

# Frequently Asked Questions about the Next Accreditation System

(Updated July 2013)

## ***The Next Accreditation System (NAS)***

### **What is the [timeline](#) for the implementation of the NAS?**

For the seven specialties in Phase I of the NAS (diagnostic radiology, emergency medicine, internal medicine, neurological surgery, orthopaedic surgery, pediatrics, and urology) and their subspecialties, implementation of the NAS occurred on July 1, 2013. For all other specialties, the Transitional Year, and Institutional Review, implementation of the NAS will occur on July 1, 2014.

### **What are the components of the Annual Data Reporting each program will submit to the Accreditation Council for Graduate Medical Education (ACGME)?**

The final reporting systems for the NAS are still under development. However, much of the data that will be used to accredit programs in the NAS are available now, and used in the accreditation of programs. This includes the annual Accreditation Data System (ADS) update, the ACGME Resident-Fellow Survey, Case Log and clinical experience data, and data on graduates' performance on the certifying board examinations.

New data elements for the NAS will include the Educational Milestone data from the semiannual evaluation of residents, aggregated to the level of the program, with the first reports for Phase I specialties scheduled for submission to the ACGME in December 2013 and June 2014. New data will also include a Faculty Survey (implemented for Phase I programs in Academic Year (AY) 2012–13 and for Phase II programs in AY 2013–14) and a scholarly activity report form that replaces the detailed faculty curricula vitae (CVs) currently in use.

### **How will programs generate and submit the annual data used in the NAS?**

Data will be submitted by programs, as is currently done. Much of the data for the NAS uses an “update for any changes” approach to reduce the burden on programs, and some of the new data requested replace current, more burdensome submission formats. For example, faculty CVs have been replaced with abbreviated data on faculty members' board certification status and scholarly activity. The only individual for whom a complete CV will be collected is the program director.

### **What happens to cycle length in the NAS?**

Review Committees will no longer assign cycle lengths to programs. The ACGME will be using a continuous accreditation model with collection and review of annual data from each program. All programs, with the exception of applications and very newly accredited programs, will have a scheduled self-study visit every 10 years. In addition, programs may have focused or diagnostic site visits, if the annual data submission suggests a potential problem. These site visits are described below.

### **How will subspecialty programs be reviewed in the NAS?**

Subspecialty programs will have their annual reviews together with their respective core programs, and their self-study visits will also be concurrent with the visits to their core programs. Review Committees will review annual data—including Resident-Fellow Survey and Faculty Survey data, the annual ADS Update information, and where applicable, minimum procedural numbers—in the accreditation of subspecialty programs, just as they do for core residency programs. The NAS places more responsibility for oversight of the subspecialty programs on the core programs and the departments.

### **How will new applications be reviewed in the NAS?**

All core specialty programs and most surgical subspecialty programs will have site visits; other subspecialty programs will be reviewed by the Review Committees using the written application prepared by the program, and if accredited, would be scheduled for a site visit within two years of the application.

Additional detailed information about [accreditation site visits](#) and [site visits and review of program applications](#) can be found in separate FAQs dedicated to these topics.

### **The Program Requirements have been categorized, with some labeled as “core” and others labeled as “detailed” in the NAS. What is the reason for this?**

The focus in the NAS is on educational outcomes. The common and specialty programs requirements were [categorized](#), with the expectation that programs that demonstrate good educational outcomes will not be assessed for compliance with the “detail” requirements. “Detail” requirements will be considered mandatory for new programs and for programs that have failed to meet expectations for outcomes (and have an accreditation status of “Probation” or “Continued Accreditation with Warning”), and are intended to offer these programs added guidance.

Allowing high-performing programs the freedom to meet the detailed requirements with alternatives will provide such programs the opportunity to innovate.

### ***The Clinical Learning Environment Review (CLER) Program***

#### **What are the objectives of CLER?**

Since the release of the Institute of Medicine’s report on resident hours and patient safety, there have been calls for enhanced institutional oversight of duty hour limits and of efforts to enhance the quality and safety of care in teaching hospitals. In response, the ACGME established the [Clinical Learning Environment Review \(CLER\)](#) program as a key component of the NAS, with the aim to promote safety and quality of care. CLER focuses on six areas important to the safety and quality of care in teaching hospitals and the care residents will provide in a lifetime of practice after completion of education: (1) engagement of residents in patient safety; (2) engagement of residents in quality improvement (including opportunities for reducing health disparities); (3) enhancing practice for care transitions; (4) promoting appropriate resident supervision; (5) duty hour oversight and fatigue management; and (6) enhancing professionalism in the learning environment and in reporting to the ACGME.

#### **How will CLER visits be conducted?**

CLER visits will be conducted by a team of dedicated site visitors, which may include a peer site visitor from another sponsoring institution. For the first 18-month cycle of CLER, site visitors will visit only one major participating site for each sponsoring institution. Institutions will receive no less than 10 days’ notice of the visit. Institutions will not be required to complete any documents in advance, but will be asked to share copies of existing documents—such as the participating site’s quality and safety strategy, and existing policies on supervision, duty hours, and related matters. The site visitors will use a combination of group meetings and walking rounds of clinical areas to assess the learning environment.

#### **What will be done with the data from the CLER visits?**

During the first review of all sponsoring institutions, the CLER program is in a testing phase during which the ACGME will continue to develop, test, and fully implement this new program

through visits to the nearly 400 clinical sites of sponsoring institutions that undergo an institutional review.

During this initial testing period, the CLER visits will be gathering baseline data, primarily used to provide formative feedback to the institution. Eventually, this feedback will include de-identified benchmarking data to allow for comparisons to like institutions. The CLER evaluation process is structured to provide three opportunities for feedback to the institution following a site visit: (1) an oral report at the end of the site visit; (2) a written report of the site visit that is sent to the institution prior to the submission of this report to the CLER Evaluation Committee with an opportunity for the institution to respond; and (3) the final report after review by the CLER Evaluation Committee.

### **How will the scheduling of CLER visits and institutional reviews be coordinated?**

The ACGME will make every effort to ensure that CLER visits are not scheduled during the time immediately before or after a regularly scheduled institutional review site visit.

### **How will CLER data be used in program and institutional reviews?**

For the first 18-month cycle of visits, only aggregated or de-identified data will go to the Institutional Review Committee (IRC; data for individual institutions will not be reported), and the data will not be used in accreditation decisions. The sole exception would be an instance in which the CLER site visit team discovers a potentially egregious violation of accreditation standards. In this case, the ACGME would follow its egregious violations policies detailed in the *ACGME Manual of Policies and Procedures*.

## ***The Educational Milestones***

### **What are the Educational Milestones?**

The Educational Milestones (milestones) are observable developmental steps, organized under the six competency areas, that describe a trajectory of progress on the competencies from novice (entering resident) to proficient (graduating resident) and, ultimately, to expert/master. The milestones for each specialty have been developed by a Working Group made up of members of the respective Review Committee, the American Board of Medical Specialties (ABMS) certifying board, program directors, and residents.

The benefits of the milestones are that they articulate shared understanding of expectations, set aspirational goals of excellence, provide a framework and language for discussions across the continuum, and ultimately track what is most important—the educational outcomes of the residency program.

In the context of the larger educational community's interest in measures for the professional development of health care professionals, it is important to emphasize that the milestones are only relevant for evaluation of individuals who possess MD or DO degrees, and who are currently enrolled in ACGME-accredited residency or fellowship programs. The milestones provide a framework for the assessment of the development of the physician in key dimensions of the elements of physician competency in the given specialty. They neither represent the entirety of the dimensions of six domains of physician competency, nor are they designed to be relevant in any other context.

### **How will the milestones be used in resident evaluations?**

Residents will undergo a structured evaluation against milestones (in most specialties this will be done semiannually). The Clinical Competency Committees (see below) will review and use

assessment data, including faculty member assessments of residents on rotations, self-evaluations, peer evaluations, and evaluations by nurses and other staff members. Each program may continue to use its current resident assessment tools, and phase in tools developed specifically for the milestones when these become available. Programs in Phase I specialties will submit their initial milestone data in December 2013 and June 2014.

Once a program has submitted its milestone assessments, the ACGME will construct a Milestones Evaluation Report that will be available to the program. In the initial years of the NAS, the Review Committees' annual review of milestone performance will be completed by comparing the progress on the milestones of the resident cohort in the given program over time. To gauge whether residents are progressing satisfactorily, programs may compare each individual resident's performance against that of his or her same-year cohort, while taking into account individual variations in rotations and other learning experiences. The ACGME expects that it will take several years for national data on the milestones to become available.

Use of the milestones and the predefined narrative criteria for levels of performance will assist programs in resident evaluation and will enhance transparency for learners, programs, sponsoring institutions, and the public.

### **How is the validity and reliability of the milestones being established?**

The milestones were written by a Working Group of ABMS board members, Review Committee members, program directors, and residents, and represent a broad range of specific areas of expertise that a resident in a given clinical specialty is expected to develop.

The *construct*, *criterion*, and *predictive* validity of the milestones will be established with their use in resident assessments, the accrual of national data, and comparisons to evaluation methods previously used and assessment already considered to be of high value, such as board performance data.<sup>1</sup>

Similarly, establishing the reliability of the milestones will require data from their use in resident assessments. Several specialties are currently conducting pilot studies to gather information about the clarity, feasibility, acceptability, and performance characteristics of the milestones. One advantage of the milestones, compared to the evaluation tools currently used by individual programs, is that assessment data will be collected on thousands of residents, producing a sample that, over time, will make it possible to establish their reliability and validity.

### **What is the timeline for the application of the milestones?**

Development of the milestones for all core specialties is being completed in 2013. The milestones are posted on the ACGME website and the [ACGME's NAS microsite](#), and distributed according to the plans developed by each specialty milestone's Working Group.

The timeline called for programs in Phase I of the NAS to form Clinical Competency Committees (CCCs) in the spring of 2013, and begin to evaluate residents on the milestones at the start of AY 2013–2014, with the first two milestone submissions to the ACGME scheduled to occur in December 2013 and June 2014.

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<sup>1</sup> Swing SR, Clyman SG, Holmboe ES, Williams RG. Advancing resident assessment in graduate medical education. *J Grad Med Educ.* 2009;1(2):278–286.

Development of the milestones for subspecialty programs began in 2013, and is expected to be completed in a shorter time than the development of the core specialty milestones. The subspecialty milestones will also focus to a much greater extent on medical knowledge and patient care skills.

**How do the ACGME and Review Committees plan to use the milestones?**

The Review Committees will review aggregate program-level data and de-identified milestone data. Review Committees will assess trends to help identify areas for program improvement. Over time, this is expected to include data on national trends in milestone performance.

**How often will milestones be updated?**

Once the milestones are published, they will need to be stable long enough for the specialties and the programs to develop assessment tools, and experience and familiarity with them. After adequate experience, perhaps in three to five years, and after a cohort of residents have gone through an entire cycle using the milestones, it may become clear which of the narratives need to be revised, at which time another Working Group would be convened.

**If indicated by performance on the milestones, can a resident or fellow finish his or her educational program early and be considered “board-eligible”?**

The decision to allow an “early graduation” that would render a resident or fellow board-eligible would always and only be made by the relevant ABMS certifying board. While such a decision would likely be aided by the use of the milestones, accelerating resident education is not the intent of the milestones.

**Can a resident graduate if he or she does not reach every milestone?**

The relevant section of the Common Program Requirements, which will not change with the implementation of the NAS, states that “...[the final summative evaluation by the program director] must document the resident’s performance during the final period of education, and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.”

A resident’s attainment of the level of performance on the milestones expected at graduation (Level 4) does not by itself signify that he or she has demonstrated sufficient competence to enter the practice of a specialty without direct supervision (an exception is the Transitional Year where a Level 3 performance is expected at the completion of the program). That remains a judgment of the program director, consistent with the Common Program Requirements. Similarly, failure of a resident to attain the level of performance on the milestones expected of a graduating resident does not signify that he or she has not demonstrated this sufficient competence. The program director retains judgment in this regard.

The milestones and the judgment of the CCCs are tools and a framework for evaluation that assists the program director in making this decision. Thus, a program director can graduate a resident who has not attained every milestone, when the program director has determined that resident is able to practice without direct supervision.

The requirements for board certification are the jurisdiction of the ABMS member boards. The specialty boards retain judgment regarding eligibility for certification, and may opt to use or not use attainment of the milestones in making this decision.

**The milestones will be used for program accreditation. What will keep program directors from reporting milestones in a way that leads to successful accreditation rather than accurate reporting of residents’ progress?**

The ACGME expects a high degree of professionalism from program directors and faculty members. This includes honest assessment and reporting of residents' progress on the milestones. It would be a disservice to its residents for a program to be less than candid about their performance on the milestones.

In the accreditation system prior to July 2013, leadership in many programs faced situations, often late in the educational program, in which there is a realization that a resident is not truly prepared for independent practice in the specialty. At that point, a program director has to decide whether he or she would rather postpone the fellowship or practice plans of such an individual, as no residency program wants to produce substandard graduates. Use of the milestones will enable earlier identification of residents who are not appropriately progressing in one or more areas, and allow program directors to intervene in a more timely fashion to improve the performance of those residents.

**Will the use of milestones cause a shift of focus toward these areas at the expense of other important knowledge and skills necessary for competent practice?**

The milestones were developed by members of the specialty community to encompass the aspects of the specialty in which the growth of an individual during residency is most important to preparedness for independent practice. The ACGME will use the milestones as one method of assessing whether programs are adequately preparing individuals for the unsupervised practice of the specialty. Programs should continue to maintain their curricula in all areas of knowledge, skills, and attitudes necessary for the practice of the specialty, and should ensure that residents in procedural specialties meet the minimum procedural numbers established by the applicable Review Committee. In addition, the ABMS member boards will continue to assess individuals for their acquisition of the knowledge, skills, and attitudes necessary for the unsupervised practice of the specialty.

**Are residents' milestone evaluations discoverable (for all residents and residents who do not reach the expected levels of milestone performance)?**

The degree to which information about performance during residency is "discoverable" varies from state to state. It is expected that milestone data will be considered discoverable to the same extent to which evaluations currently gathered on residents are discoverable.

**Will milestone data be shared with individual certifying boards?**

For certifying boards that want to receive milestone information, the ACGME will provide the data directly to the board with the permission of each resident. Data would be sent by the ACGME every six months, yearly, or at the end of education, depending on the given board's expressed needs.

***Clinical Competency Committees (CCCs)***

**What is the role of the CCC in resident assessment?**

Each program is expected to form a CCC and begin to develop its members before the specialty transitions into the NAS (eg, for Phase I specialties before July 2013). The members of the CCC make a consensus decision on the progress of each resident. Initially, the CCCs will use existing resident assessment data and faculty member observations to inform their evaluations of residents. Beginning in AY 2013–14, the CCC assessments will use data from the milestone assessments.

A benefit of the CCC approach is that it will offer the resident evaluation process the insight and perspectives of a group of faculty members. The CCC will also serve as an early warning

system if a resident fails to progress in the educational program, and will assist in his or her early identification and move toward improvement and remediation.

### **What are the qualifications for CCC membership?**

CCC members should include core faculty members who have the opportunity to observe and evaluate residents, but may include other members such as assessment specialists and non-MD medical educators.

### **What role should the program director have on the CCC?**

The requirements regarding the CCC do not preclude or limit a program director's participation on the CCC. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion.

### **How should members of the CCCs be prepared for their assessment role?**

Evaluation is a core faculty member competency, but most faculty members will need added training in the evaluation process, including how to aggregate and interpret data. They will initially need to discuss the milestone narratives and reach a common agreement of their meaning. There are plans to develop training resources for CCCs. In addition, the individual CCCs and the community of educators at a given institution will also serve as a venue for faculty member discussion about resident evaluation, including how many assessments are needed for any given milestone, data quality, and the application of quality improvement principles to the evaluation process.

### **How much work will be required by the CCC to conduct the semiannual resident assessments on the milestones?**

Pilot assessments on the milestones have found that it takes a significant amount of time (up to an hour) to conduct the milestone assessment for each resident the first time the evaluation is done, but that subsequent evaluations take less time, as CCC members become familiar with the milestones and their use.

### **Should the milestone assessments be made by specialists during residents' clinical rotations rather than semiannually by a committee?**

Faculty member specialists, and in some specialties, other health care personnel who contribute to 360-degree evaluations, will evaluate residents during rotations and assignments using the evaluation tools currently used by the program (and new ones that may be added in the future). The CCC will take data from these evaluations and apply them to the milestones to mark the progress of residents. The CCC will have the advantage of knowing how each of the specialists evaluated residents and can apply that knowledge as it marks the residents' progress on the milestones. Aggregate, de-identified information for all residents in the program will be reported to the ACGME.

### **Should CCCs set a threshold for a resident to have remediation and possible separation?**

One of the goals of the Milestones Project is to be able to identify residents who are not progressing with their peers in one or more areas. In the early years of utilization of the milestones, the comparisons will be to a resident's peers in a given program, and the thresholds will be set by the CCC. Interventions a program might consider include assigning a mentor with expertise in a given area of deficiency, additional required readings, sessions in a skills lab,

and/or added rotations in a given area. If, after remediation, a resident still fails to advance sufficiently on one or more milestones, a CCC might consider extending education, or counseling the resident to consider another specialty or profession.