The Next Accreditation System: A Resident Perspective

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“We improve health care by assessing and advancing the quality of resident physicians’ education through accreditation.”

ACGME Mission Statement

Purpose

- Provide a brief history of the accreditation process
- Describe the components of the Next Accreditation System, including the Milestones and the Clinical Learning Environment Review program
- Address resident/fellow questions and concerns

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Glossary of Terms

- ACGME – Accreditation Council for Graduate Medical Education
- NAS – Next Accreditation System
- CLER – Clinical Learning Environment Review program
- CCC – Clinical Competency Committee
- Institution

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A Brief History

- 1999 – The ACGME and American Board of Medical Specialties (ABMS) establish the six Core Competencies
  - Designed to shift emphasis from process-oriented to outcomes-oriented standards in physician education
  - ACGME required residency/fellowship programs to use them as a rubric (a.k.a. the “Outcome Project”)
- 2002 – Public and political pressure on the GME community to produce physicians capable of cost-conscious, patient-centered care begins to increase
- 2009 – The ACGME, ABMS boards, specialty colleges/academies, residency/fellowship program directors, and residents begin to define the Milestones

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A Brief History

- 2012 – Alpha test sites begin to implement the Milestones at the individual program level
- 2013 – Next Accreditation System (NAS) Phase I programs implement the Milestones
- 2014 – All programs are under the NAS and must implement the Milestones

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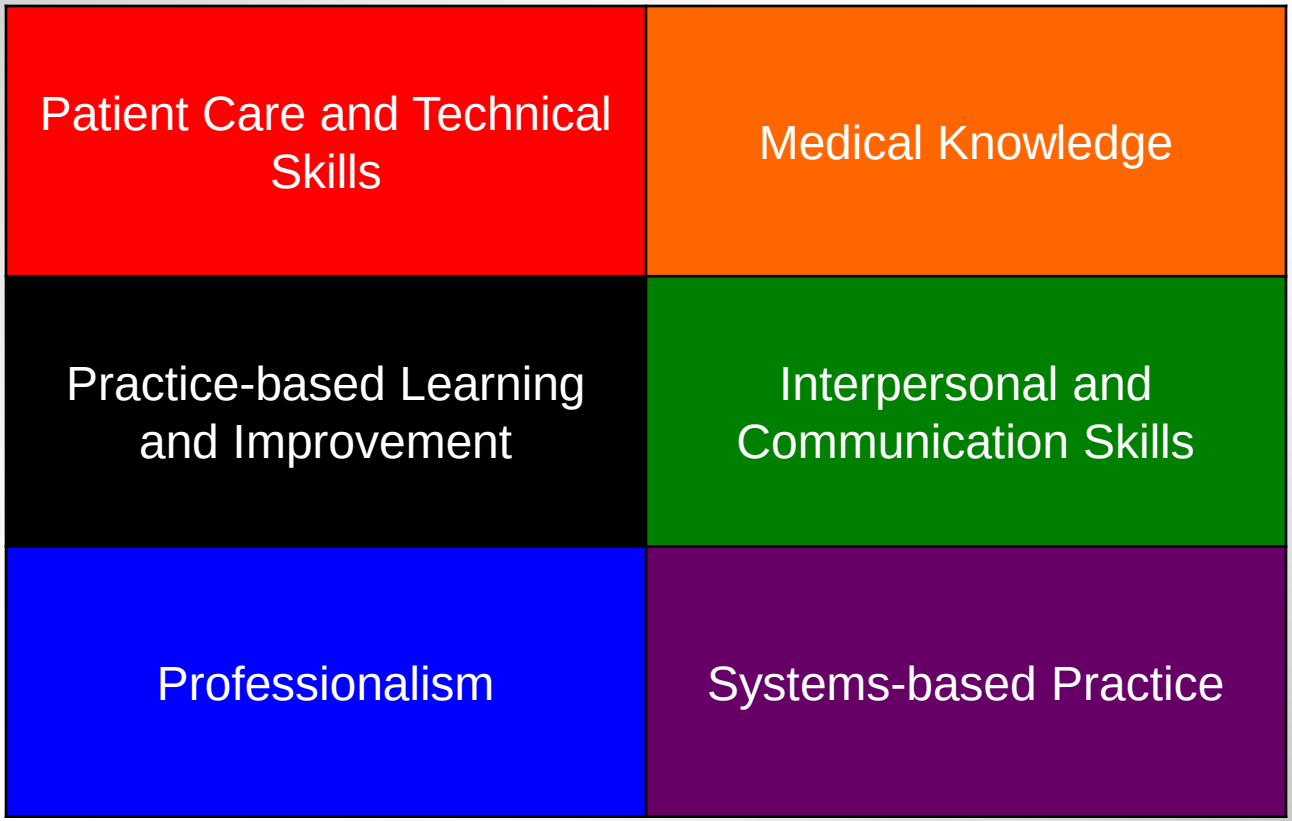
The Six Core Competencies



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Why Is a New System Needed?

- The old process-based system was “one size fits all”
- We need to standardize outcomes while simultaneously allowing programs to individualize education
- Good programs must be free to innovate
- We need to shift from a “catch them being bad” to a “reward them for being good” accreditation paradigm

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The Next Accreditation System

The NAS in a Nutshell

- A continuous accreditation model based on key screening parameters – this list is not all encompassing and is subject to change:
  - Annual program data (resident/fellow/faculty information, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
  - Aggregate board pass rate
  - Resident clinical experience
  - Resident/Fellow Survey and Faculty Survey (latter is new)
- Semi-annual resident Milestone evaluations
- 10-year Self-Study and Self Study Site Visit
- Clinical Learning Environment Review (CLER) Site Visits

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10-Year Self-Study Visits

Current Accreditation System	Next Accreditation System
Site visits every five years (or less)	Scheduled site visits every 10 years
Programs evaluated by Review Committee in conjunction with site visits	Program data evaluated annually by the Review Committee
Large printed Program Information Form (PIF)	No PIF; data transmitted electronically to ACGME annually
Periodic evaluation	Longitudinal evaluation
Process-oriented (provide appropriate documentation)	Performance-oriented (evaluate performance against goals)
Future goals not addressed	Help programs establish goals for the future

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The Review Committee in the NAS

- Use key annual data parameters to identify concerning trends or areas of concern
- Concentrate efforts on struggling programs – motivate them to improve and monitor progress in real time
- Empower strong programs to innovate
- Conduct a complete review of the program, using a team-based, department-wide evaluation of programs every 10 years
- Issue at least one accreditation decision per program annually

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Accreditation Categories

- Initial Accreditation (new programs)
- Initial Accreditation with Warning
- Continued Accreditation
- Continued Accreditation with Warning
- Probationary Accreditation
- Withhold/Withdrawal of Accreditation

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Clinical Learning Environment Review (CLER) Site Visits

An Institutional Assessment

- All programs within an institution evaluated simultaneously
- CLER is NOT tied to program or institutional accreditation
- Six areas of focus:
  - Resident engagement/participation in patient safety programs
  - Resident engagement/participation in QI programs
  - Establishment and oversight of institutional supervision policies
  - Effectiveness of institutional oversight of transitions of care
  - Effectiveness of duty hours and fatigue mitigation policies
  - Activities addressing the professionalism of the educational environment
- Formative, non-punitive learning process for institutions and the ACGME

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CLER Feedback

- Site visitors conduct “walking rounds” accompanied by resident/fellow hosts/escorts designed to facilitate contact with nursing and support staff and patients (eventually)
- Meetings held with:
  - DIO, GMEC Chair, CEO, CMO, CNO
  - CPS/CQO
  - Core faculty members
  - Program directors
  - Residents/fellows
- Answer questions honestly if approached by CLER site visitors
- No “gotchas,” and no hidden accreditation impact

Milestones

- Observable developmental steps from Novice to Expert/Master (based on Dreyfus model)
- Organized under the six domains of clinical competency
  - Set aspirational goals of excellence (Level 5)
  - Provide a blueprint for resident/fellow development across the continuum of medical education
- Development committees (Working/Advisory Groups) were anchored by members of each specialty, including board members, program directors, Review Committee members, national specialty organization leadership, and residents/fellows – with ACGME support
- General competencies were translated into specialty-specific competencies

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General Competency

Sub-competency

Developmental Progression or Set of Milestones

PC1. History (Appropriate for age and impairment)

Level 1	Level 2	Level 3	Level 4	Level 5
Acquires a general medical history	Acquires a basic physiatric history including medical, functional, and psychosocial elements	Acquires a comprehensive physiatric history integrating medical, functional, and psychosocial elements Seeks and obtains data from secondary sources when needed	Efficiently acquires and presents a relevant history in a prioritized and hypothesis driven fashion across a wide spectrum of ages and impairments Elicits subtleties and information that may not be readily volunteered by the patient	Gathers and synthesizes information in a highly efficient manner Rapidly focuses on presenting problem, and elicits key information in a prioritized fashion Models the gathering of subtle and difficult information from the patient

Specific Milestone

Milestone Assessment

- Milestones are a summary of how a resident/fellow is progressing
- Some specialties mark progress towards Entrustable Professional Activities (EPAs)
  - Real-life patient care episodes comprising the majority of the Milestones; achievement of the most sophisticated EPAs defines proficiency
- There are no hard and fast rules for how residents can or should progress through the Milestones
- The program's Clinical Competency Committee (CCC) evaluates the progress of each resident/fellow

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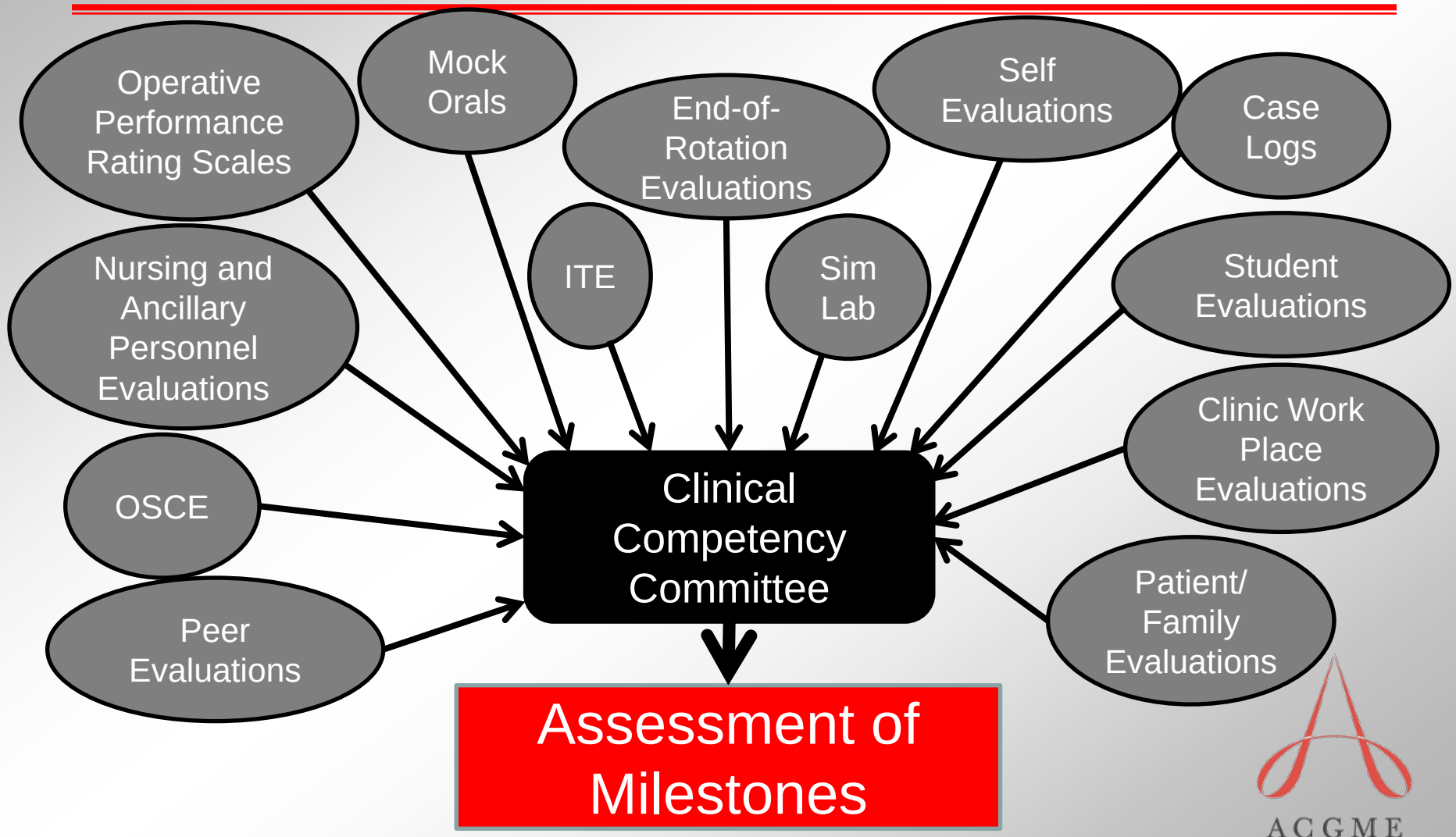
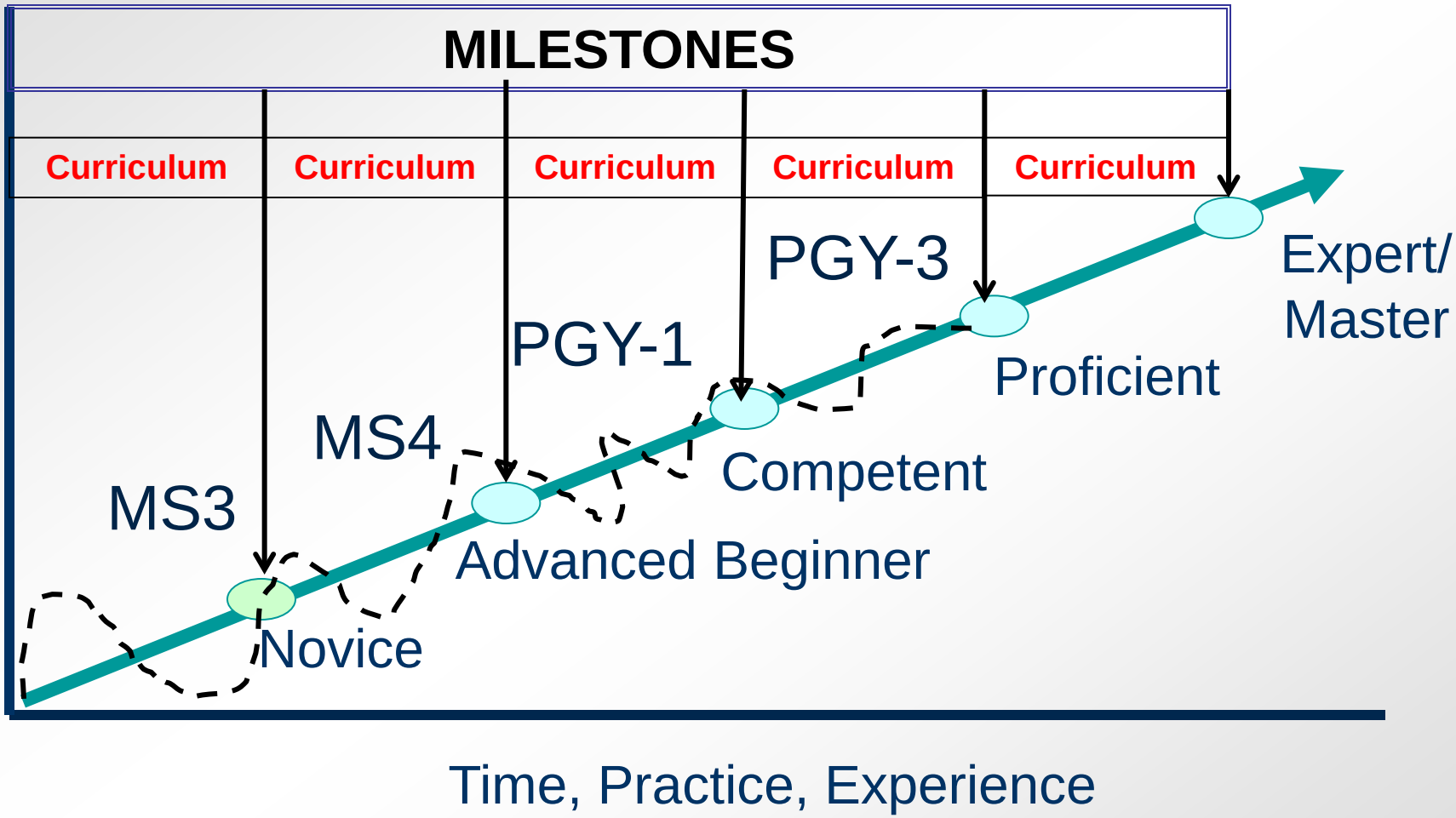
Based on Holistic Evaluation



Competency Development Model



Dreyfus SE and Dreyfus HL. 1980
Carraccio CL et al. Acad Med 2008;83:761-7

What is a Clinical Competency Committee?

- A modified promotions committee
- Composed of at least three faculty members (can include non-physicians)
  - Chief residents who have *completed* training can provide input
- Evaluates residents/fellows on the Milestones and provides feedback to residents/fellows AT LEAST semi-annually
  - Allows for more uniform evaluation of residents/fellows (less individual bias)
  - Recommends either promotion, remediation, or dismissal for each resident/fellow in a program
- Programs will submit CCC assessments to the ACGME as part of the annual review process

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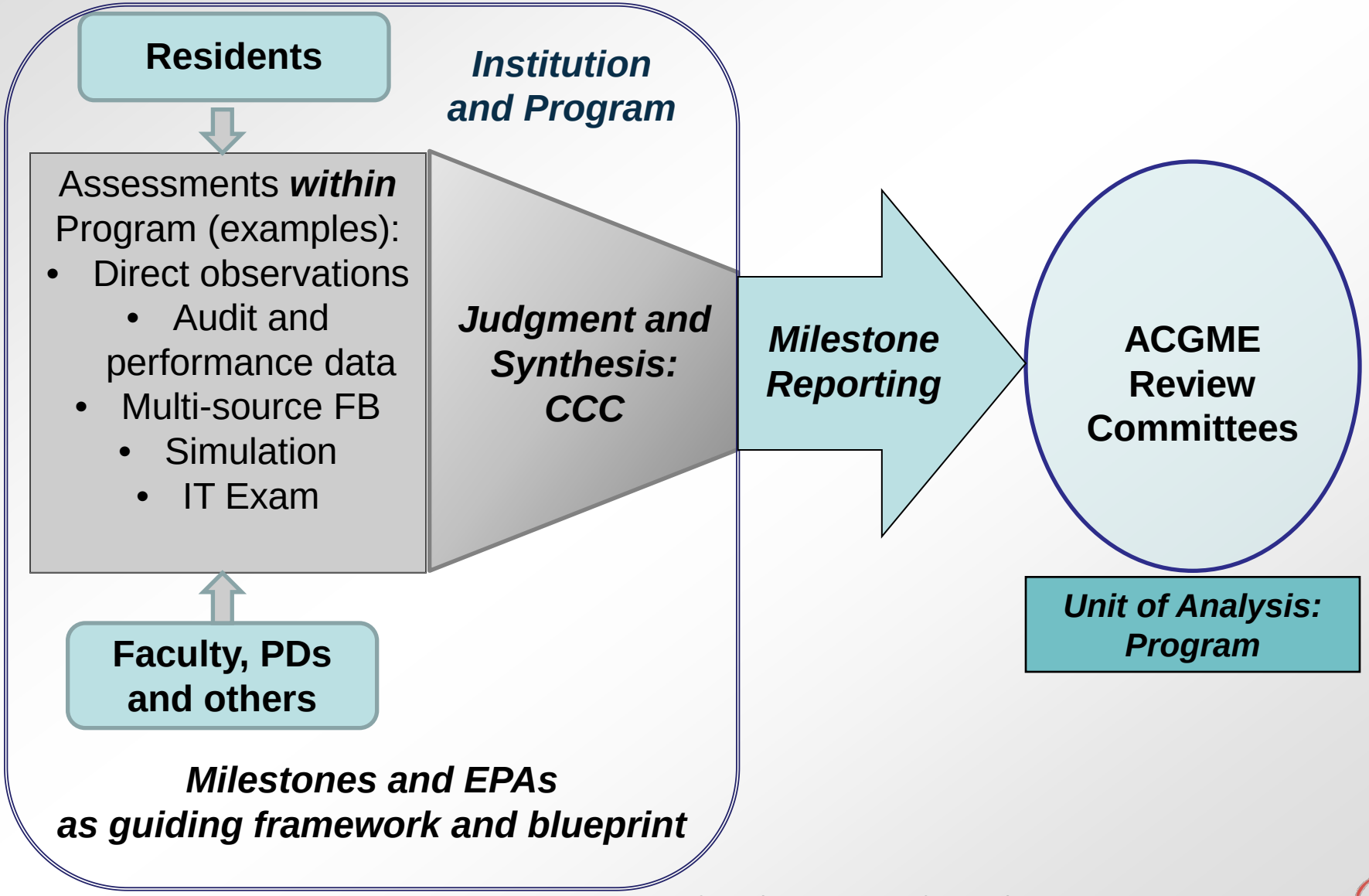
The NAS Milestone Assessment System



Information Current as of December 2, 2013

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Program Assessment

- Formal Program Evaluation Committee established
  - Should be equivalent to the annual review programs are already required to perform
- Programs are required to show that they are responding to areas of concern identified in the program review, and that interventions are having the desired effect

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Milestone Benefits

Program Benefits	Resident Benefits
Provides tools needed to define and assess outcomes	Potentially permits true graduated responsibility (proof positive that a resident/fellow is proficient to practice unsupervised)
Highlights curriculum inadequacies	Provides concrete metrics for evaluation
Guides curriculum development	No more “nice guy, showed up on time” feedback allowed
Allows early identification of under- (and over-) performers	Sets concrete expectations for resident/fellow progression

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Can Milestones Hurt Me?

- They are not graduation requirements
- They are not “one size fits all”
- They are not a means of holding you in residency/ fellowship because you are not at Level 4 in all areas
- The determination of competency to practice and board eligibility remains the purview of your program director
- They are not a means of graduating early because you achieve Level 4 in all areas – each specialty board will have to grapple with this issue as programs gain experience with using them

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In Summary

- A focus on outcomes benefits everyone (patients, programs, and residents/fellows)
- The NAS should permit innovation while ensuring that graduating residents/fellows can provide effective, independent patient care
- CLER program adds an institutional dimension that focuses on establishing a humanistic educational environment – it is not an additional accreditation wicket
- Many names are changing, but they have foundations in the current accreditation system

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In Summary

- The Milestones are not perfect – they will require revision as programs gain experience using them
- The Milestones are not absolute benchmarks that determine if and when a resident/fellow graduates
- The Milestones should lead to better understanding of what is expected of residents/fellows (and when it is expected) and improve the feedback to learners
- This is a good thing!

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Suggested References

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2. TJ Nasca, I Philibert, TP Brigham, TC Flynn. **The Next GME Accreditation System: Rationale and Benefits.** *NEJM. 2012; 366(11):1051-1056.*

3. TJ Nasca, SH Day, ES Amis, for the ACGME Duty Hour Task Force. **Sounding Board: The New Recommendations on Duty Hours from the ACGME Task Force.** *NEJM. 2010; 362(25): e3(1-6).*

4. TJ Nasca, KB Weiss, JP Bagian, and TP Brigham. **The Accreditation System *After* the "Next Accreditation System".** *Academic Medicine. 2014; 89(1):1-3.*