The Next Accreditation System (NAS) for Graduate Medical Education

Implications for Medical Staff Services Leaders

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Objectives

• At the end of this session attendees will
  - Understand the rationale for the new accreditation system (NAS)
  - Review the six domains of clinical competency
    of the Accreditation Council for Graduate Medical Education (ACGME)
  - Consider the implications of the new accreditation system on applications for medical staff appointments

Case Study - 1

• Graduate of an IM program applying to your hospital for privileges
• PD letter indicates that she is “proficient” in some areas, “competent” in others, but not “expert”
• She is recommended for privileges requested
• The Credentials Committee asks you what these terms mean - is it “code” for a problem?

What do you say?
Case Study - 2

• Your Credentials Committee is just about to interview a Medical Staff candidate who completed residency training in Urology in June. The candidate states in his application that he achieved all of the program milestones.

• Not wanting to look uninformed, your Committee Chair asks you to explain to the committee “program milestones.”

Payment for and Trends in Graduate Medical Education

GME: Medicare Support (DGME)

• Direct GME (DGME): $3.3 billion/83,000 FTEs

  ✓ Medicare’s share of the direct costs associated with training residents (trainee salary and benefits, some faculty expenses, GME office, overhead, etc.)

  ✓ Currently underpaid: outdated per resident amounts; fellow payment at 50%; varying faculty costs, etc. Estimated to cover approximately 1/4-1/3 of the actual Medicare share.
Indirect Medical Education (IME): $6.6 billion/80,000 FTEs

Medicare’s share of teaching hospital support

A patient care payment to “compensate teaching hospitals for their higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals.”

Medicare Cap (DGME and IME)

FTE limits set in 1996 based on existing approved residents and fellows

10,000 slots get no Medicare support: over “cap”

Projected shortages of patient care physicians, 2008 to 2020

Projections prepared by the Lewin Group for the AAMC
Shortages projected for both primary care and subspecialists

<table>
<thead>
<tr>
<th></th>
<th>Primary Care</th>
<th>Subspecialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>9,000</td>
<td>4,700</td>
</tr>
<tr>
<td>2015</td>
<td>29,800</td>
<td>33,100</td>
</tr>
<tr>
<td>2020</td>
<td>45,400</td>
<td>46,100</td>
</tr>
</tbody>
</table>

Source: AAMC Projections, 2010

M.D. and D.O. growth since 2002 for current schools

Unless GME Positions Grow, Someone Likely to be Squeezed Out

Projected Growth in MD and DO Entrants into GME

26,000 Currently Available Residency Positions

Sources: 2008: AAMC Dean's Enrollment Survey
2008: AACOM Enrollment Analysis
Squeeze in GME is Already Happening

Results from NRMP 2002 - 2011

Rate of USMDs likely to become PCPs are stabilizing

Percent USMD PGY-1 Residents Likely to Become PCPs

In the Void...Growth in Certified Physician Assistants

Source: GME Track (Paul Jolly)
Notes: Percent=pGP legacy USMDs entering IM, FM, or Peds minus number entering IM Subspecialties or Peds Subspecialties that same year / dividing number of PGY1 entrants.

Source: National Commission on Certification of Physician Assistants
"Certified Physician Assistant Population Trends (PA-Cs)"
Source: American Association of Colleges of Nursing Annual Surveys

1 Counts include master’s and post-master’s NP and NP/CNS graduates, and Baccalaureate-to-DNP graduates.

As Well As Nurse Practitioners

Why change now?

ACGME Mission Statement

“We improve health care by assessing and advancing the quality of resident physicians’ education through exemplary accreditation”
External Pressures

Pressures on the GME System

- 2009 - House of Representatives Codifies “New Physician Competencies”
- CMS encouraged to modulate IME payments based on competency outcomes
- Recognized need to move from “circumstantial” to “intentional” practice in resident education
- Changing Public Expectations: IOM, MedPac, Macy Reports

Evaluating Residency Programs Using Patient Outcomes

n= 4,906,169 deliveries in Florida and New York, 1992-2007
4124 physician program graduates of 107 residency programs

Rate of Major Obstetric Complications by Graduates (%)

- Difference remains after correction for USMLE performance
- Excess Risk = 33%
- Q1 vs. Q5

The 2005 ACGME Strategic Plan:

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

Anonymous

What Currently Drives the Structure and Content of Residency Programs?

In the context of local service needs, choose educational experiences within institution, faculty ACGME Standards "Curriculum" "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"

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

The Required Outcomes in Each Clinical Competency (Milestones) Design Educational Experiences Select Faculty Expert Physicians who aspire to Mastery (Outcomes) National Evaluation Tools to Track Outcomes - Formative and Summative - Clinical Outcomes Tracking (not just counting) Introduction of New Competencies Guarantees that education has the opportunity to anticipate change in the delivery system "Deliberative Practice" External Accountability for Outcomes
“One definition of insanity is doing the same thing over and over again, but expecting different results.”

The Conceptual Change From...

The Current Accreditation System

Rules

Corresponding Questions

“Correct or Incorrect Answer”

Citations and Accreditation Decision

The Conceptual Change To...

The “Next Accreditation System”

“Continuous Observations”

Assure that the Program Fixes the Problem

Number of Potential Problems

Promote Innovation

Diagnose the Problem (if there is one)
Goals of NAS:
- To foster the development of realistic outcomes
- To free good programs to innovate
- To help weak programs to improve
- To reduce the burden of accreditation
- To provide accountability for outcomes to the public

NAS 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 Visit
- Standards revised every 10 years

Organized by:
- Structure
- Resources
- Core Processes
- Detailed Processes
- Outcomes
Phased Implementation

- **Phase 1 Specialties** (and Subspecialties)
  - Internal Medicine
  - Pediatrics
  - Emergency Medicine
  - Diagnostic Radiology
  - Urology
  - Orthopedic Surgery
  - Neurological Surgery

- **Phase 2 Specialties** (and Subspecialties)
  - All Other Specialties
  - Institutional Review
  - Transitional Year

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**Implementation Timeline**

- **Phase 1**
  - Ceased routine Site Visits
  - Entered “preparation year”
  - New Policies and Procedures take effect (7/1/2013)
  - Will begin Continuous Accreditation

- **Phase 2**
  - Cease routine Site Visits
  - Will enter “preparation year”
  - Will begin Continuous Accreditation

CLER = Clinical Learning Environment Review
ACGME Goals for Milestones

- Specialty-specific normative data and common expectations for progress of individual residents
- Less prescriptive ACGME program requirements, lengthened program site visit cycles, less frequent standards revision
- Opportunity for communication and improvement across the continuum of medical education
- Development of specialty-specific evaluation tools and techniques

Essential Elements

- Continuous (as opposed to Periodic) Accreditation
- Increased Focus on Outcomes
  - Demonstration of Desired Outcomes (Milestones)
  - Enhance flexibility of programs to innovate
- Standardization Balanced with Specialty Specificity
- Increased Emphasis on Patient Safety and Quality Improvement
- Enhanced Continuity Across the Spectrum of Training
- Transparency
- Enhanced Institutional Accountability

General Competences

1) Patient Care and Technical Skill
   - Compassionate, appropriate, effective
2) Medical Knowledge
   - Know and can apply
   - Can do and apply
3) Practice-Based Learning and Improvement
   - Assessment of own patient care, evidence-based approaches, improvement
4) Interpersonal and Communication Skills
   - Effective exchange of information and collaboration with patients, their families, and health professionals
5) Professionalism
   - Committed to professional responsibilities, ethical principles and sensitivity to diversity
6) Systems-Based Practice
   - Awareness and utilization of the larger context and system of healthcare in providing optimal patient care
Trajectory of Milestones

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
<th>PGY 5</th>
<th>MOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>Proficient</td>
<td>Competent</td>
<td>Advanced Beginner</td>
<td>Novice</td>
<td>Graduating Resident</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Finishing PGY 1</td>
<td>Entering PGY 1</td>
<td></td>
</tr>
</tbody>
</table>

Reporting Template

<table>
<thead>
<tr>
<th>Milestone of Competency Development</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry - Baseline, expected level at time of entry into residency</td>
<td>Mid-Program - Developmental levels of performance</td>
<td>Mid-Program - Developmental levels of performance</td>
<td>Graduation - Expected level of performance at entry into unsupervised practice</td>
<td>Stretch Goals - Exceeds expectations</td>
<td></td>
</tr>
<tr>
<td>Provides road map and assurance that residents are attaining appropriate educational goals</td>
<td>Provides road map and assurance that residents are attaining appropriate educational goals</td>
<td>Level required to gain eligibility for ABMS certification</td>
<td></td>
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Comments:

Professionalism

**Elements of Professionalism in Internal Medicine**

- Adheres to basic ethical principles
- Demonstrates compassion and respect for Patients
- Provides timely, constructive feedback to colleagues
- Maintains accessibility
- Recognizes conflicts of interest
- Demonstrates personal accountability
- Practices individual patient advocacy

**Milestones of Training**

- Demonstrates empathy and compassion to all patients (3rd month)
- Demonstrates a commitment to relieve pain and suffering (3rd month)
- Provides support (physical, psychological, social, and spiritual) for dying patient and their families (24th month)
- Provides leadership for a team that respects patient dignity and autonomy (24th month)

Resident Competency Tracking Evaluation Form

4.4/4/2014

1. Professionalism

<table>
<thead>
<tr>
<th>Term</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Honesty, integrity, and ethical behavior</td>
<td>3</td>
</tr>
</tbody>
</table>

Resident mode is truthfulness to all members of the healthcare team, is viewed as a role model in accepting personal responsibility by members of the healthcare team, and always puts the needs of each patient above his/her own interests.

2. Humanistic Behaviors of Respect, Compassion, and Empathy

<table>
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<tr>
<th>Term</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>b. Humanistic Behaviors of Respect, Compassion, and Empathy</td>
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</tr>
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</table>

Resident models compassion, empathy with patients and family members, and is viewed as a role model and an exemplar of kindness and respect patients, family members, and all members of the healthcare team.

3. Responsibility and follow through on tasks

<table>
<thead>
<tr>
<th>Term</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>c. Responsibility and follow through on tasks</td>
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Resident models effective management of multiple competing tasks, including complex clinical situations and circumstances. Resident is regularly sought out by peers, more junior learners and other members of the healthcare team as source of guidance and support in difficult or unfamiliar circumstances.
Case Study - 1

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