Competency – based Residency Training: The ACGME Outcomes Project

Revolutionary and Evolutionary Changes in Post Graduate Medical Education

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Some Definitions

- ACGME
- AAMC
- PIF
- RRC

ACGME Outcomes Project
Outline

- What is the Outcomes Project?
- The Paradigm Shift
- Why Outcomes?
- The General Competencies
- Assessment Tools
- Continuous Improvement
- Timeline
- The Transition
- What Can You Expect from your RRC's?
- What Are We Doing at Saint Barnabas?

What is the Outcomes Project?

- The outcomes project is a long-term initiative by which the ACGME is increasing educational outcome assessment in the accreditation process. Expectations for increased emphasis on outcome assessment are reflected in changes to Program and Institutional Requirements.
- Applies to all post graduate training programs, including transitional year programs

The Paradigm Shift

The previous model of accreditation is process-based, rather than learner-based.

- **Assesses the ability of a program to provide an appropriate and structured postgraduate education.**
- **Compliance with RRC requirements necessary**
- **Established objectives & organized curriculum necessary**
- **No requirement to prove that residents actually accomplish that which is set forth in the curriculum.**

The Paradigm Shift

ACGME is moving to a learner based educational approach. Programs must demonstrate that residents actually achieve measurable educational outcomes. Programs must

- Identify learning objectives related to the ACGME General Competencies
- Use increasingly more dependable (i.e. objective) methods of assessing residents' attainment of these competency-based objectives
- Use outcome data to facilitate continuous improvement of both resident and residency program performance.

Why Outcomes?

- Other organizations have successfully used outcomes assessment to improve the quality of their products.
- Medical education relies heavily on public funding. We are accountable to the public for the physicians we train.
- Educational outcomes-based data is necessary to inform discussions with policymakers who have become increasingly focused on issues related to funding for medical education and on patient safety.
- We must demonstrate the effectiveness of our graduate medical educational programs.

SIX General Competencies

- **Patient Care**
- **Medical Knowledge**
- **Professionalism**
- **Systems-based Practice**
- **Practice-based Learning and Improvement**
- **Interpersonal and Communication Skills**

SIX General Competencies

- **Each core competency encompasses multiple skill sets.**
- **Two of the general competencies (patient care, medical knowledge) are specialty-specific; the remaining four (professionalism, systems-based practice, practice-based learning and improvement, and interpersonal and communication skills) are cross-disciplinary.**

I. Patient Care

Residents must be able to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

II. Medical Knowledge

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

III. Practice-Based Learning & Improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices

IV. Interpersonal and Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.

V. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

VI. Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Assessment Tools

ACGME OUTCOMES PROJECT "TOOLBOX" – under development

- 360 degree evaluation
- Resident portfolios
- OSCEs
- Procedure / case logs, record review
- Patient surveys
- Simulations and models
- Standardized examinations
  - Oral, written, standardized patients

Continuous Improvement

- **Programs will be expected to develop methods that produce *increasingly valid, reliable and useful assessments to measure residents' attainment of competency-based educational objectives;***
- **They will then be expected to show how this educational outcome data is used to improve individual resident and overall program performance**

Timeline

Phase 1 (7/01-6/02)--The Initial Response

- Programs
  - Define educational outcomes based on general competencies
  - Review current approaches to assessment
  - Begin integrating the competencies into the program
- RRCs
  - Develop operational definitions of “compliance”
  - Provide constructive citations and recommendations with no accreditation consequences

Timeline

Phase 2 (7/02-6/06)--Sharpen Focus and Definition

- Programs
  - Provide evidence of learning in all six competencies
  - Use progressively more dependable measurement tools
  - Provide evidence of initial efforts to use evaluation data
- RRCs
  - Review learning and assessment of all six competencies
  - Review assessment methods emerging from the field
  - Citations with consequences based on expectations
  - Revise requirements to reflect changed expectations

Timeline

Phase 3 (7/06-6/11) – Fully integrating the competencies with learning and clinical care
  - Provide evidence of learning in all six competencies
  - Use stakeholder assessments
  - Begin linking clinical quality / educational outcomes
- Phase 4 (beyond 7/11) – Expand the competencies to develop excellence models
  - Identify benchmark programs
  - Develop excellence models
  - Build knowledge about good GME

The Transition

The shift from emphasis on *structure-and-process* to emphasis on <u>*outcomes*</u> will be a gradual transition. The need for programs to provide evidence of structures and processes will not disappear but will gradually become less critical to the overall accreditation process.

What to expect from your RRC

Prior to 7/1/02

- **Progress in the development of an outcomes-based curriculum and a plan for implementation of the competencies should be evident.**

- **Individual RRCs may choose to offer constructive citations related to the competencies and assessment during the period from July 1, 2001 to June 30, 2002.**

What to expect from your RRC

After 7/1/02

- **Internal institutional reviews will begin monitoring compliance**
- **PIF's are being revised to request information regarding the competencies**
- **Programs will need to provide evidence to the RRC that they are implementing the competencies**
- **RRCs and specialty societies are working to provide resources to programs to help them implement the competencies**

Saint Barnabas

- Discuss at GMEC
- Multiple initiatives
  - Presentations to educate institution about Outcomes Project
  - Work with Mount Sinai Consortium
  - Outcomes-based curriculum development
  - Development / piloting of new assessment tools
    - 360 degree Evaluation
    - Patient satisfaction surveys
    - Objective evaluation of skills
    - Resident portfolios demonstrating self learning
  - Internal reviews will begin to assess program progress

At Saint Barnabas

- First step for programs is to develop outcomes-based curriculum. Each curriculum must include all six competencies, and be based on RRC requirements.
- Most existing curricula in institution can be adapted to an outcomes-based format.
- Next step is to decide whether current assessment methods are appropriate for each educational outcome in your curriculum.
- If not, new assessment tools will be developed and evaluated.

Resources

- ACGME Web Site—multiple resources
  - www.acgme.org
- Individual RRC requirements—can be found in Green Book or on ACGME web site
- Specialty organizations
- Bibliography available for ACGME/AAMC/AMA

Finally :

- This is a process in evolution
- The ACGME and the RRC's will be looking to the field to provide direction; expectations are fluid
- Data from residency programs will determine the future path of the project and ultimately the expectations of the accreditation bodies
- We have an opportunity to help shape the process
- This process will affect your training and development now and in the future

DUTY HOURS REGULATIONS

- **80 HOUR WEEKLY LIMIT AVG OVER 4 WKS**
- **10 HOURS BETWEEN DUTY PERIODS**
- **24 HOUR LIMIT ON CONTINUOUS DUTY**
- **6 HOURS CONTINUITY**
- **ONE DAY IN SEVEN FREE**
- **IN HOUSE CALL NO MORE THAN ONE IN THREE AVG OVER 4 WKS**

MONITORING OF DUTY HOURS

- SPOT CHECKS
- COMPLETE TIME SHEETS
- REPORT FATIGUE TO CHIEF RESIDENT/PD
- BRING ISSUES TO DIO IF UNRESOLVED

SLEEP FACTS

- **ADULTS NEED AN AVERAGE OF 8.2 HOURS SLEEP PER 24 HOURS**
- **IMPAIRMENT OF PERFORMANCE WITH LESS THAN 6 HOURS PERNIGHT**
- **SLEEP DEPT ACCUMULATES WITH TIME AND AWARENESS OF SLEEPINESS DECLINES**
- **DEPRESSION, STRESS , OBSTETRICAL COMPLICATIONS INCREASE WITH SLEEP DEPRIVATION**

RESOURCES FOR RESIDENTS

- **CHIEF RESIDENTS**
- **PROGRAM DIRECTOR**
- **CHAIR OF DEPARTMENT**
- **DIRECTOR MED EDUCATION**
- **SR. VP FOR MEDICAL AFFAIRS**
- **CEO**

THANK YOU

- **All of the following general competencies pertain to <u>all</u> disciplines <u>except</u>**
  - **Systems Based Practice**
  - **Professionalism**
  - **Research activities**
  - **Communication skills**

- Systems Based Practice refers to :
  - Understanding pathophysiology of disease
  - Awareness of the context of delivery of medical care
  - Ability to practice in an ethical manner
  - None of the above

- In order to demonstrate Practice Based Learning which tools would be useful:
  - Diary of interesting cases
  - Portfolio of presentations made at conferences
  - Self assessment questionnaires
  - Development of self study curriculum
- All of the above

- All except which of the following are outcomes measurement tools for general competencies:
  - Written exam
  - Oral exam
  - 360 degree evaluation
  - OSCE
  - Compliance with duty hours regulations

- Which of the following is not measured by 360degree evaluation by non-physicians:
  - Communication
  - Professionalism
  - Medical knowledge
  - Patient care

- All of the following pertain to the intent of the new competencies except:
  - To insure that trainees develop life-long learning habits
  - Create the concept of a team approach to patient care
  - Introduce new teaching and learning concepts and techniques
  - To weed out “problem” trainees
  - To improve patient safety

- The difference between previous and current approaches to medical education is:
  - The current approach emphasizes process(e.g. attendance at conference, number of conferences) over outcome
  - The previous approach emphasizes process over outcome
  - In the current approach process is replaced by outcome measurements
- In the previous approach there were no outcome measurements

- You have been on duty since 8am Monday and it is now 8am Tuesday. You have been caring for 6 patients and your “relief” has just arrived and there is a new admission that you have not seen. Which is true?:
  - You must leave immediately because of the 24 hour work rule
  - You have 30 minutes to relay the information.
  - You may not work up the new admission, but may stay until noon to transmit information and finish dictations
  - You may not remain on duty but may see patients in the emergency department.
  - None of the above

- Which organization is responsible for setting work rule hours:
- a. AAMC
- b. CMS
- c. OSHA
- d. ACGME
- e. NRA

- The reason that work hour rules were instituted is(are):
  - to protect patients
  - to protect trainees
  - as a result of the death of Libby Zion
  - to permit more time for self study
  - all of the above