

Accreditation Council for Graduate Medical Education

# Update from the Review Committee for Internal Medicine

*American College of Cardiology, March 2015  
Program Coordinators Session*

James A Arrighi, MD  
Chair, Review Committee- Internal Medicine

Director of Graduate Medical Education  
Rhode Island Hospital  
Program Director, Cardiology  
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# ***The Next (Now?) Accreditation System***

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- Moving towards *outcomes-based* accreditation
- New approach of the RRC
  - Working with programs to improve
  - Focus efforts on “problem programs”
  - Less emphasis on “process”
- Changes the workflow of the process of accreditation
  - Site visits only every 10 years
    - *(or as needed)*
  - Annual ADS data is foundation of system
- Fosters innovation

# Aspects of the “Old” System That Were Suboptimal

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## ACGME

- Emphasized process over outcomes
- Ineffective evaluation process
- Did not generate “data” sufficient for public accountability
- ACGME seen as an adversary

## ACC

- Lack of continuity in educational efforts from fellowship to practice

## Overall

- Little coordination among accreditation, certification, and medical specialty societies
- Lack of engagement of institutional leadership
- Rigid system stifled innovation

# Process, Process, Process

## ACGME Program Requirements for Graduate Medical Education in Cardiovascular Disease (Internal Medicine)

Common Program Requirements are in BOLD

In IV. Educational Program

In IV.A. The curriculum must contain the following educational components:

		39 Cardiology Programs Reviewed (Not Counting Progress Reports) Total of 105 Citations = 2.7 citations/program		
		Name and Description of Citations	times cited	% of total
IV.A.1.	<b>Overall education make available to</b>			
IV.A.2.	<b>Competency-based each educational and faculty at least</b>	<b>1. Evaluation of Fellows</b> - semiannual evaluation not documented; faculty do not routinely provide verbal feedback at the end of rotation; fellow's performance in continuity clinic not documented; appropriate evaluation methods not used to evaluate the fellow's achievement of the competencies; inadequate procedure logs; no summative evaluation	22	21%
IV.A.3.	<b>Regularly scheduled</b>	<b>2. Didactic Components</b> - no regularly-scheduled or -attended research conference; five hours of teaching rounds per week does not occur; review of pathological material does not occur; instruction for basic sciences not provided; insufficient continuity clinic	12	11%
IV.A.3.a)	The core of the core knowledge	<b>3. Procedural Experience</b> - program doesn't provide all fellows with clinical experience in required procedures; logbook or equivalent method not maintained	10	10%
		<b>4. Goals and Objectives</b> – goals and objectives not competency based; goals and objectives are not level specific; all rotations and/or assignments don't have goals and objectives	9	9%
		<b>5. Evaluation of the Program</b> - program evaluation did not address all required elements; does not monitor and track program quality; no written improvement plan	9	9%

# Evaluation System

<p><b>2. Patient Care</b>            Fails to review history and prior studies. Unable to synthesize data from different sources. Poor clinical judgement. Fails to analyze clinical data. Ignores evidence and patient preference when making decisions. Poor procedural skills.</p>	<p>1 2 3 4 5 6 7 8 9  <input type="checkbox"/> Insufficient contact to judge  <input type="checkbox"/> Needs attention-            Specify _____            _____            _____            _____</p>	<p>Always gathers accurate and appropriate information from interviews, examinations, and other data sources. Always analyzes available information to make diagnostic and therapeutic decisions based upon sound clinical judgement, best available evidence, and patient preferences. Stellar procedural skills.</p>
<p><b>3. Practice-Based Learning</b>            Lacks insight into strengths and weaknesses. Resists or ignores feedback. Lacks intellectual curiosity. Fails to use resources and information technology to improve knowledge base and enhance patient care.</p>	<p>1 2 3 4 5 6 7 8 9  <input type="checkbox"/> Insufficient contact to judge  <input type="checkbox"/> Needs attention-            Specify _____            _____            _____            _____</p>	<p>Constantly evaluates own performance. Incorporates feedback into improved practice. Identifies, rectifies, and learns from errors. Efficiently uses technology to access information and enhance patient care. Maintains exemplary procedure log.</p>

What is a “patient care 7” in the echo lab?

What is a “practice-based learning 6”.... Anywhere?!

# Public Accountability



THURSDAY SEP 2, 2010 11:21 AM

## Coalition Calls on OSHA to Regulate Medical Residents' Work Hours

BY LINDSAY BEYERSTEIN

### Lack of sleep causes medical errors to skyrocket

Sleep deprivation is a silent public health threat, especially for medical residents. Pulling an all-nighter reduces your judgement and reflexes to the level of someone who is legally drunk.

Forty years of psychological research proves that sleep deprivation saps our mental faculties, including our ability to notice that we're impaired. It may come to feel normal, but the effects don't go away. That's bad enough for the average person trying to juggle work, family, and a social life. But consider the implications for medical residents who are responsible for patients' lives.

The Institute of Medicine, a branch of the National Academies of Science, undertook a year-long study at the behest of Congress to assess the impact of sleep deprivation on medical trainees. The 2008 report recommended that shifts be capped at 16 hours for the safety of residents and their patients.



*(Photo courtesy Health24.com)*

“Sleep deprivation is a silent public health threat....”





Nov. 3, 2011

## OSHA Should Use Its Existing Authority to Enforce Work Hours for Doctors-in-Training, Public Citizen Tells Agency

### Agency Must Inspect Hospitals to Protect Physicians and Patients

WASHINGTON, D.C. – Although it has now rejected two requests to regulate the number of hours that medical residents work, the Occupational Safety and Health Administration (OSHA) should use its existing authority to limit resident hours, thereby better protecting patients and doctors, Public Citizen told the agency today.

OSHA is tasked with enforcing safety and health legislation. Under a "general duty clause" of the law that created the agency, employers are required to provide a workplace that is free from hazards that are likely to harm to employees. This language gives OSHA the authority to limit the number of hours that medical residents work to prevent physician fatigue and medical errors, Public Citizen said in a letter to the agency.

Public Citizen and other groups have petitioned OSHA twice to create a standard to regulate medical resident hours – in 2001 and 2010 – but recently learned that the Obama administration rejected last year's petition. Now, Public Citizen is calling on OSHA not only to enforce existing work-hour limits through the agency's general duty clause but also to protect medical residents who blow the whistle on work-hour abuses.

"It's regrettable that the Obama administration has decided to follow the lead of the Bush administration, refusing to enact a standard that would protect 110,000 resident physicians," said Dr. Sammy Almathat, researcher with Public Citizen's Health Research Group and co-author of the letter. "In the absence of a standard, which it has now twice refused to enact, OSHA must exercise its existing authority under the general duty clause to hold accountable teaching hospitals that violate the health and safety of their residents."

In justifying its denial of the petition, the Obama administration reproduced the same discredited arguments that the Bush administration used nine years ago in rejecting the first petition, Public Citizen observed. In his Sept. 14 denial letter, OSHA chief David Michaels admitted that fatigue due to extended work hours can harm the health of employees in a wide range of fields, including medical interns and residents. But because medical residents also are considered students,

## OUR EXPERTS

Learn more about our policy experts.

**Media C:** "OSHA should use its existing authority to limit resident hours, thereby protecting patients and doctors..."

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**Other Im**  
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Citizen Vo  
Texas Vox  
Consumer  
Energy Vo  
Eyes on Tr  
Facebook/

"It is regrettable that the Obama administration has decided to follow the lead of the Bush administration, refusing to enact a standard that would protect 110,000 resident physicians."

• Child L...  
Washington's Food Fight <http://t.co/6bHppliV>  
via @HuffPostPol @meeshellchen about an  
hour ago

# Influences in GME Over the Past Decade

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- Competency evaluation stalls at individual programmatic definitions
- MedPac, IOM, and others question
  - the process of accreditation
  - preparation of graduates for the “future” health care delivery system
- House of Representatives codifies “New Physician Competencies”
- MedPac recommends modulation of IME payments based on competency outcomes
- Macy issues two reports (2011)
- IOM 2012-2013

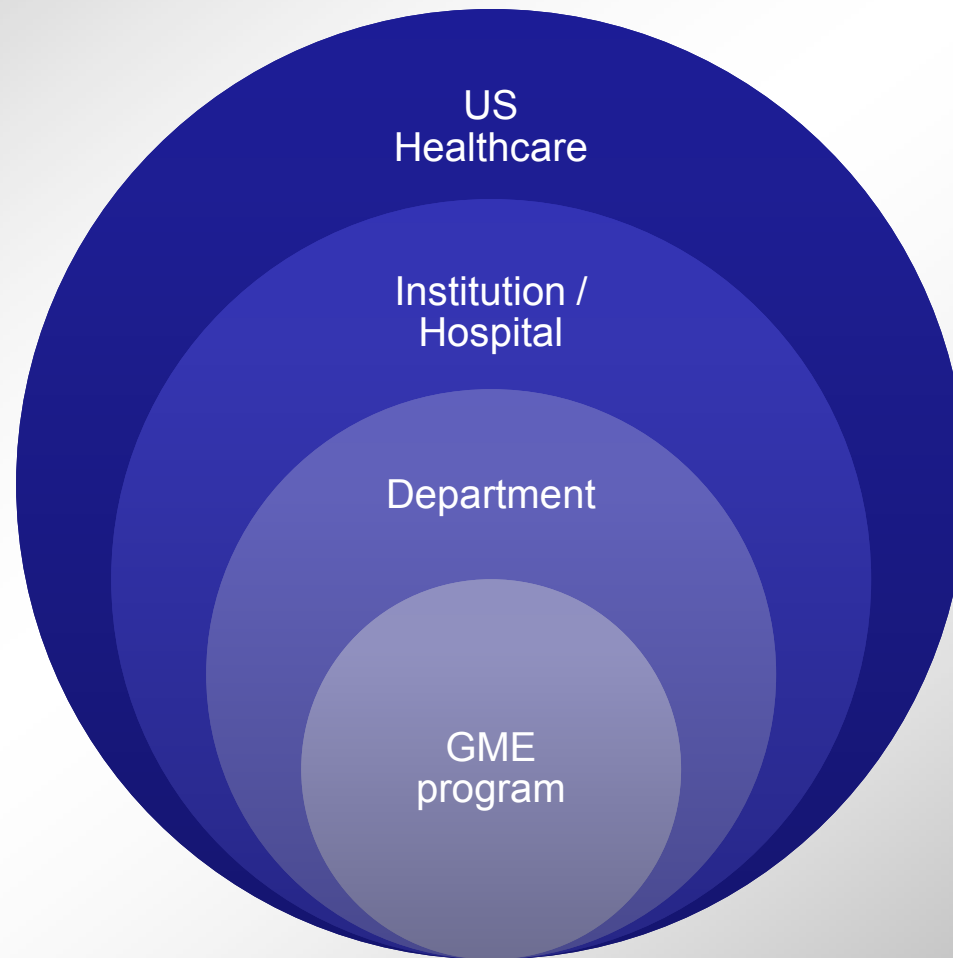


ACGME



# Recognition That GME Programs Exist Within a Complex Healthcare System

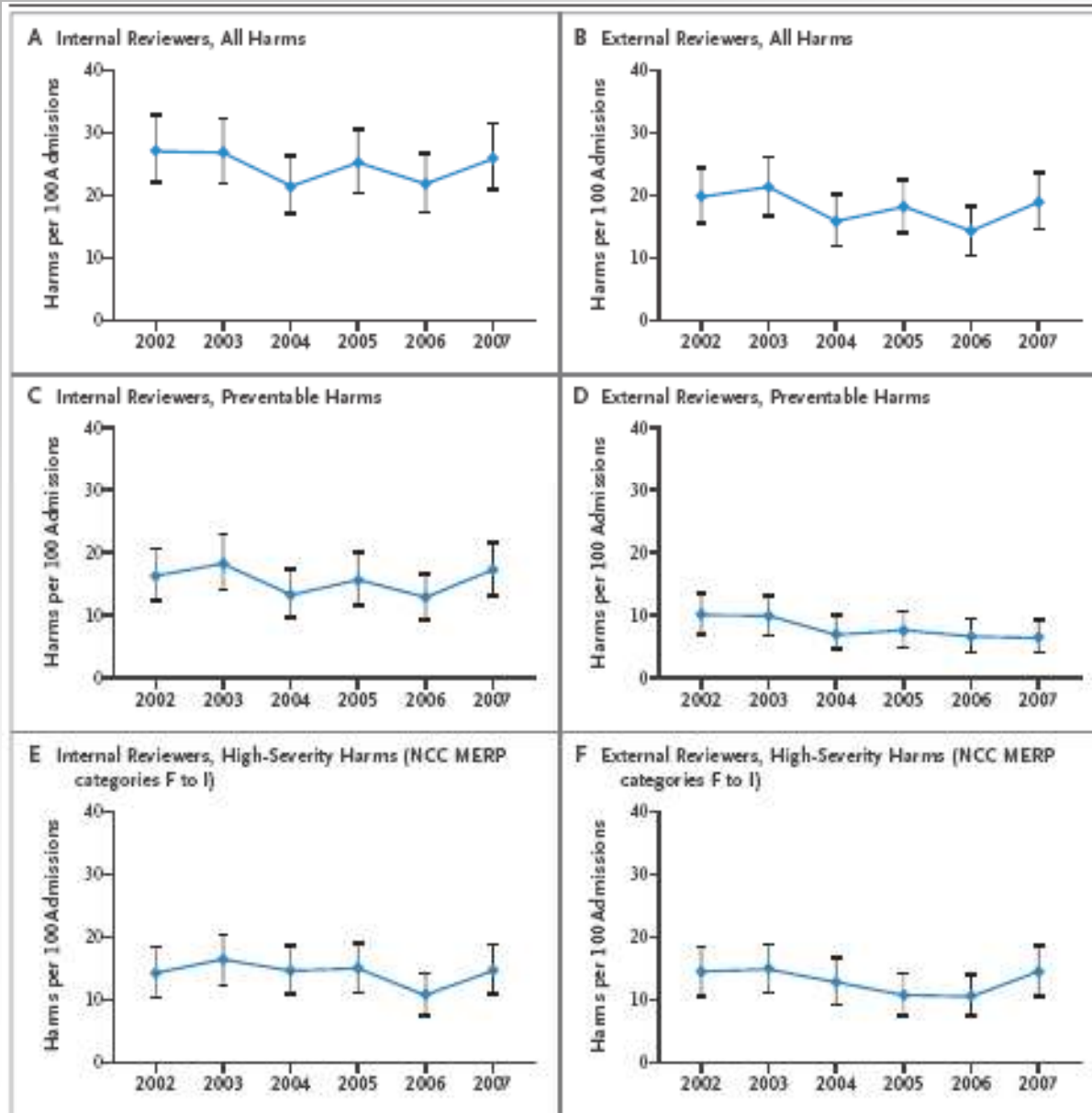
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## The North Carolina Experience

### Temporal Trends in Rates of Patient Harm Resulting from Medical Care, 2002-2007

Landrigan, C.P., et.al. NEJM 2010; 363:2124-34



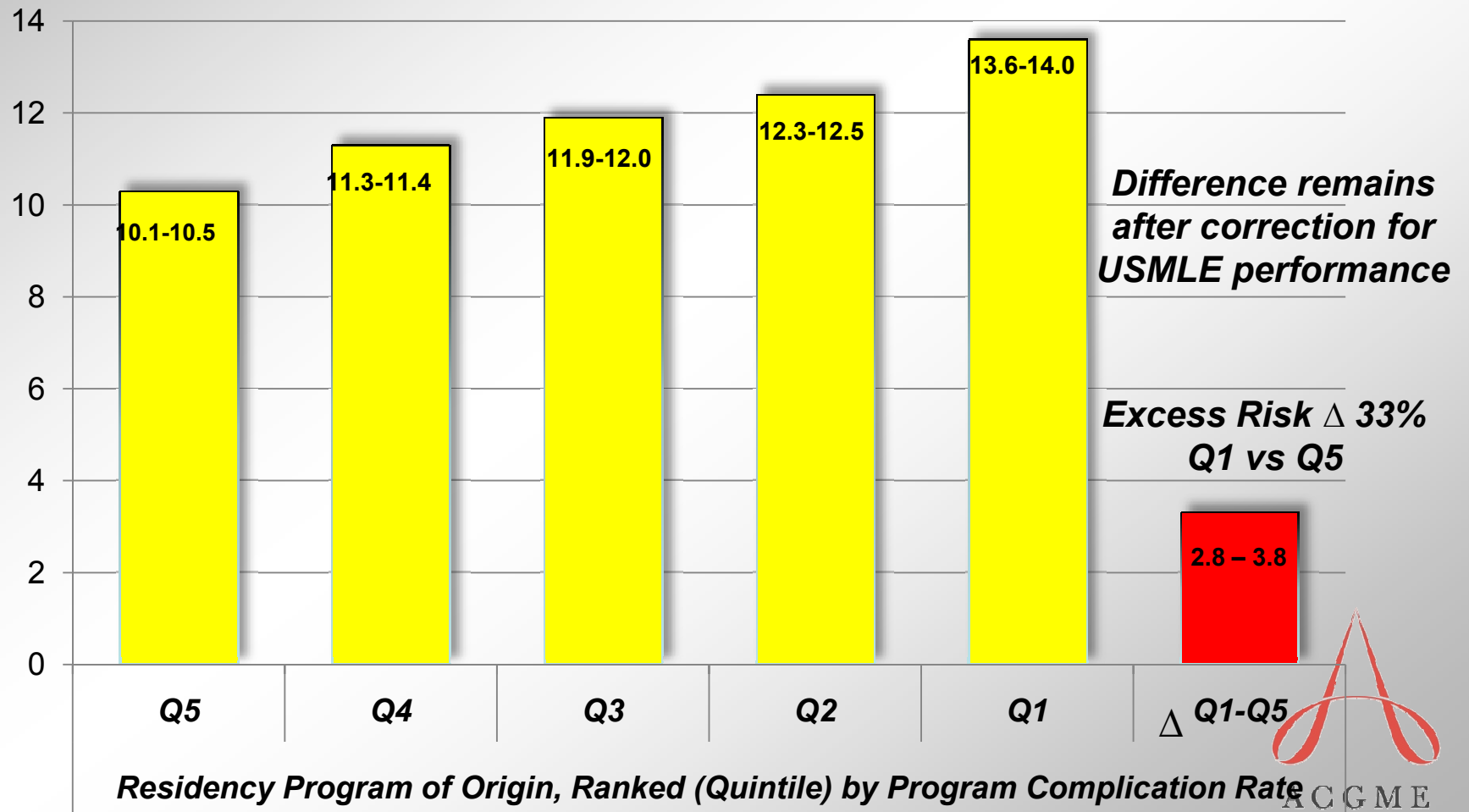
- No significant change in:
  - All Harms
  - Preventable Harms
  - High-Severity Harms
- ...whether evaluated by external or internal reviewers



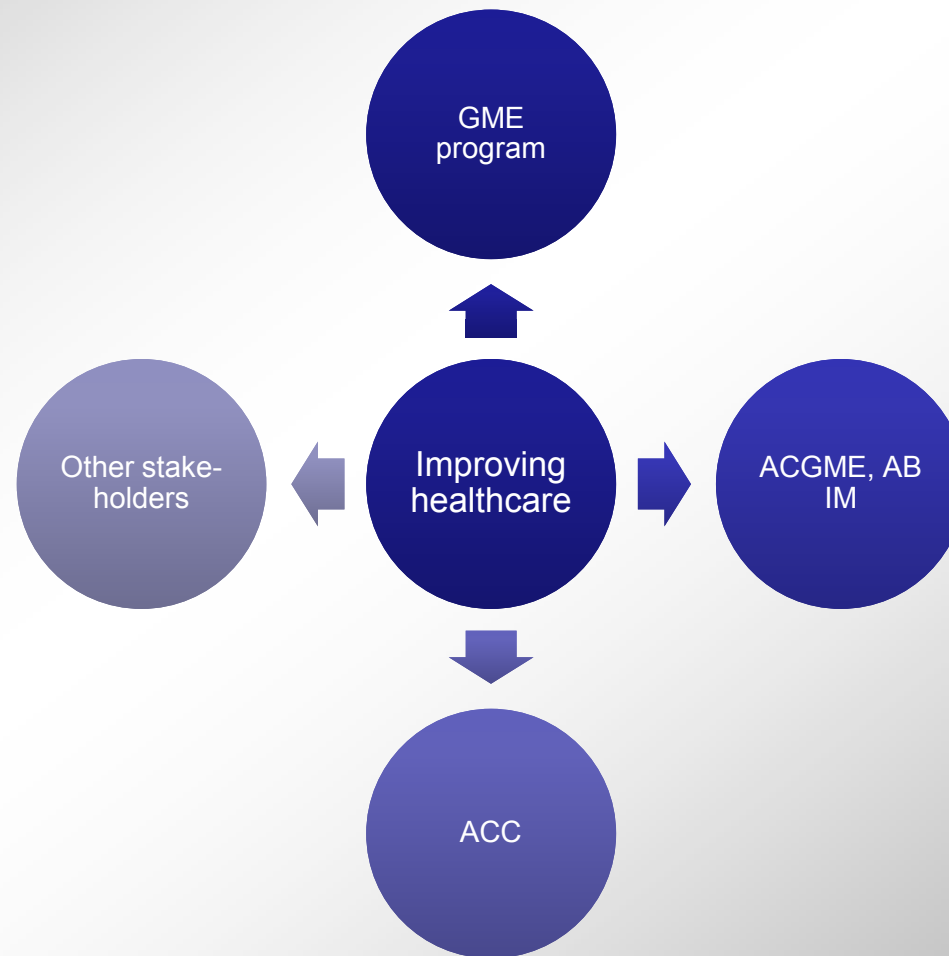
# Evaluating Residency Programs Using Patient Outcomes

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

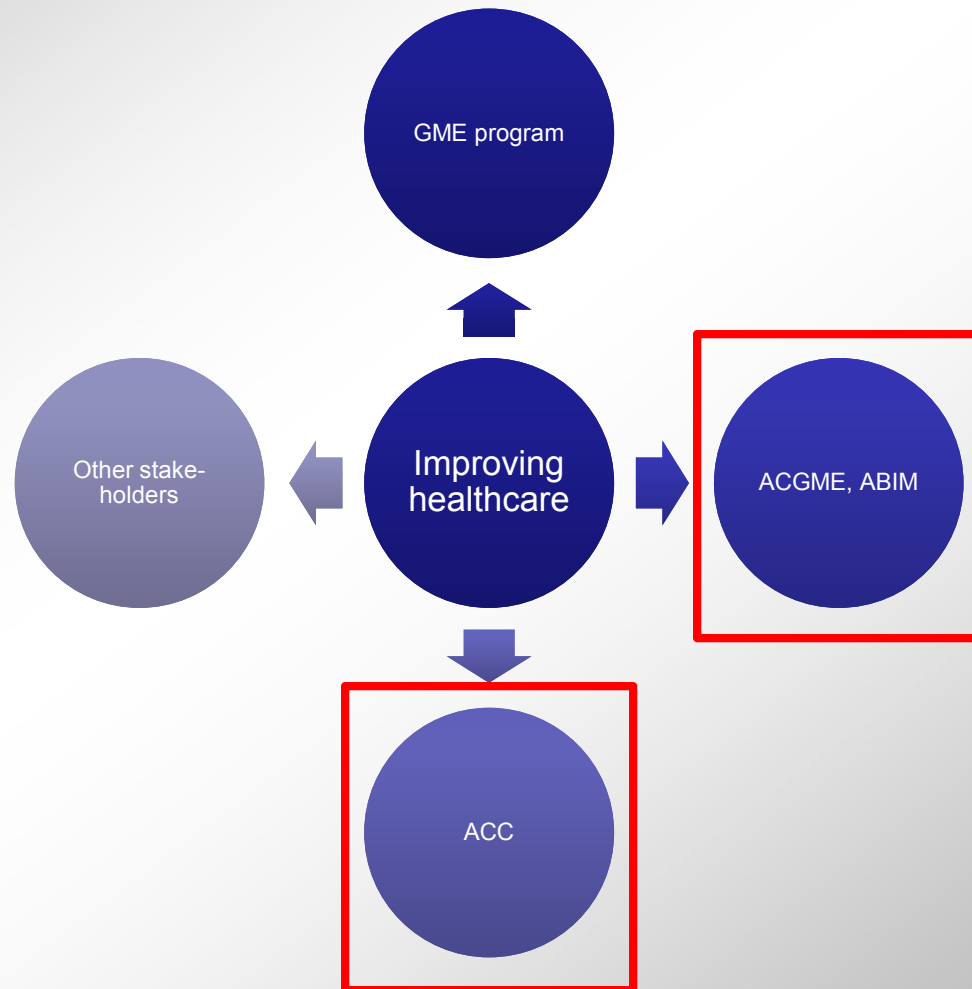
## Rate of Major Obstetric Complications by Graduates (%)



# Shared Goals: A Fundamental Aspect of the “New” GME



# Shared Goals: A Fundamental Aspect of the “New” GME





# *Goals for a “New Accreditation System”*

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Foundation for changes to accreditation began in 2005, with stated **goals**:

- 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

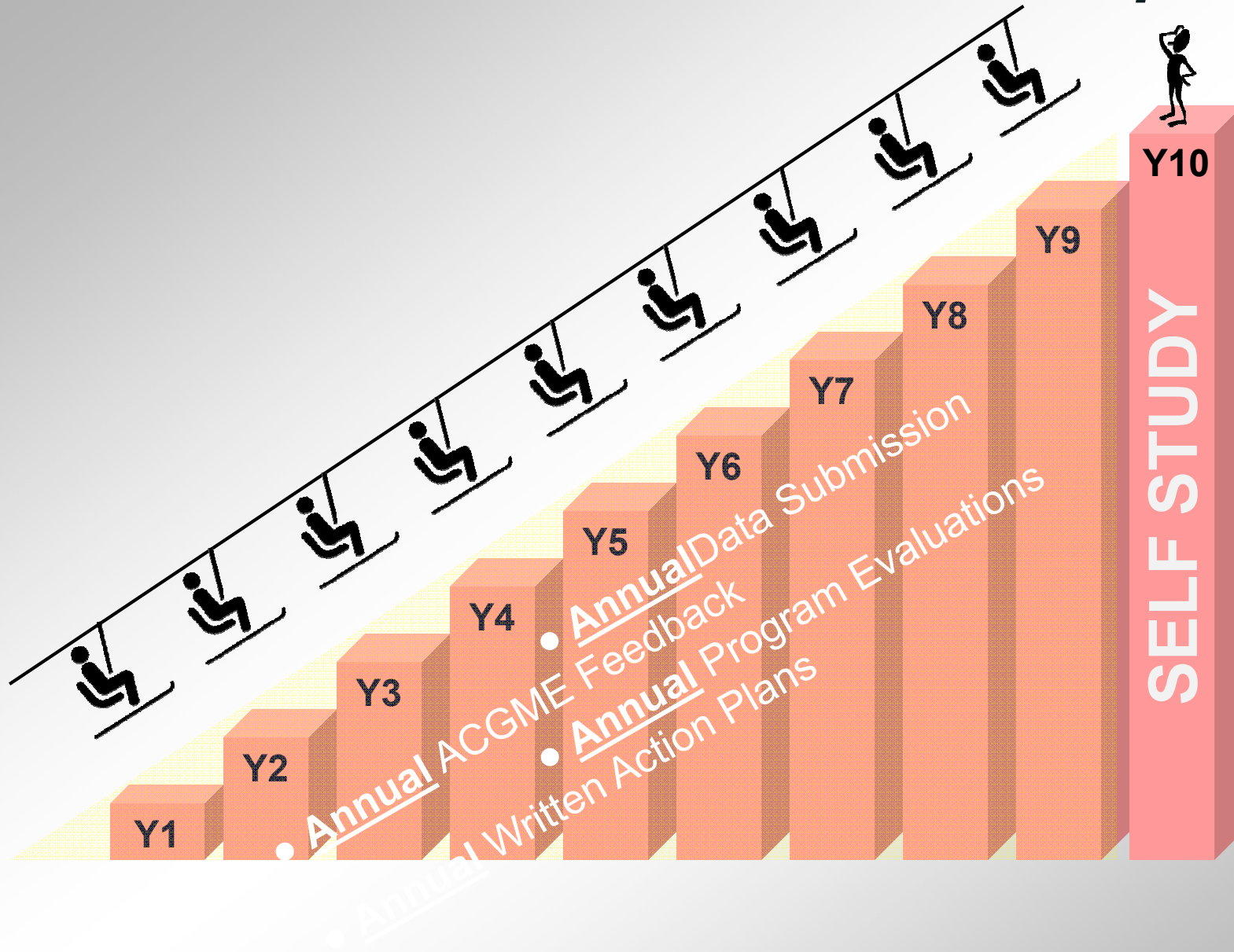
# Flight Plan For Today

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- The “rhythm” of accreditation:  
data flow and analysis
- Citations and site visits
- Encouraging innovation
- Evaluation processes
- 10-year self studies and visits

# NAS: Rhythm of annual data flow and analysis

# Continuous Improvement



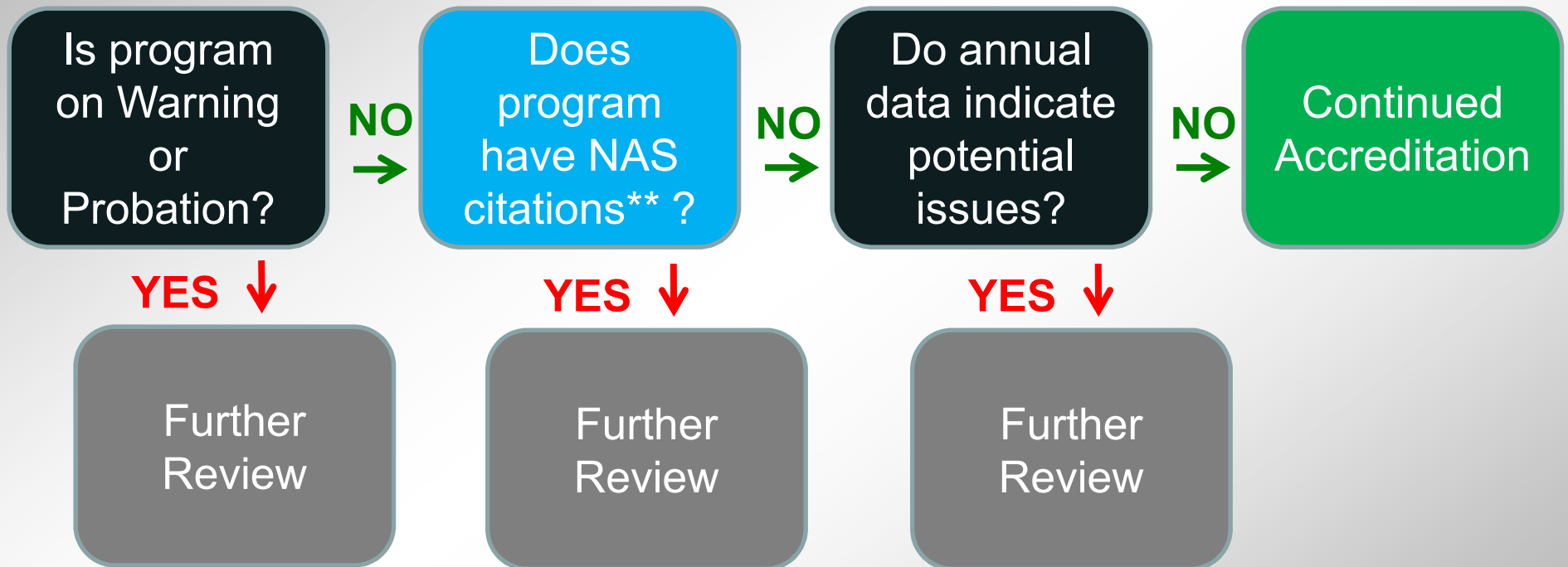
# *Role of Review Committees in NAS*

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- “Reviews” programs annually
- Makes accreditation decisions by end of academic year
- Utilizes data from previous AY to make decisions
- Use data and judgment to:
  - concentrate efforts on problem/troubled programs
  - determine whether accreditation standards are violated and provide useful feedback for programmatic improvement
  - determine whether violations rise to a level requiring alteration in accreditation status
  - over time, understand and refine the nuances of the process



# NAS: Program\* Review



\* = *applies to established programs (not on Initial Accreditation)*

\*\* = *citations given after July 1, 2013*

# *Primary Data Elements (Assessed Annually)*

Resident Survey

ABIM Pass Rate

Milestones

Clinical Experience Data

Scholarly Activity

Faculty Survey

Attrition

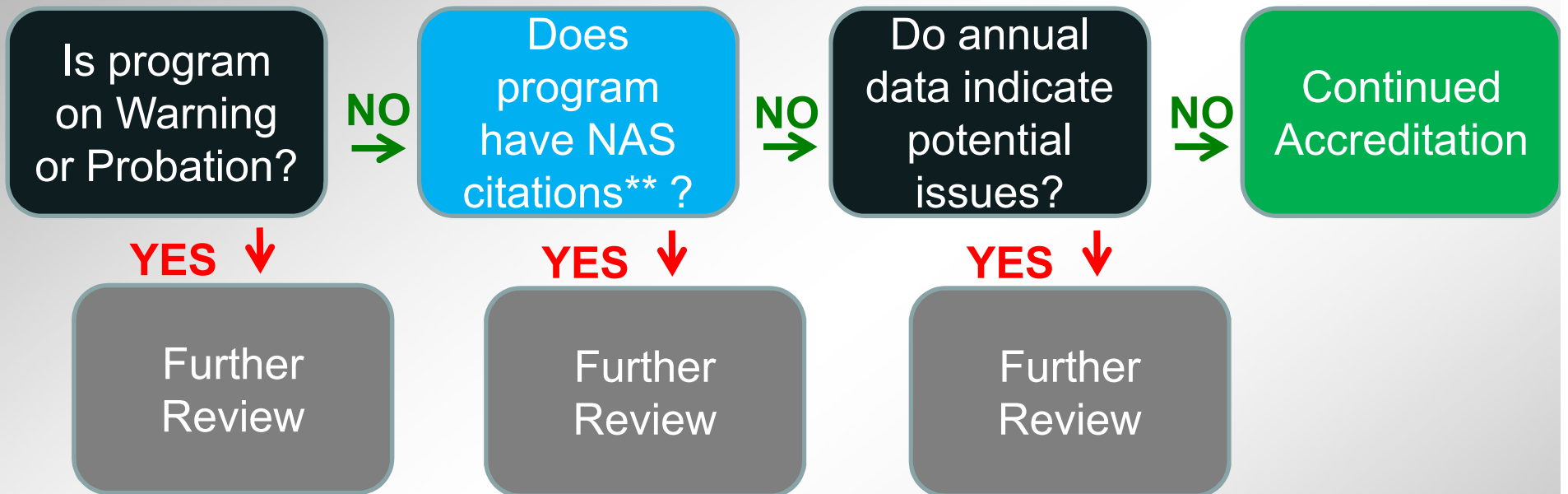
# Where did “data elements” come from?



- In 2009, data modeling project began to identify factors that predicted high and low program performance
- Model was replicated, results were reproducible
- Selection of elements needed to be
  - *Obtainable*
  - *Meaningful*
  - *Correlates w/ prior decisions*
  - *Passed statistical “muster”*
  - *Used in combination*
- Understand that this is a work-in-progress
- New data elements likely in future



# What is “Further Review”?

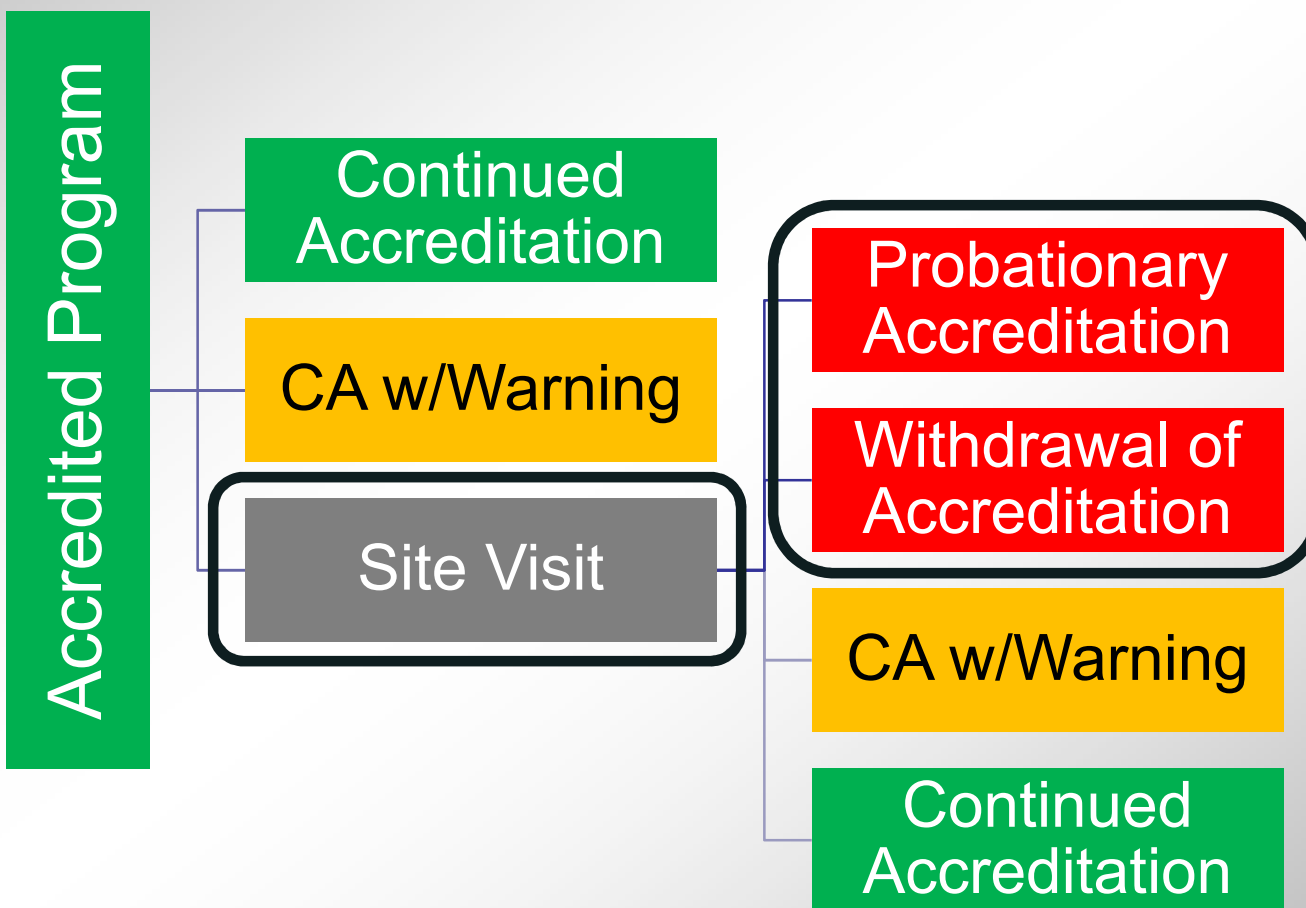


- Staff and/or RC Member review data in fall
- If recommendation can be made, proceeds to winter RC meeting
- If recommendation unclear, then may request clarifying info or site visit

\* = *applies to established programs (not on Initial Accreditation)*

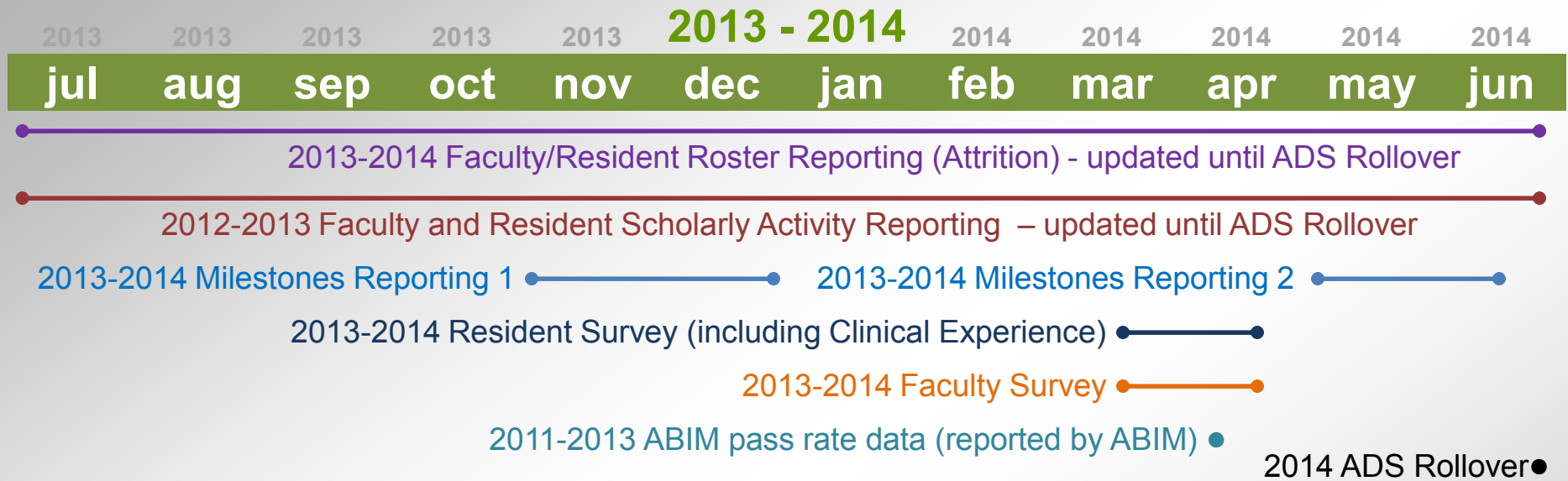
\*\* = *citations given after July 1, 2013*

# Accreditation Status Schema

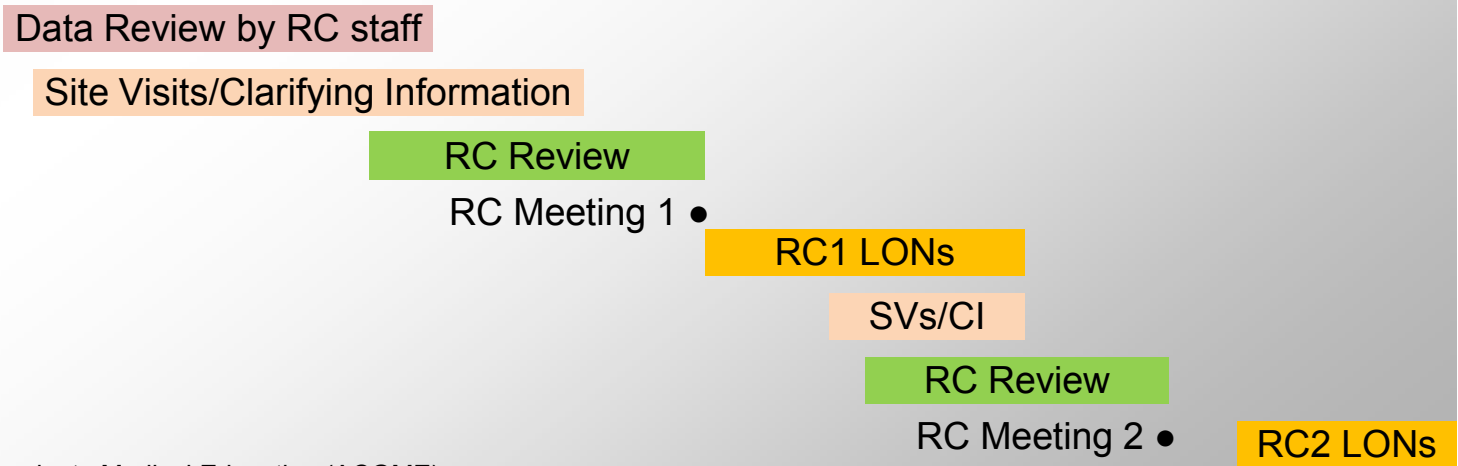




# NAS: *Data Reported* vs. *Data Reviewed*

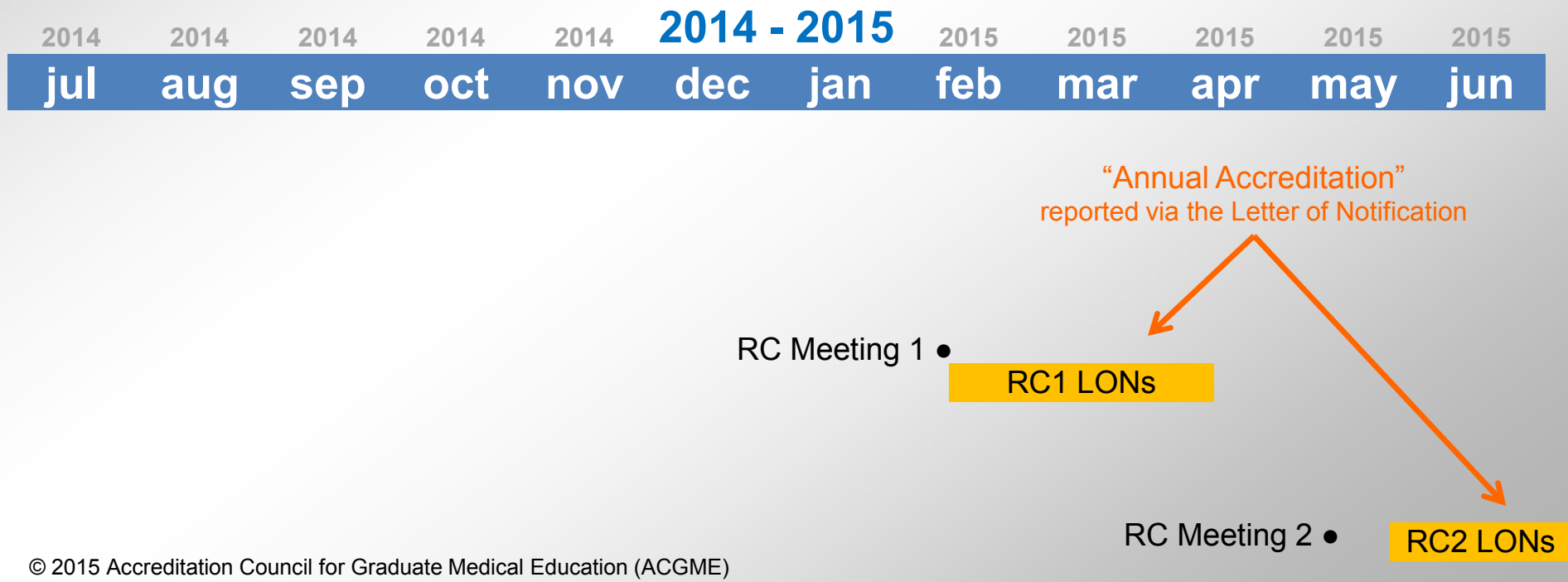


- Data Analysis**
- 2014 Annual Update
  - Responses to Citations ■
  - Major Changes ■
  - Sites/Block Diagram ■
  - “Common” Questions ■
  - Evaluations □
  - Duty Hours □
  - Patient Safety □
  - Learning Environment □



# NAS: Communication of Status Decision

- Core programs will receive results of RC's annual review after either the RC's 1<sup>st</sup> or 2<sup>nd</sup> meeting
  - This year, either after the **Feb** or the **May** meeting
  - **Vast majority** will receive status decision after 1<sup>st</sup> meeting



# ADS: Annual Update

- Update can begin after the ADS rollover (late June), but cannot be submitted until the window is open
- email will be sent with window open/close dates
  - Core IM Residency: August –September
  - **Subspecialty programs: September – October**
- Required Information:
  - Duty Hour/Learning Environment/Evaluation Responses
  - Major Changes
  - Responses to Citations
  - Resident/Faculty Rosters
  - Resident/Faculty Scholarship (for **previous** year)
  - Sites (and Block Diagram)
- Scholarship data entry is for for *last year's* productivity. (See FAQ for more detail)
- **“Omission of Data” is a data point.**

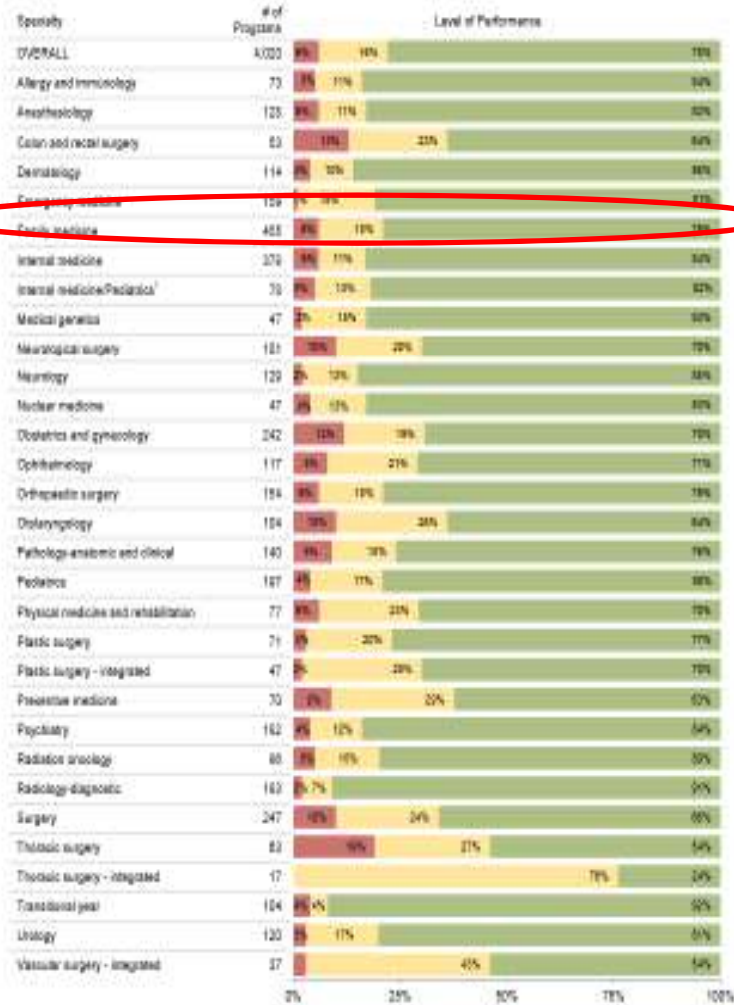


# Take Home Points (ADS)

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- Take ADS data entry very seriously
- While info is “due” in fall (to lock in faculty and fellow rosters), you may enter data anytime
  - Recommendation: Update also in May/June
- Respond to citations, indicate program improvements, etc (anything you might want RRC to see)
- Faculty roster: base on minimum requirement, scholarship, and survey

# What did we expect?



**84% of core internal medicine residency programs had a review cycle between 3-5 years \***

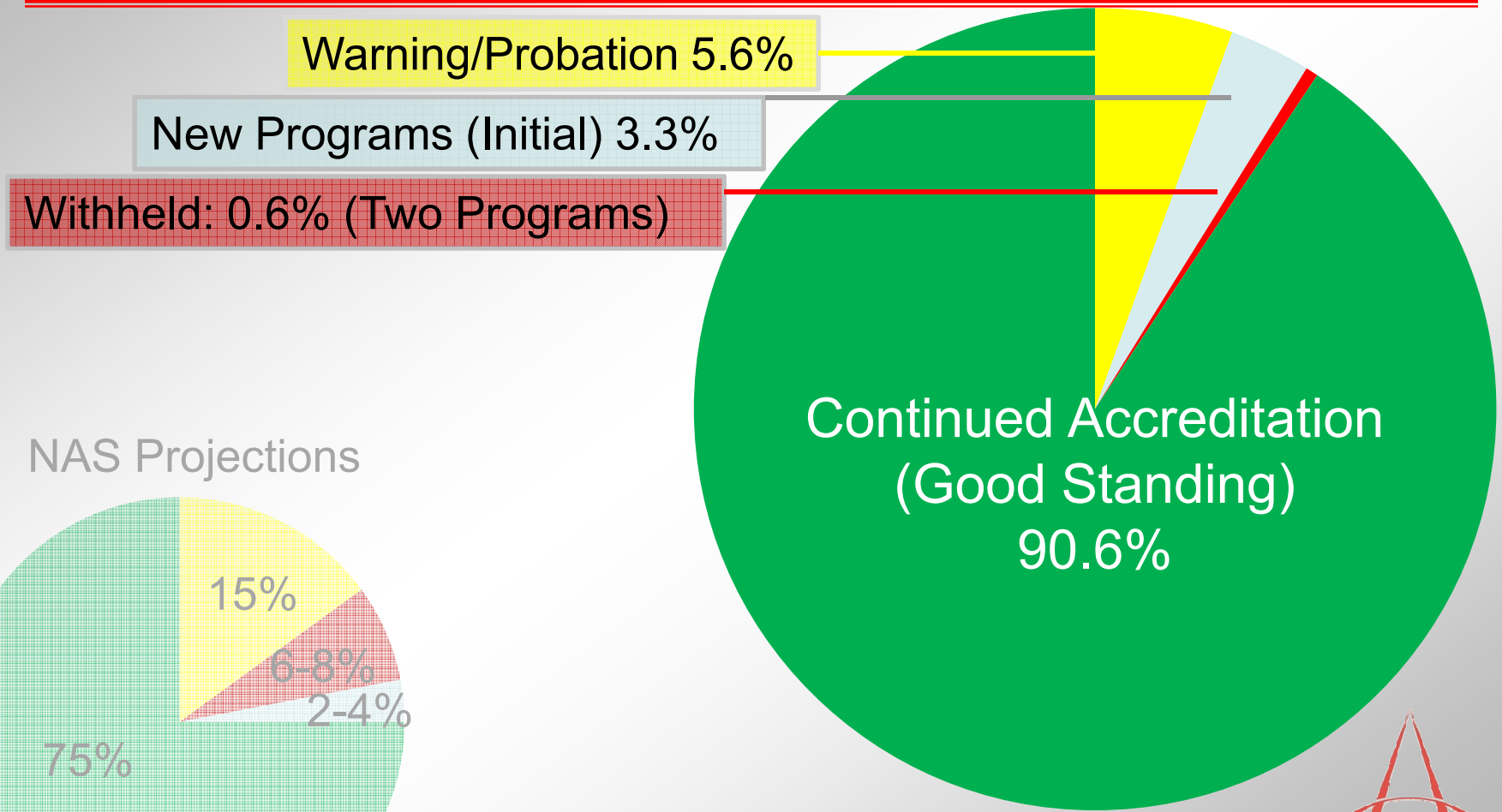
\* ACGME Data Resource Book 2012-2013, based on 378 core programs. Book available on [www.acgme.org](http://www.acgme.org).



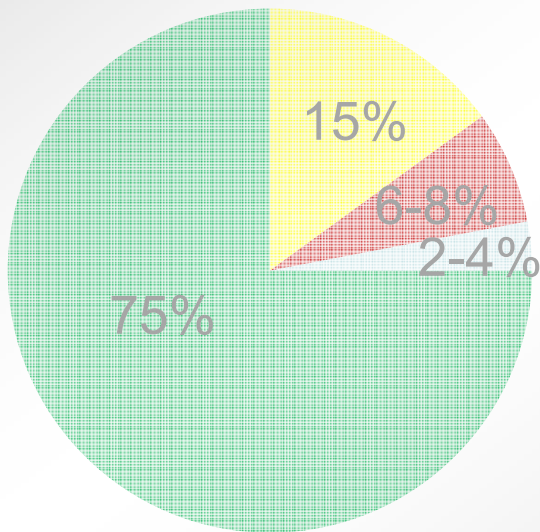
ACGME



# NAS Year 1: Expected vs Actual Outcomes CORE Programs



NAS Projections



**(396 Core Internal Medicine Programs)**



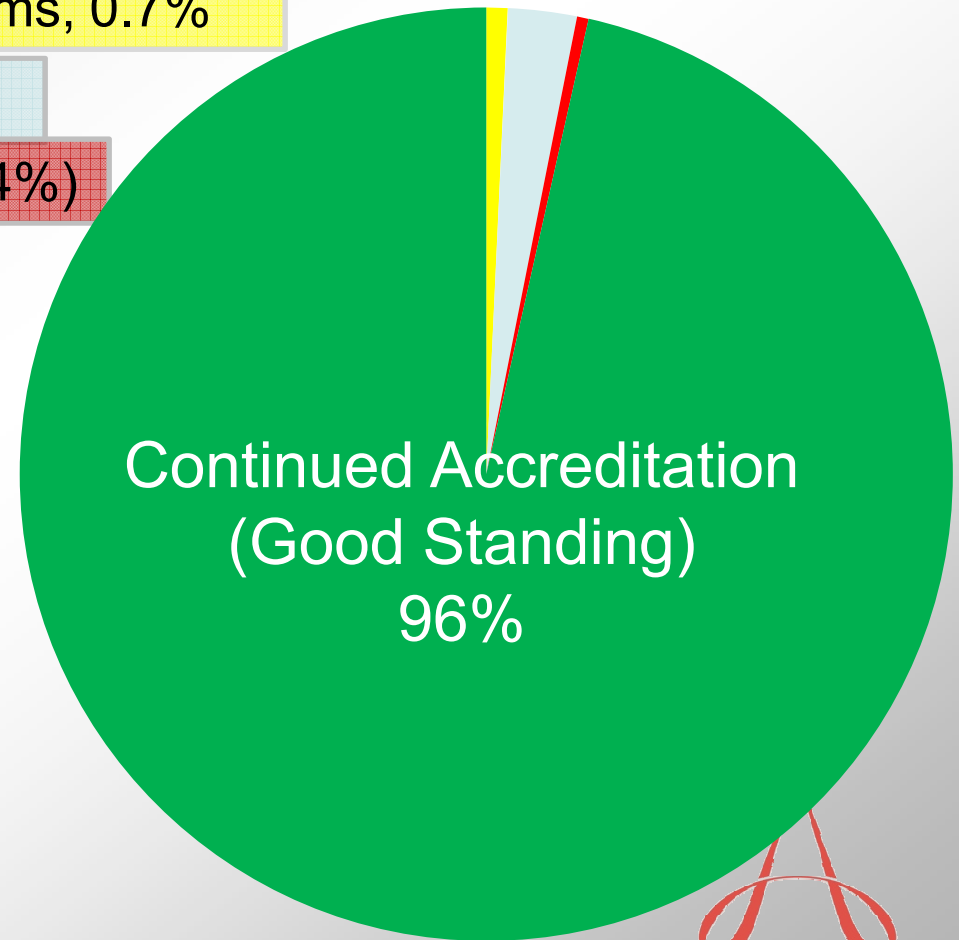
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# NAS Year 1: Expected vs Actual Outcomes SUBSPECIALTY Programs

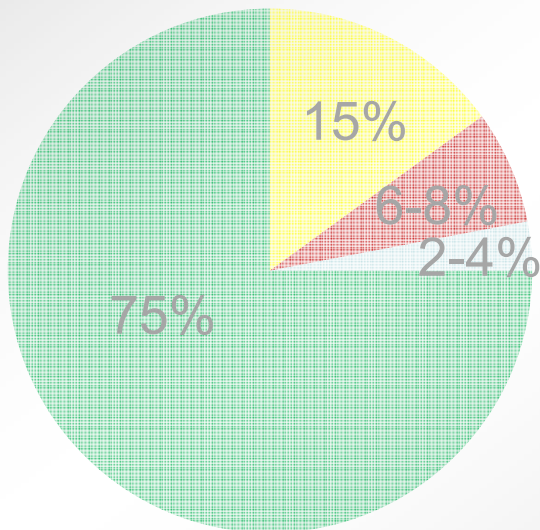
Warning/Probation - 13 programs, 0.7%

New Programs - 42 programs, 2.4%

Withheld/Withdrawn – 7 programs, 0.4%



NAS Projections



1701 Internal Medicine Subspecialty Programs) ACGME

# NAS: Citations and Site Visits

# ***NAS “As Needed” Site Visits***

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## **Full**

- Application for a new core program
- At the end of the initial accreditation period
- RC identifies broad issues/concerns
- Serious conditions or situations identified by the RC

## **Focused**

- Potential problems identified during annual review
- To diagnose reason for deterioration in performance
- To evaluate complaint

## **Both**

- One month notification
- Minimal document preparation expected
- Team of site visitors

# Citations and AFI's

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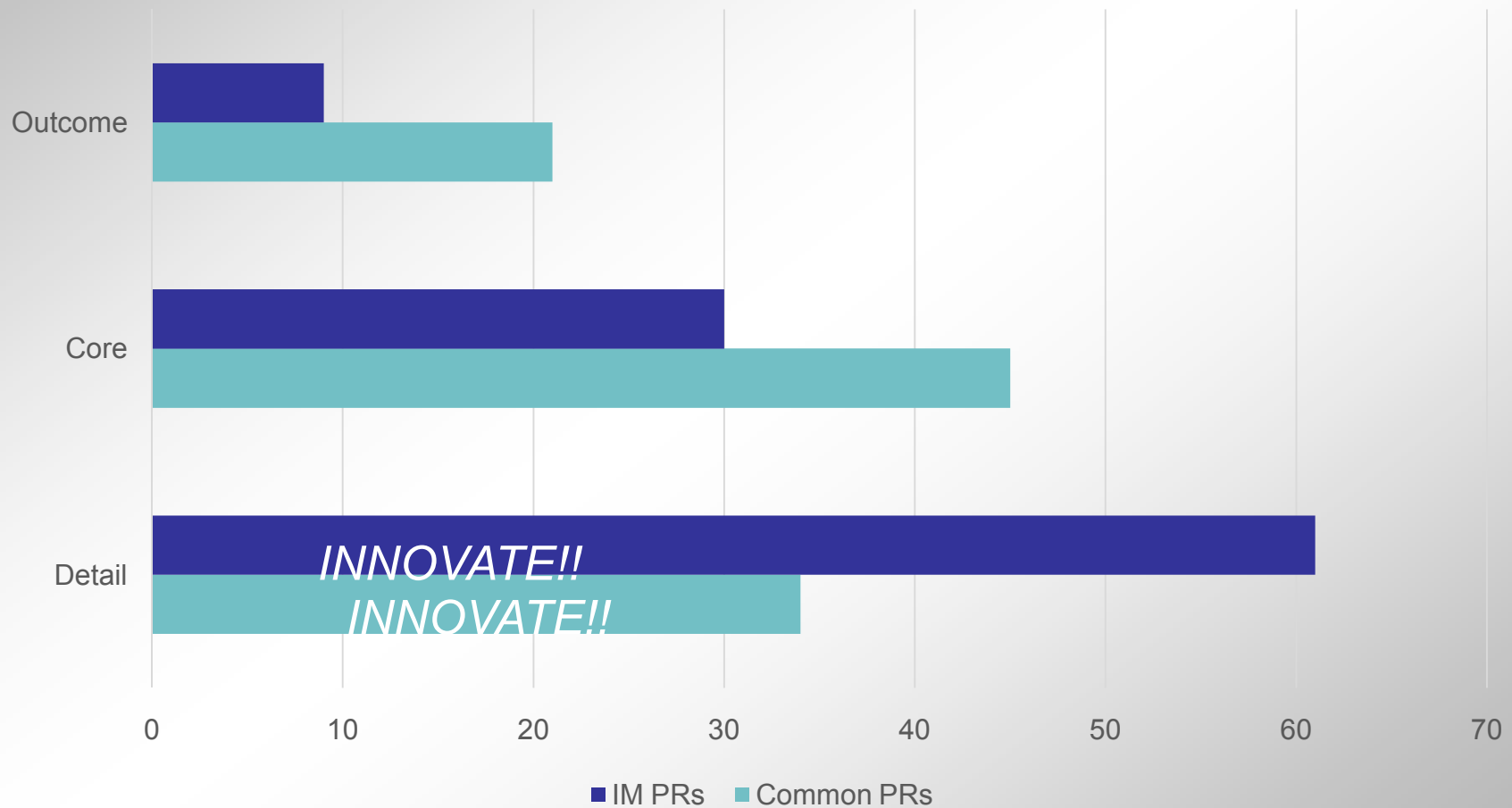
- Citations
  - Areas of noncompliance
  - Require response in ADS
  - Given and resolved by RC member review
- AFI
  - Concerns, worrisome trends
  - Expectation to be addressed locally
  - Does not require response in ADS
  - Given and resolved by RC member or staff

# NAS: Encourages Innovation



# NAS: Innovation + Accreditation

**IM PRs vs. Common PRs (% Outcome, % Core, % Detail)**



# NAS: Innovation & Detail PRs

- Some see that NAS allows for experimentation....
  - *e.g., Continuity experience*
- If programs can demonstrate compliance with **Core** and **Outcome** PRs, they will not be asked to demonstrate compliance with *Detail* PRs.
  - Program must:
    - be in *good standing* **CA (without warning)**
    - not have issues with the PR(s) to be innovated around
    - have an educational rationale (*noncompliance ≠ innovation*)
- No waiver requests necessary



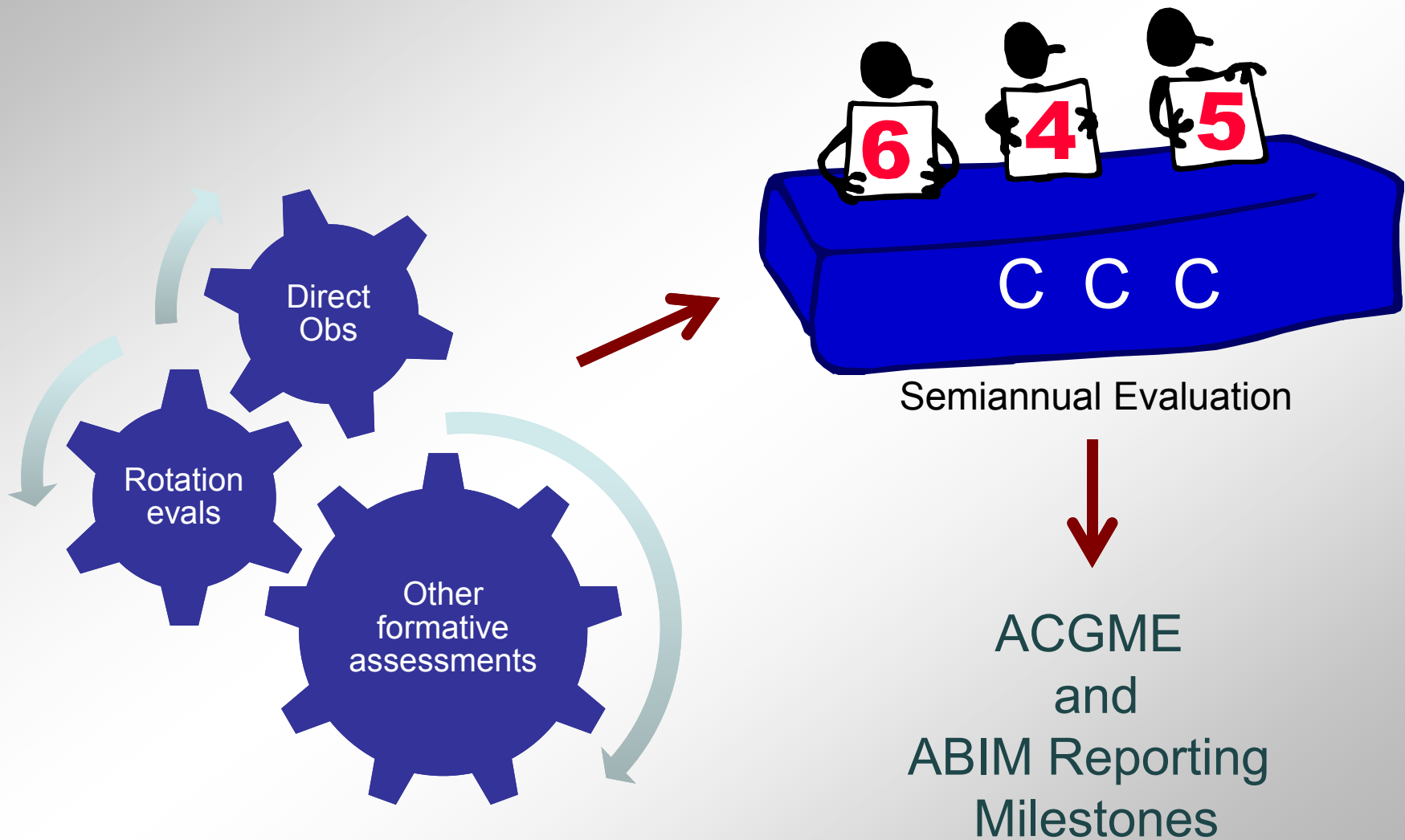
# Examples of Program Requirements

## “Detail”

- 50% key clinical faculty w/ scholarship
  - (> 50% fellows = Core PR)
- Conference structure, format
- Most PR's on # of procedures
- Some specific curricular details
  - e.g. basic sci topics, stats, simulation...
- Clinic structure & frequency
  - Incl. 6 mos blocks, # patients, interruption rules

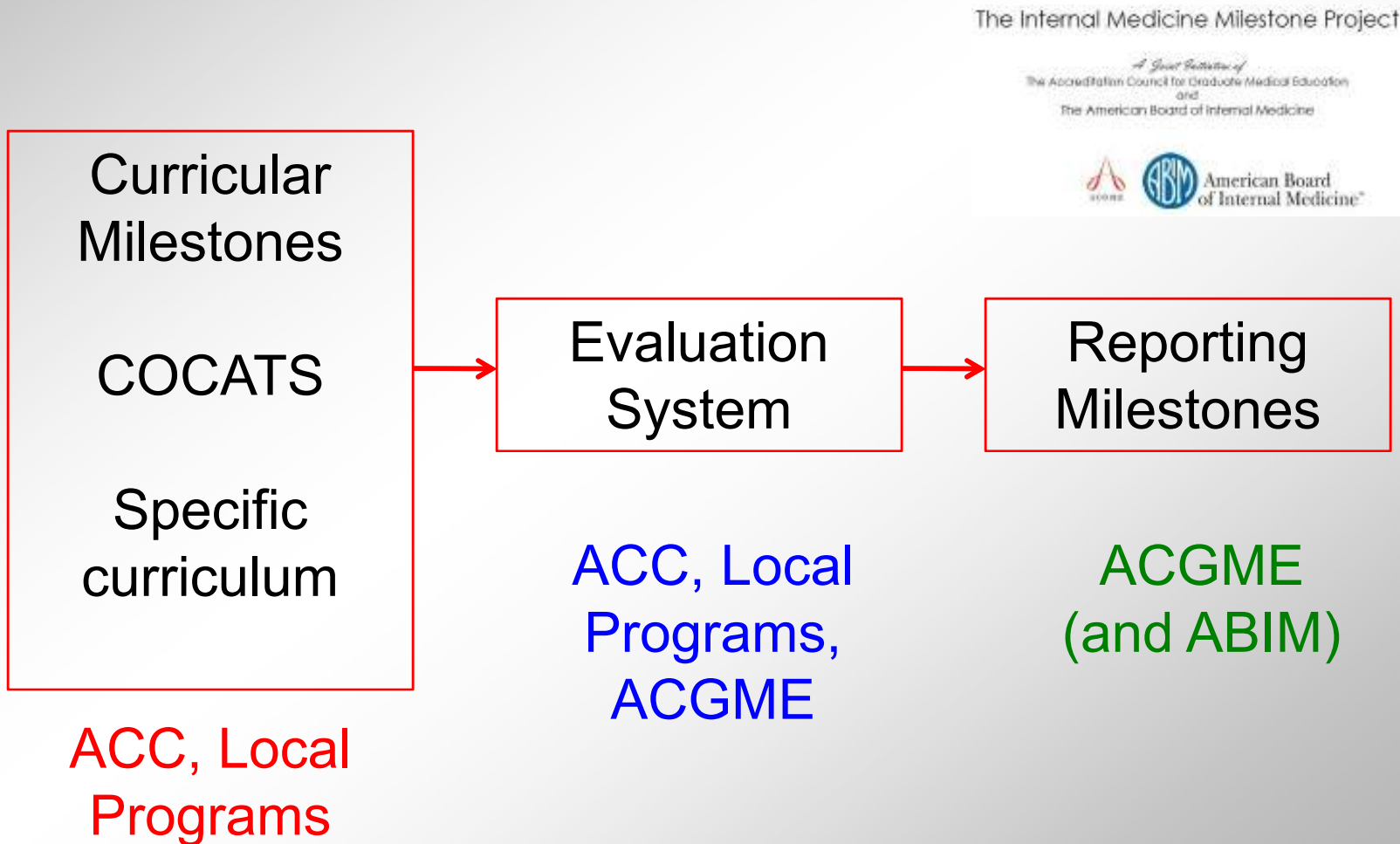
# NAS: Encouraging Better Processes of Evaluation

# Assessment → Evaluation → Reporting



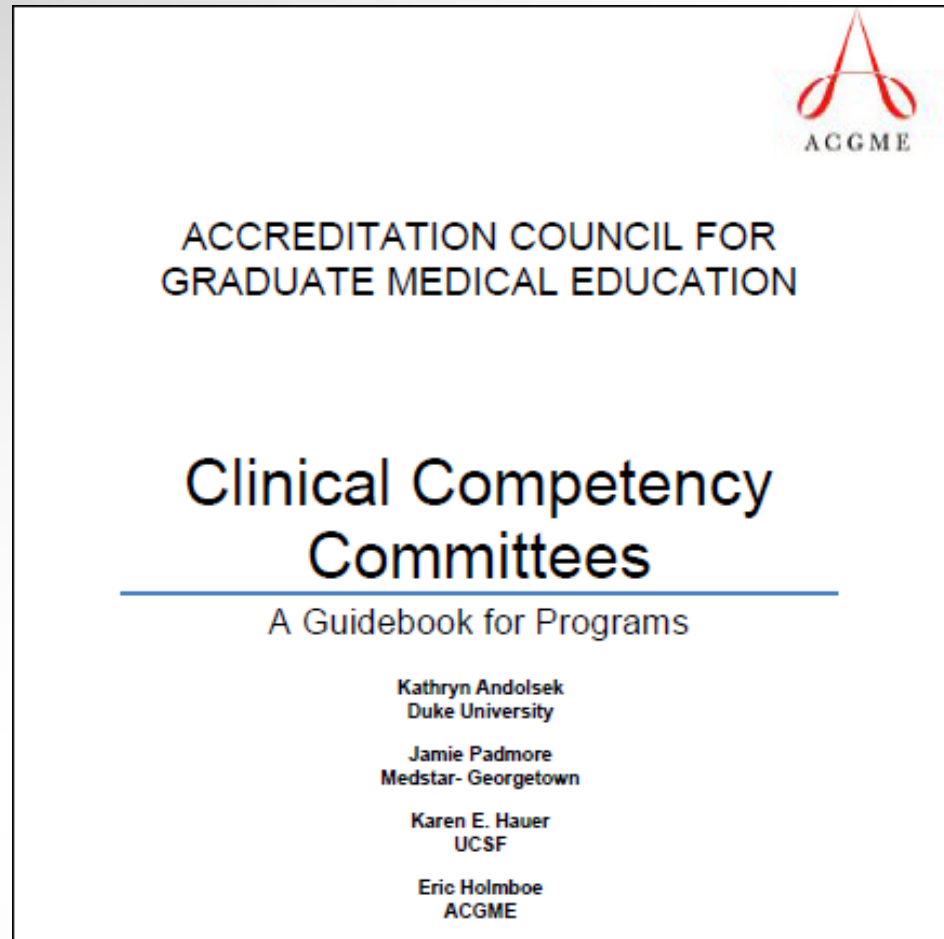
Assessment Machinery

# What specific elements of the system are ACGME?



# Milestones: CCC

## **NEW: CCC Guidebook**



# *Milestones v1.0: A Work-in-Progress*

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- Not yet used for accreditation decisions unless for reasons of “non-reporting”
- Ongoing analysis of trends, redundancies, language within and across specialties
- Obtain feedback, learn what works
- Potential to consolidate across specialties
  - Especially for the “common” competencies SBP, PBLI, IC, P
  - Subspecialties?



# IM Subspecialty Milestones

## Example

### 1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1)

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	<p>Does not or is inconsistently able to collect accurate historical data</p> <p>Does not perform or use an appropriately thorough physical exam, or misses key physical exam findings</p> <p>Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data</p> <p>Fails to recognize patient's central clinical problems</p> <p>Fails to recognize potentially life threatening problems</p>	<p>Consistently acquires accurate and relevant histories</p> <p>Consistently performs accurate and appropriately thorough physical exams</p> <p>Inconsistently recognizes patient's central clinical problem or develops limited differential diagnoses</p>	<p>Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion</p> <p>Performs accurate physical exams that are targeted to the patient's problems</p> <p>Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list</p>	<p>Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis</p> <p>Identifies subtle or unusual physical exam findings</p> <p>Efficiently utilizes all sources of secondary data to inform differential diagnosis</p> <p>Effectively uses history and physical examination skills to minimize the need for further diagnostic testing</p>	<p>Role-models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing</p>

# Objectives of ACC Competency Mapping Project

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## Standards

- ACCF Curricular Competency and Milestones documents
- ACGME Subspecialty Reporting Milestones documents

## Data Sources

- **Fellow rotation evaluations**
- In-training examination
- Direct observation

# Evaluation System: Moving from this...

<p><b>2. Patient Care</b> Fails to review history and prior studies. Unable to synthesize data from different sources. Poor clinical judgement. Fails to analyze clinical data. Ignores evidence and patient preference when making decisions. Poor procedural skills.</p>	<p><b>1 2 3 4 5 6 7 8 9</b> <input type="checkbox"/> Insufficient contact to judge <input type="checkbox"/> Needs attention- Specify _____ _____ _____ _____</p>	<p>Always gathers accurate and appropriate information from interviews, examinations, and other data sources. Always analyzes available information to make diagnostic and therapeutic decisions based upon sound clinical judgement, best available evidence, and patient preferences. Stellar procedural skills.</p>
<p><b>3. Practice-Based Learning</b> Lacks insight into strengths and weaknesses. Resists or ignores feedback. Lacks intellectual curiosity. Fails to use resources and information technology to improve knowledge base and enhance patient care.</p>	<p><b>1 2 3 4 5 6 7 8 9</b> <input type="checkbox"/> Insufficient contact to judge <input type="checkbox"/> Needs attention- Specify _____ _____ _____ _____</p>	<p>Constantly evaluates own performance. Incorporates feedback into improved practice. Identifies, rectifies, and learns from errors. Efficiently uses technology to access information and enhance patient care. Maintains exemplary procedure log.</p>

What is a “patient care 7” in the echo lab?

What is a “practice-based learning 6”.... Anywhere?!

# ... To this: Echo Evaluation Tool (Mapped to Milestones)

## Medical Knowledge

### ACGME Reporting Milestone:

**MK2:** Knowledge of diagnostic testing and procedures.

### ACC Curricular Milestones:

**M-IMAG-ECHO-MK2, MK7, MK8, MK9, MK10, MK11, MK13, MK15, MK16, MK17**

Level 1	Level 2	Level 3	Level 4	Level 5
<b>Critical Deficiencies</b>	<b>Early Learner</b>	<b>Advancing-Improving</b>	<b>Ready for Unsupervised Practice</b>	<b>Aspirational</b>
Lacks foundational knowledge regarding the appropriate indications for echocardiographic examinations.	Minimally understands the role of echocardiography in assessing patients with a variety of cardiac problems.	Understands the key echocardiographic findings for the most common cardiac problems. Understands the basic acquisition parameters and views needed to obtain a limited examination.	Consistently understands the key echocardiographic findings for a wide spectrum of cardiac problems. Understands the basic acquisition parameters and views needed to obtain a comprehensive examination.	Understands subtle nuances in interpreting test results. Pursues knowledge of emerging techniques in echocardiography.



# IM Subspecialty Milestones

## Example

### 1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1)

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	<p>Does not or is inconsistently able to collect accurate historical data</p> <p>Does not perform or use an appropriately thorough physical exam, or misses key physical exam findings</p> <p>Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data</p> <p>Fails to recognize patient's central clinical problems</p> <p>Fails to recognize potentially life threatening problems</p>	<p>Consistently acquires accurate and relevant histories</p> <p>Consistently performs accurate and appropriately thorough physical exams</p> <p>Inconsistently recognizes patient's central clinical problem or develops limited differential diagnoses</p>	<p>Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion</p> <p>Performs accurate physical exams that are targeted to the patient's problems</p> <p>Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list</p>	<p>Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis</p> <p>Identifies subtle or unusual physical exam findings</p> <p>Efficiently utilizes all sources of secondary data to inform differential diagnosis</p> <p>Effectively uses history and physical examination skills to minimize the need for further diagnostic testing</p>	<p>Role-models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing</p>

# Objectives of ACCC Competency Mapping Project

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## Standards

- ACCF Curricular Competency and Milestones documents
- ACGME Subspecialty Reporting Milestones documents



## Data Sources

- **Fellow rotation evaluations**
- In-training examination
- Direct observation



ACGME

# Echo Mapping Tool

## Medical Knowledge Example

ACC CMC Template Evaluation Tool for Echocardiography R			
Question No. ▼	Competency Area ▼	Reporting Milestones Subcompetency ▼	Link to ACC
2	Medical Knowledge	MK2: Knowledge of diagnostic testing and procedures.	M-IMAG-ECHO-MK2, MK7, MK8, MK9, MK10, MK11, MK13, MK15, MK16, MK17

M-IMAG-ECHO-MK2	Know the appropriate indications for: M-mode, two-dimensional, and three-dimensional transthoracic echocardiography (TTE); Doppler echocardiography and color flow imaging; <del>transesophageal</del> echocardiography (TEE); tissue Doppler and strain imaging; contrast echocardiography.
M-IMAG-ECHO-MK7	Know the characteristic findings of cardiomyopathies.
M-IMAG-ECHO-MK8	Know how to use echo and Doppler data to evaluate native and prosthetic valve function and diseases.
M-IMAG-ECHO-MK9	Know the echo and Doppler findings of cardiac ischemia and infarction and the complications of myocardial infarction.
M-IMAG-ECHO-MK10	Know the echo findings of pericardial disease, pericardial effusion, and pericardial constriction.
M-IMAG-ECHO-MK11	Know the characteristic findings of basic adult congenital heart diseases.
M-IMAG-ECHO-MK13	Know how to evaluate cardiac mass and suspected endocarditis.
M-IMAG-ECHO-MK15	Know how to assess pulmonary artery pressure and diseases of the right heart.
M-IMAG-ECHO-MK16	Know how to evaluate patients with systemic diseases involving the heart.
M-IMAG-ECHO-MK17	Know the indications for and the echocardiographic findings in patients with known or suspected cardio-embolic events.



# ***NAS Ten-Year Site Visits and Self-Studies***





# ***Self-Study/10-year Site Visit***

## ***The Evolution...***

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- Scheduled to begin in the *late spring of 2015* for IM
  - *5 – 7 month delay for programs due now thru AY 2015-16*
- *Departmental– core + subs together*
- Scheduled every *10 years*
- *TWO purposes:*
  - *Self-study element: to assess continuous improvement within department/program; analyze strengths, weaknesses, opportunities and threats*
  - *Full site visit element: to assess compliance with “core” + “outcome” PRs*
- *? Best temporal relationship between self study and SV*

# ***Self-Study/10-year Site Visit Update , Feb 2015***



**Accreditation Council for  
Graduate Medical Education**

e-Communication

**February 19, 2015**

The ACGME has made some important changes in the phase-in of the program self-study for the first group of Phase I programs with an initial 10-year site visit in the Next Accreditation System (NAS) scheduled between April 2015 and July 2016.

The most important change for all programs in this group will be a change in the scheduling of the initial 10-year site visit, which now will occur 12 to 18 months after the program has conducted its self-study. The intent is to allow programs to make improvements before their first scheduled 10-year site visit in the NAS.

Another important change is a pilot in which programs in this initial Phase I group may volunteer for an added self-study pilot visit, conducted three to four months after the self-study. This added voluntary visit will be a non-accreditation visit in which a group of ACGME field representatives with added training will offer feedback on the program's self-study. The aim of the pilot is to assess if this type of added site visit and feedback will accelerate program improvement.

Detailed information about the self-study and the pilot can be found in a **memorandum from ACGME Chief Executive Office Thomas J. Nasca, MD, MACP.**

# Self-Study/10-year Site Visit Update , Feb 2015

The screenshot shows a mobile application interface titled "Important Dates" with a list of key dates and statuses. Four blue callout boxes are overlaid on the interface:

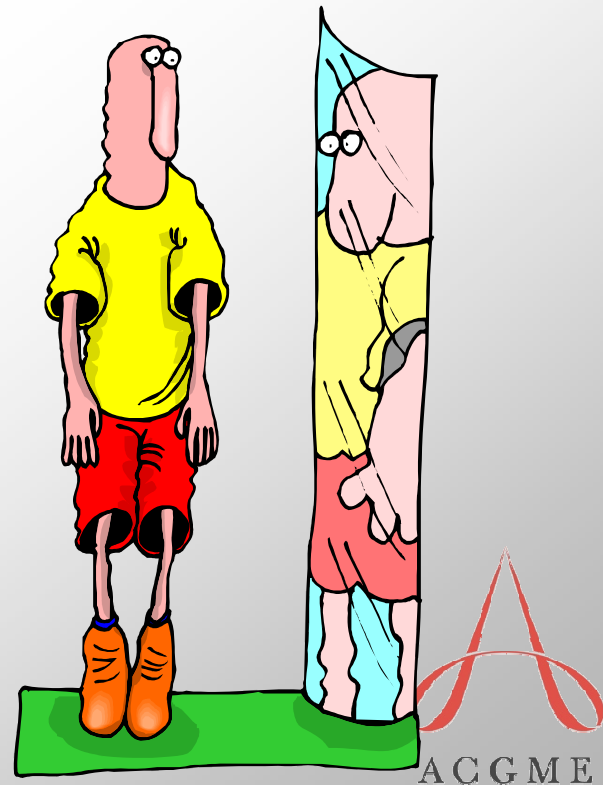
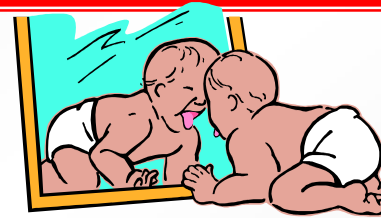
- Expect**: Points to the "Annual Update Status" section.
- on ADS**: Points to the "Next Site Visit" section.
- ths**: Points to the "Self Study Date" section.
- nce**: Points to the "Faculty Survey Status" section.

Category	Date Range
Annual Update Status	September 08, 2014 - October 09, 2014
Next Site Visit	NOT SCHEDULED
Self Study Date (APPROX)	May 01, 2017
Faculty Survey Status	Apr 13, 2015 - May 17, 2015
Resident Survey Status	Apr 13, 2015 - May 17, 2015

Pilot Study?

# What is a Self-Study?

- A procedure where an education program
  - *Describes*
  - *Evaluates*
  - Subsequently *improves* the quality of its efforts
  - Must be ongoing



# The Program Self-Study

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- A comprehensive review of the program
  - Information on how the program creates an effective learning and working environment that leads to desired educational outcomes
  - Analysis of strengths, weaknesses, opportunities and threats, and ongoing plans for improvement
- **12-18 months later:** the 10-Year Site Visit
  - Time lag is by design to give programs time to make improvements



# After the Self-Study: All Programs Prepare Self-Study Summary

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- Brief (4 to 5 pages, ~ 2300 words) summary of key dimensions of the Self-Study
  - Aims
  - External environmental assessment  
(Opportunities and Threats)
  - Process of the Annual Program Evaluation and the Self-Study
  - Learning what occurred during the self-study  
(Optional!)
- **Information on areas for improvement identified in the self-study not included in the Summary**
- Summary is uploaded into ADS



# The 10-Year Accreditation Site Visit (All Programs)

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- 18-20 months after the self-study visit
  - to allow programs time to implement improvements
- Different team of site visitors
- A “PIF-Less” Visit
- Programs update their self-study summary and provide information ONLY on the improvements that were realized from their self-study
  - No request for information on areas that have not been resolved
- Team provides verbal feedback on key strengths and suggestions for improvement
- Team prepares a written report for the RC

# Review Committee Review

## 10-Year Accreditation Visit (All Programs)

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- What is available to the Review Committee
  - ADS Data
  - The program's summary from the self-study
  - The site visitors' report from the full accreditation site visit - includes information on the improvements made based on areas identified during the self-study
- Review of program aims, context and improvements made in follow-up to the self-study allows the RC to assess the effectiveness of the self-study, with data on the improvements achieved being one measure of effectiveness



# ACGME Resources

## Planned Self-Study Webpage:

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- **I. Self-Study Overview:**
  - Self-Study Guide
  - Self-Study FAQs
  - JGME article
  - Timeline for Self-Study, SSV, 10-year compliance site visit
- **II. Self-Study Specifics:**
  - Explain PDSA cycle, with examples
  - Annual Program Evaluation template
  - Annual Program Evaluation Action Plan and Follow-up Template
- **III. Self-Study Visit Summary**
  - 10 Year-Site Visit Guide
  - 10 Year-Site Visit Summary Template

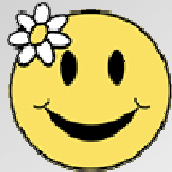
**??? Questions ???**



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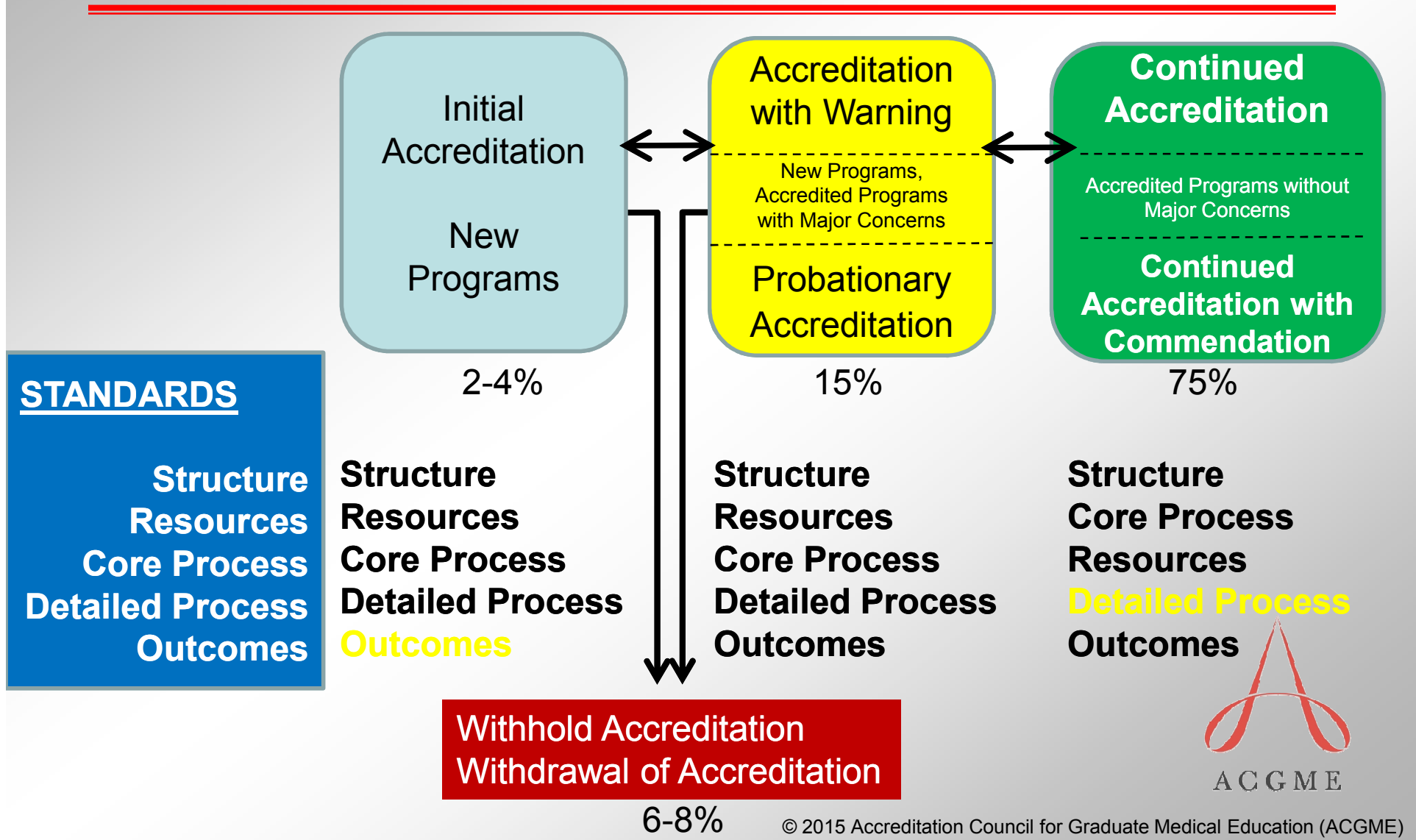
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# NAS Conceptual Model

## Expected Outcomes



# ACGME + AOA = SAS

(Single Accreditation System)



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#### Allopathic and Osteopathic Medical Communities Commit to a Single Graduate Medical Education Accreditation System

CHICAGO, February 26, 2014 – The Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) have agreed to a single accreditation system for graduate medical education (GME) programs in the U.S. After months of discussion, the allopathic and osteopathic medical communities have committed to work together to prepare future generations of physicians with the highest quality GME, ultimately helping to ensure the quality and safety of health care delivery.

"The commitment to a single accreditation system comes at a watershed moment for medical education in the U.S.," said Thomas Nasca, MD, MACP, chief executive officer of the ACGME. "As we move forward into the Next Accreditation System, this uniform path of preparation for practice ensures that the evaluation and accountability for the competency of all resident physicians – MDs and DOs – will be consistent across all programs." Nasca added, "A single accreditation system provides the opportunity to introduce and consistently evaluate new physician competencies that are needed to meet patient needs and the health care delivery challenges facing the U.S. over the next decade."

The single accreditation system will allow graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common Milestones and competencies. Currently, the ACGME and AOA maintain separate accreditation systems for allopathic and osteopathic educational programs.

"A single system standardizes the approach to GME accreditation, and ensures that all physicians have access to the primary and sub-specialty training necessary to serve patients," said AOA President Norman E. Vinn, DO. "Importantly, the system recognizes the unique principles and practices of the osteopathic medical profession and its contributions to the health of all Americans."

Stephen C. Shannon, DO, MPH, President of AACOM commented, "Healthcare and medical education in the U.S. today face many challenges. We feel that this approach to GME accreditation not only streamlines but strengthens the postdoctoral education process, and will produce physicians who are able to meet those health care challenges, enhancing the ability for all physicians to learn the unique characteristics of osteopathic medical practice."

Under the single accreditation system:

# ACGME + AOA = SAS

## What does this mean for IM?

### Numbers

- # of AOA accredited IM programs 129
- # of dually accredited IM programs 27
- # of AOA accredited IM subs 118
- # of dually accredited IM subs 2
  
- # of AOA cardiology programs 27
- # of dually accredited cardiology subs 1

### **RC-IM can likely see ~100 core applications from AOA**

- Core applications will require a site visit
- All apps will receive “Pre-Accreditation” upon submission
- Subs will not be reviewed until core receives Initial Accreditation
- Subs will not require a site visit
- Spring 2016 meetings will likely expand by 1 day