

RRC NEWS

PLASTIC SURGERY



Accreditation Council for Graduate Medical Education

DECEMBER 2011

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Review Committee Decisions October 2011 meeting of the Review Committee for Plastic Surgery

Plastic Surgery – Independent	
71 total programs; 11 programs reviewed	
Continued Accreditation	6
Progress Reports	4
Complement Changes	1

Plastic Surgery – Integrated	
31 total programs; 18 programs reviewed	
Initial Accreditation	13
Continued Accreditation	4
Complement Changes	1

Craniofacial Surgery	
5 total programs; 1 program reviewed	
Progress Reports	1

Plastic Surgery of the Hand	
16 total programs; 3 programs reviewed	
Continued Accreditation	1
Progress Reports	2

UPDATE: DEFINITION OF RESIDENT “SURGEON” FOR THE ACGME CASE LOG SYSTEM

The information that follows (pp. 2-3) was approved by the Review Committee and has been posted, [in full](#), on the [Committee’s web page](#) and on the Plastic Surgery Operative Log (PSOL).

(cont. p.2)

MEETING AND AGENDA CLOSING DATES

MEETING:	MAY 10-11, 2012
AGENDA CLOSING:	MARCH 1, 2012
MEETING:	OCTOBER 11-12, 2012
AGENDA CLOSING:	AUGUST 2, 2012
MEETING:	MAY 17-18, 2013
AGENDA CLOSING:	MARCH 8, 2013
MEETING:	OCTOBER 24-25, 2013
AGENDA CLOSING:	AUGUST 15, 2013

NOTIFICATION DEADLINES

5 DAYS AFTER MEETING:

E-MAIL NOTIFICATION OF REVIEW STATUS/
 CYCLE LENGTH AUTOMATICALLY SENT TO
 PROGRAM DIRECTOR AND DIO.

60 DAYS AFTER MEETING:

E-MAIL ALERT SENT STATING THAT LETTER
 OF NOTIFICATION IS POSTED IN ADS.

*UNTIL THE OFFICIAL LETTER IS POSTED IN ADS,
 REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/
 NOT PERMITTED TO DISCUSS THE COMMITTEE’S
 ACTION OR SPECIFIC DETAILS OF THE AREAS OF NON-
 COMPLIANCE.*

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Definition of a Resident “Surgeon” to be referenced when entering procedures into the ACGME Resident Case Log System

Basic Principle: To be recorded as the resident “surgeon” in the ACGME Resident Case Log System, a resident must be present for **all** of the critical portions of the procedure being logged, under the supervision of an attending surgeon. Involvement in the pre-operative assessment, intra-operative planning, and the post-operative management of that patient is critical to that participation. To be recorded as a resident “assistant” in the ACGME Resident Case Log System, a resident must be an active participant in the operative procedure. The attending surgeon remains responsible for resident supervision and patient care.

The coding of surgical procedures in the Resident Case Log System is based on the Current Procedural Terminology (CPT®). All procedures performed, as identified by the most recent CPT codes, may be added to the Resident Case Log System for a specific case, including the same CPT code multiple times, if appropriate, noting the clarifications listed below, and subject to Medicare unbundling rules.

Clarifications:

1. For bilateral procedures where a single CPT code is inclusive of both sides and there is only one single surgical approach (e.g., abdominoplasty), a plastic surgery resident/fellow completing **one** side of the operation may count that as **one** procedure in the Resident Case Log System. If a plastic surgery resident completes **both** sides of the procedure, he or she would still only count this as one case as resident “surgeon.”
2. For bilateral procedures where the CPT code includes only one side (e.g., reduction mammoplasty), or both sides, each through a separate surgical approach (e.g., rhytidectomy), a plastic surgery resident/fellow completing **both** sides of the operation may count **both** sides in the Resident Case Log System if his or her participation in the procedure meets the criteria for resident “surgeon” as described above. If two residents **each do one** side of a bilateral procedure, each resident can log the procedure once if his or her participation in the procedure meets the criteria for resident “surgeon” as described above.
3. In an operation that includes multiple procedures with the same CPT code (e.g., multiple flexor tendon repairs), a plastic surgery resident/fellow may record the role of “surgeon” for each of the procedures if his or her participation in the

procedures meets the criteria for resident “surgeon” described above. The following are exceptions to this rule:

- a. The “add-on” codes for additional areas of surgical wound preparation, adjacent tissue transfer, complex closure length, skin grafting, epidermal autografting, xenografting, and acellular dermal grafting **may be used a maximum of five times per case** in the Case Log System for Surgery.

EXAMPLE 1: A resident performing split thickness skin grafting on the chest of 300 cm² may log the first 100 cm² (CPT 15100) of the skin graft and the additional 200cm² (CPT 15101x2).

EXAMPLE 2: A resident performing surgical preparation and then split thickness skin grafting to bilateral arms (400 cm² on each side), may log CPT 15100 x1 (first 100 cm² of skin graft), CPT 15002 x1 (first 100cm² of surgical preparation), and then CPT15101 x 5 (the additional 500 cm² of skin graft). The resident **cannot** log the additional 200 cm² of skin graft **or** the additional areas of surgical preparation due to the limit of **five** “add-on” codes **per case**.

- b. Suction assisted lipectomy should be logged only based on the areas defined by the CPT codes, with each code used only **once per side** even if there are multiple access sites or areas addressed. A maximum of **five** suction assisted lipectomy codes may be used per case and must represent distinct anatomic areas.

EXAMPLE 3: A resident performing suction assisted lipectomy of the abdomen and back may log the CPT 15877 (suction assisted lipectomy; trunk) twice.

EXAMPLE 4: A resident performing suction assisted lipectomy of the bilateral medial and lateral thighs may only log the CPT 15879 (suction assisted lipectomy; lower extremity) twice, including each extremity only once despite the multiple sites on each extremity.

- c. The use of injectables, including neuromuscular blockers, fillers, and autologous fat, may only be logged **once per case**, independent of the number of sites or injections.

- d. In an operation that involves multiple procedures, more than one plastic surgery resident may record participation as the resident “surgeon,” provided that each resident performs the majority of the critical portions of one or more of the procedures. If there are multiples of the same procedure in one case (i.e., tendon or nerve repair), and each resident performs the major portion of one or more of the repairs, each resident may log that case as resident “surgeon.”
- e. In circumstances where a fellow (e.g., a hand fellow) oversees a plastic surgery resident in a procedure, **both** the fellow (as the teaching assistant) and the resident may log participation in the procedure as a resident “surgeon,” if the participation of each meets the criteria for resident “surgeon” as described above.
- f. If a senior plastic surgery resident oversees a junior plastic surgery resident on a particular case, **both** may log participation in the procedure as a resident “surgeon” if the participation of each meets the criteria for resident “surgeon” as described above.

ACGME RESIDENT SURVEY RESULTS

The annual Resident Survey for plastic surgery residents was administered during January and February, 2011. A total of 101 programs and 681 residents participated in the survey.

The survey results indicate highly engaged learning between faculty members and residents, as demonstrated in the survey’s “faculty” and “educational content” areas. The table below summarizes key responses from plastic surgery survey takers against the national averages for all specialties.

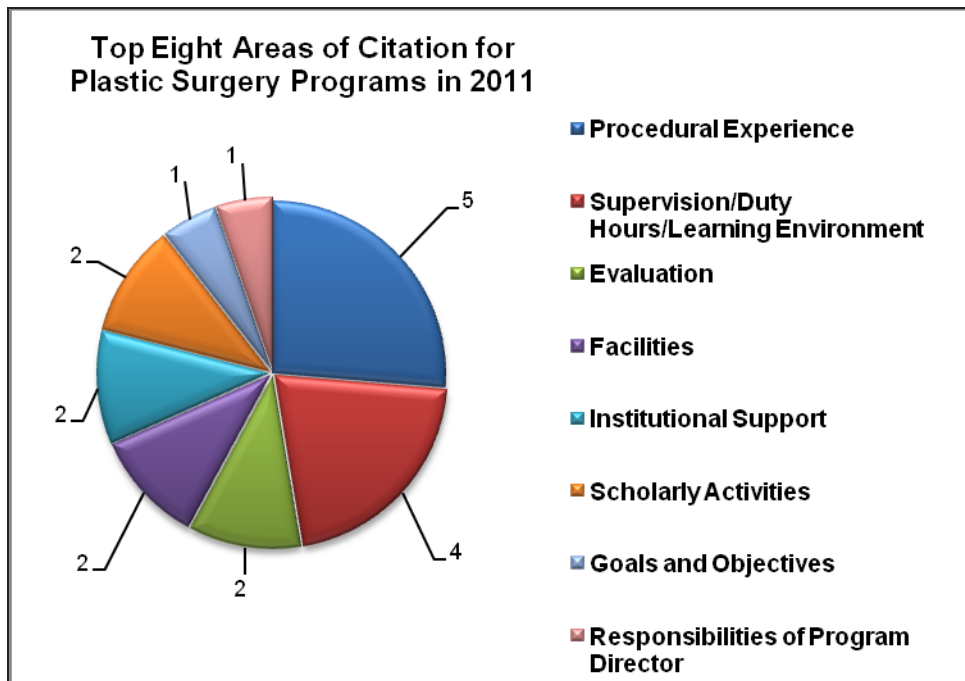
Content Area	National Average	PS Independent	PS Integrated
	All Specialties	Programs Average	Programs Average
		N = 71 programs	N = 30 programs
		335 residents	347 residents
(95.7% of all residents)		(98.6% of all residents)	
Faculty	96%	93.16%	94.52%
Evaluation	97%	88.20%	89.96%
Educational Content	91%	92.77%	94.42%
Resources	85%	90.46%	90.74%
Duty Hours	97%	96.90%	96.67%
Residents who would definitely choose current program again	56.60%	70.70%	75.20%
Residents who would probably choose current program again	30.90%	22.10%	19.90%
Residents who might or might not choose current program again	9.60%	4.20%	2.90%
Residents who would probably not choose program again	2.20%	2.40%	1.40%
Residents who would definitely not choose program again	0.70%	0.60%	0.06%

Results indicated a small number of programs require follow-up action in duty hours, as well as in the other areas covered by the survey questions. These programs should have received letters of notification regarding the Review Committee’s decisions about follow-up action by November 10, 2011.

BY THE NUMBERS: JANUARY-DECEMBER 2011 ACTIVITIES OF THE REVIEW COMMITTEE FOR PLASTIC SURGERY

- 36: number of programs reviewed (post-site visit)
- 3.6: average cycle length (includes 13 programs receiving initial accreditation cycles of three years or less)
- 19: citations
- 0.9: average number of citations per program review
- 33: administrative requests (program format changes, permanent increases)
- 45: interim requests (i.e., program director changes, participating site changes, temporary increases, program length increases)

(cont. p.4)



TRANSFER CRITERIA FOR INTEGRATED PROGRAMS DEFINED

1. Transfers into an integrated program will only be permitted as follows:
 - a. Beginning PGY-2: a transfer is permitted after completion of internship in any surgical specialty.
 - b. Beginning PGY-3: only residents who have completed at least two years of general surgery, integrated thoracic surgery, or another integrated plastic surgery residency may transfer.
 - c. Beginning PGY-4: only residents who have completed their graduate medical education in one of the traditional surgical pathways for the independent programs may transfer.
2. Vacancies in the receiving program must be documented and approved by the Review Committee.
3. The transferring resident must assume the responsibility of requesting approval from the American Board of Plastic Surgery (ABPS), and must provide the following to the Board for consideration:
 - a. verification of education form, from the *original* program director, documenting education provided; and,
 - b. verification from the *receiving* program director that the education received will be acceptable for the curriculum at the requested level of transfer.
4. Block diagrams of all completed rotations must be provided by the requesting program to the Review Committee.
5. If a temporary increase in complement is needed by the receiving program in order to accept the transferring resident, the request must be entered into the ACGME Accreditation Data System (ADS). Approval from the Review Committee must be received before the transferring resident enters the program.

COMMITTEE SUPPORT FOR ELIMINATION OF THE “COMBINED” PROGRAMS

In support of the ABPS decision to eliminate the “combined” program format, the Committee voted to amend the program requirements, eliminating PR Int.B.1.a):

“At least three years of clinical education with progressive responsibility in a single ACGME- or RCPSC-accredited surgery residency program. A transitional year or rotating internships may not be used to fulfill this requirement.”

This change to the program requirements was approved by ACGME Board of Directors at its October 2011 meeting, with an effective date of July 1, 2012.

The Committee defined the implementation of conversion procedures at its May 2011 meeting. “Combined” programs may:

- a. request that their programs be converted to an integrated format; or,
- b. remain an independent program.

The Committee agreed on the following timeline:

- Conversions may begin as early as July 1, 2012.
- The last conversion request will have a start date of July 1, 2015.
- The last start date for residents grandfathered into the “combined” format will have a start date of July 1, 2018.

If “combined” programs and their institutions wish to convert to an integrated program format, a site visit will not be required. If programs and institutions wish to add a second program format, then a site visit will be required.

To request a conversion from a “combined” to an integrated program format, submit the following items to the ACGME offices, to the attention of Dr. Peggy Simpson, Executive Director for the Review Committee for Plastic Surgery:

1. information regarding the proposed new complement (positions by PGY-level), an educational rationale, a new block diagram, a response to most recent citations, and a summary of major changes since the program’s last site visit;
2. a list of new participating sites which are not part of the current plastic surgery independent program rotation schedule;
3. goals and objectives for any new rotations (e.g., all of PGY-1-3 and any new PGY-4-6 rotations);
4. curriculum vitae for any new faculty members (e.g., faculty members not listed in the program’s most recent program information form (PIF));
5. a cover letter, co-signed by the designated institutional official (DIO) and the program director, describing the requested implementation timeline and commitment to current residents in the “combined” program; and,
6. signed letters noting support for and cooperation with the converted program from involved program directors/division heads/ department chairs of those new departments involved in the PG-1-3 years, and any new rotations in the PGY-4-6 years.

If programs in the “combined” formats wish to add both independent and integrated formats, a new PIF application for the integrated format must be submitted to the ACGME.

If programs in the “combined” format wish to convert to the integrated format, the independent format would be discontinued. Residents currently in the “pipeline” will finish their educations under the format promised when they entered the institution.

MONOGRAPH ON DUTY HOURS TASK FORCE

The AGGME has published a monograph entitled “The ACGME 2011 Duty Hour Standard Enhancing Quality of Care, Supervision and Resident Professional Development,” to which all members of the ACGME Task Force on Quality Care and Professionalism contributed. The monograph can be viewed at: <http://www.acgme-2010standards.org/pdf/monographs/jgme-monograph.pdf>.

DUALITY OF INTEREST TAKEN SERIOUSLY BY THE REVIEW COMMITTEE

While ‘*conflict of interest*’ implies a financial situation which can improperly influence the decision of the member of an organization, ‘*duality of interest*’ implies any other situation which can influence a decision. Examples of duality of interest for a Review Committee member can include being from the same state in which a program under review is located, having worked in an institution housing a program under review, or having a close relationship with the department chair or program director of a program under review. When reviewing programs, members of the Review Committee for Plastic Surgery recuse themselves when there is a duality of interest that might influence their decisions regarding a program’s accreditation status. Recusals always occur for those Committee members from the same state as the program under review to avoid any conflicts of interest. ACGME staff members provide periodic education on and monitoring of conflict and duality of interest for all Review Committees to ensure the policy on this issue is constantly in mind, and always governs the way in which business is conducted during meetings.

REQUESTS FOR VOLUNTARY WITHDRAWAL MUST BE SUBMITTED THROUGH ADS

ACGME policy permits a program or sponsoring institution to request voluntary withdrawal of accreditation when a decision has been made by that program or institution to discontinue participation in ACGME accreditation. Requests for voluntary withdrawal of accreditation must be submitted using ADS. Review Committee staff will not accept letters requesting this action sent directly to them. The program director initiates the request within ADS by

answering a series of questions, including: the proposed effective date which should coincide with the end of the current academic year; the reason for program closure; and a plan to place all active residents in other programs. Once submitted, ADS automatically generates an e-mail to the DIO requesting approval. Once the DIO approves the request, ADS notifies the Review Committee staff. After a staff member processes the request, the program director and DIO receive official notification, and the accreditation status is changed to voluntary withdrawal.

DIO approval of this request for voluntary withdrawal of the program or sponsoring institution finalizes the request, which means the program:

1. may not accept new residents/fellows
2. may not request “reversal” of the action (regardless of the proposed effective date)

The program or institution *may seek* accreditation at a future date by undergoing the application process pursuant to ACGME policy. See “[How to Apply for Accreditation in Eight Steps](#)” on the Program Director & Program Coordinator area of the [ACGME website](#) for an overview.

ACGME POLICY ON OUTSIDE VENDORS

Intermittently, the ACGME is made aware of an increased effort by software vendors, accreditation consultants, former employees, former Review Committee members, and other organizations, to solicit business from ACGME-accredited residency/fellowship programs and sponsoring institutions. The ACGME does not endorse any vendors of software, newsletters, educational services, consulting services or other products. We provide no information to these entities other than that which is publicly available on our website (accessed by going to: www.acgme.org; clicking “Search Programs/Sponsors”; clicking “Accredited Programs”; selecting the specialty/program; then click “View Details” to see the program’s contact information and general information about its accreditation, including accreditation status and approximate date of next site visit). Services provided by these outside vendors have no guarantee with regards to a program’s accreditation status.

PROGRESS REPORTS TO THE COMMITTEE

The Review Committee continues to remind program directors that progress reports should only be submitted for review upon request, as noted specifically in the accreditation notification letter. The Committee will not review unsolicited progress reports. Such reports will be administratively

acknowledged with no further action. It is also important to note that the Review Committee does not rescind (remove) citations from a program’s history upon review of a (requested) progress report. A progress report should update the Committee on how the program is addressing those areas identified for comment in the Committee’s request for the report. Citations can only be identified as corrected at the time of a full program review when they are thoroughly evaluated through the site visit and review of accreditation materials.

ACGME.ORG QUICK LINKS

- [ACGME Duty Hour Standards information and resources](#)
- [Virtual Program Director Handbook](#)
- [FAQs on Master Affiliation Agreements and Program Letters of Agreement](#)
- [Case Log Tutorials](#), or follow these steps from the ACGME [home page](#):
 1. Click “Data Collection Systems” from the left-hand main menu
 2. Click “Resident Case Log System” from the next drop-out menu
 3. Click “Case Log Information” from the next drop-out menu
 4. Select the top link on the next page (“New - Resident Case Log System Tutorials Web page”)
- [ACGME Data Book](#)

2012 ACGME Annual Educational Conference

Encouraging Excellence

March 1-4, 2012
Walt Disney World Swan and Dolphin
Orlando, Florida

Click [here](#) for more information
Registration Now Open

RRC NEWS PROVIDES TIMELY AND CURRENT REVIEW COMMITTEE AND SPECIALTY UPDATES, AS WELL AS GENERAL ACGME INFORMATION AND EXPLANATIONS OF ITS SYSTEMS, POLICIES, AND PROCEDURES. IT ALSO SERVES AS A VEHICLE FOR COMMUNICATION BETWEEN THE REVIEW COMMITTEE AND ITS CONSTITUENTS.

PLEASE CONTACT THE EDITOR WITH SUGGESTIONS OR COMMENTS ABOUT THIS NEWSLETTER: MSCHWAB@ACGME.ORG.

NEWSLETTERS ARE TYPICALLY AVAILABLE FOLLOWING A REVIEW COMMITTEE MEETING, BETWEEN ONCE AND THREE TIMES PER YEAR.