Residency Review Committee for Internal Medicine (RRC-IM) Update – NAS and the IM Program Requirements

2012 APDIM Fall Meeting
Phoenix, AZ

James Arrighi, MD, Chair
Jerry Vasilias, PhD, Executive Director
The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,¹ and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Ac-

¹ Nasca, T.J., Philibert, I., Brigham, T.P., Flynn, T.C.
The Next GME Accreditation System: Rationale and Benefits.
What does NAS mean?

• Describe NAS
• Description of NAS Metrics
• Timeline
What does NAS mean?

• Describe NAS
• Description of NAS Metrics
• Timeline

“What fresh hell is this?”
Dorothy Parker
Why NAS?

• Foundation for NAS started in 2005: At its retreat, the ACGME Executive Committee endorsed four strategic priorities designed to enable emergence of the new accreditation model:
  • Foster innovation and improvement in the learning environment
  • Increase the accreditation emphasis on educational outcomes
  • Increase efficiency and reduce burden in accreditation
  • Improve communication and collaboration with key internal and external stakeholders

• Realization that PRs have become very prescriptive
• Process-oriented accreditation, discouraging innovation
Next Accreditation System (NAS)

Big picture…

• Less prescriptive program requirements that promote curricular innovation
• “Continuous accreditation model”
• Monitoring of programs based on “performance indicators”
• Continuously holding sponsoring institutions responsible for oversight of educational and clinical systems – via CLER (Clinical Learning Environment Review) program
NAS: Categories of PR’s

• Categorization of PRs: **Outcome, Core and Detailed Process**

• **Why is categorization of PRs important in the NAS?**
  • Programs identified as being in “good standing” based on defined metrics will be allowed to “**innovate**”, meaning they will not be asked whether they are adhering to detailed process PRs.
  • Detailed process PRs do not go away. PDs will not need to demonstrate compliance w/ these PRs, unless it becomes evident that a particular outcome or core process is not being achieved.

• Categorizations approved at the Sept 2012 ACGME Board meeting (for Core and Subs)
Program Requirements

![Bar chart showing Program Requirements for Common and IM categories]

- **Core**
- **Detail**
- **Outcome**

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Examples of Program Requirements

“Core”

- PD salary support
- Inpatient caps
- Faculty qualifications (e.g. certification)
- Overall resources needed “for resident education”
  - Specific resources, e.g. angiography, are detail
- Continuity clinic experience inclusive of “chronic disease management, preventive health, patient counseling, and common acute ambulatory problems.”
- Major duty hours rules
Examples of Program Requirements

“Detail”

- Simulation
- Minimum 1/3 ambulatory, 1/3 inpatient
- Critical care min (3 mos) and max (6 mos)
- 130-session clinic rule
- Specific conference structure
- Verbal discussion of evaluation at end rotation
- Specific aspects of evaluation structure
  - Semiannual evals remain core
- 5 year rule for PD’s
Examples of Program Requirements

“Outcome”

- Sections listed under the 6 competencies
- 80%/80% board take/pass rule
- PR’s related to principles of professionalism
  - Safety, recognition of fatigue, commitment to LLL, honesty of reporting, etc.
- Effective handovers
Questions on categorization of the PR’s?
Continuous Accreditation (focus on annual data elements)

- Continuous observations
- Confirmation of a “fix”
- Promote Innovation
- Diagnosis (e.g. program PI, focused SV)
- Identify potential “rules” problems

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Annual Data Review Elements

1) Program Attrition
2) Program Changes
3) Scholarly Activity
4) Board Pass Rate
5) Clinical Experience Data
6) Resident Survey
7) Faculty Survey
8) Milestones
9) CLER site visit data
Annual Data Review Elements

Where did they come from?

Modeling: What data predicted short cycles or adverse actions?

History: What data did RRCs traditionally think was quite important?

Fine print: This is a work in-progress, subject to change!
Common Citations for Problem Programs

Core

- Excessive service
- Evaluation of residents
- Certification of APD, SEC
- Non-IM sub experience
- Patient caps
- On-call rooms
Common Citations for Problem Programs

Subs

• Procedural experience
• Inadequate curriculum
• Core conferences
• Scholarly activity
• Evaluation structure
• Annual review
• # mos. of clinical experience
Annual Data Review Elements
A Mix of “Old” and “New”

Annual review of the following indicators:

1) **Program Attrition**
   - Collected now as part of the program’s annual ADS update.

2) **Program Changes**
   - ADS streamlined this year: 33 fewer questions & more multiple choice or Y/N

3) **Scholarly Activity**

4) **Board Pass Rate**
   - Boards provide annually

5) **Clinical Experience**
   - Collected now as part of annual administration of survey

6) **Resident Survey**

7) **Faculty Survey**

8) **Milestones**

9) **CLER site visit data**

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Use of Annual Data Review Elements

• Indicators will be similar across specialties
• RRC-IM controls weighting factors
  • From minimally important to very important
• RRC-IM controls trigger points for “human” review
• Indicator development and use will be an iterative process
Annual Data Review Element #1: Program Attrition

- **General Definition**: Composite variable that measures the degree of personnel and trainee change within the program.

- **How measured**: Has the program experienced any of the following:
  - Change in PD?
  - Decrease in core faculty >10?
  - Residents withdraw/transfer/dismissed >5?
  - Change in Chair?
  - DIO Change?
  - CEO Change?
Annual Data Review Element # 2: Program Changes

- **General Definition**: Composite variable that measures the degree of structural changes to the program.
- **How measured**: Has the program experienced any of the following:
  - Participating sites added or removed?
  - Resident complement changes?
  - Block diagram changes?
  - Major structural change?
  - Sponsorship change?
  - GMEC reporting structural change?
Program Changes and “Attrition”

- RRC understands that these are not necessarily “bad”
- Goal of weighting is to identify programs in significant flux
- If threshold is reached, “human” review can determine whether a problem exists
Annual Data Review Element #3: Scholarly Activity

• General Definition: Indicator that measures scholarly productivity within a program for faculty and for learners.

• ACGME will eliminate faculty CVs and replace them with a new “table” to collect scholarly activity information.

• RRC has determined that there should be no change in the expectations for core IM and subspecialty programs.
**Annual Data Review Element #3: Scholarly Activity: Faculty (Core)**

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>PMID 4</th>
<th>Conference Presentations</th>
<th>Other Presentations</th>
<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
<th>Leadership or Peer-Review Role</th>
<th>Teaching Formal Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12433</td>
<td>32411</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>Y</td>
<td>N</td>
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</tbody>
</table>

**RC-IM Expectation/Threshold:** Within the last academic year, at least 50% of the program’s “core” faculty need to have done **at least one type** of scholarly activity from the list of possible activities in the table above.
# Annual Data Review Element #3:
**Scholarly Activity: Faculty (Subs)**


<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>PMID 1</th>
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<table>
<thead>
<tr>
<th>Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012</th>
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<tbody>
<tr>
<td>Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012</td>
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<tr>
<td>Number of chapters or textbooks published between 7/1/2011 and 6/30/2012</td>
</tr>
<tr>
<td>Number of grants for which faculty member had a leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012</td>
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<tr>
<td>Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012</td>
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<tr>
<td>Between 7/1/2011 and 6/30/2012, held responsibility for seminars, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants’ performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.</td>
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**RC-IM Expectation/Threshold:** Within the last academic year, at least 50% of the program’s minimum KCF need to have done at least one type of scholarly activity from the list of possible activities in the table above; AND, the “productivity” metric remains.
### Annual Data Review Element #3:
#### Scholarly Activity: Residents

<table>
<thead>
<tr>
<th>Resident</th>
<th>PMID 1</th>
<th>PMID 2</th>
<th>PMID 3</th>
<th>Conference Presentations</th>
<th>Chapters / Textbooks</th>
<th>Participated in research</th>
<th>Teaching / Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>June Smith</td>
<td>12433</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>N</td>
<td>Y</td>
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</table>

**RC-IM Expectation/Threshold:** Within the last academic year, at least 50% of the program’s recent graduates need to have done at least one type of scholarly activity from the list of possible activities in the table above.

The RC-IM felt strongly that core programs should not provide data on every resident in the program, too burdensome. After discussions w/ ACGME senior leadership decision was: programs will input information for recent graduates only.
Annual Data Review Element #4: Board Pass Rates

- V.C.1.c).(1) At least 80% of those completing their training in the program for the most recently defined three-year period must have taken the certifying examination.
- V.C.1.c).(2) A program’s graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first time takers of the examination in the most recently defined three-year period.

- RRC is aware of declining pass rates
Annual Data Review Element #5: Clinical Experience Data (Core)

- Composite variable on residents’ perceptions of clinical preparedness based on the specialty specific section of the resident survey.

How measured: 3rd year residents’ responses to RS

- Adequacy of clinical and didactic experience in IM, subs, EM, & Neuro
- Variety of clinical problems/stages of disease?
- Do you have experience w patients of both genders and a broad age range?
- Continuity experience sufficient to allow development of a continuous therapeutic relationship with panel of patients
- Ability to manage patients in the prevention, counseling, detection, diagnosis and treatment of diseases appropriate of a general internist?
Annual Data Review Element #5: Clinical Experience Data (Subs)

- Composite variable on fellows’ perceptions of clinical preparedness based on the specialty specific section of the fellow survey.
- Brief fellow-specific survey is being developed, analogous to the IM-specific survey.
- Initially, questions will be identical across all subs
  - Generic questions on clinical experience
  - RRC is currently finalizing questions
- Over time, probably will get more sophisticated ()
  - Specialty-specific questions
  - Case logs
Annual Data Review Element #6: ACGME Resident Survey

Survey Components

- ACGME (all specialties)
- IM-specific
Annual Data Review Element #6: ACGME Resident Survey

- Administered annually Jan-May
- Questions on RS relate to 7 areas:
  - Duty Hours
  - Faculty
  - Evaluation
  - Educational Content
  - Resources
  - Patient Safety
  - Teamwork

- *In 2009:* All core programs and fellowships with 4 or more need to complete survey annually

- *In 2012:* RS revised to align with new CPRs. All residents & fellows were surveyed.
Update: IM Survey
Kinder, Gentler, Simpler, Shorter

- **Significantly streamlined IM survey**: of the 92 items on the survey, the RC-IM removed 64 b/c they were associated with program requirements categorized as “Detail” or were redundant with other items on the ACGME survey

- **Items retained**:
  - Adequacy of on-call facilities
  - Availability of support personnel
  - Adequacy of conference rooms & other facilities used for teaching
  - Patient cap questions
  - Questions related to clinical experience (see previous slide)

- The 2013 administration of the IM survey will be
  - **28 items long for PGY3s, and**
  - **14 items long for PGY1 & 2s**
Update: IM Survey Fellows?

- “General” subspecialty survey:
  - Currently under development
- Items:
  - To be defined
  - Questions related to clinical experience
- Will be brief
Annual Data Review Element #7: Faculty Survey

- “Core” faculty only because they are most knowledgeable about the program
  - ABIM certified internists who are clinically active
  - dedicate an average of 15 hours/week
  - trained in the evaluation and assessment of the competencies;
  - spend significant time in the evaluation of the residents
  - advise residents w/ respect to career and educational goals

- Similar domains as the Resident Survey
- Will be administered at same time as Resident Survey
  - Start in winter-spring 2013 for 2012-2013 for Phase 1
Will “monitoring” work?
The MonCom Experience (2011-12)

• Monitoring Committee has been reviewing data from surveys
• Programs with potential problems:
  • 4% with non-DH issues (2+ areas)
  • 3% with DH issues
    • Vast majority of IM programs were 1st time offenders
• RRC meeting Sept 2012
  • 12 programs reviewed by RRC members
  • Interventions in about half (PR, SV, CL)
<table>
<thead>
<tr>
<th>Survey Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident response rate</td>
<td>93%</td>
</tr>
<tr>
<td>Programs not achieving 70% threshold</td>
<td>0.2%</td>
</tr>
<tr>
<td>Programs without significant DH issues</td>
<td>96%</td>
</tr>
<tr>
<td>Programs in substantial noncompliance</td>
<td>1.6%</td>
</tr>
<tr>
<td>Continued DH issues</td>
<td></td>
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<tr>
<td>DH + several other issues</td>
<td></td>
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<tr>
<td>Isolated DH issues</td>
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</tbody>
</table>

> 9000 programs, >100,000 trainees
Annual Data Review Element #8: ACGME or Narrative Milestones

- Definition: Observable developmental steps moving from beginning resident to the expected level of proficiency at graduation from residency, ultimately, the level of expert/master.

- The Milestones for each specialty have been developed by an expert panel made up of members of the RRCs, the ABMS certifying board, and specialty societies (including PDs).

Internal Medicine:
1) Previously developed “milestones” document used as a starting point
2) Developed based on projected needs of ACGME & ABIM
3) AAIM and ABIM were primary drivers
4) Language was/is being codified
5) ABIM pilot tested feasibility
Performance Indicator # 8: ACGME or NAS Milestones

Compencies (6)

Sub-Competencies (23)

NAS Milestones (5 per sub-competency)
## Annual Data Review Element #8: NAS Milestones

<table>
<thead>
<tr>
<th>Sub-Competency</th>
<th>Critical Deficiencies</th>
<th>Milestones</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Gather and synthesize essential and accurate information to define each patient’s clinical problem(s).</td>
<td>Does not collect accurate and thorough historical data.</td>
<td>Struggles to acquire accurate and thorough historical information in an organized fashion.</td>
<td>Acquires accurate and relevant histories from patients in an efficient, prioritized, and hypothesis driven fashion.</td>
<td>Obtains relevant historical subtleties and unusual physical exam findings that inform the differential diagnosis.</td>
</tr>
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<td></td>
<td>Does not use physical exam to confirm history.</td>
<td>Does not perform an accurate physical exam and misses key physical exam findings.</td>
<td>Seeks and obtains data from secondary sources when needed.</td>
<td>Efficiently utilizes all sources of secondary data to inform differential diagnosis.</td>
</tr>
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<td></td>
<td>Relies on documentation of others to inform own database.</td>
<td>Does not seek or is overly reliant on secondary data.</td>
<td>Performs accurate physical exams that are targeted to the patient’s complaints.</td>
<td>Obtains sensitive information that may not be volunteered by the patient.</td>
</tr>
<tr>
<td></td>
<td>Differential diagnoses are limited, inaccurate or are developed by others.</td>
<td>Struggles to synthesize data to develop a prioritized differential diagnosis.</td>
<td>Uses collected data to define a patient’s central clinical problem(s).</td>
<td>Role models how to obtain historical subtleties, or unusual physical exam findings from a patient.</td>
</tr>
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<td></td>
<td>Synthesizes data to generate a prioritized differential diagnosis.</td>
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<td>Role models how to gather subtle or difficult information from a patient.</td>
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Annual Data Review Element #8: Milestones for Core IM Programs

• Draft should be completed by December 2012
• Programs to start milestones by July 2013
  
  First milestones to be reported to ACGME -- December 2013,
  second reporting --- June 2014

• Clinical Competency Committees (CCCs) should be used to evaluate residents on the milestones
  • Many/most programs have CCCs in place
  • In future, ACGME will likely have Common PR for CCCs
  • Not just the PDs assessing residents
  • Multiple faculty review evaluations

• No EPAs
Milestones for Subspecialties

• Development in Academic Year 2013-14

• Implementation in AY 2014-15

• Process is currently being defined
  • Relationship to core IM milestones
  • Identification of stakeholders
What is the most important source of angst around the milestone and CCC concept?
Annual Data Review Element #8: CLER Visit Data

• CLER visits will focus on
  1) engagement of residents in patient safety;
  2) engagement of residents in quality improvement;
  3) enhancing practice for care transitions;
  4) identifying opportunities for reducing health disparities;
  5) promoting appropriate resident supervision;
  6) duty hour oversight and fatigue management; and
  7) enhancing professionalism in the learning environment and reporting to the ACGME.

• Initially, CLER visit data will not be used as an indicator. How such data will be used annually is currently under discussion.
• Alpha testing completed
• Entering year one of beta testing
Feedback from Alpha Testing of CLER Visits

- Feasible
- DIOs recognize value
- No serious infractions
- Feedback loop at end of visit was very helpful
  - Action plans often formed immediately
Review of NAS Timeline

• In 2011, the ACGME Board approved the framework for NAS and its phased implementation.

• Phase 1 specialties: Pediatrics; Internal Medicine; Diagnostic Radiology; Emergency Medicine; Orthopedic Surgery; Neurological Surgery; Urological Surgery

• Phase 1 specialties will enter preparatory year 7/2012

• Phase 1 specialties “go live” 7/2013

• Phase 2 specialties enter preparatory year 7/2013

• Phase 2 specialties “go live” 7/2014

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NAS Timeline

- May 2012: Self Study Visits (SSV) Assigned; Programs W <3 cycles had site visits replaced w SSV
- September 2012: Categorization Of IM PRs Approved at ACGME Board Mtg
- December 2012: Core Milestones Completed
- March 2013: Final Site Visit in Current System
- July 2013: Subspecialty Milestone Development begins
- January 2014: RC Reviews Annual Data From AY 2012-2013
- May 2014: SSV Begin

- March 2012:
  - ADS Update – September 2012
  - Faculty Survey – Fall 2012/spring 2013
  - Resident Survey – late spring 2013
  - NAS Preparation: Data
- September 2012 - June 2013
- July 2013: NAS Begins
- January 2014: Milestone Submission
- September 2014

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Self Study Visits (SSV)

- SSV to begin in spring of 2014
- SSV of the core will also be the SSV of the subs
- Focus on program’s improvement efforts using self-assessment

The NAS will eliminate the program information form, which is currently prepared for site visits.

Programs will conduct a 10-year self-study, similar to what is done by other educational accreditors. It is envisioned that these self-studies will go beyond a static description of a program by offering opportunities for meaningful discussion of what is important to stakeholders and showcasing of achievements in key program elements and learning outcomes. (NEJM article, pg 2)

- **Internal Reviews**: “DIOs are not required to schedule internal reviews for early adopter specialties” (DIO News, Jun 2012).
ACGME Webinars for the NAS

ACGME is planning webinars for the following:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Target Date</th>
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<tbody>
<tr>
<td>• CLER Visit Program</td>
<td>December 2012</td>
</tr>
<tr>
<td>• Implementation of NAS:</td>
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<tr>
<td>Implications for Programs &amp; Institutions</td>
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<tr>
<td>• Self-Study Visits</td>
<td>January 2013</td>
</tr>
<tr>
<td>• Milestones, CCCs, &amp; Resident Evaluation</td>
<td>April, 2013</td>
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Webinars will repeat throughout 2013
Q: How will the transition to NAS affect my site visit tentatively scheduled for early/mid 2013?

- All programs:
  - Assigned self-study date
  - Begin in the spring of 2014; rolling; linked core + sub; every 10 years.

- Most programs in “good standing” (3-5 yr cycles):
  - No scheduled site visit

- Programs with review cycles of 2 years or less:
  - Site visit as usual

- Programs with a status of initial accreditation:
  - Site visit as usual

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Q: Now that my site visit was replaced w/ a Self-Study visit does that mean I will not be reviewed except for every 10 years?

- Although the Self-Study will take place every 10 years, the RC will be reviewing information supplied by the program (Fellow Survey, Faculty Survey, Board score data, Milestones data, etc.) annually and will be able to request site visits whenever data element(s) show outliers/extreme responses.

- In the NAS, the RC will be able to request site visits not associated with Self-Study.

- These visits will be focused visits and will not require a PIF.
RC-IM

• 3 nominating organizations - ABIM, ACP, AMA
• Currently 18 voting members
• 6 year terms -- except resident (2 years)
• Generalists and subspecialists
  Cardiology, CCEP, Critical Care Medicine, Endocrinology,
  Gastroenterology, General Internal Medicine, Geriatric Medicine,
  Hematology/Oncology, Infectious Disease, Medicine-Pediatrics,
  Nephrology, Pulmonary/Critical Care Medicine, Sleep Medicine,
  Transplant Hepatology
• Ex-officio members from each nominating organization (non-voting)
Who is the RC-IM?

James A. Arrighi, MD – Chair
Beverly M.K. Biller, MD
Robert Benz, MD
Christian Cable, MD
Andres Carrion, MD
Gates Colbert, MD
E. Benjamin Clyburn, MD – Vice-Chair
John Fisher, MD
Andrew S. Gersoff, MD
Lynne Kirk, MD
Betty Lo, MD
Furman McDonald, MD
Elaine A. Muchmore, MD
Susan Murin, MD
Victor J. Navarro, MD
Andrea Reid, MD
Ilene Rosen, MD
Stephen M. Salerno, MD
Jennifer C. Thompson, MD
Information on NAS:
http://www.acgme-nas.org/

The Next Accreditation System

The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits more than 9,000 residency programs in 135 specialties and subspecialties in the United States, affecting more than 116,000 residents. Its mission is to improve health care in the U.S. by assessing and advancing the quality of graduate medical education for physicians in training through accreditation.

This website shares background and detail regarding the ACGME's next accreditation system, an outcomes-based accreditation process through which the doctors of tomorrow will be measured for their competency in performing the essential tasks necessary for clinical practice in the 21st century.

Recent News

− Announcement From ACGME CEO Dr. Thomas J. Nasca, February 22, 2012
I am pleased to tell you that today, the ACGME announced the rollout of the Next Accreditation System (NAS) in the online issue of the New England Journal of Medicine. The NAS is a significant evolution of...
Thank you.
Questions?

“You can’t teach an old dogma new tricks.”

Dorothy Parker