



ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

*Symposium on
Physician Well-Being*

NOVEMBER 17-18, 2015



Understanding the ACGME

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Chief Executive Officer
ACGME

Disclosure

- Professor of Medicine and Physiology
- Full Time Salaried by ACGME
- No Conflicts to Disclose

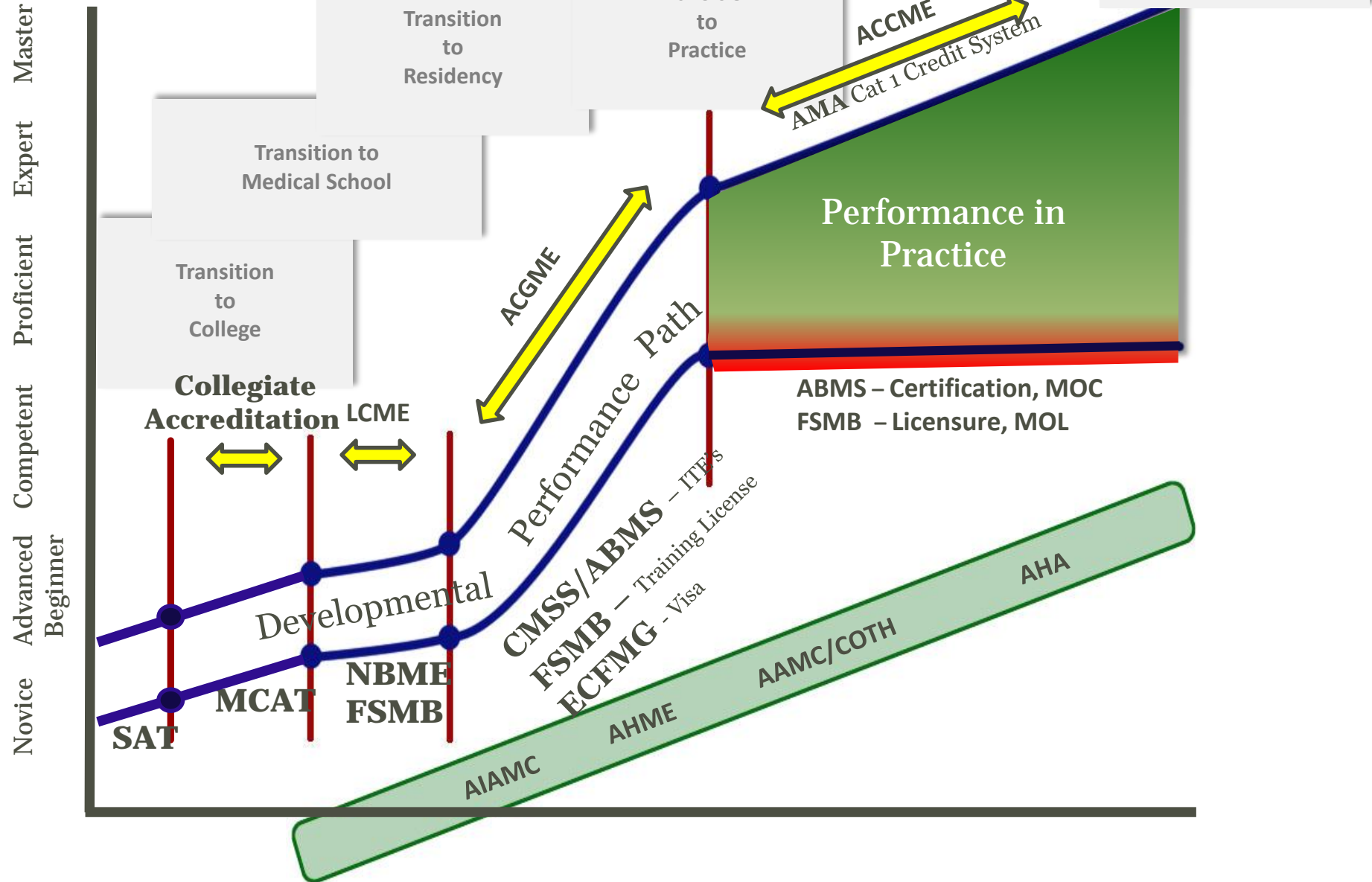


The ACGME

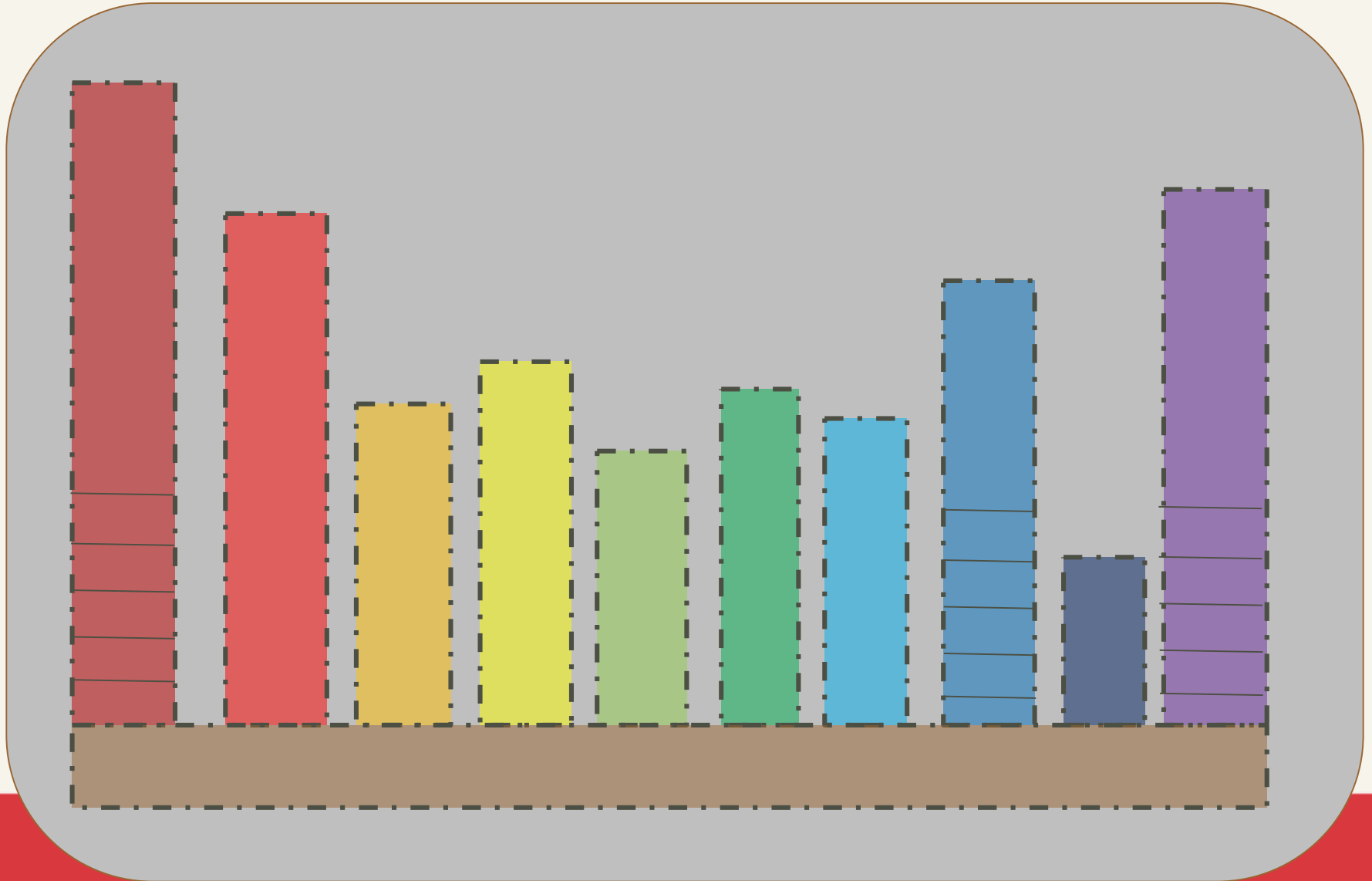
- *Mission:* We improve health and health care by assessing and advancing the quality of resident physicians' education through accreditation
- *Basis for our engagement:* Impairment of Physician Well-Being impairs the profession's ability to improve the health and health care provided to the public



The Continuum of Development of the Specialist Physician



See Programs Immersed In, Influenced By, and Influencing the Sponsoring Institution(s)



SPECIAL REPORT

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 Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education⁸ and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Perform-

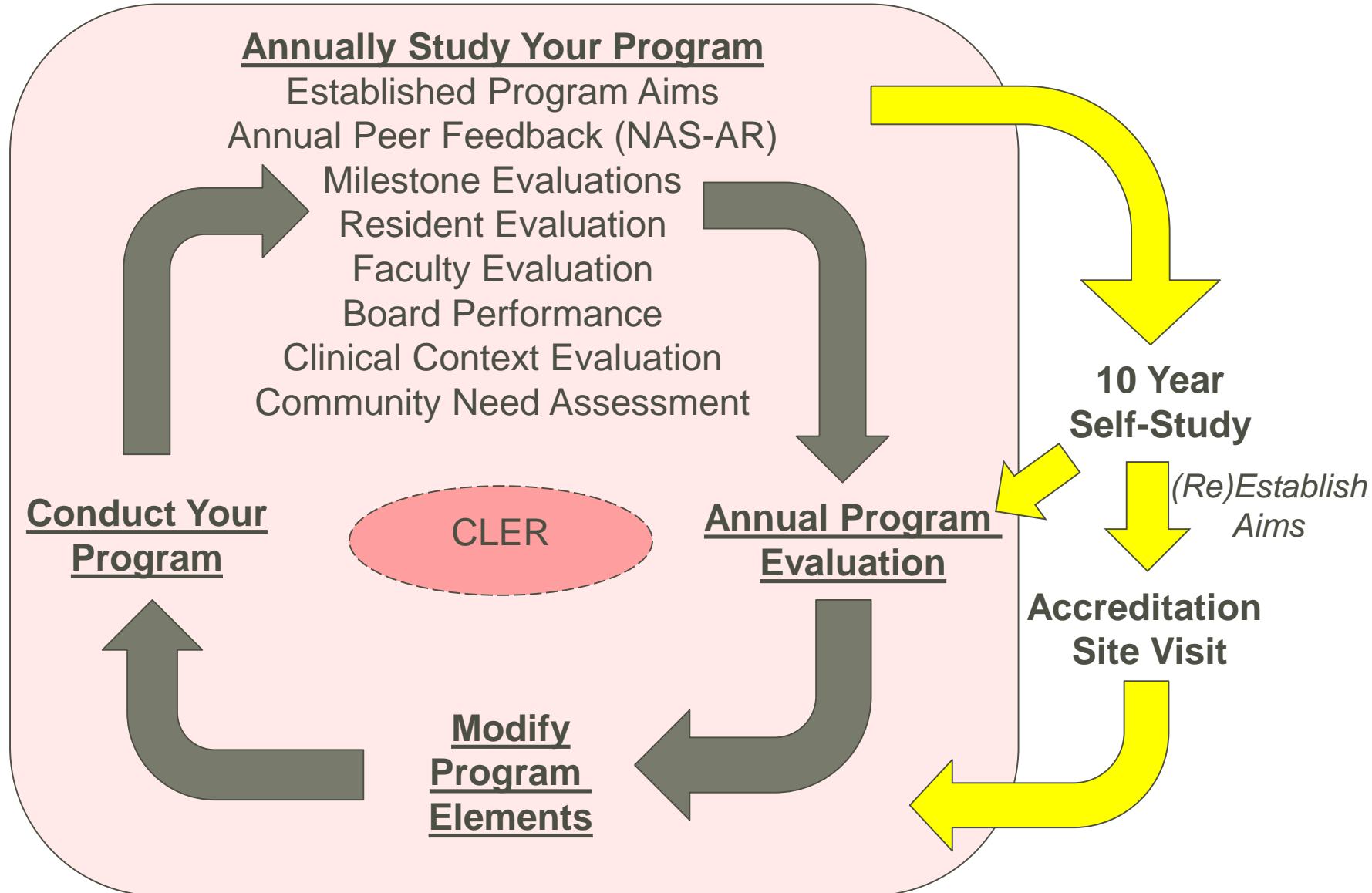
¹ Nasca, T.J., Philibert, I., Brigham, T.P., Flynn, T.C.
The Next GME Accreditation System: Rationale
and Benefits. *NEJM*. 2012.366;11:1051-1056.



Continuous Program Improvement Cycle

“Practice Based Learning and Improvement for Programs”

Goal: *Excellence in Achievement of Program Aims*



Original Investigation

Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries


Candice Chen, MD, MPH; Stephen Petterson, PhD; Robert Phillips, MD, MSPH;
Andrew Bazemore, MD, MPH; Fitzhugh Mullan, MD

IMPORTANCE Graduate medical education training may imprint young physicians with skills and experiences, but few studies have evaluated imprinting on physician spending patterns.

OBJECTIVE To examine the relationship between spending patterns in the region of a physician's graduate medical education training and subsequent mean Medicare spending per beneficiary.

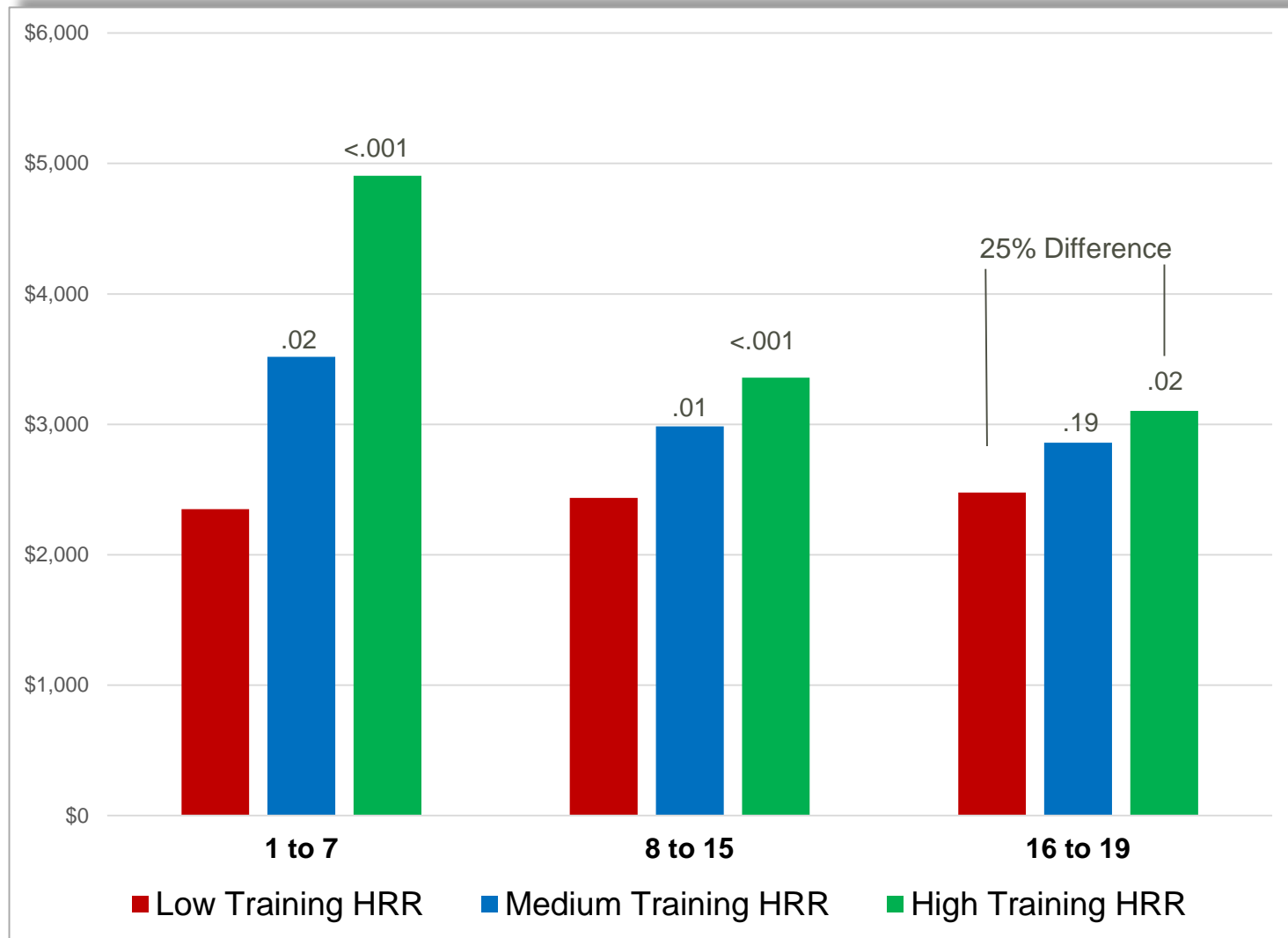
DESIGN, SETTING, AND PARTICIPANTS Secondary multilevel multivariable analysis of 2011 Medicare claims data (Part A hospital and Part B physician) for a random, nationally representative sample of family medicine and internal medicine physicians completing residency between 1992 and 2010 with Medicare patient panels of 40 or more patients (2851 physicians providing care to 491 948 Medicare beneficiaries).

EXPOSURES Locations of practice and residency training were matched with Dartmouth Atlas Hospital Referral Region (HRR) files. Training and practice HRRs were categorized into low-, average-, and high-spending groups, with approximately equal distribution of beneficiary numbers. There were 674 physicians in low-spending training and low-spending practice HRRs, 180 in average-spending training/low-spending practice, 178 in high-spending training/low-spending practice, 253 in low-spending training/average-spending practice, 417 in average-spending training/average-spending practice, 210 in high-spending training/average-spending practice, 97 in low-spending training/high-spending practice, 275 in average-spending training/high-spending practice, and 567 in high-spending training/high-spending practice.

 Supplemental content at
jama.com

Chen, C., Petterson, S., Phillips, R.,
Bazemore, A., Mullan, F.
JAMA. 2014;312(22):2385-2393

Physician Median Medicare Spending per Beneficiary Stratified by Residency Program Hospital Referral Region vs Years in Clinical Practice



Data from Table 2., Chen, C., Petterson, S., Phillips, R., Bazemore, A., Mullan, F. JAMA. 2014;312(22):2385-2393

Summary

Chen, C., Petterson, S., Phillips, R., Bazemore, A., Mullan, F.
JAMA. 2014;312(22):2385-2393

- Clinical training environment patient care expenditures are reproduced in clinical practice of graduates
- The effect persists even when the graduate practices in a different clinical care setting
- The effect persists for up to 19 years after graduation



Evaluating Obstetrical Residency Programs Using Patient Outcomes

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Sean Nicholson, PhD

Sindhu Srinivas, MD, MSCE

Jeph Herrin, PhD

Andrew J. Epstein, PhD, MPP

MANY PHYSICIANS AND NON-physicians likely assume that some residency programs tend to produce better physicians than others—either because those residency programs train physicians better or because those residency programs can recruit more capable trainees. Although plausible, these intuitions have not been empirically tested. This information could be useful in at least 2 different ways.¹ First, identifying which training programs produce better physicians and separating out the effects that are due to the ability to attract better trainees might indicate what makes better programs better. Some of these factors might be exportable to other programs, raising the quality of medical education more broadly. Second, by

Context Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

Objective To assess whether obstetrics and gynecology residency programs can be evaluated by the quality of care their alumni deliver.

Design, Setting, and Patients A retrospective analysis of all Florida and New York obstetrical hospital discharges between 1992 and 2007, representing 4 906 169 deliveries performed by 4124 obstetricians from 107 US residency programs.

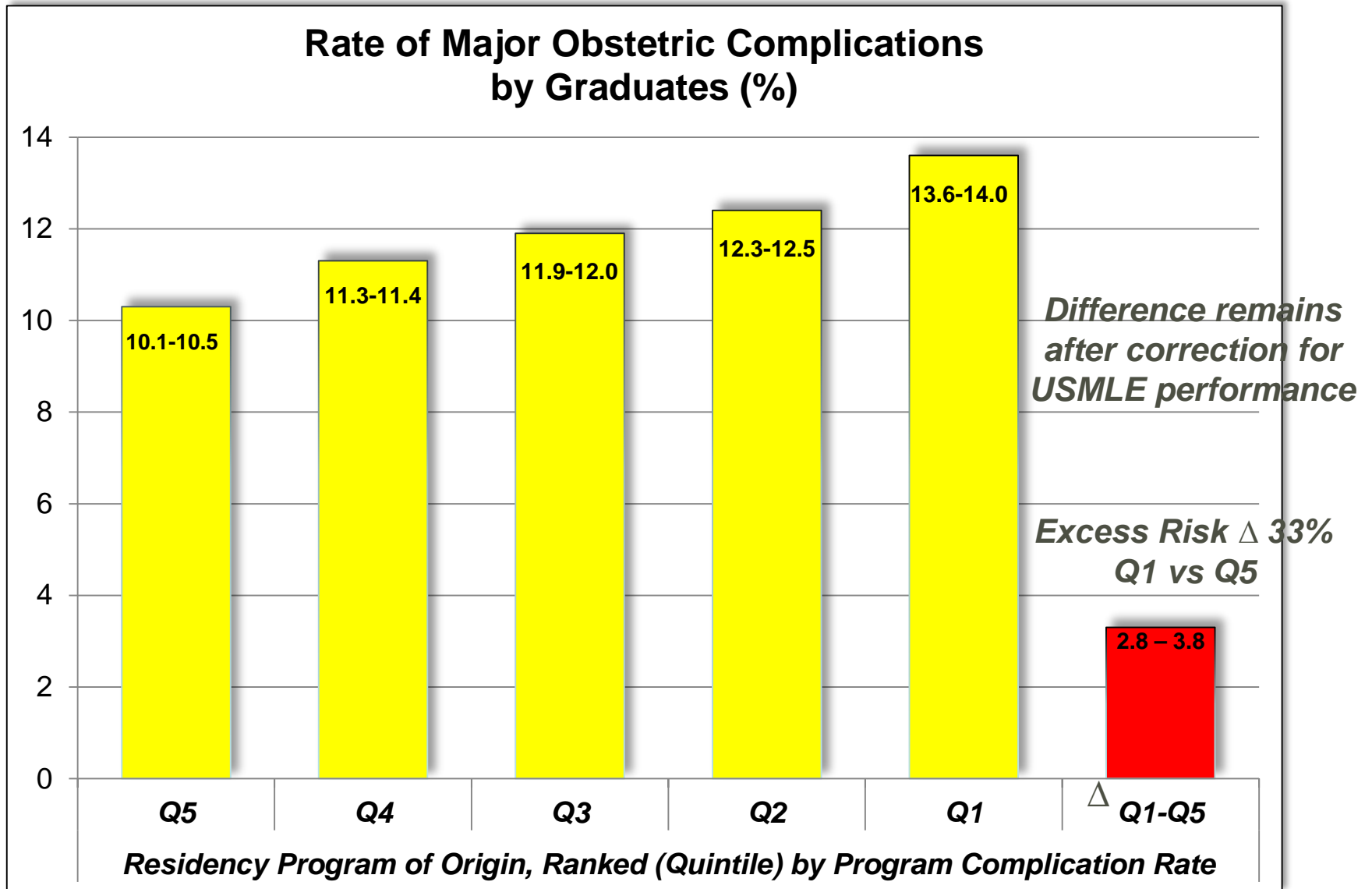
Main Outcome Measures Nine measures of maternal complications from vaginal and cesarean births reflecting laceration, hemorrhage, and all other complications after vaginal delivery; hemorrhage, infection, and all other complications after cesarean delivery; and composites for vaginal and cesarean deliveries and for all deliveries regardless of mode.

Results Obstetricians' residency program was associated with substantial variation in maternal complication rates. Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had an adjusted complication rate of 13.6%, approximately one-third higher than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar. Adjustment for medical licensure examination scores did not substantially alter the program ranking.

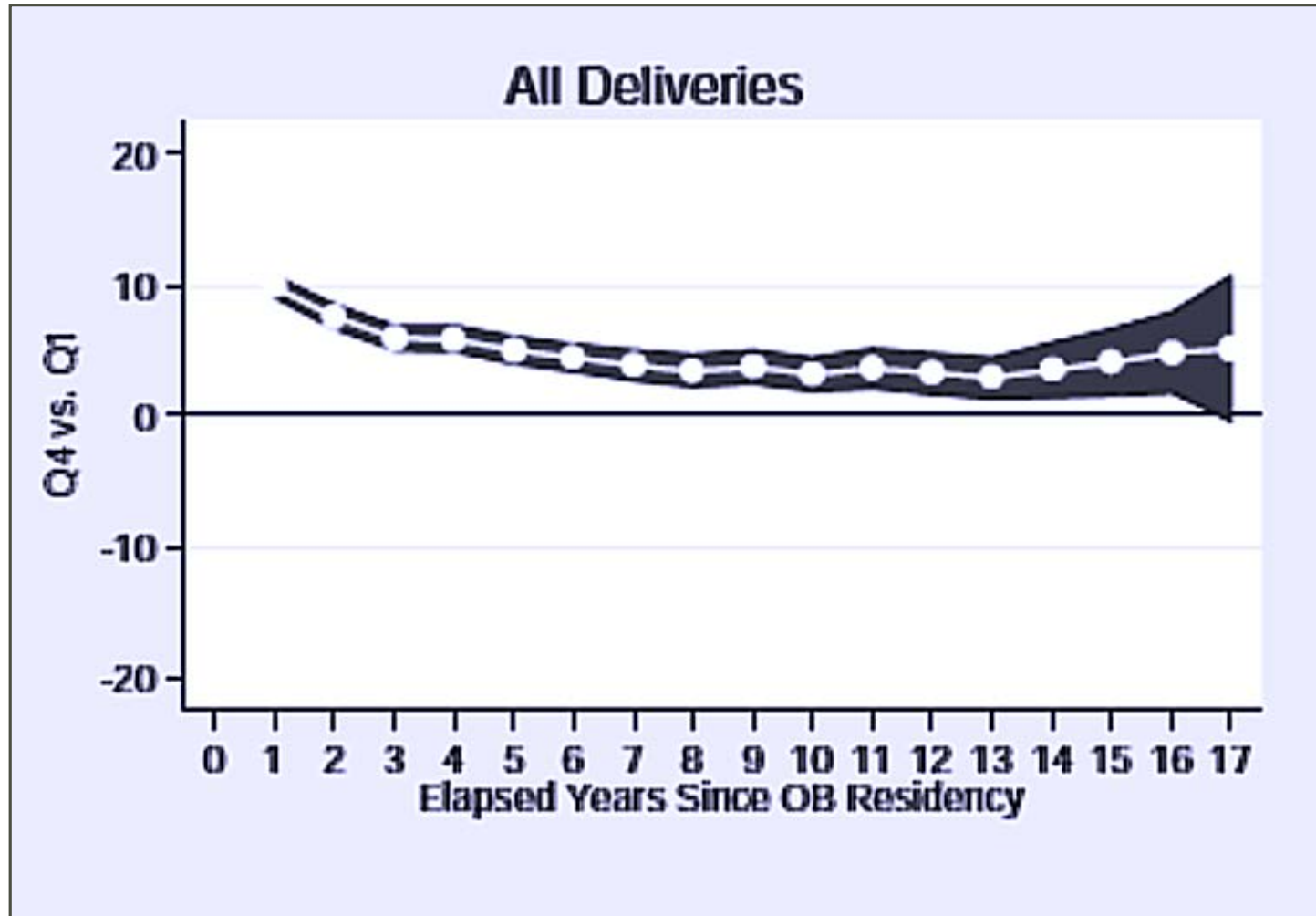
Conclusions Obstetrics and gynecology training programs can be ranked by the maternal complication rates of their graduates' patients. These rankings are stable across individual types of complications and are not associated with residents' licensing examination scores.

Evaluating Residency Programs Using Patient Outcomes

n= 4,906,169 deliveries in Florida and New York, 1992-2007
4124 physician program graduates of 107 residency programs



Difference in Complication Rate Fourth versus First Quartile



Epstein, AJ, Nicholson, S, Asch, DA. The Production Of and Market For New Physicians' Skill.

Working Paper 18678 – <http://www.nber.org/papers/w18678>

National Bureau of Economic Research

January, 2013

ACGME

- Commit
- Convene
- Collaborate
- Change



Medical School/Residency Impact is Career Long

- Opportunity to constructively intervene with Educational Program Structure/Content
 - LCME, COCA
 - ACGME
 - ACCME
- Opportunity to constructively intervene in the Learning Environment
 - AAMC, AMA, AOA, AIAMC, AHME, N-CICLE, Alliance for Physician Accountability, OPDA
- National Medical Culture Change
 - AAMC, AMA, AOA, AACOM, CMSS, FSMB, ABMS



ACGME

- Committed to helping to solve this challenge through collaboration across the continuum
 - Includes keeping the issue in the forefront
- Consistent with our commitment to the Public Trust
- Cannot be done alone
 - Requires ongoing commitment of all of us

