Single Accreditation System: Crossing that Bridge

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Graduate Medical Education
Disclosures

• No relevant financial relationships with commercial interests to disclose.

• ACGME Osteopathic Recognition Committee
• Past Chair CEE –
  – American Osteopathic Academy of Sports Medicine
  – 2008-2015
• Chief Academic Officer
  – KCU-COM Educational Consortium (OPTI)

• Observations are mine and do not reflect the perspective of the ACGME
Define the Single Accreditation System.
Review standards and requirements.
Review Osteopathic Recognition requirements.
Discuss the potential challenges.
Examine best practices.
Discuss ACGME expectations and what’s next.
Kerrie Jordan, MS, C-TAGME

• University GME Administrator for 3 years
  – Institutional Site Visit
  – Surgical and OBGYN Site Visits
  – IRIS Cost Reporting
  – Residency Management Software Expert
• Children’s Hospital GME Administrator for 8 years
  – Institutional Site Visit
  – Pediatric and Pediatric Subspecialty site visits
  – IRIS Cost Reporting
  – Residency Management Software Expert
• TAGME - “GME Administration of ACGME Training Programs” since 2012
  – Participated in development of assessment tools and one of the first to be certified in specialty
  – Participate on specialty review board committee
  – Member-at-Large acting as review board Chair as directed by Chair
• College of Medicine GME Administrative Director since 2014
  – Program Development & Consultant
  – Specialty Colleges: FM, Sports Medicine, IM, Psychiatry, EM, General Surgery, OBGYN, Orthopedic Surgery, and Anesthesiology
  – HCPro contributor for newsletters and webinars
  – Residency Management Software Expert
Future of Graduate Medical Education

- Culture Barriers
- Funding Restrictions
- Limited positions for graduating students
- Not enough new training positions being created
- Evolving with no consensus on the future of healthcare delivery

Progress is impossible without change, and those who cannot change their minds cannot change anything.

– George Bernard Shaw
The Single Accreditation System (SAS)

• Unified Accreditation System for Graduate Medical Education programs in the U.S.

• Standardizes, streamlines, and strengthens the postdoctoral accreditation process.

• Opportunity for MD and DO graduates to complete any ACGME-accredited GME training program.
GME History

- CMS established through the SSA of 1965
  - Funding for residency training as component

- DO graduates trained in “Osteopathic Hospitals” with robust GME training programs

- Public Health Service Act of 1970
  - Provided significant $’s for expansion of medical schools under Title VII

- 1983 CMS introduced Perspective Payment System
  - Funding formula for GME developed
    - DGME,IME
GME History

- Late 1980’s and early 90’s many Osteopathic Hospitals acquired by larger systems
  - Loss of long standing GME infrastructure
- 1996 AAMC report speculated oversupply of physicians
- Balanced Budget Amendment of 1997
  - Capitated existing programs to # as of Jan 1, 1997
- 1998 the AOA developed Osteopathic Postgraduate Training Institute (OPTI)
GME History

- 2006 AAMC report reassessed 1997 report stating nation facing significant physician shortage
- 2008 call for 20% increase of physician workforce via medical school expansion
- Affordable Care Act proposes universal health care coverage
  - Increased # of enrolled
  - Proposed payments reflective of outcomes measures
- No adjustment to Residency Cap under BBA 1997
GME History

- Medicare Payment Advisory Committee (MedPAC) 2010 report
  - Recommended performance-based GME funding structure with payments contingent on educational outcomes

- ACGME “Outcomes Project” in 2011 developed the Next Accreditation System (NAS)
  - Goal to improve trainee outcomes in the six defined competencies.
    - Performance parameters
    - Resident Milestone achievement
GME History

• ACGME Fellowship training programs requirement successful accomplishment of required milestones

• AOA certified residency graduates not assessed by NAS therefor potential for limited matriculation
  • “Exceptional candidate” allowable

• Discussions initiated 2011 to address discrepancy
GME History

• February 2014, AACOM, AOA, and ACGME reached agreement to collaborate an integrated governance and operations under ACGME.

• July 19, 2014, AOA House of Delegates approved resolution granting the AOA Board of Trustees authority to proceed in good faith towards a Single Accreditation System for GME

• Single Accreditation System agreed to fall of 2014
AOA Application for Accreditation Process

OPTI collaborates with Base Site to develop application

Step 1-

Institutional Data
- Hospital Bed Size: 286
- Percentage of Occupied Beds: 43%
- Medical Staff D.O.’s: 2
- Medical Staff M.D.’s: 99

Annual Data
- Admissions: 11,952
- Births: 1,186
- Emergency Room Visits Per Year: 50,493
- Inpatient Surgeries: 3,050
- Outpatient Surgeries: 3,725
- Outpatient Procedures: 38,120

Facilities Description
- Residency Goals and Objectives
- Rotation Goals and Objectives

Curriculum
- Teaching Faculty Roster with Certification Status

Core Competency Plan

Policy
- Segregated Totals

AFFILIATION AGREEMENT

1. COMMITMENT TO OSTEOPATHIC GRADUATE MEDICAL EDUCATION

Kansas City University of Medicine and Biosciences®
AOA Application for Accreditation Process

Step 2-
OPTI submits application through fileworks for AOA to review

Step 3-
AOA reviews and sends to Specialty College

Step 4-
Specialty College Committee on Education and Evaluation (CEE)

Step 5-
CEE makes comments and seeks follow-up from OPTI and Base Site if application needs clarification

Step 6-
CEE notifies AOA of approval

AOA sends Approval Letter to OPTI (can take between 3-12 months)

New Programs can no longer be approved by AOA after June 30th
Standards vs. Requirements

AOA Standards
- OPTI & Training Institution
- General Program
- Specialty
- “Must”

ACGME Requirements
- Institution
- Common Program
- Program-specific
- “Should” = “Must”

Institutional Application
Osteopathic Recognition Requirements

• Osteopathic Recognition
  – Conferred upon any ACGME-accredited graduate medical education program providing requisite training in osteopathic principles and practice after appropriate application and review for adherence to established requirements.

• Osteopathic Principles and Practice
  – The conceptual understanding and practical application of the distinct behavioral, philosophical, and procedural aspects of osteopathic medicine.
Osteopathic Recognition Requirements

• Osteopathic-focused programs or tracks within a program

• Programs must integrate OPP into the six ACGME core competency areas

• Embed the four tenants of osteopathic medicine into program

• Should participate in a community of learning that promotes the continuum of OME such as an OPTI

• http://www.acgme.org/acgmeweb/Portals/o/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf
ACGME Core Competencies

- Medical Knowledge
- Interpersonal and Communication Skills
- Systems-Based Practice
- Professionalism
- Practice-based Learning and Improvement
- Patient Care
- Interpersonal and Communication Skills
- OPP Integration
Osteopathic Recognition Requirements

- Resident must be DO graduate or MD graduate with sufficient background and/or instruction in osteopathic philosophy and techniques in manipulative medicine sufficient to prepare them to engage in the curriculum of the program.

- Candidates applying for fellowship programs must have completed an osteopathic-focused residency program or track in the required field of study.
Governing Body Comparison

AOA- Educational Affairs

Board of Trustees

Bureau of Osteopathic Education (BOE)

Council of Osteopathic Postdoctoral Training (COPT)

Council on Osteopathic Postdoctoral Training Institutions (COPTI)

Program and Trainee Review Council (PTRC)

Specialty College Evaluating Committee (SPEC)

Program

ACGME – only covers accreditation

Board of Directors

Executive Committee

Committee on Requirements

Education Committee

Monitoring Committee

Residency Review Committees (RRCs)

Osteopathic Principles Committee (OPC)

Program

Single Accreditation System: Crossing that Bridge
<table>
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<th>ACGME</th>
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<tr>
<td>Evaluations and Program Improvement</td>
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<td>Competencies, with exception of OMM</td>
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<td>TIVRA</td>
<td>Web ADS (Annual Updates)</td>
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<td>OGME</td>
<td>GMEC</td>
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<td>NMS</td>
<td>NRMP</td>
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<td>Opportunities</td>
<td>FREIDA</td>
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<tr>
<td>ERAS</td>
<td>ERAS</td>
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<tr>
<td>Annual OPTI Site Visits</td>
<td>AIR</td>
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</table>
• ACGME under one umbrella only covering Accreditation
• Sponsoring Institution & Program Site Visits are more detailed
  – CLER with little notice (2 weeks)
  – Program self-study and site visit every 10 years
• Board Pass Rates can affect accreditation (ABMS, AOA)
• Time Off depends on specialty (qualify for boards)
• Duty Hours – min of 14 hours off instead of 12 after working 24 hours; PGY 1 residents must be off for 10 hours between shifts; ER rotation restrictions; Night float

• Evaluations – Rotation, semi-annual, self, peer, patient, “360” and APE

• Milestone reporting as reported to CCC - Web ADS

• Annual Faculty & Resident Survey’s

• Curriculum – patient encounters

• Programs are eligible to take MD
Learn the ACGME Language!

ACGME Acronym - Timeline

- Accreditation Data System (ADS) – May/June
- Annual Institutional Review (AIR) – GMEC annually
- Annual Program Evaluation (APE) – Self Study every May/June
- Program Letter of Agreement (PLA) – 5 years
- Master Affiliation Agreement (MAA) – 5 years
- Clinical Competency Committee (CCC) – semi annually
- Clinical Learning Environment Review (CLER)
- Designated Intuitional Officer (DIO)
- Electronic Residency Application Service (ERAS) - annually
- Fellowship and Residency Interactive Database (FREIDA) – AMA National GME Census every August or October
- Graduate Medical Education Committee (GMEC) - quarterly
- Intuitional Review Committee (IRC)
Learn the ACGME Language!

ACGME Acronym - Timeline

• Major Participating Site – 2yr=4mo; 3yr+=6mo
• Participating Site
• Medical Specialty College
• National Resident Matching Program (NRMP) - annually
• Supplemental Offer and Acceptance Program (SOAP) -annually
• Post Graduate Year (PGY)
• Residency Review Committee (RRC)
• Osteopathic Principles Committee (OPC)
• Program Evaluation Committee (PEC) – V.C.1 Common PR
• Core Faculty – devote at least 15 hours per week to resident education and administration
Who will be the Sponsoring Institution?

AOA

- Programs shall function under the authority of an OPTI.
- OPTIs shall not assume this responsibility for base institutions; however, shall be copied on all official correspondence.
- Community-based training consortium comprised of at least one college of osteopathic medicine and one hospital and may include additional hospitals and ambulatory training facilities.

ACGME

- Programs must function under the ultimate authority and oversight of one Sponsoring Institution. Oversight of the resident assignments and the quality of the learning and working environment by the sponsor extends to all participating sites.
- The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner’s office, a consortium, an educational foundation).
Institutional Oversight
-DME=DIO

AOA – OPTI

• IV.B.4.1 – All “base” institutions shall be in substantial compliance with AOA requirements for institutional and programs in accordance with all AOA general requirements and specialty standards.

• VI.A.6.1 – There must be a DME with authority, responsibility, resources, protected time for administrative activities and reporting relationship within hospital administration for the oversight of programs. Each institution shall have an IEO and may have an ADME

ACGME – Sponsoring Institution

• I.A.2 – must be in substantial compliance with ACGME institutional requirements and must ensure that its programs are in substantial compliance with ACGME Institutional, Common, and Specialty specific Program requirements, as well as ACGME Policies and Procedures.

• I.A.5.a – DIO (can be non-physician) in collaboration with GMEC must have authority and responsibility for the oversight of each program as well as ensuring compliance with Institutional, Common, and Specialty specific Program requirements
Institutional Oversight -Committees

AOA=OGME & Subcommittees

• OPTI must have OGME
• Each “base” institution must have MEC
• Minutes are important
• Meetings at least 10 times a year
• Oversight of Base Institution and each Program including participating sites

ACGME=GMEC & Subcommittees

• Programs must be under authority of GMEC
• Must have peer selected resident in attendance or sub in place
• Subcommittees actions must be reviewed and approved by GMEC
• Minutes are important
• Meetings at least once a quarter (4 times a year)
• Oversight of Sponsoring Institution and each Program including participating sites
Institutional Requirement
-Support Services, Salary, and Benefits

AOA
- IV.A.4.4 - The base Institution must provide administrative, financial, educational, technological and other support services for each program to provide quality training programs including faculty development, curriculum, evaluation methods, and OPP training.
- VII.B.1 – Base institution shall provide all residents with salary and benefits to achieve educational objectives.

ACGME
- II.B. - Sponsoring institution in collaboration with each program must ensure PDs have sufficient financial support and protect time to carry out educational, administrative, and leadership responsibilities.
- II.D. – Sponsoring Institution, in collaboration with each program, must provide residents with salary and benefits to ensure they are able to fulfill responsibilities.
- IV.F.1 & IV.F.2 – must provide health and disability insurance for residents beginning 1st day of employment or access to interim coverage
Application for “Pre-Accreditation”

AOA – programs with matriculated residents

- Sponsoring Institution submits application online between 4/1/15-6/30/20 and receives “Pre-Accreditation Status”
- Program submits application online between 7/1/15-6/30/20 and receives “Pre-Accreditation Status”
- Review Committee assigned
  * may have AOA certified co-program director
  * AOA faculty members are acceptable
- Review Committee makes comments and seeks clarification if needed
- Application Approval for “Pre-Accreditation” (timeframe unknown at this time)
- Programs with Pre-Accreditation status can begin the application process for Osteopathic Recognition.

Dually Accredited

- If current ACGME programs are not counting the AOA residents in ADS, the program will need request a complement increase.
- If current ACGME programs are counting the AOA residents in ADS, the program does not need to do anything. The program will however want to apply for osteopathic recognition.

There are no fees for institutional accreditation or Osteopathic Recognition.

The program application fee is $6,200 payable at the time of application.
Application Process for New Programs seeking Accreditation as of July 1st

All core specialties require site visits before the Review Committee will review an application.

DIO initiates a new program application within ADS

Program Director notified to log into ADS to complete the application

Once application complete the ACGME schedules a site visit (expect these steps to take up to 8 months)

Site Visitor submits “Site Visit Report” to Residency Review Committee at least 2 months prior to Review Committee meeting

Residency Review Committee meets to review “Site Visit Report” and make final decision on approval

Site Visit (Core Specialty Only)

Residency Review Committees meet on average three times a year

Application Approval (process may take between 12-18 months)
CHALLENGES

- ACGME standards do not mirror AOA
- DO students not currently always accepted into ACGME residencies
- Web ADS (AOA=TIVRA) required once program receives pre-accreditation status
  - Resident Survey required annually
  - Faculty Survey required annually
  - Program Updates required annually
  - Milestone Reporting required semi-annually
- Scholarly Activity for Faculty and Residents
- CCC requirements (AOA=No equivalent)
- Deadlines
  - FREIDA (AOA=Opportunities)
    - AAMC National GME Census information
    - Program Survey in May
    - Residency Survey in July
  - Evaluation Completion
BEST PRACTICES
STRUCTURE=FUNCTION

• OPTI can serve as Sponsoring Institution
• OPTI committee structure to meet Graduate Medical Education Committee (GMEC) requirements
  – Similar to what the OPTI BOD and other committees are already doing
  – Add a few committees such as CQPI
  – Update Bylaws, GME Policy and Procedure Manual, Resident Handbooks
• Meet regularly and have open dialogue with programs
BEST PRACTICES
STRUCTURE=FUNCTION

• Program Oversight – Timeline Checklist – Residency Management Suite (RMS)
  – Semi-annual and Annual reviews
  – CCC and 6-month Milestone reporting to Web ADS
  – Annual Program Evaluation (APE)
  – Annual program reporting in Web ADS (AOA=TIVRA)
  – Process Improvement
  – Evaluation completion
  – Faculty Development & Resident Scholarly Activity
  – Self-study annual data gathering – 10 year site visit
Committee Structure (Sponsoring Institution=OPTI)

CCC Review
CCC meets every 6-months prior to the semi-annual review. CCC reviews evaluation feedback, procedure logs, duty hours, conference attendance, scholarly activity progress, and in-service exam results.

Report Findings
CCC Chair reports findings from CCC review to the Program Director.

Semi-annual Review
The Program Director conducts a 6-month review with the resident sharing the findings from CCC, discussed progress in the program, residents goals next 6-months, strengths, and areas of improvement.
Committee Oversight using Collaborative Reporting (RMS)

- Duty Hours & Time Off
- Procedure Logs / Patient encounters
- Scholarly Activity
**RMS Reporting**

- Semi and annual reviews
- Curriculum Requirements

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<tr>
<th>Requirement</th>
<th>Actual</th>
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<th>Target</th>
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<td>Anesthesiology</td>
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**Diagram:**

1. Add Reporting Widgets
2. Arrange Review Form

- Continuity Clinic Counts
- Compliance per Rotation
- Rotation Requirements
- Conference Attendance
- Curriculum Confirmed
- Duty Hour Violations

*Click and drag Report Widgets to reorder their appearance on the Review Form.*
### PC1. Gather essential and accurate information about the patient

<table>
<thead>
<tr>
<th>Score</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
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<tr>
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<td>Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. Still relies primarily on analytic reasoning through basic pathophysiology to gather information, but has the ability to link current findings to prior clinical encounters allows information to be filtered, prioritized, and synthesized into pertinent positives and negatives, as well as broad diagnostic categories.</td>
<td>Demonstrates an advanced development of pattern recognition that leads to the creation of illness scripts, which allow information to be gathered while simultaneously filtered, prioritized, and synthesized into specific diagnostic considerations. Data gathering is driven by real-time development of a differential diagnosis early in the information-gathering process.</td>
<td>Creates well-developed illness scripts that allow essential and accurate information to be gathered and precise diagnoses to be reached with ease and efficiency when presented with most pediatric problems, but still relies on analytic reasoning through basic pathophysiology to gather information when presented with complex or uncommon problems.</td>
<td>Creates robust illness scripts and instance scripts (where the specific features of individual patients are remembered and used in future clinical reasoning) that lead to unconscious gathering of essential and accurate information in a targeted and efficient manner when presented with all but the most complex or rare clinical problems. These illness and instance scripts are robust enough to enable discrimination among diagnoses with subtle distinguishing features.</td>
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- CCC Review for Pediatric Resident  (OGME 1/PGY 1)

<table>
<thead>
<tr>
<th>1st Year</th>
<th>2nd Year</th>
<th>3rd Year</th>
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<tbody>
<tr>
<td>December 2014</td>
<td>June 2015</td>
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**Patient Care**

PC1. Gather essential and accurate information about the patient

Score: 2.5

PC2. Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient

Score: 2.5

PC3. Provide transfer of care that ensures seamless transitions

Score: 2.5

PC4. Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment

Score: 3
- CCC Review for Pediatric Resident (OGME 2/PGY 2)

PC1. Gather essential and accurate information about the patient

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Score: 4

Review Feedback from Evaluation Responses

Checkbox: Not yet assessable
### CCC Review for Pediatric Resident (OGME 3/PGY 3)

#### Patient Care

**PC1. Gather essential and accurate information about the patient**

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Score: 4.5

Review Feedback from Evaluation Responses

Not yet assessable
CCC reviews Resident progress over last year (June 2014 & December 2014) during June 2015 review.
ACGME EXPECTATIONS

- GMEC oversight over Sponsoring Institution and each Program including participating sites
- Centralized Duty Hour Reporting
- 360 evaluations
- Clinical Competency Committee (CCC)
ACGME EXPECTATIONS

• Annual Reporting (Program Evaluation Committee (PEC))
  – MEC’s currently reviewing programs on an annual basis
  – Now programs will need to form a separate PEC to reflect on program improvement / action plans from annual reviews, review curriculum, scholarly activity for core faculty and residents, board passage rates, and

• 10 year self study
  – Reflect on progress over the years
  – Track strengths, weaknesses, and action plans annually
  – Action Plan follow up reported at next year’s PEC

• RMS CCC reports to meet ACGME requirements
What We Have Learned

• The similarities and differences

• How to meet in the middle where the two paths cross

• “Should” = “Must” do to meet ACGME requirements for accreditation

• How to adapt the requirements to fit your institutional and program structure (“OPTI”) in order to provide oversight using RMS and timeline checklists
WHAT’S NEXT?

• One accreditation process
  • *Sponsoring Institution Application* – April 2015 thru June 2020
  • *Program Application* – July 2015 thru June 2020
• “Requirements” for all GME training programs
• Accepting change, know what to expect, and become familiar
  • *ACGME Language*
  • *ACGME Keywords*
  • *ACGME “Strict” Deadlines*
• Assure compliance (Structure=Function)
  • *Incorporating OPTI*
• Unrestricted access for DOs & access to Osteopathic training for MDs
• OPTI’s may combine
• Discussions of a Single match system
References

- ACGME Intuitional Requirements - https://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf
- ACGME Common Program Requirements – https://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs_07012015.pdf
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- ACGME Faculty Survey – Program FAQs http://www.acgme.org/acgmeweb/Portals/0/ACGME%20Faculty%20Survey%20-%20Program%20FAQs.pdf