Next Accreditation System: What it Means for Surgery Programs, Residents, and GME

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Disclosures

- Fiduciary
  - Full-time employee of ACGME (Potts, Simpson)
- Financial
  - None (Potts, Hebert, Simpson)

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- Ajit Sachdeva, MD, Ex-Officio ACS

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Accredited Programs 2013-2014

	Total Programs	Cont. Accred.	Cont. Accred. w/warning	Initial Accred.	Prob.
Surgery	253	219	19	10	5
Surgical Oncology	18	0	0	18	0
Pediatric Surgery	45	37	0	7	1
Surgical Critical Care	107	91	4	12	0
Hand	1	1	0	0	0
Vascular-Independent	104	91	6	7	0
Vascular-Integrated	47	25	1	21	0
TOTAL	575	464	30	75	6

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NAS & Milestones

- NAS: Background
- NAS: Goals
- NAS: Structural overview
- NAS: What's different?
- Milestones

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NAS & Milestones

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- **NAS: What's different?**
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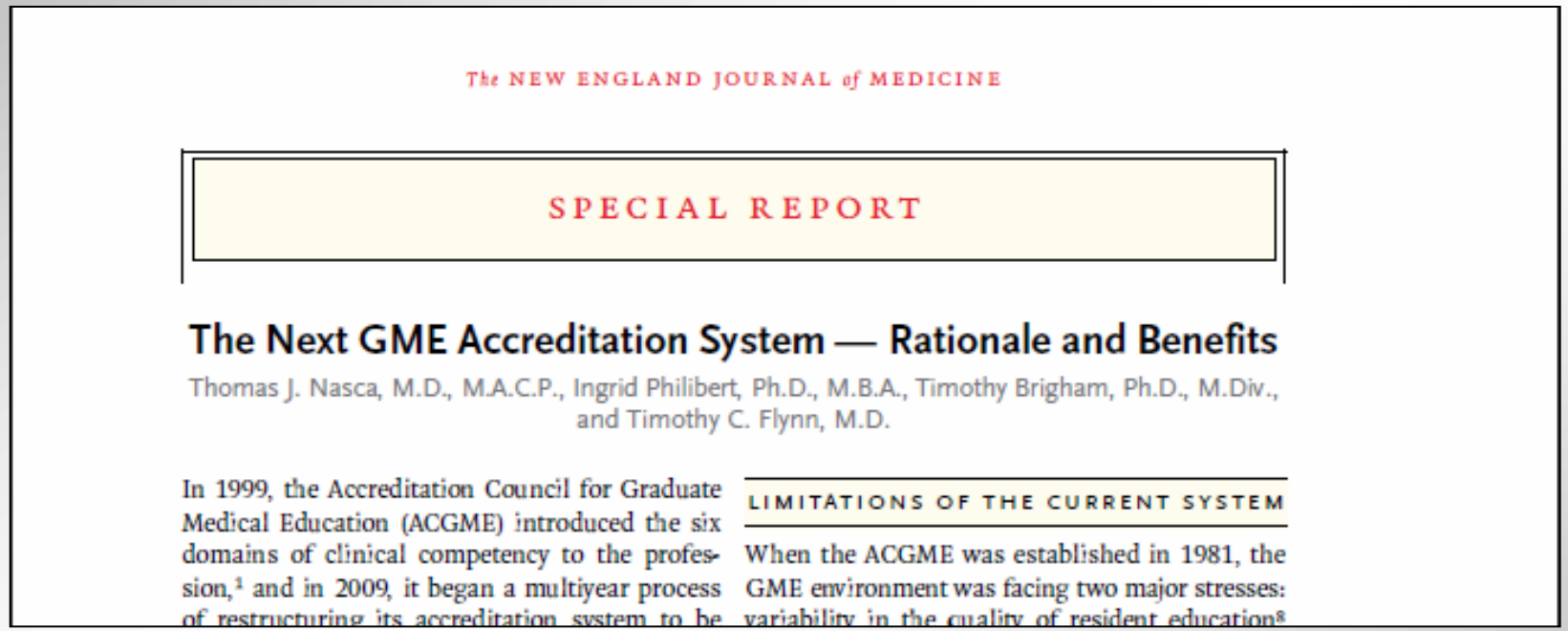
NAS Background



The NEW ENGLAND JOURNAL of MEDICINE

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

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[8]

N Engl J Med. 2012 Mar 15;366(11):1051-6

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NAS Background

- GME is a public trust
- ACGME accountable to the public

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NAS Background

- Patients & payers expect doctors to be:
  - Health information technology literate
  - Able to use HIT to improve care
  - Sensitive to cost-effective care
  - Involve patients in their own care

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NAS Background

- ACGME created 1981
- From inception, emphasized:
  - Program structure
  - Increase in quality & quantity of formal teaching
  - Balance between service and education
  - Resident evaluation & feedback
  - Financial & benefit support for trainees

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NAS Background

- Efforts rewarding by many measures
- But:
  - Program requirements increasingly prescriptive
  - Innovation squelched
  - PDs have become “Process Developers”*

*Term borrowed from Karen Horvath, M.D.

NAS & Milestones

- NAS: Background
- **NAS: Goals**
- NAS: Structural overview
- NAS: What's different?
- Milestones

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Next Accreditation System: Goals

- Produce physicians for 21st century
- Accredit programs based on outcomes
- Reduce administrative burden of accreditation

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Next Accreditation System: Goals

- Free *good* programs to innovate
- Help *underperforming* programs improve
- Realize the promise of “Outcomes Project”
- Provide public accountability for outcomes
- Reduce the burden of accreditation

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NAS & Milestones

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The "Old" Accreditation System

Rules

↓

Corresponding Questions

↓

"Correct or Incorrect" Answer

↓

Citations and Accreditation Decision

Rules

↓

Corresponding Questions

↓

"Correct or Incorrect" Answer

↓

Citation and Accreditation Decision

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The Next Accreditation System

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NAS & Milestones

- NAS: Background
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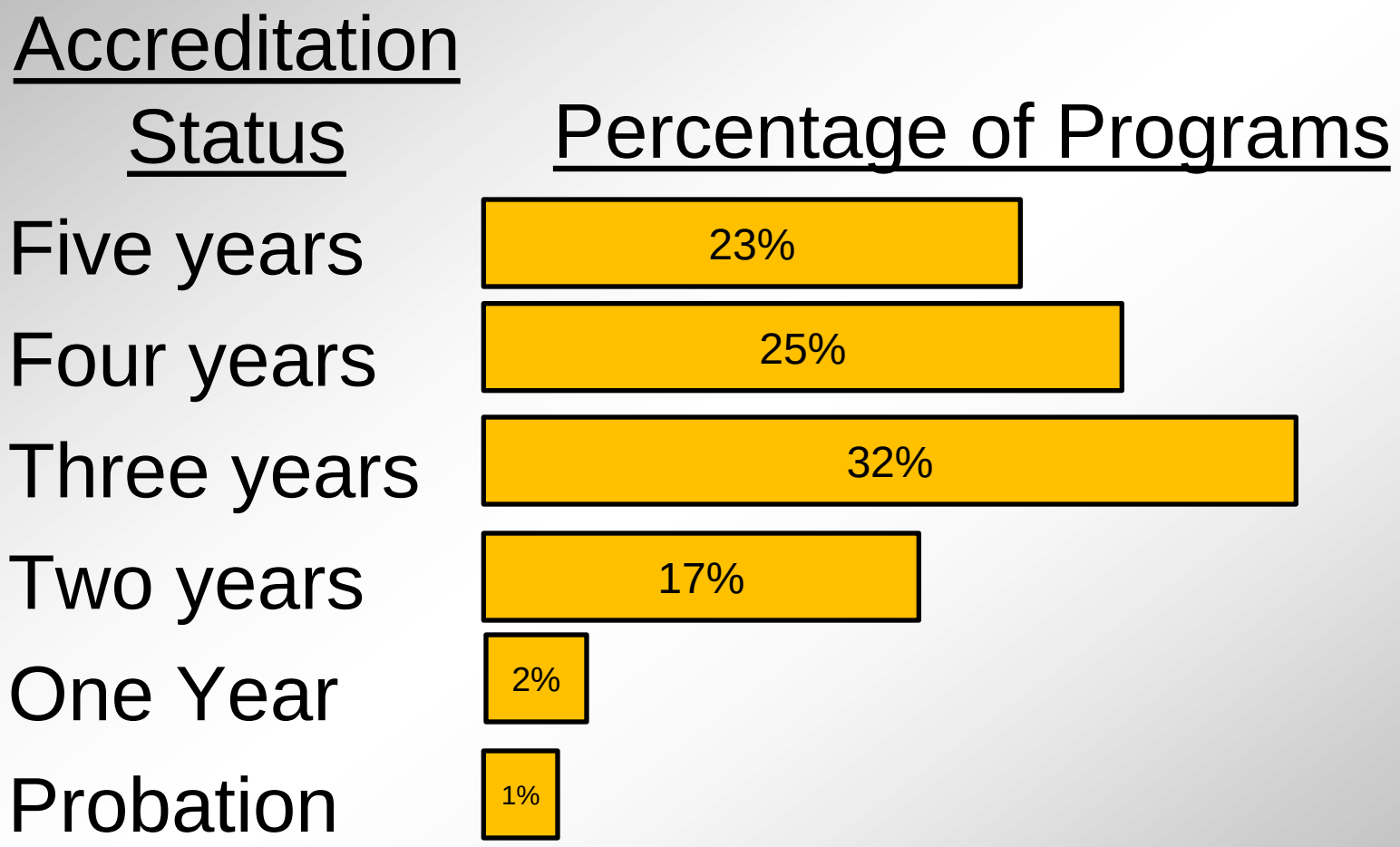
The Old Accreditation System



Surgery programs 30 June 2013

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NAS: What's Different?

- Continuous accreditation model
- No cycle lengths

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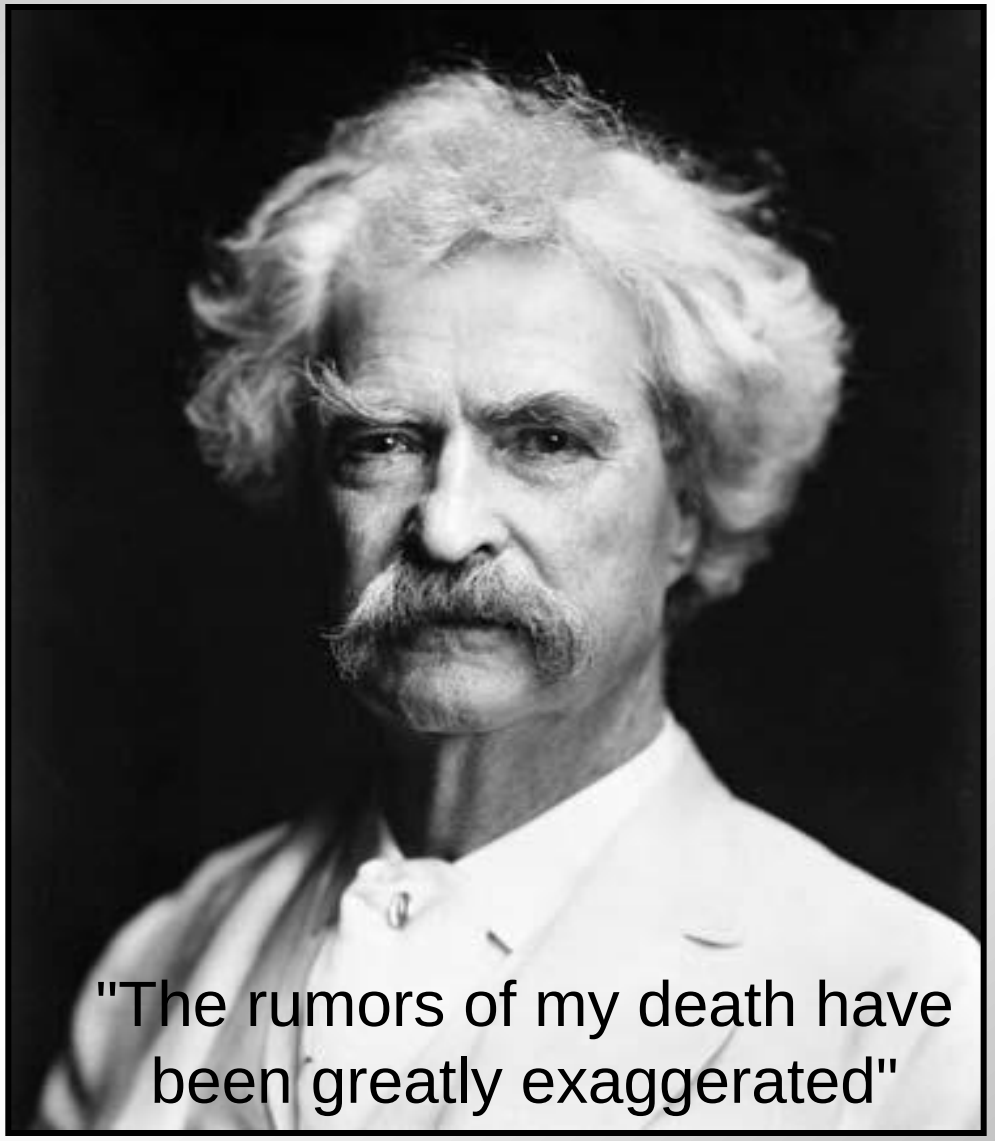
NAS: What's Different?



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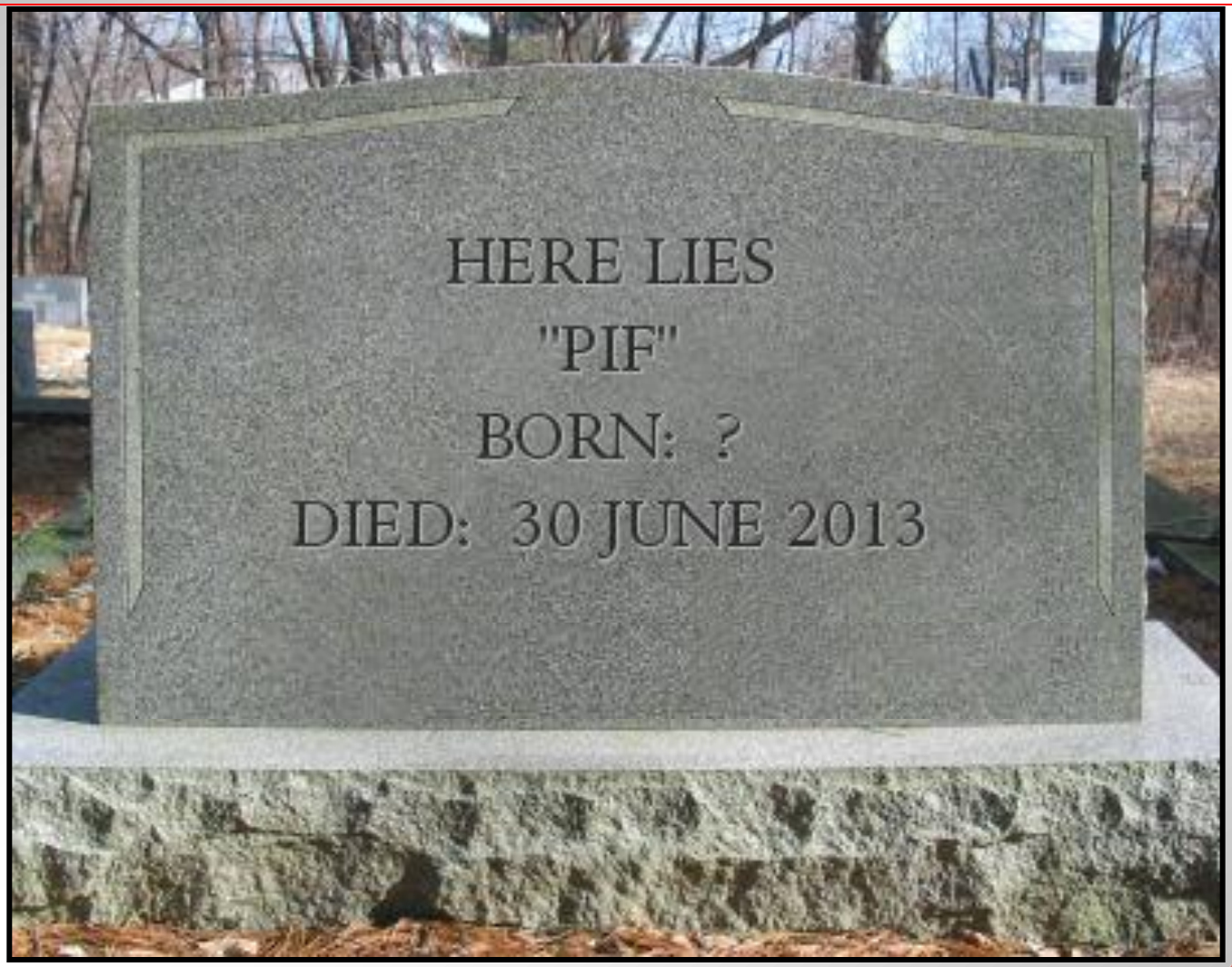
NAS: What's Different?



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NAS: What's Different?

- No PIFs
- No Internal Review
- Programs notified of status *at least* annually
- Requirements revised every ten years

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NAS: What's Different?

- Citations *can* be levied annually by RRC
- But, *could* be removed quickly based upon:
  - Progress report
  - Site visit (focused or full)
  - New annual data from program

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NAS: What's Different?

- No site visits (as we know them)

  but…

- Focused site visits for an "issue(s)" (no PIF
- Full site visit (no PIF)
- Self-study visits every ten years

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Focused Site Visits

- Assesses *selected* aspects of a program and may be used:
  - to address *potential* problems identified during review of annually submitted data;
  - to diagnose factors underlying deterioration in a program's performance
  - to evaluate a complaint against a program

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Focused Site Visits

- Minimal notification given (30 days)
- Minimal document preparation expected
- Team of site visitors
- Specific program area(s) investigated as instructed by the RRC

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Full Site Visits

- Application for new program
- At the end of the initial accreditation period
- RRC identifies broad issues / concerns
- Other serious conditions or situations identified by the RRC

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Full Site Visits

- Minimal notification given (60 days)
- Minimal document preparation expected
- Team of site visitors

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Ten Year Self-Study Visit

- *Not* fully developed
- *Not* a traditional site visit
- Will be implemented in 2015

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Self Study
A Departmentally Coordinated Effort

- Respond to any Active Citations
- Evaluate Programmatic Performance against Goals (written plans of action)
- Review Previous 10 year “Annual Program Evaluations” (APE’s)
- Demonstrate effectiveness of modifications of the Program over time
- Establish Programmatic Goals for the future

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Ten Year Self-Study Visit

- Assess a broader unit of the GME educational environment
- Will review core and any affiliated sub programs together
  - General Surgery
    - Surgical Critical Care
    - Pediatric Surgery
    - Vascular Surgery-Independent
    - Vascular Surgery-Integrated
    - Complex General Surgical Oncology

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Self Study Visit *(Draft)*

- Team of site visitors
- Review the Self Study of the Departmental Educational Effort (Core and Subs)
- Conduct a “PIF-less” Site Visit
- Validate most recent Annual Data submitted
- Potentially serve as a vehicle for:
  - Description of Salutary Practices
  - Accumulation of Innovations in the field

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Ten Year Self-Study Visit

- Review annual program evaluations (PR-V.C.)
  - Response to citations
  - Faculty development
- Judge program success at CQI
- Learn future goals of program
- *Will* verify compliance with Core and Outcome Requirements

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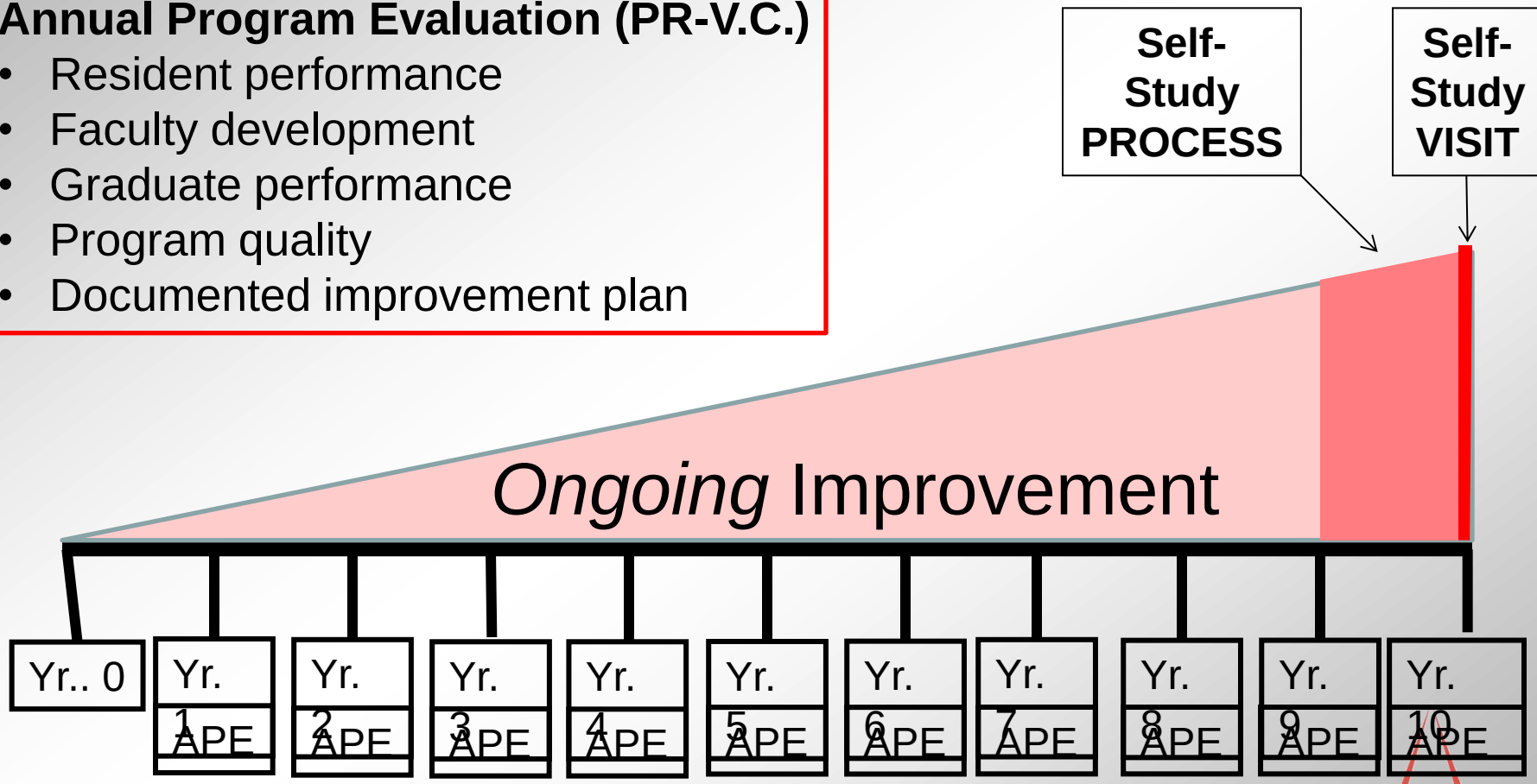
Ten Year Self-Study Visit

Annual Program Evaluation (PR-V.C.)

- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan



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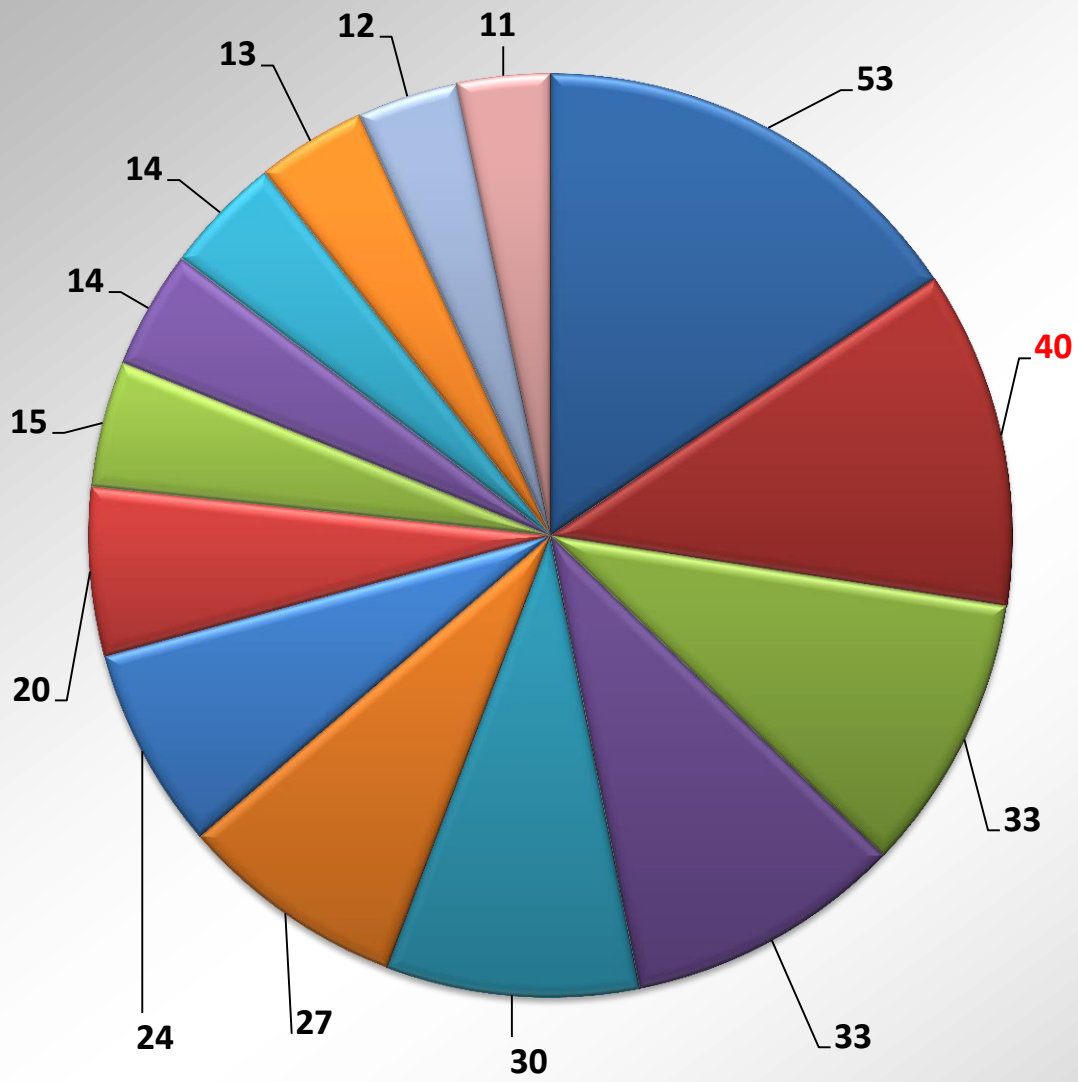
AY 2013 Top Areas of Citation



- Procedural Experience
- Program Evaluation
- Duty Hours & Work Environ.
- PD Responsibilities
- Faculty Qualifications
- Continuity of Care
- Resident Evaluation
- Faculty Responsibiliteis
- Professional Respons Culture
- Resident Appointment
- Scholarly Activities
- Service /Education Imbalance
- Performance on Board Exams
- Curricular Development

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Next Accreditation System

- Program Requirements revised every ten years
- *Each* standard categorized:
  - Outcome - All programs must adhere
  - Core - All programs must adhere
  - Detail - Good programs may innovate

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Continued Accreditation

STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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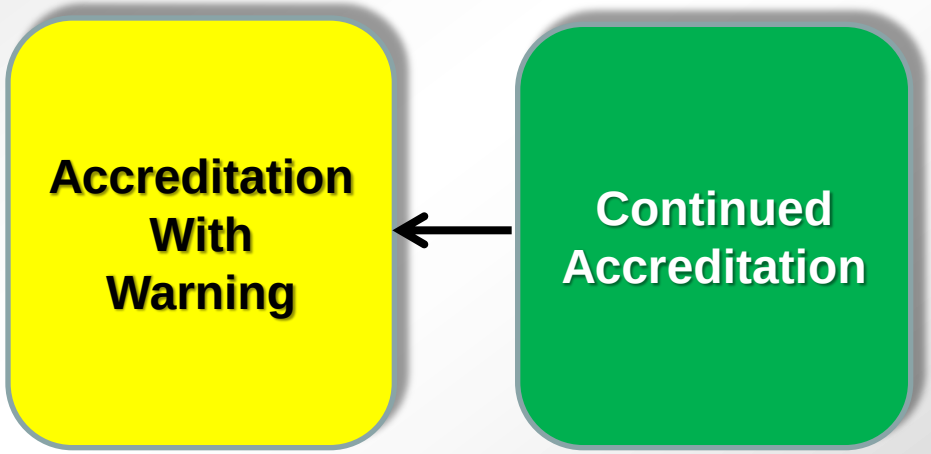
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

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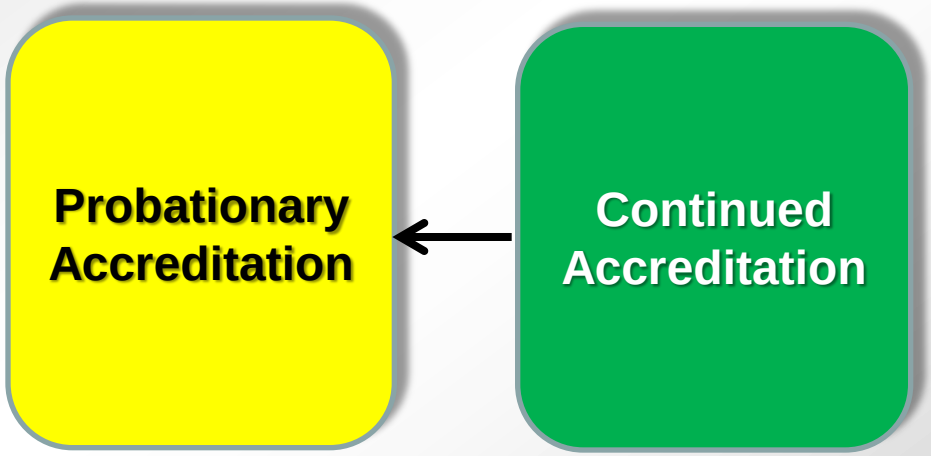

STANDARDS

Outcomes
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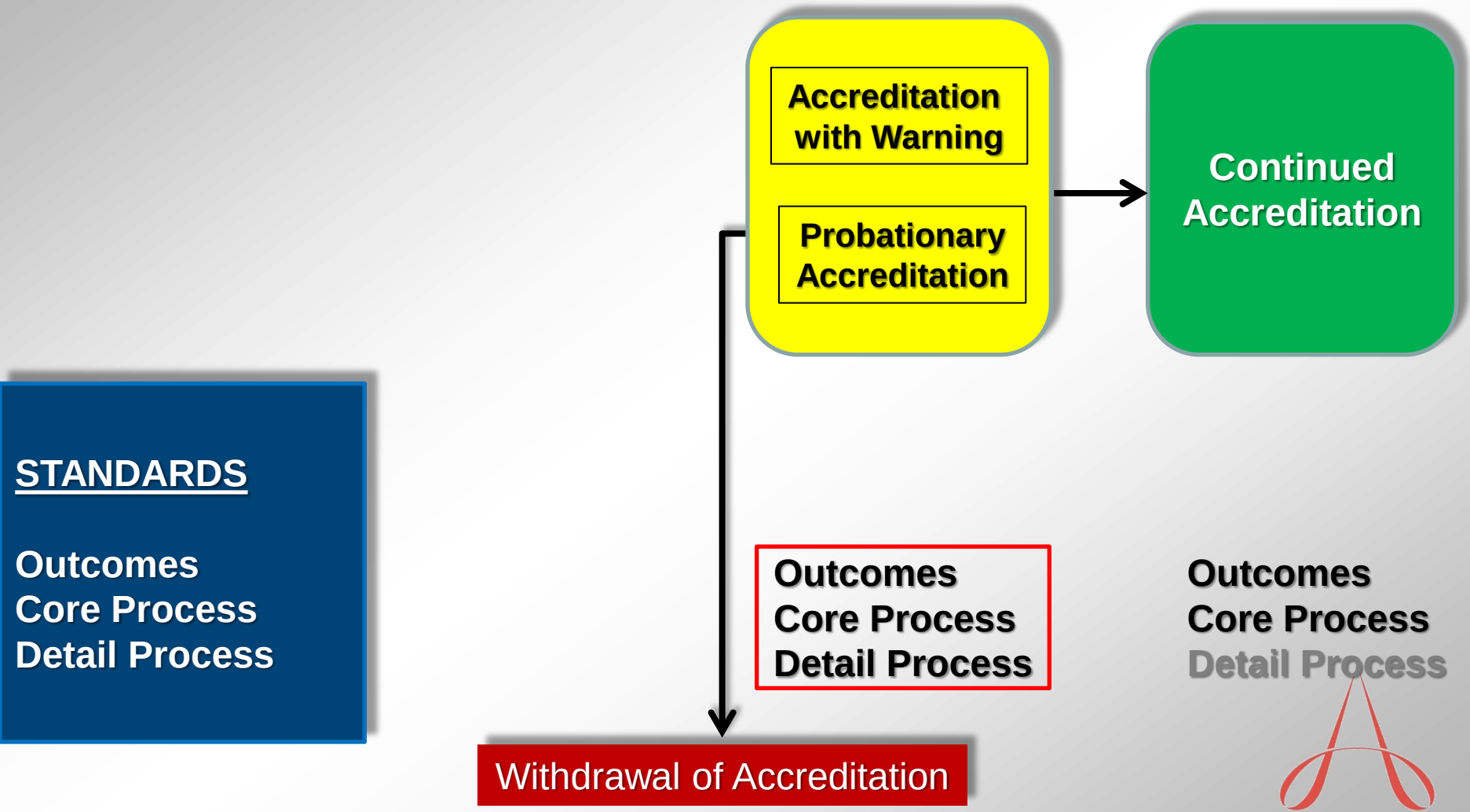

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Some Data Reviewed by RRC
Most already in place

- ✓ Annual ADS Update
  - ✓ Program Characteristics – Structure and resources
  - ✓ Program Changes – PD / core faculty / residents
  - ➢ Scholarly Activity – Faculty and residents
  - ➢ Omission of data
- ✓ Board Pass Rate – 5 year rolling averages
- ✓ Resident Survey – Common and specialty elements
- ✓ Clinical Experience – Case logs
- ✓ Semi-Annual Resident Evaluation and Feedback
  - ➢ Milestones
- ➢ Faculty Survey
- ➢ Ten year self-study

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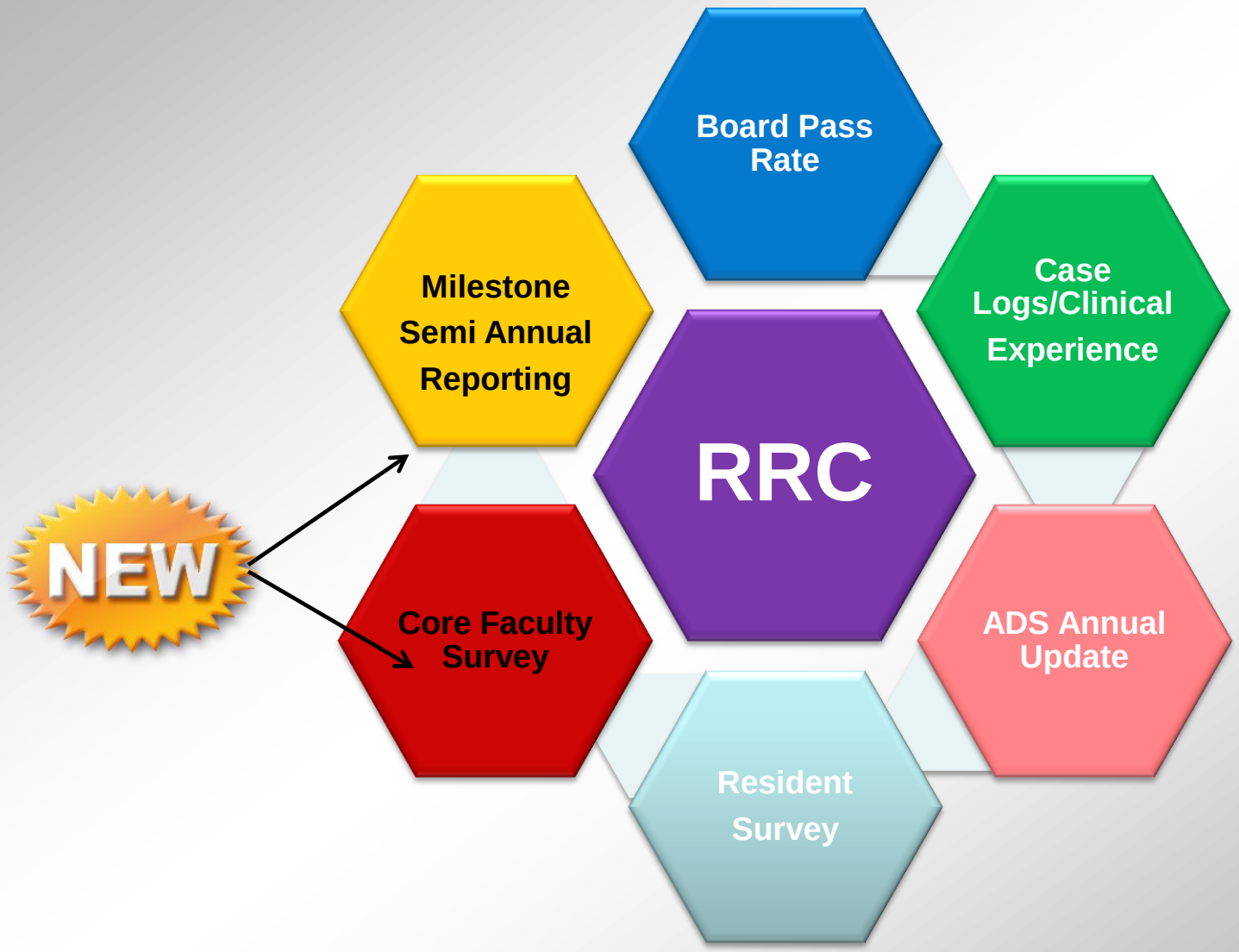
Review of Annual Data



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RRC Actions in NAS

- Programs notified of status *at least* annually
- Citations *may* be levied by RRC based on annual data provided
  - *Could* be removed quickly based upon
    - Progress report
    - Site visit (focused or full)
    - New annual data from program

After Review of Annual Data RRC can…

- Request Progress Report
- "Resolve" Citations
  - Need to continue to respond is removed
- "Continue" Citations
  - Need to respond with updates continues
- Change Accreditation Status, e.g.:
  - Continued Accreditation with Warning →Continued Accreditation
- Require Focused or Full Site Visit
  - All Site Visits are PIFLess

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After Review of Annual Data RRC ***will***…

- Post a letter to every program
  - Confirming accreditation status
    - Self-Study Visit Dates do not change
  - Indicated which citations are continued and which citations are resolved
  - Indicated if additional information is needed
    - Via a progress report
    - Clarifying report
    - Interim Site Visit
      - Focused visit (Letter will specify areas of focus)
      - Full visit

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Milestones

Via Ignatia

Key West, FL

Yorkshire Moors

Portadon Ireland

Gemas
Malaysia

Milion of
Constantinople

Boston, MA

County Cork

Aplan Way

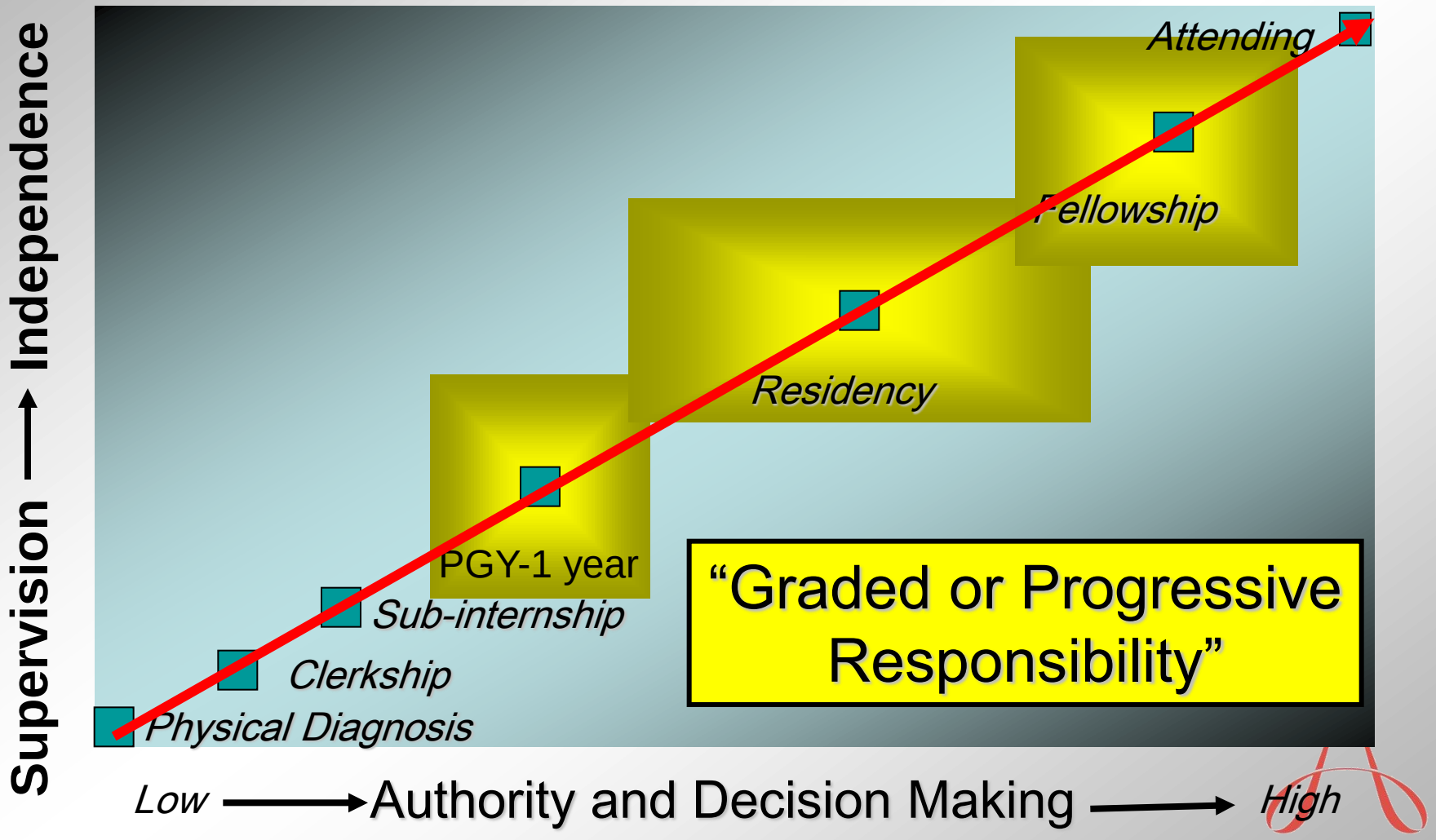
Milestones

- Why?
- What?
- Who?
- When?

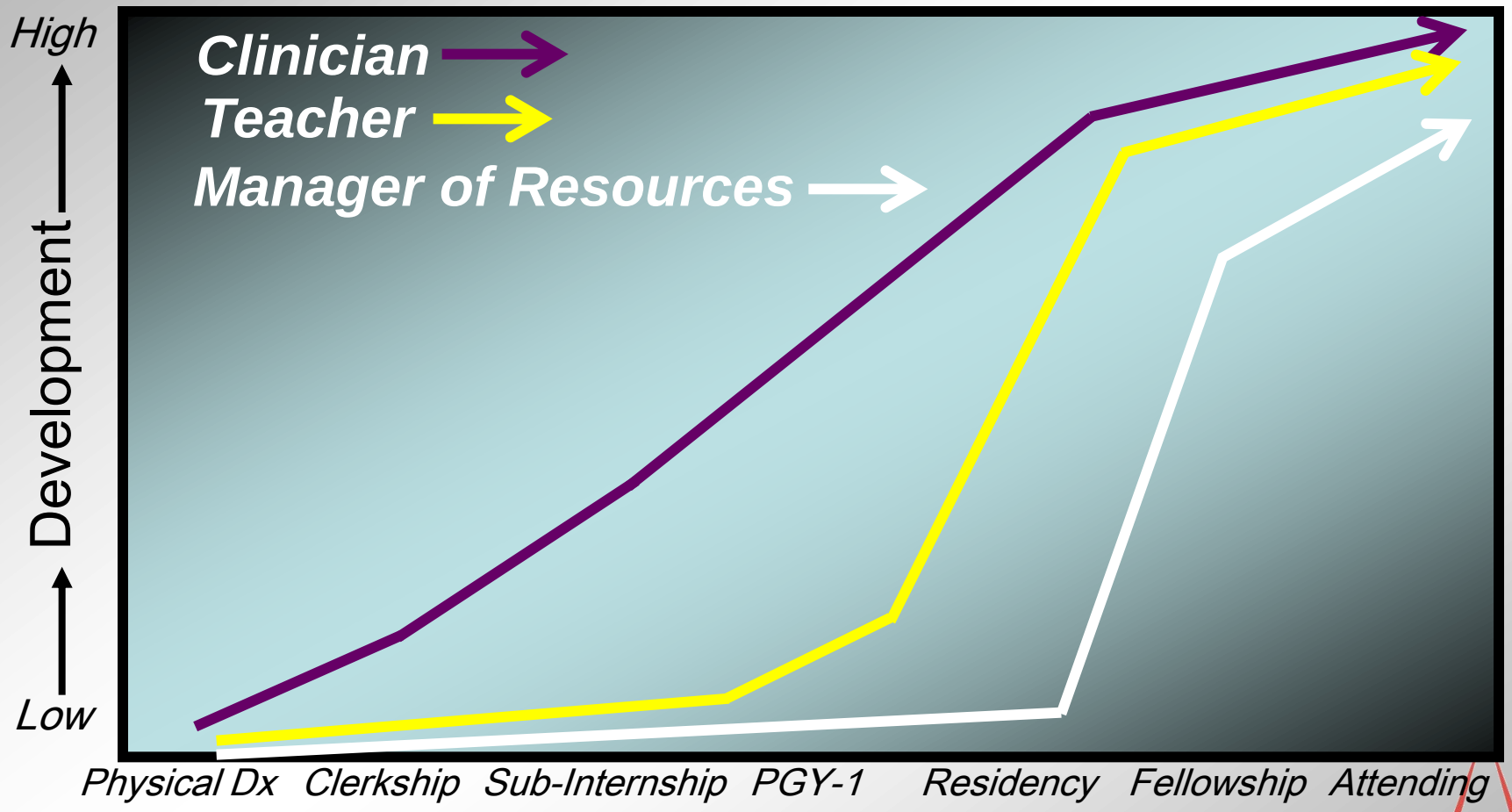
Milestones

- Why?
- What?
- Who?
- When?

The Continuum of Clinical Professional Development

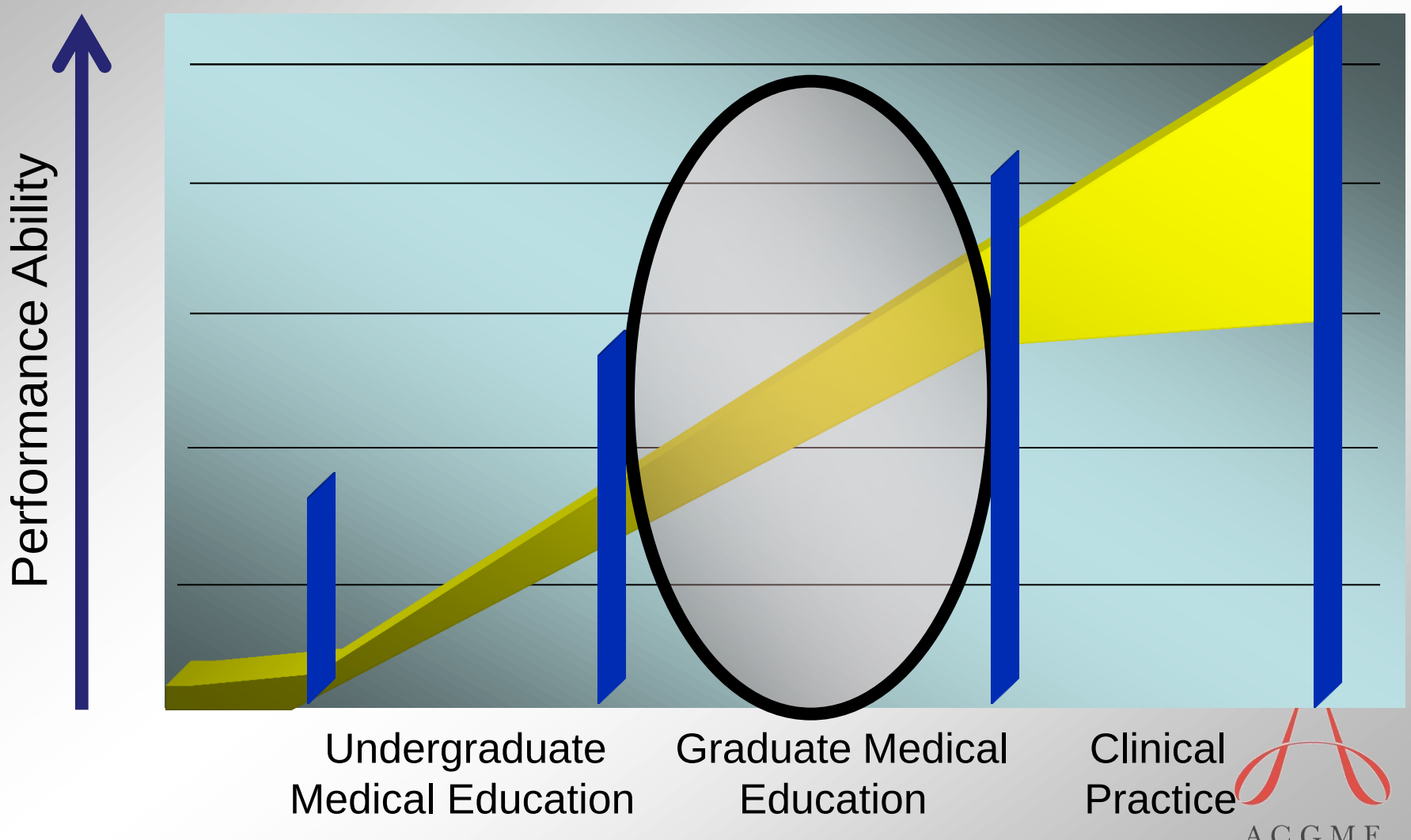


The Continuum of Professional Development
The Three Roles of the Physician[1]



[1]As conceptualized and described by Gonnella, J.S., et. al. Assessment Measures in Medical Education, Residency and Practice. 155-173. Springer, New York, NY. 1993, and in 1998 Paper commissioned by ABMS. Descriptively graphed by Nasca, T.J.

Clinical Professional Development



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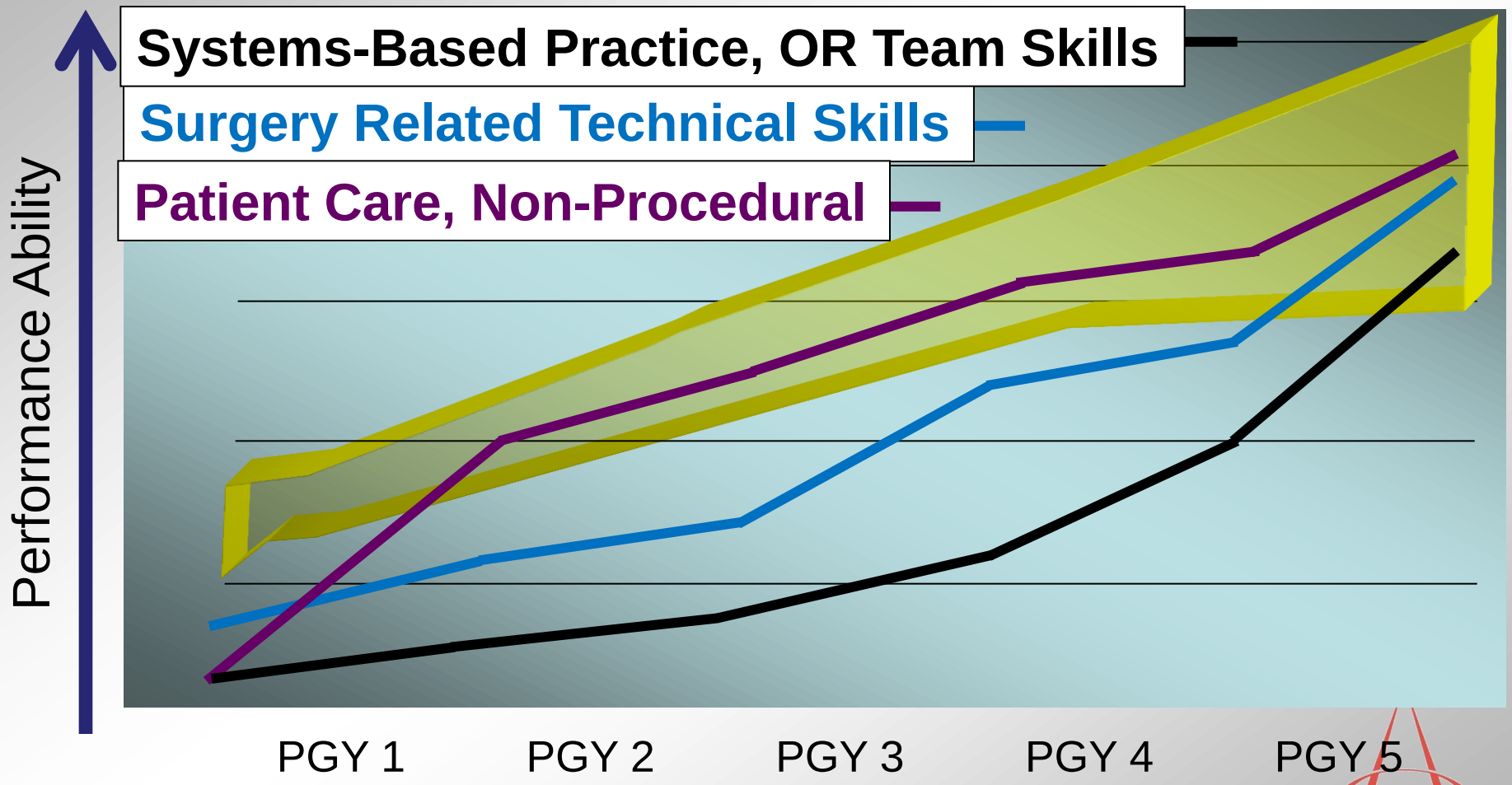
Professional Development in the 5 year Preparation of the Surgeon



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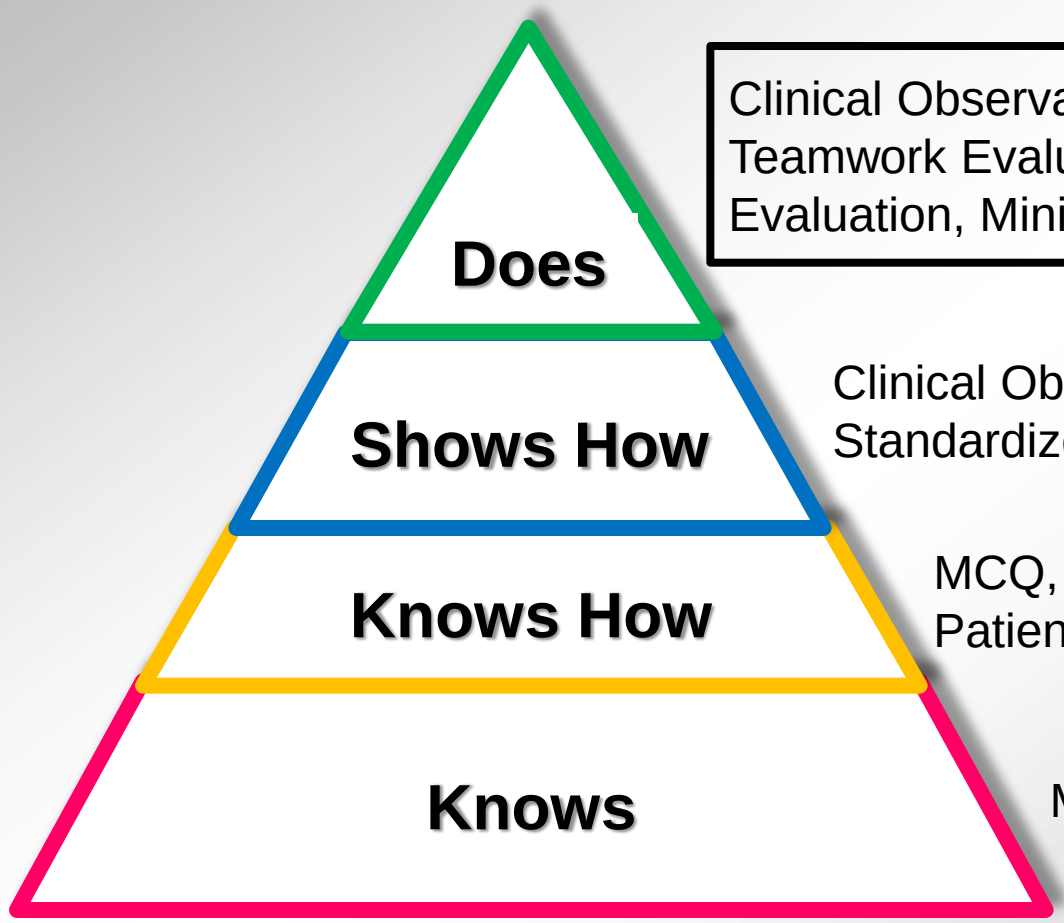
Miller's[1] Pyramid of Clinical Competence



Clinical Observations, Multi-Source Feedback, Teamwork Evaluation, Operative (Procedural) Skill Evaluation, Mini CEX

Clinical Observation, Simulation, Standardized Patients, Mini CEX

MCQ, Oral Examinations, Standardized Patients

MCQ, Oral Examinations

[1]Miller, GE. Assessment of Clinical Skills/Competence/Performance. Academic Medicine (Supplement) 1990. 65. (S63-S67)

van der Vleuten, CPM, Schuwirth, LWT. Assessing professional competence: from Methods to Programmes. **Medical Education 2005; 39: 309–317**

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Move from Numbers to Narratives

- Numerical systems produce range restriction
- Narratives:
  - easily discerned by faculty
  - shown to produce data without range restriction[1]

[1] Hodges and others
Most recent reference: Regehr, et al. Using "Standardized Narratives" to Explore New Ways to Represent Faculty Opinions of Resident Performance. **Academic Medicine. 2012. 87(4); 419-427.**

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The Power of Narratives

The illustration above shows:	○	○	○	○	○

The Power of Narratives

The illustration above shows:	○	○	○	○	○

A. A prolate spheroid which is 725 mm in long circumference and 550 mm in transverse circumference. It is similar to a rugby ball but slightly smaller, more rounded at the ends and more elongated. Red balls are used for day matches and yellow for night matches.

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The Power of Narratives

The illustration above shows:	○	○	○	○	○

B. This has the form of a prolate spheroid, 11 inches long axis; 28 inches long circumference; 21 inches short circumference. It is less rounded at the ends than a rugby ball and has a pebble grained leather case of natural tan color.

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The Power of Narratives

The illustration above shows:

C. A prolate spheroid ball which is 28 cm long, 60 cm in circumference at its widest point and 76 cm in circumference end to end.

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The Power of Narratives

The illustration above shows:	○	○	○	○	○

D. A spherical ball with a circumference of 68-70 cm, which may be white, consisting of 32 panels of leather or plastic including 12 panels that are regular pentagons and 20 panels that are hexagons.

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The Power of Narratives

The illustration above shows:	○	○	○	○	○

E. A white spherical ball which is of 25 cm diameter. The pattern of panels consists of six groups perpendicular to each other, each group being composed of two trapezoidal and one rectangular panel; 18 panels in all.

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Milestones

- Why?
- What?
- Who?
- When?

Milestones

- Organized under six domains of clinical competency
- Observable steps on continuum of increasing ability
- Describe trajectory from neophyte to practitioner
- Intuitively known by experienced specialty educators
- Provide framework & language to describe progress
- Articulate shared understanding of expectations

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ACGME Goals for Milestones

- Permits fruition of the promise of “Outcomes”
- Track what is important
- Uses *existing tools* for *observations*
- Clinical Competence Committee *triangulates* progress of each resident
  - Essential for valid and reliable clinical evaluation system
- RRCs track aggregated program data
- ABMS Board *may* track the identified individual

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ACGME Goals for Milestones

- Specialty specific normative data
- Common expectations for individual resident progress
- Development of specialty specific evaluation tools

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Uses for the Milestones

- Program Director
  - Provide feedback to residents
  - Benchmark her residents to program mean
  - Determine program strengths
  - Determine program opportunities for improvement
  - Benchmark her residents nationally
  - Benchmark her program nationally

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Uses for the Milestones

- Resident
  - Get specific feedback
  - Benchmark herself against peers in program
  - Determine individual strengths
  - Determine individual opportunities for improvement
  - Benchmark herself against peers nationally

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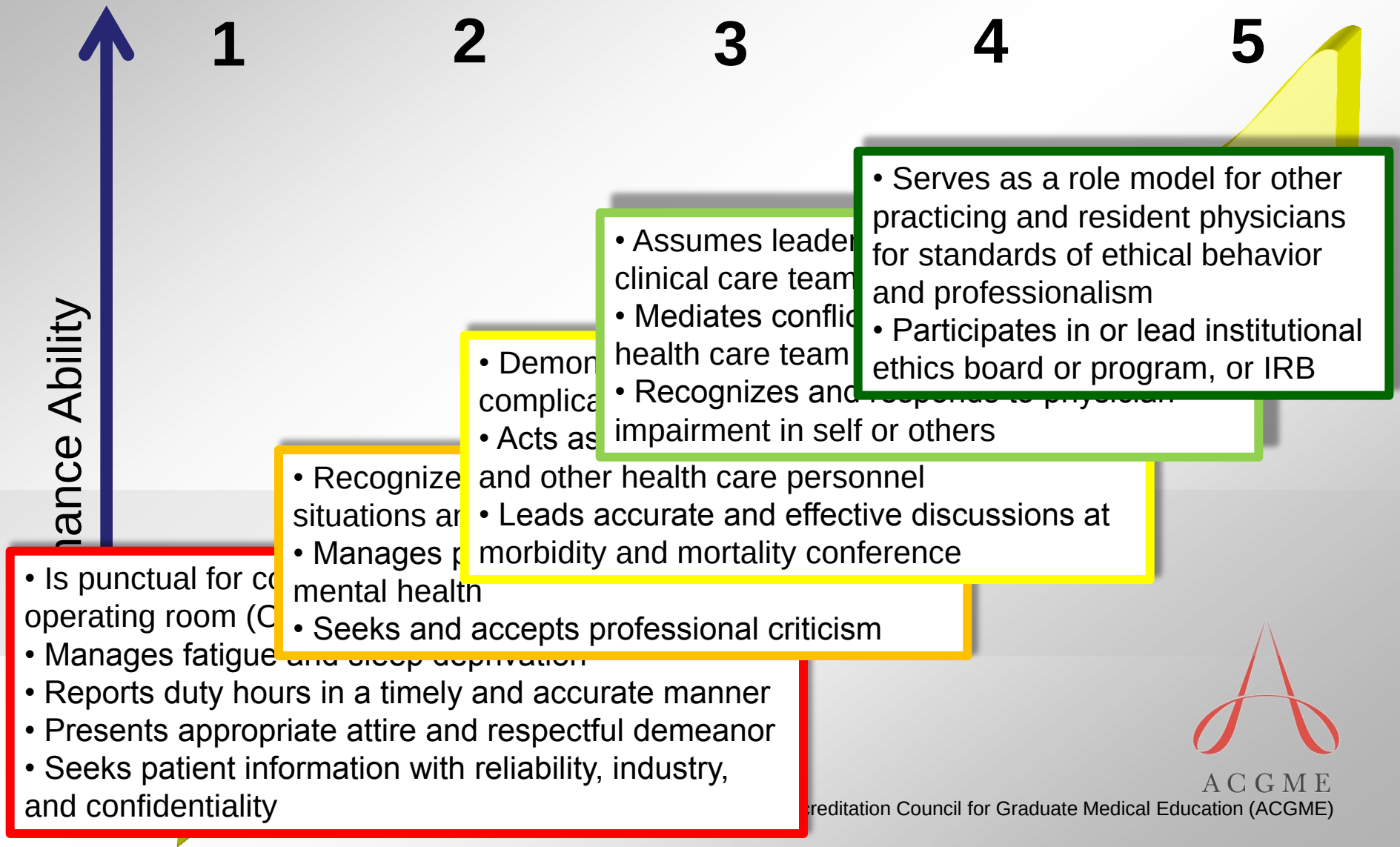
The "Envelope of Expectations" Professionalism



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Organization of Surgery Milestones

Practice Domains

- Care for Diseases and Conditions (CDC)
- Performance of Operations & Procedures (POP)
- Coordination of Care (CC)
- Improvement of Care (IC)
- Teaching (TCH)
- Self-directed Learning (SDL)
- Maintenance of Physical & Emotional Health (MPEH)
- Performance of Assignments and Administrative Tasks (PAT)

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Milestones: Domains Mapped to Competencies

Domain	Patient Care & Proecdural Skills	Medical Knowledge	Practice-based Learning & Improvement	Interpersonal & Communication Skills	Pro-fessionalism	Systems-Based Practice
CDC	PC1, PC2			ICS1		
POP	PC3	MK1,MK2		ICS3	PROF1	
CC				ICS2		SBP1
IC			PBLI3			SBP2
TCH			PBLI1			
SDL			PBLI2			
MPEH					PROF2	
PAT					PROF3	

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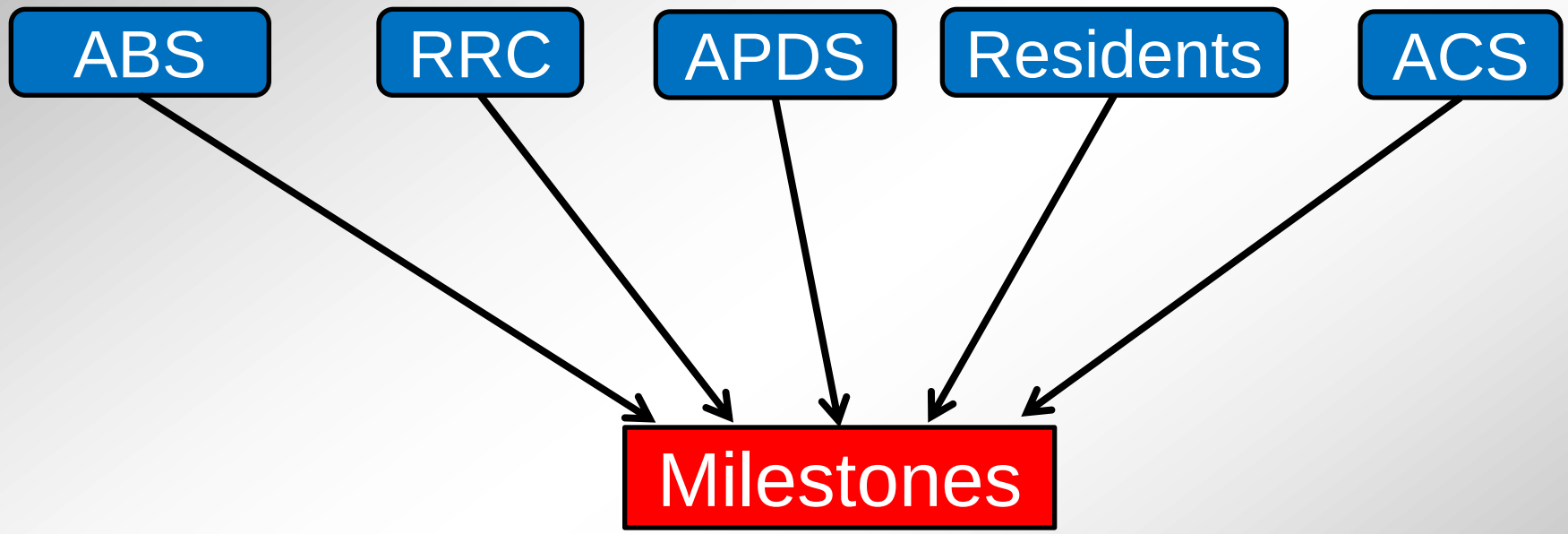
Surgery Milestones PC1

Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care For Diseases and Conditions (CDC)	PATIENT CARE (PC1)	This resident is not able to perform an efficient and accurate initial history and physical for patients admitted to the hospital.	This resident performs a focused, efficient, and accurate initial history and physical of a full spectrum of patients admitted to the hospital, including critically-ill patients.	This resident accurately diagnoses *many* "broad" surgical conditions in the SCORE curriculum and initiates appropriate management for *some* common, "broad" conditions. This resident can develop a diagnostic plan and implement initial care for patients seen in the Emergency Department (ED).	This resident accurately diagnoses *most* "broad" conditions in the SCORE curriculum and *some* "focused" conditions and initiates appropriate management for *most* "broad" surgical conditions independently.	This resident can lead a team that cares for patients with common and complex conditions and delegates appropriate clinical tasks to other health care team members. This resident recognizes atypical presentations of a large number of conditions.
		☐	☐	☐	☐	☐
		Comments:				

Milestones

- Why?
- What?
- Who?
- When?

Creation of Milestones



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GS Milestones Working Group

- Dick Bell[1,5]
- Tom Cogbill[1,3,5]
- Stan Ashley[1,5]
- Karen Borman[1,3,5]
- Jo Buyske[1,5]
- Joe Cofer[1,3,5]
- Adeline Deladisma[6]
- Mark Friedell[3,5]
- Jim Hebert[2,4,,5]
- Mark Malangoni[1,2]
- Paula Termuhlen[3,5]
- Jim Valentine[1,3,5]
- Reed Williams[4]
- Charles van Way[3]
- Peggy Simpson, EdD[7]
- Susan Swing, PhD[7]

[1] American Board of Surgery
[2] RRC-Surgery
[3] Association of Program Directors in Surgery
[4] Association for Surgical Education
[5] American College of Surgeons
[6] Resident
[7] ACGME Staff

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Evaluation of Miller's "Does"

- Trained observers
  - Common understanding of the expectations
  - Sensitive "eye" to key elements
  - Consistent evaluation of levels of performance
- Requires certain number of observations
- Interpreter/Synthesizer Experts
  - Clinical Competency Committee (Resident Evaluation Committee)

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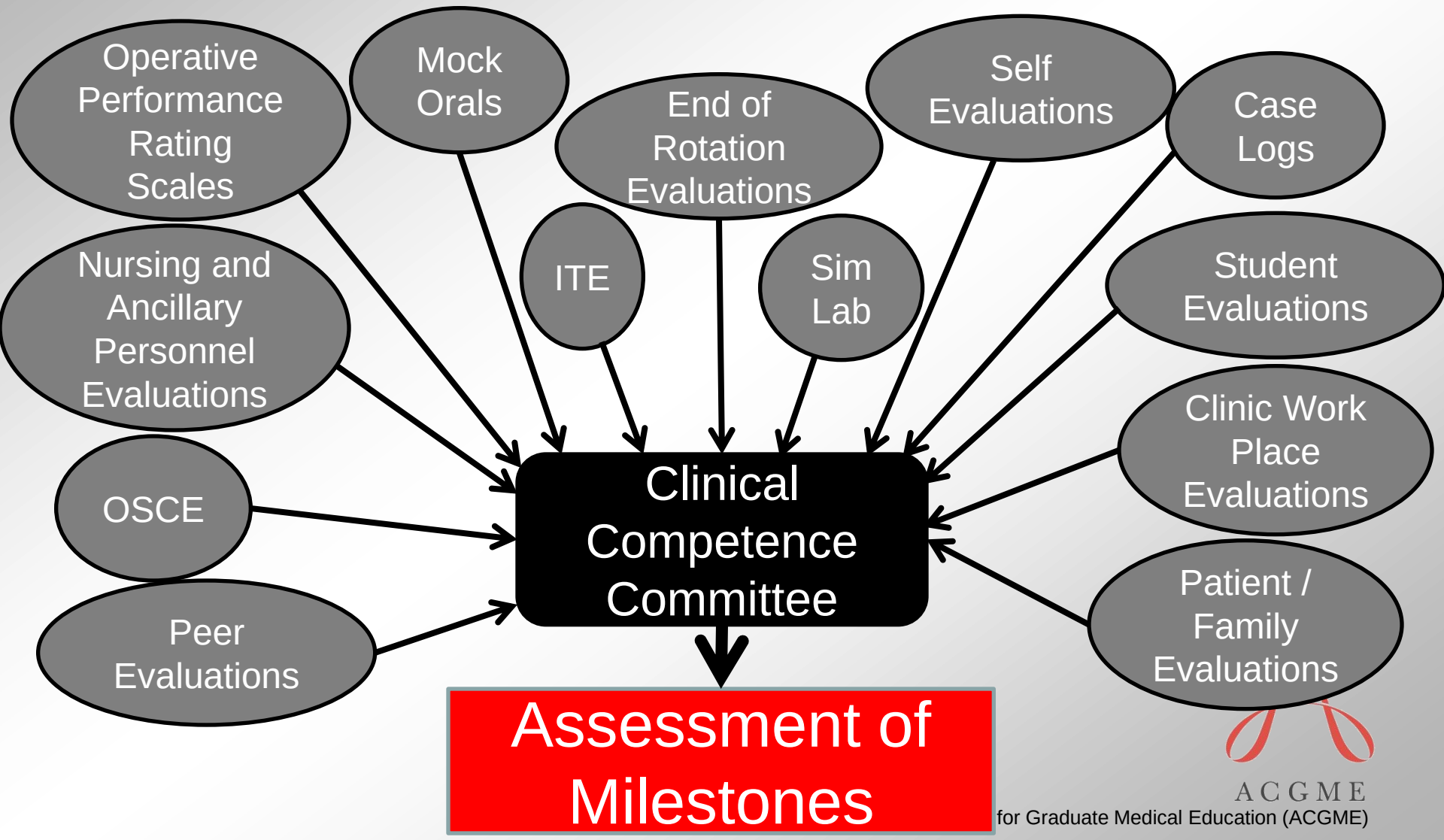
Clinical Competence Committee



ACGME Goal for Milestones - Permits fruition of the promise of "Outcomes Based Accreditation"

- Tracks what is important - Outcomes
- Begins using *existing tools* and *observations of the faculty*
- Clinical Competency Committee triangulates progress of each resident
  - Essential component of a valid and reliable clinical evaluation system
  - ABMS Board has the opportunity to track the identified individual
  - ACGME Review Committee tracks unidentified individuals' trajectories

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Sample Professionalism Milestones

Level	D		1		2		3		4
a.) Honesty, integrity and ethical behavior	○	○	○	○	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○	○	○	○	○
c.) Humanistic behaviors of respect, compassion and empathy	○	○	○	○	○	○	○	○	○
d.) Receiving and giving feedback	○	○	○	○	○	○	○	○	○

Sample Professionalism Milestones

Level	D		1		2		3		4
a.) Honesty, integrity and ethical behavior	○	○	○	○	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○	○	○	○	○
c.) Humanistic behaviors of respect,	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○

Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team

ACGME

Sample Professionalism Milestones

Level	D		1		2		3		4
a.) Honesty, integrity and ethical behavior	○	○	○	○	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○	○	○	○	○
c.) Humanistic behaviors of respect, compassion	○	○	○	○	○	○	○	○	○
d.) Receiving				○	○	○	○	○	○

Resident demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in more complex clinical situations or settings. Occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.

ACGME

Sample Professionalism Milestones

Level	D		1		2		3		4
a.) Honesty, integrity and ethical behavior	○	○	○	○	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○	○	○	○	○
c.) Humanistic behaviors of respect, compassion and empathy								○	○
d.) Receiving and giving fe								○	○

Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients; and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

Milestones

- Why?
- What?
- Who?
- When?

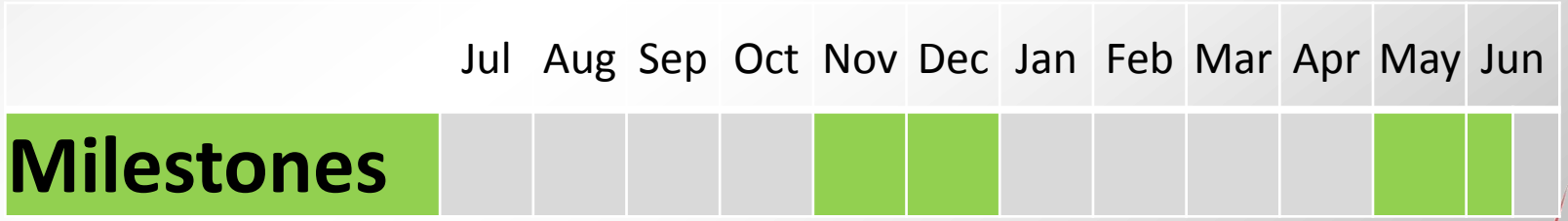
Milestones: When?

Publication:

General Surgery: July 2013

Implementation (data collection):

General Surgery Programs: AY 2014



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NAS & Milestones

- NAS: Background
- NAS: Goals
- NAS: Structural overview
- NAS: What's different?
- Milestones

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