Update from the Review Committee for Internal Medicine (RC-IM)

American Society of Hematology
December 3-6, 2016
San Diego, CA

Christian Cable, MD, MHPE
Chair, RC-IM
Scott & White Health Care
• No conflicts to disclose
Plan for Session

• Review of NAS Process
• Reminder to Innovate
• Update on Self-Study-10 year visit
• Report on SAS
• Changes
Plan for Session

- **Review of NAS Process**
- Reminder to Innovate
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It’s a new dawn
It’s a new day…
Well…it’s a relatively new day…
As of July 1, 2013, Next Now or New Accreditation System

- Delivers on promise of outcomes-based accreditation

- Provides annual RRC review to identify “problem programs” and help them improve

- Changes the workflow of the process of accreditation
  - Annual review – no more review cycles
  - Site visits only every 10 years (or as needed)
  - Annual ADS data entry replaces PIFs

- Categorized program requirements (PRs)
  - Detail PRs = potential for innovation
NAS is about Continuous Improvement

- Annual Data Submission
- Annual ACGME Feedback
- Annual Program Evaluations
- Annual Written Action Plans

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NAS is about…
Annual Review w/ Data Elements

- Resident Survey
- Clinical Experience
- ABIM Pass Rate
- Faculty Survey
- Scholarly Activity
- Attrition/Changes
- Subspecialty Performance (for cores)
- Omission of Data
Rate how strongly you agree or disagree with the following statements:

- I have had clinical experiences with patients with a **variety of clinical problems and stages of disease**
- I have had clinical experiences with patients of **both genders and a broad age range**
- My **continuity ambulatory clinic experience** provided me sufficient exposure to the breadth and depth of the sub-specialty
- At the completion of training, I will be able to competently perform all of the **medical and/or diagnostic procedures** considered essential for a sub-specialist in this area
- At the completion of training, I will be able to manage patients in the practice of health **promotion**, disease **prevention**, **diagnosis**, and **care and treatment** of diseases/disorders appropriate of a sub-specialist in this area
Annual Data: Reported vs. Reviewed

2014-2015 Faculty/Resident Roster Reporting (Attrition/Changes) - updated until ADS Rollover

2013-2014 Faculty and Resident Scholarly Activity Reporting – updated until ADS Rollover


2015 Resident Survey (including Clinical Experience)

2015 Faculty Survey

2012-2014 ABIM pass rate data (reported by ABIM)

2015 ADS Rollover

* Milestones data are not reviewed by RC

Data Analysis

2015 Annual Update
Responses to Citations
Major Changes
Sites/Block Diagram
“Common” Questions
Evaluations
Duty Hours
Patient Safety
Learning Environment

Data Review by RC staff

Site Visits/Clarifying Information

RC Review
RC Meeting 1
RC1 LONs
SVs/CI

RC Review
RC Meeting 2
RC2 LONs

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Good practice for annual ADS update…

• Proactively use the “major changes and other updates” field in ADS
  • If see high non-compliance on survey and you implement corrections, inform the RC via this field
  • Provides RC context if program is flagged
  • Reminder: RC reviews data from previous AY
Annual Program Review

1. Warning or Probation? (NO) → Next
2. Previous Citations? (NO) → Next
3. Annual Data Issues? (NO) → PASS (Continued Accreditation)
4. Further Review
5. Further Review
6. Further Review
QUESTION #1: Are flags real?

- **Which** data elements were flagged?
  (Not all data elements have same weight/importance)
- **How many** elements were flagged?
- Are there **trends**?
  - Has RC cited program for this issue in the past?
  - Are other data elements corroborating?

*If reviewer believes the signal is real…*

QUESTION #2: Is more information (clarifying information or site visit) necessary?
Comparing Pre-NAS to NAS

- Pre-NAS: 98%
- NAS: 99%

CA: 2 Pre-NAS, 1 NAS
CA with warning: 0 Pre-NAS, 1 NAS
Probation: 0 Pre-NAS, 1 NAS

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The big deal of NAS...

7.1.2015*, % of IM programs w ZERO citations = 95%

* In 7.1.2015, all programs that …
  - had not had pre-NAS citations actively extended, and
  - had not received any new citations in previous 2 years…
  had their pre-NAS citations removed from ADS.
# of citations has declined steadily, even though the pool of programs reviewed annually has got **bigger**

- Starting AY 2013-14 *ALL* programs are reviewed annually
RC-Identified “Areas for Improvement”

• Maybe you didn’t receive a citation, but you may have received an AFI
• New way of communicating with programs…less punitive. Less onerous.
• AFI = un-citation. Unlike citations, AFIs do not require specific response in ADS.
• RC assumes the program and institution will address AFIs. Will draw further scrutiny (possibly become citations) if the trend continues
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NAS: Encourages Innovation
In NAS, PRs were categorized: **Outcome, Core and Detail**

**Why is categorization important?**

- *Programs in good standing can innovate with “detail” PRs.*
- “Detail” PRs do not go away. PDs will not need to demonstrate compliance w/ these PRs, unless it becomes evident that “outcome” or “core” PRs are not being achieved.
• Programs that have a status of *Continued Accreditation* and have not been cited for not being able to meet *outcome* or *core* PRs.
  
  • *But, noncompliance ≠ innovation*
NAS Objective - Innovation
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What is a Self-Study?

• Self-Study = Self-Assessment
• Commitment to change for the better
  • Not just maintaining status quo (meeting bare minimum of program requirements to get a pass from the ACGME)
Elements of the Self-Study

- What is our mission? What are our aims?
- Systematic/thorough evaluation of program
- Need input from those involved in the program
- Must be ongoing
- Plan-Do-Study-Act…
  - Important to “do” not just “plan”
Self-Study: “An Opportunity, Not a Burden”

The ACGME Self-Study—An Opportunity, Not a Burden

Susan Guralnick, MD
Tamika Hernandez, BS
Mark Corapi, MD
Jamie Yedowitz-Freeman, DO
Stanislav Klek, MD

Introduction

In 2013, the Accreditation Council for Graduate Medical Education (ACGME) implemented the Next Accreditation System. A major goal of the new system is for program accreditation to become a continuous process of quality improvement. Accredited residency and fellowship programs report specified data annually to the ACGME. These data are then reviewed by the specialty review committees for compliance with each specialty’s requirements. The newest component of this process is the self-study.

The self-study is a new and evolving approach to residency and fellowship accreditation. Although a self-study has been used by many educational accreditors, it has not been used in graduate medical education. The ACGME now requires programs, as part of their 10-year review cycle, to perform a self-study.

Why is this a challenge for programs? This is a new process and tested models are lacking. The approach used by the Liaison Committee for Medical Education is time-consuming and not truly applicable to a graduate medical education program, as it is a much smaller unit of analysis compared to a medical school.

To date, there are no templates or sample documents available, nor have any seminars or workshops been presented by representatives from programs that have done this successfully. Programs need to “start from scratch,” and this is not an easy task. Additionally, the more time programs spend on developing a new process, the less time they may have to actually perform the self-study.

The purpose of this article is to provide an example of a successful self-study process, along with a sample timeline and self-study materials. This will hopefully guide other programs through the process, and decrease the time spent on developing a new self-study process. Ultimately, this should allow more time to be spent on the performance of a rich and informative self-study.

The Self-Study Process

Programs are notified approximately 6 to 7 months prior to their self-study submission date.

The self-study process requires the key steps shown in Box 1.

Engagement of key stakeholders is essential, as is an organized and facile process. If several programs are being reviewed together (core specialty and subspecialty programs), representatives from all programs should work together to develop a unified and logical self-study process, as well as to identify shared needs, and resources to meet these needs. It does not make sense for each program to create a parallel process, as such a duplicate effort wastes valuable time and other resources. Additionally, broad engagement in the process by those with diverse knowledge and experience may result in a richer outcome than might occur with 1 program alone. Box 2 shows key considerations for the self-study process.

It is important to note that the self-study summary document does not include information on program strengths and areas for improvement. This is to encourage programs to honestly address problems, concerns, and faults in their self-study process without fear of a negative accreditation outcome. For the program’s 10-year accreditation site visits, scheduled 12 to 18 months after the self-study, the program is asked to submit a list of program strengths, and a summary of the improvements and achievements that were made in areas that were identified during the self-study.

Guralnick, S, Hernandez, T, Corapi, M, Yedowitz-Freeman, J, Klek, S, JGME, September 2015
**Self-Study/10-year Timeline (Example)**

**ACGME DFA**

November 2016
Announces Self-Study

**Program**

May 2017
Uploads Self-Study Summary

~ August 2018 (+/- 3 months)
Updates ADS
Uploads Summary of Achievements

~ August 2018 (+/- 3 months)
Conducts 10-year compliance visit

~ May 2018 (+/- 3 months)
Announces 10-year compliance visit

12-18 months between Self-Study and 10-year compliance visit

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Expectations for NEW SAS Applications

PD, APD, CF, KCF, SEC…AOA is AOK!
SAS Update
Expectations for non-SAS Applications

PD, APD, CF, KCF, SEC…AOA is AOK!
What positions can an AOBIM-certified internist hold in “non-SAS” programs?

**Beyond SAS…**

PD, APD, CF, SEC, or KCF may be either ABIM- or AOBIM-certified, regardless of whether program is an AOA program applying to ACGME, a new non-SAS application, or an existing ACGME-accredited program.

This is a local decision. Local, program, and institutional leadership need to select the most appropriately qualified and certified internist for the leadership position within the program.
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Revision of Common Program Requirements
Phase I: Section VI of the CPRs

January 7, 2016

Dear Members of the Graduate Medical Education Community,

I trust that this letter finds you well and looking forward to another year of opportunity to serve, and to prepare the next generation of physicians to serve the American Public. At the ACGME, we are continuing the process of remodeling the accreditation of graduate medical education sponsors and programs into one of continuous improvement and aspiration to excellence. When we began this journey, we were faced with many challenges, and while the nature of those challenges may have changed, challenges continue to present opportunities to improve and evolve.

The next step in this evolution is for us to review the framework of the ACGME’s requirements. In this regard, a major effort will commence this month. The ACGME will embark on a full review of its Common Program Requirements in two phases over the next 18 months. The ACGME Board of Directors has commissioned a Common Program Requirements Phase 1 Task Force to concentrate on collecting information and producing recommended updates to Section VI, Resident Duty Hours in the Learning and Working Environment, to fulfill our commitment to review these requirements every five years. This section of the Common Program Requirements includes expectations for faculty members and residents in: Professionalism, Personal Responsibility, and Patient Safety; Transitions of Care, Alertness Management/Fatigue Mitigation; Supervision of Residents; and Clinical Responsibilities in areas of Teamwork and Resident Duty Hours.

At the completion of Phase 1, a second Task Force (Phase 2) will be convened to assess and propose revisions to ACGME Common Program Requirements Sections I-V. This includes expectations for: Sponsoring Institutions and Participating Sites; Program Personnel and Resources; Resident Appointments and Eligibility; Dimensions of the Educational Program; and Evaluation of Residents, Faculty, and the Educational Program.
Revision of CPRs
Phase II: All other CPRs
What is “trending” at ACGME…

Professional expectations → public expectations
Expert based approach to PRs → evidence-based
Process → Outcomes
Focus on rules → Improvement
ACGME/RC oversight → local oversight
Episodic review → Annual review
Paper PIFs → electronic data collection
ACGME focus → Focus on collaboration
Composition of the RC-IM

Robert Benz, MD
Christian Cable, MD Chair
Jessica Deslauriers, MD Resident
Alan Dalkin, MD
Andrew Dentino, MD
Sanjay Desai, MD
Sima Desai, MD
Oren Fix, MD
Andrea Reid, MD Resident
Kristin Jacob, MD
Betty Lo, MD
Monica Lypson, MD

Brian Mandell, MD Vice-Chair
Elaine Muchmore, MD
Cheryl O’Malley, MD
Jill Patton, DO
Kris Patton, MD
Donna Polk, MD
Ilene Rosen, MD
Samuel Snyder, DO
David Sweet, MD
Jacqueline Stocking, RN
Heather Yun, MD
Patrick Alguire, MD ex officio, ACP
Furman McDonald, MD ex officio, ABIM

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24 VOTING MEMBERS

- 6 ABIM-nominated
- 6 ACP-nominated
- 6 AMA-nominated
- 3 AOA-nominated
- 2 resident members
- 1 public member

ACGME/RC Staff

2 ex officio, non-voting (ABIM, ACP)
ACGME/RC Staff

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