Accreditation Council for Graduate Medical Education

The Next Accreditation System, and The Clinical Learning Environment Review (CLER)

Where Are We in Implementation?

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ACGME

Disclosure

- Professor of Medicine, Jefferson Medical College *(volunteer)*
- Internist Nephrologist
- Full Time Salaried by ACGME
- No conflicts of interest to report

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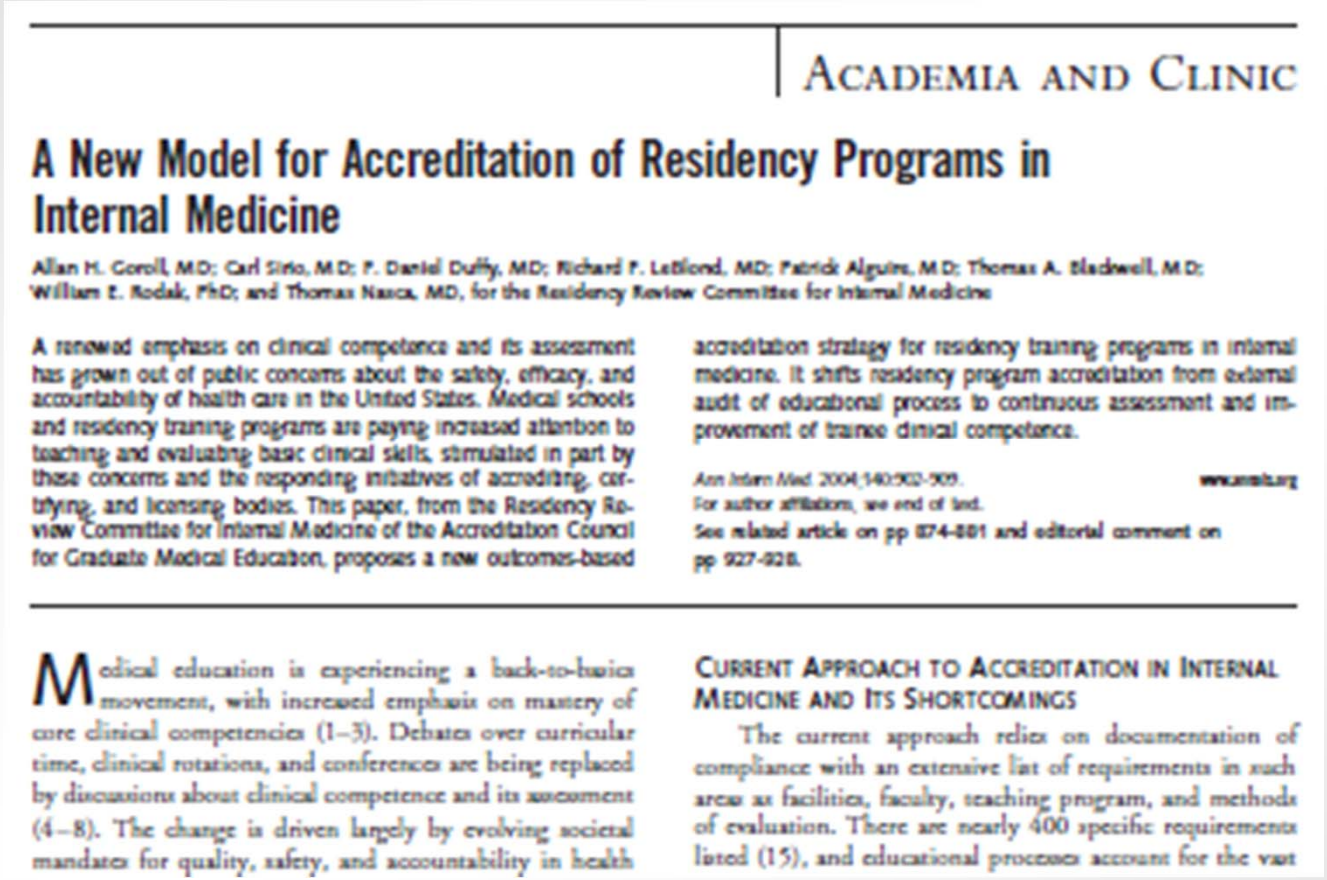
Intellectual Foundation of the Educational Innovations Project (EIP)



ACADEMIA AND CLINIC

A New Model for Accreditation of Residency Programs in Internal Medicine

Allan H. Goroll, M.D.; Carl Sirio, M.D.; F. Daniel Duffy, M.D.; Richard F. LeBlond, M.D.; Patrick Alguire, M.D.; Thomas A. Blackwell, M.D.; William E. Rodak, PhD; and Thomas Nasca, M.D., for the Residency Review Committee for Internal Medicine

A renewed emphasis on clinical competence and its assessment has grown out of public concerns about the safety, efficacy, and accountability of health care in the United States. Medical schools and residency training programs are paying increased attention to teaching and evaluating basic clinical skills, stimulated in part by these concerns and the responding initiatives of accrediting, certifying, and licensing bodies. This paper, from the Residency Review Committee for Internal Medicine of the Accreditation Council for Graduate Medical Education, proposes a new outcomes-based accreditation strategy for residency training programs in internal medicine. It shifts residency program accreditation from external audit of educational process to continuous assessment and improvement of trainee clinical competence.

Ann Intern Med. 2004;140:902-909. www.annals.org
For author affiliations, see end of text.
See related article on pp 874-881 and editorial comment on pp 927-928.

Medical education is experiencing a back-to-basics movement, with increased emphasis on mastery of core clinical competencies (1–3). Debates over curricular time, clinical rotations, and conferences are being replaced by discussions about clinical competence and its assessment (4–8). The change is driven largely by evolving societal mandates for quality, safety, and accountability in health

Current Approach to Accreditation in Internal Medicine and Its Shortcomings

The current approach relies on documentation of compliance with an extensive list of requirements in such areas as facilities, faculty, teaching program, and methods of evaluation. There are nearly 400 specific requirements listed (15), and educational processes account for the vast

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The 2005 ACGME Strategic Plan[1]: Emergence of "The New Accreditation Model"

"At its November 2005 retreat, the ACGME Executive Committee endorsed four strategic priorities designed to *enable emergence* of the new accreditation model:

- 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 "

[1] **ACGME 2005 Strategic Plan**. *(Emphasis Added, TJN)*

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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 based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education[8] and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Perfor-

[1] Nasca, T.J., Philibert, I., Brigham, T.P., Flynn, T.C.
The Next GME Accreditation System: Rationale and Benefits.
New England Journal of Medicine. Published Electronically, February 22, 2012. In Print, March 15, 2012.
DOI:10.1056/nejmsr1200117 www.nejm.org .
NEJM. 2012.366;11:1051-1056.

The Building Blocks or Components of The "Next" Accreditation System

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Emphasis of CLER
Assessment of Effectiveness of Sponsor in:

- integration of residents into **Patient Safety** programs of the institution, and demonstration of impact
- integration of residents into **Quality Improvement** programs of the institution, efforts to **reduce Disparities in Health Care Delivery,** and demonstration of impact
- establishment and implementation of **Supervision** policies
- oversight of **transitions in care**
- oversight of **duty hours** standards implementation
- *Emphasis on Professionalism throughout*

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The actions of the ACGME must fulfill the social contract, and must cause sponsors to maintain an educational environment that assures:

- the safety and quality of care of the patients under the care of residents today
- the safety and quality of care of the patients under the care of our graduates in their future practice
- the provision of a humanistic educational environment where residents are taught to manifest professionalism and effacement of self interest to meet the needs of their patients

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Implementation of CLER

- Senior Vice President and Administration
- Regional Vice Presidents (3)
- Physician Site Visitors (9)
- CLER Evaluation Committee
  - Co-Chairs:
    - Kevin Weiss MD MPH
    - James Bagain MD PE
- Alpha Phase 7-9/2012
- Beta Phase 9/2012-Present

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The Building Blocks or Components of The "Next" Accreditation System

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The “Next Accreditation System” in a Nutshell

- Continuous Accreditation Model – annually updated
  - Based on annual data submitted, other data requested, and program trends
- Scheduled Site Visits replaced by 10 year Self Study and Self Study Visit
- Standards revised every 10 years
  - Standards Organized by Core and Detailed:
    - Structure
    - Resources
    - Processes
    - Outcomes

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Trended Annual Data
"8.5 of 9" Already in Place

- ✓ Annual ADS Update, including:
  - ✓ Program Attrition – Changes in PD/Core Faculty/Residents
  - ✓ Program Characteristics – Structure and Resources
  - ✓ Scholarly Activity
- ✓ Board Pass Rate – Rolling Rates
- ✓ Resident Survey – Common and Specialty Elements
- ✓ Clinical Experience – Case Logs, Resident Survey, Other
- ✓ Faculty Survey – Core Faculty
- ✓ Semi-Annual Resident Evaluation and Feedback
  - ➢ Milestones
- ✓ CLER Visit (Institutional, after first phase)

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The Building Blocks or Components of The "Next" Accreditation System

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Self Study
A Departmentally Coordinated Effort

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

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Self Study Visit *(Draft)*

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

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What is our Focus?

- 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

[1] **ACGME 2005 Strategic Plan**.

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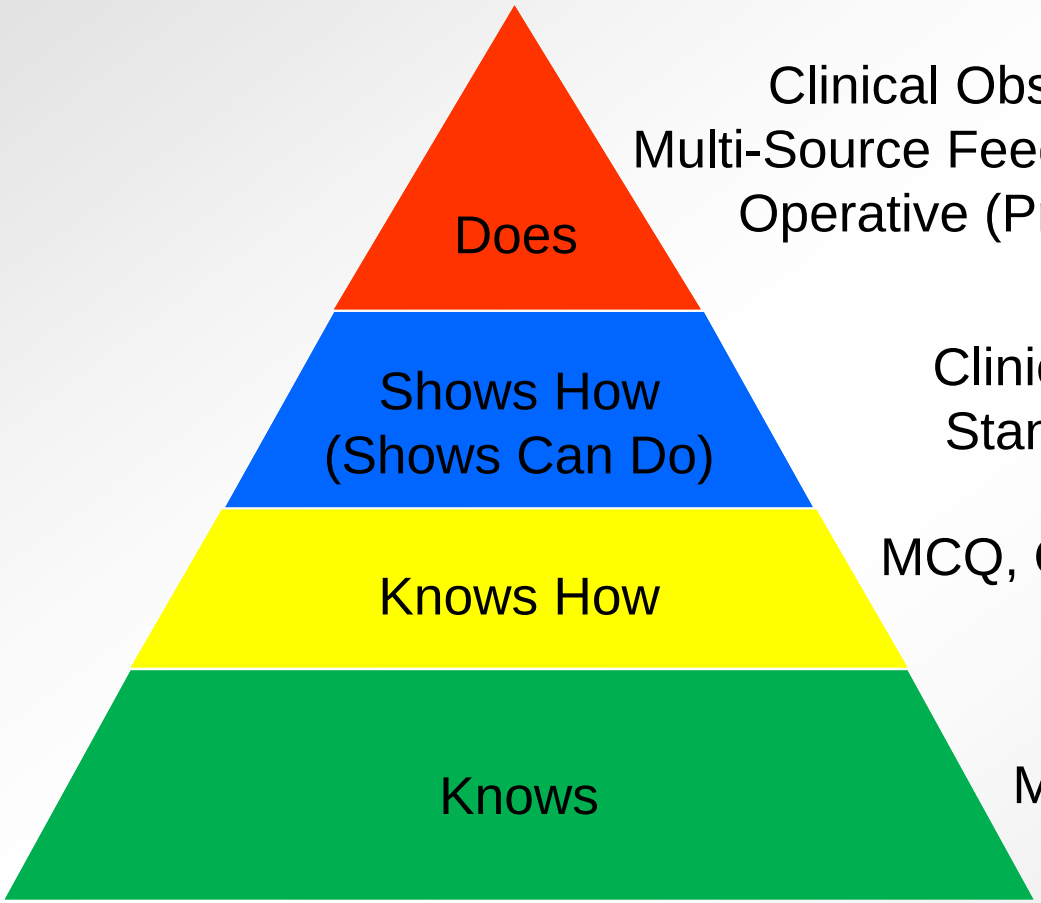
Miller's Pyramid of Clinical Competence[1]

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



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

Clinical Observation, Simulation, Standardized Patients, Mini CEX

MCQ, Oral Examinations, Standardized Patients

MCQ, Oral Examinations

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

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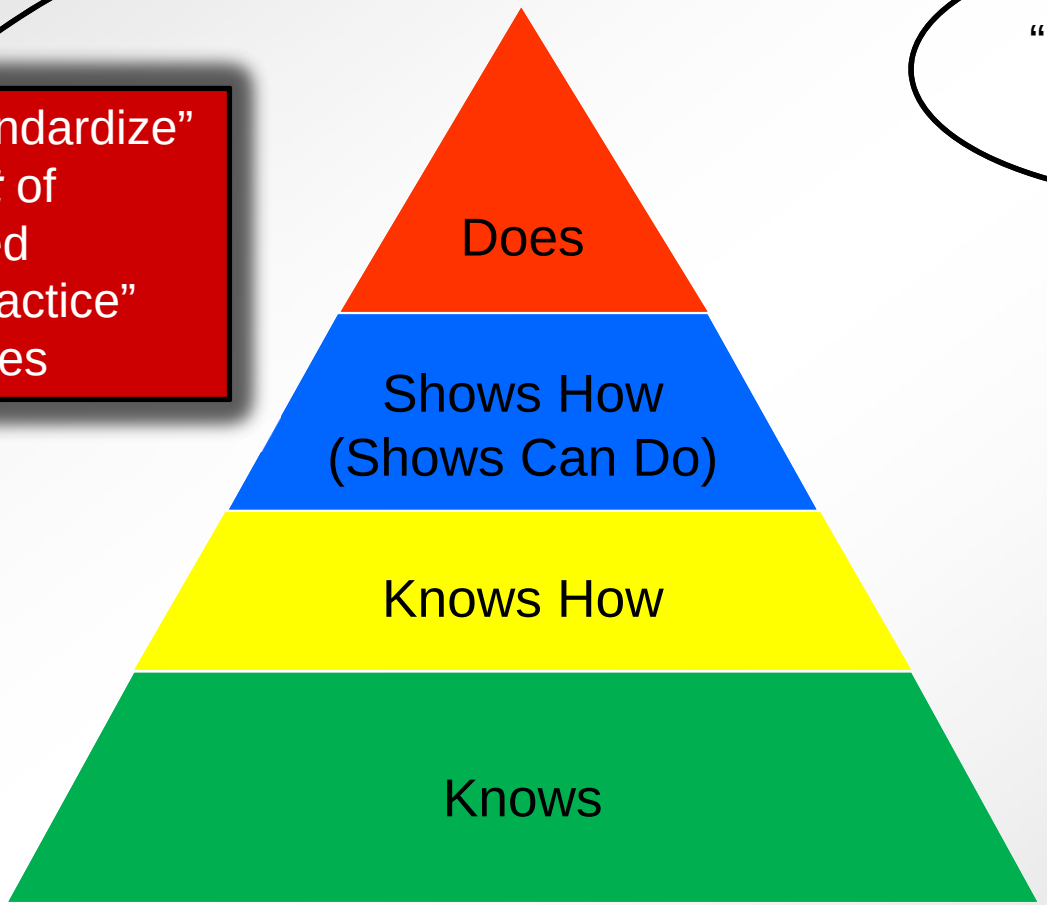
Miller's Model of Clinical Competence

Milestones "standardize" a ***subset*** of expected "Habitual Practice" Outcomes

"Habitual Practice" Evaluation Tools



Psychometrically Validated "Objective" Measurement Tools

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

van der Vleuten, CPM, Schuwirth, LWT, Scheele, F, Driessen, EW, Hodges, B. **The assessment of professional competence: building blocks for theory development.** Best Practice & Research Clinical Obstetrics and Gynaecology 24 (2010) 703–719

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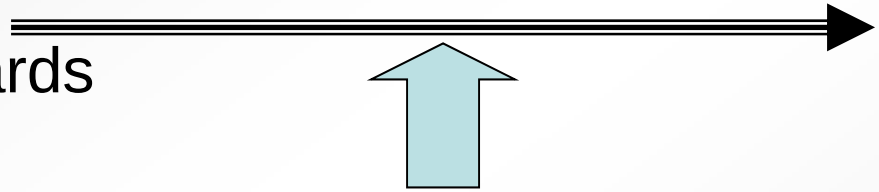
What Currently Drives the Structure and Content of our Residency Programs?

In the context of local service needs,
Choose Educational Experiences
within Institution, Faculty

"Curriculum"
ACGME Standards



"Educate"
Residents

Identify/Develop Evaluation Idiosyncratic Tools
- Formative and Summative
- Experience Tracking

Guarantees that education is institutionally idiosyncratic,
and lags rather than anticipates change in the delivery system

"Circumstantial Practice"

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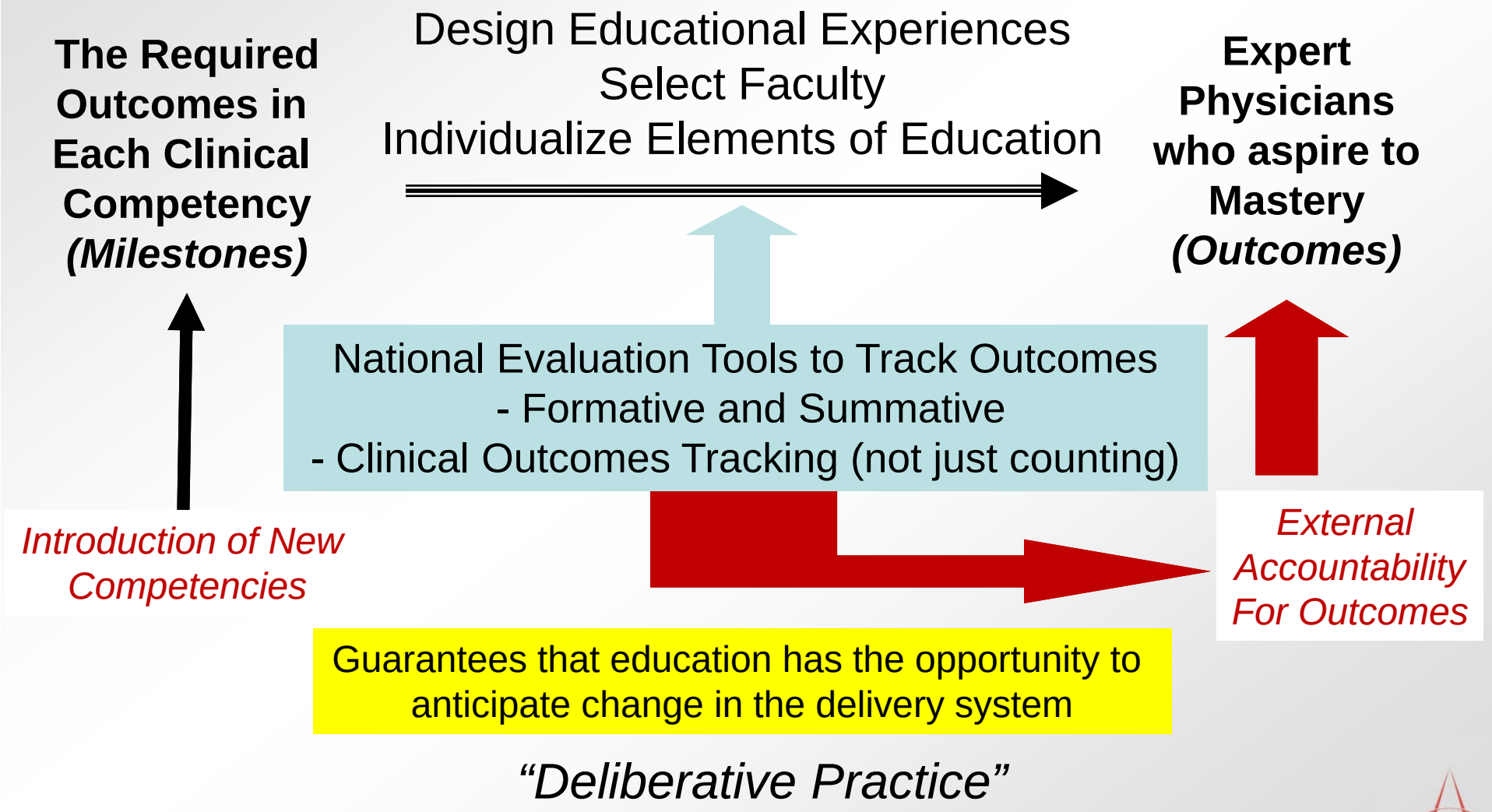
What Will Drive the Structure and Content of our Residency Programs in the Near Future?



"Deliberative Practice"

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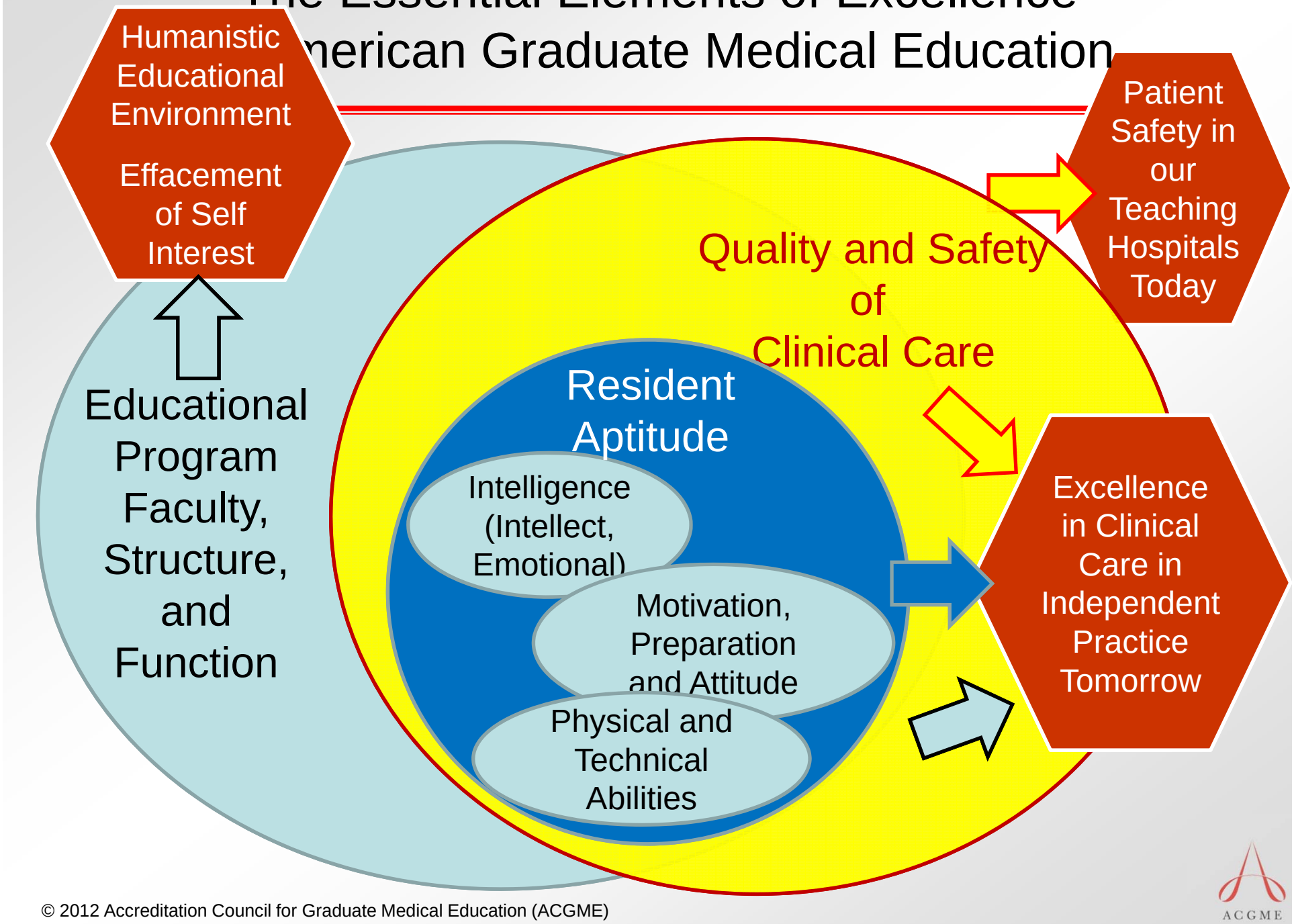
The Essential Elements of Excellence
nerican Graduate Medical Education



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Phased Implementation of The "Next" Accreditation System

- Phase 1 Specialties (and Subspecialties)
  - Internal Medicine
  - Pediatrics
  - Emergency Medicine
  - Diagnostic Radiology
  - Urology
  - Orthopaedic Surgery
  - Neurological Surgery
- Phase 2 Specialties (and Subspecialties)
  - All Other Specialties
  - Institutional Review
  - Transitional Year

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Implementation Timeline for The "Next" Accreditation System

- First "round" of CLER Visits – underway
  - 9/2012-6/2014
- New Policies and Procedures take effect 7/1/2013
- Phase 1 Specialties
  - 1/2012 Ceased routine Site Visits
  - 7/2012 Entered "preparation year"
  - 7/2013 Begin Continuous Accreditation
- Phase 2 Specialties, Institutional, Transitional Year
  - 1/2013 Will cease routine Site Visits
  - 7/2013 Will enter "preparation year"
  - 7/2014 Will begin Continuous Accreditation

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Parting Thoughts…

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"All systems are perfectly designed to get the results they are getting."

Various Attributions:

Paul Batalden MD

Donald Berwick MD

W. Edwards Deming

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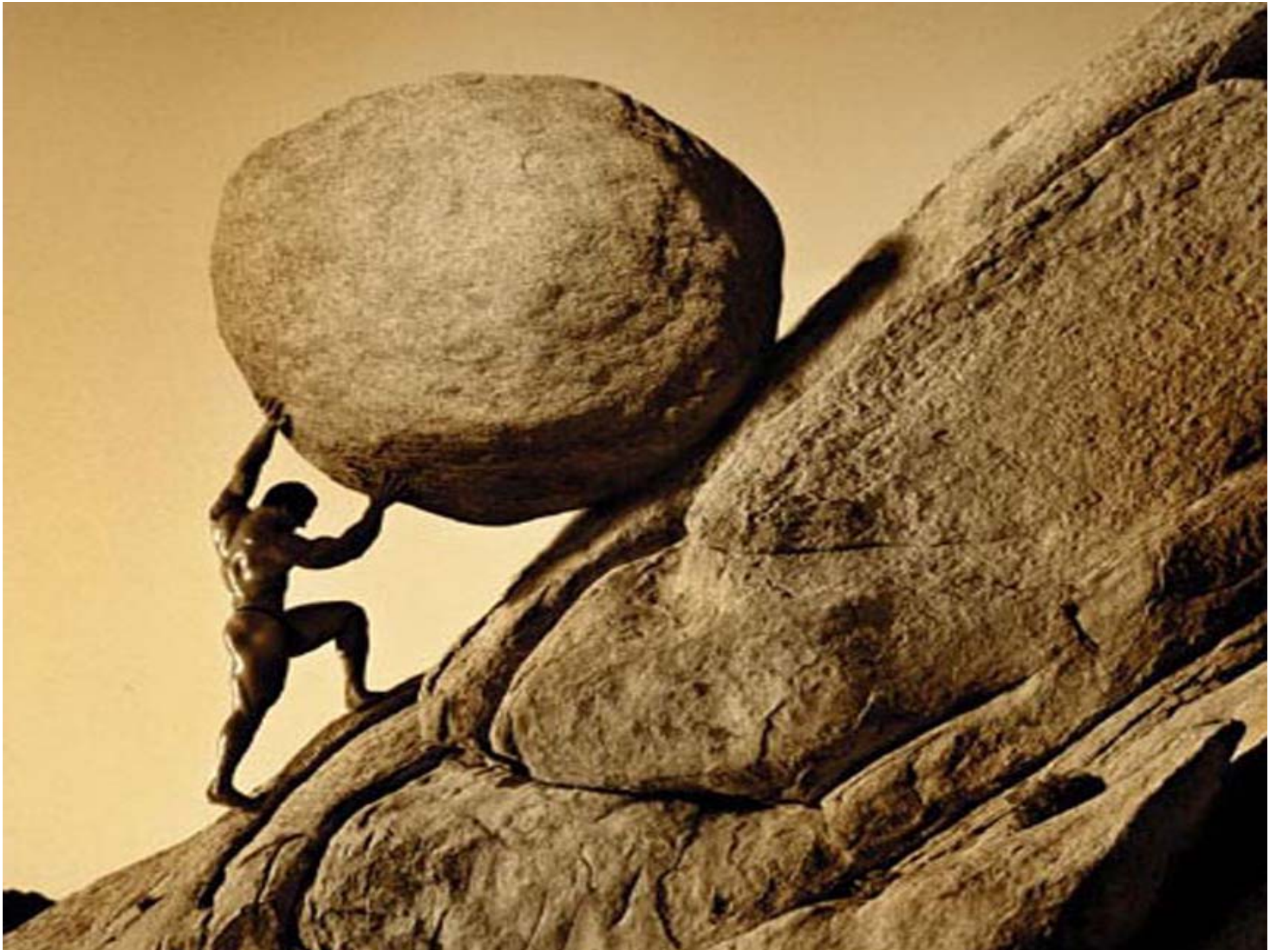

Denial

"Faced with the choice between changing one's mind and proving that there is no need to do so,

almost everybody gets busy on the proof."

John Kenneth Galbraith
American Economist

The Next Phase

"Somebody has to do something,
and it's just incredibly pathetic
that it has to be us."

Jerry Garcia

The Grateful Dead

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Overcoming Inertia

Never be afraid to try something new.
Remember that amateurs built the ark,
and professionals built the Titanic.

Anonymous

Optimism

"What lies behind us
and what lies before us
are tiny matters compared to
what lies within us."

Oliver Wendell Holmes

Thank You!