EMARC New Coordinators Workshop
March 5, 2013
Denver, CO
Lynne Meyer, PhD, MPH; RC-EM Executive Director

Disclosure

• No conflicts of interest to report

RRC-EM Composition – AY 2012-2013

AMERICAN BOARD OF EMERGENCY MEDICINE
Michael Beeson, M.D. Vice-Chair
Wallace Carter, M.D., Chair
Philip Shayne, M.D.
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Christine Sullivan, MD

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Lance Brown, MD
Victoria Thornton, M.D.
Suzanne R. White, MD
Marjorie Geist, Ph.D., Ex-officio

EMERGENCY MEDICINE RESIDENTS ASSOCIATION
Jonathan Heidt, MD
Responsibilities of RC Members

- Attendance at 2 or 3 meetings each year
- Exercise fiduciary responsibility
  - Fealty to ACGME overrides allegiance to sponsoring organizations
- Maintain confidentiality
- Avoid conflict or duality of interest
- Program reviews (20-30 hours before each meeting)

Where Can I Find Information?

- Main ACGME web page
  http://www.acgme.org/acgmeweb/
- EM ACGME web page
  http://www.acgme.org/acgmeweb/ProgramandInstitutionalGuidelines/Hospital-BasedAccreditation/EmergencyMedicine.aspx
- Next Accreditation System (NAS) web page
  http://www.acgme-nas.org/
This is the link to the public website.

Where to log into ADS.

Emergency Medicine.
RC-EM Web Page Recommended Links

- Program Requirements: Approved but not in Effect – Same as currently in effect, only categorized for Next Accreditation System (NAS)
- PIFs: New Application
- Common Resources:
  - ACGME Glossary of Terms
  - Apply for Accreditation in Eight Easy Steps
  - Program Director Guide to Common Program Requirements
  - Program Directors’ Virtual Handbook

RC-EM Web Page Recommended Links

- FAQs:
  - ACGME FAQ on master affiliation agreements and program letters of agreement
  - Duty Hour FAQs and Resources
  - Emergency Medicine FAQs
- Site Visit: FAQs: New Programs
Find your last “Letter of Notification” on ADS for your program’s citations

- Citation = the program has not provided evidence of compliance with the requirements, or, an area identified by the site visitor is non-compliant
  - Don’t Have
    - Patients (# & types); required certified faculty; required experience; facilities/equipment; time/support; required program personnel
  - Don’t
    - Lack of evidence that required experience is provided; no documentation of compliance with requirements
  - Didn’t Carefully Proof/edit PIF
    - Incomplete or inaccurate information; did not fully describe/provide sufficient details; discrepant data

MOST COMMON CITATIONS
Core EM AY 2011/2012

- Program Personnel & Resources:
  Qualifications of Faculty (e.g. faculty staffing levels, faculty to resident ratio; board certification)
- Scholarly Activities (e.g. faculty and residents)
- Responsibilities of PD (e.g. PIFmanship, procedure documentation, leadership and stability, faculty development)

Program Requirements

- Common Program Requirements – bold font and must be adhered to by all specialties
- Specialty Specific Program Requirements – non-bolded font, specific to Emergency Medicine
What are core, detail and outcome program requirements?

- **Core Requirements**: Statements that define structure, resource, or process elements essential to every graduate medical educational program.
- **Detail Requirements**: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
- **Outcome Requirements**: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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**What are core, detail and outcome program requirements?**

(EM example)

- II.A.3. Qualifications of the program director must include:
  - II.A.3.b) current certification in the specialty by the American Board of Emergency Medicine, or specialty qualifications that are acceptable to the Review Committee; (Core)
  - II.A.3.d) at least three years’ experience as a core faculty member in an ACGME-accredited emergency medicine program. (Detail)
  - IV.A.5.b).(1).d) [Residents must demonstrate proficiency in] narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data; (Outcome)
Program Requirement Revisions & Updates

- EMS (New)
  • Effective 9/30/2012
- Core Emergency Medicine (Revised)
  • Effective 7/1/2013
- Medical Toxicology (being revised)
  • In process

Resident Survey

- Results aggregated into 7 areas (duty hours, faculty, evaluation, educational content, resources, patient safety, teamwork)
- Results compared to national normative data
- Potential RC actions: warning letter, request for progress report, advanced or expedited site visit
- Will be one of the sets of data used in the Next Accreditation System (NAS)

Faculty Survey - New

- This academic year - Phase I NAS only
- Faculty asked questions in the following areas:
  • Supervision and teaching
  • Educational content
  • Resources
  • Patient Safety
  • Teamwork
  • Overall evaluation of the program
- Faculty asked to base their responses on experiences in the current academic year, 2012/2013.
Click on the down arrows for more information.

Look for the green checkmarks or the word "complete".

Choose the type of faculty you want listed.

Only the PD has a CV, you can edit each person's info.

Those identified as a core faculty member will be given the faculty survey and must have scholarly activity entered into ADS.

If these 4 boxes total 15 hours or more, then this person is considered to be a core faculty member.
Scholarly Activity NEW

Area where programs will log the scholarship by residents. Currently this function appears for Phase One NAS specialties only.

 Resident/Fellow Quick Update

Gives a snapshot view of individual resident/fellow information and allows the user to make updates.

 Add Resident

Area where programs list residents/fellows in the program or add new residents.

Edit

Area where general information can be updated for existing residents/fellows.

Block Diagram Upload

Detailed on following slide.

+ Add Site

Section where new participating sites should be added.
Current Citations
Clicking on the link to current citations allows users to view their current citations and responses if they have been entered.

Site Visit Evaluation
For programs who had a site visit, the site visitor evaluation form can be completed here.

Program Information Form (PIF)
Programs can either print a paper copy of the Annual Report/PIF or save a PDF version by using their buttons.

Specialty Specific PIF
A link is provided which routes the user to the specialty specific PIF.
This is the data that is similar to what the EM Pilot programs had to submit annually.

Survey Access to aggregate reports by program, specialty, or nationally are available.

Download My Data NEW Programs are now able to download data entered into ADS in Excel format.

Why The ‘Next Accreditation System’ (NAS)?

- The ACGME's public stakeholders have heightened expectations of physicians.
- Patients, Payers, and the public demand:
  - information-technology literacy,
  - sensitivity to cost-effectiveness,
  - the ability to involve patients in their own care, and
  - the use of health information technology to improve care for individuals and populations.
- To review programs based on reporting of outcomes through educational milestones which is the next step for the competencies.
- To allow more programs the opportunity to innovate.
Phase I Programs

Phase I, aka Early Adaptors, Early 7:
- Diagnostic Radiology
- Emergency Medicine
- Internal Medicine
- Neurologic Surgery
- Orthopedic Surgery
- Pediatrics
- Urology

NAS Background

- GME is a public trust
- ACGME accountable to the public

What is the NAS and when does it start?

- The Next Accreditation System (NAS) begins July 1, 2013 for all core EM and EM subspecialty programs
- NAS 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
NAS Phase I Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
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<tr>
<td>July 2013</td>
<td>Phase I specialties and sub-specialties begin operating under next accreditation system</td>
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<tr>
<td>July 2013</td>
<td>Subspecialties Milestone development begins</td>
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<tr>
<td>Fall 2013</td>
<td>Phase I Milestones assessments begin for core programs</td>
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<tr>
<td>December 2013</td>
<td>Programs in Phase I submit the first set of Milestone assessments to ACGME</td>
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<tr>
<td>June 2014</td>
<td>Programs in Phase I submit the second set of Milestone assessments to ACGME</td>
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<tr>
<td>Fall 2014</td>
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The Building Blocks of The Next Accreditation System

NAS and ADS Annual Updates

- Each year, programs data will be required to entered in ADS such as:
  - Faculty information
  - Fellow information
  - Block diagrams/curricular information
  - Scholarly activity information
  - Participating site information
  - Responses to previous citations
  - Duty Hour, Patient Safety and Learning Environment information
  - Evaluation information
  - Reporting of major changes in the program
NAS

Instead of biopsies, annual data collection
- Trends in key performance measurements
- Milestones, Residents, fellows and faculty survey
- Scholarly activity template
- Operative & case log data
- Board pass rates
- Scheduled accreditation visits every 10 years with focused site visits if annual data trends suggest problems
- PIF replaced by self-study

NAS

Ongoing data collection and trend analysis
- Enhance oversight to ensure high quality education and a safe and effective learning environment
- High-quality programs will be freed to innovate – detailed process standards
- Programs with continued accreditation in good standing do not have to adhere to the “detail” program requirements as written, but are allowed to innovate

NAS and Quality Improvement...

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)
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Core and Detailed: Structure, Resources, Process, Outcomes

Initial Accreditation
New Programs
2-4%

Accreditation with Warning
New Programs, Accredited Programs and More Concerns
10-15%

Probationary Accreditation
Accreditation Programs with More Concerns

Maintenance of Accreditation
Withhold Accreditation
Withdrawal of Accreditation
75%-80%

Withhold Accreditation
Withdrawal of Accreditation
2.8%

Do I have to adhere to the “detail” program requirements?

- Programs that have initial accreditation or are in trouble must demonstrate compliance with all “detail” program requirements as written.
  - e.g. “educational methods should include problem-based learning, evidence-based learning, laboratory-based instruction, and computer-based instruction” (detail)
- Programs that have continued accreditation will be allowed to “innovate” or use alternate ways for those program requirements that are identified as “detail”.

Some Data Reviewed by RRC
Most already in place

- Annual ADS Update
- Program Characteristics – Structure and resources
- Program Changes – PD / core faculty / residents
  - Scholarly Activity – Faculty and residents
  - Omission of data
- Board Pass Rate – 3-5 year rolling averages
- Resident Survey – Common and specialty elements
- Clinical Experience – Case logs or other
- Semi-Annual Resident Evaluation and Feedback
  - Milestones
- Faculty Survey
- Ten year self-study
Milestones: Timelines

- Phase 1 (EM) to start using milestones by July 2013
  - First milestones (Core EM) report December 2013
- EM subspecialties to start using milestones by July 2014
  - First milestones (subs) report December 2014
- Clinical Competency Committees
  - Should be formed for core programs no later than July 2013

Uses and Implications

ACGME
- Accreditation – continuous monitoring of programs, lengthening of site visit cycles
- Public Accountability – report at a national level on competency outcomes
- Community of practice for evaluation and research, with focus on continuous improvement

Residency Programs
- Guide curriculum development
- More explicit expectations of residents
- Support better assessment
- Enhanced opportunities for early identification of under-performers

Certification Boards
- Potential use – ascertain whether individuals have demonstrated qualifications needed to sit for Board exams

Residents
- Increased transparency of performance requirements
- Encourage resident self-assessment and self-directed learning
- Better feedback to residents

Milestones

- Observable developmental steps moving from Novice to Expert/Master (Level 1: entrance to Level 4: fellowship graduation or even Level 5: expert or mastery level)
- "Intuitively" known by experienced medical educators in each specialty
- Organized under the rubric of the six domains of clinical competency
  - Trajectory of progress: neophyte → independent practice
  - Articulate shared understanding of expectations
  - Set aspirational goals of excellence
  - Framework & language for discussions across the continuum
Professionalism

Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients; and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team.

Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team.

Resident demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in more complex clinical situations or settings. Occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.

Core EM Milestones: Patient Care

• PC1- Emergency Stabilization
• PC2- Performance of Focused History and Physical Examination
• PC3- Diagnostic Studies
• PC4- Diagnosis
• PC5- Pharmacotherapy
• PC6- Observation and Reassessment
• PC7- Disposition
• PC8- Multi-tasking (Task-switching)

Core EM Milestones: Patient Care continued

• PC9- General Approach to Procedures
• PC10- Airway Management
• PC11- Anesthesia and Acute Pain Management
• PC12- Other Diagnostic and Therapeutic Procedures: Ultrasound (Diagnostic / Procedural)
• PC13- Other Diagnostic and Therapeutic Procedures: Wounds Management
• PC14- Other Diagnostic and Therapeutic Procedures: Vascular Access
Core EM Milestones

- MK- Medical Knowledge
- PROF1- Professional values
- PROF2- Accountability
- ICS1- Patient Centered Communication
- ICS2- Team Management
- PBLI- Practice Based Performance Improvement
- SBP1- Patient Safety
- SBP2- Systems-based Management
- SBP3- Technology

- Note that the EM subspecialty milestones will be developed during 2013 to be effective July 1, 2014

Clinical Competency Committee

- May already be in place under a different name
- Start thinking about this and decide on composition, procedure, data elements
- What should be reviewed:
  - Continue to look at current evaluations forms
  - Milestones
- Issues:
  - Time: pilot studies
  - Large residency programs
  - Small fellowship programs

Note that the EM subspecialty milestones will be developed during 2013 to be effective July 1, 2014
Clinical Competency Committees

- Learn your specialty milestones (will be developed this calendar year)
- Decide how to measure milestones
- Tools to evaluate from program director associations, specialty boards, colleges
- Teach the faculty the definitions
- Teach the faculty the tools
- FACULTY DEVELOPMENT IS KEY

The Clinical Competency Committee

- A group of faculty members trained in looking at milestones
- The same set of eyes looking at other evaluations:
  - End of rotation/shift
  - SDOT
  - Nurses
  - Patients and families
  - Peers
  - Others
- The same process is applied uniformly

Milestone Question

- Does every resident have to reach at least "Level 4" for every milestone in order to graduate?
- No, they do not. However, it will still remain the program director's responsibility to verify and determine whether each resident has demonstrated sufficient competence to enter practice without direct supervision.
Self-Study & Program Improvement

- ACGME self-study visits begin July 2014
- Fellowships will be reviewed with their core programs
- All new programs (initial accreditation) will require a site visit after approximately 2 years to gain continued accreditation before they can have their first self-study visit (SSV).
- Once a subspecialty program has been granted continued accreditation, their SSV will be scheduled with the core program. After the first SSV, they occur every 10 years.
- Tool for program improvement
- Individualized Learning Plan (ILP) on steroids

Tool for program improvement

- Regular goal setting
- Longer term: 3-5 years
- Includes self-reflection/self-study
- Consider SWOT (strengths/weaknesses/opportunities and threats)/stakeholders
- Consider program outcome trends
- Don’t have to wait until ACGME announces visit

Next Accreditation System: Goals

- Accredit programs based on outcomes
- Free good programs to innovate
- Provide public accountability for outcomes
- Produce physicians for 21st century
- Reduce the burden of accreditation
NAS Webinars

- Series of 4 free webinars geared to inform DIOs and PDs about the latest information regarding new accreditation initiatives
  - 12/13/2012 – The Clinical Learning Environment Review (CLER) Program: Early Experiences
  - 1/24/2013 – Implementing the NAS
Access at: http://www.acgme-nas.org/

September 2013 Meeting Deadline

- The deadline for receipt of information or materials is July 12, 2013 in order to be reviewed at the September 6-7, 2013 RC Meeting

TIPS

- Read your program requirements
- Find your last Letter of Notification and read it
- Find your last Program Information Form (PIF) and read it
- Work with the staff in other local residency programs and in your GME office
**ACGME Staff Contact List**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director</td>
<td>Lynne Meyer, PhD, MPH</td>
<td>312-755-5006</td>
<td><a href="mailto:lmeyer@acgme.org">lmeyer@acgme.org</a></td>
</tr>
<tr>
<td>Senior Accreditation Administrator</td>
<td>Sara Thomas</td>
<td>312-755-5044</td>
<td><a href="mailto:stthomas@acgme.org">stthomas@acgme.org</a></td>
</tr>
<tr>
<td>Accreditation Administrator</td>
<td>Lauren Johnson</td>
<td>312-755-5085</td>
<td><a href="mailto:lajohnson@acgme.org">lajohnson@acgme.org</a></td>
</tr>
<tr>
<td>Emergency Medicine ADS Representative</td>
<td>Raquel Eng</td>
<td>312-755-7120</td>
<td><a href="mailto:reng@acgme.org">reng@acgme.org</a></td>
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- Thank you for attending this session
- Any **QUESTIONS**?