“ACGME 101: Nuts and Bolts” Introduction to ACGME and the NAS

AFMA
September 30, 2015
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References and Sources for Material and Slides

- ACGME
- Oakland University William Beaumont
- AAMC
- Stanford SOM
- *O ten Cate*
- *Cees van der Vleuten, PhD*
- *Dreyfus and Dreyfus*
- Google Images
- *Eric Holmboe, MD and Carol Carraccio, MD*

Purpose/Objective

Gain familiarity with what is coming!

Single Accreditation System (SAS) Timeline "Pre-accreditation"

- **April 1, 2015**: Institutional sponsorship application process began
- Training programs to follow once the institution is pre-accredited
- **July 1, 2015**: Residency///Core residency program application process began
- Fellowships to follow once the core residency is pre-accredited
- **July 1, 2015-June 30, 2020**: five year time span to earn ACGME initial accreditation
- Consider application for **osteopathic recognition**

Program Director Credentials and AOA Board Certification (19 so far)

- Transitional Year
- FM
- IM
- EM
- Diagnostic Radiology
- Dermatology
- Ob/Gyne
- PM&R
- Preventive Medicine
- Neurology

-Surgery
-Ophthalmology
-Pediatrics
-Pathology
-Allergy and Immunology
-Anesthesiology
-Plastic Surgery
-Orthopedic Surgery
-Psychiatry

Pre-Accreditation for Programs with Matriculating Residents on July 1, 2015

- Graduates are eligible for training in ACGME programs as per the standards in place on June 30, 2013
- Faculty requirements are waived
- AOA-certified co-program director (already waived for 19 specialties).
- Eventual Site visit and report written; along with review of application
- Deemed to be in "substantial compliance"---then ***initial accreditation*** is granted.

What you'll be asked to do…

- Submit the completed application for pre-accreditation

- Once **pre-accredited…must participate in all required ACGME reporting**
  - →ADS Annual update
  - →Resident Case Log Reporting
  - →Resident Survey
  - →Faculty Survey
  - →Milestone assessment and reporting

Accreditation Costs

- **Institutional accreditation**: no fees
- **Pre-accreditation**: $6200.00 per program through June 30, 2020
- **Accreditation annual fees**: January 1 annually
  - → $4300.00 per program for **</= 5 residents**
  - → $5200.00 per program for **> 5 residents**

Location of Information on Program/Faculty/Staff: ACGME Website Under *Institutional Review*…

…

http://www.acgme.org/acgmeweb/

- The following documents are organized by topic across all program requirements as a useful reference for determining varying expectations among specialties. These documents will be updated periodically to reflect changes in requirements.
- Duty Hours
- Expected Time for Program Coordinator
- Expected Time for Program Director
- Expected Time for Faculty
- Faculty Scholarly Activity
- Number of Faculty
- Program Director Qualifications
- Program Director Scholarly Activity
- Resident/Fellow Scholarly Activity

Program Director Time Requirements

- **Family Medicine:** Sponsor and participating sites must provide 70% salary support (28 hours per week) as protected time for administration, evaluation, teaching, resident precepting and scholarship. This 70% cannot include time in direct patient care without the presence of residents.

- **Internal Medicine:** 50% salary support (20 hours per week) must be provided…and PD must dedicate this time to administrative and educational activities of the IM educational program.

- **Emergency Medicine:** Salary support and protected time must be provided. Must not work more that 20 hours per week clinically on average (not > 960 hours per year)

- **General Surgery:** must be provided with a minimum of 30% protected time, which may take the form of direct or indirect salary support, such as release from clinical activities provided by the institution.

Requirements: Number of Faculty

- **Family Medicine:** PD; and 6:1 ratio of residents to core faculty
- **Internal Medicine:** 4 core faculty if < 60 residents
- **Emergency Medicine: must be a minimum** 3:1 ratio of residents to core faculty
- **General Surgery:** ratio is based upon number of approved chief residents…must have one PD for the program plus one core faculty member per chief resident

Requirements: Expected Time for Faculty

- **Family Medicine:** Core faculty must dedicate at least 60% (24 hours per week///1200 hours per year) to the program ***exclusive*** of patient care without residents…dedicated to teaching, administration, scholarly activity, and patient care within the program.

- **Internal Medicine:** must provide 20 hours per week salary support for each APD. Core faculty must dedicate 15 hours per individual per week to residency training.

- **Emergency Medicine:** salary support and protected time for→each Assoc PD (not to average > 24 hours clinical time per week…1152 hours per year); each core physician faculty member (must not be required to generate revenue in kind through clinical activity to support reduced clinical hours).

- **General Surgery: NONE**

Requirements: Expected Time for Coordinator(s)

- **Family Medicine:** Support for a FT residency coordinator and other necessary support personnel
- **Internal Medicine:** support for program administrators and other support personnel
- **Emergency Medicine:** at least one program coordinator dedicated solely to program administration; 2.5 FTE support for programs with 61-75 residents (including one coordinator)
- **General Surgery:** at least one FT coordinator; if > 20 residents, then additional support should be provided.

Requirements: PD Scholarly Activity

- **Family Medicine: None**
- **Internal Medicine: None**
- **Emergency Medicine: None**
- **General Surgery:** Some scholarly activity required…

Requirements: Scholarly Activity for Faculty

- **Family Medicine:** Some members should demonstrate scholarship…
- **Internal Medicine:** Similar to above…
- **Emergency Medicine:** "one piece" scholarly activity per year per core…and one scientific peer reviewed publication **per year** per 5 core members (averaged over 5-year period)
- **General Surgery:** Similar to FM and IM…must show scholarly activity

Requirements: Resident Scholarly Activity

- **Family Medicine: similar to EM;** two projects required (one must be a QI project)
- **Internal Medicine: similar to EM**
- **Emergency Medicine:** "how to" curriculum; residents required to participate in scholarly activity; sponsor should allocate adequate educational resources…
- **General Surgery: similar to EM;** encouraged to participate in clinical/laboratory research

AOA: highly centralized…

ACGME: Not so much…

Your ACGME Contacts:

Senior Vice Presidents

Executive Directors

Eileen Anthony, MJ

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312-755-5047

How Big is the ACGME?

>9000 postdoctoral training programs

30 Review Committees…26 specialties;TY; Institutional; NMM;OPC

>120,000 postdoctoral trainees

How Do They Do What They Do?

Board of Directors…4 members each for AOA and AACOM

Monitoring Committee (Oversight)

Committee on Requirements

Review Committees (each is "independent"…all volunteer…

six year appointments …authorized by the Board)

What are the RCs?

- Three types…residency, institutional, TY
- Volunteer physicians (6-15 members)
- 30 RCs
- Six year terms
- "Oversight" by an SVP
- Executive Director
- Chair
- Public member on each
- DOs on respective RCs in which AOA offers accredited programs
- Why does everyone use RRC?

How Are RCs Organized (1)

Hospital Based Specialties

- Anesthesiology
- Diagnostic Radiology
- Emergency Medicine
- Medical Genetics
- Nuclear Medicine
- Pathology
- Preventive Medicine
- Radiation Oncology
- Transitional Year

Medical Specialties

- Allergy and Immunology
- Dermatology
- Family Medicine
- Internal Medicine
- Neurology
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry

How Are RCs Organized (2)?

Surgical Specialties

- Colon and Rectal Surgery
- Neurological Surgery
- Obstetrics and Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology
- Plastic Surgery
- Surgery
- Thoracic Surgery
- Urology

Others…

- Osteopathic Principles Committee
- Osteopathic Neuromusculoskeletal Medicine
- Institutions
- **TY**

What's Different About the OPC?

- **How do the DOs fit into the ACGME scheme?**

- Writes and adjudicates standards for "osteopathic focus" **(**or what is now entitled **OR…Osteopathic Recognition)**

- **These standards move across many RCs, so they are not actually making final accreditation decisions.**

Osteopathic Recognition Requirements (1)

- Explains the 4 tenets
- Lists skills necessary for demonstration by a trainee based upon the **six** ACGME core competencies
- Explains curriculum as well as "osteopathic track"
- Explains RPD or Track Director requirements
- Explains faculty requirements

Osteopathic Recognition Requirements (2)

- Explains resident eligibility (including IMG and MD pre-requisites)
- Osteopathic focus residency is required for osteopathic focus fellowship
- Suggests OPTI membership as a satisfactory means to participate in the continuum
- Now approved by ACGME Board
- Not developing specialty-specific standards

What's the Irony of the OPC?

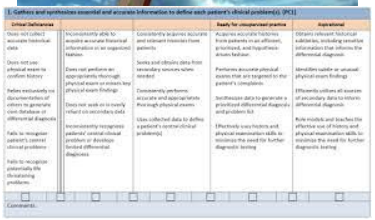
It may enhance implementation and utilization of OPP/OMM.

Now that we are one family…

What is this accreditation system all about; and why was it implemented?

Next Accreditation System

Fully Implemented by December 2014



Definition: Entrustable Professional Activities (EPAs)

"EPAs are the acts in professional practice that really matter. Whereas competencies are abstract constructs, describing capabilities of persons. EPAs just constitute the work that must be done."[1]

ten Cate, Billett 2014

PEC

Annual Reports

DIO

The Next Accreditation System

SELF STUDY (10-year)

Clinical Competency Committee

- *Must be appointed by the PD/ Assistant.*
- *Composed of members of the residency faculty*
- *Have a written description of its responsibilities including its responsibility to the sponsoring institutions and to the program director*
- *participate actively in*
  - *reviewing the evaluations of both the faculty and residents*
  - *making recommendations to the program director for resident progress, including*
    - *Promotion*
    - *Remediation*
    - *Dismissal*

1 PATIENT SAFETY

CLER Eval Process

Provide 3 opportunities for feedback

1. **Oral report**
2. **Written report to institution before submission to CLER Evaluation Committee – Institution respond**
3. **Final report to CLER Evaluation Committee**

WILL THE NEW SYSTEM CONTAIN SOME OF THE SAME AOA PROCESSES?

- Internal Reviews?
- q 5-year Site Visits?
- PTRC/COPT

What is the NAS?

- **Continuous** accreditation model
- **Surveillance with 9 sources of data**:
- Based on key screening parameters

  →**Annual Program Data** (resident/fellow/faculty data, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
- **Semi-annual resident Milestone evaluations**
- **10-year self-study and Self-Study Site Visit…help programs establish goals and evaluate performance against those goals.**
- **CLER Site Visits (Clinical Learning Environment Review)**

What about the RCs in the NAS?

- Identify trends/concerns based on annual data review

- Emphasis on helping struggling programs
- Allow strong programs to innovate

- Complete program review every 10 years

- Issue at least one accreditation decision per program per year

Next Accreditation System (NAS)

Moves the ACGME accreditation system away from meeting minimum standards to "achieving excellence in a way that works for your program". (Is this the newly flexible ACGME?)

Yes…the long-term goal is to "decrease the burden of accreditation".

Moves away from **PROCESS**: *How do you do it?*...TO...

OUTCOME...

(What is the result of what you do?)

OR as explained by a senior leader of ACGME: ***stop torturing good programs to catch the toxic ones; celebrate good programs and assist struggling programs.***

NAS

Moves beyond "needs to read more" and "well liked by others" as the gold standards of resident assessment…

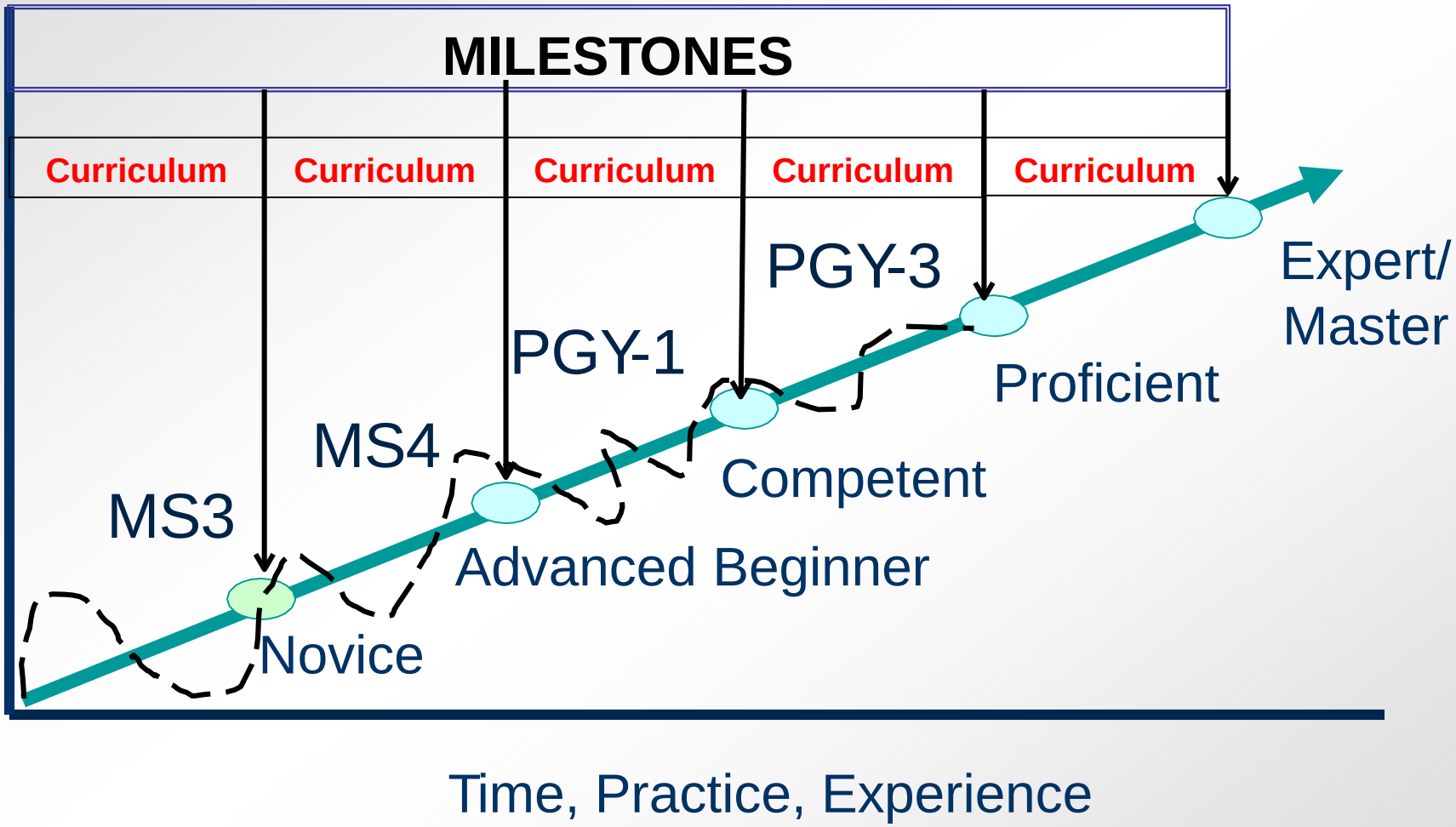
CBME and Core Competencies

It all starts here…

In Competency-Based Medical Education, the educational model acknowledges that each trainee learns at a different pace, and any one trainee advances in different areas of practice at different speeds.

CBME counters the myth that a trainee "should know _____(fill in the blank)_____ because s/he is an OGME-3 resident, and all OGME-3's should know this".

Competency Development Model



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

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Information Current as of December 2, 2013

ACGME

CBME incorporates variable length of time for training with a defined outcome. (Formative Emphasis/Knowledge Application)

"The old ways" (Structure/Process Method) incorporated a fixed length of training with variable outcomes. (Summative Emphasis/Knowledge Acquisition)

CBME

Involves more than using a six (or seven) competency-based end of rotation evaluation form on which the evaluator checks a number from 1-5 for a competency that may not be well-understood by both the evaluator or the trainee…

jargon.

Competent (Definition)

- **Competence entails more than the possession of knowledge, skills and attitudes…it requires you to apply these abilities in the clinical environment to achieve optimal results.**

What is a Competency?

- Broad domains of knowledge, skills, and attitudes *(K/S/A) the learner needs to demonstrate
- An observable ability of a health professional integrating the above
- Not always tangible

Core Competencies (Six)

Established 2002

Must have a level of proficiency in all six.

- ***The TANGIBLE Competencies:***

- **Patient Care/Procedural Skill:** Provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

- **Medical Knowledge:** Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavior sciences, as well as the application of this knowledge to patient care.

Six Competencies

- ***The INTAGIBLE Competencies (items 3-6):***

- **Interpersonal and Communication Skills:** that result in the effective exchange of information and collaboration with patients, families, and health professionals…across a broad range of socioeconomic backgrounds; work as a leader or team member; and maintain comprehensive, timely, and legible medical records.

- **Professionalism:** commitment to carrying out professional responsibilities and an adherence to ethical principles…compassion, integrity, respect, responses that supersede self-interest.

Six Competencies

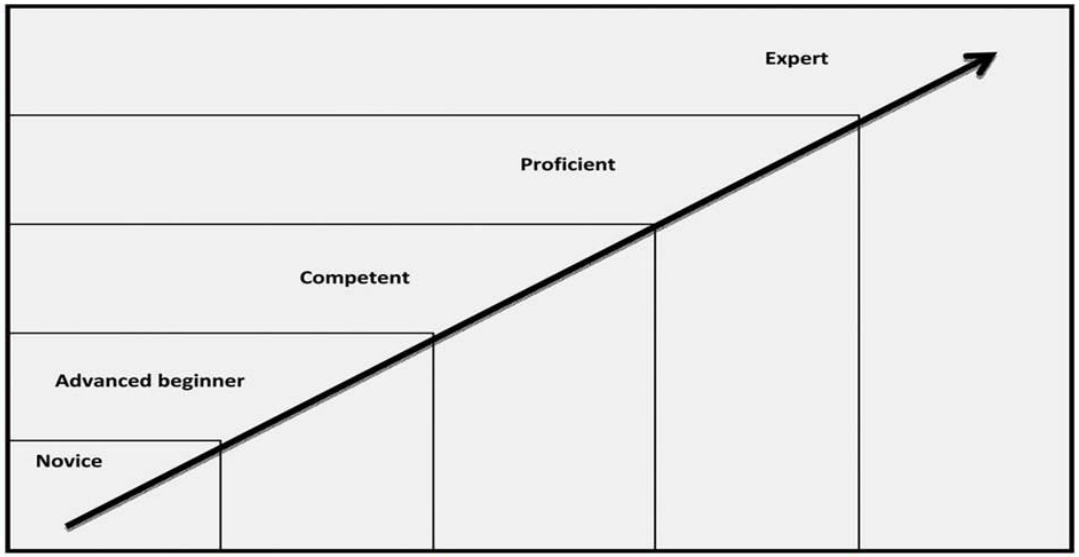
- **Practice-Based Learning and Improvement:** self-evaluate care of patients; appraise and assimilate scientific evidence; continuously improve patient care; engage in QI; incorporate formative feedback into practice; incorporate evidence-based medicine; use IT to optimize learning; educate others.

- **Systems-Based Practice:** awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care…incorporating cost awareness and risk analysis; work in inter-professional teams; participate in error identification, analysis, and improvement; coordinate care within a system.

Dreyfus and Dreyfus Model: Novice to Expert

Used as a reference to develop Milestones.

Responsibility extends to others and the environment	
Sense of responsibility increases with experience	
Sense of responsibility arises from actively making decisions	
Still does not experience personal responsibility	
Only feels responsible to follow the rules	



Scope of vision & Range of capability	Follows specific rules for specific situations. Rules are not conditional. "Only capable of following the rules"	Begins to create and identify conditional rules. "Rules have nuance and become conditional in nature"	Learns organizing principals. Information sorting by relevance begins "Higher order rules shape contexts and conditions"	Uses pattern recognition to assess what to do. Uses rules to determine how to do it "Intuition aides in identifying the situation; the actions are governed by the principals"	No analysis or planning. Pattern recognition extends to plan as well as action "Just does what works"

Milestones:

- Observable Developmental Steps (5) from Novice to Master
- **28** specialty/sub-specialty groups molded the six general competencies into specialty specific competencies **(national tools)**
- Includes "aspirational" goals of excellence (Level 5)
- Assesses a sub-competency of a general competency
- Allows trainee and faculty to summarize progress in training

Any one competency has sub-competencies…and so on…

Professionalism→COMPETENCY

Honesty and Integrity→Sub-Competency

How to assess? … MILESTONES → 5 narratives per competency that a specialty group developed when considering what is expected of any physician from the stages of novice to expert.

Designed for the learner to actually receive useful feedback.

With national data collection, this will allow the faculty member to know what to expect as the residents advance through training.

Reassures the public that safety is being addressed.

Milestones

MK-2 Applies critical thinking skills in patient care					
Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Recognizes that an in-depth knowledge of the patient and a broad knowledge of sciences are essential to the work of family physicians Demonstrates basic decision making capabilities Demonstrates the capacity to correctly interpret basic clinical tests and images	Synthesizes information from multiple resources to make clinical decisions Begins to integrate social and behavioral sciences with biomedical knowledge in patient care Anticipates expected and unexpected outcomes of the patients' clinical condition and data	Recognizes and reconciles knowledge of patient and medicine to act in patients' best interest Recognizes the effect of an individual's condition on families and populations	Integrates and synthesizes knowledge to make decisions in complex clinical situations Uses experience with patient panels to address population health	Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans Collaborates with the participants necessary to address important health problems for both individuals and communities
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Comments:					

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones

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

LIST OF CRITICAL DEFICIENCIES IN IM

Specific Milestone

EARLY LEARNER

LEARNER SHOWING IMPROVEMENT

READY FOR UNSUPERVISED PRACTICE

ASPIRATIONAL

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DESCRIPTION OF DESIGNATIONS and TEMPLATES

Ready for Unsupervised Practice: is a target for the graduating resident...but decision on readiness for graduation is the purview of the program director

Each column should NOT be assigned a resident year...

For example, some CCC's may choose to designate first column as PGY-1, second column as PGY-2, third column as PGY-3, but this practice is discouraged.

IM Milestones: 22 total; 5 Patient Care, 2 Medical Knowledge; 4 Systems Based Practice, 4 Problem Based Learning and Improvement, 4 Professionalism, 3 Interpersonal and Communication Skills, OVERALL CLINICAL COMPETENCY EVALUATION

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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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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NAS MILESTONES

It's all about feedback…the most common critique from residents in training →virtually no , or no useful, feedback from faculty).

CAUTION: It does not stand alone…not the only form of feedback; and it is not complete.

Why is good feedback necessary?

The resident who is competent but not confident will know the s/he is meeting the standard.

More importantly, the resident who is confident but not competent ("the dangerous type") will be identified prior to promotion.

Milestones and the EPAs

- 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**

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EPA's→

- **Professional activities that define the specialty (links CBME to clinical practice)**
- **So…the EPA describes the work/competency describes the person**
- Ground the competencies in a physician's everyday work
- Activities lead to some outcome that can be observed
- Complexity of the activities requires an integration of **K/S/A** across competency domains
- **NOT REQUIRED**

EPA's: how are they written?

- Short title
- Description of what is being done
- Description of the limitations of the task/procedure
- K/S/A needed to execute
- How to assess for learner progress
- Identification of the standard that creates entrustment

What are the decisions made for granting EPA's?

- **Five Levels of Entrustment**:

- 1) NOT allowed to practice the EPA
- 2) Practice with full supervision
- 3) Practice with supervision on demand
- 4) ***Unsupervised practice allowed **(STAR)**
- 5) Supervision task may be given

"Statement of Awarded Responsibility"

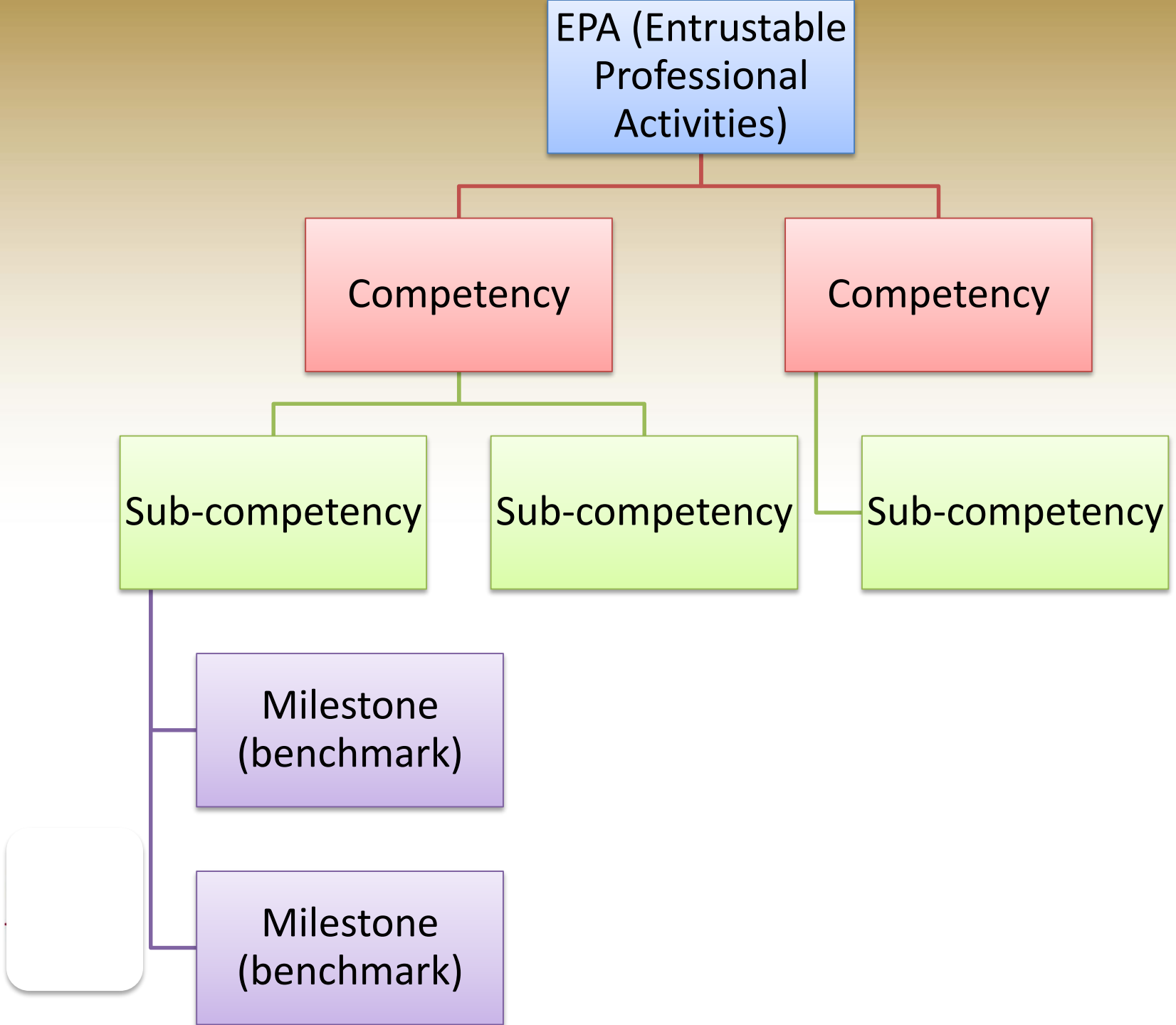
EPA vs Milestone: Procedures

Version 7/2014

4. Skill in performing procedures. (PC4)				
Critical Deficiencies			Ready for unsupervised practice	Aspirational
Attempts to perform procedures without sufficient technical skill or supervision Unwilling to perform procedures when qualified and necessary for patient care	Possesses insufficient technical skill for safe completion of common procedures	Possesses basic technical skill for the completion of some common procedures	Possesses technical skill and has successfully performed all procedures required for certification	Maximizes patient comfort and safety when performing procedures Seeks to independently perform additional procedures (beyond those required for certification) that are anticipated for future practice Teaches and supervises the performance of procedures by junior members of the team
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				

- **EPA** would describe the entrustment process for a single procedure and all of the **competencies** necessary to be mastered in order to perform the procedure

- **Milestone** reviews "procedural skill" in general as a single **sub-competency** of Patient Care/Procedural Skill


EPA (Entrustable Professional Activities)
Competency
Competency
Sub-competency
Sub-competency
Sub-competency
Milestone (benchmark)
Milestone (benchmark)

Why EPA's?

- Milestones provide a "learning roadmap"
- The roadmap needs to be grounded in clinical context to make it meaningful
- They make sense to faculty, trainees and the public
- **They add a valuable dimension to assessment (trust or *entrustment*)**

Entrustment

- You make this decision every day when you work clinically with a trainee (or student)
- EPA's formalize the process
- Entrustment is awarded when the learner can perform the EPA without supervision (which infers competence)

EPA's (ENTRUSTMENT)

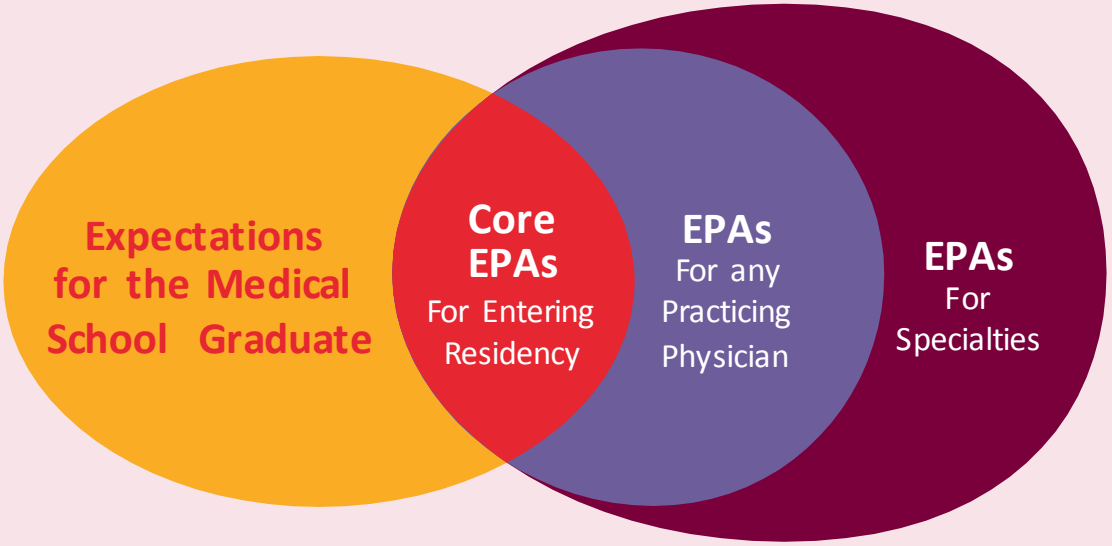


Figure 1. The relationships among the Core EPAs for Entering Residency to a medical school's graduation requirements, the EPAs for any physician, and specialty-specific EPAs

EPA's in Pre-doctoral Education

- AAMC project
- Differs from the postdoctoral model
- 13 EPA's
- Pilots underway
- CCOM planning for possible implementation

AAMC EPA's

- EPA 1: Gather a history and perform a physical examination
- EPA 2: Prioritize a differential diagnosis following a clinical encounter
- EPA 3: Recommend and interpret common diagnostic and screening tests
- EPA 4: Enter and discuss orders and prescriptions
- EPA 5: Document a clinical encounter in the patient record
- EPA 6: Provide an oral presentation of a clinical encounter
- EPA 7: Form clinical questions and retrieve evidence to advance patient care
- EPA 8: Give or receive a patient handover to transition care responsibility (responsibly)
- EPA 9: Collaborate as a member of an inter-professional team
- EPA 10: Recognize a patient requiring urgent or emergent care and initiate evaluation and management
- EPA 11: Obtain informed consent for tests and/or procedures
- EPA 12: Perform general procedures of a physician
- EPA 13: Identify system failures and contribute to a culture of safety and improvement

Clinical Competency Committee

Each program must have a CCC.

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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Clinical Competency Committee

PD

- Identify assessment methods and tools and how they align with milestones
- Determine how to report data to committee

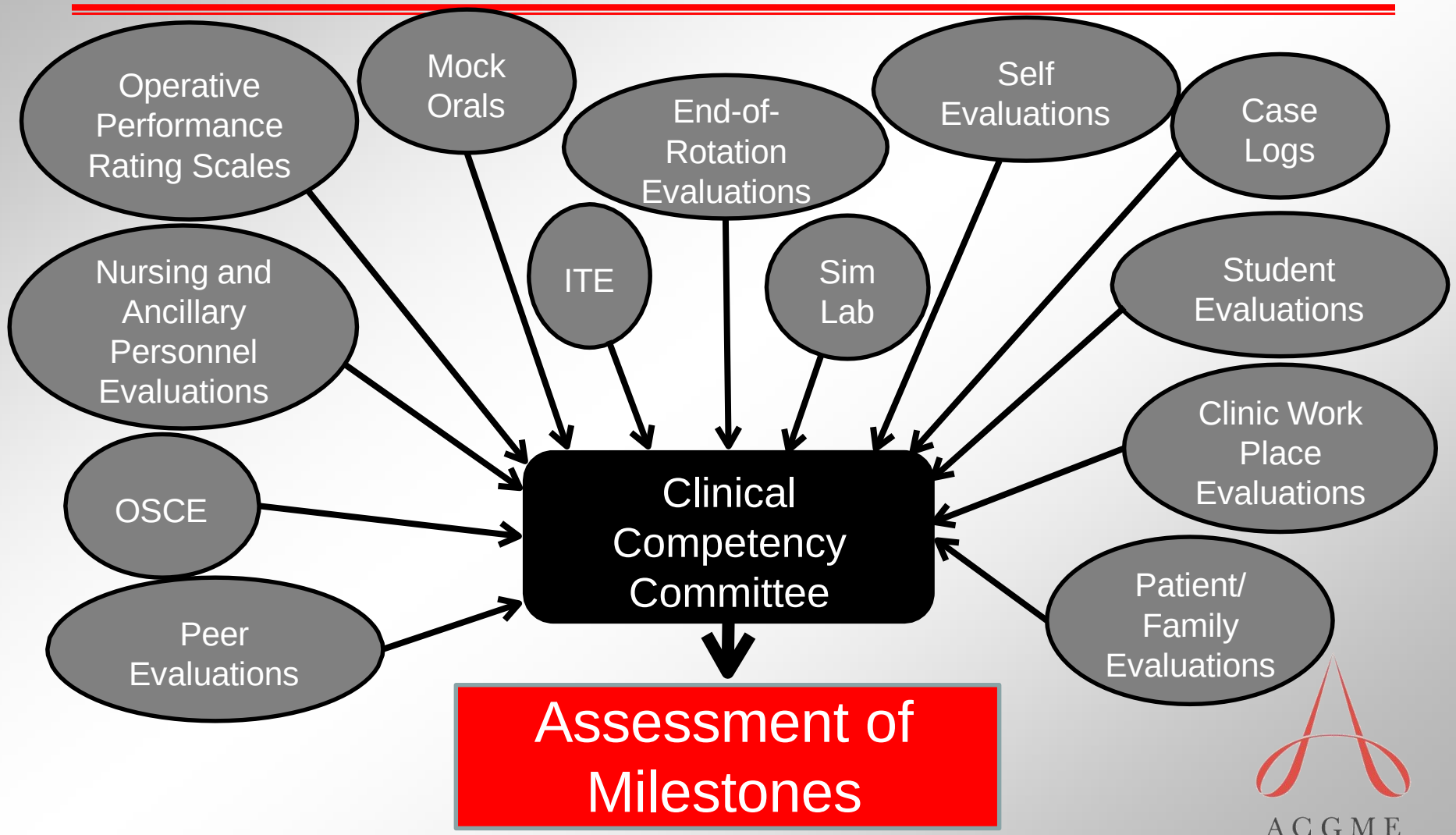
Committee

- Review resident performance on assessment tools
- Determine if resident has met the milestones
- Determine faculty development needs re: assessment

Program Director

- Conduct semi-annual evaluations
- Provide feedback to resident about milestone achievement
- Develop learning plan

Based on Holistic Evaluation



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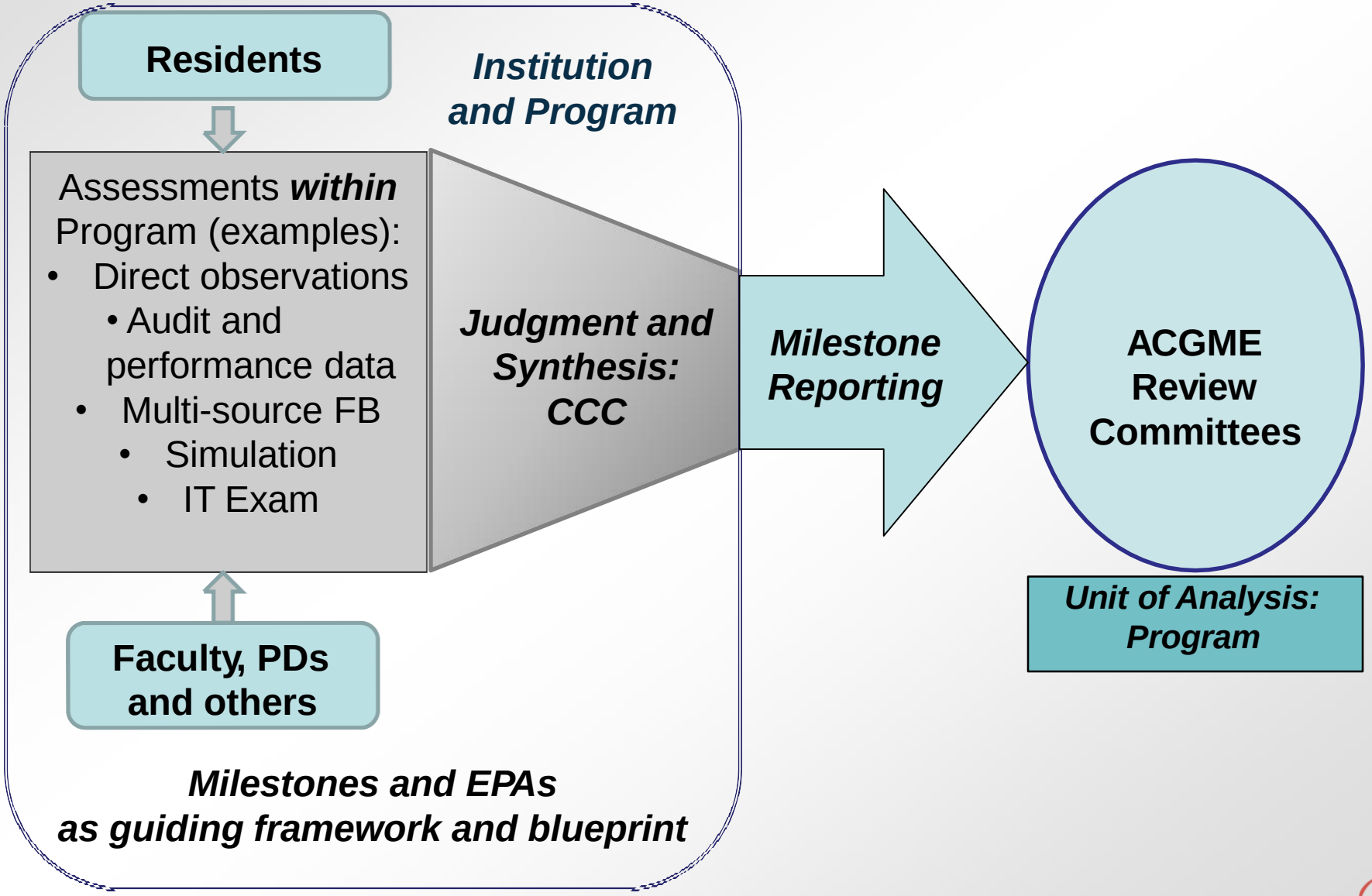
CCC allows for judgment of the faculty to guide resident assessment.

There is substantial evidence that judgment of a group is valid and reliable when assessing resident progress.

The NAS Milestone Assessment System



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Information Current as of December 2, 2013

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Common Program Requirements

Requirements that apply to all programs.

Serve as the starting point, not the end point, for standards. The RC's my tighten the requirements, but they may not loosen the standards.

Clinical Learning Environment Review (CLER) Site Visits

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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

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Program Assessment
(Another Committee)

- 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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PEC Function

- There are no requirements on how the PEC should carry out its duties
- The PEC or the program director may carry out the improvement plans
- The work of the PEC can go beyond meeting minimum standards

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Program Evaluation Committee

V.C.1. The program director must appoint the Program Evaluation Committee (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

ACGME Common Program Requirements
Approved: February 7, 2012; Effective: July 1, 2013
Approved focused revision: June 9, 2013; Effective: July 1, 2013

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Program Evaluation Committee

V.C.1.a).(3) should participate actively in:

- V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)
- V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)
- V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)
- V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

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Program Evaluation Committee

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation. (Core)

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Program Evaluation Committee

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.d) program quality; (Core)

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Program Evaluation Committee

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)

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Program Evaluation Committee

The program must monitor and track:

V.C.2.e) progress on the previous year's action plan(s). (Core)

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Program Evaluation Committee

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

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ACGME Self-Study Process

- Objective and comprehensive evaluation of the residency and fellowship programs
- Goal is to develop a longitudinal road map of program improvement over several years through "self-identification of strengths and areas of improvement"
- Likely implemented after the site visit that occurs at the close of initial accreditation period
- Two areas of focus:
  - →"Aims of the program"
  - →Assessment of program's institutional, local, and possibly regional environment

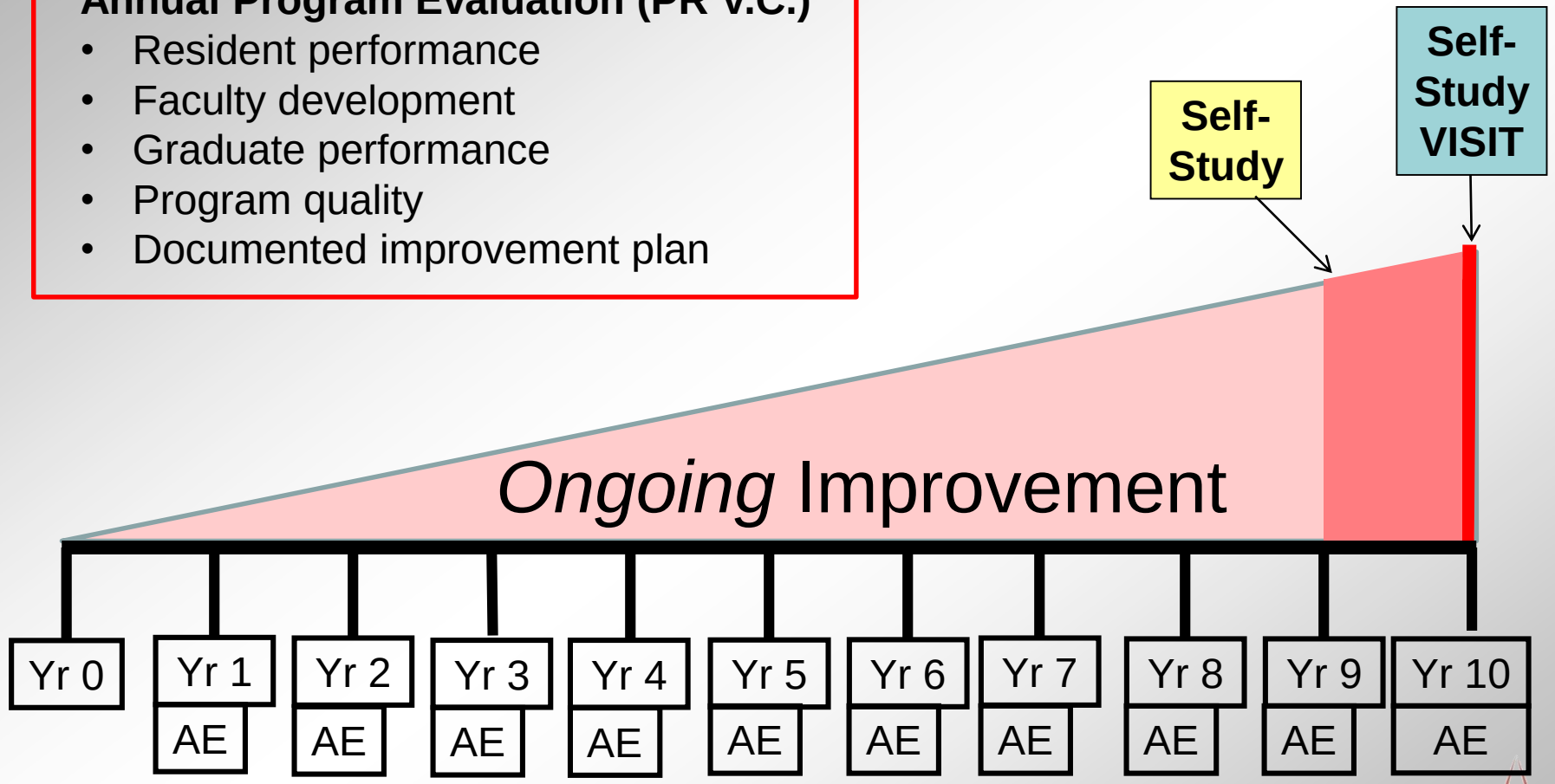
Process for the Self-Study

- Pilot studies (voluntary) now underway
- 1) **Assemble the self-study group.**..possibly the **PEC** as a starting point, along with others who can add perspective (i.e. chief resident, assessment professional, etc.)
- 2) Group should **develop** the **"Program aims"...**what is the emphasis of your program?; what do you want to develop?
- 3) Evaluate **opportunities and threats**
- 4) **Aggregate and analyze data** to generate a longitudinal assessment of the program's improvement (such as the Annual Report)
- 5) **Stakeholder input** (resident/faculty surveys, etc.)
- 6) **Interpret the data and aggregate the self-study findings**
- **7) Discuss findings with stakeholders...validate findings; discuss results with the stakeholders**
- **8) Upload succinct document that summarizes the self-study process and key findings, program aims, environmental assessment, strengths and areas of improvement...report submitted will not include the last 2 items**
- **Site visit 18 months later which includes a description of program improvements that resulted from the self-study**

Ten Year Self-Study Visit

Annual Program Evaluation (PR V.C.)

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



AE: Annual Program Evaluation

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Information Current as of December 2, 2013

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Impressions…

- More **(much more)** expected of AOA faculty **AND** trainees
- Data-heavy
- NAS is non-negotiable for AOA-accredited programs
- Old ACGME is introducing the NAS (and now the SAS) as the new ACGME.
- There will be another new ACGME as a result of the SAS
- CEO "gets it"
- Trickle down of his message will take time

Challenge:

ACGME accredits Fords, and only Fords.

Structurally, AOA will introduce…