Keep Your Eyes on the Dashboard

October 15, 2015

Presented by:
Candace DeMaris, MAIS
Consultant
Partners in Medical Education
Introducing Your Presenter...

Candace DeMaris, MAIS
GME Consultant

- 30+ years experience throughout the spectrum of medical education: from undergraduate to GME, primary care to surgical specialties, in academic medical centers and community based-teaching hospitals.

- Expertise in both institutional and program requirements and the area of GME finances – including maximizing CMS reimbursement, assessing the financial feasibility of starting new programs and demonstrating the value of established programs.
Learning Objectives

- Identify the key metrics that ACGME requires to be tracked, and others that should be tracked
- Organize a dashboard in a clear, concise format
- Discuss the use of dashboards in...
  - APE and Self Study
  - AIR and GMEC Special Review
  - CLER
- Describe 6 reasons why institutions and programs should consider using a dashboard to track performance
Your Car’s Dashboard...

...shows how your vehicle is performing in quick glance
Your GME Dashboard…

…shows your *programs'* performance at-a-glance. Aggregated program data can show your *institution’s* performance at-a-glance.
Outcomes-based accreditation
Annual RC review to identify under-performing programs and help them to improve
Accreditation process changes:
- Annual review (no more cycles)
- Site visits every 10 years or as needed
- Annual ADS update replaces PIF
Continuous Accreditation Model based on annual review of data:

- ADS Annual Update
- Resident and Faculty Survey
- Board Exam Performance
- Milestone Data
- Case Log Data
- Faculty and Resident Scholarly Activity
- Hospital Accreditation Data
- Attrition

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So…

- The Programs, the DIO, the GMEC, and the programs must devise a way of continually monitoring program quality and demonstrating improvement.

**Dashboards!**
Dashboards in 3 Simple Steps
Step 1: Choose Your Metrics

What does the ACGME require?
- Program Requirements
- Institutional Requirements

What does your institution require?

What is important to your program?
Step 2: Obtain the Data

- **ACGME**
  - Accreditation status
  - Case logs
  - Resident and faculty survey

- **Boards**
  - Certifying exam pass rates
  - In-training exam scores

- **Hospital data systems**

- **Program files**

- **Web-based residency management systems**
Step 3: Organize the Data

- “At-a-Glance” = Keep it simple

- Use database or spreadsheet software to format, calculate, trend, query, and analyze data.
Dashboards and Annual Program Evaluation
Annual Program Update has been streamlined, but still requires reporting on:

- Program Characteristics
- Board Pass Rates
- Clinical Experience (Case Logs)
- Resident and Faculty Survey
- Resident and Faculty Scholarly Activity
- Milestones Assessments
- Attrition

**MUST TRACK THESE!**
New Emphasis: Annual Evaluation & Improvement Processes

ANNUAL PROGRAM EVALUATION (APE)

“The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.” V.C.2

- Formalized the name: Annual Program Evaluation (APE)
- Added a requirement for a formal Program Evaluation Committee (PEC)
- Clarified the expectation of a performance improvement component
- RRCs may have additional requirements. Check the current specialty-specific requirements
The program must monitor and track…

- Resident Performance, including aggregated milestones assessments
- Faculty Development
- Graduate Performance, including performance of program graduates on the certification examination
- Program Quality (using the results of confidential, written assessments of the program by residents and faculty)
- Progress on the previous year’s action plan(s)

TRACK THESE TOO!
Other “High Value” Data – You Decide

- Major changes
- Curriculum Goals & Objectives
- Resident QI & Patient Safety Engagement
- Match results
- In-Training Exam Scores
- Policies (DH, supervision, handoffs, etc.)
- Graduate feedback
- “Where did our graduates end up?”

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Annual Program Dashboard…
an example
Dashboards and Self-Study
A few words about Dashboards and Self-Study...

- Self-study is based on successive APEs
- You cannot go back and re-create an APE
- Dashboards will show trending from Year 1-Year 9
- Catch deterioration and do something about it before it comes to the attention of the ACGME
NAS is about Continuous Improvement

- **Annual** Data Submission
- **Annual** ACGME Feedback
- **Annual** Program Evaluations
- **Annual** Written Action Plans

Y1, Y2, Y3, Y4, Y5, Y6, Y7, Y8, Y9, Y10
Dashboards and Annual Institutional Review
New Emphasis: Annual Evaluation & Improvement Processes

ANNUAL INSTITUTIONAL REVIEW (AIR)

- The sponsoring institution’s evaluation of itself
- Demonstrates ongoing attention to effective institutional oversight
- ACGME does not specify how and by what criteria AIR should be conducted

Must include:
- Results of the most recent institutional self-study visit
- Results of ACGME resident and faculty surveys
- Notification of programs’ accreditation statuses and self-study visits
“The Graduate Medical Education Committee must demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review” (1.B.5)

- The GMEC must identify institutional **performance indicators** for AIR

- The AIR must include monitoring procedures for **action plans** resulting from the review

- The DIO must submit a written annual **executive summary** of the AIR to the Governing Body”
What Can Institutions Learn by Aggregating Program Dashboards?

- Aggregated program dashboards show the institution’s performance at-a-glance.
- Aggregated program dashboards identify what the institution is doing well.
- Aggregated program dashboards identify areas where the DIO and GMEC must monitor, intervene, facilitate, or resolve at the institutional level.
## 2014-15 Performance At-a-Glance

<table>
<thead>
<tr>
<th>ACGME Accreditation Status</th>
<th>Threshold</th>
<th>IM</th>
<th>FM</th>
<th>Peds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Accreditation</td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
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</table>

<table>
<thead>
<tr>
<th>Resident Survey</th>
<th>National % Compliance</th>
<th>IM</th>
<th>FM</th>
<th>Peds</th>
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</thead>
<tbody>
<tr>
<td>Duty Hours</td>
<td>97.1%</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Faculty</td>
<td>87.6%</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Evaluation</td>
<td>87.2%</td>
<td>●</td>
<td>★</td>
<td>●</td>
</tr>
<tr>
<td>Educational Content</td>
<td>83.7%</td>
<td>●</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Resources</td>
<td>87.4%</td>
<td>●</td>
<td>●</td>
<td>★</td>
</tr>
<tr>
<td>Patient Safety/Teamwork</td>
<td>95.7%</td>
<td>●</td>
<td>●</td>
<td>●</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty Survey</th>
<th>National % Compliance</th>
<th>IM</th>
<th>FM</th>
<th>Peds</th>
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</thead>
<tbody>
<tr>
<td>Faculty Teaching &amp; Supervision</td>
<td>93.7%</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Educational Content</td>
<td>93.0%</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Resources</td>
<td>96.5%</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>89.4%</td>
<td>●</td>
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<td>●</td>
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<tr>
<td>Teamwork</td>
<td>98.7%</td>
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<tr>
<th>First Time Board Pass Rate (3-year)</th>
<th>Threshold</th>
<th>IM</th>
<th>FM</th>
<th>Peds</th>
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<tr>
<td></td>
<td>80%</td>
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<tr>
<th>NRMP Fill Rate</th>
<th>Threshold</th>
<th>IM</th>
<th>FM</th>
<th>Peds</th>
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<tbody>
<tr>
<td></td>
<td>100%</td>
<td>●</td>
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</table>
## 2014-15 Improvement Priorities

<table>
<thead>
<tr>
<th>Institutional</th>
<th>Peds</th>
<th>IM</th>
<th>FM</th>
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<tbody>
<tr>
<td><strong>Resident Survey</strong> – DIO to meet with residents before the ACGME resident survey is administered to clarify questions and program requirements</td>
<td><strong>Subspecialty Rotations</strong> – Improve didactic and clinical experiences, with a focus on Heme-Onc and Nephrology</td>
<td><strong>Ward Redesign</strong> – Continue full implementation of ward team redesign, changing the call model, and graduated levels of responsibility</td>
<td>Feedback – Develop timely and actionable feedback mechanisms for resident-to-peer feedback, faculty-to-resident feedback, and resident-to-faculty feedback</td>
</tr>
<tr>
<td><strong>Evaluation</strong> – GME office to centralize confidential written evaluations of the programs and of the faculty</td>
<td><strong>Transitions of Care</strong> – Possible action plans may include standardized sign-out, reviewing the impact of AM -&gt; PM -&gt; night float sign-out, and reviewing faculty sign-out on weekends</td>
<td><strong>Elective Rotations</strong> – Subspecialty liaison to oversee all subspecialty rotations, review the curricula, and provide consistent expectations</td>
<td><strong>Curriculum Redesign</strong> – Introduce longitudinal curriculum components; develop structured educational opportunities in the Family Medicine Center and on the Family Medicine Inpatient Service</td>
</tr>
<tr>
<td><strong>Professionalism</strong> – GMEC to develop and approve an institutional policy on Professionalism</td>
<td><strong>Duty Hours in the ICU</strong> – Reduce vulnerability to duty hours violations through education that addresses reasons to extend shifts, need or Program Director notification, and compensatory mechanisms</td>
<td><strong>Scholarly Activity</strong> – Generate list of ongoing clinical research and mentors within PHS. Subspecialty liaison has agreed to mentor academic projects for residents interested in competitive fellowships.</td>
<td><strong>Maternity and Neonatal Care</strong> – Improve acceptance and support for residents on L&amp;D and in the NICU</td>
</tr>
<tr>
<td><strong>CLER Readiness</strong> – Provide ongoing awareness to C-Suite hospital staff of ACGME expectations for the Clinical Learning Environment Review</td>
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</tbody>
</table>
Dashboards and GMEC
Special Review
New Emphasis: Annual Evaluation & Improvement Processes

GMEC SPECIAL REVIEW

- NOT an internal review

- IS a review for underperforming programs that do not meet the GMEC’s performance criteria

- GMEC must develop a protocol and identify program performance indicators.

- Results in a report that describes quality improvement goals, corrective action, and a process for monitoring outcomes
“The Graduate Medical Education Committee must demonstrate effective oversight underperforming programs through a Special Review Process” I.B.6

The Special Review process must include a protocol that:

- Establishes criteria for identifying underperformance; and

- Results in a report that describes the quality improvement goals, corrective actions, and process for GMEC monitoring of outcomes.
So….Flag the metrics that will trigger a GMEC Special Review

- Non-compliant performance
- Performance below benchmark
- Deterioration
Dashboards and Clinical Learning Environment Review
New Emphasis:

CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)

- Oversight and documentation of resident/fellow engagement in improvement processes within the learning and working environment
- Ensure that assignments are made to facilities that promote quality and safety
- Review and approval of responses to CLER reports
The Sponsoring Institution is responsible for oversight and documentation of resident/fellow engagement in the following: III.B

- Patient Safety
- Quality Improvement
- Transitions of Care
- Supervision
- Duty Hours
- Professionalism
CLER Pathways to Excellence

- Framework for evaluating the clinical learning environment
- Protocols for CLER visits align with the Pathways document
- Tool for promoting discussions and actions that will optimize the clinical learning environment
CLER Pathways to Excellence

6 FOCUS AREAS

34 PATHWAYS believed to be essential to creating an optimal clinical learning environment

89 PROPERTIES that can be assessed from low to high along a continuum of resident and faculty engagement within the learning environment.
**SAMPLE CLER PATHWAYS WORKSHEET**

### CT PATHWAY 1: Education on care transitions
- Residents/fellows and faculty members know the clinical site’s transitions of care policies and procedures
- Residents/fellows participate in simulated or real-time interprofessional training on communication to optimize transitions of care at the clinical site
- Faculty members participate in simulated or real-time professional training on transitions of care at the clinical site

### CT PATHWAY 2: Resident/fellow engagement in change of duty hand-offs
- Residents/fellows use a common clinical site-based process for change of duty hand-offs.
- Resident/fellow change of duty hand-offs involve, as appropriate, interprofessional staff members (e.g., nurses) at the clinical site.
- Resident/fellow change-of-duty handoffs involve, as appropriate, patients and families at the clinical site

### CT PATHWAY 3: Resident/fellow and faculty member engagement in patient transfers between services and locations
- Residents/fellows use a standardized direct verbal communication process for patient transfers between services and locations at the clinical site.
- Resident/fellow transfers of patients between services and locations at the clinical site involve, as appropriate, interprofessional staff members.
- Residents/fellows participate with clinical site leadership in the development of strategies for improving transitions of care.

### CT PATHWAY 4: Faculty member engagement in assessing resident/fellow-related patient transitions of care
- Through program-based standardized processes and direct observation, resident/fellows are assessed for their ability to move from direct to indirect faculty member supervision in the conduct of patient transfers at change of duty, and in patient transfers between services and locations at the clinical site.
- Faculty members periodically monitor resident/fellow transfers of patient care at change-of-duty, and resident/fellow transfers of patients between services and locations for quality control at the clinical site.

### CT PATHWAY 5: Resident/fellow and faculty member engagement in communication between primary and consulting teams
- Residents/fellows and faculty members use direct communication in the development of patient care plans among primary and consulting teams

### CT PATHWAY 6: Clinical site monitoring of care transitions
- The clinical site’s leadership monitors transitions of patient care managed by residents and fellows
- The clinical site’s leadership involves program directors in the development and implementation of strategies to improve transitions of care.
Take a critical look…

at your CLER report

- Organize the findings from the written report to identify improvement opportunities
- Look for alignment in responses
- Look for low response rates
### SAMPLE TABLE OF CLER REPORT FINDINGS

#### PATIENT SAFETY

Senior Leadership Patient Safety Priorities
- Increase resident reporting into the patient safety reporting system
- Improve hand hygiene
- CAUTI
- CLABSI
- VAP
- Eliminating never events
- Improve results on Culture of Safety Survey

<table>
<thead>
<tr>
<th>% residents who knew hospital’s priorities</th>
<th>Residents</th>
<th>Faculty</th>
<th>Program Directors</th>
<th>Senior Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>reducing risk of falls</td>
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<tr>
<td>hand hygiene</td>
<td></td>
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<tr>
<td>antibiotic stewardship</td>
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<tr>
<td>% faculty who knew hospital’s priorities</td>
<td>Nearly all</td>
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<tr>
<td>hand hygiene</td>
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<tr>
<td>right site surgery</td>
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<tr>
<td>safety event reporting</td>
<td></td>
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<tr>
<td>protective gear for isolated patients</td>
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<tr>
<td>decreasing VAPs</td>
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<tr>
<td>improving flu shot compliance</td>
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<tr>
<td>% PDs who knew hospital’s priorities</td>
<td>95%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>hand hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>decreasing infections</td>
<td></td>
<td></td>
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<tr>
<td>preventing CLABSI</td>
<td></td>
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<tr>
<td>reducing medication errors</td>
<td></td>
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<tr>
<td>safe handoffs and good discharge summaries</td>
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<tr>
<td>obtaining consent</td>
<td></td>
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<tr>
<td>time-outs prior to procedures</td>
<td></td>
<td></td>
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<tr>
<td>% residents who reported receiving formal education about PS</td>
<td>90%</td>
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<tr>
<td>% residents who reported they had experienced an adverse event or near miss</td>
<td>60%</td>
<td></td>
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</tr>
<tr>
<td>Of those experiencing a safety event, % who reported the event</td>
<td>40%</td>
<td>30%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>% who reported the event</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% relied on physician to report</td>
<td></td>
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<td></td>
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<tr>
<td>% relied on a nurse to report</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% did not report</td>
<td></td>
<td></td>
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<tr>
<td>% faculty believed that 1/2 of residents reported a safety event</td>
<td>75%</td>
<td>80%</td>
<td></td>
<td></td>
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<tr>
<td>% residents who received feedback</td>
<td>53%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% participation in safety investigation</td>
<td>40%</td>
<td>62%</td>
<td>65%</td>
<td></td>
</tr>
</tbody>
</table>

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### SAMPLE TABLE OF CLER REPORT FINDINGS

**HEALTHCARE QUALITY**

| Senior Leadership Quality Improvement Priorities |
|-------------------------------------|---------------------|
| decreasing falls                    | decreasing infections |
| core measures                       |                      |

<table>
<thead>
<tr>
<th>% residents who knew hospital's priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>preventing infections</td>
</tr>
<tr>
<td>improving hand washing</td>
</tr>
<tr>
<td>preventing post-op pneumonia</td>
</tr>
<tr>
<td>order sets</td>
</tr>
<tr>
<td>preventing PE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% faculty who knew hospital's priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>best practice alerts in the EMR</td>
</tr>
<tr>
<td>use of coordinators to improve transitions of care</td>
</tr>
<tr>
<td>decreasing readmissions</td>
</tr>
<tr>
<td>improving patient use of the EMR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% PDs who knew hospital's priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication at discharge</td>
</tr>
<tr>
<td>meeting meaningful use measures</td>
</tr>
<tr>
<td>medication reconciliation</td>
</tr>
<tr>
<td>appropriate use of translators</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% residents who were engaged with hospital leadership in advancing the hospital quality agenda</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>% residents reported access to data collection systems</th>
</tr>
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### HEALTHCARE DISPARITIES

<table>
<thead>
<tr>
<th>Senior Leadership priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to care</td>
</tr>
<tr>
<td>Diabetic patients</td>
</tr>
<tr>
<td>Childhood obesity</td>
</tr>
<tr>
<td>Coordinating for uninsured and underinsured</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Rural population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Residents, faculty, and PDs who knew hospital's priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and quality regardless of ability to pay</td>
</tr>
<tr>
<td>Enrolling pts in insurance programs</td>
</tr>
<tr>
<td>Assisting patients with meds and transportation</td>
</tr>
<tr>
<td>Community clinics</td>
</tr>
<tr>
<td>Reducing language barriers</td>
</tr>
<tr>
<td>Cultural competency</td>
</tr>
</tbody>
</table>
# SAMPLE TABLE OF CLER REPORT FINDINGS

## TRANSITIONS IN CARE

### Senior Leadership priorities
- Follow-up after discharge
- Frequent ED patients
- Hospital to outpatient
- Discharge to nursing home

### % residents who knew hospital’s priorities
- Improving reporting and conducting formal sign-out at shift change
- Identifying level of care needed
- Verbal and written sign-outs
- EMR functionality

<table>
<thead>
<tr>
<th>Residents</th>
<th>Faculty</th>
<th>Program Directors</th>
<th>Senior Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td></td>
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### % faculty who knew hospital’s priorities
- Verbal and written signoffs
- Interprofessional discharge planning and follow up
- Transition from ED to floors

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<tbody>
<tr>
<td></td>
<td>90%</td>
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### PDs who knew hospital’s priorities
- Standardized system for signouts and for patients changing floors
- Discharge medication reconciliation
- Adequate discharge summaries
- Nursing staff use of SBAR to admit patients

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<td></td>
<td></td>
<td></td>
<td>95%</td>
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### Standardized process for signoff and transfer at shift change
- at shift change
- between floors
- inpatient to outpatient care

<p>| | | | |</p>
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<th></th>
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</thead>
<tbody>
<tr>
<td>nearly all</td>
<td>nearly all</td>
<td>nearly all</td>
<td>81%</td>
</tr>
</tbody>
</table>

### Interprofessional rounding observed
- Use of templates observed
- Level of detail relayed
- Read-back observed
- Faculty supervise/monitor handoffs regularly

## SUPERVISION

### Objective way of knowing which procedures a resident was allowed to perform with or without supervision

|65% | Nearly all | Nearly all | Few |

### Safety event due to lack of supervision

|15% | 20% |

### Patients able to identify roles

|20% | 35% | 50% |
DUTY HOURS, FATIGUE MANAGEMENT, FATIGUE MITIGATION

Received education on fatigue management and mitigation
Scenario
- Power through the end of the shift
- Notify supervisor and expect to be taken off duty
- Notify supervisor and expect to stay
- Approach another resident
- Other action
Safety event involving fatigue

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PROFESSIONALISM

Incidents concerning professionalism
Received education on professionalism topics at orientation
Received education on professionalism topics throughout training
Pressure to compromise their integrity to satisfy an authority figure
Cut and pasted from another note
Shared exam questions not available in the public domain
Scenario
- Advise colleague to discuss with CR or PD
- If not resolved contact HR
- Call the medical center's anonymous hotline
- Submit an incident report
- Report to ACGME
- Other

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Take a critical look…
at BOTH documents -- together

- Look for alignment
- Beliefs and perceptions vs. fact
- Inventory your own activities around the 6 focus areas
- Estimate your position along each of the pathways
- National data, when available

Presented by Partners in Medical Education, Inc. 2015
Where Do We Start?

Consider a subcommittee of the GMEC

- Composed of PD’s, APD’s, PC’s, residents, and the DIO
- What are we going to measure and how often?
- What is the benchmark?
- Devise a rating scale
- What will the dashboard look like? What software are we going to use?
Where Do We Start?

- Where is the data?
- Who is going to collect the data?
- Where does the dashboard go after it is completed?
- Who will see the dashboard and how will it be used?
Reasons Why Programs and Institutions Should Consider Using a Dashboard

1. Programs, DIO, and GMEC must devise a way of continually monitoring program quality. Dashboards represent continuous reporting.

2. ACGME requires that programs and institutions track certain data. Dashboards can be used assist data collection for the Annual Program Update...
   …which feeds Annual Program Evaluation
   …which feeds 10-year Self-Study
   …which feeds Annual Institutional Review
   …which feeds GMEC Special Review

3. Dashboards will be valuable as one of the tools to document institutional oversight for a Clinical Learning Environment Review

4. A dashboard can identify best practices as well as performance gaps, which represent opportunities for improvement

5. Regular monitoring of program dashboards demonstrates GMEC oversight

6. Aggregated program dashboards identify areas where the DIO and GMEC must monitor, intervene, facilitate, or resolve at the institutional level
Final Thoughts…

✓ Do not wait to begin.

✓ Trend your metrics over time.

✓ Share your dashboard with everyone.
Upcoming Live Webinars

**Strategies for Resident Engagement in Patient Safety & QI**
Tuesday, October 27, 2015
12:00pm – 1:30pm EST

**Meet the Experts – Fall Freebie**
Thursday, November 5, 2015
12:00pm – 1:00pm EST

**Evaluations to Support Milestone Assessments**
Thursday, November 19, 2015
12:00pm – 1:30pm EST

**PC Series**
Thursday, December 10, 2015
12:00pm – 1:30pm EST

On-Demand Webinars

**Self-Study Visits**

**Introduction to GME for New Program Coordinators**

**Milestones & CCCs**

**GME Financing – The Basics**

**Single Accreditation System**

**The IOM Report**

**Institutional Requirements: What’s New?**

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Phone: 724-864-7320
Fax: 724-864-6153
Email: Info@PartnersInMedEd.com

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