Accreditation Council for Graduate Medical Education

Update from the Review Committee for Internal Medicine

American College of Cardiology, March 2015

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

Director of Graduate Medical Education
Rhode Island Hospital
Program Director, Cardiology
Alpert Medical School of Brown University

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The Next (Now?) Accreditation System

- 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

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Flight Plan For Today

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

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Rhythm of annual data flow and analysis: Attention to details

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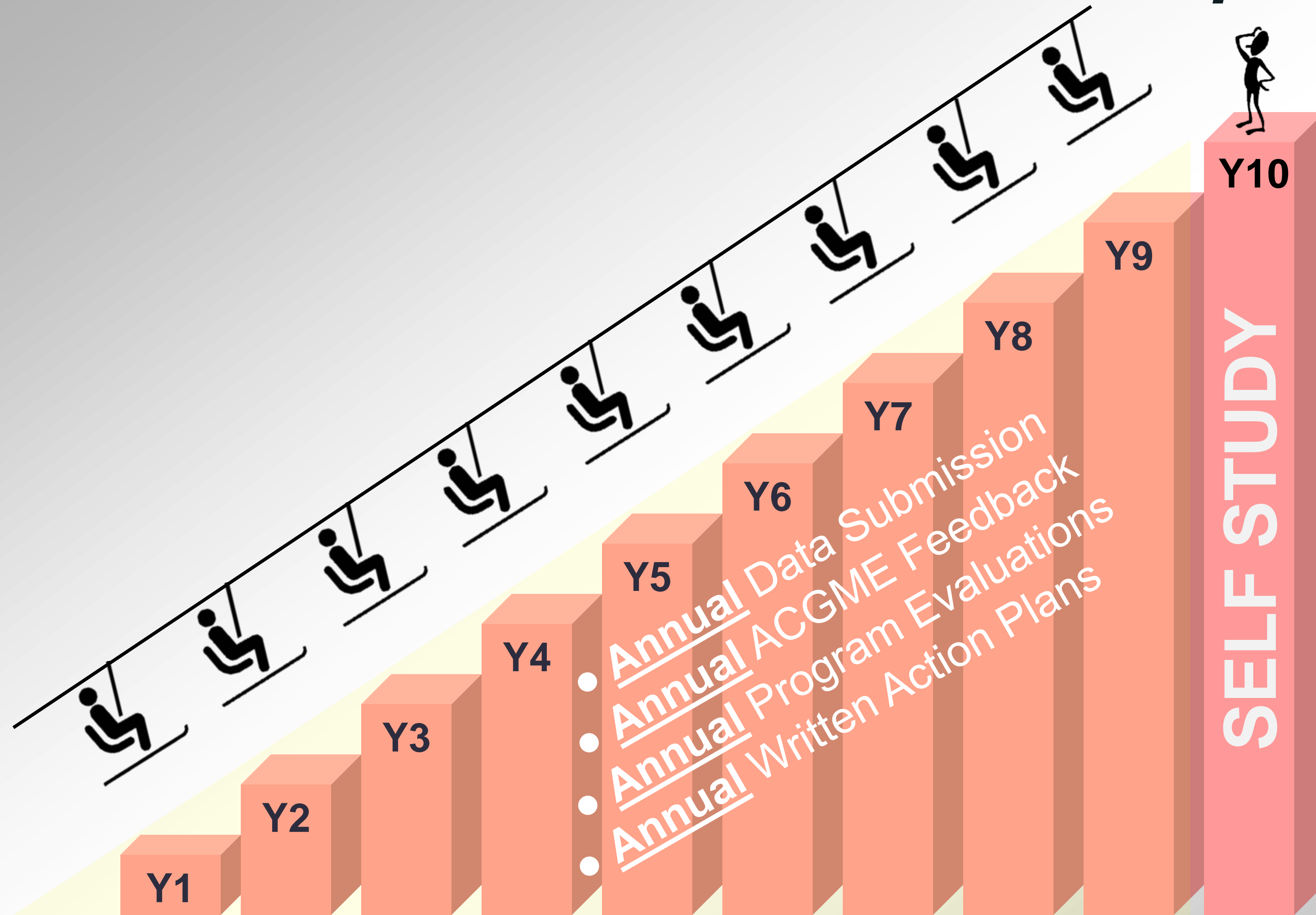
Continuous Improvement



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Role of Review Committees in NAS

- “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

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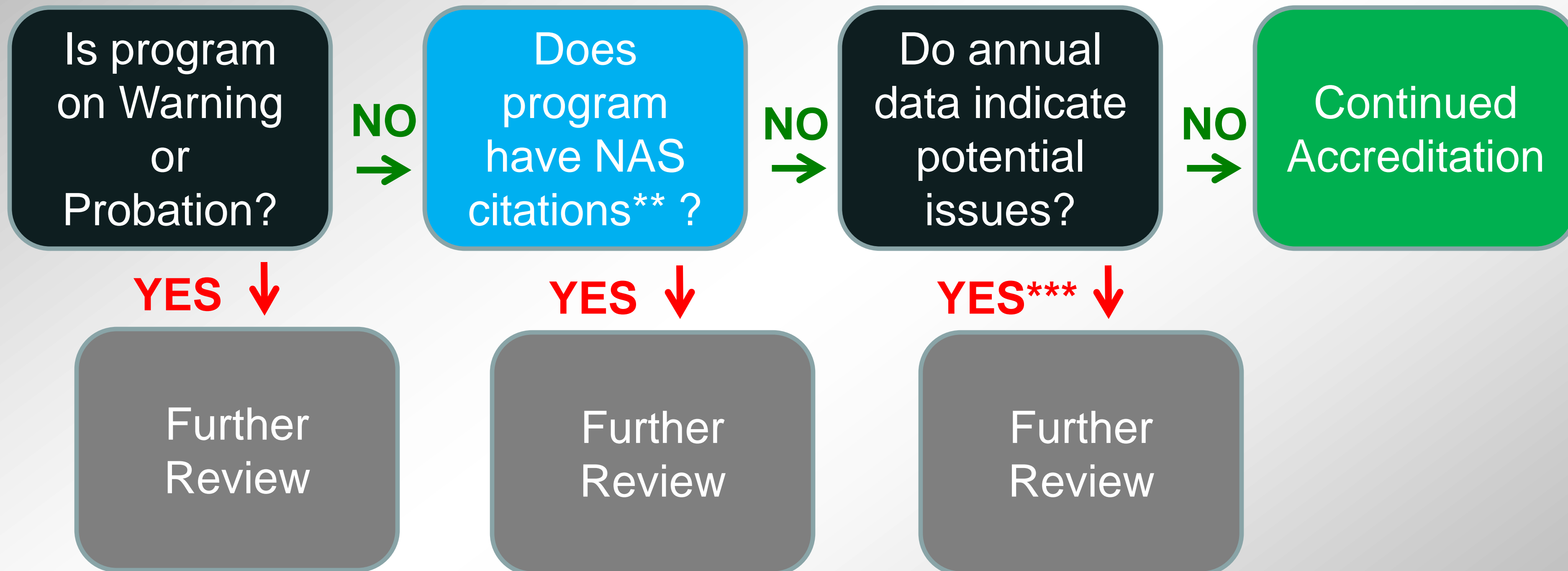
NAS: Program* Review



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

** = citations given after July 1, 2013

*** = scholarly activity, survey data are most common (very preliminary!)

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Primary Data Elements (Assessed Annually)

- Resident Survey
- ABIM Pass Rate
- Milestones
- Clinical Experience Data
- Scholarly Activity
- Faculty Survey
- Attrition

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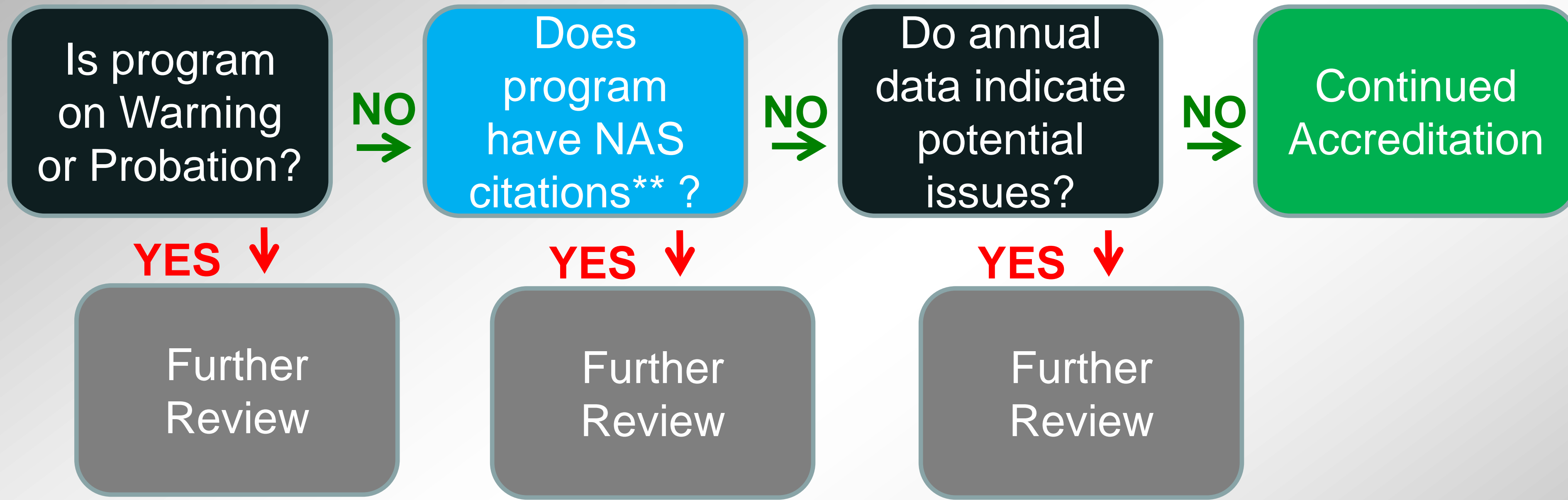
What is “Further Review”?



- 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*

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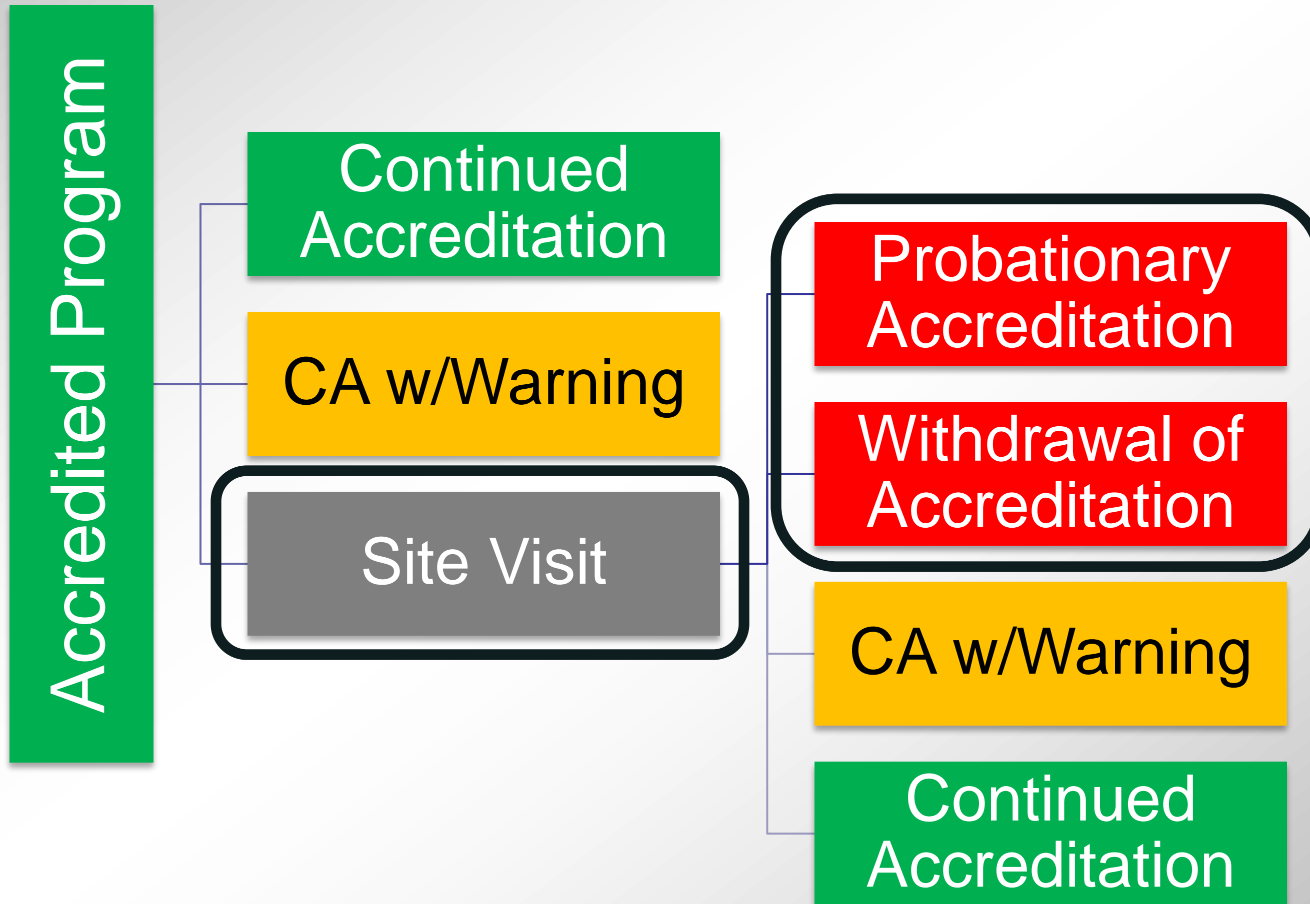
Accreditation Status Schema



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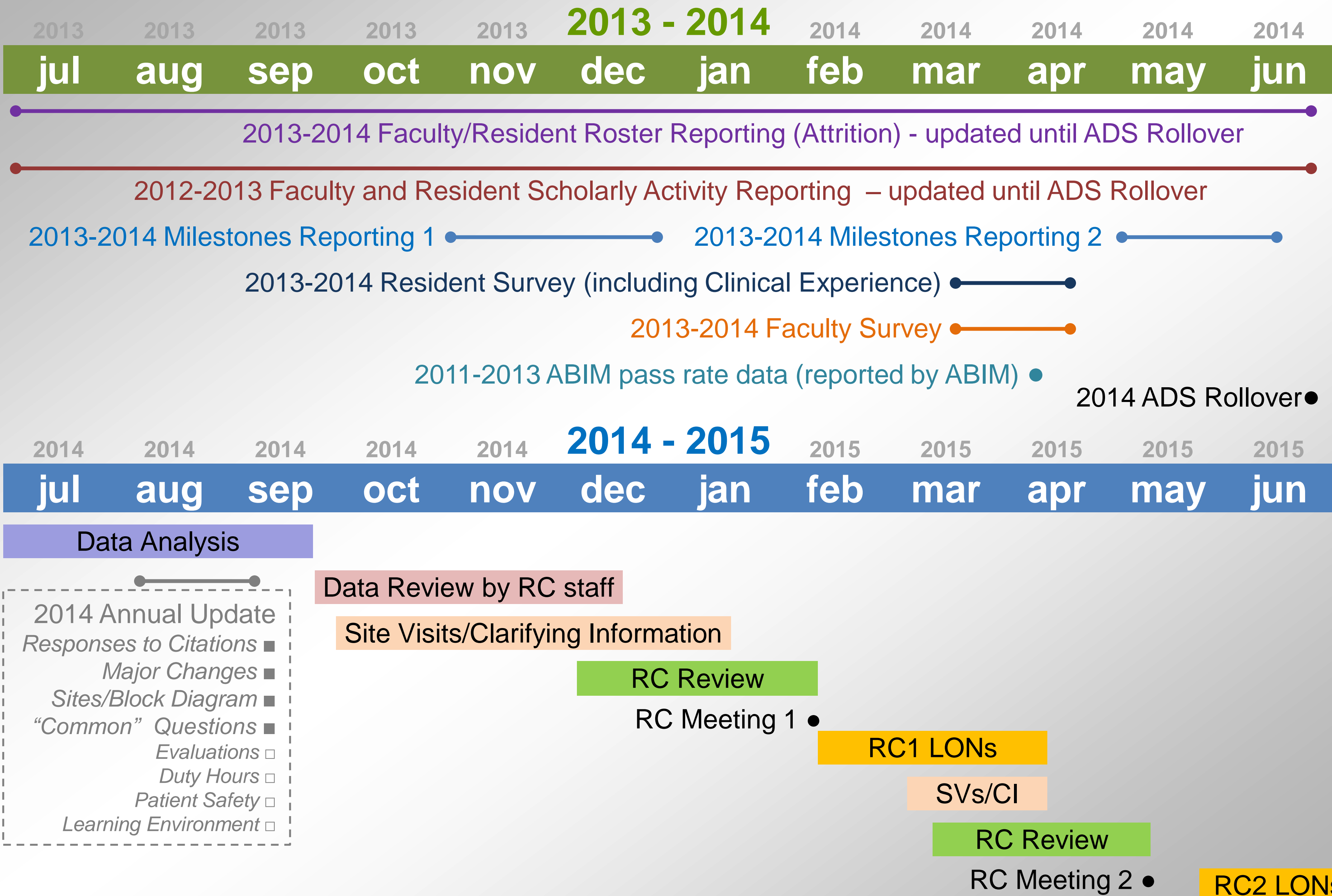
NAS: Data Reported vs. Data Reviewed



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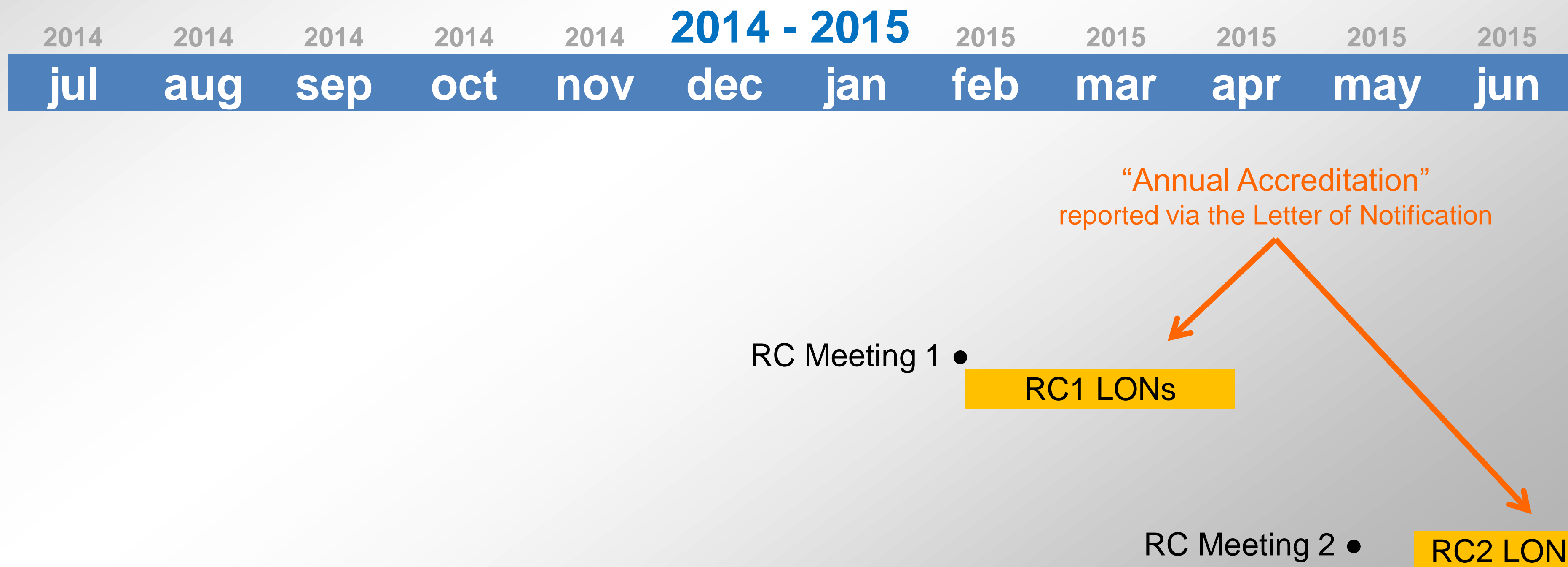
NAS: Communication of Status Decision

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



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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.**

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Take Home Points (ADS)

- 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

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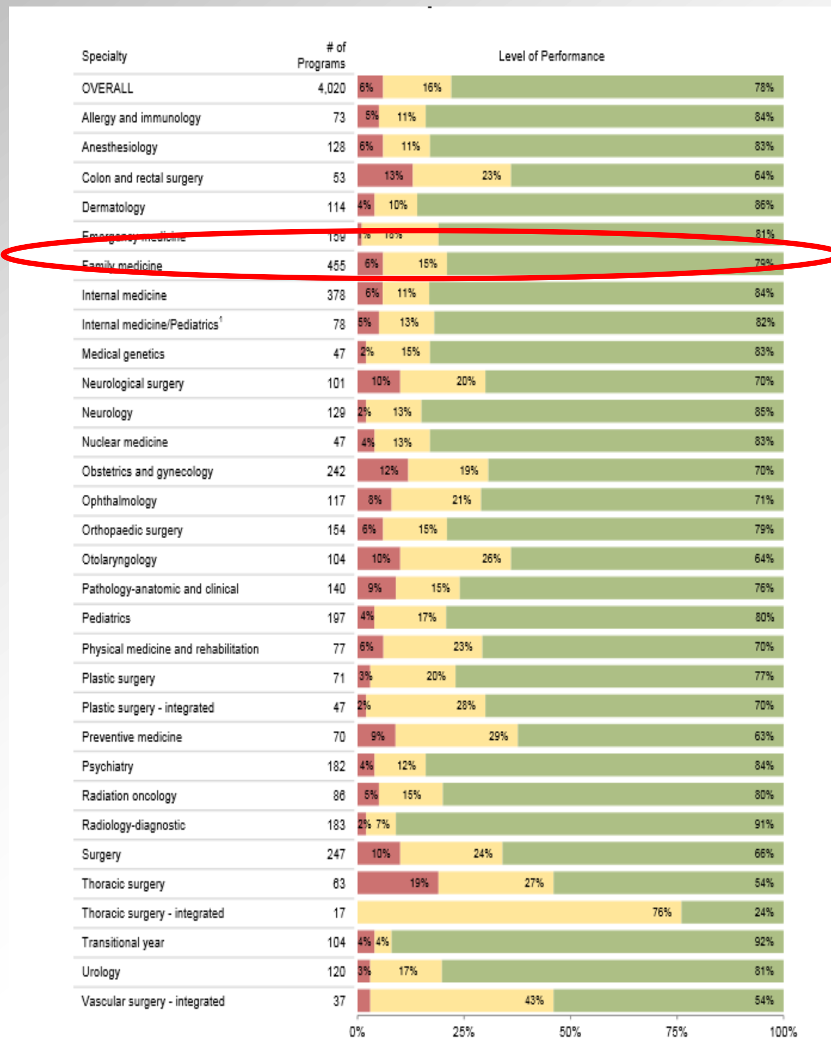
What did we expect?



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*.

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NAS Year 1: Expected vs Actual Outcomes CORE Programs

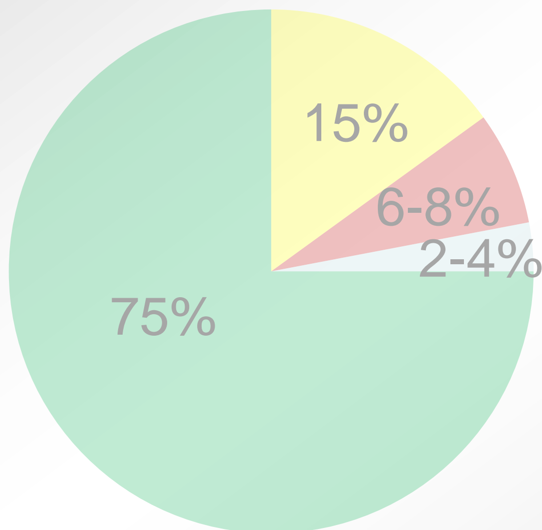
Warning/Probation 5.6%

New Programs (Initial) 3.3%

Withheld: 0.6% (Two Programs)

Continued Accreditation (Good Standing) 90.6%

NAS Projections



(396 Core Internal Medicine Programs)

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NAS Year 1: Expected vs Actual Outcomes SUBSPECIALTY Programs

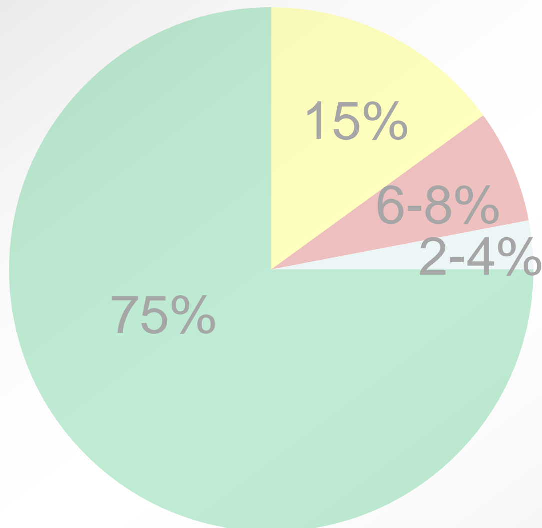
Warning/Probation - 13 programs, 0.7%

New Programs - 42 programs, 2.4%

Withheld/Withdrawn – 7 programs, 0.4%)

Continued Accreditation (Good Standing) 96%

NAS Projections



1701 Internal Medicine Subspecialty Programs)

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NAS: Citations and Site Visits

"Hi, I'm from the ACGME, and I'm here to help."

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NAS "As Needed" Site Visits

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

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Citations and AFI’s

- 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

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NAS: Encourages Innovation

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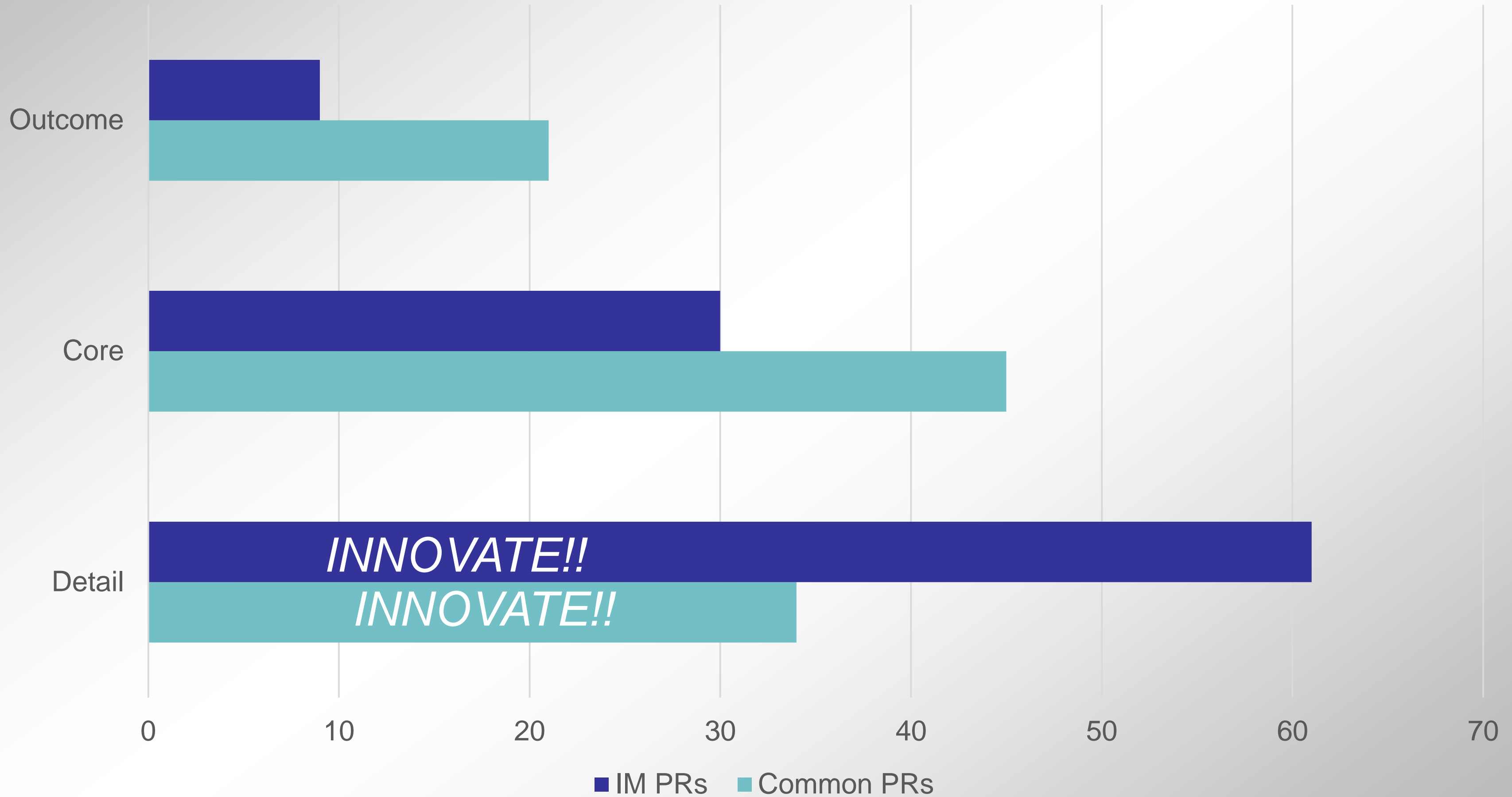
NAS: Innovation + Accreditation

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



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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

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NAS Ten-Year Site Visits and Self-Studies

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Self-Study/10-year Site Visits
The Evolution…

- 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 asses compliance with "core" + "outcome" PRs*
- *? Best temporal relationship between self study and SV*

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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**.

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

Expect

on ADS

Pilot Study?

ths

Fu

nce

Important Dates

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

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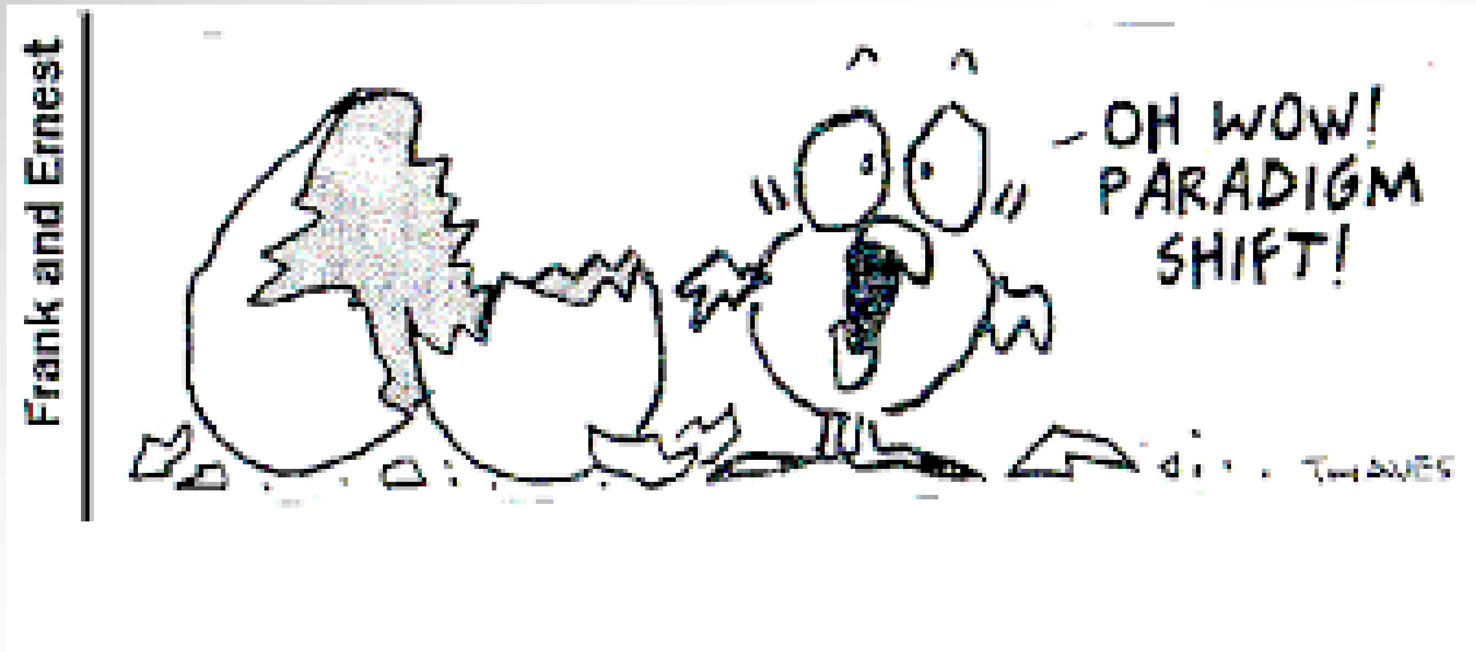
ACGME Resources
Planned Self-Study Webpage:

- 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

NAS: Encouraging Better Processes of Evaluation



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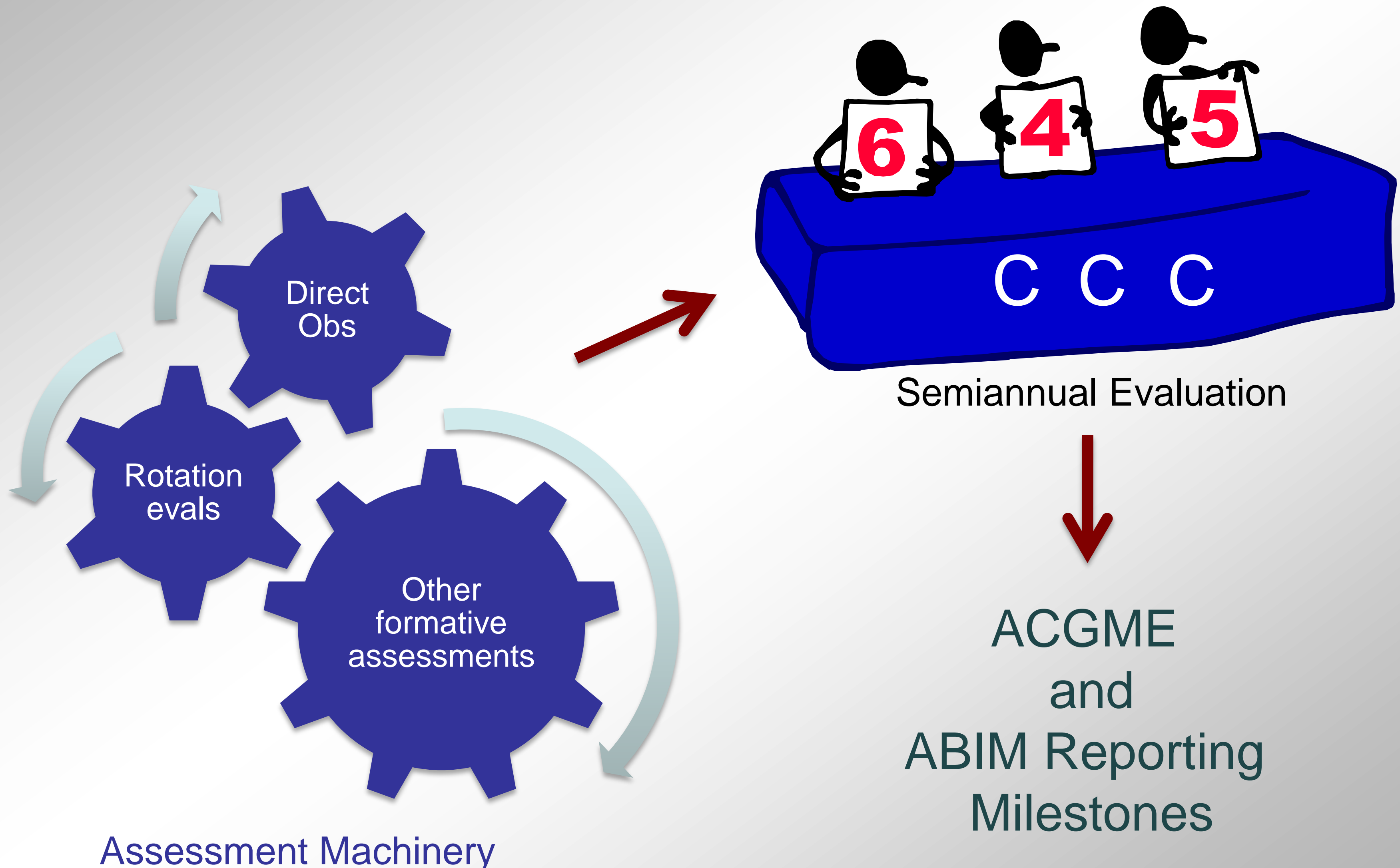
Assessment → Evaluation → Reporting



ACGME
and
ABIM Reporting
Milestones

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What specific elements of the system are ACGME?

The Internal Medicine Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Internal Medicine

Curricular Milestones

COCATS

Specific curriculum

→ Evaluation System → Reporting Milestones

ACC, Local Programs

ACC, Local Programs, ACGME

ACGME (and ABIM)

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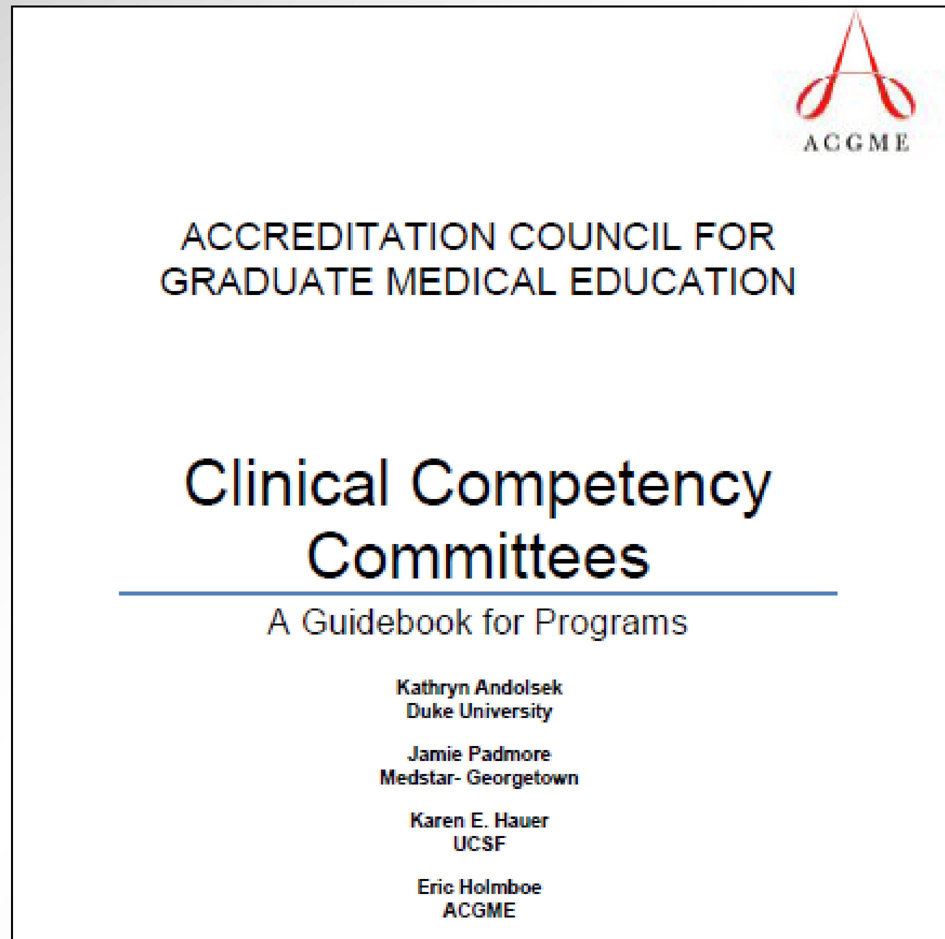
Milestones: CCC

NEW: CCC Guidebook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ACCREDITATION COUNCIL FOR
GRADUATE MEDICAL EDUCATION

Clinical Competency
Committees

A Guidebook for Programs

Kathryn Andolsek
Duke University

Jamie Padmore
Medstar- Georgetown

Karen E. Hauer
UCSF

Eric Holmboe
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Milestones v1.0: A Work-in-Progress

- 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?

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Evaluation System: Moving from this…

2. **Patient Care** 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.	**1 2 3 4 5 6 7 8 9** ❑ Insufficient contact to judge ❑ Needs attention- Specify____	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.
3. **Practice-Based Learning** 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.	**1 2 3 4 5 6 7 8 9** ❑ Insufficient contact to judge ❑ Needs attention- Specify____	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.

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

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

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… 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
Critical Deficiencies	Early Learner	Advancing-Improving	Ready for Unsupervised Practice	Aspirational
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.

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? ? ? Questions ? ? ?

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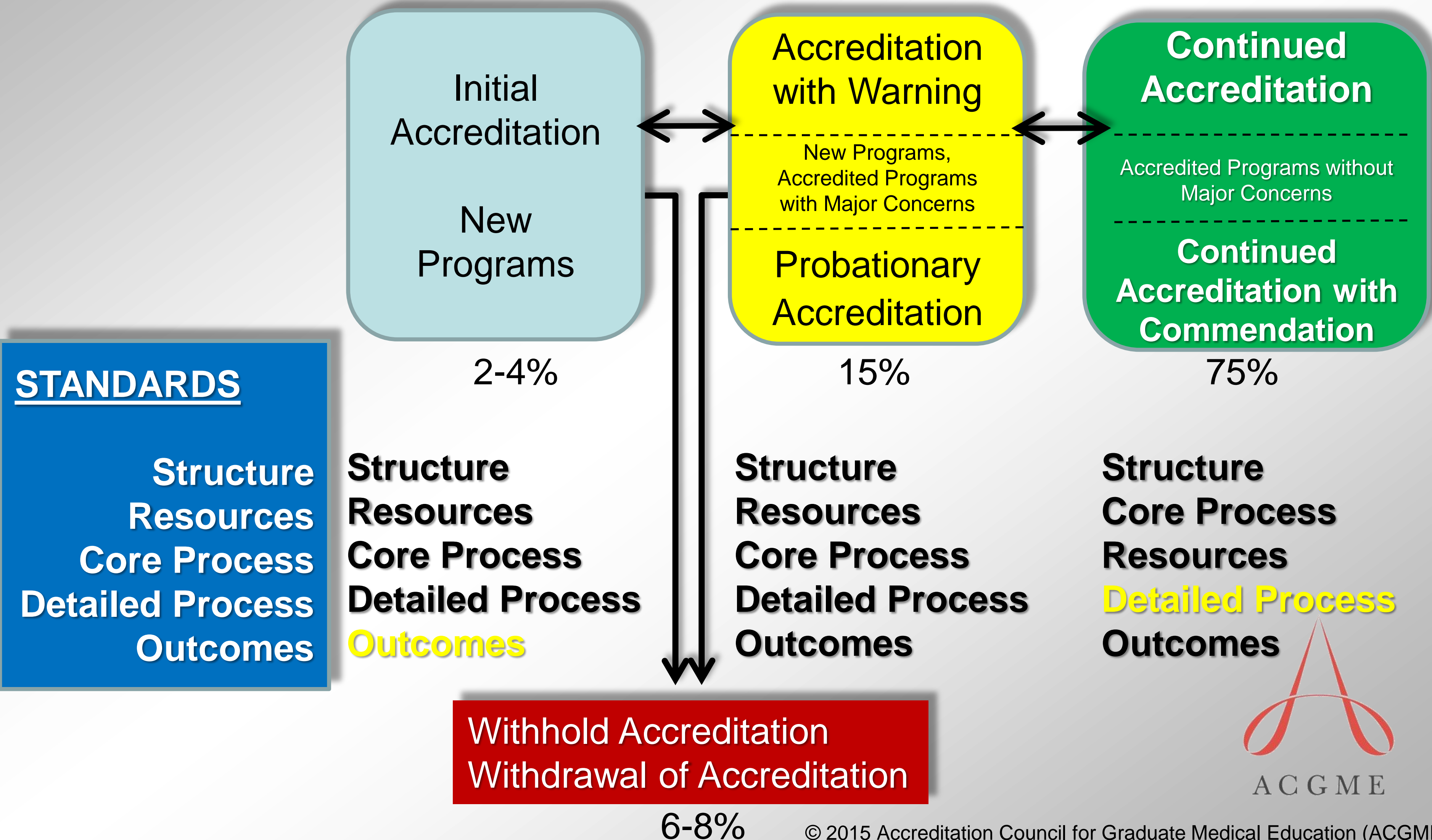
NAS Conceptual Model

Expected Outcomes



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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 of 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:

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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

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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

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