Implementing the Next Accreditation System for Colon and Rectal Surgery Programs

Bruce A. Orkin, MD, RRC Chair
Pamela Derstine, PhD, MHPE, Executive Director

ACGME Webinar
November 6, 2013
Discussion Topics

1. RRC: Membership and Accreditation Statistics
2. Program Requirements and Minimum Numbers
3. CRS Case Log System
4. Milestones and the Next Accreditation System
1. RRC: Membership and Accreditation Statistics
RRC Membership

- 7 voting members
  - ABCRS – 2 members
  - ACS – 2 members
  - AMA (CME) – 2 members
  - 1 resident member

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  - Anthony J. Senagore, MD, Vice-Chair (AMA)
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• Anthony J. Senagore, MD **RRC Vice-Chair**
• Matthew G. Mutch, MD
• Michael J. Snyder, MD
• Michael J. Stamos, MD
• Jacquelyn Seymour Turner, MD Resident Member
• Charles H. Whitlow, MD
• Patrice G. Blair, MPH Ex-Officio ACS
• David J. Schoetz, Jr, MD Ex-Officio ABCRS

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- Russell W. Farmer, MD
  (replacing Jacquelyn Turner, MD)
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  Executive Director
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  Associate Executive Director
• Jennifer M. Luna  
  Accreditation Administrator
• Deidre M. Williams*  
  Accreditation Assistant

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WebADS Representative
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- Senior VP for Hospital-based Accreditation: Louis J. Ling, MD
- Senior VP for Medical Accreditation: Mary Lieh-Lai, MD, FAAP, FCCP
- Senior VP for Institutional Accreditation: Kevin B. Weiss, MD
ACGME and RRC New Structure

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- Medical Genetics
- Nuclear Medicine
- Pathology
- Preventive Medicine
- Radiation Oncology
- Transitional Year

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### Accreditation Statistics

#### Total # Accredited Programs

<table>
<thead>
<tr>
<th># Core</th>
<th>55</th>
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#### Total # Residents/Fellows

<table>
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<th>90</th>
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# Accreditation Statistics

<table>
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<tr>
<th>Status</th>
<th># Programs</th>
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<tbody>
<tr>
<td>Continued Accreditation</td>
<td>48</td>
</tr>
<tr>
<td>Continued Accreditation w/ Warning</td>
<td>3</td>
</tr>
<tr>
<td>Initial Accreditation</td>
<td>3</td>
</tr>
<tr>
<td>Initial Accreditation w/ Warning</td>
<td>1</td>
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<tr>
<td>Probation</td>
<td>0</td>
</tr>
<tr>
<td>Withhold</td>
<td>0</td>
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</table>
Accreditation Statistics 2013

### Other RRC Meeting Decisions

<table>
<thead>
<tr>
<th>Decision</th>
<th>Requested/Approved</th>
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<tbody>
<tr>
<td>Complement increases</td>
<td>4/1</td>
</tr>
<tr>
<td>Progress/Reports</td>
<td>14/3</td>
</tr>
<tr>
<td>Case Log Reviews</td>
<td>53*</td>
</tr>
</tbody>
</table>

*RRC began annual case log reviews September 2012. Beginning with the 2013/14 graduates, case log reviews will take place at the February RRC meeting.*
2. Program Requirements and Minimum Numbers
Program Requirements Revision

1. Why and why now?

2. Overview of the new PRs
Program Requirements Revision

From the *ACGME Policies and Procedures*

15.20 Major Revision of Existing Requirements
a. Review Committees must review existing requirements every five years…
b. The Following Procedures Apply:
   …

1996 Last major revision
2001 Revision was due
2007 Common Requirements updated

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Program Requirements Revision

Common Program Requirements (CPR) [BOLD] vs specialty specific requirements [Regular]

IV.A.5. ACGME Competencies
The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

IV.A.5.a).(1) must demonstrate proficiency in the evaluation and management of patients with all of the essential colon and rectal surgical disorders.

IV.A.5.a).(1).(a) Proficiency in evaluation and management must include:

IV.A.5.a).(1).(a).(i) preoperative diagnosis, indications, alternatives, risks and preparation;
Program Requirements Revision

Problems with the current PRs – *Not Specific to CRS*

- 1996 document - 10 – 9 vague, difficult to understand, difficult to enforce
- Hard to measure up to “standards” that are not written out

2011 document - > 50 specific, in addition to listing diagnoses and procedures
Program Requirements Revision

Changing environment

- Evolving GME and competencies
- Changing spectrum of practice
- Need to define the specialty
- Need for educational standards

- Blue Ribbon Commission 2006-08 recs
- ABCRS minimum requirements
Program Requirements Revision

Goals

- Wide range of input – stakeholders
  RC, PDs, ABCRS, ASCRS, field leaders
- Multiple input opportunities
- Transparency
- Specificity, clarity – PRs, FAQs, PIF
- Streamline process and forms
# Program Requirements Revision Process

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2008</td>
<td>Blue Ribbon Commission work</td>
</tr>
<tr>
<td>3/28/08</td>
<td>RRC meeting - Process initiated, sub-committee appointed</td>
</tr>
<tr>
<td>5/21/08</td>
<td>Initial review of materials</td>
</tr>
<tr>
<td>6/12/08</td>
<td>Conf call PR sub-committee</td>
</tr>
<tr>
<td>9/19/08</td>
<td>RRC meeting - Minimum numbers reviewed</td>
</tr>
<tr>
<td>11/29/08</td>
<td><strong>1st request for comments – general, sent to PDs</strong></td>
</tr>
<tr>
<td>1/5/09</td>
<td>Input RRC, PDs, ABCRS, ASCRS and prior RRC members reviewed</td>
</tr>
<tr>
<td>2/19/09</td>
<td>PR v1 completed</td>
</tr>
<tr>
<td>3/20/09</td>
<td>RRC Meeting</td>
</tr>
<tr>
<td>3/23/09</td>
<td><strong>2nd request for comments - PR v2 posted ACGME.com, PDs notified</strong></td>
</tr>
<tr>
<td>4/27/09</td>
<td>PR v4 and issues sheet sent to RC</td>
</tr>
<tr>
<td>5/2/09</td>
<td><strong>3rd commentary – PDA presentation</strong></td>
</tr>
<tr>
<td>7/3/09</td>
<td>Request for comments Min Numbers v 1 e-mailed</td>
</tr>
<tr>
<td>7/20/09</td>
<td>PR v 7 First full RDC review completed</td>
</tr>
<tr>
<td>8/1/09</td>
<td><strong>4th request for comments - PR v7, sent to PDs</strong></td>
</tr>
<tr>
<td>9/6/09</td>
<td>PR v8, FAQs v1, Min Numbers v2 to RRC</td>
</tr>
<tr>
<td>9/25/09</td>
<td>RRC meeting</td>
</tr>
<tr>
<td>10/1-11/15/09</td>
<td><strong>5th request for comments – formal 45 day review period, PDs notified</strong></td>
</tr>
<tr>
<td>1/25/2010</td>
<td>PR v8 Second full RDC review</td>
</tr>
<tr>
<td>3/20/10</td>
<td><strong>RRC meeting – PR v9, Min Numbers v3, FAQs, PIF v3 approved</strong></td>
</tr>
<tr>
<td>4/10</td>
<td>RDC Approved and sent to ACGME for final approval</td>
</tr>
<tr>
<td>6/18/10</td>
<td>ACGME BOD meeting – final approval pending</td>
</tr>
<tr>
<td>7/1/2011</td>
<td><strong>Implementation begins</strong></td>
</tr>
<tr>
<td>Program Requirements</td>
<td>9 major versions, dozens of sub-versions</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Minimum Numbers</td>
<td>3 versions</td>
</tr>
<tr>
<td>Separate document</td>
<td></td>
</tr>
<tr>
<td>PIFs</td>
<td>3 versions</td>
</tr>
<tr>
<td>FAQs</td>
<td>5 versions</td>
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</tbody>
</table>

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Program Requirements Revision
Changes

- Program Director
  - Support
  - Qualifications
  - Coordinator
- Faculty - Qualifications
- Resident Eligibility
- Educational Program
  - ACGME Competencies
  - Case Numbers
- Residents’ Scholarly Activities
- Evaluation

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Program Director - Qualifications

- Certification by the American Board of Colon and Rectal Surgery, or specialty qualifications that are acceptable to the Review Committee
- Current medical licensure and appropriate medical staff appointment
- 3 years of clinical practice in colon and rectal surgery.
- 3 years of prior experience as a faculty member
- Membership on the medical staff

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Faculty

- Minimum of 3 FTE ABCRS-certified faculty members

- At least one faculty member must be
  - actively involved in regional or national specialty societies
  - active in scholarly inquiry

  Research performed by the resident must not substitute for active faculty involvement

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ACGME Competencies

1. Patient Care
2. Medical Knowledge
3. Practice-based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-based Practice

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ACGME Competency
1. Patient Care

- Residents must demonstrate proficiency in the evaluation and management of patients with all of the essential colon and rectal surgical disorders.
- Residents must demonstrate a high level of skill and dexterity in the performance of all essential colon and rectal surgical procedures.
ACGME Competency
2. Medical Knowledge

• Residents must demonstrate expertise in their knowledge of the *anatomy, embryology and physiology of the colon, rectum, anus and related structures.*

  AND

• Residents must demonstrate *competence* in their knowledge of the *essential colorectal disorders.*

• Residents must demonstrate *substantial familiarity* with additional colon and rectal surgery-related issues.

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“Essential” vs “Substantial Familiarity”

Essential disorders and procedures
➢ those that are integral to the practice of CRS and are explicitly the province of colon and rectal surgeons. They are common enough that all residents should have formal instruction in and clinical experience with all during their 12 months of training, leading to proficiency.

Substantial Familiarity
➢ disorders and procedures that are within the province of CRS but not all residents may have the opportunity to actually see during their residency. This requirement specifies that residents must become familiar with these entities so that, if encountered in clinical practice, they will recognize them and will be able to manage them directly or by referral.
Curriculum and Experience

IV.A.6.f) Residents must participate in the evaluation and treatment of patients with the following diagnoses:

- **110** - anorectal and physiologic disorders including hemorrhoids, fistulas, abscesses, fissures, constipation, incontinence and pelvic floor problems; and

- **215** - abdominal disorders including neoplasia of the colon, rectum and anus, inflammatory bowel disease, diverticular disease and rectal prolapse
IV.A.6.g) Overall case numbers:

- **120** abdominal operations
  - 30 laparoscopic resections
  - 30 pelvic dissections
- **60** anorectal operations, and
- **185** evaluation procedures
  - sigmoidoscopy/proctoscopy, anoscopy, ultrasound, pelvic floor evaluation, and
  - colonoscopies - 140 total including 30 interventional
- no more than 50% endoscopic procedures
3. Case Log System
Case Log Revision 2011

- More accurate collection of resident case data
- Attain the Minimum Case Numbers
- Diagnoses and procedures

Examples
- Pelvic dissections – includes IPAA, LAR, APR, TPC
- Colectomies – open, laparoscopic, ileocolic
- Laparoscopy
- Stomas

Reports specific to residents, PDs, RRC, ABCRS
Case Log

- Case Log program reports for all 2011-2012 graduates were reviewed and discrepancies noted (NOT CITED)
- Case Log program reports for all 2012-2013 graduates were reviewed and discrepancies noted cited
- Residents graduating 2012-2013 and beyond are expected to demonstrate compliance with the minimum numbers

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Case Log

• Both diagnoses and procedures are being counted. They will be tallied separately.

• All acceptable ICD9 and CPT codes are listed in the spreadsheet. *Do not use any other codes.*

• The RRC is not currently tracking office visits or consults (E&M codes). However, all *new diagnoses* are needed to assess your exposure to the broad spectrum of CRS.
Case Log

• Use the code that is closest to what was done. Not all ICD9 and CPT codes are available. Some have been altered to be more encompassing or to more clearly reflect current practice. A few have been entirely redefined to capture CRS diagnoses/procedures not currently assigned a code but that the RRC wishes to track.

See the lists.
Case Log

- Each case/encounter requires at least one diagnosis (ICD9) code and one procedure (CPT) code. If no procedure was performed, use the 99499 code for No Procedure Performed.

- Up to 2 diagnoses and 2 procedures may be entered per resident per case per day.
Case Log Data Flow

1. Residents enter cases
2. Programs monitor progress by utilizing reports
3. Residents graduate
4. Programs verify completing graduate data accuracy & electronically submit to ACGME
5. National Data Reports Created in ADS
6. Assess set minimums

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Case Log Development

Mobile Website:

acgme.org/mobilercl
Case log Development - continued
### Colon and Rectal Surgery

#### CRS Case Log Coding

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>Procedure Category</th>
<th>Defined Case Category</th>
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<tbody>
<tr>
<td>46288</td>
<td>Fistula, advancement flap repair, skin or mucosal</td>
<td>Anorectal Procedures</td>
<td>Endorectal Advancement Flap</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fistulotomy, fistula repair</td>
</tr>
<tr>
<td>46020</td>
<td>Fistula, seton placement only</td>
<td>Anorectal Procedures</td>
<td>Fistulotomy, fistula repair</td>
</tr>
<tr>
<td>46030</td>
<td>Fistula, seton/drain removal</td>
<td>Anorectal Procedures</td>
<td>Fistulotomy, fistula repair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>Procedure Category</th>
<th>Defined Case Category</th>
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</thead>
<tbody>
<tr>
<td>45395</td>
<td>Proctectomy, APR, Colostomy, laparoscopic</td>
<td>Abdominal procedures</td>
<td>Abdominoperineal resection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Laparoscopic resection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pelvic dissection</td>
</tr>
<tr>
<td>45110</td>
<td>Proctectomy, APR, Colostomy</td>
<td>Abdominal procedures</td>
<td>Abdominoperineal resection</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Stoma</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Laparoscopic resection</td>
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<td>Pelvic dissection</td>
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<th>Procedure Category</th>
<th>Defined Case Category</th>
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<tbody>
<tr>
<td>44385</td>
<td>Ileostomy, stoma or ileal pouch, diagnostic</td>
<td>Endoscopy/Pelvic Floor</td>
<td>Colonoscopy</td>
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<tr>
<td>44388</td>
<td>Colonoscopy via colostomy - Diagnosis/decompress</td>
<td>Endoscopy/Pelvic Floor</td>
<td>Colonoscopy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>Procedure Category</th>
<th>Defined Case Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>565.00</td>
<td>Fissure, anal</td>
<td>Disease Management</td>
<td>Anal fissure</td>
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<tr>
<td>565.10</td>
<td>Fistula, anorectal</td>
<td>Disease Management</td>
<td>Anal fistula</td>
</tr>
<tr>
<td>619.10</td>
<td>Fistula, entero-vaginal/recto-vaginal</td>
<td>Disease Management</td>
<td>Anal fistula</td>
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<td>153.5</td>
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<td>Carcinoma of the colon</td>
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<td>Carcinoma of the colon</td>
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<tr>
<td>154.10</td>
<td>Ca, rectum</td>
<td>Disease Management</td>
<td>Carcinoma of the rectum</td>
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### ACGME RRC for CRS Minimum Case Numbers

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<tr>
<th>SURGICAL MANAGEMENT</th>
<th>Effective 7/1/11</th>
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<tbody>
<tr>
<td>Anorectal Procedures (1)</td>
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</tr>
<tr>
<td>Hemorrhoidectomy - excisional any kind, PPH</td>
<td>20</td>
</tr>
<tr>
<td>Fistulotomy, fistula repair</td>
<td>20</td>
</tr>
<tr>
<td>Endorectal Advancement Flap</td>
<td>2</td>
</tr>
<tr>
<td>Sphincteroplasty</td>
<td>2</td>
</tr>
<tr>
<td>Internal Sphincterotomy</td>
<td>2</td>
</tr>
<tr>
<td>Transanal excision</td>
<td>10</td>
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<tr>
<td>Total AR</td>
<td>60</td>
</tr>
<tr>
<td>Abdominal Procedures (2)</td>
<td></td>
</tr>
<tr>
<td>Segmental colectomy (Include ileocolic resection)</td>
<td>50</td>
</tr>
<tr>
<td>Laparoscopic Resections</td>
<td>30</td>
</tr>
</tbody>
</table>
Colon and Rectal Surgery Case Log Instructions

Review Committee for Colon and Rectal Surgery

Background
The ACGME Case Log System is a data depository which provides a mechanism that supports programs in complying with requirements and provides a uniform mechanism to verify the clinical education of residents among programs. The Case Log System is designed to capture and categorize a resident’s experience with patient care. It was initially instituted in 2001, and the Review Committee for Colon and Rectal Surgery has required its use by accredited programs since 2005.

FAQs

Which codes should be used for case entry?
Only the codes listed in the document, CRS Case Log Coding.pdf, should be used. Only cases using the defined codes will be counted toward a resident’s case volume.

The Case Log System uses diagnosis (ICD9) and procedure (CPT) codes that were developed by the American Medical Association (AMA). These codes are commonly used for billing purposes by billers and insurers, and so are fairly detailed. Often the detail and specificity of
Case Log

- Accurate data entry is critically important, both for the residents and the program
- The PD and the coordinator need to be familiar with the system and must educate the residents from day one
- The PD should review the data at least quarterly to assess resident progress
- **Know the FAQs**
Case Logs:
Proposed Role Definitions

- Surgeon
- Teaching Surgeon
- Assistant
Case Logs: Proposed Role Definitions

Surgeon

- The resident must be present for the majority of the procedure and must perform the key or critical portions of the procedure under faculty supervision.
- Only one resident may claim this role per case.

Teaching Surgeon

- The resident must guide a more junior resident through a procedure in which the junior resident performs the key or critical portions of the procedure.
- The faculty surgeon acts as an assistant or observer, as appropriate.
Assistant Surgeon

- The resident must be present for the majority of the procedure and must act as the first assistant to the faculty member or resident surgeon performing the procedure.
- Only one resident may claim this role per case.
- The RRC recognizes that first-assisting at operations is an important part of the resident experience, particularly in complex or relatively uncommon cases.
Colon and Rectal Surgery

- Institutional Data Report Form
- CRS Case Log Coding
- CRS Minimum Case Numbers
- CRS Case Log Instructions
- Resident Complement

Program Requirements
- Currently in Effect
- Approved but not in Effect

Milestones
- Colon and Rectal Surgery

New Applications
New program applications must use the online application process within ADS. For further information, review the “Application Instructions” located under Common Resources.

Common Resources
- ACGME Glossary of Terms
- Application Instructions
Online Resources for Programs

RRC Website
- Colon and Rectal Surgery FAQs
- Common Duty Hour FAQs and Resources
- CRS Coordinator 2012 Workshop Presentation
- CRS Case Log Coding (guide to CPT code mapping)
- CRS Minimum Numbers
- CRS Case Log Instructions (Guidelines and FAQs)

ACGME e-Communication (weekly)

ACGME Website-Next Accreditation System
- Categorized CRS Program Requirements
- Policies and Procedures (eff. 7/1/2013)
4. Milestones and The Next Accreditation System
What Are Milestones?

- Observable steps on continuum of increasing ability
- Intuitively known by experienced specialty educators
- Organized under six domains of clinical competency
- Describe trajectory from neophyte to practitioner
- Articulate shared understanding of expectations
- Set aspirational goals of excellence
- Provide framework & language to describe progress

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ACGME Goal for Milestones

- Permits fruition of the promise of “Outcomes”
- Tracks what is important
- Begins using existing tools for faculty observations
- Clinical Competence Committee triangulates progress of each resident
  - Essential for valid and reliable clinical evaluation system
  - ACGME RCs track unidentified individuals’ trajectories
  - ABMS Board may track the identified individual
ACGME Milestones Project

Joint effort of
• the ABMS – American Board of Medical Specialties (ABCRS), and
• the ACGME – Accreditation Council for Graduate Medical Education (RC for CRS)

• Based on the six general competency domains
• Transition from time-based training to competency-based outcomes.
• An effort to break down training into definable, measurable points that can be taught and evaluated over time
• Specialty specific
Milestone Project – Value Added

- More explicit expectations of residents
- Increased resident self-assessment and self-directed learning
- Better feedback to residents
  observable, measurable behaviors
- Early identification of under-performers
- Guide curriculum development
CRS Milestone Development

ABMS

ACGME

ABCRS

ASCRS

PDA

RRC-CRS

Milestones Advisory Group
4 members

Milestones Working Group
8 voting members + additional experts
CRS Milestones Committees

Working Committee

- Charles Whitlow, MD – Chair, RRC
- Anthony Senagore, MD, RRC
- Glenn Ault, MD, PDA
- Gerry Isenberg, MD, PDA
- Jen Beaty, MD, PDA
- Jan Rakinic, MD, ABCRS
- Bert Chin, MD, PDA
- Resident Representative

Advisory Committee

- Eric Weiss, MD, RRC Chair
- Bruce Orkin, MD, RRC Vice Chair
- David Schoetz, MD, Dir ABCRS
- ASCRS
- PDA

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CRS Milestones (21)

- Benign Perianal Disease Processes MK & PC
- Colonic Neoplasia MK & PC
- Crohn’s Disease MK & PC
- Large Bowel Obstruction MK & PC
- Rectal Cancer MK & PC
- Rectal Prolapse MK & PC
- Rectovaginal Fistula MK & PC
- Pelvic Floor Disorders MK & PC
- Anatomy and Physiology MK
- IPCS (1); Professionalism (1); PBLI (1); SBP (1)
# Milestone Description: Rectal Prolapse – Patient Care

<table>
<thead>
<tr>
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Milestones

• Translate “general” competencies into **specific competencies** to be met by all residents
• Create “core” resident outcomes in the competencies, not “standardization” of all outcomes
• **MILESTONES ARE OUTCOMES, NOT ELEMENTS of a CURRICULUM**
  • Not intended to include all elements of training….IS a selective biopsy
  • Not intended to be an assessment form….IS a report of assessment results aggregated over the previous six months

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Milestones

Additional CRS Milestone Resources

• Colon & Rectal Surgery Examples (located on the milestones page of the NAS microsite)

http://www.acgme-nas.org/milestones.html

Educational Materials

- Colon and Rectal Surgery Examples
- Family Medicine Presentation
- Nuclear Medicine Examples
- Plastic Surgery Assessment Tools
- Preventive Medicine Milestone Assessment Method List
The Next Accreditation System

The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits more than 9,000 residency programs in 135 specialties and subspecialties in the United States, affecting more than 116,000 residents. Its mission is to improve health care in the U.S. by assessing and advancing the quality of graduate medical education for physicians in training through accreditation.

This website shares background and detail regarding the ACGME's next accreditation system, an outcomes-based accreditation process through which the doctors of tomorrow will be measured for their competency in performing the essential tasks necessary for clinical practice in the 21st century.
Why are we doing NAS?

- Help produce physicians for 21st century
- Accredit programs based on outcomes
- Reduce administrative burden of accreditation
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
NAS: What’s different?

- Standards revised every ten years
- No PIF’s
- Programs reviewed every year; accreditation status updated every year
- Citations still levied but may be quickly removed following review of new annual data, site visit (focused or full), progress report
- Scheduled (self-study) visits every ten years
NAS: What’s different?

- No site visits (as we know them)
- **Focused** site visits for an “issue”
- **Full** site visits for board issues (but no PIF)
- **Self-study** visits every ten years
Focused Site Visits

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

• Minimal notification given (30 days)
• Minimal document preparation expected
• Team of site visitors
• Specific program area(s) investigated as instructed by the RRC
Full Site Visits

- 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
Full Site Visits

- Minimal notification given (60 days)
- Minimal document preparation expected
- Team of site visitors
Ten Year Self-Study Visit

- Not fully developed
- Not a traditional site visit
- Implemented in 2016 for colon & rectal surgery programs
Ten Year Self-Study Visit

- Review of
  - annual program evaluations (PR V.C)
  - response to citations
  - faculty development
- Judge program success at CQI
- Learn future goals of program
- Will verify compliance with core Program Requirements

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Ten Year Self-Study Visit

Annual Program Evaluation (PR-V.C.)
- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan

Ongoing Improvement

Self-Study PROCESS

Self-Study VISIT

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When Is My Program Reviewed?

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

- Each Program requirement categorized:
  - Outcome - All programs must adhere
  - Core - All programs must adhere
  - Detail - Good programs may innovate
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Continued Accreditation

STANDARDS
Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

Accreditation With Warning

Continued Accreditation

STANDARDS
Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

Outcomes
Core Process
Detail Process

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

STANDARDS
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Core Process
Detail Process
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty

STANDARDS
Outcomes
Core Process
Detail Process

Withdrawal of Accreditation

Accreditation
Outcomes
Core Process
Detail Process

Continued Accreditation

Withdrawal of Accreditation

Probationary Accreditation

With Warning
Annual Data Reviewed by RRC

- Annual ADS Update
  - Program Changes – Structure and resources
  - Program Attrition – PD / core faculty / residents
  - Scholarly Activity – Faculty and residents
- Board Pass Rate – 5 year rolling average
- Clinical Experience – Case logs
- Resident Survey – Common and specialty elements
- Faculty Survey
- Semi-Annual Resident Evaluation and Feedback
  - Milestones
- Omission of data
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:** MIA  
**Last Name:** Smith

**Present Position:** Department Chairman  
**Medical School Name:** North Univ, Roos, CA

**Degree Awarded:** MD  
**Year Completed:** 1993

**Graduate Medical Education Program Name:**  
**State Program:**

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

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**Concise Summary of Role in Programs:**  
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] 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, American Urological Association
- [1998 - Present] Member, American Urological Society

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

- Names. Two popular treatment options for neurogenic bladder therapy. 2009 6:2, 133-134.

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

- Multi-institutional experience with sacral neuromodulation in children for dysfunctional elimination syndrome or neurogenic bladder with incontinence. Urological Annual meeting 2010 (presented by Katherine Hubert)
- Overactive bladder and Interstim Therapy, Advanved-Advanced Medical Technology Association, Washington, DC, 2008
- Stress Urinary Incontinence and prolapse, Case presentations and complications Urogynecology Society Annual meeting 2007
- Abdominal Sacral Colpopathy with Soft Polyurethane mesh is safe and effective at Three-Year Follow-Up. Names. SUMMA Postgraduate Day, 2006

If not ABMS board certified, explain equivalent qualifications for RC consideration:
# Scholarly Activity as Performance Indicator

## Templates for Scholarly Activity

### Faculty Scholarly Activity

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<th>Other Presentations</th>
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### Resident Scholarly Activity

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## Mouse-over definitions:
- Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012. List up to 4.
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Faculty Scholarly Activity

Enter Pub Med ID #’s


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**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

**Other Presentations**

- Enter a number: 1
### Faculty Scholarly Activity

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

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Faculty Scholarly Activity

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

Grant Leadership

3

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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.

Leadership or Peer-Review Role

Y

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Teaching Formal Courses

Answer: No
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

Answer Yes or No

N

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Scholarly Activity as Performance Indicator

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Categories for points: Peer Review Publication, Other Scholarly, Grantsmanship, Leadership / Peer Review, Education.
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Annual RRC Program Review

• Board Pass Rate – 5 year rolling average
  ➢ ABCRS has provided pass rates to the ACGME electronically for each year beginning with 2008 through 2012 for parts 1 and 2 for all programs
  ➢ ABCRS will provide an annual electronic update to the ACGME, beginning with the 2013 exam results
  ➢ Annual ABCRS reports to ACGME may preclude the need for programs to provide this information
Annual RRC Program Review

• Clinical Experience – Case logs
  - RRC began annual case log reviews in fall 2012 (pre-NAS)
    - compliance with minimums not required
  - RRC case log review fall 2013 (pre-NAS)
    - compliance with minimums required
  - RRC case log reviews will continue when specialty enters NAS in July 2014
    - NAS case log reviews will occur as part of the annual data review that takes place in spring
    - case logs for 2013-2014 graduates will be reviewed at the February 2015 RRC meeting
• Resident Survey – Common and specialty elements
  ❖ 7 survey question domains: duty hours; faculty; evaluation; educational content; resources; patient safety; teamwork
  ❖ 70% response rate required
  ❖ Aggregated non-compliant survey responses for each domain are reviewed; thresholds for non-compliance
Annual RRC Program Review

- **Faculty Survey** 5 question domains:
  - supervision and teaching
  - educational content
  - resources
  - patient safety
  - teamwork
  - Intended to mirror most resident survey questions and provide opportunity to compare responses by question domain
  - First survey completed: spring 2014
  - First RRC review of faculty survey data: spring 2015
Annual RRC Program Review

- **Milestones**
  - First milestone evaluation period: July – December 2014
    - Residents evaluated as usual by the program (competency-based, multiple evaluators)
  - First milestone reports to ACGME: Nov/Dec 2014
    - Collected evaluations reviewed by the CCC
    - CCC determines milestone level for each resident for each milestone
    - Milestone reporting will be done through a link in ADS (not yet available)
  - Second milestone reports to ACGME: May/June 2015
  - First RRC review of milestone data: spring 2016
Annual RRC Program Review

• Annual ADS Update

  ➢ Omission of data
    ∗ If any required annual ADS update information is missing, the program will be flagged by the NAS data system
    ∗ Data omission could result in an altered accreditation status
## NAS: Annual Data Submission

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- **Resident Survey**: Yr 1
- **ADS Update**: Yr 1
- **Case Logs**: Yr 0

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- Milestones: Yr 1 in Sep
- Faculty Survey: Yr 1 in Dec
- Resident Survey: Yr 1 in Jul
- ADS Update: Yr 1 in Jul
- Case Logs: Yr 0 in Sep

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Year 1 Data reviewed in February of Year 2

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NAS Timeline for Colon & Rectal Surgery

- Fall 2012: Program Requirements categorized
- Fall 2012: Milestones piloted
- Spring 2013: Milestones published
- Spring 2013: Most self-study dates assigned
- Training/Transition phase begins 7/2013
Transition Year

• Begin July 1, 2013
• Policies and Procedures: 7/1/2013
  http://www.acgme-nas.org/assets/pdf/FinalMasterNASPolicyProcedures.pdf

  - NO proposed adverse actions
  - Potential Actions (if currently accredited): progress report; focused site visit; continued accreditation; accreditation with warning; probation; complement reduction
Transition Year

• Training phase activities
  - RRC reviews all data for all programs at spring 2014 meeting (includes 2013 surveys, annual ADS update info, case log reports)
  - RRC determines benchmarks for follow-up actions (e.g., progress report, focused site visit, etc.)
  - Traditional program reviews for programs on probation, short cycle or initial accreditation (PIF-less); non-accreditation requests reviewed as usual (Fall 2013, Spring 2014 RRC meetings)
  - Programs establish process for use of milestone reporting tools (Clinical Competency Committees)

• Enter NAS 7/2014

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July 1, 2014: Begin NAS

Spring 2015 RRC Meeting
Data review of all programs includes:

- Spring 2014 Resident survey (AY 2013-14)
- Spring 2014 Faculty survey (AY 2013-14)
- June 2014 program graduates Case log reports (AY 2013-14)
- Fall 2013 ADS update (AY 2013-14)
- Milestone data not included
Milestones Timeline

NAS Program Activities

• Spring 2014: Form a CCC and prepare for milestone evaluations
• July – December 2014: First evaluation period
• Nov 1 – Dec 31 2014: First milestone evaluations submitted to ACGME (via ADS)
Milestones Timeline

NAS Program Activities

• January – June 2015: second evaluation period
• May 1 – June 15 2015: Second milestone evaluations submitted to ACGME (via ADS)

February 2016: RRC review of AY 14/15 data, including milestones
Clinical Competency Committee

New Common Program Requirements for Resident Evaluation (V.A.1)

- The program director must appoint the Clinical Competency Committee.
- CCC must have at least three program faculty
- CCC members may also include non-physician members of the health care team and residents in their final year
Clinical Competency Committee

New Common Program Requirements for Resident Evaluation (V.A.1)

- CCC activities include:
  - reviewing all resident evaluations completed by all evaluators semi-annually
  - preparing and ensuring the reporting of Milestones evaluations of each resident semi-annually to the ACGME
  - making recommendations to the program director for resident progress, including promotion, remediation, and dismissal

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Clinical Competency Committee

- Milestone data will be reported semiannually (Nov/Dec and May/June) via a link in ADS
- Programs should be forming their CCC now
- Faculty should be oriented to the milestones and faculty development in assessment should be provided
THANK YOU!