ACCOMPANING TEXT FOR
THE NEXT ACCREDITATION SYSTEM:
A RESIDENT PERSPECTIVE POWERPOINT

SLIDE 1—History and Purpose
This presentation was developed by residents, for residents, in an effort to explain some of the changes coming as we transition to the Next Accreditation System. The NAS continues to evolve, so continue to consult your program director, program coordinator, or the ACGME website for the latest information.

SLIDE 2
No text

SLIDE 3
This presentation was developed to address questions and concerns raised by individual Review Committee resident/fellow representatives on behalf of themselves and the residents/fellows in their programs.

SLIDE 4
The ACGME is a body dedicated to assessing the quality of resident and fellow education. It provides impartial review of most of the residency and fellowship programs and their sponsoring institutions in the United States, and renders accreditation decisions through its Review Committees. There is one Review Committee for each specialty. Review Committees are composed of a single resident and several practicing physicians from the applicable specialty area. The Next Accreditation System (NAS) takes full effect on July 1, 2014 and is the culmination of long-term efforts to shift residency/fellowship education from a process-oriented to an outcomes-oriented system. The Clinical Learning Environment Review program (CLER) is a new entity developed to complement the NAS by assessing the institutional learning environment and providing feedback about how residents/fellows can be better integrated into patient safety and quality initiatives. By “institution” we mean the affiliated health care or university system that hosts your residency/fellowship program; an institution may comprise anywhere from a single residency program to dozens. The Clinical Competency Committee (CCC) is a formal review and promotions committee that is tasked with assessing residents/fellows using the Milestones as the evaluation framework. Each program within an institution is required to have its own CCC.

SLIDE 5
Residency and fellowship accreditation had been a largely process-based system since its inception. Programs were required to document various components of resident/fellow

education, but no data was required on the specific capabilities or performance of their graduates. About 10 years ago, the medical community and the public became more aware of medical errors and their impacts on patient safety, beginning with the Institute of Medicine's "To Err Is Human (1999)" and "Crossing the Quality Chasm (2002)" reports. Increased public and political pressure caused a re-examination of graduate medical education with a focus on preparing future doctors to incorporate error reduction, patient safety, and quality improvement into daily practice.

SLIDE 6
The Milestones are an integral part of the NAS. Working Groups composed of residents and practicing physicians from each specialty, supported by ACGME staff, were formed to develop the first implementation drafts of Milestones. Some Milestones have been tested by some programs (alpha test sites), and the seven NAS Phase I specialties started using the Milestones to evaluate their residents/fellows at the start of the 2013-14 academic year (beta test sites). Effective July 1, 2014, all ACGME-accredited residency and fellowship programs in all specialties will use the Milestones to evaluate their residents and fellows.

SLIDE 7
These should look familiar to everyone. The six Core Competencies, developed and implemented in 2002, form the rubric upon which you have been evaluated during residency/fellowship. The Core Competencies were part of the movement to better measure the desired outcome – physicians who can competently practice independently. Unfortunately, individual programs had great difficulty in defining those outcomes, much less in measuring them, and systematic tools were lacking. The Milestones will allow programs (and the ACGME) to start to track residents' and fellows' progress as they become competent to practice independently – the ultimate measure of the outcomes of residency/fellowship education.

SLIDE 8
The current accreditation system is based on measuring how a program documents the process of teaching its residents or fellows. It expects the same process for all programs, and there is no way to modify standards to accommodate individual programs' different circumstances and settings. The NAS was conceived as a means of allowing each program more flexibility and latitude to teach in a way that makes the most sense locally, provided that the desired outcome – physicians who are competent to practice independently – is achieved. The old system required programs to meet a minimum standard, but there was no incentive to achieve anything beyond the minimum. Conversely, the structure of the NAS is intended to foster a spirit of innovation and encourage good programs to be even better, while allowing the bulk of the Review Committees' efforts to be focused on struggling programs.

SLIDE 9
No text

SLIDE 10—NAS

Most of the annual program data will be the same information currently used to accredit programs. The difference is that each program will be considered annually by the Review Committee rather than every five years (or less) under the current system. The program data parameters considered integral to program performance will necessarily vary between specialties. Expect them to include most of the factors currently considered by the Review Committees. Programs that seem to be doing well will remain accredited while programs performing below expectations will get a closer review by their respective Review Committee. For the first time, the system will also help to identify strong performers and (hopefully) foster recognition and adoption of "best practices" by all programs.

SLIDE 11
The slide contains a comparison of site visits under the prior accreditation system and the NAS. Scheduled site visits will occur every 10 years and emphasize programs' own attempts to improve through a self-study process. Programs will be asked to consider their own strengths and weaknesses and identify opportunities to improve their programs. The goal is to ensure that programs meet and exceed the minimums outlined in the Common Program Requirements.

SLIDE 12
The work of the Review Committee will change from reviewing every program on a scheduled basis to concentrating the bulk of its energy on programs that might be struggling the most. Conversely, the most successful programs will be allowed to carry on with minimal oversight. Because program data will be reviewed annually, a program that is struggling can be identified earlier than in the old system where a program would have to come up for a scheduled site visit, sometimes up to five years after problems first surfaced, before it could be reviewed by the Review Committee.

SLIDE 13
There are some changes to the accreditation status categories that you should know about. New programs will still receive Initial Accreditation and can expect to have a site visit no more than two years after Initial Accreditation. The majority of programs will fall under Continued Accreditation, but there is no longer a cycle length attached to that status (annual renewal). Programs that have some weaknesses but are still in substantial compliance with the Common Program Requirements will receive Continued Accreditation with Warning, while programs that are in serious danger of losing accreditation will be placed in Probationary Accreditation, similar to the current system. Programs lacking substantial compliance with program requirements will have their accreditation either withheld or withdrawn.

SLIDE 14—CLER
No text

SLIDE 15
CLER site visits are designed to assess institutional policies and programs and to ascertain the level of resident/fellow engagement/involvement in patient safety and quality improvement programs. They are also designed to assess whether institutional policies are effective in

fostering a humane work environment for all members of the health care team. These visits are non-punitive, and the Review Committees will not receive CLER site visit findings. CLER site visits are intended to provide a benchmark for institutional performance and encourage all institutions to meet and/or exceed a minimum standard. Results from CLER site visits will in no way be used to inform program or institutional accreditation.

SLIDE 16
CLER site visitors will meet with residents/fellows as a large group, and may use audience response systems to obtain anonymous responses. Site visitors will also walk around hospitals and engage with people at all levels of the health care team. A summary of the findings will be provided to institutional leadership, programs, and residents/fellows; and those findings will highlight institutional performance and areas for improvement. If approached by a CLER site visitor, you should answer questions honestly, as the goal is to improve institutional processes. There is no "correct" answer, and it expected that different residents/fellows will have different experiences.

SLIDE 17—Milestones
No text

SLIDE 18
The Milestones were developed predominantly by representatives of each specialty with the support of the ACGME. They were not dictated by the ACGME staff or the Review Committees. They represent an effort to provide a systematically-developed consensus, based on available evidence and educational theory, on what performance abilities should be expected at what stage of residency/fellowship and to provide a blueprint for resident/fellow progression. At the same time, the Working Groups developing the Milestones and the ACGME recognize that each resident/fellow is an individual and that each program is different. There is no intent for the Milestones to be applied rigidly or as an isolated measure of resident/fellow development, and the program director retains ultimate responsibility for deciding when an individual resident or fellow is competent to pursue independent practice.

SLIDE 19
This slide describes the anatomy of the Milestone system. The General Competency is based in one of the six Core Competencies, and "PC" stands for "Patient Care" in this instance. Each Competency is further broken down into Subcompetencies, which comprise specific skills necessary to achieve the Competency as a whole. A milestone is actually a description of how a resident is doing, and this slide contains nine of them. The entire grouping of milestones for one Subcompetency is referred to as a "Set of Milestones."

Milestone levels do not refer to specific PGY levels of the educational program; rather, they simply represent progression, with a Level 3 milestone being more advanced than a Level 2 milestone. Residents and fellows are expected to progress at different rates, and some will spend more time at one Level than another Level. Level 5 is aspirational – this is the expected performance level of someone who has been in practice a few years.

SLIDE 20
The Milestones are an integrated, summary assessment that should be based on at least several types of evaluations. It should be expected that rotation evaluation forms or tools may need to be redesigned to align with the Milestones language, and they may even use some of the language in a Set of Milestones. Some Subcompetencies are evaluated on a continual basis while others are completion-based and will be evaluated just once.

SLIDE 21
The take home point from this slide is that many things go into resident/fellow evaluation, and the ACGME continues to expect holistic evaluation of residents and fellows. Each program will have to determine the appropriate mechanisms by which its residents or fellows will be evaluated, and will also have to determine how much weight to assign to each evaluation tool. The Clinical Competency Committee (CCC) is tasked with synthesizing all feedback and evaluating the whole resident or fellow and his or her longitudinal progress. Numerous studies have shown that better decisions are rendered through systematic group decision making processes, and having the same group of people reviewing all residents and fellows in the same way should improve the quality and consistency of formative and summative feedback that residents and fellows receive.

SLIDE 22
This slide shows how Milestones can help to define key destinations, or stages, along the road to independent practice. The curriculum provides the necessary experiences that enable a resident or fellow to move between the Milestones stages.

This example highlights the Dreyfus model of professional development on which the Milestone concept is based. Knowledge, skills, and attitudes develop over time and with experience. We expect different levels of competence for different skills.

SLIDE 23
The CCC is a group of faculty members that will review each resident's or fellow's evaluations and make an overall determination of each individual's performance. They will also evaluate each resident or fellow on his or her progress in reaching specialty milestones at least twice a year. The CCC should have a mechanism to provide the results of its deliberations as feedback to the resident or fellow.

SLIDE 24
This slide is a graphic of how the ACGME envisions the Milestone system will work. Programs will choose the right combination of assessment tools and methods based on the needs of their program and specialty, and then the CCC will use this information and the Milestones framework to discuss and create a holistic synthesis of resident or fellow progress twice a year. The program Director will submit the aggregate Milestone data to the ACGME where the Review Committees will look at it as part of the program review. Individual residents' and fellows' assessments will stay within their respective programs.

SLIDE 25
Establishment of the Program Evaluation Committee formalizes the informal annual program review that is already occurring in ACGME-accredited residency and fellowship programs. The Annual Program Evaluation includes a written summary of findings and description of progress on program improvement. Annual Program Evaluations will comprise an important component of the 10-year Self-Study site visit.

SLIDE 26
The Milestones should confer benefits on both residents/fellows and programs, and these are detailed on this slide. Currently, the ACGME only expects each program to collect and use milestones in assessing their residents/fellows. The ACGME will never expect that every resident/fellow meet a specific level since the goal is to use the Milestones honestly and thoughtfully for resident/fellow assessment. The ACGME will not be looking at an individual's Milestone attainment, and each specialty board will determine on its own whether and how to use Milestone data.

In addition to the ideas presented on the slide, some alpha test site program directors have also suggested other benefits. For example, some programs discovered that their current curriculum was not teaching a competency to the expected level (Level 4), and were able to use the Milestones as a framework for improving curriculum.

The Milestones also clearly signal to the public that the graduate medical education community is embracing the need to ensure physicians-in-training are acquiring competencies needed for 21st century health care. It is also hoped that the Milestones will allow policy makers to appreciate the skills that future physicians are learning and foster an environment that relieves attending physicians and institutions of the substantial documentation requirements and billing constraints currently imposed by the Centers for Medicare and Medicaid Services on care provided by residents/fellows.

SLIDE 27
Milestones are a method of improving feedback to residents and fellows and are designed to help programs identify strengths and weaknesses to facilitate professional growth. They may allow early identification of residents or fellows who are having difficulty and permit early remediation. Although it is possible that some residents or fellows may feel that they are being negatively impacted, effective early remediation will improve the learning process and overall performance. A resident/fellow does not need to reach Level 4 in all milestones during residency/fellowship, and it is still up to the program director to determine when an individual resident or fellow should graduate.

SLIDE 28—Summary
The NAS is a natural outgrowth of a desire to emphasize outcomes while decreasing reliance on documentation. It allows good programs to be more flexible while identifying weaker programs earlier than would have been possible in the old accreditation system. The CLER

program is a new complementary tool that encourages institutions to improve through an alternate route that is not tied to accreditation.

SLIDE 29

The Milestones will be new and unfamiliar for all of us. They will not be a perfect tool, but they will improve the evaluation and feedback process for residents and fellows. As more experience with the Milestones is gained, it is fully expected that they will be revised and rewritten. Remember, the overall goal of the NAS, including the Milestones and the CLER program, is to improve residency and fellowship education.

SLIDE 30

These references can provide some background and rationale for the NAS. Note: reference four suggests further areas for improvement of GME.