Frequently Asked Questions about the Next Accreditation System

August 2012

The Next Accreditation System (NAS)

What is the timeline for the implementation of the NAS?

For the seven specialties in Phase I of the NAS (Emergency Medicine, Internal Medicine, Pediatrics, Neurological Surgery, Orthopaedic Surgery, Diagnostic Radiology, and Urology) and their subspecialties, implementation of the NAS will occur on July 1, 2013. For all other specialties, the Transitional Year and the Institutional Review implementation of the NAS will occur on July 1, 2014.

What are the components of the Annual Data Reporting each program will make to the ACGME?

While the final reporting systems are under development, much of the data that will be used in the NAS is available now and used in the accreditation of programs. This includes the Annual Accreditation Data System (ADS) update, the ACGME Resident Survey, case log and clinical experience data, and data on graduates' performance on the certifying board examination.

New data elements for the NAS will include the Educational Milestone data from the semiannual evaluation of the residents, aggregated to the level of the program, with the first reports for Phase I specialties scheduled for submission to the ACGME in December 2013 and June 2014. New data also will include a faculty survey (scheduled for implementation in 2012/13), and a scholarly activity report form that replaces the detailed faculty curricula vitae presently being used.

How will programs generate and submit the annual data that will be used in the NAS?

Data will be submitted by programs, as is currently done. Much of the data for the NAS uses an "update for any changes" approach to reduce the burden on programs, and some of the new data sources replace current more onerous submission formats. An example is the replacement of the complete faculty curricula vitae (CVs) for faculty with abbreviated information that collects data only on faculty members' board certification status and scholarly activity. The only individual for whom a complete CV will be collected is the program director.

What happens to cycle length in the NAS?

In the NAS, the ACGME will be using continuous accreditation model with - collection and review of annual data from each program. All programs, with the exception of applications and very newly accredited programs, will have a scheduled self-study visit every 10 years. In addition, programs may have focused or diagnostic site visits, if the annual data submission suggests a potential problem. These site visits are described below.

How will subspecialty programs be reviewed in the NAS?

Subspecialty programs will have their annual review together with their respective core program, and also will have their self-study visit concurrent with the visit to the core program.

Review Committees will review annual data, including fellow survey and faculty survey data, and the annual ADS update information and, where applicable, minimum procedural numbers, in the accreditation of subspecialty programs just as they do for core residencies. The NAS places more responsibility for oversight of the subspecialty programs on the core program and the department.

Development of the Educational Milestones for subspecialties will begin in July 2013. Over time, these Milestones will be used for the accreditation of fellowship programs just as they are for residency programs.

How will new applications be reviewed in the NAS?

All core specialty programs and subspecialty programs in most surgical specialties will have a site visit; other subspecialty programs will be reviewed by the RRCs using the written application prepared by the program, and if accredited, would be scheduled for a site visit within two years of the application.

The Program Requirements (PRs) have been re-categorized, with some labeled as "core" and other labeled as "detailed" in the NAS. What is the reason for this?

The NAS will focus on outcomes. The ACGME recategorized the requirements with the expectation that programs will not be assessed for compliance with the "detail" requirements if they can demonstrate good educational outcomes. "Detail" requirements will be considered mandatory for new programs and for programs that have failed to meet expectations for outcomes (and have an accreditation status of probation or continued accreditation with warning), and are intended to offer these programs added guidance. Allowing high-performing programs freedom to meet the detailed requirements with alternatives will offer these programs the opportunity to innovate.

The Clinical Learning Environment Review (CLER)

What are the objectives of the CLER visits?

Since the release of the Institute of Medicine's report on resident hours and patient safety, there have been calls for enhanced institutional oversight of duty hour limits and of efforts to enhance the quality and safety of care in teaching hospitals. In response the ACGME established the CLER program as a key component of the NAS, with the aim to promote safety and quality of care. CLER focuses on seven areas important to the safety and quality of care in teaching hospitals and the care residents will provide in a lifetime of practice after completion of training: 1) engagement of residents in patient safety; 2) engagement of residents in quality improvement; 3) enhancing practice for care transitions; 4) identifying opportunities for reducing health disparities; 5) promoting appropriate resident supervision; 6) duty hour oversight and fatigue management; and 7) enhancing professionalism in the learning environment and in reporting to the ACGME.

How will CLER Visits be conducted?

CLER visits will be done by a team of site visitors, which will include one peer visitor from another sponsoring institution. Institutions will have up to three weeks of advance notice of the visit. No advance preparation of documents will be required. The visit will use interviews, review of existing reports and data, such as duty hour monitoring data, and visits into the clinical learning environment to obtain an accurate picture of the learning environment.

What will be done with the data from the CLER visits?

In the first 18 months of the CLER program, the ACGME will develop, test, and fully implement this new program through visits to the nearly 400 clinical sites of sponsoring institutions with two or more specialty or subspecialty programs. During this period, the CLER visits will be used to provide a formative evaluation of the learning environment. After the CLER visit, a report will be provided to the institution.

How will the CLER data be used in program and institutional reviews?

For the first 18-month cycle of visits, only the aggregated data will go to the Institutional Review Committee (IRC) (data for individual institutions will not be reported), and the data will not be used in accreditation decisions. The sole exception would be an instance in which the CLER visit team discovers a potential egregious violation of the accreditation standards. In this case, the ACGME would follow the ACGME egregious violations policies detailed in the ACGME Policies and Procedures Manual, *Section 20.00*

The Educational Milestones

What are the Educational Milestones?

The Milestones are observable developmental steps moving from beginning resident to the expected level of proficiency at graduation from residency, ultimately, the level of expert/master. The Milestones for each specialty have been developed by an expert panel made up of members of the RRCs, the ABMS certifying board, program directors and residents. The Milestones are organized under the six competencies and describe a trajectory of progress from neophyte towards independent practice. The benefits of the Milestones is that they articulate shared understanding of expectations, set aspirational goals of excellence, provide a framework and language for discussions across the continuum, and ultimately track what is most important – the educational outcomes of the residency program.

How will the Educational Milestones be used in resident evaluations?

The Milestones will supplement, rather than replace, current assessment tools used by residency programs, including faculty assessments of residents on rotations, self-evaluations, peer evaluations, evaluations by nurses and others. Initially, the CCC will review these evaluations and use them to inform their assessment of each resident. Programs in Phase I specialties will submit their initial Milestone data in December 2013 and June 2014.

Once programs have submitted the Milestones assessments, the ACGME will construct a Milestones evaluation report for each resident based on what the program submitted. These reports will be available to programs. Programs may use them for any of the following purposes: formative feedback and summative evaluation of residents, resident promotion decisions, and curriculum and educational program assessment and improvement.

In the initial years of the NAS, Milestones assessments at the program level will be done by comparing the progress on the Milestones of the resident cohort in the given program over time. The ACGME expects that it will take several years for national data on the Milestones to become available.

Use of the Educational Milestones and the pre-defined narrative criteria for levels of performance will assist programs in resident evaluation and will enhance transparency for learners, programs, sponsoring institutions and the public.

How will the validity and reliability of the Milestones be established?

The Milestones were written by an expert panel of board members, RRC members, program directors and residents and represent a broad range of specific areas of expertise that a resident in the given clinical specialty is expected to develop.

Establishing the *construct, criterion* and *predictive* validity of the Milestones will require the use of the Milestones in resident assessments, and the accrual of national data and

comparisons to evaluation methods previously used and assessment already considered to be of high value, such as board performance data.

Similarly, establishing the reliability of the milestones will require data from their use in the assessment of residents. One advantage of the Milestones, compared to the evaluation tools currently used by individual programs, is that assessment data will be collected on thousands of residents, producing a sample that over time will make it possible to establish their reliability and validity.

What is the timeline for the application of the Educational Milestones?

Development of the Milestones for all core specialties will be completed by December 2012. Programs in Phase I of the NAS are expected to form Clinical Competency Committees (CCCs) in the spring of 2013, and begin to evaluate residents on the Educational Milestones at the start of Academic Year 2013-14, with the first two Milestones submission to the ACGME scheduled to occur in December 2013 and June 2014.

Development of the Milestones for subspecialty programs is scheduled to begin in July 2013, and is expected to be completed in a shorter time than the development of the core specialty Milestones. The subspecialty Milestones will also focus to a much greater extent on medical knowledge and patient care skills.

Clinical Competency Committees

What is the role of the Clinical Competency Committee in resident assessment?

Each program is expected to form a Clinical Competency Committee (CCC) and begin to develop its members by June 2013. The members of the CCC make a consensus decision on the progress of each resident. Initially, this will use the existing resident assessment data, tools and faculty observations. Beginning in 2013, the CCC assessments will use data from the Educational Milestone assessments.

A benefit of the CCC approach is that it will offer the resident evaluation process the insight and perspectives of a group of faculty. The CCC will also serve as an early warning system if a resident fails to progress in the education program, and will assist in their early identification and move toward improvement and remediation.

How will members of the CCCs be prepared for their assessment role?

Evaluation is a core faculty competency, but most faculty members will need added training in the evaluation process, including how to aggregate and interpret data. There are plans to develop training resources for CCCs. In addition, the individual CCCs and the community of educators at a given institution will also serves as a venue for faculty discussion about resident evaluation, including issues around sample size, data quality, and the application of QI principles to the evaluation process.

How much work will be required by the CCC to conduct the semi-annual resident assessments on the Milestones?

Pilot assessments on the Milestones have found that it takes a significant time (up to an hour) to conduct the Milestones assessment for each of the residents the first time the evaluation is done, but that subsequent evaluations take less time as CCC members become familiar with the Milestones and their use.

Should the Milestones assessments be made by specialists during residents' clinical rotations rather than semi-annually by a committee?

Faculty specialists and, in some specialties, other health care personnel who contributes to 360 degree evaluations, will evaluate residents during rotations and assignments using the evaluation tools program currently use (and new ones may be added in the future). The CCC will take data from these evaluations and apply them to the Milestones to mark the progress of the individual resident. The CCC will have the advantage of knowing how each of those specialists evaluates residents and can apply that knowledge as they mark the progress of the residents on the Milestones.

Should CCCs set a threshold for a resident to have remediation and possible separation?

One of the goals of the Milestones project is to be able to identify residents who are not progressing with their peers in one or more areas. In the early years of the Educational Milestones, the comparisons will be to a resident's peers in the given program and the thresholds will be set by the CCC. Interventions a program might consider include: assigning a mentor with expertise in a given area of deficiency, additional required readings, sessions in a skills lab, and/or added rotations in a given area. If, after remediation, a resident still fails to advance sufficiently on one or more Milestones, a CCC might consider extending training, or counseling the residents to consider another specialty or profession.

The Milestones will be used for program accreditation. What will keep PD's from reporting milestones in a way that leads to successful accreditation rather than accurate reporting of residents' progress?

The ACGME expects a high degree of professionalism from program directors and faculty. This includes honest assessment and reporting of the residents' progress on the Milestones. It would be a disservice to its residents for the program to be less than candid about their performance *vis a vis* the Milestones. In the current accreditation system, most if not all programs have faced situations, often late in training, in which the program leadership discovered that a resident is not really prepared for independent practice in the specialty. At that point, the program director has to decide whether they would rather postpone the fellowship or practice plans of those individuals, as no residency program wants to produce substandard graduates. Use of the Milestones will allow earlier identification of residents who are not appropriately progressing in one or

more areas and allow them to intervene in a more timely fashion to improve the performance of those residents.

If indicated by performance on the Milestones, can a trainee finish early and be "Board-eligible"?

The decision to allow an "early graduation" that would render the resident board eligible would always be made by the relevant American Board of Medical Specialties (ABMS) certifying board. While such a decision would likely be aided by the use of the Educational Milestones, accelerating resident training is not the intent of the Milestones.

Will the use of Milestones cause a shift of focus towards these areas at the expense of other important knowledge and skills necessary for competent practice?

The Milestones were developed by members of the specialty community to encompass the aspects of the specialty in which the growth of an individual during residency is most important to preparedness for independent practice. The ACGME will use the Milestones as one method of assessing whether programs are adequately preparing individuals for the unsupervised practice of the specialty. Programs should continue to maintain in their curricula in all areas of knowledge, skills and attitudes necessary for the practice of the specialty, and should ensure that residents in procedural specialties meet the minimum procedural numbers established by the RRC. In addition, the ABMS member Boards will continue to assess individuals for their acquisition of the knowledge, skills and attitudes necessary for the unsupervised practice of the specialty.

Will the assessments of residents and the documents that record individuals' skills be discoverable for residents who do not reach the expected levels of Milestone performance?

The degree to which information about performance during residency is 'discoverable' varies from state to state. It is expected that Milestone data will be considered 'discoverable' to the same extent to which evaluations currently gathered on residents are 'discoverable.'

Site Visits in the NAS

How will programs know that they are having another site visit in the current system?

To date, the majority of core and subspecialty programs in Phase I have received letters from the ACGME indicating their first self-study date in the NAS. Newly accredited programs and some programs on short accreditation cycles will have one more site visit in the current system. If your program has not received a letter indicating its first self-study date, you may contact your RRC team or the Department of Field Activities and

inquire about the date of the next visit. Programs with one more site visit in the current system will be notified by e-mail and the posting of a detailed site visit announcement letter in ADS.

How will the RRCs/ACGME communicate with programs scheduled for a focused or diagnostic visit?

The aim of a focused or diagnostic visit is an in-depth exploration of a potential problem identified in the review of the data the program provided in the annual data submission.

Programs will be given a few weeks of advance notice, with the option of one postponement if there are scheduling problems that meet the current justifications for a postponement.

Focused and diagnostic site visits will not use a Program Information Form, making a shorter announcement period feasible.

How much advance notice will programs get before a self-study visit?

The ACGME expects that there will be a 12 to 15 month advance notice of the approximate month of the self-study, as well as a 120-day advance notice with the specific date of the self-study visit.

The details of the format of the self-study visit as currently under development by the ACGME.

How will the move to the NAS affect the required internal review of accredited programs?

In the NAS, the ACGME expects sponsoring institutions to use Internal Reviews on an as needed ("prn") basis, as decided by the institution's designated institutional official (DIO) and graduate medical education Committee (GMEC). DIOs are not required to schedule internal reviews for Phase I programs that have received notice of an extended date for program self-study visits. Programs in Phase II should continue their scheduled internal reviews until the program receives a notice from the ACGME that its next site visit is being transitioned to the NAS.

Would the Milestone information be shared with individual Certifying Boards? Should it be?

For Certifying Boards that want to receive Milestone information, the ACGME will provide the data directly to the board. Data would be sent by the ACGME every six months, yearly or at the end of training, depending on the given Board's expressed needs.