Accreditation Council for Graduate Medical Education

Implementing the Next Accreditation System for Urology Programs

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Michael Coburn, MD
Patricia Levenberg, PhD
Susan Swing, PhD

ACGME Webinar
April 22, 2013

Disclosures

Next Accreditation System

- Background & rationale
- Goals
- Structural overview
- Program Perspective
- Milestones

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www.acgme.org/acgmeweb/

Google

Program and Institutional Guidelines | Data Collection Systems | Meetings and Conferences | Graduate Medical Education

The Next Accreditation System

Click here to visit the ACGME Next Accreditation System Microsite

Upcoming Meetings and Events

- 2013 ACGME Annual Educational Conference Call for Abstracts
- 2012 Board of Directors Annual Meeting
- 2013 ACGME Annual Educational Conference

Recent News

Announcements

- Welcome to the new ACGME website! The goal of the new website design is to make the site easier to navigate and to furnish up-to-date information in real time. Questions or comments about the new website should be directed to: webfeedback@acgme.org

Quick Links

RESIDENTS | PD / COORDINATORS | DIO'S

- Resident Services
- Resident Case Log System
- Resident Survey
- Duty Hours
- Complaints
- GME Focus

CHOOSE YOUR SPECIALTY

Data Collection Systems

Accreditation Data System	LOGIN
Resident Fellow Survey	LOGIN
Resident Case Log System	LOGIN

Next Accreditation System

1. When does this happen?

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NAS Timeline

Phase I specialties

- Diagnostic Radiology
- Emergency Medicine
- Internal Medicine
- Neurological Surgery
- Orthopaedic surgery
- Pediatrics
- **Urology**

JGME 2012; 4:399

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NAS Timeline: Phase 1 Specialties

- **July 2012 – June 2013**
  - Phase 1 programs report annual data
- **January 2013**
  - Milestones published for Phase 1 core specialties
- **Spring 2013**
  - Identify and train CCCs
- **July 2013: Go live**
- **December 2013:** First Milestones report

http://www.acgme-nas.org/assets/pdf/KeyDatesPhase1Specialties.pdf

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Next Accreditation System

2. Why are we doing it?

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL REPORT

The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,[1] and in 2009, it began a multiyear process of restructuring its accreditation system to be

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education[8]

N Engl J Med. 2012 Mar 15;366(11):1051-6

Why are we doing NAS?

- Free good programs to innovate
- Assist underperforming programs to improve
- Realize the promise of the Outcomes
- Provide public accountability for outcomes
- Reduce the burden of accreditation

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Next Accreditation System

3. How does this reduce burden?

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Reduced Burden

- Standards revised every ten years
- “Infernal Review” no longer <u>required</u>
- No PIF’s
- Scheduled (self-study) visits q ten years

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Some Data Reviewed by RRC

Most already in place

- ✓ Annual ADS Update
  - ✓ Program Characteristics – Structure and resources
  - ✓ Program Changes – PD / core faculty / residents
  - ➢ Scholarly Activity – Faculty and residents
  - ➢ Omission of data

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Some Data Reviewed by RRC

Most already in place

- ✓ Board Pass Rate – 3 year rolling averages
- ✓ Resident Survey – Common and specialty elements
- ✓ Clinical Experience – Case logs or other
- ✓ Semi-Annual Resident Evaluation and Feedback
  - ➢ Milestones
- ➢ Faculty Survey
- ➢ Ten year self-study

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Streamlined ADS Annual Update

- 33 questions removed
- 14 questions simplified
- *Very* few essay questions
- Self-reported board pass rate removed
- Faculty CVs removed
- 11 MCQ or Y/N questions added

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Current PIF Faculty CV

First Name: **John**	MI: **A**	Last Name: **Smith**
Present Position: **Department Chairman**		
Medical School Name: **North Univ, Roots, CA**		
Degree Awarded: **MD**		Year Completed: **1993**
Graduate Medical Education Program Name: **State Program**		

Specialty/Field: **Urology**	Date From: **7/1993**	Date To: **6/1998**

Certification Information				Current Licensure Data	
Specialty	Certification Year	Certification Status	Re-Cert Year	State	Date of Expiration
Urology	2001	Original Certification Valid		CA	1/2014

Academic Appointments - List the past ten years, beginning with your current position.		
Start Date	End Date	Description of Position(s)
7/2009	Present	State Program
7/1999	Present	State Program
3/2002	6/2009	State Program

Concise Summary of Role in Program:
Fellowship-trained in female urology and urodynamics. Dr. Smith brings an expertise that is vital to resident training in urology. Along with Dr. James, he coordinates all resident research activities. He is an active participant at all urology conferences.

Current Professional Activities / Committees (limit of 10):

- [2009 - Present] Chairman, Department of Urology; Medical Center
- [2009 - Present] Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery, Department of Urology; City Hospital
- [2009 - Present] President, Urological Society
- [2009 - Present] Co-Chairman, Division of Female Pelvic Medicine and Reconstructive Pelvic Surgery; Medical Center
- [1999 - Present] Member, Society for Urodynamics and Female Urology
- [1999 - Present] Member, American Urogynecologic Society
- [1999 - Present] Member, International Continence Society
- [1999 - Present] Member, Section of the American Urological Association
- [1999 - Present] Member, Urologic Society
- [1998 - Present] Member, American Urological Association

Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):

- Names. Historical perspective and outcomes for neurogenic bladder. Future Medicine 6(2)165-175, 2009.
- Names. Application and comparison of the American Urological Association and European Association of Urology current recommendations for antibiotic prophylaxis in the urologic patient undergoing office procedures. Future Medicine 6(2)145-149, 2009.
- Names. Two popular treatment options for neurogenic bladder Therapy 2009 6:2, 133-134
- Names. Editorial comment. Effect of pelvic floor interferential electrostimulation on urodynamic parameters and incontinency of children with myelomeningocele and detrusor overactivity. Urology. 2009 Aug;74(2):329; author reply 329-30.
- Names. Tethered cord syndrome in a 24-year-old woman presenting with urinary retention. Int Urogynecol J Pelvic Floor Dysfunct. 18(6) 679-81, 2007.

Selected Review Articles, Chapters and / or Textbooks from the last 5 years (limit of 10):

- The Accidental Sisterhood: Take control of your bladder and your life. Names. 3rd Edition, Pelvic Floor Health, City, State, 2009
- The Accidental Sisterhood: Take control of your bladder and your life. Names. 2cd Edition, Pelvic Floor Health, City, State, 2007
- The Accidental Sisterhood: Take control of your bladder and your life. Names. Pelvic Floor Health, City, State, 2006
- Names. Whitmore, K.E. Hypersensitivity Disorders of the Lower Urinary tract. Urogynecology and Reconstructive Pelvic Surgery, 3rd edition. Mosby-Year Book, City, State, 2007.

Participation in Local, Regional, and National Activities / Presentations / Abstracts / Grants from the last 5 years (limit of 10):

- Incontinence in Women: An objective look at the options. Course faculty member AUA Annual Meeting, San Francisco, CA 2010 AUA Annual Meeting, Chicago, IL 2009 AUA Annual Meeting, Orlando, FL 2008 AUA Annual Meeting, Anaheim, CA 2007
- Multi-institutional experience with sacral neuromodulation in children for dysfunctional elimination syndrome or neurogenic bladder with intcontinence. Urological Annual meeting 2010 (presented by Katherine Hubert)
- Overactive bladder and Interstim Therapy, AdvaMed-Advanced Medical Technology Association, Washington, DC. 2008
- Stress Urinary Incontinence and Prolapse, Case presentations and complications Urologic Society Annual meeting 2007.
- Acute urinary retention status post suburethral sling, Names. Urologic Society Annual meeting 2007
- Commercial Prolapse Repair "Kits" vs. Traditional Transvaginal Prolapse Repairs: A Comparison of Efficacy and Cost. Names, A. Society for Urodynamics and Female Urology (SUFU), February 22, 2007 (Poster) Southeastern Section of the AUA, March 8-11, 2007 (Poster)
- Abdominal Sacral Colpopexy with Soft Polypropylene Mesh is Safe and Effective at Three-Year Follow-Up. Names. SUMMA Postgraduate Day, 2006.
- Early Complication Rates of the Apogee/Perigee? Prolapse Repair System for Vaginal Vault Prolapse. Names. Accepted for oral presentation, SUMMA Postgraduate Day, 2006.
- The Correlation Between Valsalva Leak-Point Pressure (VLPP) and MUCP in Determining Genuine Stress Urinary Incontinence and Intrinsic Sphincter Deficiency. Names. Postgraduate Day, Locations, June 6, 2005 Section of the AUA, September 2005

If not ABMS board certified, explain equivalent qualifications for RC consideration:

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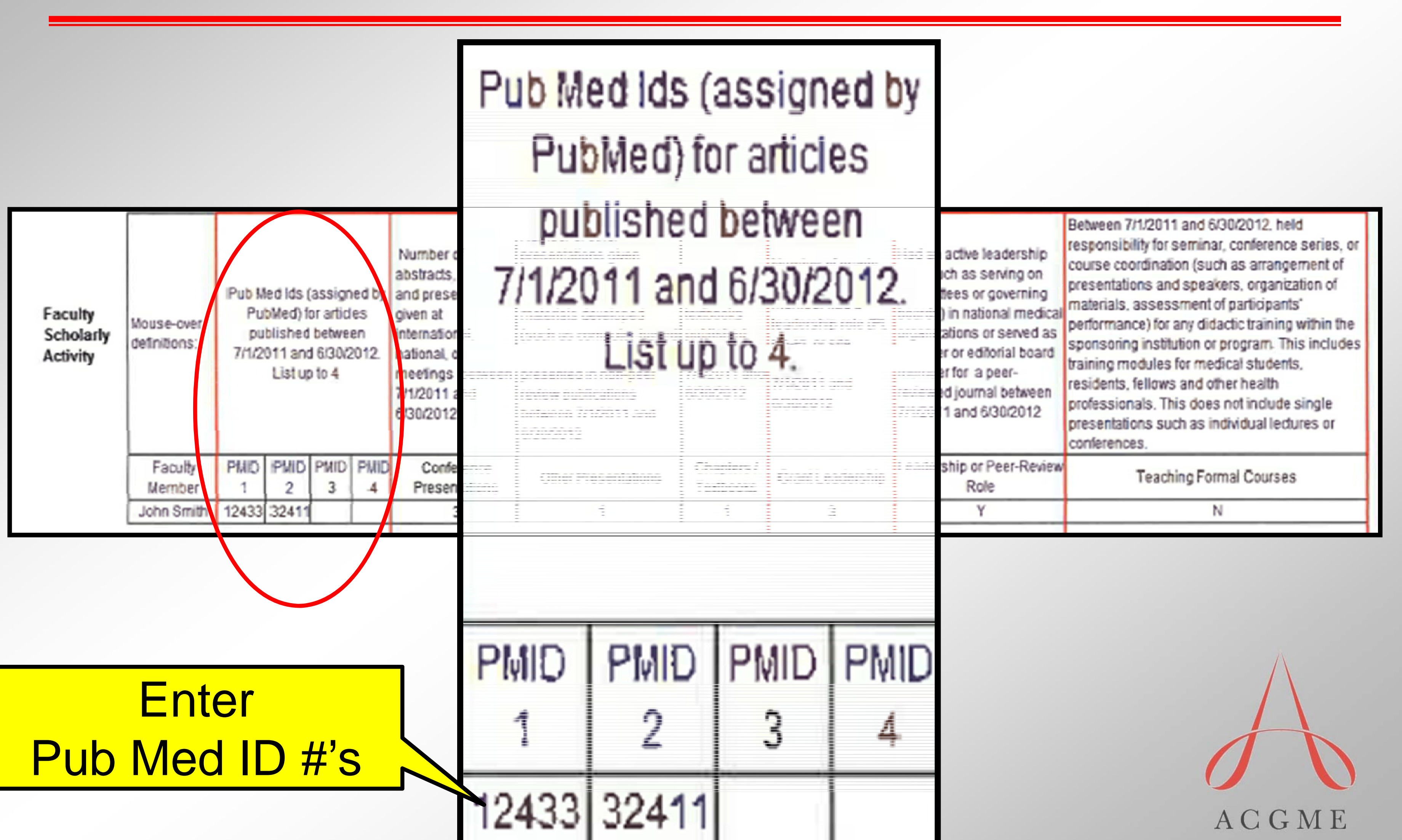
Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012	Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012	Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012	Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.
	Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Chapters / Textbooks	Grant Leadership	Leadership or Peer-Review Role	Teaching Formal Courses
	John Smith	12433	32411			3	1	1	3	Y	N
Resident Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 3.				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012		Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012		Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012
	Resident	PMID 1	PMID 2	PMID 3		Conference Presentations		Chapters / Textbooks	Participated in research		Teaching / Presentations
	June Smith	12433				1		0	N		Y
Categories for points:		**Peer Review Publication**				**Other Scholarly**			**Grantsmanship**	**Leadership / Peer Review**	**Education**

Faculty Scholarly Activity



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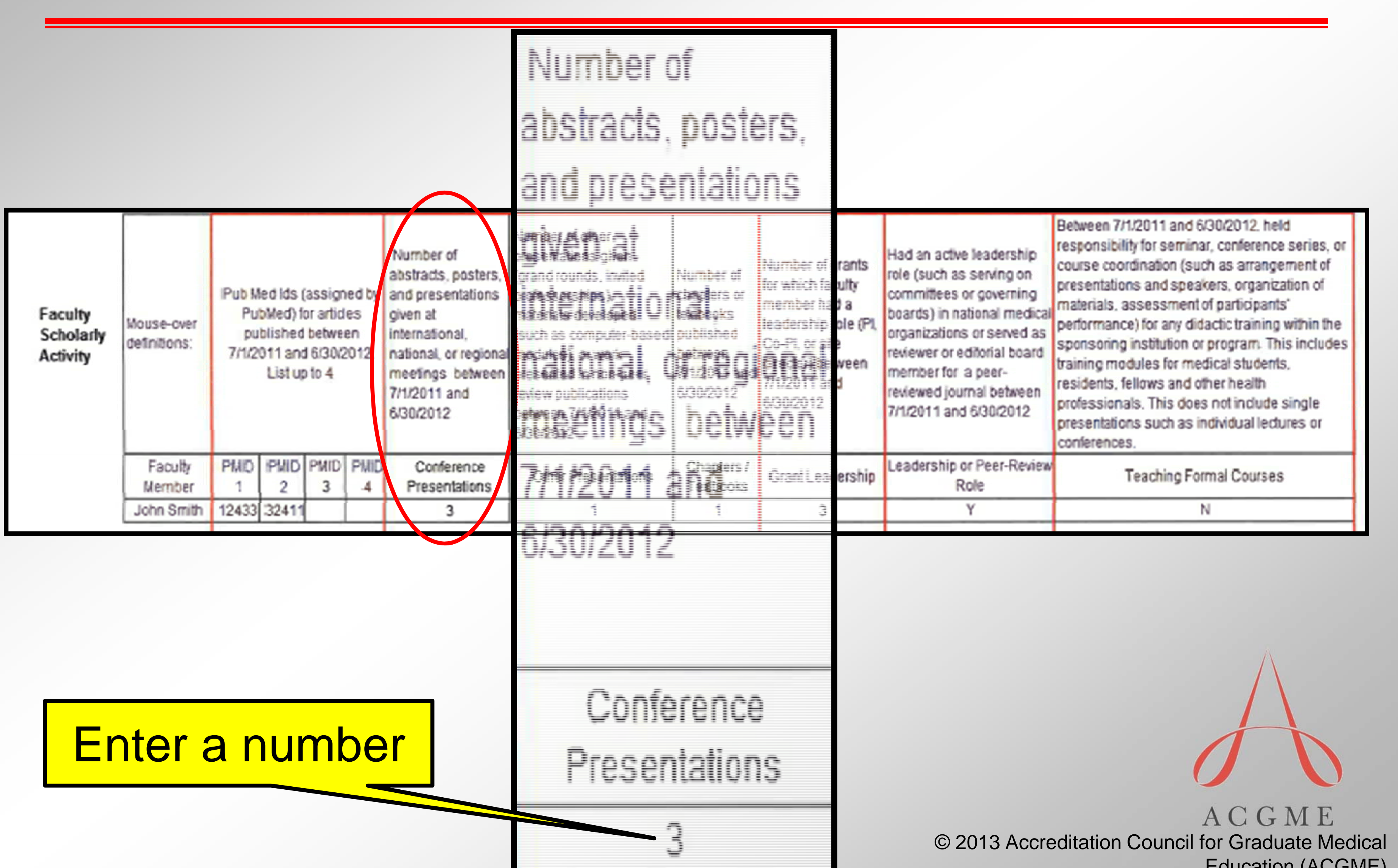
Faculty Scholarly Activity



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	John Smith	12433	32411			3	1	1	3	Y	N

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Faculty Scholarly Activity

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	Faculty Member	PMID 1	PMID 2	PMID 3	PMID 4	Conference Presentations	Other Presentations	Leadership or Peer-Review Role	Teaching Formal Courses
	John Smith	12433	32411			3	1	Y	N

Enter a number

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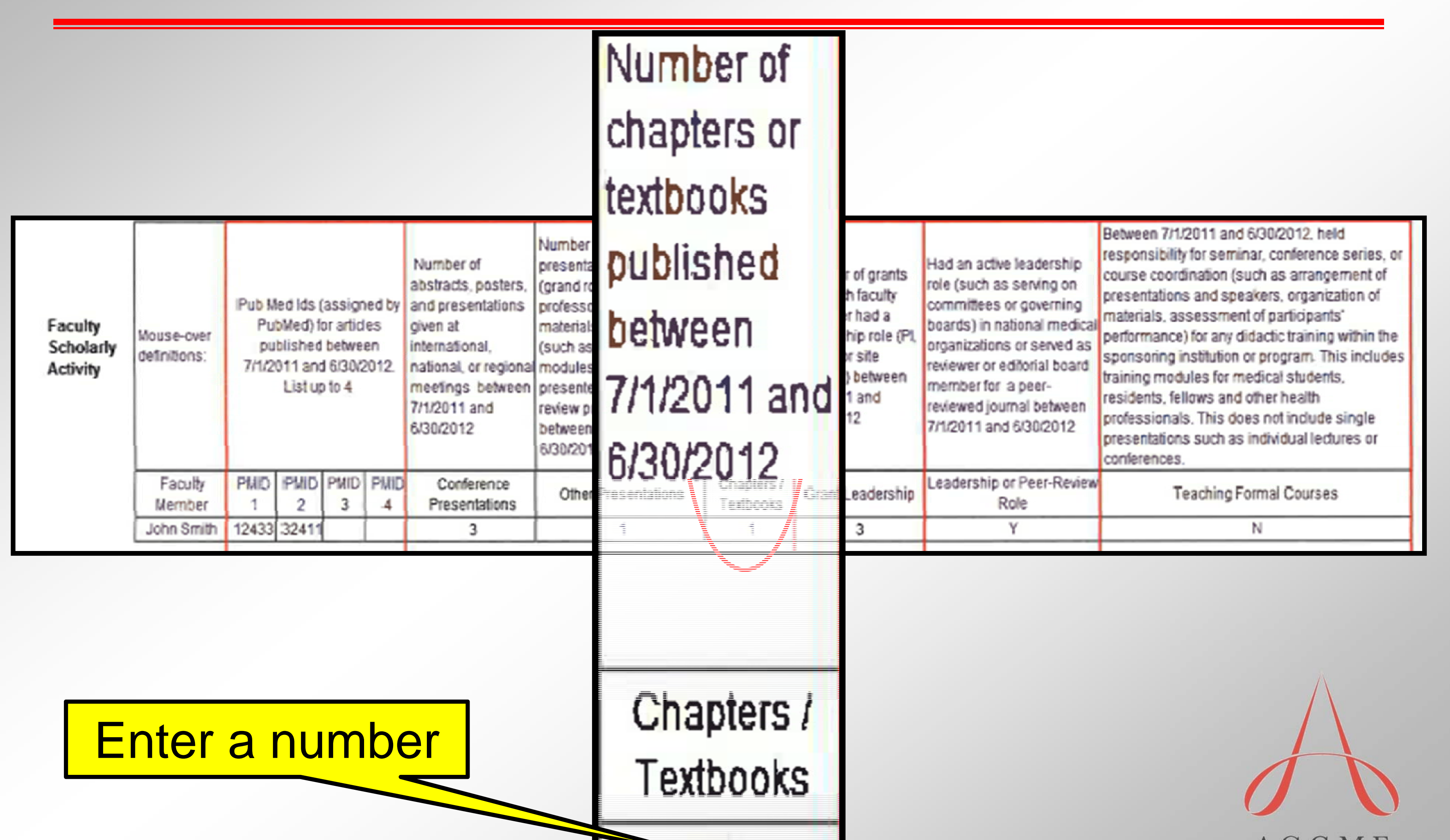
Faculty Scholarly Activity



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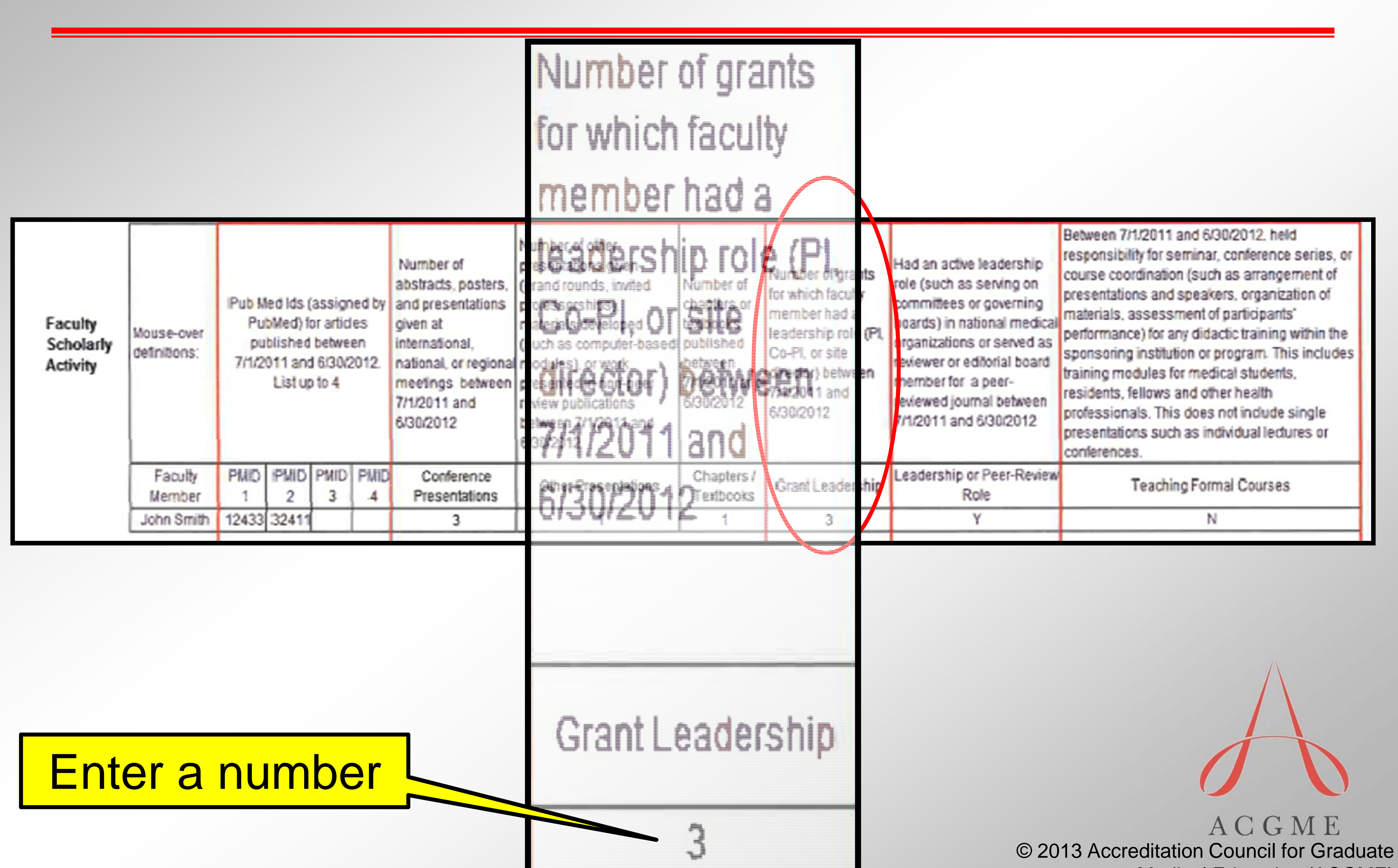
Faculty Scholarly Activity



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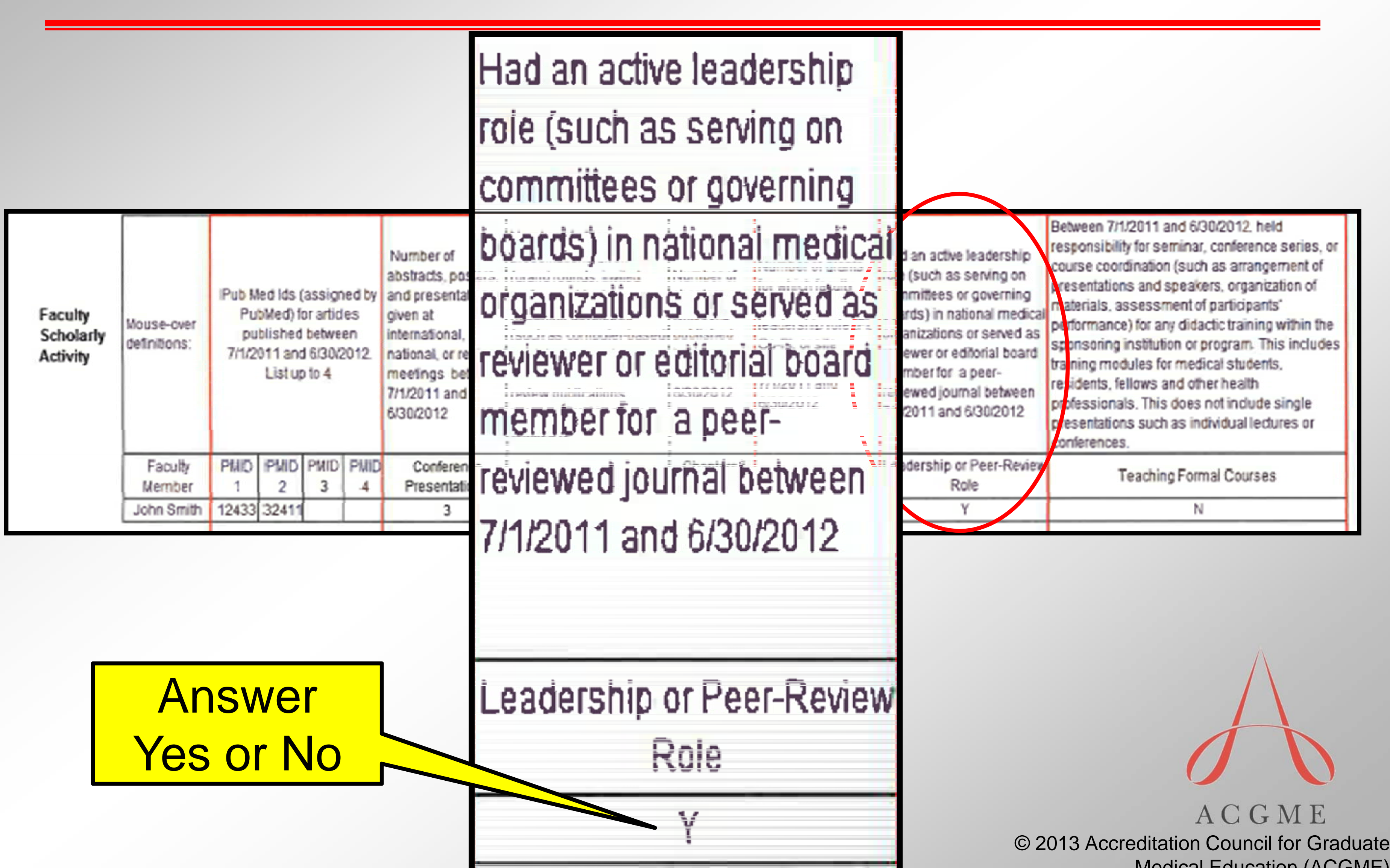
Faculty Scholarly Activity



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Faculty Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assign PubMed) for artic published betwe 7/1/2011 and 6/30/2 List up to 4		
	Faculty Member	PMID 1	PMID 2	PMID 3
	John Smith	12433	32411	

Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.

Teaching Formal Courses
N

Answer Yes or No

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Scholarly Activity Template

Scholarly Activity as Performance Indicator

Templates for Scholarly Activity

Faculty Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012	Number of other presentations given (grand rounds, invited professorships), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012	Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012	Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.
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	John Smith	12433	32411			3	1	1	3	Y	N
Resident Scholarly Activity	Mouse-over definitions:	Pub Med Ids (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 3.				Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012		Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2011 and 6/30/2012		Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2011 and 6/30/2012
	Resident	PMID 1	PMID 2	PMID 3		Conference Presentations		Chapters / Textbooks	Participated in research		Teaching / Presentations
	June Smith	12433				1		0	N		Y
Categories for points:		**Peer Review Publication**				**Other Scholarly**			**Grantsmanship**	**Leadership / Peer Review**	**Education**

Scholarly Activity Template

- For each core faculty* member enter:
  - x Pub Med ID's
  - Four numbers
  - Answer two Y/N questions

* Core Faculty defined as spending 15 hrs/wk

- For each resident with scholarly activity enter:
  - x Pub Med ID's
  - Two numbers
  - Answer two Y/N question

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4. How Can Programs Innovate?

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How Can Programs Innovate?

- Program Requirements classified:
  - Outcome
  - Core
  - Detail
- Programs in good standing*:
  - May freely innovate in detail standards
  - May innovate in core standards with approval

* “Green Bucket”

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5. What’s the big picture?

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Continued Accreditation

STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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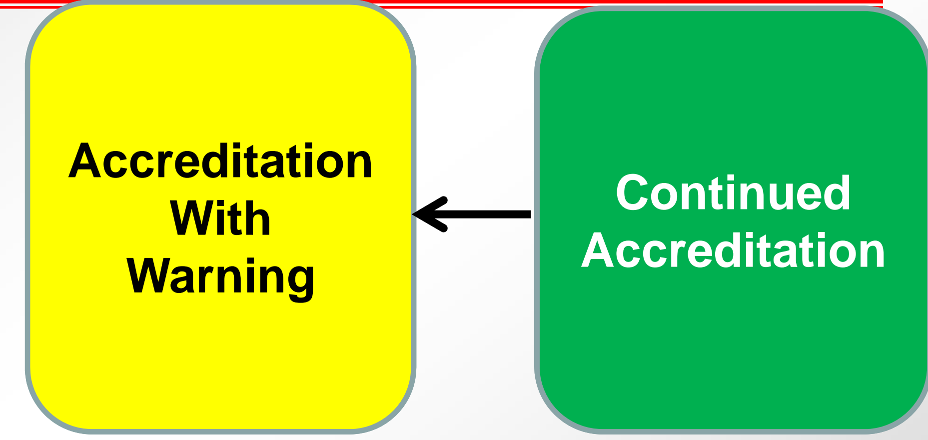
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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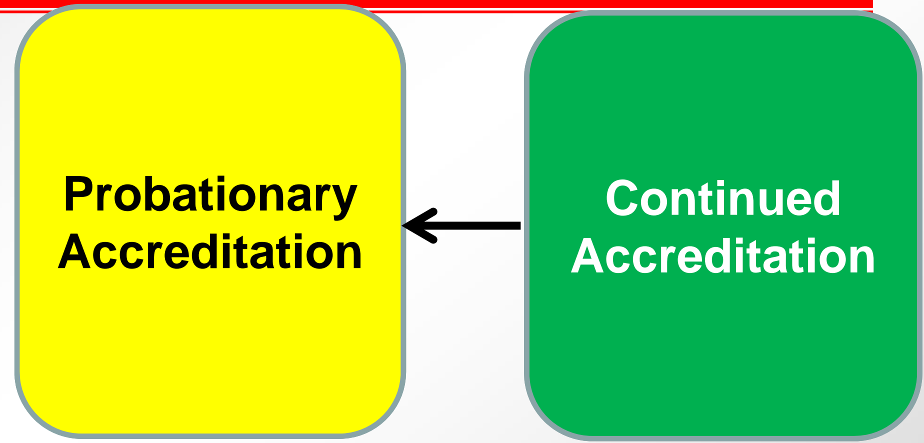
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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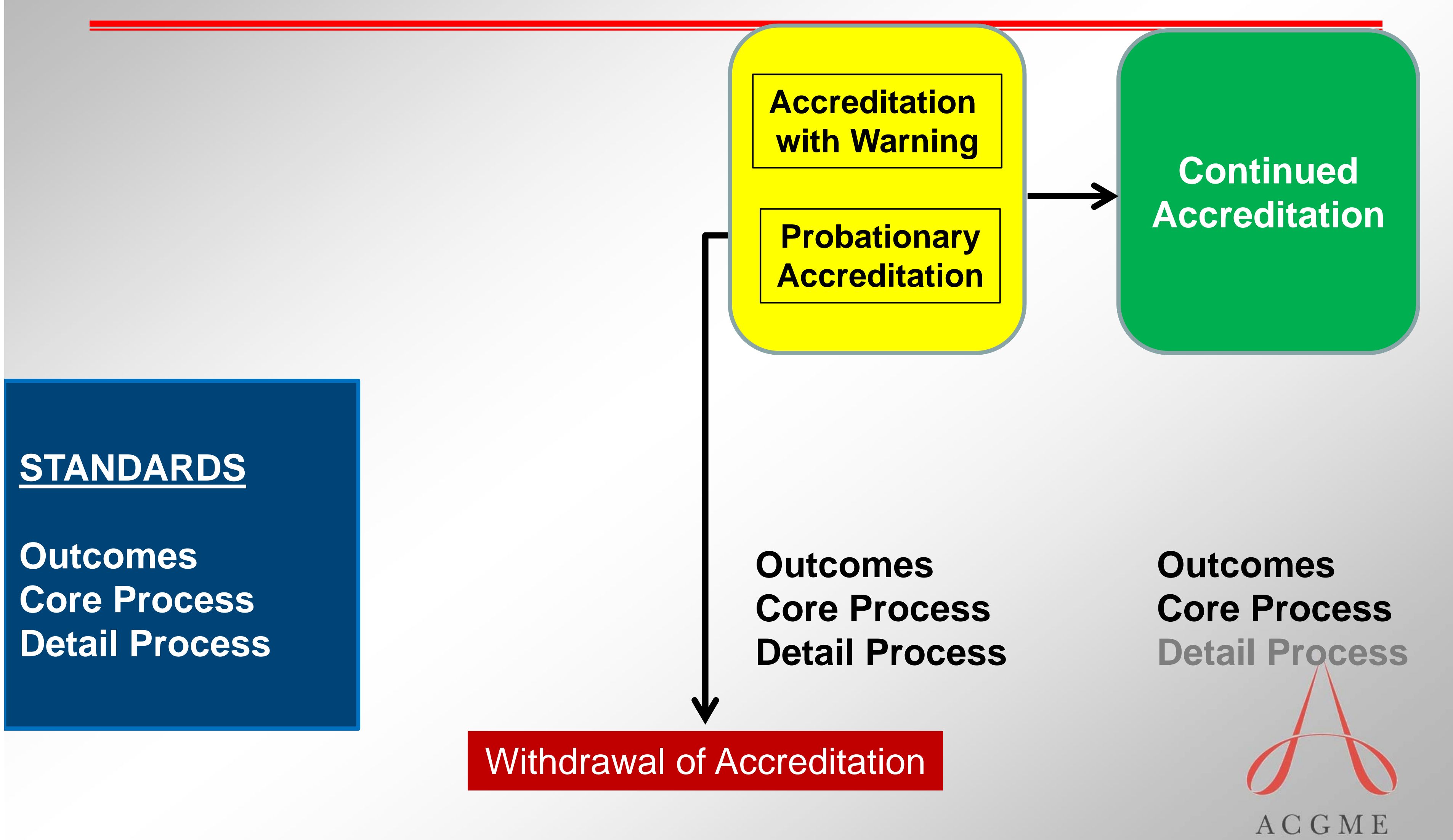

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program

STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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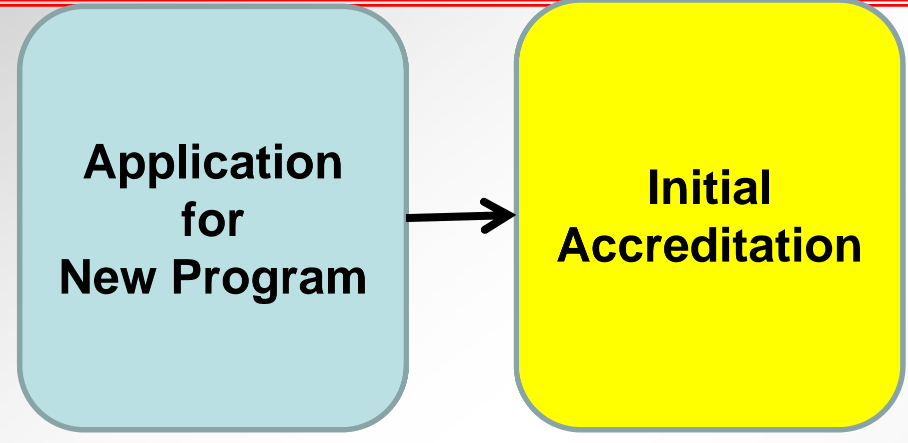
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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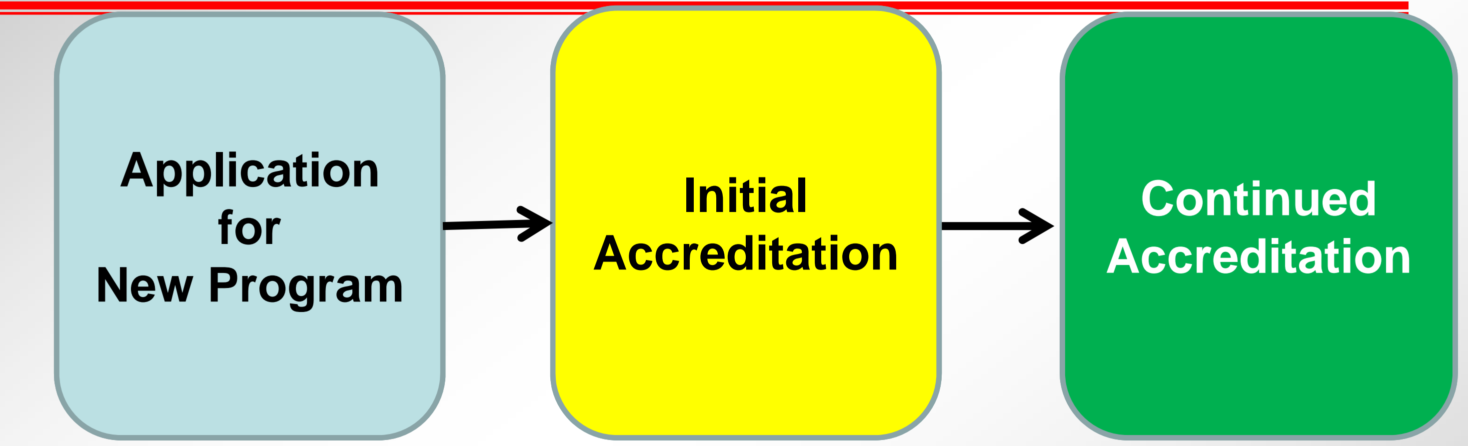
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



STANDARDS

Outcomes
Core Process
Detail Process

Application for New Program	Initial Accreditation	Continued Accreditation
Outcomes	Outcomes	Outcomes
Core Process	Core Process	Core Process
Detail Process	Detail Process	Detail Process

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program

STANDARDS

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Withhold Accreditation

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Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Application for New Program

2-4%

Accreditation with Warning

Probationary Accreditation

10-15%

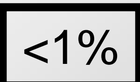
Continued Accreditation

85-95%

STANDARDS

Outcomes
Core Process
Detail Process

Withdrawal of Accreditation



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Next Accreditation System

6. What Happens at *My* Program?

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What Happens at *My* Program?

- Annual data submission
- Annual Program Evaluation (PR V.C.)
- Self-study visit every ten years
- Core and subspecialty programs together
- *Possible* actions by the RRC:
  - Progress reports for potential problems
  - Focused site visit
  - Full site visit
  - Site visit for potential egregious violations

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NAS: Annual Data Submission

<table>
<tr><td></td><td colspan="12">Year 1</td></tr>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr>
<tr><td>Milestones</td><td>Yr 0</td><td></td><td></td><td></td><td></td><td colspan="2">Yr 1</td><td></td><td></td><td></td><td></td><td>Yr 1</td></tr>
<tr><td>Faculty Survey</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="3">Yr 1</td><td></td><td></td></tr>
<tr><td>Resident Survey</td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="5">Yr 1</td><td></td></tr>
<tr><td>ADS Update</td><td colspan="5">Yr 1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Case Logs</td><td colspan="3">Yr 0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yr 1</td></tr>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr>
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Next Accreditation System

7. What is a self-study visit?

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What is a Self-Study Visit?

- *Not* fully developed
- Scheduled every ten years
- Conducted by a team of visitors
- Minimal document preparation
- Interview residents, faculty, leadership

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What is a Self-Study Visit?

- Examine annual program evaluations
  - Response to citations
  - Faculty development
- Focus: Continuous improvement in program
- Learn future goals of program
- Will verify compliance with core requirements

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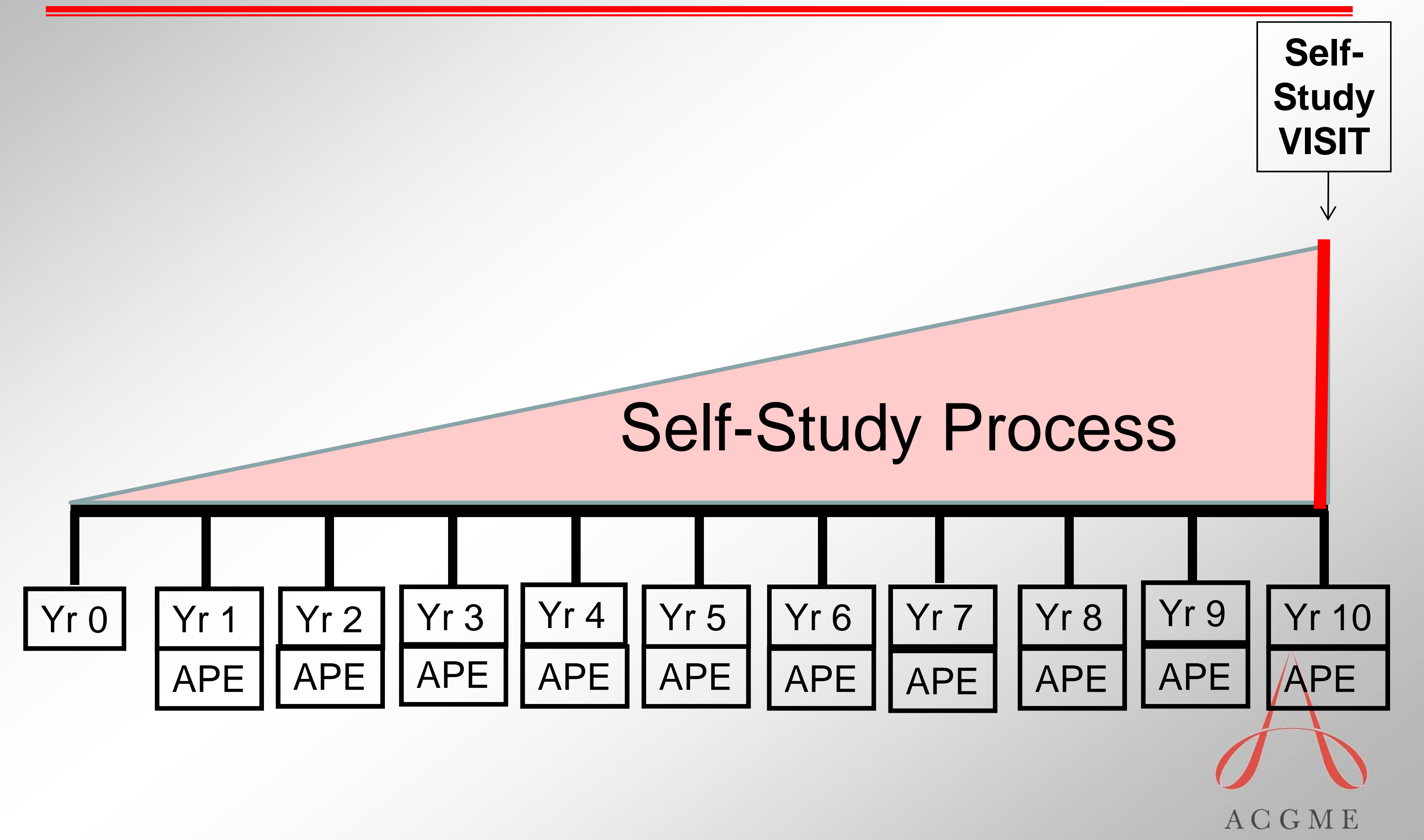
Ten Year Self-Study Visit



Next Accreditation System

8. What is a focused site visit?

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What is a Focused Site Visit?

- Assesses *selected* aspects of a program and may be used:
  - to address *potential* problems identified during review of annually submitted data;
  - to diagnose factors underlying deterioration in a program's performance
  - to evaluate a complaint against a program

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What is a Focused Site Visit?

- Minimal notification given
- Minimal document preparation expected
- Team of site visitors
- Specific program area(s) investigated as instructed by the RRC

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Next Accreditation System

9. When do full site-visits occur?

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When do Full Site Visits Occur?

- Application for new program
- At the end of the initial accreditation period
- RRC identifies broad issues / concerns
- Other serious conditions or situations identified by the RRC

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Next Accreditation System

10. When is <u>my</u> program reviewed?

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When Is My Program Reviewed?

- *Each* program reviewed *at least* annually
- NAS is a continuous accreditation process
  - Review of annually submitted data
  - Supplemented by:
    - Reports of self-study visits every ten years
    - Progress reports (when requested)
    - Reports of site visits (as necessary)

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When Is My Program Reviewed?

- "Cycle Lengths" will not be used
- Programs will receive feedback from RRC each time they are reviewed
- Status:
  - Continued Accreditation
  - Accreditation with Warning
  - Probationary Accreditation
  - Withdrawal of Accreditation

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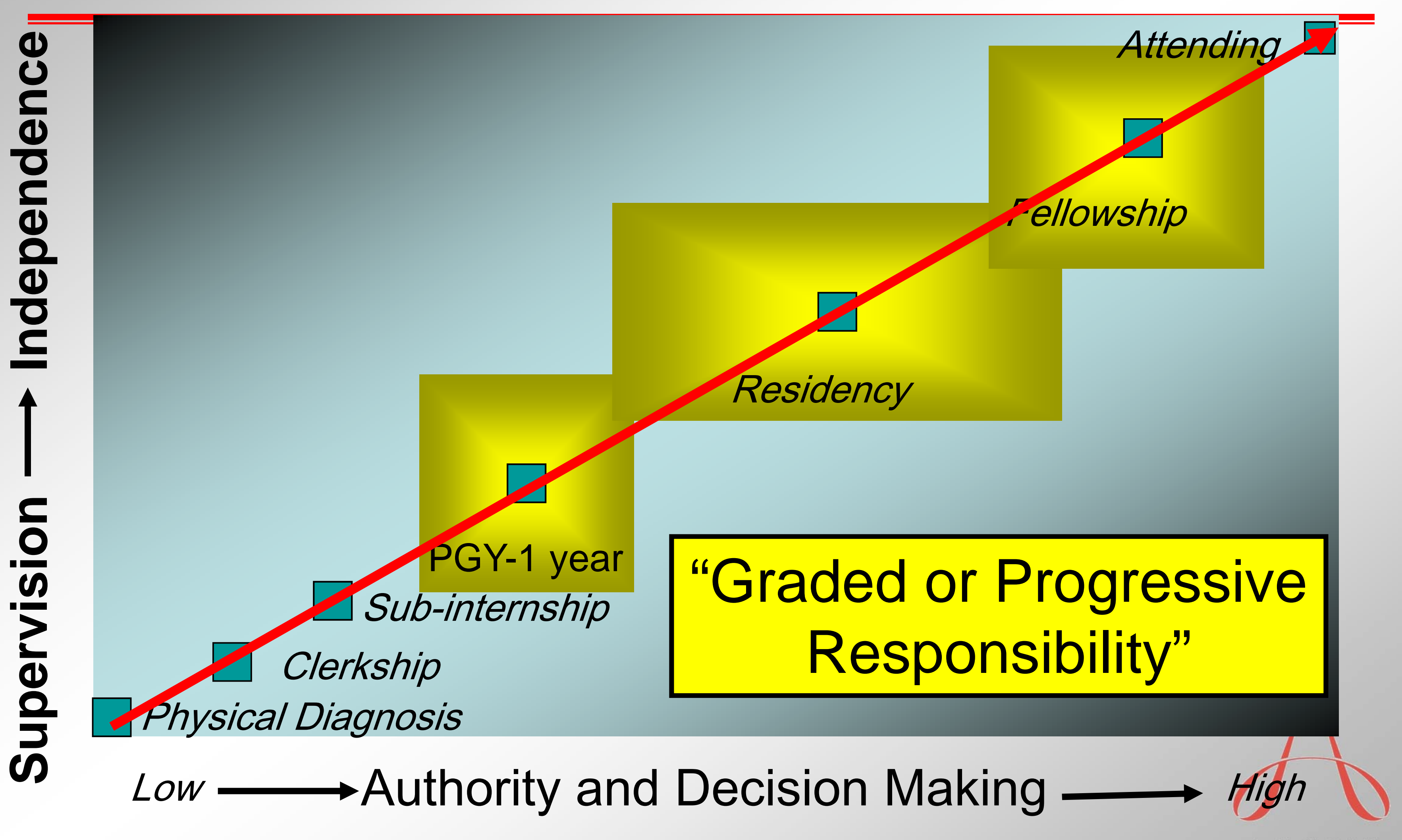
Milestones

The Continuum of Clinical Professional Development



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Milestones: When?

Publication: Jan 2013
Implementation: AY 2013
First Report: Dec 2013

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Milestones												

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General Competency

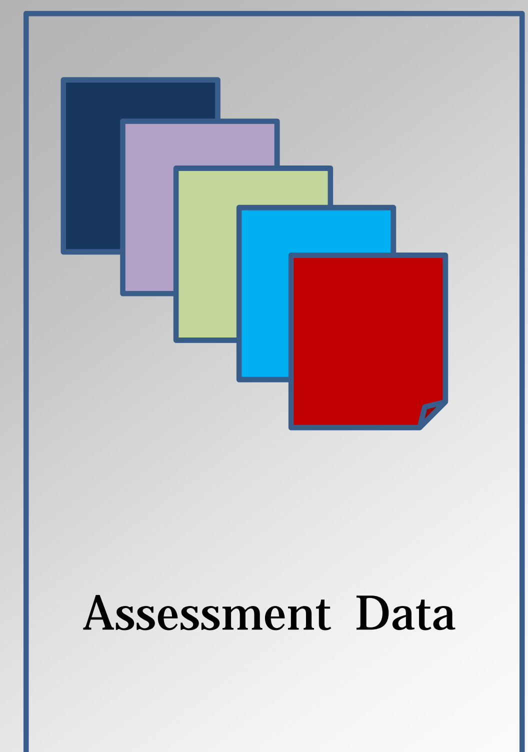
Sub-competency

Developmental Progression or Set of Milestones

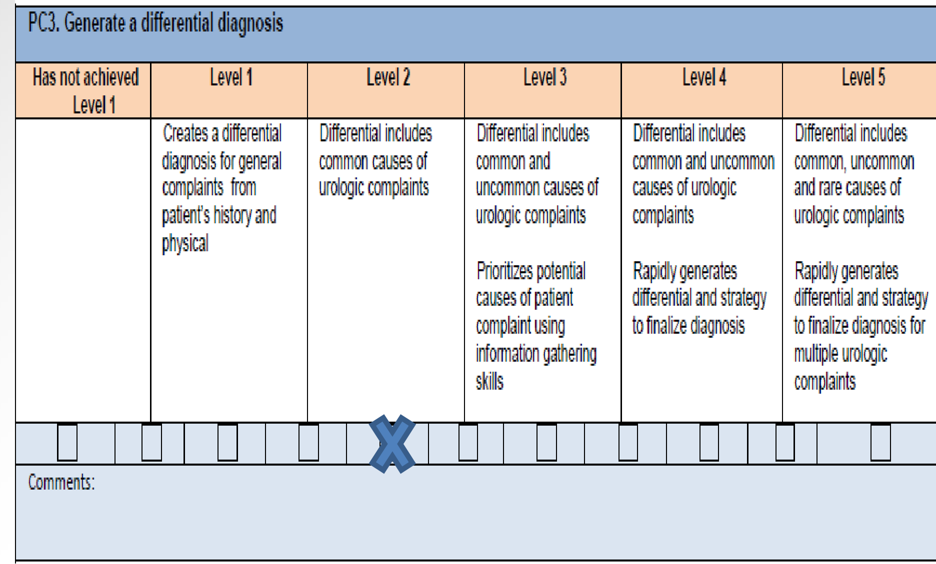
Milestone

SBP2. Incorporates cost awareness and risk-benefit analysis into patient care.

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes the concept of risk-benefit analysis associated with obtaining and providing health care Identifies basic laboratory and radiographic tests that are commonly performed, recognizing that each is associated with specific costs	Knows common socio-economic barriers that impact patient care Describes how cost-benefit analysis is applied to patient care Knows relative costs of frequently used diagnostic and therapeutic interventions, and the extent and ways they contribute to diagnostic accuracy and positive patient outcomes	Identifies the role of various health care stakeholders (health care systems, hospitals, insurance carriers, health care providers, etc.) and their varied impact on the cost of and access to health care Demonstrates the incorporation of cost awareness and risk-benefit principles into standard clinical judgments and decision-making	Demonstrates the incorporation of cost awareness and risk-benefit principles into complex clinical scenarios Minimizes unnecessary care by ordering appropriate laboratory tests and radiographic studies Uses essential equipment with efficiency in the OR	Consistently incorporates cost awareness and risk-benefit principles into all clinical scenarios Masterfully uses common and highly-specialized equipment within the OR



Clinical Competency Committee



PC3. Generate a differential diagnosis					
Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Creates a differential diagnosis for general complaints from patient's history and physical	Differential includes common causes of urologic complaints	Differential includes common and uncommon causes of urologic complaints Prioritizes potential causes of patient complaint using information gathering skills	Differential includes common and uncommon causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis	Differential includes common, uncommon and rare causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis for multiple urologic complaints
Comments:					

Examples of Assessment Data:

- Faculty Direct Observation and Evaluation
- Multi-source Evaluation
- Audit
- In-Training Exams
- Work Products (QI Project)

Select the milestone description that best describes the resident's performance and submit residents' milestone reports to ACGME

CCC: Who should be on it?

- Decision for PD
- Minimum of three faculty
- May include chief resident
- Consider:
  - Familiarity with the residents' performance
  - Dedication to education
  - Representation from each major site

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Clinical Competence Committee

CCC: How does it work?

- Understand the milestones & their use
- Leave personal bias at the door
- Determine a review method (e.g. a CCC member reviews evaluations for a resident in advance and makes a recommendation; the CCC discusses
- For each resident, decide for each milestone, the narrative that best fits that resident

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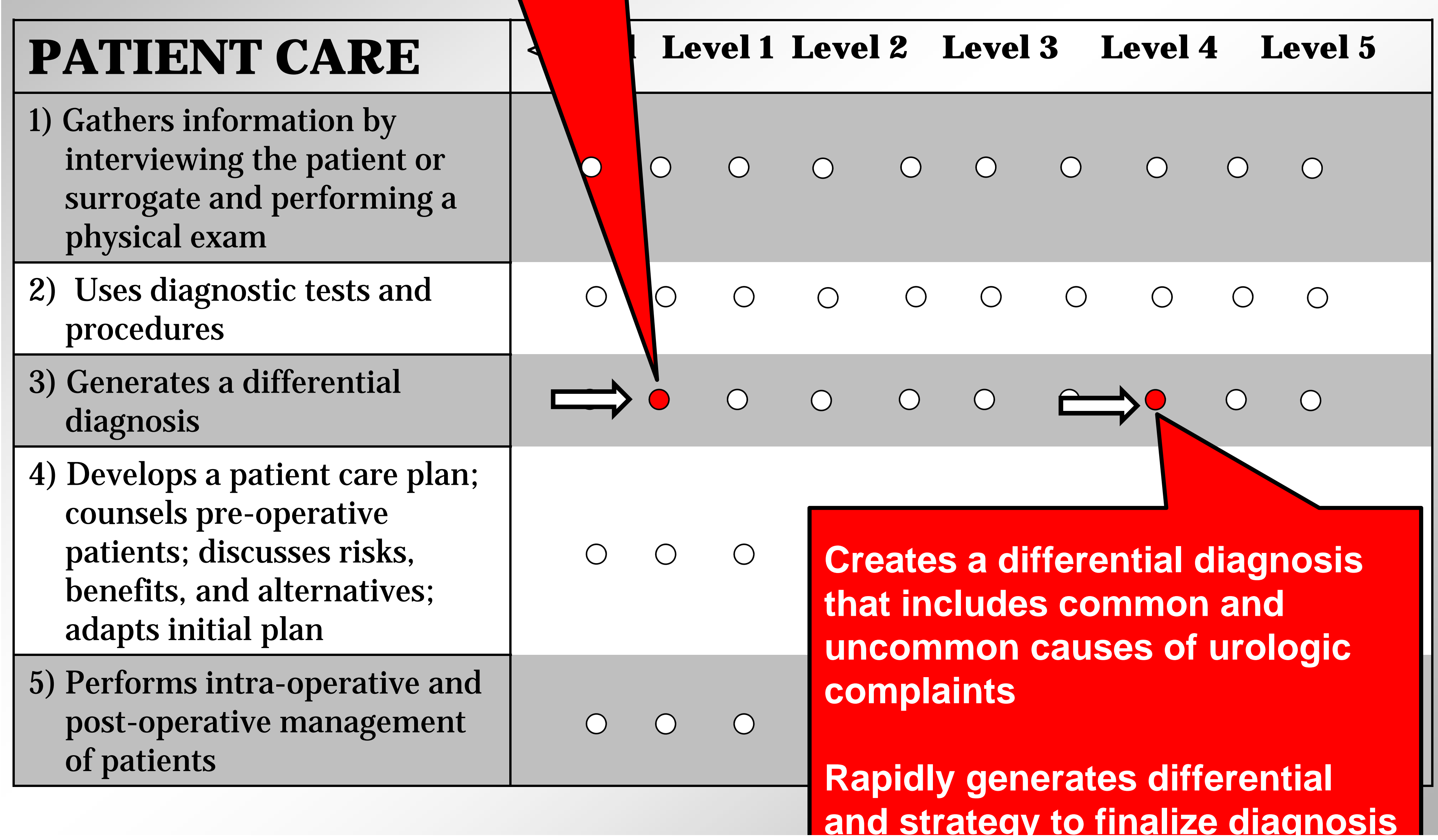
Milestone Reporting

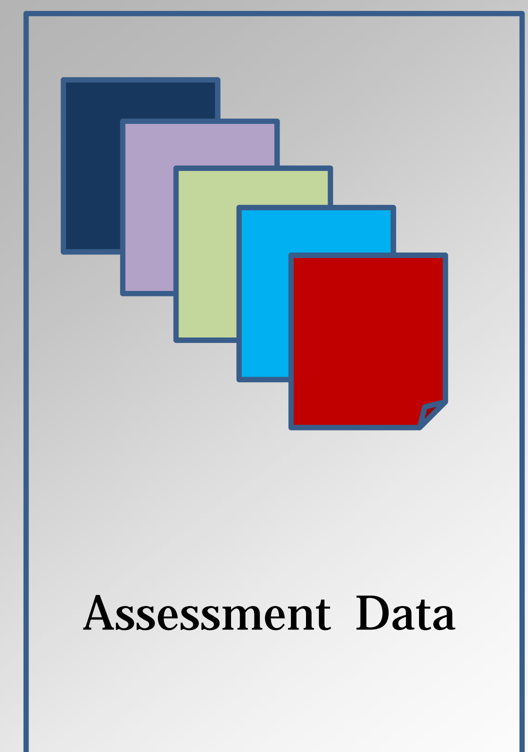
A Sample from a Milestone Reporting Worksheet

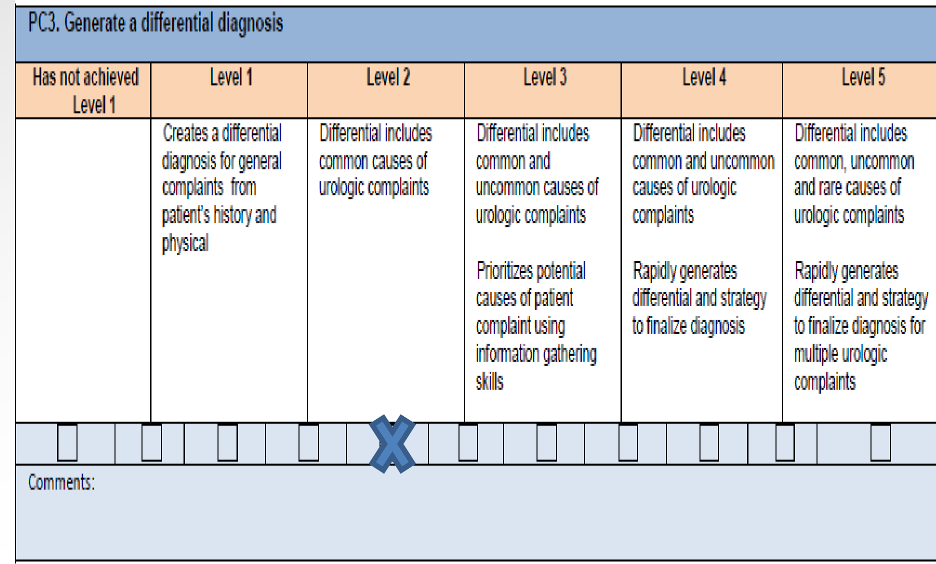
PC3. Generate a differential diagnosis					
Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Creates a differential diagnosis for general complaints from patient's history and physical	Differential includes common causes of urologic complaints	Differential includes common and uncommon causes of urologic complaints Prioritizes potential causes of patient complaint using information gathering skills	Differential includes common and uncommon causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis	Differential includes common, uncommon and rare causes of urologic complaints Rapidly generates differential and strategy to finalize diagnosis for multiple urologic complaints
Comments:					

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).


Creates a differential diagnosis for general complaints from patient's history and physical
PATIENT CARE
Level 1
Level 2
Level 3
Level 4
Level 5
1) Gathers information by interviewing the patient or surrogate and performing a physical exam
2) Uses diagnostic tests and procedures
3) Generates a differential diagnosis
4) Develops a patient care plan; counsels pre-operative patients; discusses risks, benefits, and alternatives; adapts initial plan
5) Performs intra-operative and post-operative management of patients
Creates a differential diagnosis that includes common and uncommon causes of urologic complaints
Rapidly generates differential and strategy to finalize diagnosis





PC3. Generate a differential diagnosis

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Comments:

Examples of Assessment Data:

- Faculty Direct Observation and Evaluation
- Multi-source Evaluation
- Audit
- In-Training Exams
- Work Products (QI Project)

Select the milestone description that best describes the resident's performance and submit residents' milestone reports to ACGME

Key Points: Resident Assessment

- Programs decide on methods and tools
- Highly recommended to align tools with milestones
- Perfection is not expected; do your best; strive to incrementally improve
- Direct observation is key
- Sample milestone-related behaviors
- Prioritize, prioritize, prioritize

Can milestone reporting forms be used for end-of-rotation performance ratings?

- Some sub-competency tables may be appropriate
- Too many sub-competencies to use all for each rotation
- Global ratings are subject to bias
- Need some direct observation and immediate assessment to substantiate global ratings

Examples of Basic Patient and Family Interpersonal and Communication Skills

The physician:

1. Listens actively, e.g., allows the patient to tell his or her story or to provide his or her perspective; does not interrupt and talk over
2. When explaining, presents smalls pieces of information at a time; avoids use of technical, medical words; paces speech appropriately (i.e., not fast)
3. Ensures that his or her message was understood, e.g., when applicable, the patient can repeat/summarize treatment options, the patient can describe signs that would signal a need to contact the physician, the patient can repeat home care instructions
4. Responds supportively and empathetically to patients' emotions and concerns
5. Defuses emotionally charged situations to enable communication
6. Invites and encourages the patient and his or her family/advocates to participate in shared decision making
7. Allows the opportunity for patient questions throughout the encounter
8. Keeps patients and families up to date on care plans, test results, and health status during hospitalization
9. Demonstrates sensitivity to differences in patients, including race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious belief
10. Utilizes translation services as needed to communicate with patients

	ICS1. The physician communicates effectively with patients and families with diverse socioeconomic and cultural backgrounds.				
Fundamental Skills	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The physician demonstrates the following skills when communicating with patients and families: ☐ Listens actively ☐ Presents information in small chunks ☐ Invites questions ☐ Responds supportively to emotion ☐ Ensures understanding (e.g. uses teach-back) ☐ Defuses emotionally charged situations ☐ Utilizes translation services ☐ Uses the 4-step model for delivering bad news	Demonstrates adequate skills of listening without interrupting, ensuring his/her message was understood, and allows an opportunity for questions. Demonstrates sensitivity to patients' culture	Exhibits most of the basic communication skills during medical interviews, counseling and education, and hospitalization updates where the patient condition is non-acute or non-life-threatening	Consistently and capably exhibits basic communication skills in non-stressful situations and in some stressful, challenging situations,	Consistently and capably exhibits basic communication skills in a variety of contexts. In addition, can consistently, capably and confidently deliver bad news to the family about complications and death and inform them of a medical error that caused harm.	Capable of effective communication in the most challenging and emotionally charged situations. Invites participation from all stakeholders
Context:	○ ○	○ ○	○	○ ○	○ ○
Patient Condition:	Comments:				

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Operative Performance: Open Surgical Procedures					
Resident: Operation: Patient Condition:					
		No	**Yes, Done Well**	**Yes, Needs to Improve**	**Not Applicable**
SBP3	1. Engaged in pre-operative briefing with team				
PC5	2. Identified potential complications				
PC6	3. Opened and closed wound				
PC6	4. Manipulated, repaired, and excised internal structures				
PC6	5. Used appropriate technique				
PC5	6. Managed complications				
PC5	7. Asked for help when needed				
ICS5	8. Treated team members with respect				
PROF6	9. Demonstrated sensitivity to patient's culture and gender				

Preparing for Milestone Reporting NOW: A Few First Steps

Conduct a Mini-Pilot:

- Compile assessments for a few residents
- Ask potential CCC members to complete a milestone report
- Target a few modifications and improvements needed to assessments

Data Collection Integration

Case Log Data Collection

Accreditation Activity System

Survey Data

ADS Reporting System

External Data:
Board Pass Rate

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Accreditation Data System (ADS)

- A Web-based system that contains critical accreditation data for all sponsoring institutions and programs.
- Serves as an ongoing communication tool with programs and sponsoring institutions and incorporates several ACGME applications and functions.
- Basic set up and password assignment is required to access ADS. One per program

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Annual Data Collection (Focus on Existing)

- **Annual ADS Update**
  - Resident and Faculty Information
  - Major Changes
  - Citation Response
  - Program Characteristics – Structure and Resources
  - Scholarly Activity – data driven - New
  - Block Diagram - New
- **Board Pass Rate Data (external)**
- **Resident Clinical Experience**
- **Resident Survey**
- **Faculty Survey** - New
- **Semi-Annual Resident Evaluation**
  - Milestone Reporting - New Reporting Only

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www.acgme.org/acgmeweb/

Program and Institutional Guidelines | Data Collection Systems | Meetings and Conferences | Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States.

Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

The Next Accreditation System

Click here to visit the ACGME Next Accreditation System Microsite

Upcoming Meetings and Events

- 2013 ACGME Annual Educational Conference Call for Abstracts
- 2012 Board of Directors Annual Meeting
- 2013 ACGME Annual Educational Conference

Recent News

Announcements

- Welcome to the new ACGME website! The goal of the new website design is to make the site easier to navigate and to furnish up-to-date information in real time. Questions or comments about the new website should be directed to: webfeedback@acgme.org

Quick Links

RESIDENTS | PD / COORDINATORS | DIO'S

- Resident Services
- Resident Case Log System
- Resident Survey
- Duty Hours
- Complaints
- GME Focus

CHOOSE YOUR SPECIALTY

Data Collection Systems

Accreditation Data System	LOGIN
Resident Fellow Survey	LOGIN
Resident Case Log System	LOGIN

Secured Login Access

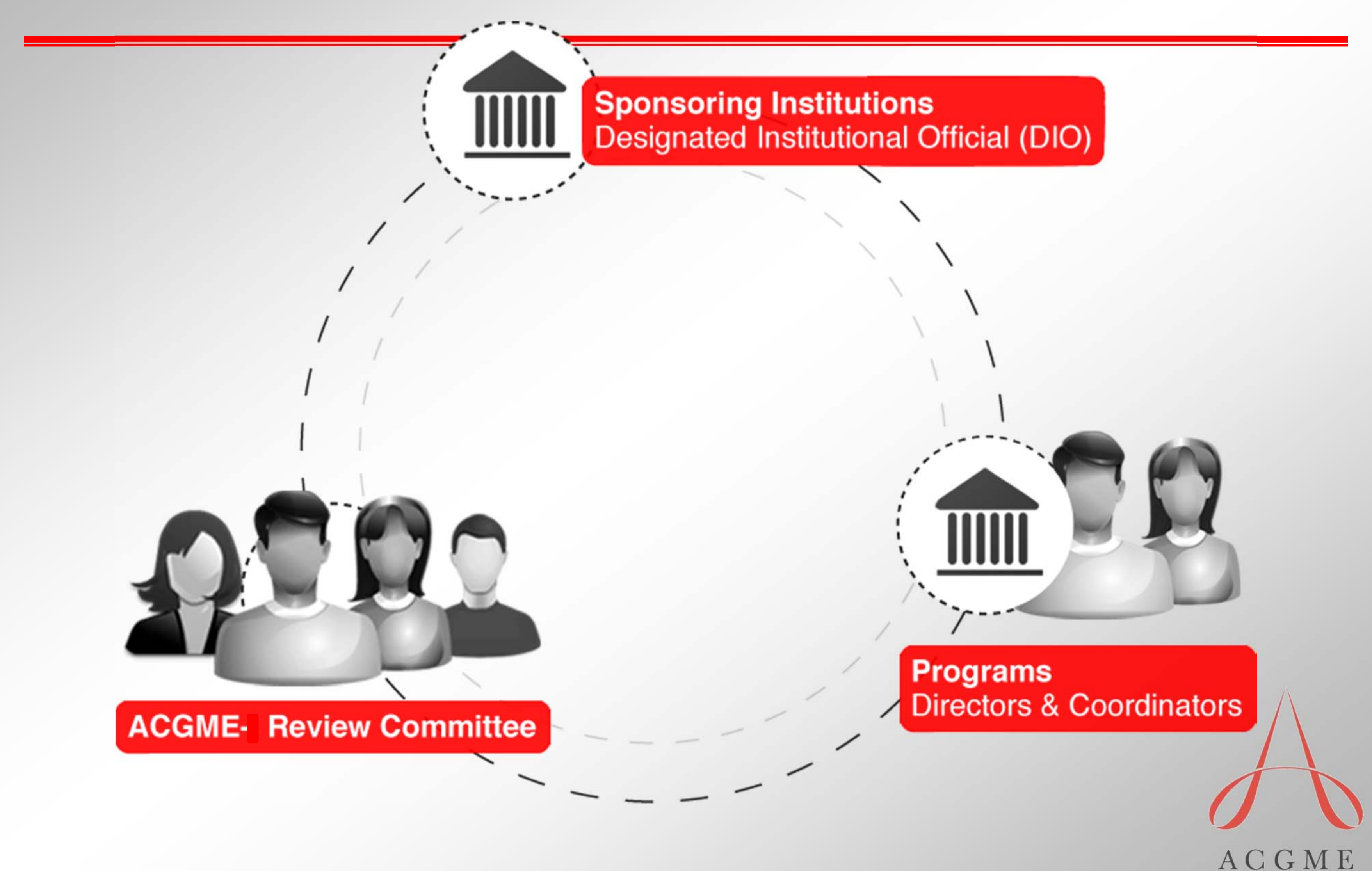
Secure Login

VeriSign Secured
128-bit SSL encryption

Account Assistance

Forgot Your Password

Who are the System Users?



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What are ADS Required Tasks?

- **Initial Application Completion**
- **Annual ADS Update**
- **Changes (minor and significant)**
- **Faculty Survey Administration**
- **Resident Survey Administration**
- **Resident Competency Evaluation**
- **Resident Case Log System**

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Program Application Process

- Electronic Process – July 1, 2013
- Initiated by DIO
- Program Director sent User Name and Password for application completion
- Two sections: Common and Specialty Specific
- Requires DIO sign-off
- Locked after submission

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Programs Must

- Provide annual data
- Submit changes
- Update and generate site visit materials for applications-citations and summary
- Monitor resident and faculty survey participation
- Report resident milestone data
- Oversee resident participation in Case Logs
- Official review and sign off - coming

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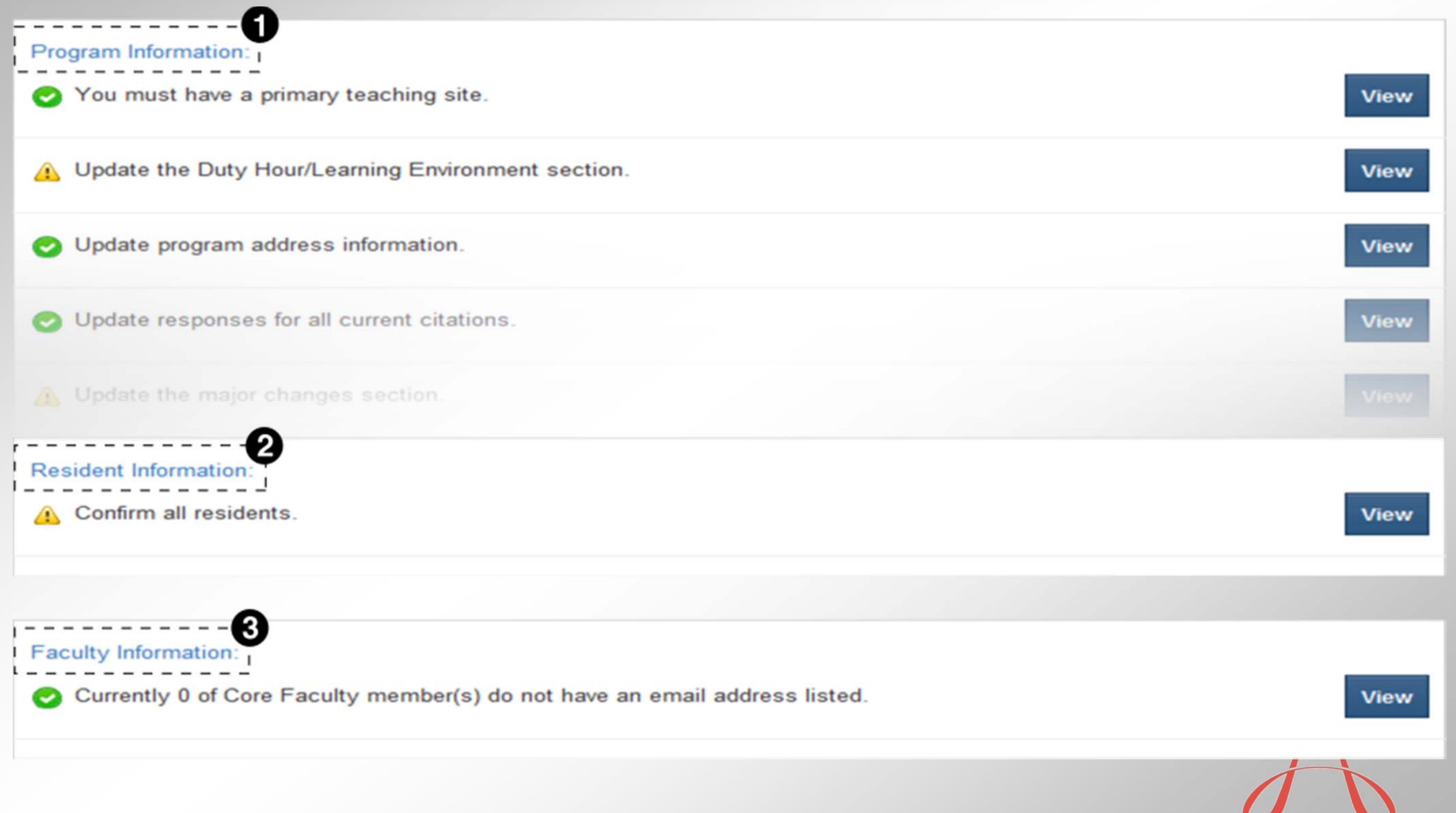
Program Annual Update - Overview



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Program Annual Reporting

- **Update Program Data**
  - Faculty Information—Only the PD has a CV, you can edit each person's information
  - Resident Information
  - Block Diagrams/Curricular Information
  - Scholarly Activity—Faculty and Residents
  - Participating Site Information
  - PD/Coordinator information
  - Major changes
  - Respond to Previous Citations
  - Participating sites
  - DH and Patient Safety data
  - General Competency Assessment Methods
  - Block Diagram – Typical Rotation Schedule

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Some Data Reviewed by RRC
Most already in place

- **Annual ADS Update (being done for 8 years)**
  - Program Characteristics
  - Program Changes—PD/core faculty/residents/structure and resources
  - Scholarly Activity-Core Faculty (15 hrs or more) and Residents**
  - Omission of data

Board Pass Rate—3 year rolling average

Resident Survey—Common and Specialty Specific

Clinical Experience--Case Logs

Semi Annual Resident Evaluation and Feedback

- Milestones

Faculty Survey (Core Faculty Only)

Ten Year Self Study

Program Annual Reporting

- **Update Resident Data**
  - Add new residents- verify prior training
  - Confirm all active and graduating residents – unconfirmed each year
  - Enter scholarly activity (2013)
- **Update Faculty Data**
  - Add / remove faculty – with credentials
  - Enter scholarly activity (2013)

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Resident Status

- **Newly Added Residents**
  - Active Full Time
  - Active Part Time (counted as 0.5)
  - Started Program Off Cycle (automatically chosen depending on start dates)

- **Completed Training**
  - Completed All Accredited Training (for this specialty) and prepared for independent practice

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Resident Status continued

- **Inactive Residents**
  - In Program but Doing Research/Other Training (intends to resume accredited training in this program)
  - Not in Program Yet and/or Doing Preliminary Year Elsewhere
  - Leave of Absence
- **Left Program**
  - Completed all training but NOT PREPARED for independent practice
  - Withdrew from Program
  - Transferred to Another Program (prior to completing required training)
  - Dismissed
  - Deceased

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What are ADS Required Tasks?

- Initial Application Completion
- Annual ADS Update
- Changes (minor and significant)
- Faculty Survey Administration
- Resident Survey Administration
- Resident Competency Evaluation
- Resident Case Log

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Make Changes in ADS Immediately

- **All data should be current (resident, faculty, and program level)**
- **Major changes require sign-off and approval (DIO & RRC**
  - Approved resident complement – PD initiates
  - New Program Director – DIO initiates
  - Participating site affiliations – DIO initiates
  - Request voluntary withdrawal - PD initiates
  - Major structural changes
  - Citation responses
- **RRCs review changes**
- **No changes to historical data**

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What are ADS Required Tasks?

- Initial Application Completion
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- Changes (minor and significant)
- **Faculty Survey Administration**
- Resident Survey Administration
- Resident Competency Evaluation
- Resident Case Log System

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Faculty Survey- Background

- The faculty survey seeks input regarding the overall educational environment and compliance with the standards
- Implemented for Core faculty & PD in accredited specialty programs – phase 1 in 2013
- Implemented for all faculty in subspecialties - with rollout exception
- Email addresses source for contact – accuracy important

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Faculty Survey Content

- **Questions focusing on residents and overall program – similar to Resident Survey**
  - Faculty Supervision / teaching
  - Educational content
  - Resources
  - Patient Safety
  - Teamwork

  AND

  - Program overall assessment question

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Faculty Survey - Administration

- Administered annually Jan- May (5 weeks)
- Managed at the program level – monitor respondents
- Core faculty assigned username (program ID) and password (last name first initial)
- All data are maintained anonymously and confidentially
- Aggregate reports available if 3 respondents and 60% response rate
- Areas of deficiency should be noted and addressed

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What are ADS Required Tasks?

- Initial Application Completion
- Annual ADS Update
- Changes (minor and significant)
- Faculty Survey Administration
- Resident Survey Administration
- Resident Competency Evaluation
- Resident Case Log System

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Resident Survey Content

- **Not a single, unique survey**
- **Using a bank of questions that differ depending on responses and level of training**
- **Focus on general content areas**
  - Duty hours
  - Resources
  - Faculty supervision/teaching
  - Evaluation
  - Educational content
  - Patient safety
  - Teamwork

  AND
  - Program overall assessment question

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What are ADS Required Tasks?

- Initial Application Completion
- Annual ADS Update
- Changes (minor and significant)
- Faculty Survey Administration
- Resident Survey Administration
- **Resident Competency Evaluation**
- Resident Case Log System

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Resident Competency Evaluation – Data and Feedback

- **Summarized data will be part of the information considered during the accreditation process - looking for patterns**

- **Reports will be provided to programs displaying overall performance by cohort**

- **Narrative reports will be provided to programs for formal feedback**

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What are ADS Required Tasks?

- Initial Application Completion
- Annual ADS Update
- Changes (minor and significant)
- Faculty Survey Administration
- Resident Survey Administration
- Resident Competency Evaluation
- Resident Case Log System

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Resident Case Log System

- Web-based application developed in 2000 for residents to track clinical experiences
- Procedures and cases grouped into categories created by Review Committees
- Review Committees establish key indicators and minimum expectations
- Review Committees assess program performance and assess residents' ability to meet the minimums for each key indicator

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Case Log Update

- Minimum Numbers

Category	Min. #
ADULT UROLOGY	
General Urology	200
Transurethral Resection	100
TRUS/prostate biopsy	25
Scrotal/inguinal surgery	40
Urodynamics (participate and interpret)	10
Endourology/Stone Disease	120
Shock Wave Lithotripsy	10
Ureteroscopy	60
Percutaneous renal	10
Laparoscopy/ Robotic (new)	50
Reconstruction	60
Male	15
Penile/Incontinence	10
Urethra	5
Female	15
Intestinal diversion	15

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Case Log Update

- Minimum Numbers

Category	Min. #
Oncology	100
Pelvic	40
Prostate	25
Bladder	8
Retroperitoneal	40
Kidney	30
PEDIATRIC UROLOGY	10
Minor	30
Endoscopy	5
Hydrocele/Hernia	10
Orchioplexy	10
Major	15
Hypospadias	5
Ureter	5

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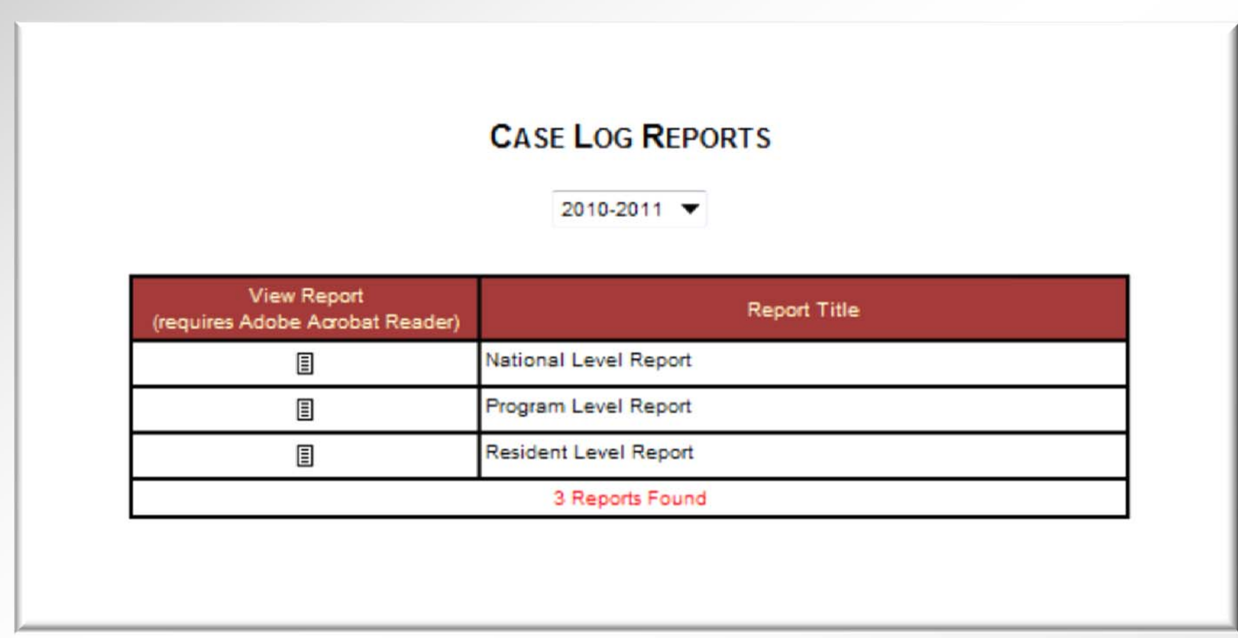
National Data



CASE LOG REPORTS

2010-2011

View Report (requires Adobe Acrobat Reader)	Report Title
	National Level Report
	Program Level Report
	Resident Level Report
3 Reports Found	

National Reports located in ADS, left side menu -> Case Log Reports

National Data Level Definitions

National Level – National picture of educational experiences. Data is broken out by resident role and procedural category.

Program Level – Indicates by category, where your program falls nationally (role / category).

Resident Level – Indicates how your individual residents compare nationally (role / category).

* For all reports, currently the ROLES which are being examined are Surgeon & Surgeon + Teaching Assistant.

Summary Report Information

- The urology summary report summarizes the data according to the categories that the RRC uses to review programs for accreditation.
- Residents do not need to unbundle their codes.
- Case minimums are based on total cases.
- Only one resident may code as surgeon, unless a bilateral procedure, where each resident performs one side.

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FAQ:

Q: What are the definitions of the role assignments?

FAQ:

Surgeon To be recorded as surgeon, the resident must be present for all of the critical portions of the case and must perform a significant number of critical steps of the procedure. It is expected over the course of the their education, residents will develop skills necessary to perform progressively greater portions of complex cases. The Committee views involvement in preoperative assessment and post operative management of patients to be important elements of resident.

Teaching Assistant The chief or senior resident acts as a teaching assistant. To be recorded as the teaching assistant, the chief or senior resident acts as teaching assistant (supervisor) directing and overseeing major portions of the procedure being performed by the more junior resident surgeon while the supervising attending physician (staff) functions as a second assistant or observer.

Assistant Only one resident can claim credit as an assistant on a given case. Though it may well be valuable educationally, activity as a “second assistant” should not be recorded.

Frequently Asked Questions

1. How often do the residents need to log their data?

How long before data accuracy suffers? The fact is the more the residents own it, the better it will be. More consistent, regular logging always means better data which reflects a more positive result for the program.

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Frequently Asked Questions

2. Do residents have the ability to enter data from the past?
   Backlogging, yes.

3. Can the Program Director log cases or at least have access to the logging mechanism?
   Not at the current time, no.

4. Should residents stop logging cases once they have reached the minimum number of procedures?
   Resident should not stop logging procedures

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Resident Level Data

Residents should know the data are used for accreditation purposes with other benefits:

- Secure record of cases with export feature
- Data is widely used for privileges and various post-training positions
- Depending on specialty data may be used for Boards (data access agreement must be submitted electronically by resident)

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Data Download (Raw Data File)

- Home
- Log Off
- Case Entry
  - Add
  - Search/Update
  - Update Procedure Year
  - My Favorite Codes
  - Download Procedures

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Good News

- No PIFs except for initial accreditation
- No Cycle Lengths
- No internal reviews
- RRC feedback is annual
- Full Site Visits occur with applications for new programs, at end of initial accreditation, RRC identifies broad issues/concerns
- Other serious conditions and situations identified by the RRC

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CLER Visits

Clinical

Learning

Environment

Review

- JGME 2012; 4:396-8

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CLER Program

- Focus on institutional environment – *not* individual programs
- PD role limited to:
  - Facilitating peer selection of residents
  - Participation in group interview
  - Ongoing involvement of residents in quality and safety initiatives that are integrated into the institution

JGME 2012; 4:396-8

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Upcoming Events

- ACGME Webinar
  - Milestones, Evaluation, CCCs 24 April
- SUCPD presentation
  - 3 May 2013

Previous ACGME Webinars

- CLER
- Overview of Next Accreditation System
- http://www.acgme-nas.org/index.html under "ACGME Webinars"

Recent Development

- There will be NO 2014 self-study dates
- Instead, there may be a PIF-less site visit
- 14 Urology programs affected
- LONs will soon be issued those 14

ACGME Staff Assistance

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