NAS: What Have We Learned and What Does the Future Hold?

John R. Potts, III, M.D.
Senior Vice President, Surgical Accreditation
ACGME

SAU Program Directors, Chairs & Coordinators Workshop
Phoenix, AZ
21 January 2017
08:00-08:30

Disclosures

In recovery:

21 years as a Program Director

Fiduciary:

ACGME

Financial:

Of course not. This is education!

Outline

- Review NAS as envisioned
- NAS (to date) in Urology
- What can I learn from you?
- What have we learned?
- What does the future hold?

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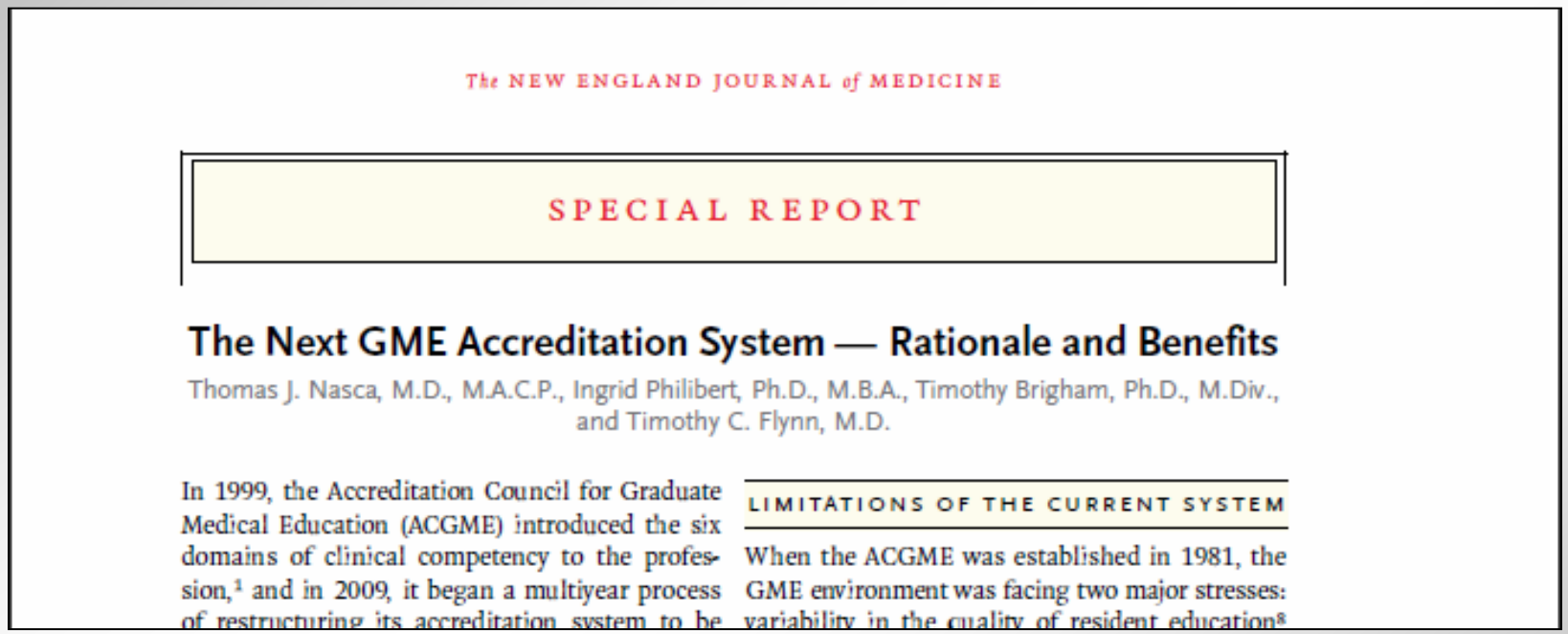
NAS as Envisioned



The NEW ENGLAND JOURNAL of MEDICINE

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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Next Accreditation System: Goals

- Help produce physicians for 21st century
- Accredit programs based on outcomes
  - Realize the promise of “Outcomes”
  - Provide public accountability for outcomes
- Free good programs to innovate
- Assist poor programs to improve
- Reduce the burden of accreditation

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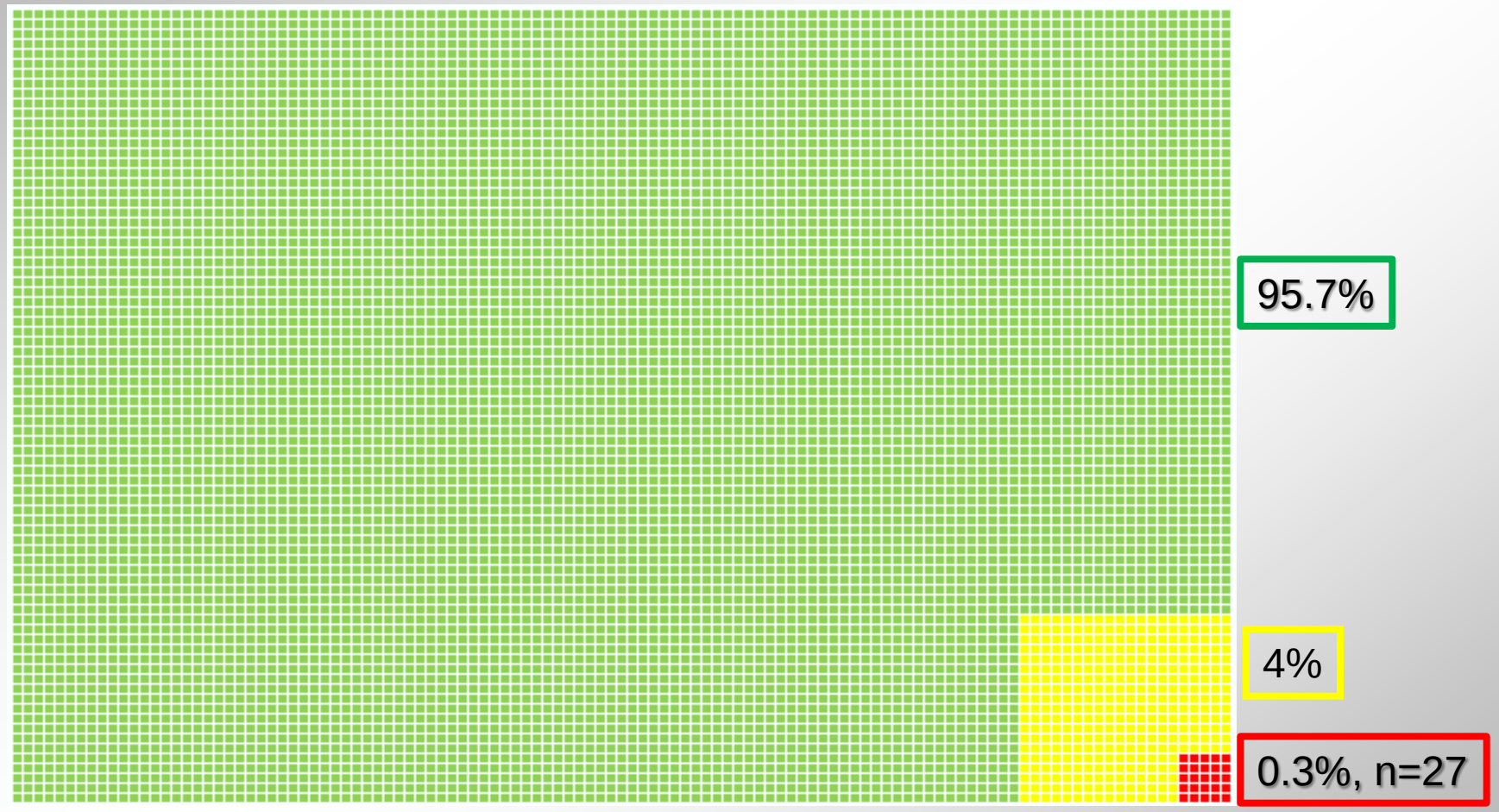
9,022 ACGME Accredited Programs*



*As of 1 January 2013
Excludes programs with Initial Accreditation

ACGME

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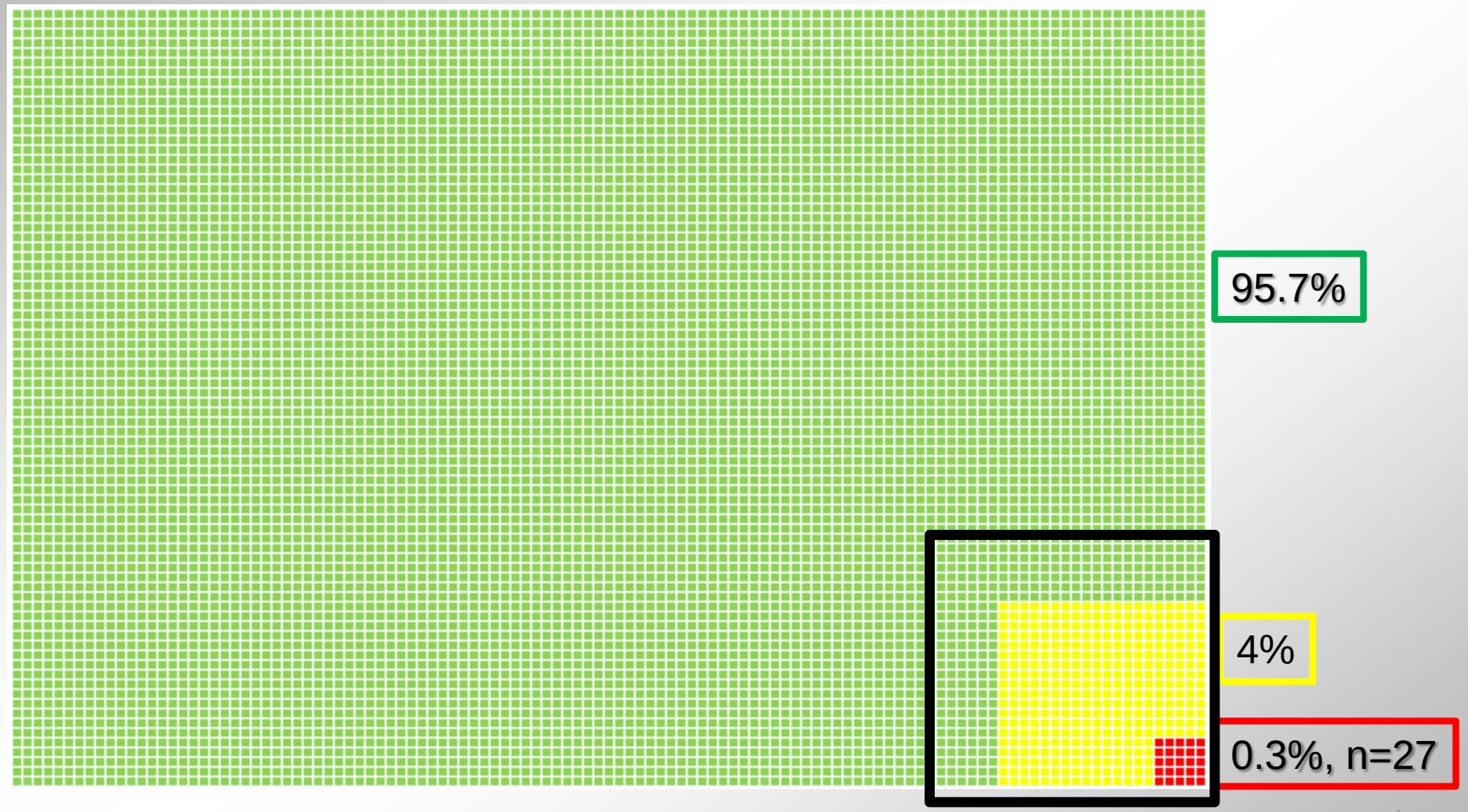

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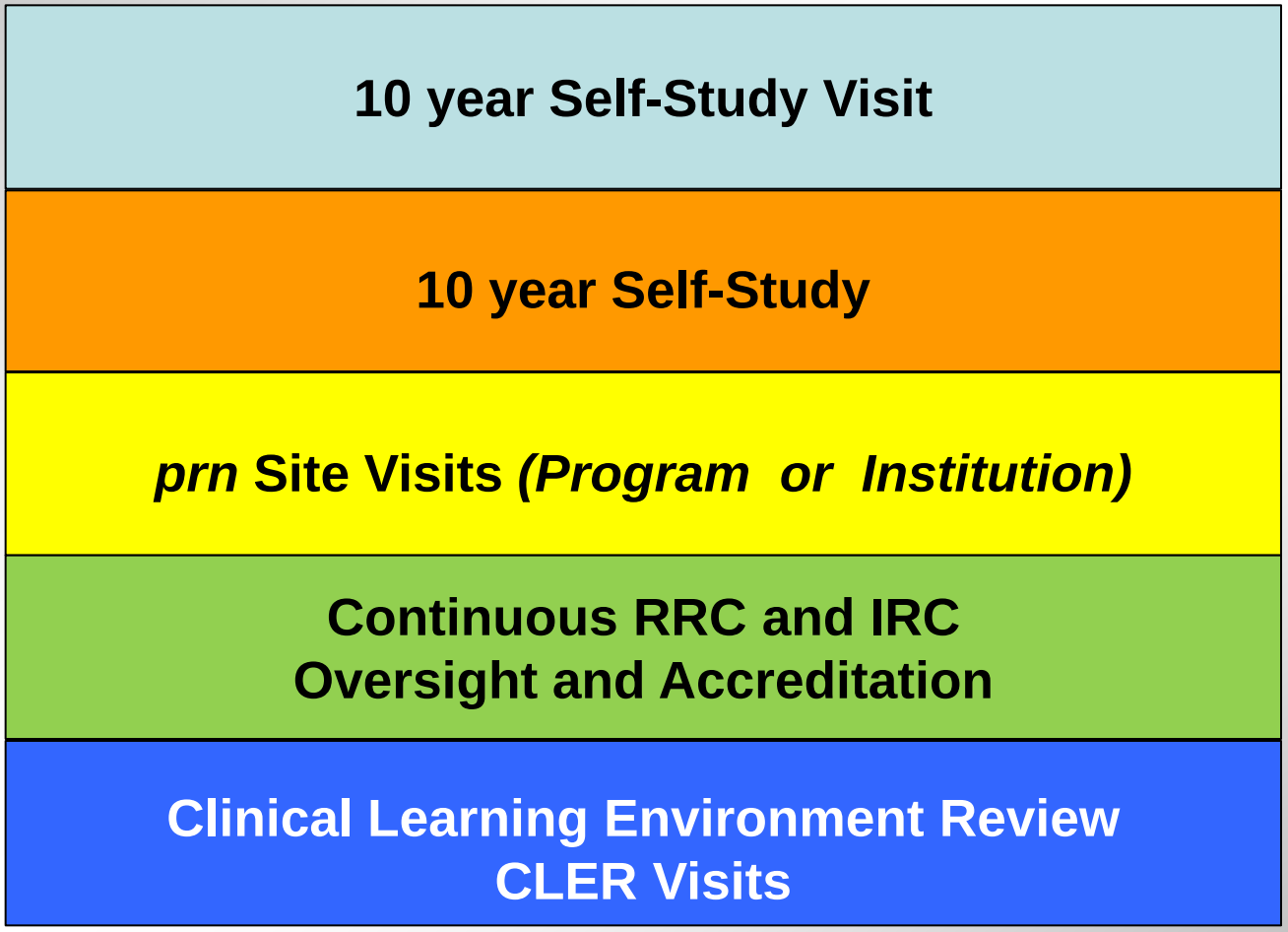
The Building Blocks of NAS



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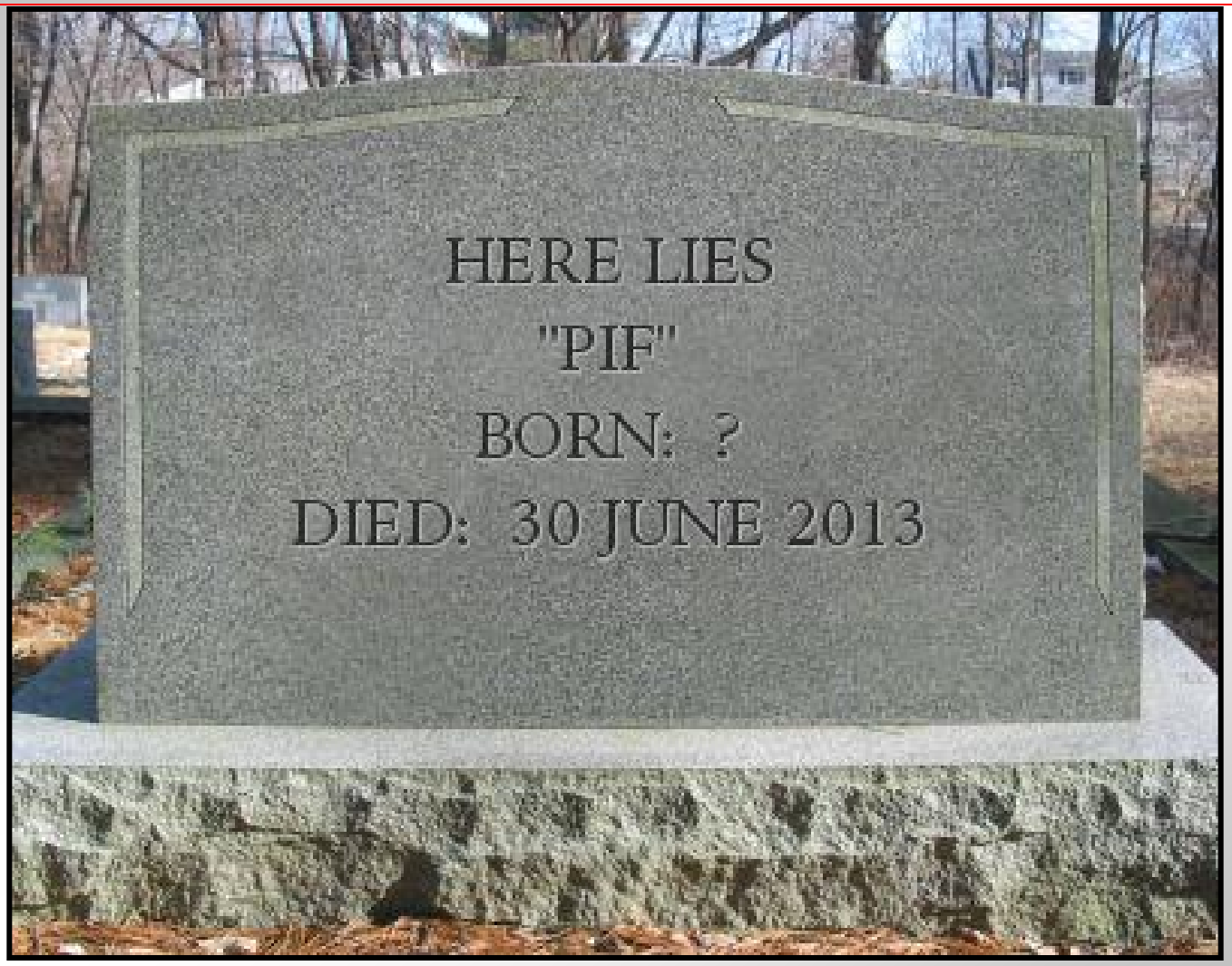

Some Data to be Reviewed by RRC

- ✓ 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-year rolling averages
- ✓ Resident Survey – Common and specialty elements
- ✓ Clinical Experience – Case logs
- ✓ Semi-Annual Resident Evaluation and Feedback
  - ➢ Milestones
- ➢ Faculty Survey
- ➢ Ten year self-study

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Streamlined ADS Annual Update

- 33 questions removed
- 14 questions simplified
- *Very* few essay questions
- Self-reported board pass rate removed
- Faculty CVs removed
- 11 MCQ or Y/N questions added

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Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012	Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012	Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012	Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.
	Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Chapters / Textbooks	Grant Leadership	Leadership or Peer-Review Role	Teaching Formal Courses
	John Smith	12433	32411			3	1	1	3	Y	N
Resident Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 3.				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012		Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012		Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012
	Resident	PMID 1	PMID 2	PMID 3		Conference Presentations		Chapters / Textbooks	Participated in research		Teaching / Presentations
	June Smith	12433				1		0	N		Y
Categories for points:		**Peer Review Publication**				**Other Scholarly**			**Grantsmanship**	**Leadership / Peer Review**	**Education**

NAS Timeline: Phase 1 Specialties

- **Spring 2012:**
  - Most programs with > 2 year cycles moved to NAS
- **July 2012 – June 2013**
  - Phase 1 programs report annual data
- **January 2013**
  - Milestones published for Phase 1 core specialties
- **Spring 2013**
  - Identify and train CCCs
- **July 2013: Go live**

http://www.acgme-nas.org/assets/pdf/KeyDatesPhase1Specialties.pdf

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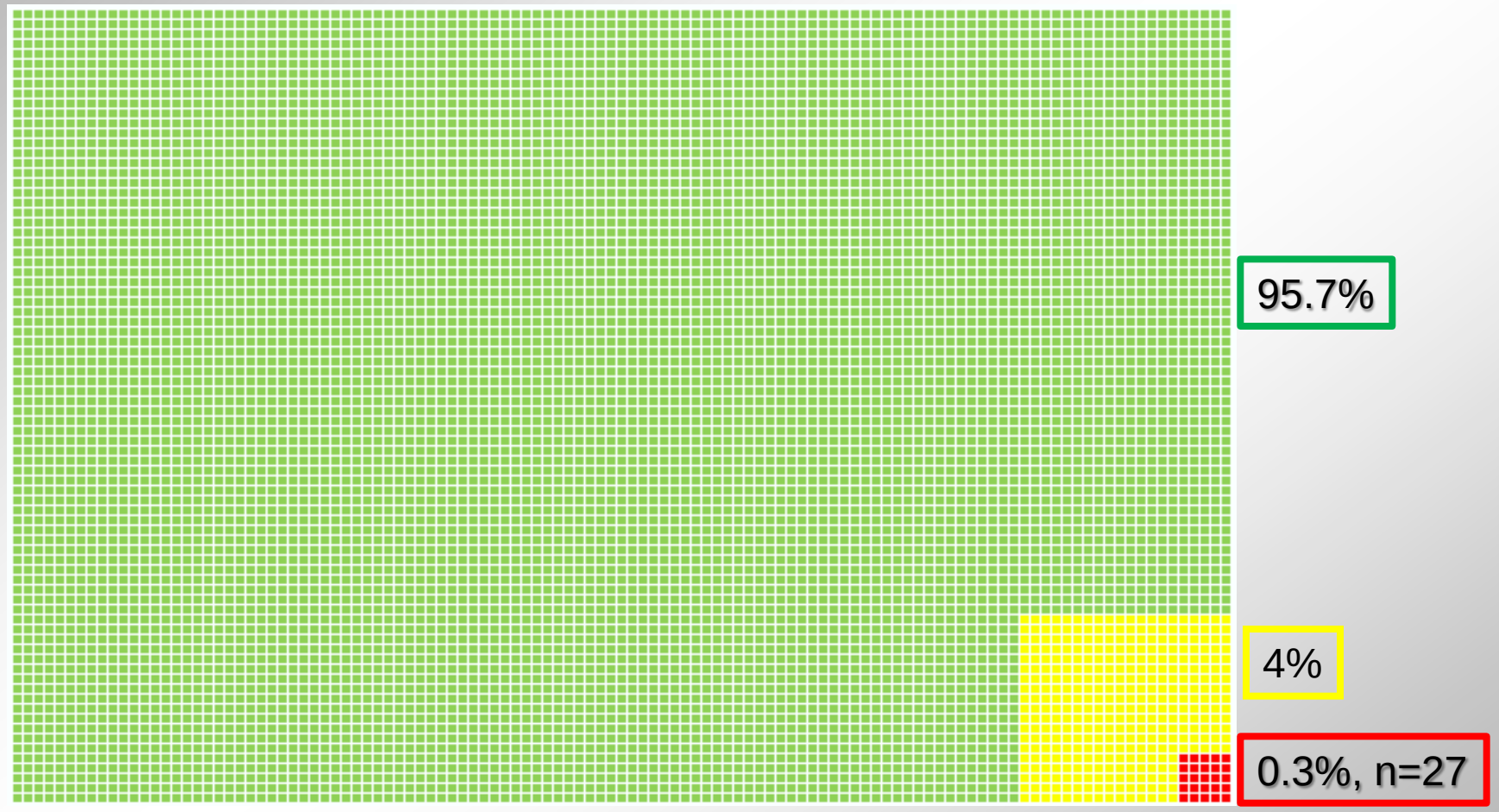

*As of 1 January 2013
Excludes programs with Initial Accreditation

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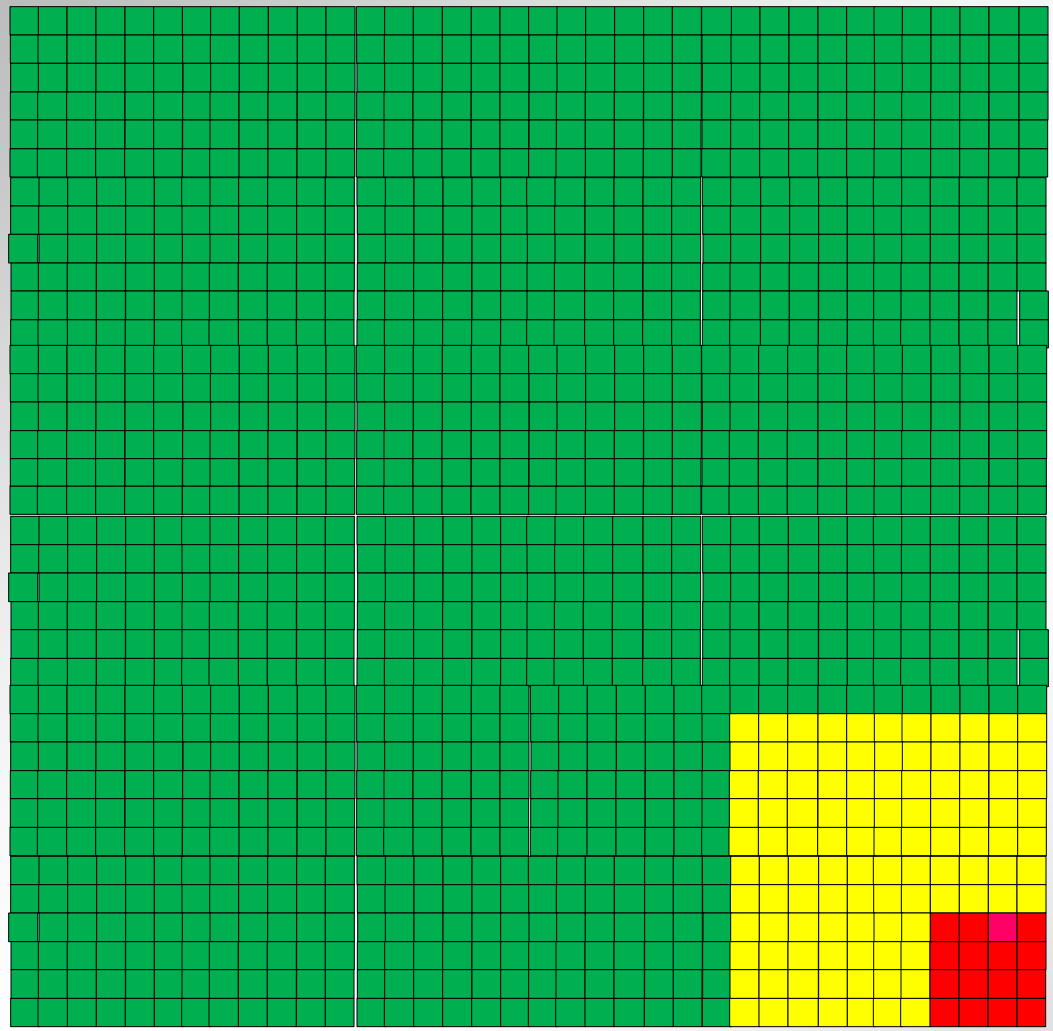
All Core Surgical Programs



As of January 2014:

1177 Continued Accreditation

105 Accreditation with Warning

16 Probation

70 Initial Accreditation

6 Initial Accreditation w/ Warning

8.1%

9.3%

1.2%

(Graph excludes programs with Initial Accreditation)

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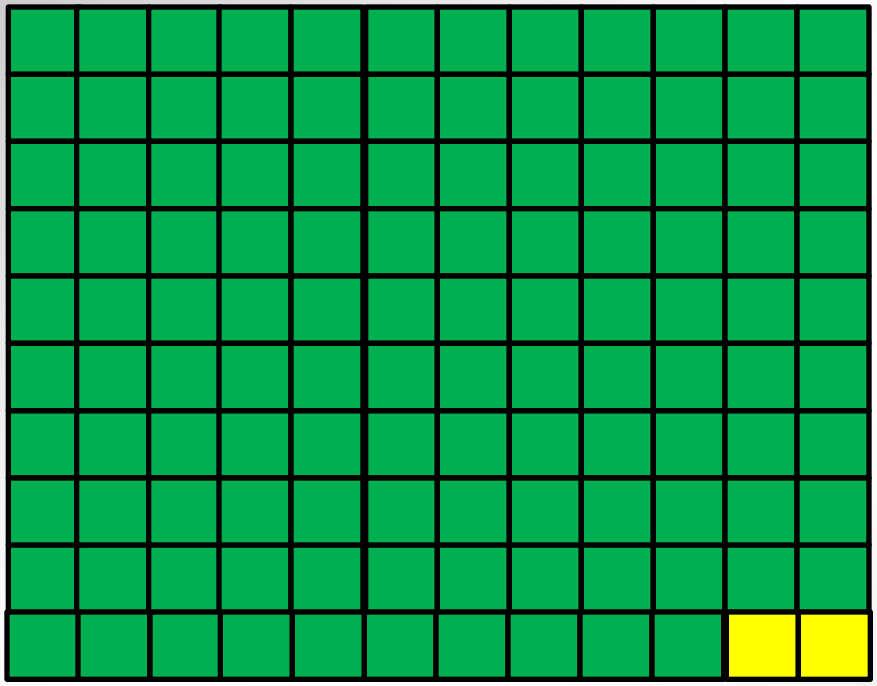
Urology Programs-2014



As of January **2014**:

118 Continued Accreditation

2 Accreditation with Warning

0 Probation

3 Initial Accreditation (not shown)

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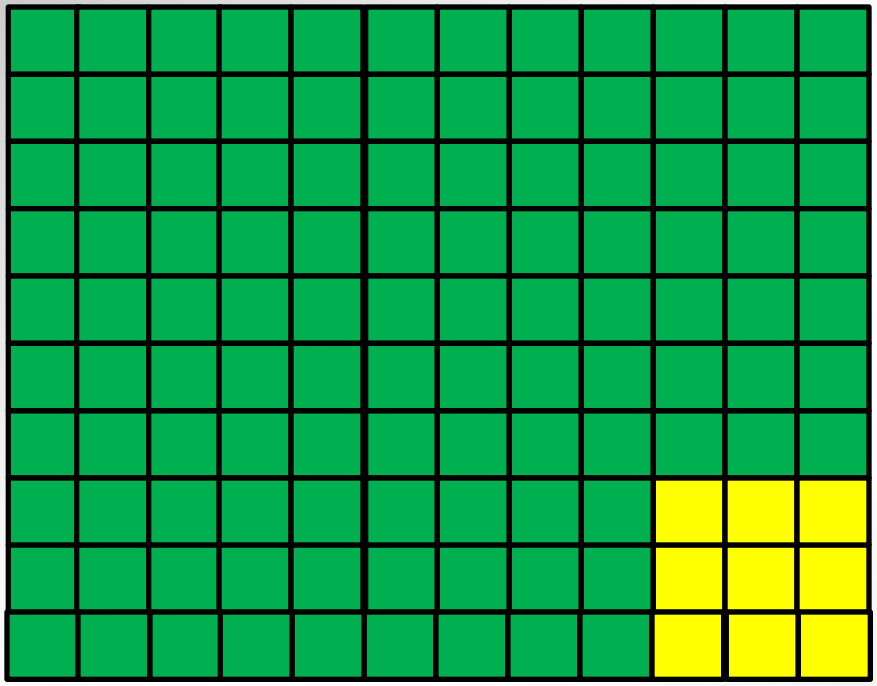
Urology Programs-2017



As of January **2017**:

113 Continued Accreditation

9 Accreditation with Warning

0 Probation

12 Initial Accreditation (not shown)

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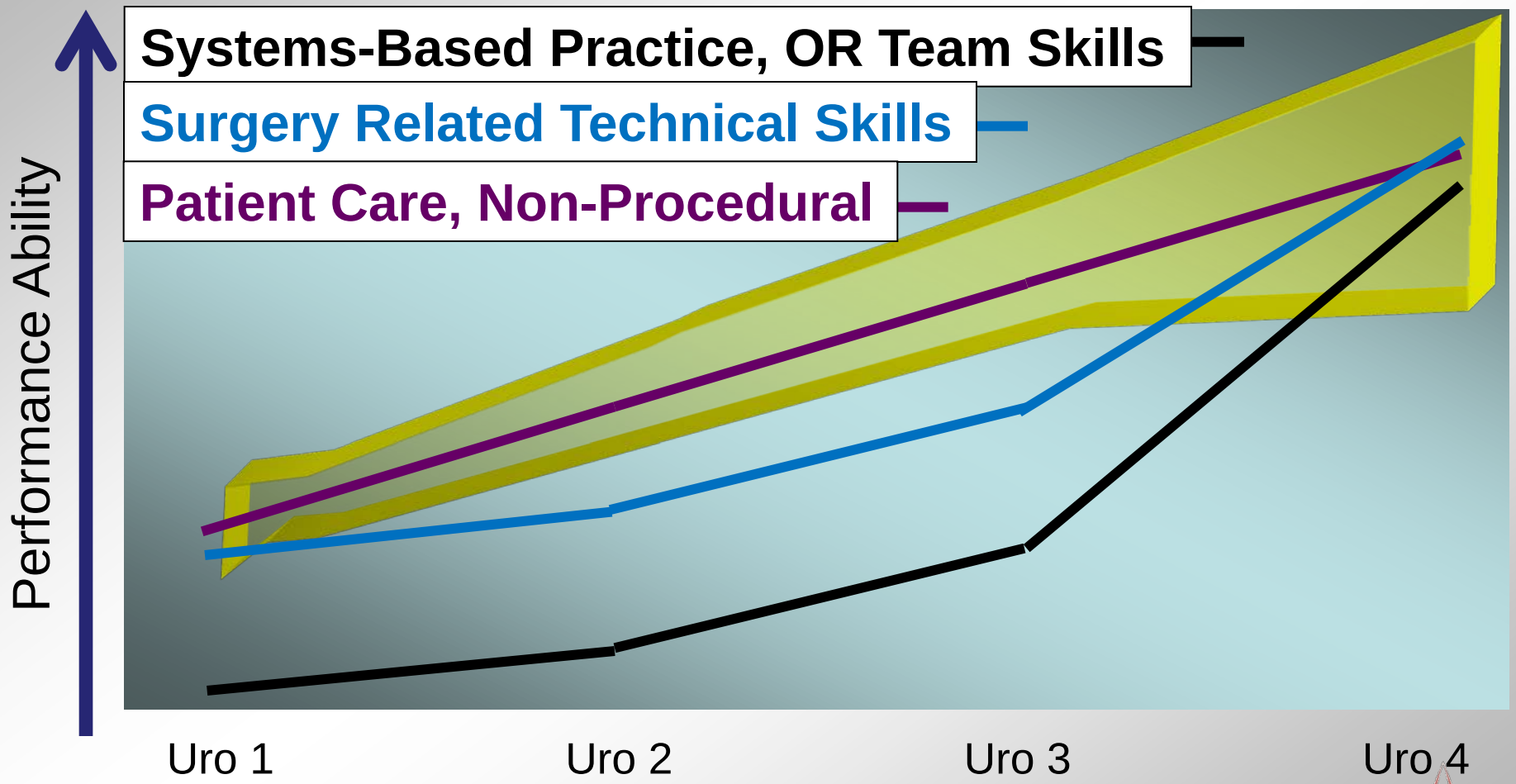
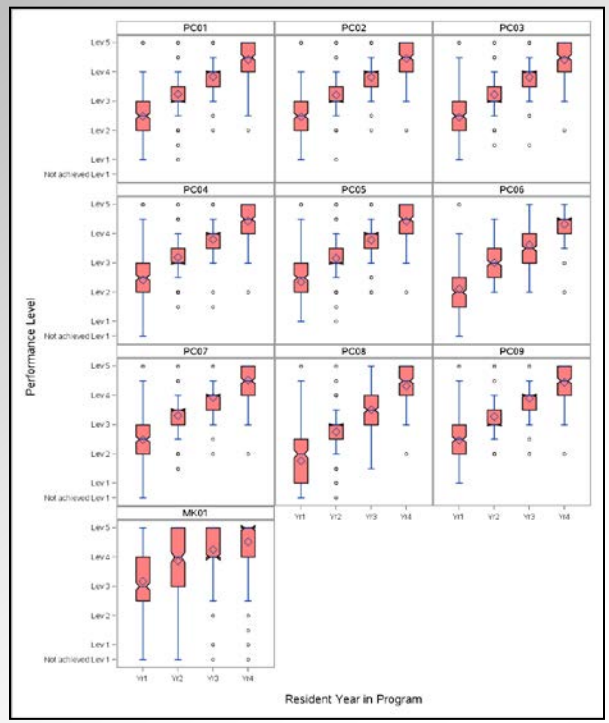
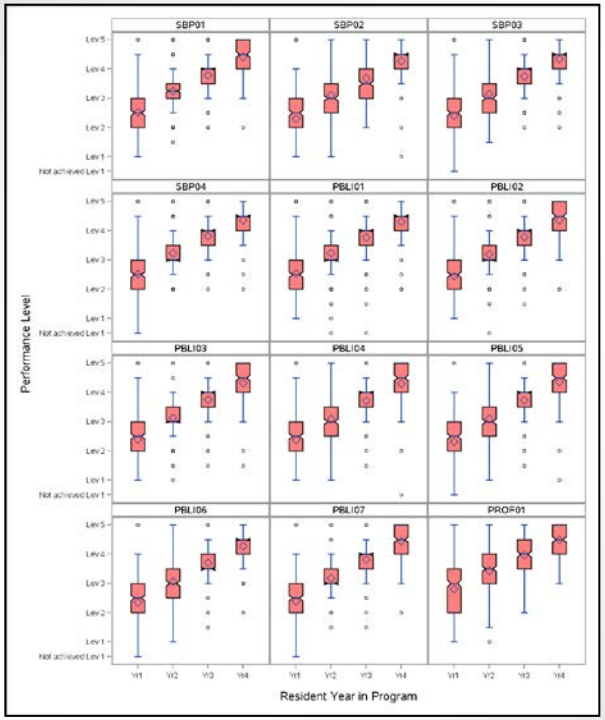
Hypothetical Professional Development in the 4 year Preparation of a Urologist



Attainment of Urology Milestones





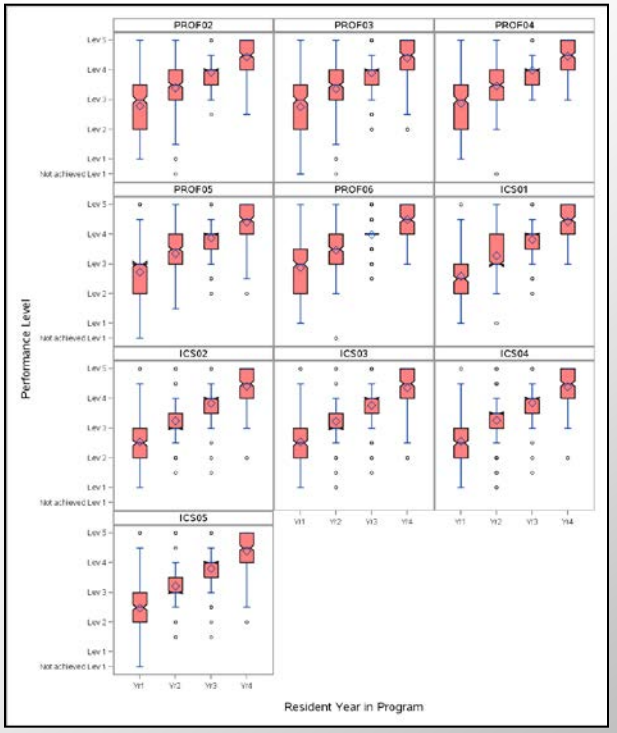


Table 30 (pp. 98-100)
Milestones Annual Report 2016
http://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesAnnualReport2016.pdf

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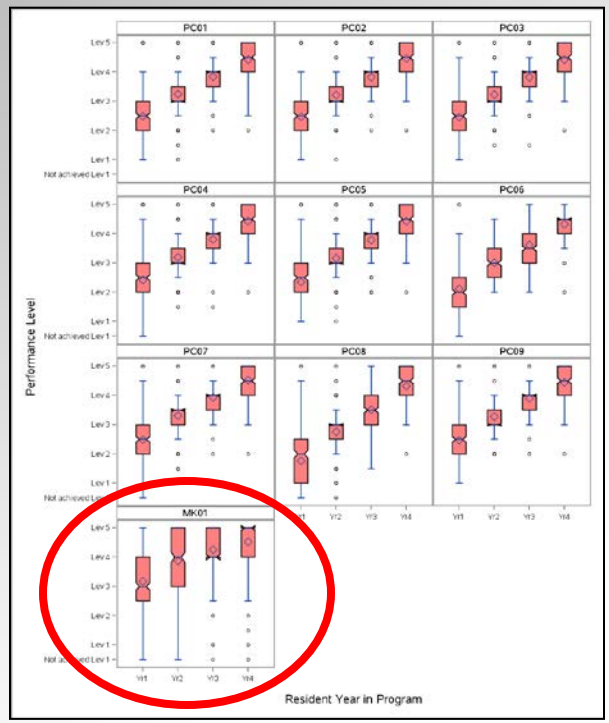
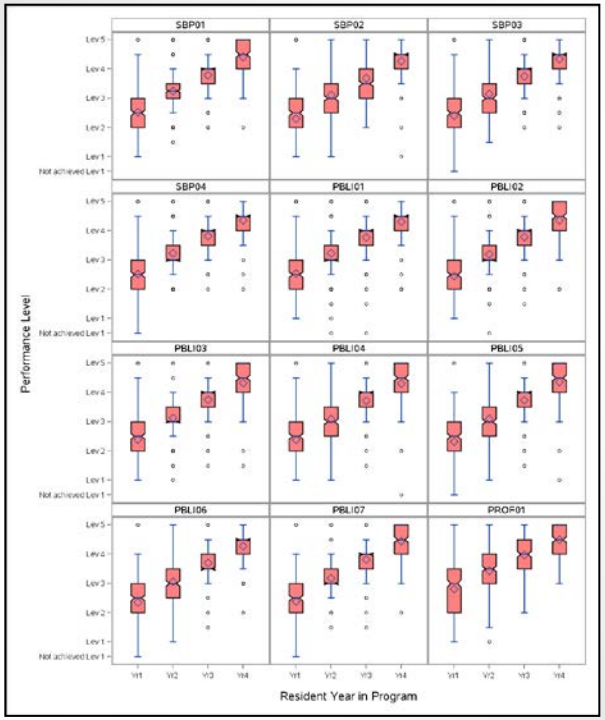
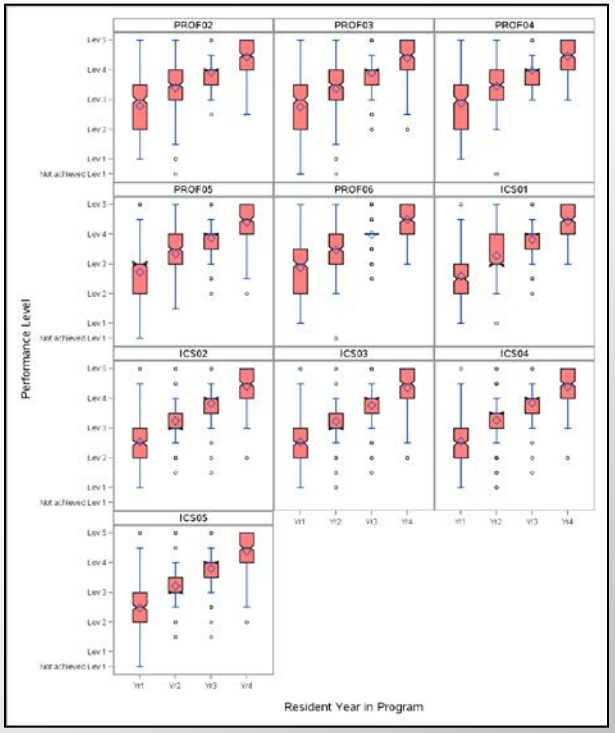
Attainment of Urology Milestones







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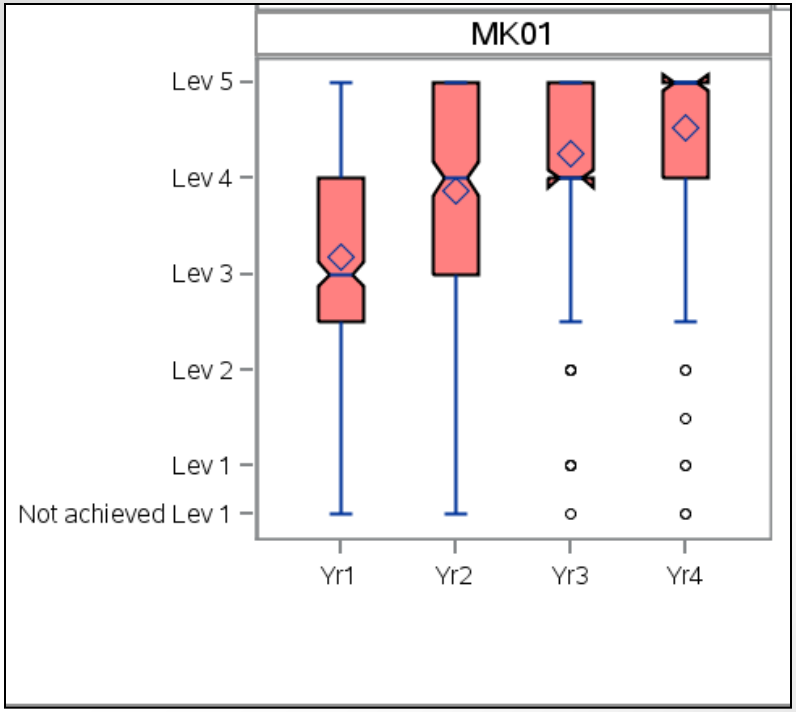

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Urology MK Milestone 2013

MK. **Demonstrates level-appropriate competency in the following core domains as indicated by performance on the ABS ITE and AUA Resident ISE.**		
Female pelvic medicine Neurogenic bladder and incontinence BPH and Voiding dysfunction Reconstruction Calculous disease Fistulae Adrenal disease transplantation	Pediatrics Reproductive and sexual dysfunction Uroradiology and Radiation safety Biostatistics and Epidemiology Infectious disease Hypertension and Renovascular disease Renal	Trauma Medical oncology Anatomy Physiology Geriatrics Infections Uropathology

Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Achievement of a percent correct score of **26-35** on the **AUA Resident ISE** *URO-1 only*: Achievement of a percent correct score of **26-40** on the the **ABSITE**	Achievement of a percent correct score of **36-45** on the **AUA Resident ISE**	Achievement of a percent correct score of **46-55** on the **AUA Resident ISE**	Achievement of a minimum percent correct score of **56-65** on the **AUA Resident ISE**	Achievement of a minimum percent correct score of **> 65** on the **AUA Resident ISE**
☐	☐	☐	☐	☐	☐

Comments:

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Urology MK Milestones 2016

MK1. Surgical Care					
Has not achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Understands normal physiology, fluid and electrolyte balance, hemostasis, sepsis, and wound healing Understands the principles of safe surgical practice (e.g., checklist, surgical consent, aseptic technique, patient positioning, skin preparation, draping, use of appropriate instruments, universal precautions)	Understands the effects of age, pregnancy, and obesity on the surgical patient Understands alterations in nutrition, including obesity and cachexia; understands the indications for enteral and parenteral feeding Understands the effects of alcohol, tobacco, and substance abuse	Understands the effects of comorbidities on the surgical patient (e.g., cardiac, pulmonary, renal, hepatic failure) Understands the impact of psychosocial disorders (e.g., depression, body dysmorphic disorder) on pre- and post-operative management Understands the effects of chemotherapy, radiation, immunosuppression, and medications, including homeopathic regimens	Understands the management of complex multisystem surgical pathophysiology, including intensive care and organ system support (e.g., dialysis, ventilator use) Understands potential reasons to decline offering surgical services Understands the process of professional and legal discharge of a patient from practice	Applies an evidence-based approach to innovative and complex obstetric procedures Systematically reviews outcomes and publishes in peer-reviewed journals
☐	☐	☐	☐	☐	☐
Comments:					

MK2. Differential Diagnosis					
Has not achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Creates a differential diagnosis for general complaints from patient's history and physical *Example:* *For abdominal pain, considers urologic and non-urologic etiologies*	Creates a differential diagnosis that includes common causes of urologic complaints *Examples:* *For flank pain, considers common etiologies, such as urinary lithiasis and pyelonephritis* *For hematuria, considers common etiologies, such as infection, prostatic hyperplasia, and malignancy*	Creates a differential diagnosis that includes common and uncommon causes of urologic complaints Prioritizes potential causes of patient complaint using information gathering skills *Examples:* *For flank pain, considers less common etiologies, such as spontaneous hemorrhage from possible benign or malignant renal neoplasm (in addition to common etiologies listed in Level 2)* *For hematuria, considers less common etiologies, such as renal source of bleeding*	Creates a differential diagnosis that includes common and uncommon causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis *Examples:* *Generates differential and diagnostic strategy for range of urologic complaints, such as potential genitourinary malignancy, lower urinary tract symptoms, and flank pain*	Creates a differential diagnosis that includes common, uncommon, and rare causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis for multiple urologic complaints *Examples:* *Generates differential and diagnostic strategy for multiple urologic complaints, such as lower urinary tract symptoms (LUTS) and renal mass*
☐	☐	☐	☐	☐	☐
Comments:					

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What Can *I* Learn From *You*?

Coordinators:

- Is there less burden in NAS?
- Is the Annual Update working for you?
- Does the milestone reporting tool work?
- Have the ADS folks supported you?
- Has the ED/staff supported you?
- Topics to address at AEC?
- What can ACGME do to improve NAS?

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What Can *I* Learn From *You*?

Program Directors:

- Is there less burden in NAS?
- Is the Annual Update working for you?
- Is your CCC now more adept at Milestones?
- Has the ED/staff supported you?
- Topics to address at AEC?
- What can ACGME do to improve NAS?

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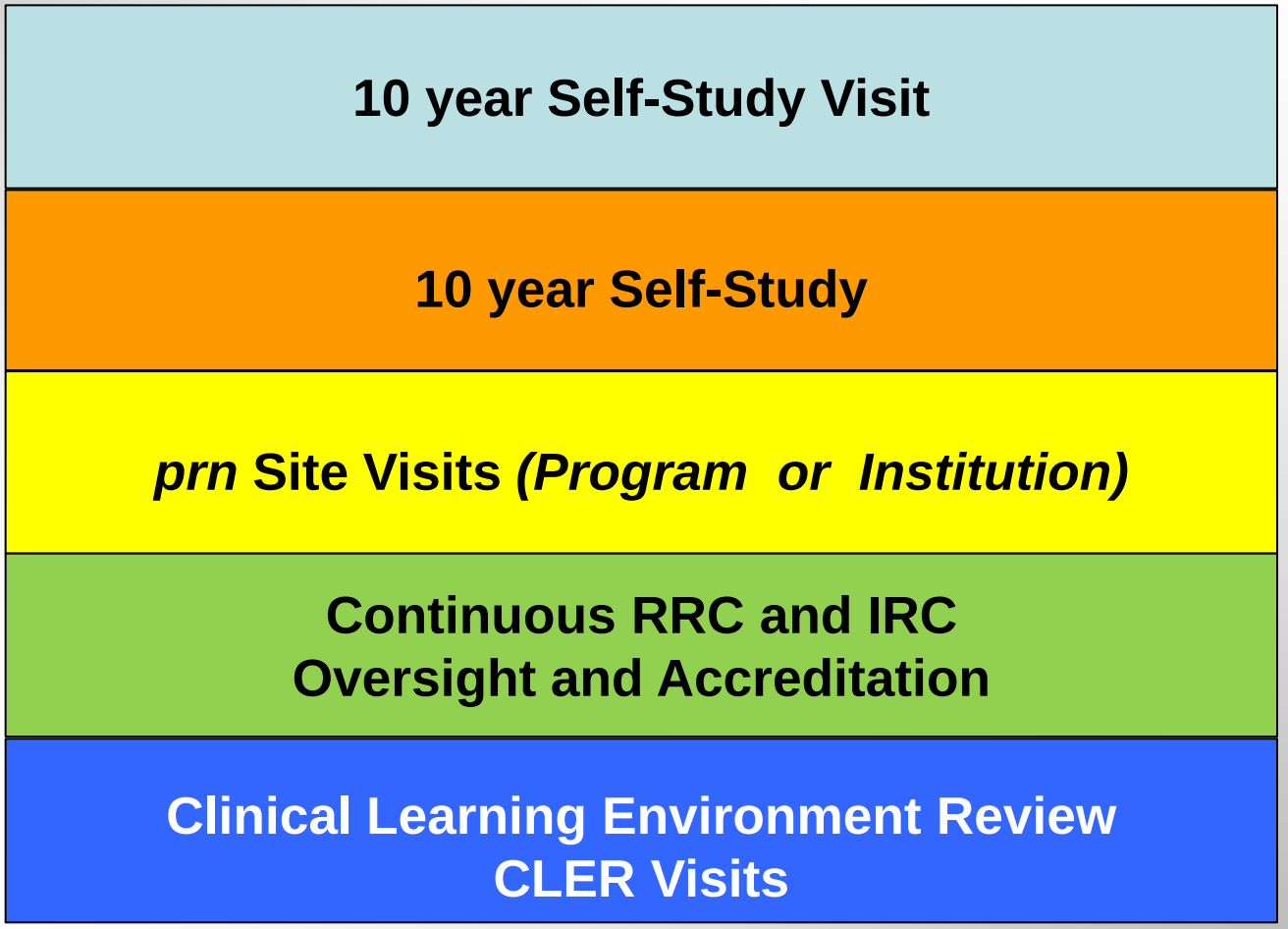
ACGME NAS Lookback

8-9 November 2016

ACGME

The Building Blocks of NAS



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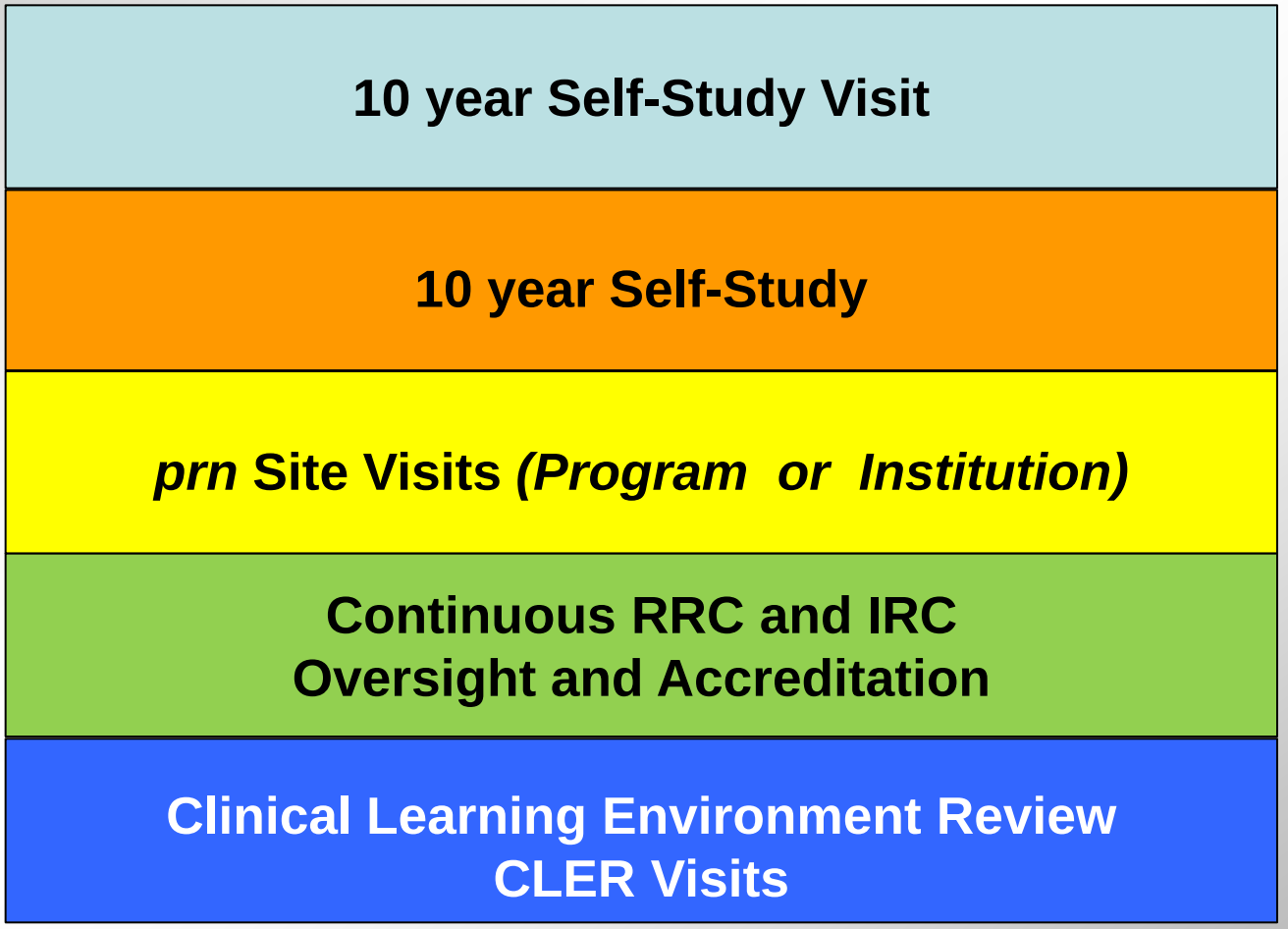

NOT used in accreditation

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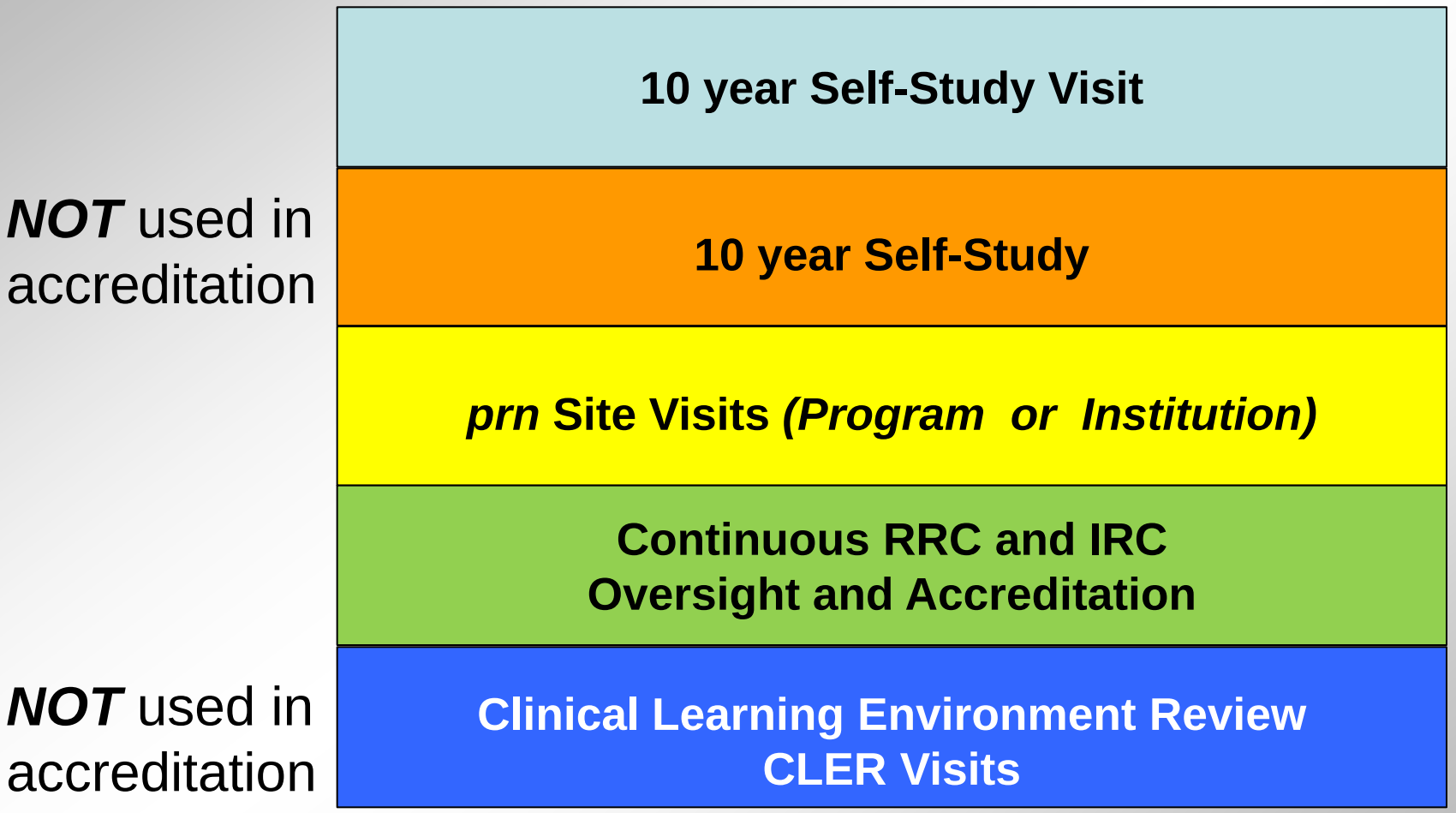

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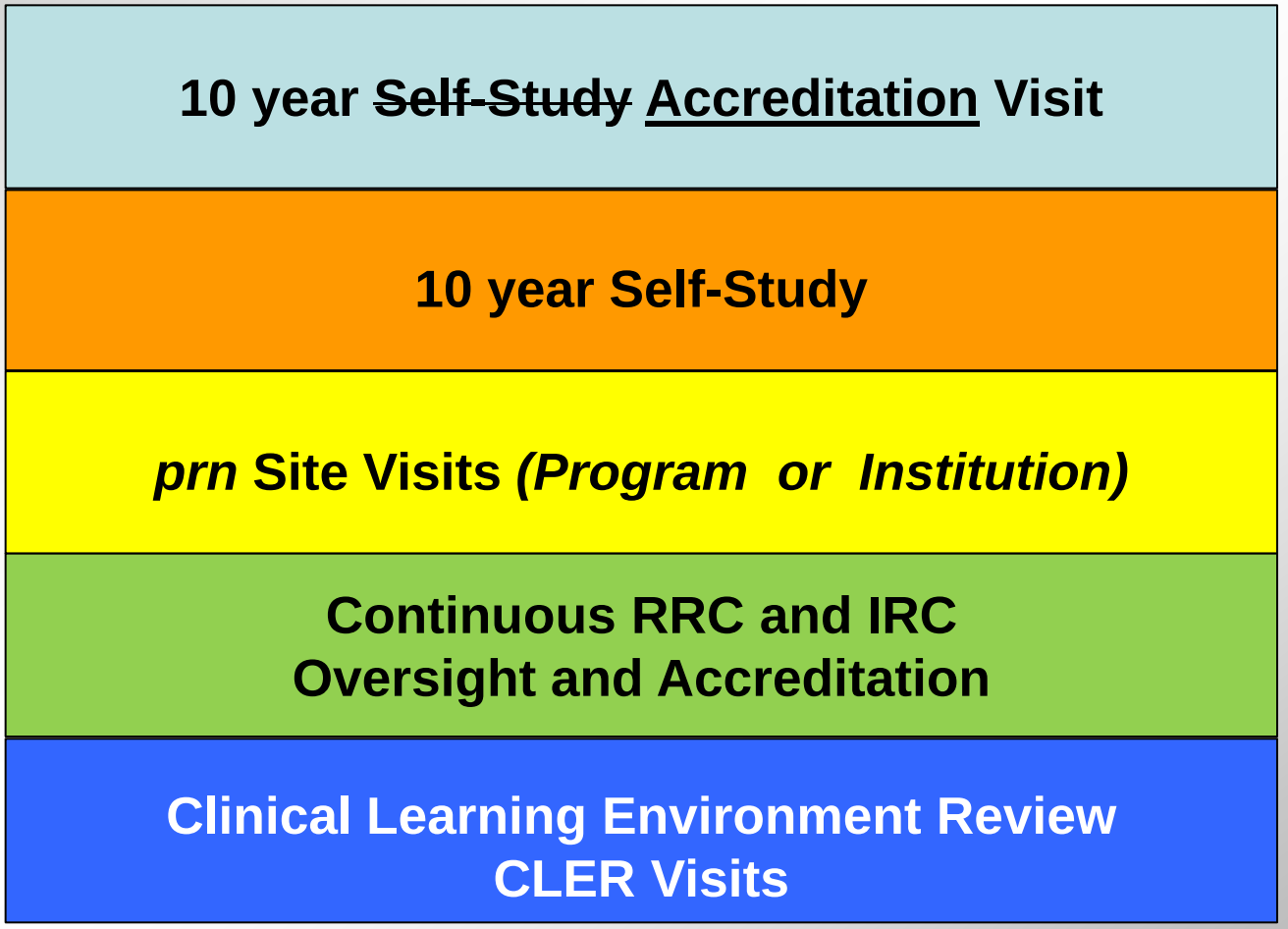

NOT used in accreditation

NOT used in accreditation

NAS: Lessons Learned

- Annual review *is* better than periodic
  - Problems are identified earlier
  - Citations can be resolved faster
  - Greater consistency in decisions

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NAS: Lessons Learned

- NAS works better in larger programs
  - Small fellowships especially problematic
  - Small residency programs *can be* problematic
  - Examples:
    - Small number of survey responses
    - Annual variation in board pass rates

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NAS: Lessons Learned

- Annual updates now *really* matter!
- Emphasis on Resident Survey amplified
- Scholarly activity better viewed cumulatively
- AFIs viewed differently by different SI's
- Definition of "core faculty" problematic
- Innovation (as allowed by NAS) rare

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NAS: Lessons Learned

- Milestones cannot be used in accreditation

NAS: Lessons Learned

- Unfortunately, then, board pass rates (+/- case logs) are ***still*** the only outcomes that we have

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What Does the Future Hold?

NAS *will* be here for a while

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What Does the Future Hold?

Short-term

- Changes is Resident Survey
- Revision of Milestones
- Greater utilization of trended data
  - Survey results
  - Scholarly activity
- Emphasis on QI as scholarly activity
- “Core Faculty” identified differently
- Metric for faculty development likely

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What Does the Future Hold?

Long-term

- Accommodation for CBRE
- Incorporation of institutional:
  - Patient outcome data
  - Patient safety data
  - Quality data
- Incorporation of program graduates':
  - Patient outcome data
  - Patient safety data
  - Quality data

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What Does the Future Hold?

Commentary

The Accreditation System *After* the "Next Accreditation System"

Thomas J. Nasca, MD, MACP, Kevin B. Weiss, MD, James P. Bagian, MD, PE, and Timothy P. Brigham, MDiv, PhD

Abstract

The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties and its member boards introduced the six domains of physician competency in 1999. This initiated a national dialogue concerning the elements of competency of the physician, and incorporation of these elements into the framework of evaluation of residents and fellows, as well as the educational programs within which they are trained. The next step in this process will be the ACGME's Next Accreditation System, which the authors describe in this commentary. Recognizing that there are already developments in the assessment of medical education that will influence future models of accreditation, the authors consider some of these innovations and discuss how they may shape the next accreditation system *after* the Next Accreditation System.

Acad Med 2014;89(1):24-26.

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Wrap-up

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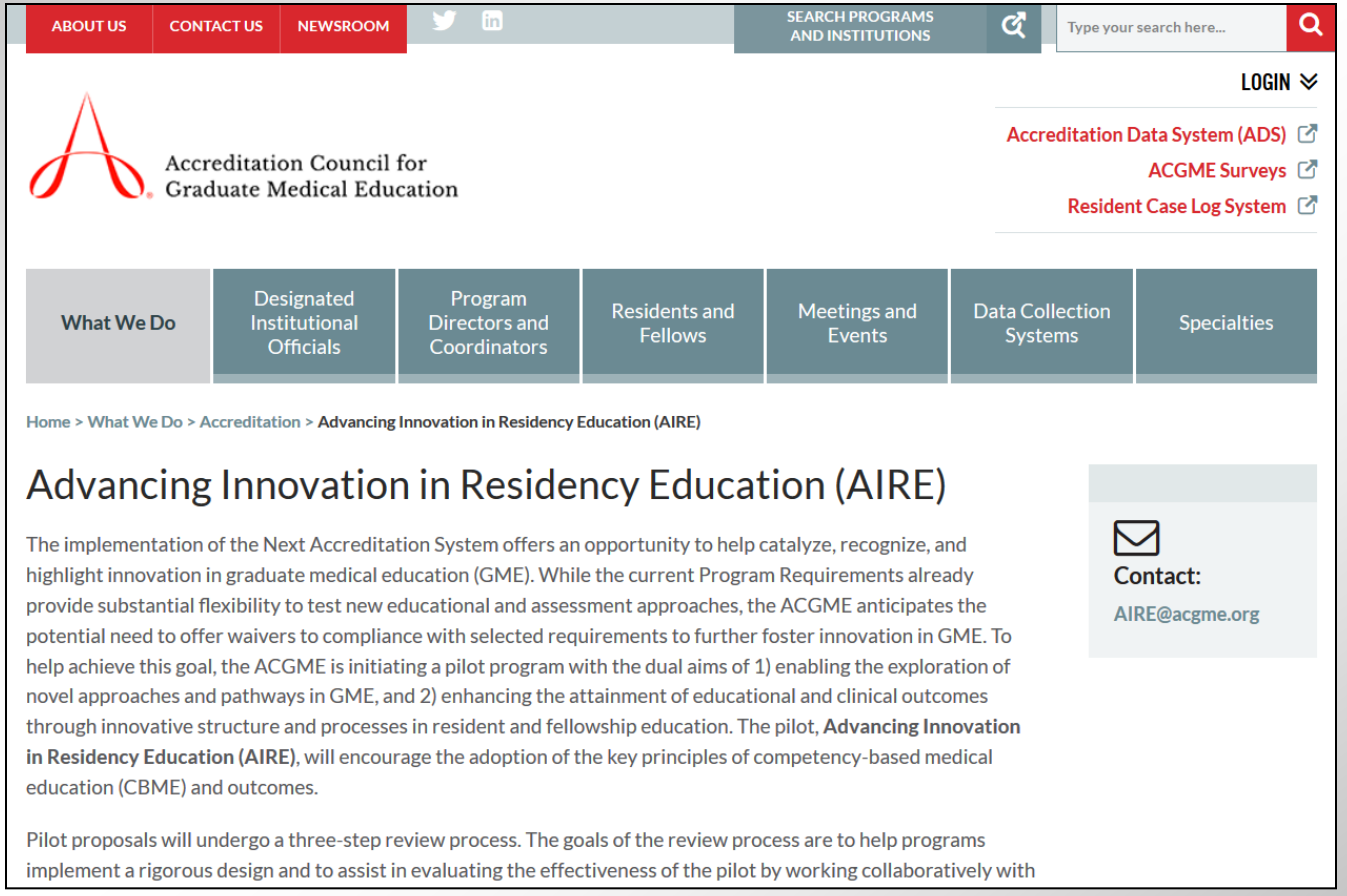
AIRE

Advancing Innovation in Residency Education



ACGME Policies and Procedures: Subject 24.00

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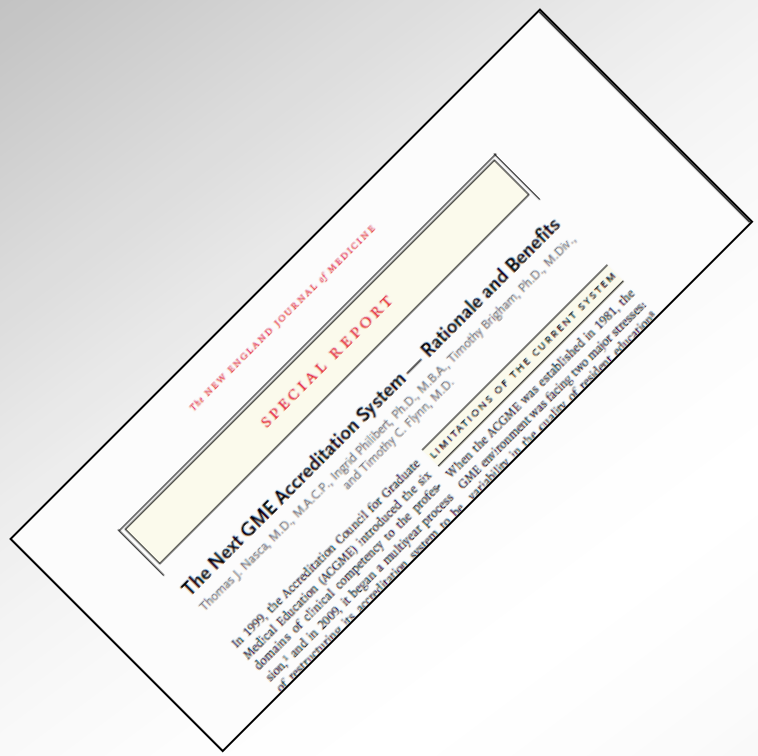
ACGME NAS Lookback

8-9 November 2016

ACGME NAS Lookback



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