Colon & Rectal Surgery Program Coordinator Workshop

Pamela L. Derstine, PhD, MHPE
Executive Director

ACGME
May 4, 2012
Colon & Rectal Surgery Program Coordinator Workshop

Session 1: Program Requirements and PIF
Overview

• DAS/RRC Update
• Duty Hour Requirement Update
• Program Information Form
DAS/RRC Update
Department of Accreditation Services

• Surgical Section
  John R. Potts III, MD, Senior Vice President
  ➢ Derstine Team: Colon & Rectal Surgery; Neurological Surgery; Orthopaedic Surgery; Otolaryngology
  ➢ Johnston Team: Obstetrics & Gynecology; Committee of Review Committee Chairs
  ➢ Levenberg Team: Ophthalmology; Urology
  ➢ Simpson Team: Plastic Surgery; General Surgery; Thoracic Surgery
Department of Accreditation Services

- **Medical Section**
  - Mary Lieh-Lai, MD, Senior Vice President
    - **Anthony Team**: Dermatology; Family Medicine
    - **Fischer Team**: Pediatrics; Physical Medicine & Rehabilitation
    - **King Team**: Allergy & Immunology; Neurology; Psychiatry
    - **Vasilias Team**: Internal Medicine
Department of Accreditation Services

- Hospital-based Section
  Louis J. Ling, MD, Senior Vice President
  - Lewis Team: Anesthesiology; Preventive Medicine; Transitional Year
  - Meyer Team: Diagnostic Radiology; Emergency Medicine; Nuclear Medicine
  - Thorsen Team: Medical Genetics; Pathology; Radiation Oncology
Derstine Team

- Pamela L. Derstine, PhD, MHPE
  Executive Director
  (312) 755-5083 – pderstine@acgme.org

- Susan Mansker
  Associate Executive Director
  (312) 755-5028 – smansker@acgme.org

- Jennifer Luna
  Accreditation Administrator
  (312) 755-5036 – jluna@acgme.org

- Deidra Williams
  Accreditation Assistant
  (312) 755-5055 – dwilliams@acgme.org
Review Committee Members

- Eric Dozois, MD
- Patrice Gabler Blair, MPH
  Ex-Officio (ACS)
- Karin M. Hardiman, MD
  Resident (term ends 6/30/12)
- Bruce A. Orkin, MD
  Vice Chair (Chair-elect)

- David J. Schoetz, Jr., MD
  Ex-Officio (ABCRS)
- Anthony Senagore, MD
  Vice Chair-elect
- Michael J. Stamos, MD
- Eric G. Weiss, MD
  Chair (term ends 6/30/12)
- Charles Whitlow, MD

New Members as of July 1, 2012
- Matthew G. Mutch, MD
- Jacquelyn Turner, MD (Resident)
Upcoming RRC Meetings

• September 21, 2012
  ➢ Agenda closing date August 10, 2012

• April 5, 2013 (tentative)*
  ➢ Agenda closing date February 22, 2013

• September 19, 2013 (tentative)
  ➢ Agenda closing date August 8, 2013
April Newsletter

• Photos!
• Statistics!
• Reminders!
• Announcements!
Colon and rectal surgery residents are considered to be in the final years of education.

- 80 hours/week
- 1 day off in 7
- Maximum duty period 24+4 hours
- 1 day in 3 free of in-house call
- <8 hours between duty periods is allowed
Duty Hour Requirements Update

- Specialty-specific requirements requested for 3 common requirements in section VI: Resident Duty Hours in the Learning and Working Environment
  - Supervision
  - Teamwork (new)
  - Circumstances for less than 8 hours between scheduled duty periods
VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.

**Only attending physicians will be ultimately responsible for a patient’s care.**
VI.F. Teamwork *
Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

* Each resident must have the opportunity to interact with other providers such as nurses, enterostomal therapists, other specialists, social workers, and mid-level providers.
VI.G.5.c).(1) Minimum Time Off between Scheduled Duty Periods

While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

The Review Committee defines such circumstances as required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
Program Requirement

- Program Director support
  - I.A.1 SI must provide 10% protected time
  - I.A.2 Salary support must be provided by SI, foundation or practice
  - I.A.3 PD must not be required to generate clinical or other income for this support

- Qualifications of the Program Director
  - II.A.3.b) ABCRS certification (rare exceptions must be reviewed and approved by RRC)
  - II.A.3.d) Must have 3 years CRS clinical practice
  - II.A.3.e) Must have 3 years prior faculty experience
Documentation

- Program Director Support
  - Specialty-specific PIF
    - Section: Sponsoring Institution items 1-2
    - SV verifies
- Qualification
  - Common PIF PD info section
  - Staff verifies with ABCRS
  - Specialty-specific PIF
    - Section: Program Personnel and Resources
    - A. Program Director items 1-2 (y/n)
Program Requirement

• Qualifications of the Faculty
  II.B.6 Three FTE ABCRS-certified faculty (including program director)
  II.B.5.e) Min one active in scholarly activity:
    - regional or national societies
    - research
    - national/international meetings
    - peer-reviewed pubs
    - contributing current standards papers to medical pubs
Documentation

• Faculty Number
  ➢ Common PIF physician faculty roster
  ➢ Staff verifies certification with ABCRS

• Scholarly activity
  ➢ Common PIF physician faculty roster
  ➢ Specialty-specific PIF
    Section: Program Personnel and Resources
    B. Faculty items 1-2 (y/n)
  ➢ SV verifies
Program Requirement

- Other Program Personnel
  
  II.C.1 Program coordinator
  
  10% time (1 resident)
  15% time (2 residents)
  20% time (3 residents)
  25% time (4 residents)
  30% time (5 residents)
Documentation

• Program Coordinator
  - Specialty-specific PIF
  - Section: Program Personnel and Resources
  - Items C.1-2
  - SV verifies
Program Requirement

- Resident Eligibility Criteria
  - III.A.2.a) Must complete ACGME- or RCPSC-accredited surgery program
  - III.A.2.b) Must be ABS-certified or completed requirements for ABS qualifying exam

- Non-US and non-Canada residents cannot fill an ACGME-approved position
- If such residents or other learners are appointed, the program should reduce the number of on-duty ACGME-approved residents
Documentation

- Eligibility
  - Common PIF resident appointment section
  - Certification status verified by staff or at site visit
- Other learners
  - Specialty-specific PIF Section: Appointment of Other Learners table
  - Staff/SV cross check with number of on-duty residents

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Name of Rotation</th>
<th>Length of Rotation</th>
<th>Number of Residents/Fellows Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Program Requirement

• Educational Program/Didactic Sessions and Conferences
  IV.A.1.a) Comprehensive curriculum required (APDCRS curriculum a starting point but not sufficient)
  IV.A.2.a) Goals & objectives jointly reviewed beginning and end of each rotation
  IV.A.3.a) Structured didactic sessions
  IV.A.3.b).(2) Conference attendance (min. 70% for residents)
  IV.A.3.c).(1) Monthly M&M with resident presentations
  IV.A.3.c).(2) Quarterly Journal Club with resident presentations
Documentation

• Goals and Objectives
  ➢ Specialty-specific PIF Section: Educational Program A. Competency-based G&O items 1-2 (y/n)
  ➢ SV verifies
Documentation

• Didactic Sessions
  – Specialty-specific PIF Section: Educational Program B. Regularly Scheduled Didactic Sessions items 1-3
  – Be detailed and complete – RRC carefully reviews (SV will verify)
Documentation

Provide the titles of the conference lectures for the program over the last year, including whether or not staff or resident (underline resident’s name) is giving the presentations. (PR IV.A.3.a))

Are regular colon and rectal conferences coordinated among program sites to allow attendance by a majority of faculty and residents? (PR IV.A.3.b)) ( ) YES ( ) NO

How is resident and faculty attendance monitored? (PR IV.A.3.b).(1))

Does each resident attend at least 70% of all educational conferences (excluding excused time away for meetings, vacation and illness)? (PR IV.A.3.b).(2)) ( ) YES ( ) NO

<table>
<thead>
<tr>
<th>Name of Session/Conference</th>
<th>Frequency (weekly, monthly, etc.)</th>
<th>Required or Elective</th>
<th>Presented by Residents (Y/N)</th>
<th>Colon and Rectal Surgery Faculty Participation (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity and Mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal Club</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal clinical teaching rounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related pathology and radiology studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACGME Competencies (Patient Care/Medical Knowledge/PBLI)

IV.A.5.a-c) Outcomes specified (will link to milestones)
IV.A.5.a).(1).(a) Patient evaluation and management
IV.A.5.a).(1).(b); IV.A.5.a).(2) Essential disorders and procedures

Definition: All residents must have formal instruction and clinical experience leading to proficiency

IV.A.5.b).(3-4) Substantially familiar disorders and procedures

Definition: All residents must receive education
Able to recognize and refer
Not included in index case categories

IV.A.5.c).(9-10) analyze patient care outcomes
use EBM approach to patient care
Table 1. (develop proficiency in evaluation and management)

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Settings/Activities</th>
<th>Method Used to Evaluate Fellow Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>preoperative diagnosis, indications, alternatives, risks and preparation;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[PR IV.A.5.a).(1).(a).(i)]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assessment of patient risk, nutritional status, co-morbidities, and need for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>preoperative treatment and perioperative prophylaxis;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[PR IV.A.5.a).(1).(a).(ii)]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appropriate non-operative management;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[PR IV.A.5.a).(1).(a).(iii)]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>operative management including all technical aspects, intraoperative decision-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>making, avoidance and management of intraoperative complications, and management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of unexpected findings; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[PR IV.A.5.a).(1).(a).(iv)]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>postoperative management including recognition and treatment of complications;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and, appropriate follow-up and additional treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[PR IV.A.5.a).(1).(a).(iv)]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Documentation

• Specialty-specific PIF Section: Educational Program C: Patient Care
  Table 2. (develop proficiency in evaluation and management essential disorders)
    Similar to table 1 but in addition asks settings/activities/evaluation methods in which residents develop competence in their knowledge

• Specialty-specific PIF section: Educational Program C: Patient Care
  Table 3 (demonstrate skill and dexterity in performance of procedures)
    Similar to Table 1
    SV reviews evaluation forms and verifies PIF information

PC Settings (e.g., OP/clinic/office) in hospital, ambulatory surgery center, free-standing clinic, office suite, laboratory, endoscopy center, etc.

****helpful to reference block diagram****
PC Activities (patient evaluation, management, surgery, physiologic testing, data analysis, etc.)
Documentation

• Specialty-specific PIF Section: Educational Program D: Medical Knowledge Table 1. (demonstrate expertise in knowledge-general)

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Settings/Activities</th>
<th>Method Used to Evaluate Resident Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy, embryology and physiology of the colon, rectum, anus and related structures; [PR IV.A.5.b).(1)]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Specialty-specific PIF section: Educational Program D: Medical Knowledge Tables 2 and 3. (demonstrate substantial familiarity in knowledge of disorders and procedures)
  ➢ Similar to above
  ➢ SV reviews evaluation forms and verifies PIF information

MK settings/activities (e.g., type of didactic session, including rounds)
Evaluation methods (e.g., direct observation, simulation, multi-course evaluation)
Documentedness

• Specialty-specific PIF Section: Educational Program E: Practice-based Learning and Improvement Items 7-8 (redundant questions 5-6 will be removed)

Describe how residents develop skills and habits to be able to evaluate and analyze patient care outcomes. [PR IV.A.5.c).(9)]

Describe how residents develop skills and habits to be able to utilize an evidence-based approach to patient care. [PR IV.A.5.c).(10)]

Residents should evaluate a targeted dataset of outcomes for patients under their care and demonstrate the use of a plan-do-study-analyze (PDSA) cycle approach (e.g., use of a specific post-operative care modality).

EBM steps: resident develops a clinical question arising from care of a patient; select resources and conduct search; appraise the evidence; integrate evidence with clinical expertise and apply to patient care as appropriate; evaluate results.
Program Requirement

• Curriculum Organization and Resident Experiences
  IV.A.6.a) Patient evaluation and care in specific settings
  IV.A.6.b) Basic and complex patient conditions
  IV.A.6.c) Broad operative experience
  IV.A.6.d) Exposure to testing methods
  IV.A.6.f) Minimum numbers patient disorders
  IV.A.6.g) Minimum numbers operative procedures
Documentation

- Specialty-specific PIF Section: Curriculum Organization and Resident Operative Experiences
  - Block diagram
  - Items 2-4 (y/n questions)
  - ADS case log reports for program graduates
Program Requirement

• Residents’ Scholarly Activities

IV.B.2.a) Each resident must participate in at least 2 of the following:

- ongoing faculty research study
- resident-initiated research project
- scientific presentation
- article preparation/submission to peer-reviewed publication
- write book chapter or current standards paper
Documentation

- Specialty-specific PIF Section: Residents’ Scholarly Activities items 1-4
  - Ensure all citation information is complete
    - Project: exact title, dates, supervisor, project/research sponsor (funding info if relevant)
    - Presentation: exact presentation title, presentation date; co-presenters; name of meeting, meeting location
    - Publication: exact title, author/co-authors, date, publication name, volume and issue, first through last pages
  - Underline resident name
Program Requirement

- Resident and Program Evaluation
  V.A.1.a).(1-2) Quarterly formative evaluation (all competency domains; case log review)
  V.A.1.d-e) Use of CARSITE for formative evaluation; ABSITE must not be used
  V.C.1.d).(3) 70% program graduates must take ABCRS certifying exam within 3 years
  V.C.1.d).(4) 70% of first time takers in the preceding 5 years must pass ABCRS certifying exam
• Specialty-specific PIF Section: Evaluation
  - Resident Evaluation information verified by site visitor and RRC review of ADS case log reports
  - ABCRS certification data verified with ABCRS
Resources

- CRS FAQs
  http://acgme.org/acWebsite/downloads/RRC_FAQ/060_colon_rectal_surgery_FAQs.pdf

- Duty Hour Common FAQs

- Duty Hour Glossary of Terms

- CRS newsletters
  http://acgme.org/acWebsite/RRC_060_News/060n_Index.asp

- ACGME weekly e-communication
Overview

• Case Log Interface
• Case Log Reports
• RRC Monitoring
• Announcements and Resources
Welcome to Resident Case Logs

The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the accreditation of post-MD medical training programs. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

Access to the Resident Case Logs System is secured by an encryption certificate obtained through the Verisign Corporation. We use 128-bit SSL encryption to help ensure the secure transfer of information. If you are using a less secure encryption level you may experience difficulty and should upgrade.

The data you provide us will be used by ACGME for accreditation, will be maintained confidentially, and will not be distributed for commercial use.

Summary data and other information about programs, institutions, resident physicians or resident physician education which is not identifiable by person or organization may be published in a manner appropriate to further the quality of GME and consistent with ACGME policies and the law.

Accreditation Data System | System for Evaluation of Competencies in Residencies
Minimum Browser Requirements

About SSL Certificates

Please report any problems or suggestions to the oplg@acgme.org

© 2010 Accreditation Council for Graduate Medical Education (ACGME)
Case Log Reports

- Unique purposes
- Only the Index Case Report distinguishes between indexed and non-indexed codes (see resources)

**Filtering reports:**
- Resident (all or specific)
- Location (e.g., ambulatory, clinic, endoscopy suite, ER, physiology lab, etc.)
- Resident Status (active/inactive)
- Date Range
- Institution (all or by participating site)
- Resident Role (all/surgeon/teaching assistant)
- Attending (all or by name)
- Defined Category (re: stoma)
- Type Description (all or by specific type within an area)
- CPT or ICD9 code
Case Log Reports: Resident Activity

Use this report to answer:

• Are residents logging data?
• How much data are they logging and with what frequency?
• How can I quickly and easily see what residents are doing?
**Case Log Reports:**

**Resident Experience Summary**

*Use this report to answer:*

- What is the overall experience for (as filtered)?

### Resident Experience Summary Report

- **Program ID:** 9601234567
- **Program Name:** Test Colon and Rectal Surgery Program
- **For All Attendings at All Institutions**
- **Colon/Rectal Resident Number**
- **For Cases/Encounters in All Years**
- **For All Roles**
- **For All Settings**
- **For All CPT/ICD9 Codes**
- **For All Areas**
- **For All Types**
- **As Of 5/2/2012**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Surgeon</th>
<th>Teaching Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorectal Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abscess I&amp;D</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Congenital disorders</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fistula procedures</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hemorrhoidectomy</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Fecal incontinence</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Fissure</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Hidradenitis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pilonidal disease</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rectal excisions, other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rectal prolapse - perineal</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Case Log Reports:
Resident Full Detail

<table>
<thead>
<tr>
<th>Date</th>
<th>Resident Year:</th>
<th>Role:</th>
<th>Setting:</th>
<th>Case ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/4/2011</td>
<td>1</td>
<td>Surgeon</td>
<td>Hosp (inpatient day adm)</td>
<td>d46d6f</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/5/2011</td>
<td>1</td>
<td>Surgeon</td>
<td>Hosp (inpatient day adm)</td>
<td>g6gd6d</td>
</tr>
</tbody>
</table>

Use these reports to answer:
• Does each case include at least one CPT and one ICD9 code?
• Does each case contain no more than 2 CPT and 2 ICD9 codes?
• Are there more than 2 cases per day/resident?
• What are the details of “unassigned” codes?
Use these reports to answer:

- Is each resident making progress in achieving required minimum numbers?
Case Log Monitoring

- Programs should use the Resident Index Case Log Report (available within Case Log System) to monitor resident progress.
- RRC will review ADS Case Log reports for all programs at each fall RRC meeting.
  - Residents graduating in 2012 and beyond are expected to achieve required minimum numbers in all index case categories.
  - Programs will receive feedback following annual Case Log Review.
Announcements

• Opportunity to archive case logs for graduates now open
• Programs may wait until the end of June to begin archiving data
Resources

• Guidelines and FAQs
  http://acgme.org/acWebsite/RRC_060/060_CRS_Case_Log_Instructions.pdf

• Required Minimum Numbers
  http://acgme.org/acWebsite/RRC_060/060_CRS_Minimum_Case_Numbers.pdf

• Case Log Coding
  http://acgme.org/acWebsite/RRC_060/060_CRS_Case_Log_Coding.pdf

• Printable Case Log Data Card (Opt.)
  http://acgme.org/acWebsite/RRC_060/060_CRS_Printable_Case_Log_Data_Card.pdf
Colon & Rectal Surgery Program Coordinator Workshop

Session 3: Next Accreditation System
Overview

- Background and Rationale
- Program Requirements
- Milestones
- Timeline

http://www.acgme-nas.org/
Background and Rationale
ACGME Mission

We improve healthcare by assessing and advancing the quality of resident physicians’ education through accreditation.
Goals of
The “Next Accreditation System”

• Begin the realization of the promise of Outcomes
• Free good programs to innovate
• Assist poor programs to improve
• Reduce the burden of accreditation
• Provide accountability for outcomes (in tandem with ABMS) to the Public
The “Next Accreditation System” in a Nutshell

- Continuous Accreditation Model – annually updated
  - Based on annual data submitted, other data requested, and program trends
- Scheduled Site Visits replaced by 10 year Self Study Visit
- Standards revised every 10 years
  - Standards Organized by
    - Core Processes
    - Detailed Processes
    - Outcomes
Conceptual Change
The Current Accreditation System

- Rules
  - Corresponding Questions
    - “Correct or Incorrect”
      - Answer
        - Citations and Accreditation Decision

- Rules
  - Corresponding Questions
    - “Correct or Incorrect”
      - Answer
        - Citation and Accreditation Decision
Conceptual Change

The “Next Accreditation System”

“Continuous” Observations

Assure that the Program Fixed the Problem

Number of Potential Related “Rules” Problems

Promote Innovation

Diagnose the Problem (if there is one!)
Next Accreditation System

Continuous Accreditation
No Cycle Lengths
No PIF!!!!!!
Program Requirements
Program Requirements

• Definition of Categories

  ➢ **Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

  ➢ **Detail Requirements:** Statements that describe a specific structure, resource, or process for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

  ➢ **Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
Program Requirements

Examples for CPRs

- Core Requirement:
  Qualifications of the program director must include:
  II.A.3.b) current certification in the specialty by the American Board of Colon and Rectal Surgery (ABCRS), or specialty qualifications that are acceptable to the Review Committee; and, (Core)

- Detail Requirement:
  The program director must:
  II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; (Detail)

- Outcome Requirement:
  Residents are expected to:
  IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)
Milestones
Brief History of Competencies/Milestones

- Competency evaluation stalls
- MedPac, IOM, and others question the quality of preparation of graduates for the “future” health care delivery system
- House of Representatives codifies “New Physician Competencies” in original Health Care Reform Package
- MedPac calls on CMS to modulate IME payments to hospitals based on quality of competency outcomes in same areas
- Macy Report: Ensuring an Effective Physician Workforce
- IOM new initiative: Governance and Financing of Graduate Medical Education
ACGME Goal for Milestones - Permits fruition of the promise of “Outcomes Based Accreditation”

- Tracks what is important - Outcomes
- Begins using *existing tools* and *observations of the faculty*
- Clinical Competency Committee triangulates progress of each resident
  - ABMS Board has the opportunity to track the identified individual
  - ACGME Review Committee tracks unidentified individuals’ trajectories
- ACGME and ABMS are able to provide accountability for effectiveness of educational program in producing outcomes, and achieved outcomes of individual trainees
- ACGME can work with AAMC to improve graduation level preparation
ACGME Goal for Milestones - Permits fruition of the promise of “Outcomes Based Accreditation”

- Specialty specific normative data and common expectations for progress of individual residents
- Less prescriptive ACGME program requirements, lengthened program site visit cycles, less frequent standards revision
  - Promote curricular innovation
  - Enhance curricular and rotation design flexibility
- Opportunity for communication and improvement across the continuum of medical education
- Development of specialty specific evaluation tools and techniques
CRS PC/MK Milestone Domains

- Anorectal
- Colonic Neoplasia
- Large Bowel Obstruction
- Pelvic Floor
- Rectal Prolapse
- Rectovaginal Fistula
- Ulcerative Colitis
Next Accreditation System Timeline

• Seven specialties/RRC’s begin training 7/2012 (phase 1)
  - Pediatrics
  - Internal Medicine
  - Diagnostic Radiology
  - Emergency Medicine
  - Orthopedic Surgery
  - Neurological Surgery
  - Urological Surgery

• Phase 1 specialties/RRC’s “go live” 7/2013

• Remaining specialties/RRC’s begin training 7/2013 (phase 2)

• Phase 2 specialties/RRC’s using the Next Accreditation System 7/2014
NAS Timeline for CRS

- Complete draft milestones: 12/31/2012
- RRC prepares proposed categorization of program requirements for phase 2 specialties
  - post for public comment spring 2013
  - ACGME Board approval fall 2013
- RRC staff schedules self-study dates for phase 2 programs (will begin 7/2015)
  - notify programs spring 2013
  - programs with adverse accreditation or short cycles will be scheduled for traditional site visit no later than 1/2014
NAS Timeline for CRS

• Training phase begins 7/2013
  - RRC reviews all data for all programs (includes 2013 surveys, annual ADS update info, case log reports, milestone reports): does not ‘count’
  - RRC determines benchmarks for follow-up actions (e.g., progress report, focused site visit, etc.)
  - Programs establish process for use of milestone reporting tools
• Enter NAS 7/2014
• First self-study visits begin 7/1/2015