Symposium on Physician Well-Being

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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

- ABMS – Certification, MOC
- FSMB – Licensure, MOL
- LCME
- NBME
- MCAT
- SAT
- ACGME
- ACCME
- AMA Cat 1 Credit System
- Transition to Residency
- Transition to Medical School
- Transition to College
- Performance in Practice
- Transition to Practice
- ABMS – Certification, MOC
- FSMB – Licensure, MOL
- Transition to Retirement
- AHA
- AAMC/COTH
- AIAMC
- AHME
- Transition to College
- Collegiate Accreditation
- Performance Path
- CMSS/ABMS – Training License
- ECFMG – Visa
- Novice
- Advanced
- Competent
- Proficient
- Expert
- Master
- Transition to Retirement
- Transition to Practice
See Programs Immersed In, Influenced By, and Influencing the Sponsoring Institution(s)
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, 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 education 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. Perfor-
Continuous Program Improvement Cycle

“Practice Based Learning and Improvement for Programs”
Goal: *Excellence in Achievement of Program Aims*

**Annually Study Your Program**
- Established Program Aims
- Annual Peer Feedback (NAS-AR)
- Milestone Evaluations
- Resident Evaluation
- Faculty Evaluation
- Board Performance
- Clinical Context Evaluation
- Community Need Assessment

**Conduct Your Program**

**CLER**

**Annual Program Evaluation**

**Modify Program Elements**

**10 Year Self-Study**

(Re)Establish Aims

Accreditation Site Visit
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 (2,851 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.
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

David A. Asch, MD, MBA
Sean Nicholson, PhD
Sindhu Srinivas, MD, MSCE
Jeph Herrin, PhD
Andrew J. Epstein, PhD, MPP

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.


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.

JAMA. 2009;302(12):1277-1283
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

Rate of Major Obstetric Complications
by Graduates (%)

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Rate (10.1-10.5)</th>
<th>11.3-11.4</th>
<th>11.9-12.0</th>
<th>12.3-12.5</th>
<th>13.6-14.0</th>
<th>Excess Risk △ 33% Q1 vs Q5</th>
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<td>Q1</td>
<td>13.6-14.0</td>
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Difference remains after correction for USMLE performance

\[ \text{Excess Risk} \ △ 33\% \]

Residency Program of Origin, Ranked (Quintile) by Program Complication Rate

JAMA 2009;302(12):1277-1283. Asch, DA, et.al., Table 4
Difference in Complication Rate
Fourth versus First Quartile

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