NAS, CLER and Enhancing Geriatrics Education

Lynne M. Kirk, MD, MACP

With thanks to Eric Holmboe and Kevin Weiss of the ACGME

Disclaimer

Dr. Kirk is a Director of the Accreditation Council for Graduate Medical Education (ACGME)

Goals

- Describe the ACGME Next Accreditation System (NAS)
- Describe the Clinical Learning Environment Review (CLER)
- Describe where we have come in geriatrics
- Describe where we might go in the future

“We improve healthcare by assessing and advancing the quality of resident physician education through accreditation”

ACGME Mission Statement

A Brief History of NAS

- 1999 – The ACGME and American Board of Medical Specialties (ABMS) establish the six core competencies
  - Designed to shift emphasis from process-oriented to outcomes-oriented standards in physician education
  - ACGME "Outcome Project"
- 2002 – Public and political pressure on the GME community to produce physicians capable of cost-conscious, patient-centered care begins to increase
- 2009 – The ACGME, ABMS boards, specialty colleges/academies, residency program directors, and residents begin to define the "Milestones"

A Brief History

- 2012 – Alpha test sites begin to implement Milestones at the individual program level
- 2013 – Phase I programs implement Milestones
- 2014 – All programs are under the Next Accreditation System (NAS) and must implement Milestones

Why Is a New System Needed?

- The old process-based system was “one size fits all”
- We need to standardize outcomes while simultaneously allowing programs to individualize education
- Good programs must be free to innovate
- We need to shift from a “catch them being bad” to “reward them for being good” accreditation paradigm

The NAS in a Nutshell

- A Continuous Accreditation Model based on key screening parameters
  - Annual program data (resident/faculty information, major program changes, citation responses, program characteristics, scholarly activity, curriculum)
  - Aggregate board pass rate
  - Resident clinical experience
  - Resident survey and faculty survey (latter is new)
- 10 year Self Study and Self Study Site Visit
- Semi-annual resident Milestone evaluations
- Clinical Learning Environment Review (CLER) Visits

10 Year Self Study Visits

Old Accreditation System	Next Accreditation System
Site visits every 5 years (or less)	Scheduled site visits every 10 years
Programs evaluated by RRC in conjunction with site visits	Program data evaluated annually by the RRC
Large printed Program Information File (PIF)	No PIF; data transmitted electronically to ACGME annually
Periodic evaluation	Longitudinal evaluation
Process oriented (provide appropriate documentation)	Performance oriented (evaluate performance against goals)
Future goals not addressed	Help programs establish goals for the future

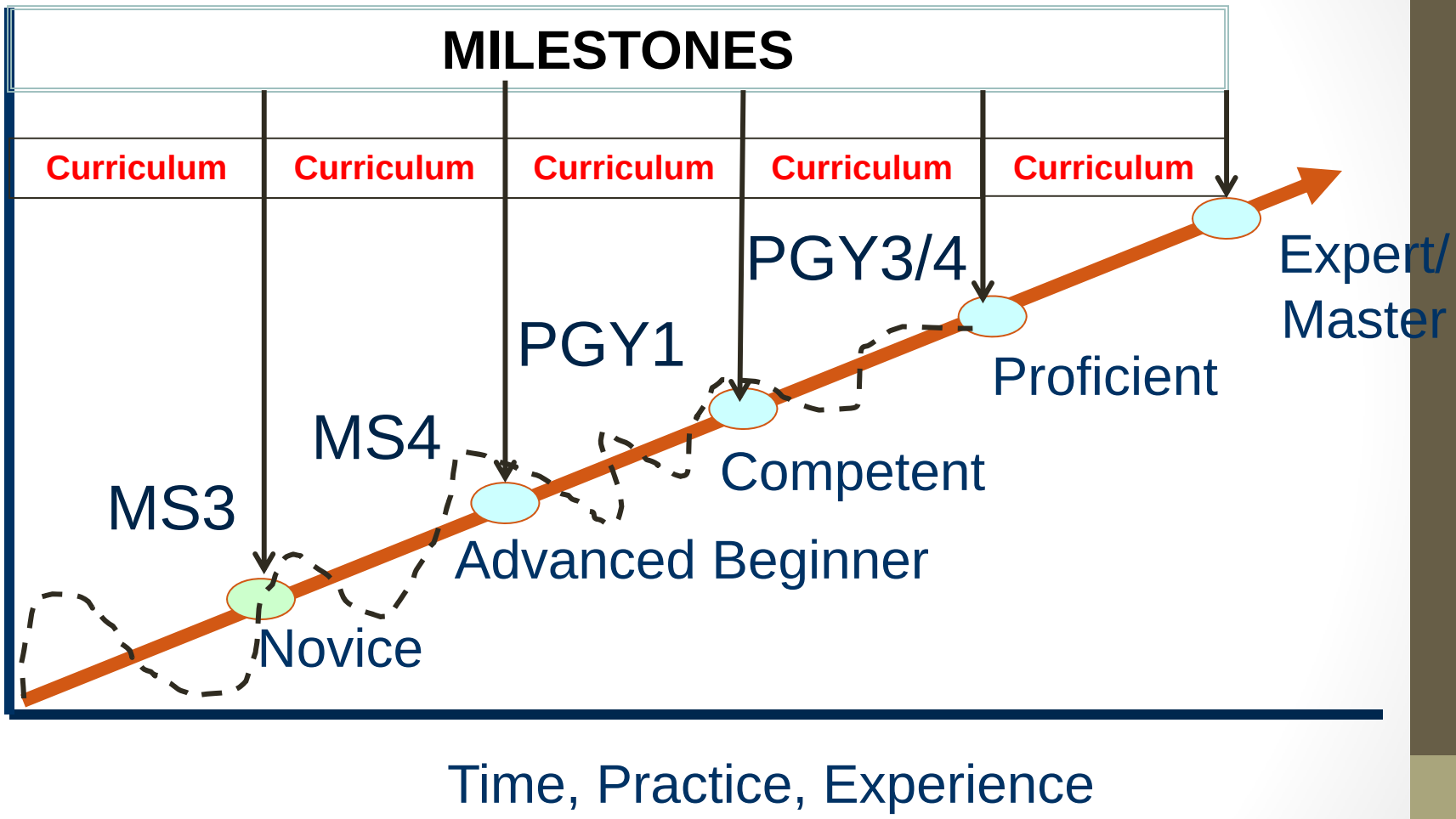
Accreditation Categories

- Initial Accreditation (new programs)
- Initial Accreditation with Warning
- Continued Accreditation
- Continued Accreditation with Warning
- Probationary Accreditation
- Withhold/Withdrawal of Accreditation

Milestones

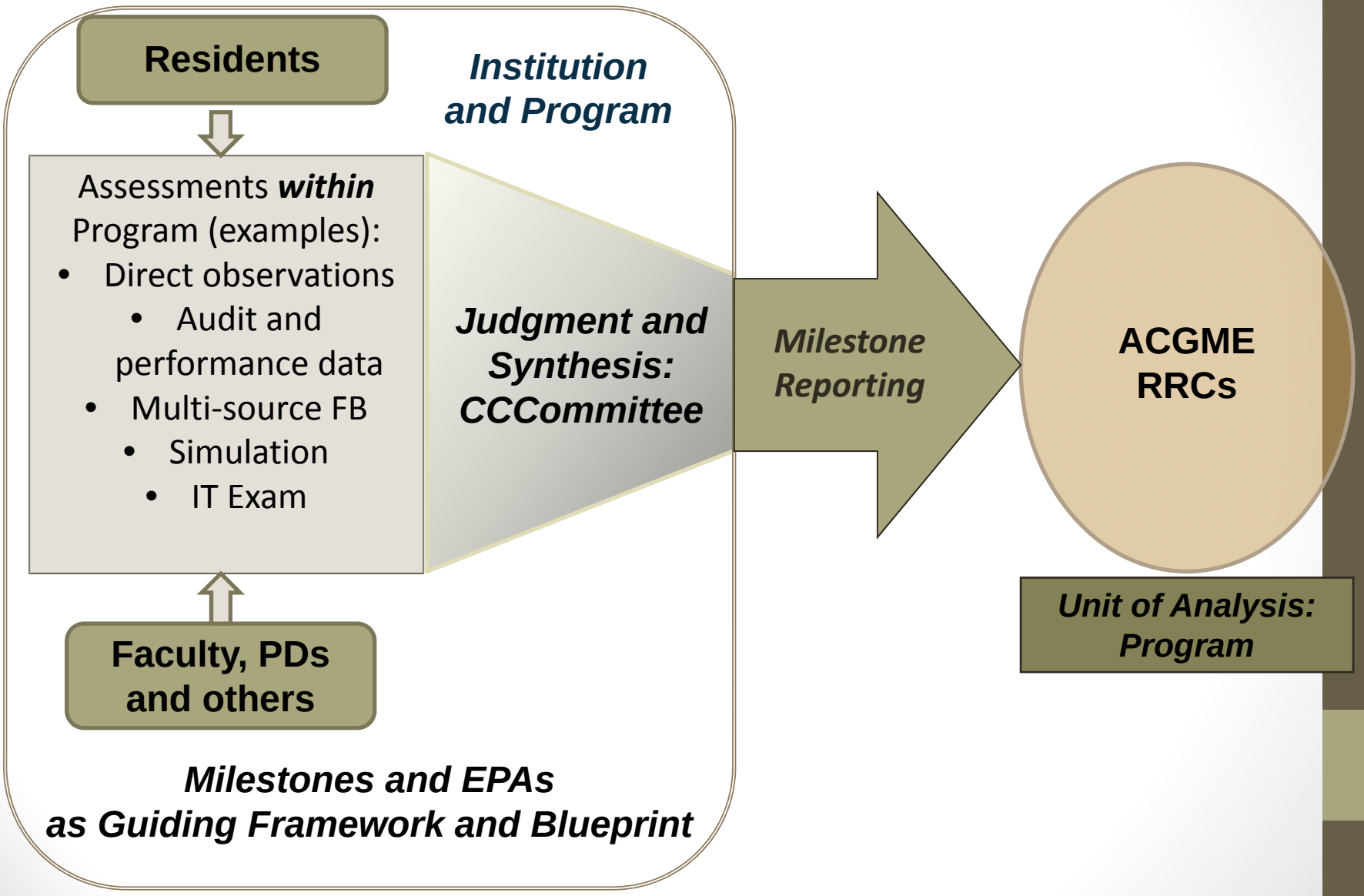
- Observable developmental steps from Novice to Expert/Master (based on Dreyfus model)
- Organized under the six domains of clinical competency
  - Set aspirational goals of excellence (Level 5)
  - Provide a blueprint for resident development across the continuum of medical education
- Development committees were anchored by members of each specialty including board members, program directors, RRC members, national specialty organization leadership, and residents – with ACGME support
- General competencies were translated into specialty-specific competencies

Competency Development Model



Dreyfus SE and Dreyfus HL. 1980
Carraccio CL et al. Acad Med 2008;83:761-7

The NAS Milestone Assessment Syster



Shared Mental Model Challenge

* From TeamSTEPPS/AHRQ

Entrustable Professional Activities

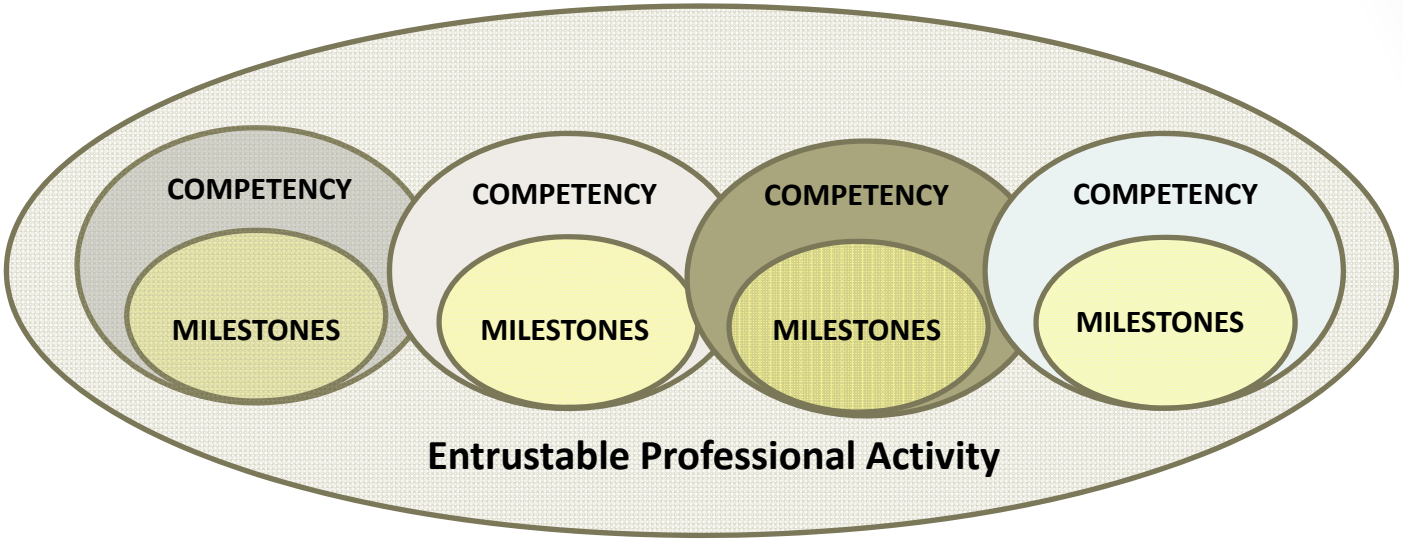
- EPAs represent the routine *professional*-life activities of physicians based on their specialty and subspecialty
- The concept of "entrustable" means:
  - ‘‘a practitioner has demonstrated the necessary knowledge, skills and attitudes to be trusted to perform this activity [*unsupervised*].’’[1]

[1]Ten Cate O, Scheele F. Competency-based postgraduate training: can we bridge the gap between theory and clinical practice? Acad Med. 2007; 82(6):542–547.

EPA # 9. Skillfully facilitate a family meeting.

- Geriatricians skillfully facilitate family meetings by providing a safe and culturally appropriate environment, and when eliciting patient/family values, goals, and preferences, or negotiating goals of treatment, utilizing advanced communication skills (e.g., jargon-free language, nonverbal behavior, response to emotion, conflict mediation).
  - Demonstrate advanced communication skills (language choice, cultural awareness, nonverbal behavior, response to emotion, conflict mediation) when eliciting patient and family values, goals, and preferences; when negotiating goals of treatment; and when communicating with other healthcare providers. (1, 2, 3, 4, 6, 7, 23, 40)
  - Assess and incorporate family and caregiver needs and limitations, including caregiver stress, into patients' management plans. (24, 34, 35)
  - If appropriate, counsel patients, families, and caregivers about the range of options for palliative and end-of-life care, including pain management, artificial nutrition and hydration, and hospice care. (27, 40)

Competencies, Milestones and EPAs



Clinical Learning Environment Review (CLER) Visits

An Institutional Assessment

- All programs within an institution evaluated simultaneously
- CLER is NOT tied to program or institutional accreditation
- Six areas of focus:
  - Resident engagement/participation in patient safety programs
  - Resident engagement/participation in QI programs
  - Establishment and oversight of institutional supervision policies
  - Effectiveness of institutional oversight of transitions of care
  - Effectiveness of duty hours and fatigue mitigation policies
  - Activities addressing the professionalism of the educational environment
- Formative, non-punitive learning process for institutions and the ACGME

CLER Feedback

- Site visitors conduct “walk arounds” accompanied by resident hosts/escorts designed to facilitate contact with nursing and support staff and patients (eventually)
- Meetings held with:
  - DIO, GMEC Chair, CEO, CMO, CNO
  - CPS/CQO
  - Core faculty
  - Program directors
  - Residents
- Answer questions honestly if approached by CLER visitors
- No “gotchas”, and no stealth accreditation impact

In Summary

- A focus on outcomes benefits everyone (patients, programs, and trainees)
- The NAS should permit innovation while ensuring that graduating residents can provide effective, independent patient care
- CLER adds an institutional dimension that focuses on establishing a humanistic educational environment

In Summary

- The Milestones are not perfect - they will require revision as programs gain experience using them
- The Milestones are not absolute benchmarks that determine if and when trainees graduate
- The Milestones should lead to better understanding of what is expected of trainees (and when it is expected) and improve the feedback trainees receive

Where are We in Geriatrics?

- For Fellows:
  - Competencies (Curriculum Milestones) Defined (JAGS, 2014)
  - EPAs developed (JAGS, 2014)
  - Reporting Milestones developed
  - CCCs formed and reporting milestones (12/31/14)
- For Residents:
  - Geriatric competencies for IM, FM (JGME, 2010)
  - Milestones reported 6/14 for IM, 12/14 for FM
- For Students:
  - Geriatric competencies (2009)
  - EPAs from AAMC (11/13)

Where Can we Go in Geriatrics?

- Implement and refine EPAs/milestones for fellows.
- Develop assessment of milestones for geriatrics and other rotations in our own residency programs and possibly nationally.
- Develop milestones and assessments for geriatrics competencies for students.

How Reynolds Has Helped

- Facilitated (at these meetings) development of geriatric fellow competencies/curricular milestones, and EPAs (assisted by Hartford).
- Made all of us highly integrated, visible and credible in the geriatrics education of medical students and residents and IPE at our institutions, regionally, and nationally.

IOM report on GME (7/29/14)

- Maintain Medicare/Medicaid GME support ($15B)
- Build GME Financing and Policy Infrastructure
  - Office of GME Policy in HHS responsible for Medicare GME financing
  - GME Center in CMS
- Two funds for GME
  - Operations Fund-support positions
  - Transformation Fund-develop and evaluate innovative GME
- Modernize GME payment system
  - Per-resident amount to institutions sponsoring GME
- Require similar accountability and transparency for Medicaid GME funds

Conclusion

- We've accomplished a lot in geriatrics education at all levels of the education continuum.
- Our strengths include high value care, shared decision making, focus on quality and safety, achieving good outcomes for older patients, and interprofessional collaboration.
- These are just the outcomes CMS is looking for in funding GME.
- We need to continue to innovate, document what we accomplish, and share it with the education and policy communities.