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A Primer on the Next Accreditation System

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In July 2013, all internal medicine residency programs will begin a new era of program accreditation under the Next Accreditation System (NAS). Developed by the Accreditation Council for Graduate Medical Education (ACGME) who accredits all allopathic graduate medical education programs, the NAS aims to reduce the reporting burden of the current accreditation system, which focuses heavily on the processes and structure of resident's and fellow training. Instead, the NAS aims to accelerate the ACGME's movement toward program accreditation on the basis of educational outcomes (i.e. the demonstrated competence of the trainees that it produces). Through these changes, the ACGME hopes to enhance our system of peer-reviewed regulation and its ability to prepare physicians for practice in the 21st century.[1]

This focus on educational outcomes is nothing new. In fact, the ACGME first established the goal of a competency-based system of accreditation over a decade ago with the implementation of the Outcomes Project, which outlined six general competencies in which every resident should be evaluated: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and system-based practice.[2] Although these general terms are ubiquitous in graduate medical education today, their impact on curriculum and assessment remains somewhat limited. Moreover, there is evidence that residency programs are training physicians who are not ready to function in our complex health care system.[3]

Key Performance Indicators

In the NAS, program directors will be responsible for reporting on a series of key performance indicators that collectively indicate the overall health of the training program. Some elements, such as turnover in program or departmental leadership, certification board pass rate, and an annual survey of residents, will continue. New elements that will impact some faculty members include an annual survey of core clinical faculty and an updated expectation of scholarly activity by core clinical faculty and residents. Institutions that sponsor a training program will also be responsible for assessing and ensuring a positive and healthy environment for learning as well as incorporating residents and fellows into system-wide efforts aimed at quality improvement and patient safety.

Milestones

The key performance indicator that has gained the most attention from program directors is the reporting of program outcomes via resident attainment of educational milestones. In the context of graduate medical education, milestones describe a series of discreet observable behaviors that reflect the expected developmental progress of a trainee over the course of time. Categorized under the six general competencies, they illustrate the normal progression of trainees from beginning learner to an internist who is ready for unsupervised practice. Written as descriptions of a learner's knowledge, attitudes, and skills, the milestones allow for program directors to accurately attest to a resident's current performance, the trajectory of that resident over time, and ultimately the resident's competence and ability to enter into unsupervised practice.

As always, training programs will need to use assessments of trainees produced through typical educational activities (e.g. clinical rotations, simulation) as data to document a resident's performance in

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Table 1
Conditions of Entrustable Professional Activities[4]

1. Is part of essential professional work in a given context
2. Must require adequate knowledge, skill, and attitude
3. Must lead to recognized output of professional labor
4. Should be confined to qualified personnel
5. Should be independently executable
6. Should be executable within a time frame
7. Should be observable and measurable in its process and outcome (well done or not well done)
8. Should reflect one or more competencies

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the six general competency domains. However, in the milestones reporting framework, the typical assessments used by many programs may not provide adequate data to help program directors attest to the developmental progress of an individual learner in this new reporting system.

An emerging framework that is being used to help program directors and faculty collect meaningful assessment data is the Entrustable Professional Activity (EPA) (Table 1).[4] By focusing assessment towards the direct observation of a resident's clinical skills, EPAs provide a meaningful context for faculty to assess attainment of the activities and behaviors internists are expected to perform. Over time, assessments that capture performance through a series of EPAs will allow program directors to adequately attest to a trainee's achievement of the necessary educational outcomes. The 2011 SGIM Patient-centered Medical Home (PCMH) Education Summit developed 25 internal medicine PCMH EPAs that provide an excellent example of the activities expected of a trainee working in this model of care.[5] Other internal medicine stakeholders and some residency training programs have also developed EPAs and are working on processes to assist program directors and faculty at developing meaningful assessments.

Challenges Moving Forward

Questions remain about the implementation of the NAS, specifically about the time commitment of program directors and faculty to develop and complete these competency-based assessments and report these outcomes to the ACGME. It is anticipated that each program director will need to appoint a clinical competency committee to assist in determining a resident's developmental progression toward competence. In addition, significant faculty development is necessary not only for core faculty but also any faculty who have significant contact with residents. Finally, meeting the long-term expectations of the NAS will necessitate re-engineering of existing curricula and rotation-based assessments to provide faculty with greater opportunities for direct observation of learners.

To help chart these waters in a meaningful and productive manner, SGIM and other key stakeholders throughout the internal medicine educational community have teamed with senior leadership of the ACGME and the American Board of Internal Medicine (ABIM) to develop an Internal Medicine Advisory Board on Education Redesign. The goal of this board is to facilitate cooperation and collaboration among the stakeholders to meet the challenges of the NAS and hopefully achieve the goals of competency-based medical education.

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