Implementing the Next Accreditation System for Urology Programs

John R. Potts, III, MD
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
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
1. When does this happen?
NAS Timeline

Phase I specialties

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

2. Why are we doing it?
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, and in 2009, it began a multiyear process of restructuring its accreditation system to be more responsive to the needs of contemporary medical education.

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...
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
3. How does this reduce burden?
Reduced Burden

- Standards revised every ten years
- “Infernal Review” no longer required
- No PIF’s
- Scheduled (self-study) visits q ten years
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
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
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
Current PIF Faculty CV

First Name: John  
Middle Initial: M. 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
Certification Information:

- Certification Year: 2001
- Current Certification: Valid
- Original Certification: Valid
- Date of Expiration: 1/2014

Academic Appointments - List the past ten years, beginning with your current position:

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<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Description of Position(s)</th>
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<tbody>
<tr>
<td>7/1993</td>
<td>6/1995</td>
<td>State Program</td>
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<tr>
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<td>State Program</td>
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<tr>
<td>3/1999</td>
<td>Present</td>
<td>State Program</td>
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Consultee 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 Urogynecological Society
- [1999 - Present] Member, International Continence Society
- [1999 - Present] Member, Section of the American Urological Association
- [1999 - Present] Member, Urological Society
- [1998 - Present] Member, American Urological Association

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


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


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


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

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# Scholarly Activity as Performance Indicator

## Faculty Scholarly Activity

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<th>Faculty Member</th>
<th>PMID 1</th>
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<th>Conference Presentations</th>
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<th>Chapters / Textbooks</th>
<th>Grant Leadership</th>
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<th>Teaching Formal Courses</th>
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## Resident Scholarly Activity

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## Categories for Points:

- Peer Review Publication
- Other Scholarly
- Grantsmanship
- Leadership / Peer Review
- Education

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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 Scholarly Activity

Enter Pub Med ID #’s

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**Number of abstracts, posters, and presentations given at international national, or regional meetings 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.

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## Faculty Scholarly Activity

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

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## Faculty Scholarly Activity

### Number of chapters or textbooks published between 7/1/2011 and 6/30/2012

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Enter a number
## Faculty Scholarly Activity

**Enter a number**

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Number of grants for which faculty member had a leadership role (PL, Co-PL, 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 professional 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 Scholarly Activity

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.

Answer: Yes or No

Leadership or Peer-Review Role
Y
Faculty Scholarly Activity

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
# Scholarly Activity Template

## Scholarly Activity as Performance Indicator

<table>
<thead>
<tr>
<th>Templates for Scholarly Activity</th>
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**Faculty Scholarly Activity**

- Number of 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).
- 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.

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**Resident Scholarly Activity**

- Number of 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.

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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
4. How Can Programs Innovate?
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”*
5. What’s the big picture?
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Outcomes
Core Process
Detail Process

Continued Accreditation

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

STANDARDS
Outcomes
Core Process
Detail Process

Accreditation With Warning
Continued Accreditation

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

Probationary Accreditation

Continued Accreditation

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

STANDARDS
Outcomes
Core Process
Detail Process

Accreditation
with Warning

Probationary Accreditation

Continued Accreditation

Withdrawal of Accreditation

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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

Application for New Program → Initial 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

Application for New Program ➔ Initial Accreditation ➔ Continued Accreditation

STANDARDS
Outcomes
Core Process
Detail Process
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

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

STANDARDS
Outcomes
Core Process
Detail Process

Application for New Program
2-4%

Accreditation with Warning
10-15%

Probationary Accreditation

Continued Accreditation
85-95%

Withdrawal of Accreditation
<1%

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6. What Happens at My Program?
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
# NAS: Annual Data Submission

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7. What is a self-study visit?
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
Ten Year Self-Study Visit

Self-Study Process

Yr 0  Yr 1  Yr 2  Yr 3  Yr 4  Yr 5  Yr 6  Yr 7  Yr 8  Yr 9  Yr 10
APE   APE   APE   APE   APE   APE   APE   APE   APE   APE   APE
8. What is a focused site visit?
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
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
9. When do full site-visits occur?
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
10. When is my program reviewed?
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)
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
Milestones
The Continuum of Clinical Professional Development

“Graded or Progressive Responsibility”

Supervision → Independence

Physical Diagnosis → Clerkship → Sub-internship → PGY-1 year → Residency → Fellowship → Attending

Low Authority and Decision Making → High
## Milestones: When?

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Jan 2013</strong></td>
<td></td>
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</tr>
<tr>
<td>Implementation</td>
<td></td>
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<td></td>
<td></td>
<td><strong>AY 2013</strong></td>
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</tr>
<tr>
<td>First Report</td>
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<td></td>
<td></td>
<td><strong>Dec 2013</strong></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>General Competency</th>
<th>Sub-competency</th>
<th>Developmental Progression or Set of Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes the concept of risk-benefit analysis associated with obtaining and providing health care</td>
<td>Knows common socio-economic barriers that impact patient care</td>
<td>Consistently incorporates cost awareness and risk-benefit principles into all clinical scenarios</td>
</tr>
<tr>
<td>Identifies basic laboratory and radiographic tests that are commonly performed, recognizing that each is associated with specific costs</td>
<td>Describes how cost-benefit analysis is applied to patient care</td>
<td>Masterfully uses common and highly-specialized equipment within the OR</td>
</tr>
<tr>
<td>Knows relative costs of frequently used diagnostic and therapeutic interventions, and the extent and ways they contribute to diagnostic accuracy and positive patient outcomes</td>
<td>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</td>
<td>Minimizes unnecessary care by ordering appropriate laboratory tests and radiographic studies</td>
</tr>
<tr>
<td></td>
<td>Demonstrates the incorporation of cost awareness and risk-benefit principles into standard clinical judgments and decision-making</td>
<td>Uses essential equipment with efficiency in the OR</td>
</tr>
<tr>
<td></td>
<td>Demonstrates the incorporation of cost awareness and risk-benefit principles into complex clinical scenarios</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone**
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
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
### Milestone Reporting

A Sample from a Milestone Reporting Worksheet

<table>
<thead>
<tr>
<th>PC3. Generate a differential diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not achieved Level 1</td>
</tr>
<tr>
<td>Level 1</td>
</tr>
<tr>
<td>Level 2</td>
</tr>
<tr>
<td>Level 3</td>
</tr>
<tr>
<td>Level 4</td>
</tr>
<tr>
<td>Level 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has not achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Creates a differential diagnosis for general complaints from patient's history and physical</td>
<td>Differential includes common causes of urologic complaints</td>
<td>Differential includes common and uncommon causes of urologic complaints</td>
<td>Differential includes common and uncommon causes of urologic complaints</td>
<td>Differential includes common, uncommon and rare causes of urologic complaints</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prioritizes potential causes of patient complaint using information gathering skills</td>
<td></td>
<td>Rapidly generates differential and strategy to finalize diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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).
<table>
<thead>
<tr>
<th>PATIENT CARE</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Gathers information by interviewing the patient or surrogate and performing a physical exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Uses diagnostic tests and procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Generates a differential diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Develops a patient care plan; counsels pre-operative patients; discusses risks, benefits, and alternatives; adapts initial plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Performs intra-operative and post-operative management of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Creates a differential diagnosis for general complaints from patient’s history and physical
- Creates a differential diagnosis that includes common and uncommon causes of urologic complaints
- Rapidly generates differential and strategy to finalize diagnosis
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 small 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.
<table>
<thead>
<tr>
<th>Fundamental Skills</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The physician demonstrates the following skills when communicating with patients</td>
<td>Demonstrates adequate skills of listening without interrupting,</td>
<td>Exhibits most of the basic communication skills during medical</td>
<td>Consistently and capably exhibits basic communication skills in non-</td>
<td>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.</td>
<td>Capable of effective communication in the most challenging and emotionally charged situations. Invites participation from all stakeholders</td>
</tr>
<tr>
<td>and families:</td>
<td>ensuring his/her message was understood, and allows an opportunity for</td>
<td>medical interviews, counseling and education, and hospitalization</td>
<td>stressful situations and in some stressful, challenging situations,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Listens actively</td>
<td>questions.</td>
<td>updates where the patient condition is non-acute or non-life-threatening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Presents information in small chunks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Invites questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Responds supportively to emotion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>□ Ensures understanding (e.g. uses teach-back)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Defuses emotionally charged situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Utilizes translation services</td>
<td></td>
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</tr>
<tr>
<td>□ Uses the 4-step model for delivering bad news</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Context:</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Patient Condition:</td>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBP3</td>
<td>1. Engaged in pre-operative briefing with team</td>
<td>No</td>
<td>Yes, Done Well</td>
<td>Yes, Needs to Improve</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
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<td>----------------</td>
<td>------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>PC5</td>
<td>2. Identified potential complications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC6</td>
<td>3. Opened and closed wound</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC6</td>
<td>4. Manipulated, repaired, and excised internal structures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC5</td>
<td>5. Used appropriate technique</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC5</td>
<td>6. Managed complications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC5</td>
<td>7. Asked for help when needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICS5</td>
<td>8. Treated team members with respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROF6</td>
<td>9. Demonstrated sensitivity to patient’s culture and gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
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
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 Microsoft.

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

Quick Links

RESIDENTS | PD / COORDINATORS | DIOS
Resident Services
Resident Case Log System
Resident Survey
Duty Hours
Complaints
GME Focus

Data Collection Systems

Accreditation Data System
Resident Fellow Survey
Resident Case Log System
Secured Login Access

Secure Login
VeriSign Secured
128-bit SSL encryption
Account Assistance
Forgot Your Password
Who are the System Users?

- Sponsoring Institutions
  - Designated Institutional Official (DIO)

- ACGME Review Committee

- Programs
  - Directors & Coordinators

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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
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
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
**Program Annual Update - Overview**

1. **Program Information:**
   - You must have a primary teaching site.
   - Update the Duty Hour/Learning Environment section.
   - Update program address information.
   - Update responses for all current citations.
   - Update the major changes section.

2. **Resident Information:**
   - Confirm all residents.

3. **Faculty Information:**
   - Currently 0 of Core Faculty member(s) do not have an email address listed.

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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
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)
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
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
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
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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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
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
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
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
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
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
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
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
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

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

## Minimum Numbers

<table>
<thead>
<tr>
<th>Category</th>
<th>Min. #</th>
</tr>
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<tbody>
<tr>
<td><strong>Oncology</strong></td>
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<tr>
<td>Pelvic</td>
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<tr>
<td>Prostate</td>
<td>25</td>
</tr>
<tr>
<td>Bladder</td>
<td>8</td>
</tr>
<tr>
<td>Retroperitoneal</td>
<td>40</td>
</tr>
<tr>
<td>Kidney</td>
<td>30</td>
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<tr>
<td><strong>PEDIATRIC UROLOGY</strong></td>
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</tr>
<tr>
<td>Minor</td>
<td>10</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>30</td>
</tr>
<tr>
<td>Hydrocele/Hernia</td>
<td>5</td>
</tr>
<tr>
<td>Orchioplexy</td>
<td>10</td>
</tr>
<tr>
<td><strong>Major</strong></td>
<td></td>
</tr>
<tr>
<td>Hypospadias</td>
<td>15</td>
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National Data

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.
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.
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.
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*
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)
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
CLER Visits

Clinical Learning Environment Review

• JGME 2012; 4:396-8
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
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

- Patricia Levenberg, PhD Executive Director at plevenberg@acgme.org
- Jenny Campbell, MA Accreditation Administrator at jcampbell@acgme.org
- Linda Roquet, Accreditation Assistant at lroquet@acgme.org