

Summer 2008

Surgery and Pediatric Surgery Program Requirements

Minor revisions to the Surgery and Pediatric Surgery program requirements were approved at the ACGME Board meeting in June 2008. The new requirements are effective August 10, 2008 and eliminate the need for a site visit when programs request a permanent increase in resident complement. Programs are still required to complete a change in resident complement in the Accreditation Data System (WebADS). All requests for a permanent increase in complement will be reviewed at an RRC meeting. Please note the meeting agenda closing dates as you plan your requests and their implementation (see page 7 of this newsletter). When making a request for an increase in resident complement, it is important to document the percentage of "uncovered" cases at participating sites.

RRC Welcomes New Chair and Vice-Chair

The Committee elected Thomas V. Whalen, MD as Chair and J. Patrick O'Leary, MD as Vice Chair for the July 1, 2008 through June 30, 2010 term.

In addition, the Committee re-appointed Adeline M. Deladisma, MD to serve a second one-year term as the resident member.

The following new members joined the RRC

on July 1, 2008

Timothy R. Billiar, MD
Linda M. Harris, MD
James C. Hebert, MD
George W. Holcomb, III, MD

The RRC wishes to congratulate the following members whose terms concluded on June 30, 2008 and thank them for their dedication and service to the RRC over the last six years:

Paul M. Colombani, MD
Jerry Goldstone, MD
Donald L. Kaminski, MD
Linda M. Reilly, MD, *Chair*

Resident Complement Requesting Changes

The Surgery program requirements state in III.B that all resident positions must be approved in advance by the Review Committee:

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program. All resident positions must be approved in advance by the Review Committee.

And, III.B.1 states further that:

Residency positions must be allocated to one

of these three groups: categorical, designated preliminary or nondesignated preliminary positions.

Both temporary and permanent increases in resident complement *for any of these groups* must be approved in advance by the Review Committee, including nondesignated preliminary positions and/or designated preliminary positions.

Designated and Non-Designated Preliminary Positions

A number of specialties have recently changed their program requirements so that the PGY-1 year is now included within the specialty. Surgery program directors may find they have an “open” designated preliminary position. The RRC allocates categories of position by year. If a program determines that they would like to request a re-allocation of a position (e.g., designated preliminary to categorical), a request for a permanent increase in complement would be required. Similarly, if programs determine they would prefer to eliminate the position, a request for a decrease in resident complement would be required.

Summary of Actions, June 2008

Surgery—251 Accredited Programs

30 Agenda Items	
Propose Probation	1
Initial Accreditation	1
Continued Accreditation	11
Other Administrative Decisions	15
Voluntary Withdrawal	2

Pediatric Surgery—35 Accredited Programs

5 Agenda Items	
Continued Accreditation	2
Deferrals	2
Other Administrative Decisions	1

Surgical Critical Care—89 Accredited Programs

11 Agenda Items	
Proposed Withhold	1
Initial Accreditation	3
Continued Accreditation	7

Vascular Surgery—97 Accredited Programs

10 Agenda Items	
Initial Accreditation (<i>Integrated Format</i>)	2
Continued Accreditation	5
Other Administrative Decisions	3

Hand Surgery—1 Accredited Program

No Agenda Items

Case Log Data Entry

All programs are required to enter data into the ACGME Case Log system. The RRC reminds program directors and residents that it is essential to enter all data, even after the minimum case numbers have been reached. The RRC uses the case log data to assist in deciding whether or not a program may temporarily or permanently increase its resident complement. The RRC also reviews historical case log data when making determinations about revisions to case requirements (both minimum numbers and categories).

Credit Roles for Surgery Residents

On a particular patient, on a given day, in the same operation situation, a senior resident may take credit as surgeon while another resident takes credit as a First Assistant; or, a senior resident may take credit as a Teaching Assistant while a more junior resident takes credit as a surgeon.

SC = Surgeon Chief Year; only cases credited as surgeon during 12 months of Chief Year.

SJ = Surgeon Junior Years; all cases credited as surgeon prior to Chief Year.

TA = Teaching Assistant; a PGY-4 or PGY-5 resident working with junior resident who takes

credit as surgeon.

FA = First Assistant; any instance in which a resident assists in an operation with another surgeon (an attending or more senior resident) responsible for the operation.

Duty Hour Exceptions Update

Based upon the extreme rare and type of requests received for duty hour exceptions, the RRC has decided that it will no longer approved duty hour exception requests, nor will it renew exceptions currently in effect.

Case Log Updates

The case log system staff is currently completing the 2008 reports. Once they finish processing the 2008 graduates, the online reports will be updated to show the 750 case minimum in general surgery, as well as the new minimum required number for endoscopy cases.

The following changes in the Vascular Case Log, Vascular and Endovascular Surgery defined category cases, and minimum numbers of procedures for Laparoscopy and Endoscopy are in effect for the 2009 graduating residents.

Vascular Case Log

At its June meeting, the RRC for Surgery approved a revised case log for vascular and endovascular procedures. Key elements of the reorganized case log include:

1. Incorporation of all new CPT codes available at that time, e.g., thoracic endovascular procedures, spine exposures, etc;
2. Elimination of the “endovascular therapeutic” category; all cases in that category—including stent-grafts, angioplasty, stent placement and atherectomy—have been moved into the appropriate section, such as aneurysm

repair, cerebrovascular cases, etc.; and,

3. Rearrangement of cases between and within categories for more intuitive organization.

Vascular and Endovascular Surgery Defined Category Cases

The RRC for Surgery reviewed the current distribution of defined category cases and approved the following for Vascular Surgery residents:

1. No change in the minimum required number of cases in the categories of abdominal, cerebrovascular, peripheral and complex;
2. An increase in the required minimum number of endovascular-diagnostic cases from 50 to 100;
3. An increase in the required minimum number of endovascular-therapeutic cases from 50 to 80;
4. A change in the “endovascular-graft” category to “endovascular aneurysm repair”, and an increase in the required minimum number of cases from 5 to 20; and,
5. Counting all endovascular therapeutic cases towards the required major case minimum.

To bring the minimum required number of total major operations into line with the above changes, the RRC proposes an increase in the required major case minimum number from 200 to 250. The RRC will initiate the process for revising this requirement by soliciting feedback from program directors. These decisions were based on a review of current (2005-06) 10th percentile vascular and endovascular procedural data.

The RRC expects that the new case requirements will become effective in July 2009. All residents completing vascular surgery residency programs in July 2009, regardless of pathway, will need to meet

these new guidelines. The Surgical Operative Log system will be updated to reflect these increases. This change will occur when processing of the 2006-2007 data is completed.

Minimum Numbers of Procedures for Laparoscopy, Endoscopy

The minimum number of procedures for basic laparoscopy has been raised from 34 to 60. The minimum number for complex laparoscopic procedures has been set at 25. All residents completing their education in June 2008 must meet these new guidelines for laparoscopy. The minimum for GI endoscopy has been raised from 29 to 85 (35 endoscopic and 50 colonoscopic). The revised guidelines for endoscopy are effective for all residents completing their education in June 2009.

Minimum case log numbers for laparoscopic and endoscopic procedures were included in the Program Requirements for Surgery effective July 1, 2007. Residents who began their program on July 1, 2007 are the first class of residents expected to meet these new minimum numbers.

ACGME Resident Survey

Every two years, all programs with four or more residents complete the ACGME Resident Survey. Results of this survey are made available to the program and the DIO for programs with a 70% or greater response rate. Programs with less than 70% response rates are resurveyed the following year.

The Resident Survey is used by the site visitor to spotlight key areas of concern as well as program strengths that the residents identified; the site visitor also uses the Resident Survey to help determine serious non-compliance with duty hour standards. Alternatively, compliance with duty hours, adequate supervision, and limiting excessive service are noted as key factors

that contribute to a high-quality learning environment for residents.

The RRC has requested that site visitors provide more detailed information regarding the verification of negative comments made in the numerical or comment sections of the Resident Survey, specifically, when the site visitor records that a concern is “not an issue” or “could not be verified.”

Results of resident surveys can be used as heuristic tools by program directors to improve the quality of residency education. National averages of resident surveys can be viewed on the ACGME website www.acgme.org, within the ADS section; program summary reports should be reviewed by individual programs during annual and mid-cycle internal reviews so that resident issues are identified and addressed in a timely manner.

“Program Director Guide to the Common Program Requirements”

To help clarify the meaning and expectations of the common program requirements, the “Program Director Guide to the Common Program Requirements” is available on www.acgme.org. The guide has been very helpful to both new and experienced program directors. Please email comments and suggestions to: Guide@acgme.org.

Program Review

The RRC meets three times a year, usually in the February, June, and October to review programs. Before each meeting, two RRC members are assigned to review each program. The paperwork is distributed over a two to three month period prior to the RRC meeting, and RRC members are complete their reviews within 30 days of receiving a program. All reviews must be received in the ACGME office eight weeks prior to the meeting to allow incorporation into the reviewer book. The reviewer book is sent to the RRC members before the meeting so that they may read all the

reviews, and compare the two reviews for each program.

After the RRC meeting, the ACGME staff prepare the notification letters for the program directors regarding the accreditation decisions reached by the RRC. Before these are posted on ADS, however, the RRC chair reviews each communication and compares it with a worksheet generated during the RRC meeting, make corrections as necessary, and then certifying the entire process by signature. The purpose of this review is to ensure that the citations and final accreditation decisions reflect the intent of the RRC.

Because of this process, some survey results completed in the month or so just before an RRC meeting will likely not be reviewed at that meeting, but will be delayed until the next RRC meeting four months later.

The RRC asks program directors to be mindful of this potentially lengthy interval between a site visit and the notification of a final accreditation decision.

Accreditation Data System

The ACGME's online ADS alerts the RRC to changes in programs. Program directors should update ADS to:

- Notify the RRC of any changes in their program (i.e., new program director or adding or deleting a site)
- Request a change which needs RRC approval (i.e., an increase in resident complement). The request for a permanent increase in the resident complement must include a copy of the institutional data for all participating sites. Only one academic or one calendar year of data is necessary.
- Submit the academic year "Annual

Update" (ADS staff will email the deadline for updating faculty and resident rosters)

- Prepare for an upcoming site visit (the ADS will populate many sections of the PIF with the data entered)

Address your questions or concerns about ADS to the ADS representative for Surgery, Emilio Villatoro at webads@acgme.org. Be sure to include your program number in the subject line when contacting Emilio for assistance with ADS.

ACGME Learning Portfolio

A number of resources are available for programs that want to become more familiar with the ACGME Learning Portfolio (ALP). http://www.acgme.org/acWebsite/portfolio/cbpac_faq.pdf: The Frequently Asked Questions (FAQs) (updated April 2008) include a description of the portfolio and its benefits to both residents and program directors, in addition to common concerns about using an online portfolio system. An updated timeline for development provides additional information on the alpha and beta testing phases. http://www.acgme.org/acWebsite/portfolio/cbpac_revisedtimeline.pdf. A narrated demonstration of the portfolio can be found at <http://www.acgme.org/acWebsite/portfolio/AlphaDemonstration.wmv>.

More information is available on the ACGME Learning Portfolio website:

http://www.acgme.org/acwebsite/portfolio/learn_cbpac.asp

Description of a DIO

DIO refers to the Designated Institutional Official. This individual has the authority and responsibility for all ACGME-accredited GME programs in your institution. The DIO signs the PIF and also receives a copy of the program's accreditation status. The DIO is required to co-sign most correspondence between the institution and the ACGME.

Voluntary Withdrawal Requests

Programs must now enter requests to voluntarily withdraw accreditation (VW) using ADS only.

Programs initiate the request by answering a series of questions, including the proposed effective date, the reason for program closure, and presenting a plan to place any active residents in other programs. The request is emailed to the DIO for approval. After the DIO/GMEC approves the request, the RRC staff designee is emailed. After the program receives official notification from the RRC and the accreditation status is changed to VW, the request will automatically be removed from the report.

ACGME Educational Conference 2008 Recap

Each year, the ACGME Annual Educational Conference provides a venue for graduate medical educators to learn more about the accreditation process and ways to enhance residency program quality related to ACGME initiatives, such as general competencies, educational outcome assessment, and duty hours. This year's conference theme "Building Community, Improving Quality" emphasized how better education and better patient care can occur when individuals in diverse roles work together toward shared goals.

Post-conference information is available at: http://www.acgme.org/acWebsite/meetings/me_EducConf_08.asp

Save the date for the 2009 ACGME Annual Educational Conference, March 5-8, in Grapevine, TX.

"Red Flags" Help Programs Recognize Potential Issues
In the February 2008 issue of the [ACGME e-Bulletin](#), an article entitled "*Nine 'Red*

Flags' in Accreditation Site Visits and Reviews" by members of the ACGME Field Staff provides observations that may raise questions about program quality and compliance with program and institutional requirements. This may be of interest to programs preparing for upcoming site visits.

Preparing for a Site Visit

To help ensure a successful site visit, program directors are advised to prepare thoroughly. The ACGME Field Staff recommend that program directors should be aware of changes in requirements and the site visit process; the ACGME web site, DIO News, ACGME Bulletin, and the RRC/IRC Executive Director are good resources for the most current information. Program directors should also ensure that an internal review occurs at the mid-point between the last review and the next visit date. This candid feedback can help improve and strengthen the program.

Further pre-planning for a site visit should ensure that the program director, Chair, Chief, DIO, key faculty and peer-selected residents (as a group) are available for interview. Program directors should plan appropriately for the site visitor to review documents, tour the facility, and allow time for clarification and concluding the session. Site visitors expect that the education and training competencies are aligned, and that goals and objectives for the program and for each rotation are sequenced in competency format.

Program directors are encouraged to invest time and effort to produce a consistent, fully completed, and accurate PIF.

Internal Reviews

The sponsoring institution is required to conduct an internal review of each residency program under its purview at approximately the midpoint of the accreditation cycle (the time between the date of the most recent accreditation action and the next scheduled site visit). The institution assembles an internal review committee, which

must include at least one faculty member and at least one resident, who cannot be from the program that is being reviewed. The process involves interviews with the program director, key faculty members, peer-selected residents from each level of training, and other individuals, as appropriate. Frequently, it includes review of data, such as how the program has addressed the citations from the last accreditation survey.

The goal of the internal review is a thorough and candid assessment that identifies the program's strengths and opportunities for improvement, and allows resolution of any concerns or problems before the program's next accreditation site visit. The responsibility for timing and completion of the internal review lies with the sponsoring institution. At the same time, program directors and residents should be familiar with the process because they may be asked to participate in future internal reviews.

Neither the site visitor nor the RRC reviewer sees the data from the internal review, which is not included with the program information form (PIF). Verification of the internal review during the site visit covers the date, the participants, and the review which is presented to the institution's graduate medical education committee (GMEC). In order to ensure an unbiased assessment of program strengths and opportunities for improvement, site visitors verify that the internal review was completed in a timely manner, but they do not look at the results of the internal review.

RRC Meeting and Agenda Closing Date

Meeting: Feb 19-20, 2009
Agenda Closing: Dec 19, 2008

Meeting: June 25-26, 2009
Agenda Closing: April 10, 2009

Review Committee Members

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Timothy R. Billiar, MD
G. Patrick Clagett, MD
Adeline M. Deladisma, MD, *Resident*
Peter J. Fabri, MD
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Mark A. Malangoni, MD
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