The ACGME Accreditation System: Today and Tomorrow

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Every teaching hospital and academic medical center knows that the process of becoming accredited and re-accredited by the Accreditation Council for Graduate Medical Education (ACGME) is an arduous task. The ACGME is attempting to ease this burden by introducing a new accreditation model called The Next Accreditation System (NAS). The NAS introduces dramatic changes in the way the ACGME accredits institutions and graduate medical education (GME) programs, with the initial implementation of the NAS to start in July 2013, followed by complete implementation in July 2014. Nevertheless, the current accreditation system is still in place, which means over the next six to 18 months, sponsoring institutions and residency programs need to be cognizant of both existing ACGME accreditation rules, including tools and best practices for preparing Program Information Forms and for site visits, as well as the requirements, implications, and ramifications of the NAS.

The Current Accreditation System

The ACGME, through its 28 Residency Review Committees (RRCs), accredits over 9,000 residency programs in 133 specialties and subspecialties across the country. Each RRC is responsible for developing accreditation standards and developing the tool—the Program Information Forms (PIF)—for each residency to obtain and maintain accreditation.

Put simply, the existing process of becoming accredited and re-accredited involves an application, an audit, a report, and a review. Specifically, in completing the PIF, each residency program is given the opportunity to present to the applicable RRC the various clinical and educational components of the program, which conveys to the RRC the extent to which the program complies with the RRC's published educational standards. Thereafter, the RRC sends a site visitor to the training site to evaluate the program and verify whether everything the program said about itself in the PIF is accurate, and therefore, that the program is (or is not) in substantial compliance with RRC and ACGME requirements. The site visitor meets separately with the program's administration (Designated Institutional Official, Program Director), faculty, and residents, reviews specific program documentation, and then prepares a report for the RRC. That report, together with the PIF, allows the RRC to identify areas of non-compliance, and ultimately becomes the basis for the RRC's accreditation decision.

While the foregoing synopsis seems like a relatively simple process, it is, in fact, grueling. The PIF is a voluminous document that requires the program to provide detailed narratives about the residency, including the conferences, quality assurance functions, scholarly activity, clinical rotations, faculty qualifications, resident appointment information, institutional support data, and, most importantly, evidence that the program has incorporated the six core competencies—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice—into the curriculum. These competencies were borne out of the ACGME's Outcomes Project, which over 10 years ago tasked residency programs to approach resident education by looking beyond the medicine and board examination results, and toward the specific areas of learning necessary for each individual to succeed in both his/her clinical responsibilities and in his/her relationships with patients, patients' families, and other health care professionals.

Although it is axiomatic that graduating residents should be able to be competent clinicians, a resident's achievement in the ACGME core competencies has become the basis for determining the true effectiveness of a residency training program, and in turn, the various RRCs' accreditation decisions. The accreditation decisions available to the RRCs are initial accreditation, accreditation withheld, continued accreditation, probation, accreditation with warning (for dependent subspecialty programs when the core program goes on probation), reduction in resident complement, withdrawal of accreditation, and expedited withdrawal of accreditation. Under the existing accreditation system, the ACGME has a two-step process to review and implement adverse accreditation actions. When an RRC determines that a program is not in compliance with educational standards, it will first propose an adverse action. At this point, the program has the opportunity to submit "reconsideration" materials to the RRC in response to each of the citations of non-compliance. These materials can revise, expand upon, or correct information previously submitted, challenge elements of the site visitor's report, and contest the RRC's interpretation or application of the Program Requirements, as long as the information is true and accurate as of the date of the RRC meeting at which the program's PIF and site visitor's report were reviewed. For example, if a program were cited for non-compliance with the scholarly activity standards1, it could not submit 20 new peer-review articles that its faculty published after the RRC meeting. It could, however, submit 20 peer-review articles that it neglected to provide the site visitor or document in its PIF.

The RRC will review the program's reconsideration materials at its next meeting, and either confirm, modify or withdraw its proposed adverse action. If the RRC confirms the adverse action, the program will have the opportunity to appeal that decision to a three-member hearing panel of the ACGME. During the appeals process, the program holds the accreditation status determined by the RRC, qualified by the term under appeal, which remains in effect until the ACGME appeals panel makes a final decision on the matter. As is discussed below, this two-step review process is about to become obsolete.

Recognizing that "program requirements had become very prescriptive,"2 and that the PIF/site visit process was taking time away from resident education, on February 2, 2012, the ACGME announced that the entire accreditation process is about to change. While the fundamental principles of the Outcomes Project—namely, that there needs to be an appropriate balance between the ability to master procedural skills and the ability to practice medicine ethically, cordially, and professionally within a large health care delivery system—remain intact, the NAS is intended to offer some relief for sponsoring institutions and residency programs and, intentionally or not, the RRCs.

The Next Accreditation System

The primary (though not singular) goal of the NAS is to transform the ACGME accreditation system into a less administratively burdensome process. This will be achieved by:

Creating a continuous accreditation model that calls for annual data submissions to the ACGME, and then requires RRCs to annually evaluate trends in key performance measures Eliminating the 1-5 year review cycles and the PIF Instituting a “self-study” every 10 years that will allow programs to showcase innovative achievements, which were notably absent from the PIF Periodic follow-ups from the RRC in the form of requests for progress reports and use of focused site visits, if necessary Eliminating the proposed adverse action stage of the accreditation process

The annual data submissions will be the RRCs’ primary mechanism to stay abreast of program compliance with published educational standards. These submissions will include information relating to program attrition, changes, scholarship, board pass rates, clinical experience, resident and faculty surveys, and two new data sources: educational milestones and the clinical learning environment review (CLER) site visit.

The educational milestones essentially are the next iteration of the six core competencies. Each RRC will have a task force (consisting of its own members and other experts, including the ABMS certifying boards and medical association representatives) that will create a framework for practical behavioral and clinical expectations that each resident must achieve throughout each stage of his/her training. The resulting milestones will allow programs to track the progress of residents and assess their readiness for promotion and independent practice. Conversely, the milestones are intended to create an environment that facilitates the identification of deficiencies (in both the residents and the learning environment) so that remediation can be swift and effective. The individuals responsible for making decisions as to the progress of each resident will be members of each program’s newly formed clinical competency committee (CCC). Members of the CCC will need to undergo special training in the evaluation process, the resources for which will be developed by the ACGME.

The CLER site visit will focus on very specific program achievements: patient safety, quality improvement, transitions in care, resident supervision, duty hours and fatigue management, and professionalism. CLER site visits will be unannounced, but will occur at least every 18 months. For now, data gathered by the CLER site visitor will not be used for accreditation purposes unless egregious violations are found.

With the transition from PIFs and review cycles to annual data submissions and CLER site visits, it should come as no surprise that a congruous development emerged in the NAS accreditation decision-making process: the one-step appeal. As noted above, presently, when an RRC finds program deficiencies, it will propose an adverse action and allow the program an opportunity to rebut the RRC’s proposal. If the RRC confirms its proposed adverse action, the program can then appeal to an ACGME appeals panel. Under the NAS, however, the RRC will notify the program of the adverse action, and the program has only one opportunity to appeal that decision to the appeals panel of the ACGME. The appeals panel will make a recommendation to the ACGME Board of Directors, whose recommendation may be to uphold the RRC’s adverse action or restore the program’s previous accreditation. Regardless, the decision of the ACGME Board of Directors is final.

While certainly the NAS is intended to do more than simply reduce the administrative burden associated with the current accreditation system, there is no question that sponsoring institutions and GME programs across the country will see the NAS as a significant relief that will allow program leadership and residents to focus more on learning, innovation, and quality care. However, it remains to be seen whether the NAS' less process-based and more outcomes-based focus will lead to an environment that turns out physicians who actually are capable of practicing medicine with the balance of compassion, efficiency, and excellence that the ACGME has been working so hard to achieve.

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