



Update: RC-Surgery and ACGME

Association of Residency Coordinators in Surgery

Association for Surgical Education - Annual Meeting

San Diego, CA

19 April 2017

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Disclosures

No financial conflicts to disclose



Objectives

- RC Update
- Program Requirement Revisions - specialty
- New FAQs
- Single Accreditation System
- Milestones
- Self Study and the 10-yr Accreditation Site Visit
- Common Program Requirements



ACGME

Review Committee Update



Review Committee

Steven Stain, MD*

Chair

Paula Termuhlen, MD**

Vice Chair

Jeff Matthews, MD

Incoming Chair

John Armstrong, MD*

George Fuhrman, MD

David Han, MD

David Herndon, MD**

Joe Mills, MD

Kristy Rialon, MD*, *Resident*

John Ricotta, MD*

David Rubenstein, *Public*

Joe Stella, DO

Danny Takanishi, MD**

Richard Thirlby, MD

Tom Tracy, MD

*Term ending 2017. **Term ending 2018



Review Committee

Ex Officio Members:

Mark Malangoni, MD, ABS Patrice Blair, ACS

Incoming Members - 2018:

Robert Cromer, MD

Mary Fallat, MD

Pam Lipsett, MD

Edward Shipper, MD, *Resident*

James Valentine, MD



Overview Program Accreditation

Core Residency Programs

	Accredited Programs	Application	Approved Positions	Filled Positions
Surgery	272	2	9050	8151
DO Surgery Programs	8	46	Pre-Accreditation or Continued Pre-Accreditation	
Int. Vascular	53	0	310	260

Current programs and resident/fellow complement (as of the date of this report)



Overview Program Accreditation

Sub-specialty Programs

		Accredited Programs	Application	Approved Positions	Filled Positions
Subspecialties	Ind. Vascular	107	0	294	241
	CGSO	24	1	119	105
	SCC	117	1	288	258
	Pediatric Surgery	48	2	89	82
	Hand	1	0	8	8

Current programs and resident/fellow complement (as of the date of this report):



Overview Program Accreditation

Accreditation status summary (as of the date of this report):

	Initial	Initial w/ Warning	Continued	Continued w/o Outcomes	Continued w/ Warning	Probation or Withdrawn
Surgery	19	0	232	2	12	7
Int. Vascular	3	2	46	1	0	1
Sub-specialties	Ind. Vascular	2	0	99	4	1
	CGSO	5	2	16	1	0
	SCC	7	1	109	0	0
	Pediatric Surgery	2	1	43	1	1
	Hand	0	0	0	0	1



Most Frequent Areas of Non-Compliance

Educational Environment:

- Faculty interest in education
 - Environment of inquiry/working with resident on scholarly activity
 - Service over education
 - Process to deal with problems and concerns/Fear of retaliation
 - Resident involvement in QI/PS projects
-



Most Frequent Areas of Non-Compliance

Evaluations:

- Timely feedback
- Rotation evaluations (substantive)
- Semiannual evaluations
 - Milestones assessment
 - Case log review
 - Reviewed with and available to resident



Most Frequent Areas of Non-Compliance

Operative Experience:

- Missed minimums
 - Complex cases
 - Non-operative trauma



Most Frequent Areas of Non-Compliance

Annual Program Evaluation:

- Confidential program evaluation
- Confidential evaluation of faculty
- Action plan
 - Established and updated annually



Most Frequent Areas of Non-Compliance

Program Director and Faculty:

- Accurate and complete information
- Scholarly activity
- Faculty development (as reported on Faculty Survey)



Other Issues

Increasing frequency:

- Resident complement over the approved per year complement
 - Preliminary positions are interchangeable between PGY-1 and PGY-2 - no approval required
 - Categorical positions not interchangeable
- Chief resident rotations at non-integrated sites
- Residency coordinators with multiple programs and >20 residents without assistance



Program Requirement Revisions-Surgery (eff. 7/2017)

Continuum of Care:

Multiple requirements pertaining to the resident's need to be involved in the continuum of care

Please review the “tracked changes” version of the program requirements at:

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/440_general_surgery_2017-07-01_TCC.pdf



Program Requirement Revisions Surgery (eff. 7/2017)

Program Director Change:

II.A.1.b) - The Review Committee must approve the qualifications of the program director. (Core)

Once submitted for approval, ADS will reflect “pending approval” for 30-days.

Program may receive a request for additional information, i.e. scholarship, leadership experience, certification.



Program Requirement Revisions Surgery (eff. 7/2017)

Faculty Development:

II.B.6 - Faculty members, including the program director, must regularly participate in faculty development activities related to resident education, including evaluation, feedback, mentoring, supervision, or teaching. (Core)

V.C.2.b).(1) The program must provide documentation of faculty member participation in annual faculty development activities relating to resident evaluation and teaching. (Core)



Program Requirement Revisions Surgery (eff. 7/2017)

Teaching Assistant Cases:

IV.A.6.b).(4) - When justified by experience, a PG 4 or PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision.



Program Requirement Revisions Surgery (eff. 7/2017)

Certification Examination Pass Rate:

- No change for ABS 1st time pass rate
- New - 1st time pass rate for American Osteopathic Board of Surgery - Surgery (AOBS-S)

Qualified osteopathic trainees may take either the ABS or
AOBS-S examinations

First-time pass rate of 65% on the certifying examination and
65% on the qualifying examination for the preceding 5-years



Review and Comment

Surgery - **closed 12 April 2017**

II.A.4.w) The program director must ensure that each resident has at least 850 major cases across the five years of training. This must include a minimum of 200 major cases in the resident's chief year. (Core)



Review and Comment

Change in PR II.A.4.w) aligns with the ABS operative requirements effective with residents graduating in the 2017-2018 AY:

≥ 850 OP procedures in 5-yrs as operating surgeon

≥ 200 OP procedures in chief year

≥ 40 cases in SCC, w/ at least 1 in each category

Review Committee will apply these new minimums to the annual review in
January 2019

Category	Current minimum	Median (2013-15)	10 th percentile (2013-15)	Proposed minimum
Skin, Soft Tissue	25	47	26	25
Breast		60	31	40
Head and Neck	24	20 (no endocrine)	9 (no endocrine)	25
Alimentary Tract	72	244	174	180
Esophagus		9	3	5
Stomach		29	15	15
Small intestine		35	20	25
Large intestine		60	25	40
Appendix		55	25	40
Anorectal		27	13	20
Abdominal	65	314	235	250
Biliary		119	73	85
Hernia		120	82	85
Liver	4	8	4	5
Pancreas	3	9	3	5
Vascular	44	103	60	50
Endocrine	8	29	15	15
Operative Trauma	10	23	12	10
Non-operative Trauma	20	28	20	40
Thoracic	15	34	18	20
Pediatrics	20	25	14	20
Plastic	5	17	7	10
Surgical Critical Care	25	72	21	40
Laparoscopic Basic	60	166	101	100
Endoscopy	85	119	95	85
Upper Endoscopy	35	40	20	35
Colonoscopy	50	56	50	50
Laparoscopic Complex	25	104	60	75
Total Major Cases:	750	996	821	850
Chief year Major Cases	150	230	171	200
Teaching Ass't Cases	25	32	8	25

5 mastectomies, and 5 axilla
10 thyroid or parathyroid

10 vascular access
10 vascular anastomosis,
repair or endarterectomy

10 resuscitations as team
leader

5 thoracotomies



Review and Comment

Surgery - **closes 12 April 2017**

IV.A.6.a).(2).(c).(i) Knowledge of burn physiology, and experience with initial burn management is required. (Core)

Residents must have clinical exposure to initial burn management - not just didactics



Review and Comment

Surgery - **closed 12 April 2017**

IV.A.6.B).(4) When justified by experience, a PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision. TA cases may not count towards the 200 minimum cases needed to fulfill the operative requirements for the chief resident year. The junior resident performing the case will also be credited as surgeon for these cases. (Detail)



ACGME

Single Accreditation System



Single Accreditation System

**AOA ceases accreditation
of GME 30 June 2020**

**Application window closes 30
June 2020**

**Programs began 01
July 2015**

**Institutions began 01
April 2015**

<http://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System>



Single Accreditation System

Program	Program Director	Status	Accreditation Effective Date
HealthONE/Swedish Medical Center Program	Emmett McGuire, MD	Initial Accreditation	01 July 2016
Berkshire Medical Center Program	Michael DiSienna, DO	Initial Accreditation	01 July 2016
Botsford Hospital Program	John D. Parmely, DO	Initial Accreditation	01 July 2016
Flushing Hospital Medical Center Program	Nageswara Mandava, MD	Initial Accreditation	01 July 2016
Mercy St Vincent Medical Center Program	Constance P. Cashen, DO	Initial Accreditation	01 July 2016
Metro Health Hospital Program	Karlin E. Sevensma, DO	Initial Accreditation	01 July 2016
Henry Ford Allegiance Health Program	Mohan Kulkarni, MD	Initial Accreditation	01 July 2016
Geisinger Health System (Wilkes Barre) Program	Joseph J. Stella, DO	Initial Accreditation	01 July 2016

<https://apps.acgme.org/ads/Public>



Single Accreditation System - Eligibility

Program is accredited if status is:

Initial Accreditation

Continued Accreditation

Program not accredited if status is:

Pre-Accreditation

Continued Pre-accreditation

Initial Contingent



Single Accreditation System - Eligibility

Vascular Surgery

- Independent
 - ...completed an ACGME or RCPSC-accredited surgical residency
- Early Specialization Program
 - ...completed four years of an ACGME-accredited surgery residency that has pre-approval by the RC...



Single Accreditation System - Eligibility

Surgical Critical Care

- ...completed at least three clinical years in an ACGME-accredited program.

Pediatric Surgery

- ...completed general surgery program accredited by the ACGME or RCPSC....



Single Accreditation System - Eligibility

Complex General Surgical Oncology

- ...completed general surgery program accredited by ACGME or RCPSC...

Hand

- ...completed ACGME, AOA, or RCPSC program in general surgery, orthopaedic surgery, or plastic surgery



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Milestones



Milestones

- Surgery begins review and revision in 2017
- Survey to all program directors via APDS
 - Coming soon
- Call for volunteers to participate
- Anticipate 18-24 month process
- For questions: milestones@acgme.org

<http://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview>



Self Study 10-year Accreditation Review



Self-Study

Objective,
comprehensive
evaluation of the
program, with the aim
of improvement

Guide and materials
available on the
ACGME website

<http://www.acgme.org/What-We-Do/Accreditation/Self-Study>

The screenshot shows the ACGME website's navigation and content for the Self-Study page. At the top, there is a navigation bar with links for 'ABOUT US', 'CONTACT US', and 'NEWSROOM', along with social media icons for Twitter and LinkedIn. A search bar is located on the right side of the navigation bar. Below the navigation bar, the ACGME logo and name are displayed. A horizontal menu contains several categories: 'What We Do', 'Designated Institutional Officials', 'Program Directors and Coordinators', 'Residents and Fellows', 'Meetings and Events', 'Data Collection Systems', and 'Specialties'. The 'What We Do' category is selected. The main content area features a breadcrumb trail: 'Home > What We Do > Accreditation > Self-Study'. The title 'Self-Study' is followed by a sub-heading 'Eight Steps for Conducting The ACGME Program Self-Study'. The text explains that the suggested eight-step sequence is intended to offer guidance to programs conducting their first self-study. It describes the self-study as an objective, comprehensive evaluation of the residency or fellowship program, with the aim of improving it. Underlying the self-study is a longitudinal evaluation of the program and its learning environment, facilitated through sequential annual program evaluations that focus on the required components, with an emphasis on program strengths and "self-identified" areas for improvement ("self-identified" is used to distinguish this dimension of the self-study from areas for improvement the Review Committee identifies during accreditation reviews). To offer context for the self-study, there are two new concepts: 1) an exploration of program aims; and 2) an assessment of the program's institutional, local and, as applicable, regional environment. Both are discussed in detail below. The focus on aims and the program's environmental context is to enhance the relevance and usefulness of the program evaluation, and support improvement that goes beyond compliance with the requirements. Under the heading 'Additional Notes', there is a section titled 'Conducting the self-study for a dependent subspecialty program'. The text states that the ACGME has placed added responsibility for oversight of subspecialty programs on the core program and sponsoring institution. It notes that the self-study group for the core program should try to coordinate activities with the self-study groups for any dependent subspecialty programs, to take advantage of common dimensions, explore potential synergies, and reduce the burden that may be associated with conducting an independent self-assessment. It also mentions that the 10-year site visits for subspecialty programs will be coordinated with the visit of their respective core program. A list of steps is shown, with the first step being '1. Assemble the self-study group'. On the right side of the page, there is a 'Contact Us' section with a phone icon and a link to the 'Department of Field Activities'. Below that is a 'Quick Links' section with several links: 'Site Visit', 'The ACGME and the Accreditation Process', 'Evaluation of Your Recent Accreditation Site Visit', 'Site Visit FAQs', 'Self-Study', and 'Self-Study Tools'.



Self-Study - Four Elements

1. Program Aims
2. SVOT/SLOT Analysis:
 - Internal: Strengths
 - Areas for improvement/vulnerabilities/ limitations
 - External: Opportunities
 - Threats
3. 5-year “look back” on changes, improvements
4. 5-year “look forward” on plans for the future

“What will take this program to the next level”



Self-Study - Once Completed

ACGME Template with sections for “Key Self-Study dimensions”

- Aims
- Program Strengths, Opportunities and Threats
- Five-year look-back and look-forward
- Self-study process (who was involved, data collected and interpreted)

Omitted by design: information on areas for improvement



10-yr Accreditation Visit

12- to 18-months after the self-study to allow programs implement improvements - 90-days notice

- Site Visit
 - Full accreditation site visit w/ review of all applicable requirements
 - Programs submit “Summary of Achievements” detailing improvements made as a result of the self-study
 - Assess maturity of program improvement effort using updated self-study
 - **No information collected on areas not (yet) improved**



10-yr RC Review

- Review Committee (RC) provides Letter of Notification from the 10-year Site Visit, with citations and areas for improvement
- Formative feedback (no accreditation impact) for the RC assessment of the self-study (*no information collected on areas not yet improved)

Focus will be on the on “improvement process,” not the priorities the program has selected



ACGME

Common Program Requirements



Common Program Requirements Section VI

“At the heart of the new requirements is the philosophy that residency education must occur in a learning and working environment that fosters excellence in the safety and quality of care delivered to patients both today and in the future.” – Dr. Nasca



Accreditation Council for
Graduate Medical Education

Common Program Requirements
The Learning and Working Environment (Duty Hours)

2017 REQUIREMENTS

NEWS AND BACKGROUND

PERSPECTIVES

Clinically-Driven Standards

The ACGME Common Program Requirements are in place to ensure that ACGME-accredited specialty and subspecialty programs follow a basic, consistent set of standards in training and preparing resident and fellow physicians.

The requirements set the context within clinical learning environments for development of the skills, knowledge, and attitudes necessary to take personal responsibility for the individual care of patients. In addition, they facilitate an environment where residents and fellows can interact with patients under the guidance and supervision of qualified faculty members who give value, context, and meaning to those interactions.

The ACGME began its scheduled review of the Common Program Requirements in the fall of 2015. Phase 1 addressed Section VI of these requirements only, and was overseen by a Task Force assembled for its expertise to review the existing requirements and propose revisions. Following ACGME process, the proposed requirements were posted for public comment between October and December 2016. The revised requirements were then presented to the ACGME Board of Directors for consideration for approval in February 2017. **Section VI of the Common Program Requirements was approved and goes into effect July 1, 2017.** A second Task Force is currently reviewing Sections I-V of the Common Program Requirements, and review will follow the same procedures, with an anticipated effective date of July 1, 2018.

The requirements were revised to reflect that residency/fellowship education must occur in a learning and working environment that fosters excellence in the safety and quality of patient care. With that priority as their foundation, highlights of the changes include:

Quick Links

Common Program Requirements (Section VI) with Background and Intent

Common Program Requirements (Section VI) with Tracked Changes

Section VI Q&A

Presentation on Common Program Requirement Revisions from 2017 Annual Educational Conference

Learn more about the ACGME Common Program Requirements at [ACGME.org](https://www.acgme.org)

E-mail questions about the revised requirements to SectionVI@acgme.org

https://www.acgmecommon.org/2017_requirements



Common Program Requirements Section VI

Learning and Working Environment

- Attention to patient safety and resident/faculty well-being
- Commitment to the well-being of residents, faculty members, students, and all members of the health care team
- Supporting the development of professionalism
- Eliminating burdensome documentation requirements
- Use of appropriate flexibility as a shared responsibility of the program and residents



CPR Section VI

Patient Safety (new)

Culture: must participate in patient safety systems and contribute to a culture of safety (Core) (VI.A.1.a).(1).(a))

Education: formal educational activities that promote patient safety-related goals, tools, and techniques(Core) (VI.A.1.a).(2))

Events: reporting patient safety events, including near misses, and be provided with summary information of their institution's patient safety reports (VI.A.1.a).(3).(a)-VI.A.1.a).(3).(a).(iii))

Training: participate in real or simulated interprofessional activities (VI.A.1.a).(3).(b))



CPR Section VI

Quality Improvement (new)

Education: training and experience in quality improvement processes, including an understanding of *health care disparities* (Core) (VI.A.1.b).(1).(a))

Quality Metrics: data on quality metrics and benchmarks related to their patient populations (Core) (VI.A.1.b).(2).(a))

Engagement: participate in interprofessional quality improvement activities (Core) (VI.A.1.b).(3).(a))

include activities aimed at reducing health care disparities (Detail) (VI.A.1.b).(3).(a).(i))



CPR Section VI Supervision

Addition of italicized language providing the underlying philosophy for the supervision requirements

Changes include:

Minor changes in the Program Requirements to clarify intent – no major changes related to supervision



CPR Section VI

Professionalism

Manageable patient care responsibilities (Core) (VI.B.2.c)

varies by specialty and PGY level

assess how assignments can affect work compression, esp. PGY-1

Personal role of residents and faculty:

report unsafe conditions and adverse events (Outcome) (VI.B.4.b.)

fitness for work (Outcome) (VI.B.4.c)

Learning Environment: professional, respectful, and civil environment (Core) (VI.B.6.)



CPR Section VI

Wellbeing (new)

Focus:

Work intensity and compression

Safety

Residents and faculty

Time to attend to personal and medical care

Monitor for burnout, depression, and substance abuse

The ACGME is leveraging resources in four key areas in support of attention on well-being: education, influence, research, and collaboration

<http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>



CPR Section VI

Clinical Experience and Education

80 hours averaged over 4 weeks (must)

clinical work from home counts toward total (new)

8 hours off between...work periods (should)

flexibility for residents to make decisions that prioritize their patients

14 hours free after 24-hours in house call (must)

1 day free in 7 (must)



CPR Section VI

Clinical Experience and Education

Changed:

Removed 16-hour limit for PGY-1's

PGY-1s to function as members of the team and must be supervised in compliance with the requirements

Eliminated limit on consecutive nights of night float

At-home patient care activities (call, MR) counts toward 80-hours

Eliminated documentation for a resident, on their own initiative, electing to remain/return to the clinical site (VI.F.4.a)



Common Program Requirements

Sections I – V
Being revised now

Watch for public comment period within the
next few months



Q&A

Is it possible to receive the results of the resident and faculty survey sooner?

Is it possible to get decisions from the RC back sooner (i.e. complement increases and decisions)?

Suggestions for program manager wellness?



RC Meeting Dates

Meeting: 28-29 September 2017

Agenda Close: 21 July 2017

Meeting: 18-19 January 2018

Agenda Close: 09 November 2017

Meeting: 05-06 April 2018

Agenda Close: 25 January 2018



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Thank you!
