Osteopathic Oath in the conduct of their**
11 **professional activities that promote advocacy of patient welfare, adherence to**
12 **ethical principles, collaboration with health professionals, life-long learning, and**
13 **sensitivity to a diverse patient population. Residents should be cognizant of**
14 **their own physical and mental health in order to effectively care for patients.**

16 **REQUIRED ELEMENTS:**

- 18 **1. Demonstrate respect for patients and families and advocate for the primacy of**
19 **patient's welfare and autonomy.**

21 Suggested Methodology to Achieve Compliance

- 23 a. Present an honest representation of a patient's medical status and the implications of
24 informed consent to medical treatment plans.
- 25 b. Maintain a patient's confidentiality and demonstrate proper fulfillment of the
26 physician's role in the doctor-patient relationship.
- 27 c. Commitment to an appropriate and non-exploitive relationship with patients.
- 28 d. Inform patients accurately of the risks associated with medical research projects, the
29 potential consequences of treatment plans, and the realities of medical errors in
30 medicine.
- 31 e. Treat the terminally ill with compassion in the management of pain, palliative care, and
32 preparation for death.
- 33 f. Participate in course/program (compliance and end of life). Workshops, lectures,
34 bedside and clinic/office teaching
- 35 g. Role modeling behavior

37 Suggested Methods for Evaluation

- 39 a. Checklist Evaluation
- 40 b. Objective Structured Clinical Examination (OSCE)
- 41 c. 360-Degree Evaluation
- 42 d. Patient Surveys
- 43 e. Standardized Patient Examination
- 44 f. Videotaping
- 45 g. Monthly Service Evaluations

- 47 **2. Adhere to ethical principles in the practice of medicine.**

49 Suggested Methodology to Achieve Compliance

- 51 a. Understand conflicts of interest inherent in medicine and the appropriate responses to
52 societal, community, and healthcare industry pressures.

- b. Use limited medical resources effectively and avoid the utilization of unnecessary tests and procedures.
- c. Recognize the inherent vulnerability and trust accorded by patients to physicians and uphold the highest moral principles that avoid exploitation for sexual, financial, or other private gain.
- d. Pursue life-long learning goals in clinical medicine, humanism, ethics, and gain insight into the understanding of patient concerns and the proper relationship with the medical industry.
- e. Workshops, lectures, bedside and clinic/office teaching
- f. Role modeling behavior

Suggested Methods of Evaluation

- a. Standardized Patient Examination
- b. Objective Structured Clinical Examination (OSCE)
- c. 360-Degree Evaluation
- d. Patient Surveys
- e. Checklist Evaluation
- f. Monthly Service Evaluations

3. Demonstrate awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities.

Suggested Methodology to Achieve Compliance

- a. Become knowledgeable and responsive to the special needs and cultural origins of patients.
- b. Advocate for continuous quality of care for all patients.
- c. Prevent the discrimination of patients based on defined characteristics.
- d. Understand the legal obligations of physicians in the care of patients.
- e. Lectures/workshops, role-modeling

Suggested Methods for Evaluation

- a. Standardized Oral Examination
- b. Objective Structured Clinical Examination (OSCE)
- c. Checklist Evaluation
- d. 360-Degree Evaluation
- e. Portfolios
- f. Patient Surveys
- g. Competency Cards
- h. Sensitivity Seminars/Programs
- i. Monthly service evaluations

Competency 6: PRACTICE-BASED LEARNING AND IMPROVEMENT

DEFINITION:

Residents must demonstrate the ability to critically evaluate their methods of clinical practice, integrate evidence-based medicine into patient care, show an

1 **understanding of research methods, and improve patient care practices.**

2
3 **REQUIRED ELEMENTS:**

4
5 **1. Treat patients in a manner consistent with the most up-to-date information on**
6 **diagnostic and therapeutic effectiveness.**

7
8 Suggested Methodology to Achieve Compliance

- 9
10 a. Use reliable and current information in diagnosis and treatment.
11 b. Understand how to use the medical library and electronically mediated resources to
12 discover pertinent medical information.
13 c. Demonstrate the ability to extract and apply evidence from scientific studies to patient
14 care.
15 d. Feedback on resident presentations
16 e. Journal Clubs

17
18 Suggested Methods for Evaluation

- 19
20 a. Written Examinations
21 b. Objective Structured Clinical Examination (OSCE)
22 c. Portfolios
23 d. Record Review
24 e. Standardized Patient Examination
25 f. Chart Stimulated Recall Oral Examination (CSR)
26 g. Monthly Service Evaluations

27
28 **2. Perform self-evaluations of clinical practice patterns and practice-based**
29 **improvement activities using a systematic methodology.**

30 Suggested Methodology to Achieve Compliance

- 31
32
33 a. Understand and participate in *quality assurance* activities at the hospital and at
34 ambulatory sites.
35 b. Apply the principles of evidence-based medicine in the diagnosis and treatment of
36 patients.
37 c. Measure the effectiveness of resident practice patterns against results obtained with
38 other population groups in terms of effectiveness and outcomes.

39 Suggested Methods of Evaluation

- 40
41 a. Standardized Patient Examination
42 b. Objective Structured Clinical Examination (OSCE0
43 c. Record Reviews
44 d. Chart Stimulated Recall Oral Examinations (CSR)
45 e. Portfolios
46 f. Self Study

47
48 **3 Understand research methods, medical informatics, and the application of**
49 **technology as applied to medicine.**

50

Suggested Methodology to Achieve Compliance

- a. Participate in research activities as required by the respective specialty colleges.
- b. Demonstrate computer literacy, information retrieval skills, and an understanding of computer technology applied to patient care and hospital systems.
- c. Apply study designs and statistical methods to the appraisal of clinical studies.
- d. Journal Clubs, Evidenced-based medicine programs
- e. Feedback on resident presentations

Suggested Methods for Evaluation

- a. Objective Structured Clinical Examination (OSCE)
- b. Standardized Patient Examination
- c. Portfolios
- d. Procedure or Case Logs
- e. Resident Initiated Research
- f. Information Technology Research-Related Review/Development
- g. Self Study
- h. Monthly Service Evaluations

Competency 7: SYSTEMS-BASED PRACTICE**DEFINITION:**

Residents are expected to demonstrate an understanding of health care delivery systems, provide effective and qualitative patient care within the system, and practice cost-effective medicine.

REQUIRED ELEMENTS:

- 1. Understand national and local health care delivery systems and how they impact on patient care and professional practice.**

Suggested Methodology to Achieve Compliance

- a. Attend instruction in matters of health policy and structure.
- b. Understand business applications in a medical practice.
- d. Show operational knowledge of health care organizations, state and federal programs.
- e. Understand the role of the resident as member of the health care team in the hospital, ambulatory clinic, and community.
- f. Attend guest lectures/seminars with policy makers.
- g. Attend hospital utilization review, quality and other administrative and multi-disciplinary meetings

Suggested Methods for Evaluation

- a. Portfolios
- b. Objective Structured Clinical Examination (OSCE)
- c. 360-Degree Evaluation

- d. Chart Stimulated Recall Oral Examination (CSR)
- e. Monthly Service Evaluations

2. Advocate for quality health care on behalf of patients and assist them in their interactions with the complexities of the medical system.

Suggested Methodology to Achieve Compliance

- a. Understand local medical resources available to patients for treatment and referral.
- b. Participate in advocacy activities that enhance the quality of care provided to patients.
- c. Practice clinical decision-making in the context of cost, allocation of resources, and outcomes.

Suggested Methods for Evaluation

- a. Record Review
- b. Objective Structured Clinical Examination (OSCE)
- c. 360-Degree Evaluation
- d. Patient Surveys
- e. Checklist Evaluation
- f. Portfolios

Section 7 - Questions for Further Consideration

It is felt that the incorporation of these competencies into training programs will represent a considerable effort in community-based programs due to shortages of resources in many areas. Therefore, the OPTI consortium structure that encourages resource sharing among partner institutions must play a prominent role in the implementation of these competencies. As this process progresses a number of questions emerge for future consideration. These include the following:

1. Based upon specialty college responses, will there be a need to modify the competencies for program incorporation and site survey evaluation?
2. Based upon responses by the Bureau of Osteopathic Specialists (BOS), how will these competencies be integrated within the testing process for board certification and re-certification?
3. Based upon responses from the Committee on Continuing Medical Education (CCME), how will these competencies be integrated into the methods of the life-long learning process for AOA continuing medical education credit?
4. What processes and resources will be available to assist specialty colleges and programs in the development and monitoring of the competencies?
5. How can the OPTIs assist in development of new competency education and teaching models for use by all specialties?
6. Can a profession-wide method of exposure to educational models for the competencies, together with assessment of learning, be developed for electronic use by all OPTIs?
7. Will the COMs accept the core competencies for integration into the pre-doctoral curriculum to demonstrate the continuum nature of this educational effort?

Section 8 – Integration of All Competencies

The seven core competencies are to be completed for implementation over a four-year period. Upon approval by the AOA Board of Trustees, implementation of the first stage will begin in July 2004.

Specialty colleges are to develop specialty-specific criteria for integration of the two competencies of Medical Knowledge and Osteopathic Philosophy and Osteopathic Manipulative Medicine for review and approval by ECCOPT and COPT and for implementation by July 2004. These are to be placed into specialty standards and on-site review workbooks for program continuing approval reviews beginning January 2005.

The remaining five competencies are felt to be general in nature and, therefore, may be applicable to all specialties. Therefore the Task Force has developed these competencies, processes and methods for all specialties.

Proposed Timeline for Completion of Core Competencies:

Year 1 – July 2004: Osteopathic Philosophy and Osteopathic Manipulative Medicine Medical Knowledge

Year 2 – July 2005: Patient Care Professionalism

Year 3 – July 2006: Interpersonal and Communication Skills Practice-Based Learning and Improvement Systems-Based Practice

Process:

March 2003	Responses are due from specialty colleges in regard to the two specialty-specific core competencies of Medical Knowledge and Osteopathic Philosophy and Osteopathic Manipulative Medicine;
July 2003	Complete development of five general competencies by ECCOPT and initiation of incorporation into specialty standards by specialty affiliates;
July 2004	Implement teaching of Medical Knowledge and Osteopathic Philosophy and Osteopathic Manipulative Medicine competencies;
January 2005	Begin assessment through site review process of first two core competencies: Osteopathic Philosophy and Osteopathic Manipulative Medicine and Medical Knowledge
July 2005	Implement competencies on Patient-Care, Interpersonal and Communication Skills and Professionalism;
January 2006	Begin assessment through site review process of Patient-Care, Interpersonal and Communication Skills and Professionalism;
July 2006	Implement Practice-Based Learning Improvements and Systems-Based Practice competencies;
January 2007	Begin assessment through site review process of Practice-Based Learning Improvements and Systems-Based Practice competencies.

1 As of January 2007, all seven core competencies may be evaluated as part of the on-site
2 review process. On-site review evaluators must validate the presence of exposure to training in
3 each competency within six months after it is to be implemented. However, some flexibility in the
4 on-site evaluation must be expected during the first year of incorporation for each set of new
5 competencies as included.

6
7 Specialty college affiliates must readily introduce to their programs and program directors,
8 information and modalities to teach and evaluate resident learning of the competencies. This can
9 be accomplished by attendance at all AOA education seminars and conferences in which
10 competencies are discussed and by inviting competency education/evaluation experts to participate
11 in the specific specialty affiliate scientific seminars and program director meetings.

12
13 Incorporation of the competencies should occur in three phases. In the first phase,
14 teaching and exposure to the competency shall occur. The second phase will involve evaluating
15 what has been learned regarding the competency and finally in phase three; the learner shall
16 demonstrate the learned principles and concepts, through practice. Phase one, occurs during the
17 residency and is evaluated by documenting exposure and teaching at the time of the program on-
18 site review. Phase two will be documented through the certification examination process. Re-
19 certification, life long learning, and the CME process should provide opportunities for continued
20 utilization and practice of the learned principles. The entire process of exposure to and learning of
21 these competencies will be an ever changing and evolving one for the learner.

22
23 Therefore, the evaluation, at the time of the program on-site review, must involve greater
24 flexibility initially as programs and program directors better understand this evolving process and
25 the teaching, learning and demonstration of these concepts.

26 27 **Section 9 – Recommendations to the Board of Trustees**

28
29 The Task Force proposed the following recommendations as a resolution for action at the
30 February 2003 Meeting:

- 31
- 32 1. RESOLVED, that the BOT approved core competencies be incorporated into all
33 AOA-approved Basic Standards for internship and residency training on a progressive basis
34 over three years, to begin July 2004.
 - 35
36 2. RESOLVED that all on-site inspections will evaluate the core competency requirements and
37 that the specialty affiliates survey workbook will incorporate the core competency criteria
38 starting January 2005.

39
40 The Task Force proposes the following recommendations for action by the AOA Board of
41 Trustees in July 2003:

- 42
- 43 1. RESOLVED, that all AOA specialty certification and re-certification board examinations
44 incorporate core competency testing beginning July 2007.
 - 45
46 2. RESOLVED, that the AOA Council on Continuing Medical Education incorporate core
47 competency requirements in life-long learning and the continuing medical education process,
48 offering 1-A credit is essential.
 - 49
50 3. RESOLVED, that the intern and resident institution training programs and all specialty college

- 1 Program Director and Resident Annual Reports incorporate the core competencies into the
2 evaluation process as appropriate for each specialty.
3
- 4 4. RESOLVED, that all OPTIs are required to participate with their partner training institutions
5 and programs in training and monitoring intern and resident progress toward core competency
6 initiatives.
7
- 8 5. RESOLVED, that AOA and specialty affiliates are required to incorporate core competency
9 education, training, methodology and evaluation into conferences, conventions, and program
10 director's seminars.
11

12 Glossary of Terms

13 (Definitions of the following terms can be found in Appendix 2 on pages 3 through 7 at
14 www.acgme.org/Outcome/assess/Toolbox.pdf)
15

- 16 360-Degree Evaluation
17 Chart Stimulated Recall Oral Examination (CSR)
18 Checklist Evaluation
19 Global Rating of Live or Recorded Performance
20 Objective Structured Clinical Examination (OSCE)
21 Patient Surveys
22 Portfolio
23 Simulations and Models
24 Standardized Oral Examination.
25 Standardized Patient Examination (SP)
26
27

1

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APPENDICES

Appendix 1: Competency Based Education Model

Appendix 2: ACGME Toolbox of Assessment Methods©

@ www.acgme.org/Outcome/assess/Toolbox.pdf

Appendix 3: AGCME Outcomes Project @ www.acgme.org/outcome/assess/assHome.asp

Appendix 1

