Accreditation Council for Graduate Medical Education

# SESSION II: GRADUATE HEALTH PROFESSIONAL EDUCATION/POST-GRADUATE TRAINING

Kevin B. Weiss, MD
Senior Vice President, Institutional Accreditation

ACGME

The NEW ENGLAND JOURNAL of MEDICINE

# CT Scanners: Distribution and Planning Status in the United States

Harvey V. Fineberg, M.D., Gerald S. Parker, M.S., and Laurie A. Pearlman, B.A.

N Engl J Med 1977; 297:216-218 | July 28, 1977 | DOI: 10.1056/NEJM197707282970413

*in forming community opinion by choosing one of the options and, if they like, providing their reasons.*

CASE VIGNETTE

Jim Mathis is a 45-year-old health-conscious man who has been a patient in an internal medicine–primary care practice for several years. At today's reviewed. Mr. Mathis tells you that the family tree was constructed at a genealogy workshop that he attended after visiting cousins in Europe.

# US physician medical education continuum


LCGME
AOA

NBME

NBOME

ECFMG

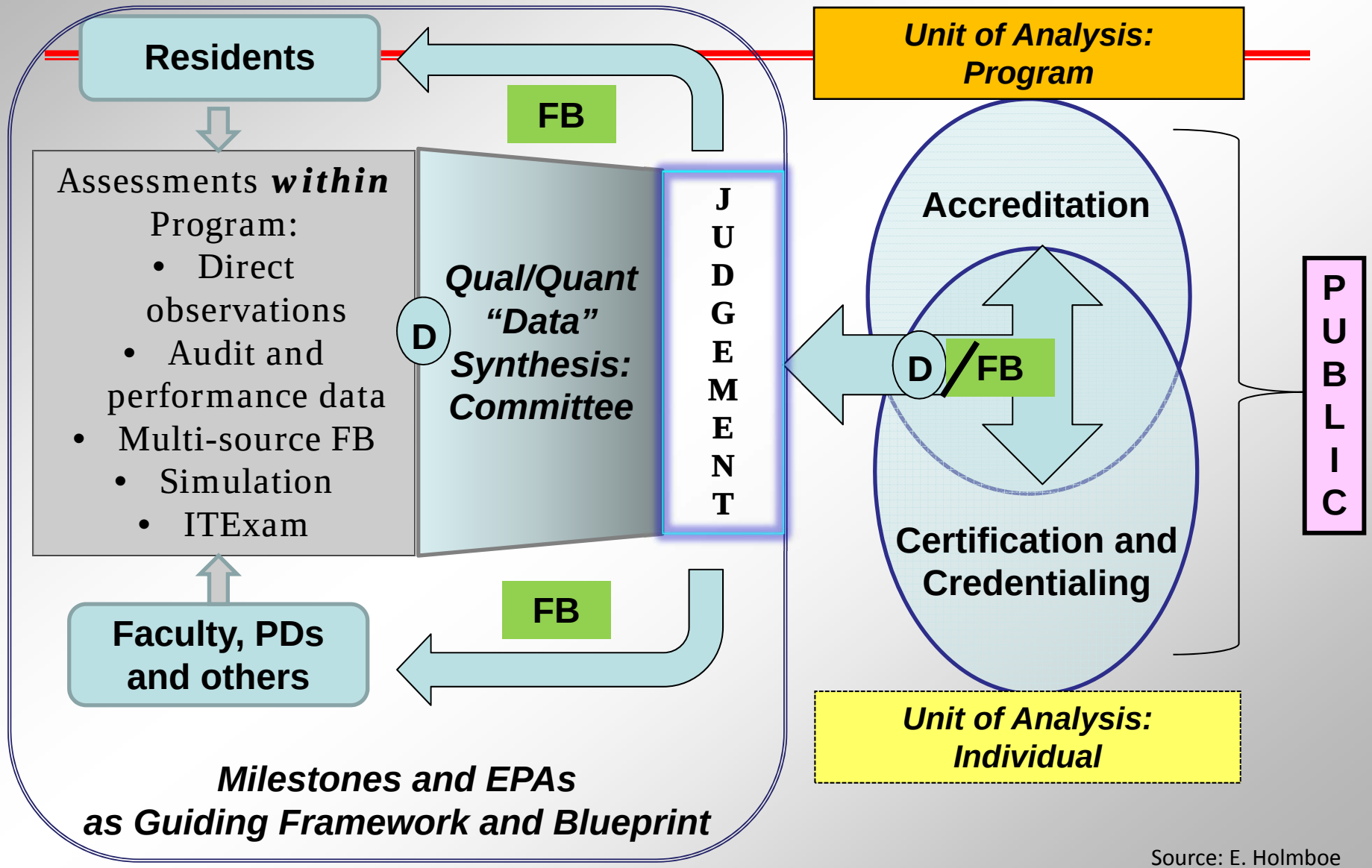
ACGME
AOA

ACCME

State Licensing (MOL)

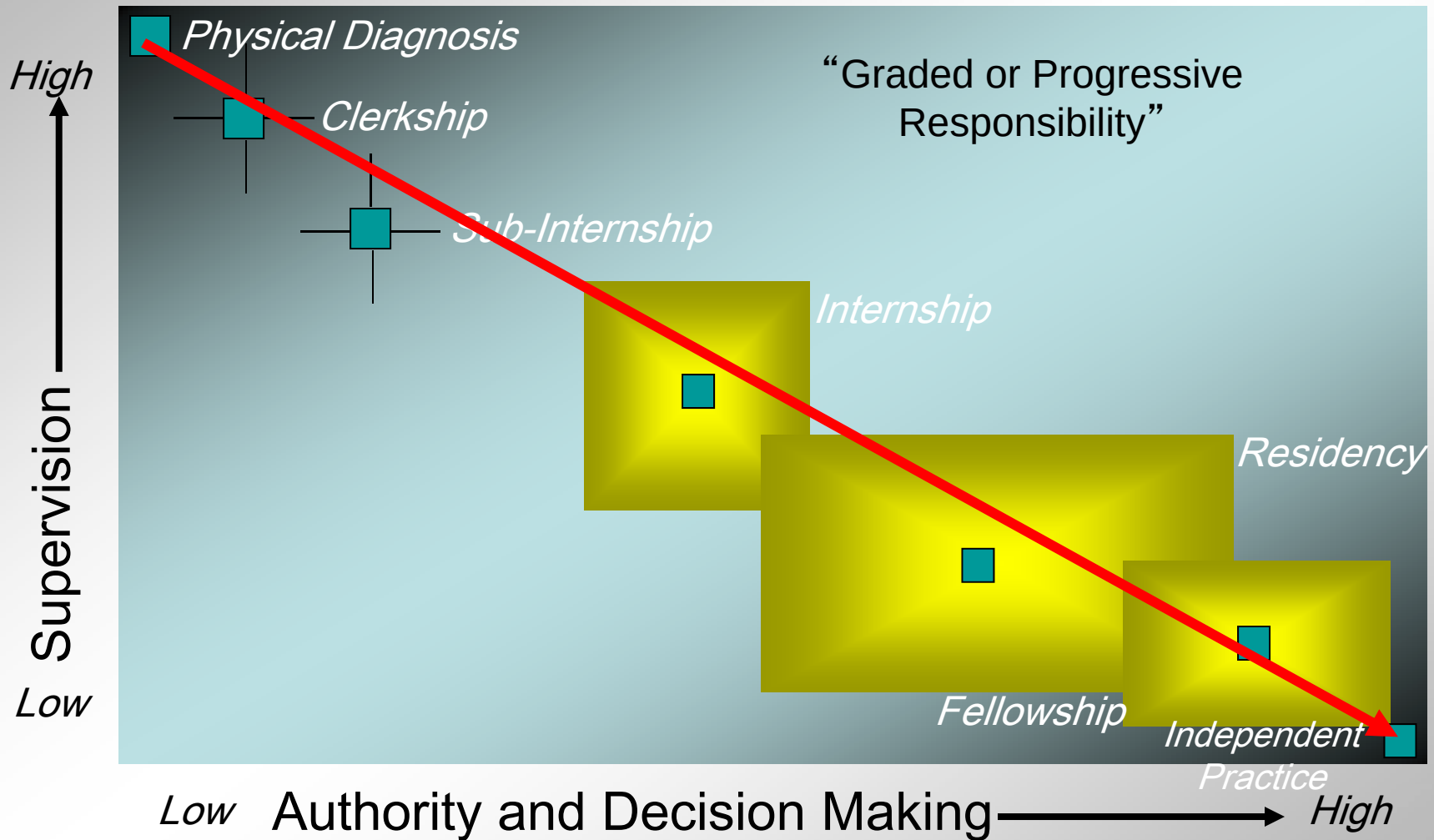
ABMS and AOA Certification (MOC)

# Professional Self-Regulatory "System"




Source: E. Holmboe

# The Continuum of Clinical Professional Development
## Authority and Decision Making versus Supervision

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# Brief history of the ACGME

1972 Under the direction of the AMA, 5 organizations created the Coordinating Council on Medical Education (CCME) and related Liaison Committee for Graduate Medical Education (LCGME).

American Medical Association
The American Board of Medical Specialties
The American Hospital Association
The Association of American Medical Colleges, and
The Council of Medical Specialty Societies.

1981 The CCME was disbanded and the LCGME evolved into the ACGME

2000 The ACGME was incorporated as an independent organization (5 members organizations still remain with some limited authority).

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# ACGME Today

**Mission Statement**
We improve health care by assessing and advancing the quality of resident physicians' education through accreditation.

**Vision**

We imagine a world characterized by:

- a structured approach to evaluating the competency of all residents and fellows;
- motivated physician role models leading all GME programs;
- high-quality, supervised, humanistic, clinical educational experience, with customized formative feedback;
- residents and fellows achieving specialty-specific proficiency prior to graduation; and
- residents and fellows prepared to become Virtuous Physicians who place the needs and well-being of patients first.

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# Physicians in ACGME Accredited Training

| | Total Residents |
|---|---|
| **ACGME Accredited Residency Programs** | 93,850 |
| **ACGME Accredited Fellowship Programs** | 19,054 |

** excludes Canadian Graduates*

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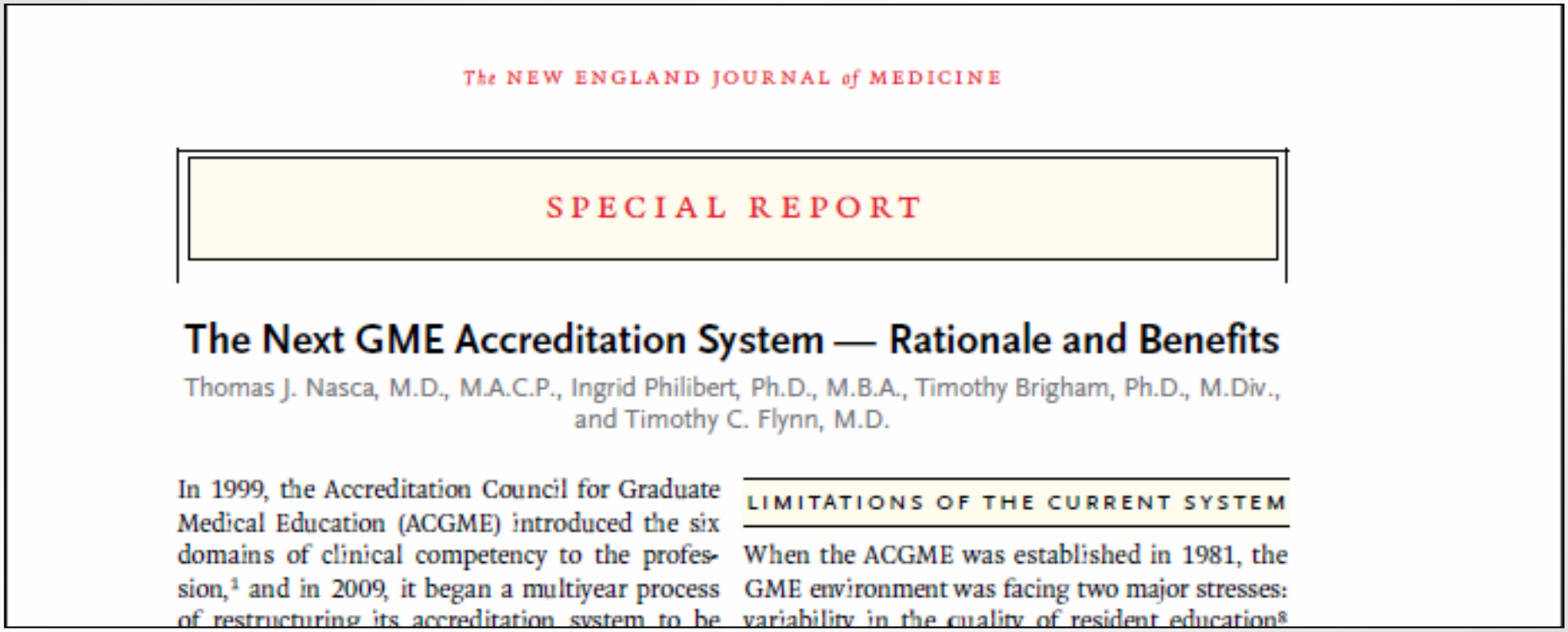
# NAS Background



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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

### 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]

N Engl J Med. 2012 Mar 15;366(11):1051-6



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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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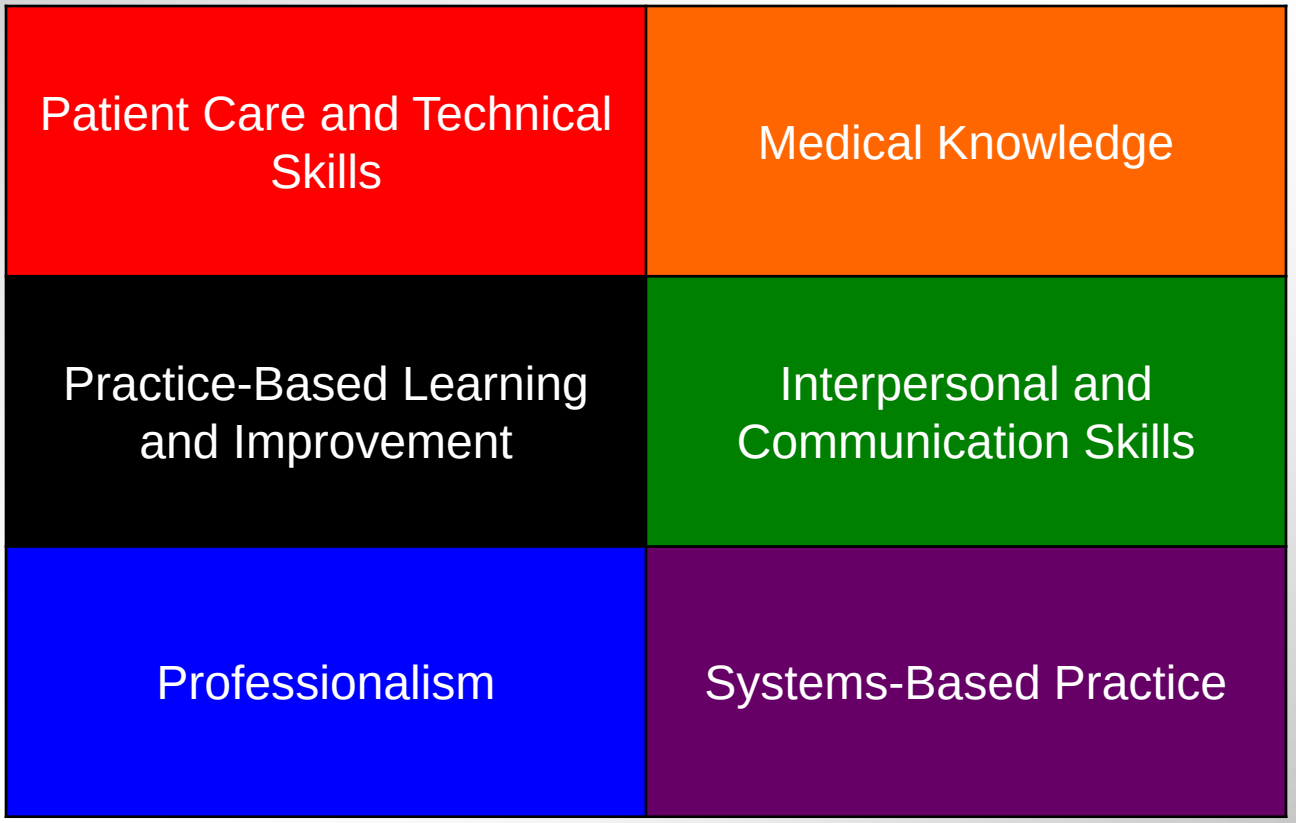
# The Six Core Competencies

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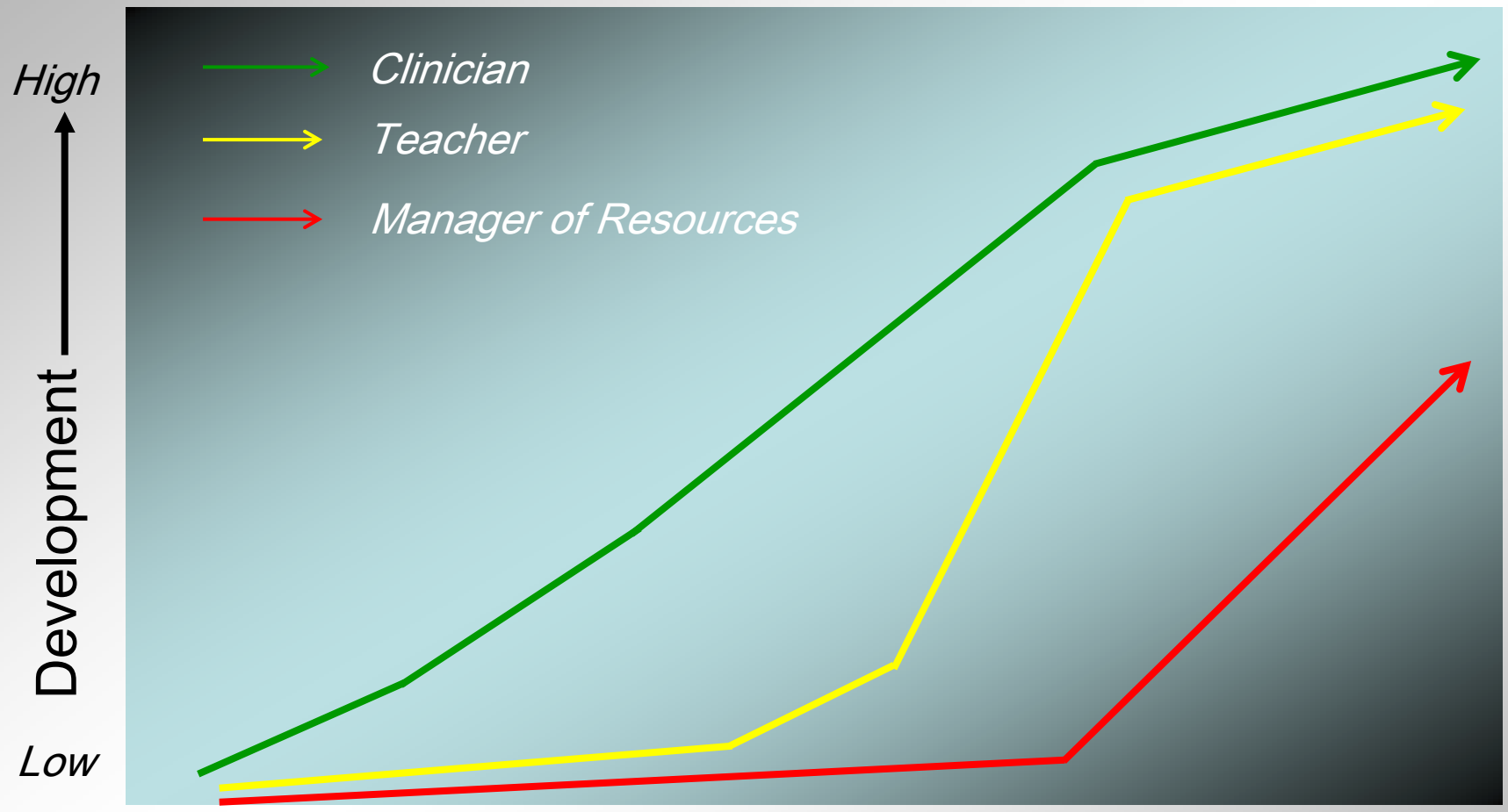
# The Continuum of Professional Development
# The Three Roles of the Physician[1]




[1] As conceptualized and described by Gonnella, J.S., et. al. Assessment Measures in Medical Education, Residency and Practice. 155-173. Springer, New York, NY. 1993, and in 1998 Paper commissioned by ABMS. Descriptively graphed by Nasca, T.J.

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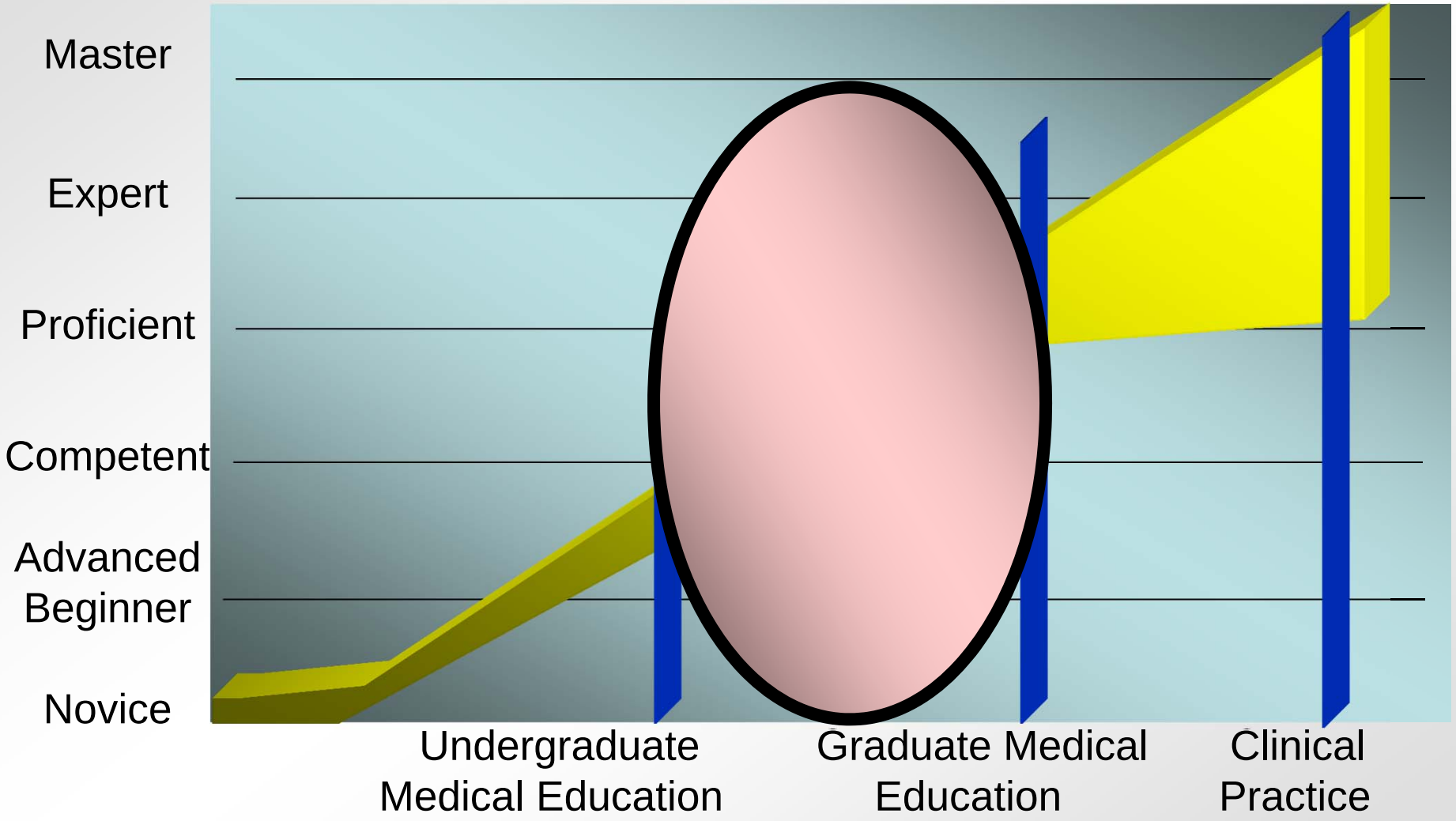
# The Goal of the Continuum of Clinical Professional Development



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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
- A ten year Self Study Visit
- Standards revised every ten years
  - Standards Organized by
    - Structure
    - Resources
    - Core Processes
    - Detailed Processes
    - Outcomes
- Required to have a CLER visit

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# Annual Data Review Elements

## Policy 17.61 Review of Annual Data

- Continuous Data Collection/Review
  - ADS Annual Update
  - Resident Survey
  - Faculty Survey
  - Milestone data
  - Certification examination performance
  - Case Log data (clinic numbers for FM)
  - Hospital accreditation data
  - Faculty member and resident scholarly activity and productivity
  - Other

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# Milestones: What

- Milestones describe performance levels residents are expected to demonstrate for skills, knowledge, and behaviors in the six competency domains.
- Milestones will lay out a framework of observable behaviors and other attributes associated with residents' development as physicians.
- In the next accreditation system , aggregate resident performance on the milestone level will be used as *one indicator* of a program's educational effectiveness.

Nasca, TJ et. al. The Next Accreditation System. NEJM 2012.366:1051-1056

# Uses and Implications


Source: E Holmboe

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


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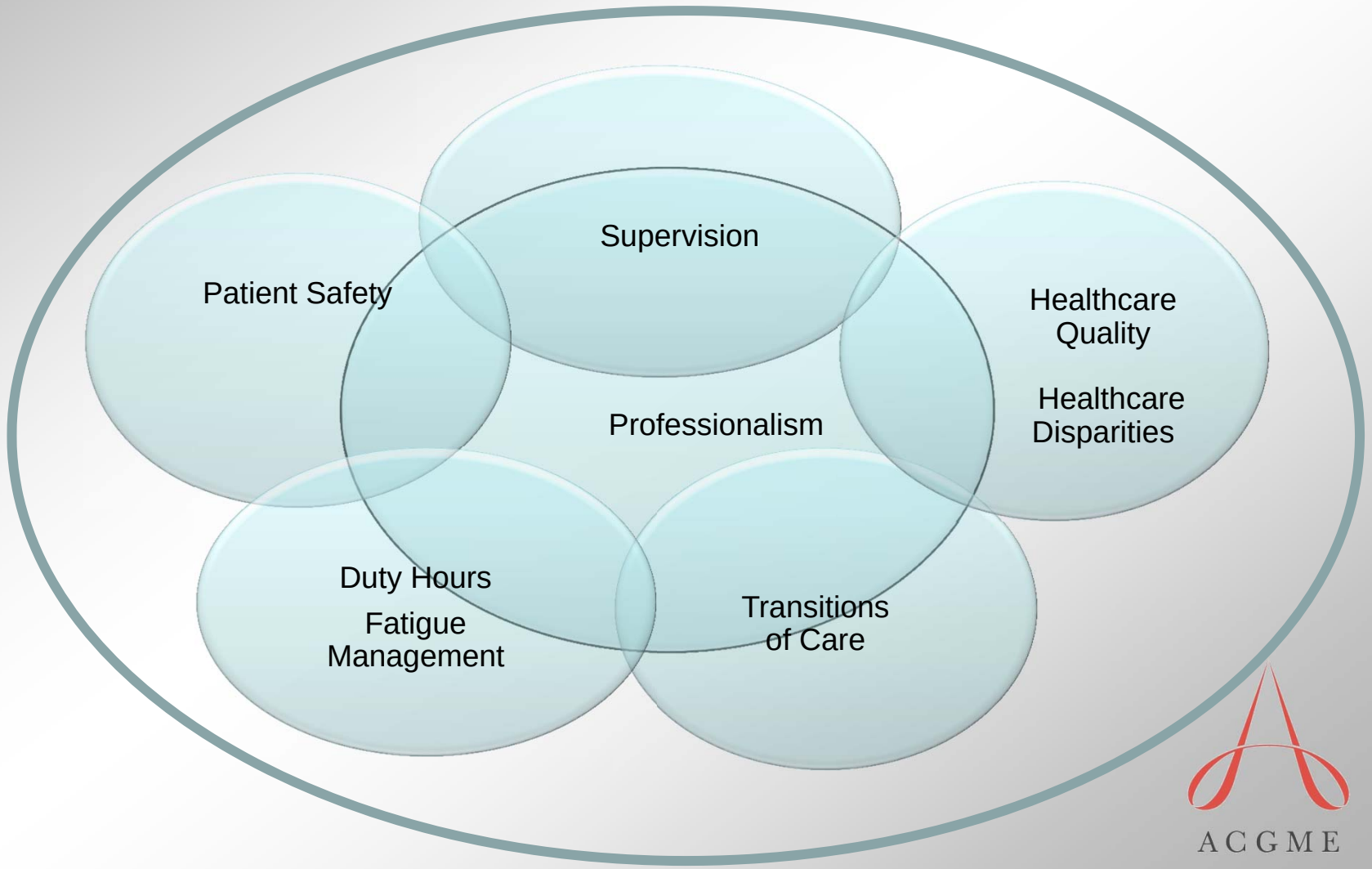
# CLER Focus Areas

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# CLER Program
# 5 key questions for each site visit

- Who and what form the hospital/medical center's infrastructure designed to address the six focus areas?
- How integrated is the GME leadership and faculty in hospital/medical center efforts across the six focus areas?
- How engaged are the **residents and fellows**?
- How does the hospital/medical center determine the success of its efforts to integrate GME into the six focus areas?
- What are the areas the hospital/medical center has identified for improvement?

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# CLER Site Visits

- Each visit, 2-3 days duration
- Every 18-24 months
- 2-4 site visitors for each visit (including volunteers)
- Group meetings and walking rounds
  - Groups: senior leadership, patient safety and HC quality leadership, residents/fellows, faculty, program directors
  - Walking rounds: physicians, nurses, allied health professionals

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# CLER Program Development

- Experience:
  - > 3,400 residents
  - > 2,800 faculty
  - > 1,900 program directors
  - > 160 CEO/Exec Directors, their ‘C-suites,’ quality and safety leadership
  - Scores of nurses, other care providers and members of staff
  - Occasional Deans

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Perspective

# Improving Clinical Learning Environments for Tomorrow's Physicians

Thomas J. Nasca, M.D., Kevin B. Weiss, M.D., and James P. Bagian, M.D.

*"Approximately 2 months ago, I had a patient where I accidently administered a wrong dose of fentanyl during a procedure. The patient developed severe hypotension, and the procedure had to be temporarily halted until we could get her blood pressure back up. My attending was close by. He responded quickly. Ultimately, no harm was done.*

*"The reason I believe this happened is that during a procedure I'm sometimes required to administer fentanyl and must dilute it during the procedure. There are two dilutions, either to directly administer by syringe, or for use as an intravenous drip. We do this dilution while we are monitoring the patient. I was told to re-review the approach to dosing fentanyl during procedures and to be more careful."*

This experience was reported by a second-year anesthesiology resident, but dozens of similar patient-care experiences have been described to us by residents in various specialties during site visits that the Accreditation Council for Graduate Medical Education (ACGME) has made to the clinical learning environments in which this country's 117,000 residents and fellows are immersed. Although the formal assessment of the CLER program's first-year experience is not complete, the early findings indicate a generalized lack of resident engagement in a "systems-based practice" of medicine in the clinical environments in which they learn and provide clinical care. Solving this problem, we believe, will require a coordinated and concerted effort by both the leadership of graduate medical education (GME) and the executive leadership and governance of U.S.

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# Clinical Learning Environment Review (CLER)

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# CLER Pathways to Excellence

Expectations for an optimal clinical learning environment to achieve safe and high quality patient care

# ACGME and Post-Graduate Education in Genomics

- Broadly shape thinking of residents/fellows preparedness for independent practice through institutional, specialty-based, and sub-specialty-based requirements
- Set expectations through formative feedback to institutional leadership
- Facilitate a national conversation on readiness for introduction of how to apply this new knowledge and associated technology

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# Post-Graduate Education in Genomics

- It appears that we are facing a rapid, and not well rationalized diffusion of a new diagnostic modality.
- Appear to need a nationally agreed on set of practice guidelines or perhaps standards that begin to define best practices related to the rapidly emerging availability and use of genomic information into health care.
- Such a resource would require a sustained effort across many key practitioner groups, patients, and other key stakeholders in health care.

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