Educational Outcomes Service Group

Addressing the ACGME Competencies

February 2003

MOVING FORWARD (Lynne Tomasa, PhD)

Welcome to the EOSG's first newsletter. Our group has met with more than half of the 47 program directors in Tucson and Phoenix. During our meetings we have identified several common themes or areas of concern. For some program directors, this first newsletter will be an introduction to the ACGME's Outcomes Project. For others, it will serve to reinforce the good job you are currently doing. There is a lot of information being disseminated by the ACGME, specialty organizations and boards, and different programs across the country. It can easily appear overwhelming, so our task as medical educators and physicians is to examine what is currently being done; to help our faculty define the behaviors within each of the six competencies; to identify specific learning objectives; and to move forward in the development of appropriate and effective evaluation tools.

WHY NOW?

It may seem like the new ACGME Outcomes Project appeared over night, especially when our days are already full with clinical care, teaching and research. But the discussion regarding graduate medical education has been going on for several years. Over the past 15 years, many observed that the health care system was changing and it was becoming more difficult to deliver good graduate medical education. The emphasis on ambulatory settings, concerns about productivity, the development of new information systems, and fiscal pressures on academic health centers were the challenges facing graduate medical education. The question of "what was good care" and "what was the right amount of care" along with reviews of poor-quality and unsafe care drew the attention of the media and public. The Outcomes Project is a direct response to concerns about residents' ability to meet the demands of a changing practice environment.

Since 1997, David Leach (executive director of the ACGME) has taken a lead role in addressing the difficult issue of competency evaluation and residents' work hours. The initial set of thirteen competencies were refined to six after extensive review of published documents; input from medical educators; feedback from physicians and residents; and interviews with individuals representing health system administrators, allied health professionals, patient advocacy, and employers. Concurrently, the American Board of Medical Specialties (ABMS) was identifying competencies for practicing physicians. The ACGME and ABMS worked together and agreed upon the six competencies. The ACGME board approved the same six competencies in February 1999.

WHERE DO WE START? (Jim Kerwin, MD)

We are currently in Phase Two (July 2002 to June 2006) of the ACGME's Outcomes Project. Beginning in July of 2002, the ACGME requires all residency programs to implement the Outcomes Project where the emphasis shifts from process to product. In other words, a process-based educational program emphasizes knowledge acquisition while a competency-based curriculum emphasizes the outcomes or the application of the knowledge gained. Programs must now educate and evaluate their residents to demonstrate competency in six general domains: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice.

After meeting with program directors, it appears that two different approaches are being used. One approach is to develop a list of specialty specific competencies in each of the six general domains. The list can be comprehensive or can be year specific. An advantage to this approach is that it clearly redefines the residency's learning objectives and allows program directors to formalize what they are currently doing and reshape their residencies. The process of identifying the specific competencies can also be an opportunity for faculty development and "buy in."

Another approach is to take current evaluation tools and align them with the six general competencies. An advantage to this approach is that it capitalizes on the evaluation process programs already have in place to assess competency. Often an evaluation tool currently in use can simply be reworded and reorganized to be more effective. Behaviors must be clearly defined to determine whether competence has been achieved. Program directors are often surprised and relieved to find that they have been assessing competency all along.

Programs can start wherever they wish. One of the unique characteristics of the Outcome Project is the flexibility given to residency directors. While it can be frustrating to feel one hasn't been given enough specific direction, there is room to be creative.

SYSTEMS BASED PRACTICE (Craig McClure, MD)

For some program directors the desire to immediately have a comprehensive program that meets the ACGME intent seems to suggest a complexity that is daunting and may serve as a barrier to getting started. One way to clear this hurdle is to start small and plan to build from there. Begin with the program goals for graduates in a general competency.

For many program directors, systems-based practice (SBP) seems the most opaque of the group. As with the other competencies, the trick is in looking at what you already do. The resident is a member of a team and SBP addresses the utilization of the health care system for the best benefit of the patient. In many parts of the country managed care skills are a necessary part of SBP. These skills include using a formulary and completing the right forms for prior approval and getting a referral in the system before consultants see patients or procedures are performed in the hospital. Depending on the type of practice, SBP might include coordinating care with nursing homes, physical rehabilitation, or hospice care.

SBP has five components: 1) the health care system (the interplay between one's personal practice, local health care organizations, and health care nationally), 2) provision of cost-appropriate care, 3) characteristics of medical practice and care delivery systems, 4) partnering with health care workers to assess, coordinate & improve health care, and 5) patient advocacy. Each will be examined briefly below.

Health care system concerns the spectrum from local to national health care organizations as an ecology with effects in both directions. From the top one sees the effect of national funding decisions on local reimbursement. Local contracts affect the use of consultants. Knowledge of the larger system tends to be taught to more senior residents as preparation for assuming practice management responsibilities; interns learn how to manage the system to provide care to patients.

Cost-appropriate care is taught beginning in orientation. Interns are taught what tests to order in what sequence to obtain a diagnosis most expeditiously and effectively. It might include discharge planning that avoids excess hospital days. Other examples include knowing when to write a prior authorization for non-formulary medications or to admit a patient to the hospital or ICU.

Characteristics of medical practice and care delivery involves understanding the differences between models (e.g., private practice, group practice) and the influence of various funding including managed care systems. With increased sophistication of practice management, understanding the finances of an office-based or hospital-based practice with corresponding attention to overhead management would be relevant.

Partnering with health care workers includes effectively working with the gamut of team members providing care in and out of the hospital (home health, social work, speech therapy, physical therapy, pharmacy, and nursing). Skills involve knowing when to recommend and how to monitor the effectiveness of care.

Patient advocacy concerns the primary responsibility of a physician seeking the best welfare and optimal function of the patient. Doing so requires an understanding of patient values, current medical knowledge, and detailed knowledge of how the system works. Advocacy extends to seeking improvements when the system does not work to the patient's best interest.

THE NEXT STEP

Once you have identified what each of the six domains mean to your specialty, the design of specific learning objectives become clearer. Faculty and resident "buy-in" is a critical component to the advancement of a competency based curriculum and evaluation process. Future newsletters will address how to engage faculty and residents and will identify important considerations in the development of an assessment system. In addition, specific examples of what different programs have developed will be presented.

REFERENCES

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