Updates on the Surgery RRC, ACGME and Case Logs

James C. Hebert, MD
Chair, Surgery Residency Review Committee

John R. Potts, III, MD
Senior Vice President-Surgical Accreditation

Peggy Simpson, Ed.D.
Executive Director, RRCs for Plastic Surgery, Surgery, and Thoracic Surgery, ACGME

Association of Residency Coordinators Meeting
April 8, 2014
Chicago, IL

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RRC—Surgery Members

- James C. Hebert, MD, Chair
- John H. Armstrong, MD
- Timothy R. Billiar, MD
- Ronald Dalman, MD
- George Fuhrman, MD
- Linda M. Harris, MD
- David Herndon, MD
- G. Whit Holcomb, MD
- John J. Ricotta, MD
- Marshall Z. Schwartz, MD
- Steven Stain, MD, Vice Chair
- Danny Takanishi, MD
- Paula Termuhlen, MD
- Jennifer Tseng, MD, Resident
- Mark Malangoni, MD, Ex-Officio ABS
- Ajit Sachdeva, MD, Ex-Officio ACS

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Agenda

- RRC Update
- ACGME Update-Recent Changes in Policies
- NAS & Milestones Update
- Clinical Competency Committees
- Program Evaluation Committees
- Resources

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RRC Update

- Accredited Programs
- Integrated Program Application Process
- Duty Hours Study

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Accredited Programs 2013-2014

	Total Programs	Cont. Accred.	Cont. Accred. w/warning	Initial Accred.	Initial Accred w/warn	Prob.
Surgery	254	221	19	9	0	5
Surgical Oncology	19	0	0	19	0	0
Pediatric Surgery	46	39	1	6	0	0
Surgical Critical Care	110	95	5	10	0	0
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Vascular-Independent	106	92	4	6	1	3
Vascular-Integrated	48	30	1	17	0	0
TOTAL	584	478	30	67	**1**	8

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Program Applications

- The transition to NAS means a self-study visit every 10 years.
- All program applications are now required to have a site visit as part of the application process.

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Duty Hours Study

- ACGME BOD approved program participation in study
- Only programs included in the randomized arm of the study will be permitted to relax SOME of the duty hour program requirements.
- Programs chosen for participation will receive an administrative letter of notification from ACGME

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Duty Hours Study (cont.)

- Some programs not eligible
  - No participation in NSQIP
  - Programs with the following accreditation statuses
    - Probation
    - Initial Accreditation
    - Initial Accreditation with Warning
- For additional information consult the ABS or the ACS.

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Recent Changes in ACGME Policy

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
  - Dependent Subspecialties
- Continuous Accreditation
- Site Visits
- Accreditation Statuses
- Appealable Accreditation Actions
- Complement Increases
- Finding the ACGME Policies

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Subspecialty Programs

- Historically, there have been two types of subspecialty programs:
  - dependent
  - independent

- Effective July 1, 2015, all fellowship programs within a specialty must be accredited as dependent subspecialty programs.

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Dependent Subspecialty Programs

- Dependent subspecialty programs are affiliated with an accredited specialty program and are under the governance of that specialty program's sponsoring institution.
- The continued accreditation of a subspecialty program is dependent on the specialty program's maintaining its accreditation.
- A dependent subspecialty program must be sponsored by the same ACGME-accredited sponsoring institution and should be geographically proximate.

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Independent Subspecialty Programs

Independent subspecialty programs historically were not directly related to, or dependent upon the accreditation status of a specialty program.

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Independent Subspecialty Programs

Effective July 1, 2013, the ACGME will not accredit new independent subspecialty programs.

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

ACGME

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Independent Subspecialty Programs

Independent subspecialty programs accredited by the ACGME as of the date of adoption of this policy (6/11/12) by the ACGME Board may continue to be accredited by the ACGME under the following circumstances, one of which must be satisfied by July 1, 2015:

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Independent Subspecialty Programs

1) an independent subspecialty program within an institution **without** an associated core residency program in the specialty must operate under the oversight of a sponsoring institution accredited by ACGME and should be geographically proximate; or

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Independent Subspecialty Programs

2) an independent subspecialty program sponsored by an ACGME accredited institution **with** an associated core residency program must function as a dependent subspecialty program to the associated core residency program.

ACGME Policies
Subject 15.00
Approved 29 September 2012
Effective 1 July 2013

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Why Make This Change?

- In the NAS, core (residency) and subspecialty (fellowship) programs will be reviewed by the Review Committee **together**.
- In particular, this is true at the time of the self-study visit.

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Why Are Subs Reviewed with Core?

- Assures that the needs of the core residency are taken into account when fellowships are implemented
- Ensures that the needs of the core residency are taken into account when decisions made regarding clinical/faculty/institutional resources
- Assures that the core residency and subspecialty programs will use the resources most effectively to execute the educational programs

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Why Are Subs Reviewed with Core?

- Ensures that the evaluation and curriculum design resources of the core residency are available to the subspecialty programs.
- Creates an environment within which coordinated self-study of the GME programs can occur.
- Makes site visits more efficient and effective for the department.

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Currently Independent Programs

by July 1, 2015 must:

1. become a dependent subspecialty of an accredited core residency within an accredited institution, *or*
2. function under the oversight of a geographically proximate sponsoring institution which is accredited by the ACGME.

Note: ACGME-accredited institutions will undergo:

- Institutional review
- Institutional Self-Study visits
- CLER visits

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
  - Dependent Subspecialties
- Continuous Accreditation
- Site Visits
- Accreditation Statuses
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- Complement Increases
- Finding the ACGME Policies

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Continuous Accreditation

The ACGME accredits GME programs and sponsoring institutions based on the demonstration of continuous oversight of processes and outcomes of education, and substantial compliance with accreditation standards, through the review of annually acquired information.

ACGME Policies
Subject 17.10
Approved 29 September 2012
Effective 1 July 2013

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
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- Continuous Accreditation
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Focused Site Visit

A focused site visit assesses selected aspects of a program or sponsoring institution identified by a Review Committee, and may be used:

ACGME Policies
Subject 17.30
Approved 29 September 2012
Effective 1 July 2013

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Focused Site Visit

(1) to address selected aspects of the program needing attention or follow-up that were identified during the annual continuous review of accreditation information;

(2) to evaluate the merits of a complaint against a program or sponsoring institution; and/or,

(3) as a diagnostic visit to explore the factors underlying deterioration in selected aspects of a program's or institution's performance identified during the continuous accreditation review or through another alert.

ACGME Policies, Subject 17.30
Approved 29 September 2012
Effective 1 July 2013

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Focused Site Visit

For these visits, the site visitor or site visit team may offer suggestions and ideas for innovative practices based on knowledge from other programs and institutions that are successful in creating an effective working and learning environment.

ACGME Policies
Subject 17.30
Approved 29 September 2012
Effective 1 July 2013

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Full Site Visit

A full site visit addresses and assesses compliance with all applicable standards and encompasses all aspects of a program or sponsoring institution. A full site visit may be scheduled:

(1) to review an application for accreditation by a new sponsoring institution or a new program in a specialty or subspecialty;

(2) when review of continuous accreditation data identifies broad issues and/or concerns;

(3) for other serious conditions or situations at the discretion of a Review Committee

ACGME Policies, Subject 17.30
Approved 29 September 2012
Effective 1 July 2013

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
  - Dependent Subspecialties
- Continuous Accreditation
- Site Visits
- Accreditation Statuses
- Appealable Accreditation Actions
- Complement Increases
- Finding the ACGME Policies

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Accreditation Statuses

Application for New Programs and Sponsoring Institutions

- Accreditation Withheld
- Initial Accreditation
- Initial Accreditation with Warning

ACGME Policies
Subject 17.60, 18.00, 18.10, 18.20
Approved 29 September 2012
Effective 1 July 2013

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Accreditation Statuses

Existing Programs

- Continued Accreditation
- Continued Accreditation with Warning
- Probationary Accreditation
- Withdrawal of Accreditation

ACGME Policies
Subject 17.60, 18.00, 18.30, 18.40, 18.50, 18.60, 18.80
Approved 29 September 2012
Effective 1 July 2013

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
  - Dependent Subspecialties
- Continuous Accreditation
- Site Visits
- Accreditation Statuses
- Appealable Accreditation Actions
- Complement Increases
- Finding the ACGME Policies

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Appealable Accreditation Actions

- Accreditation Withheld
- Probationary Accreditation
- Withdrawal of Accreditation
- Non-voluntary Reduction in Resident Complement

ACGME Policies
Subject 18.00
Approved 29 September 2012
Effective 1 July 2013

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
  - Dependent Subspecialties
- Continuous Accreditation
- Site Visits
- Accreditation Statuses
- Appealable Accreditation Actions
- Complement Increases
- Finding the ACGME Policies

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Complement Increases

Programs with the status of *Continued Accreditation with Warning* may *not* request a permanent increase in resident complement.

Programs with the status of *Probationary Accreditation* may *not* request an increase in resident complement.

ACGME Policies
Subjects 18.30 and 18.40
Approved 29 September 2012
Effective 1 July 2013

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Recent Changes in Policies

- Subspecialty Programs
  - Independent Subspecialties
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- Continuous Accreditation
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- Finding the ACGME Policies

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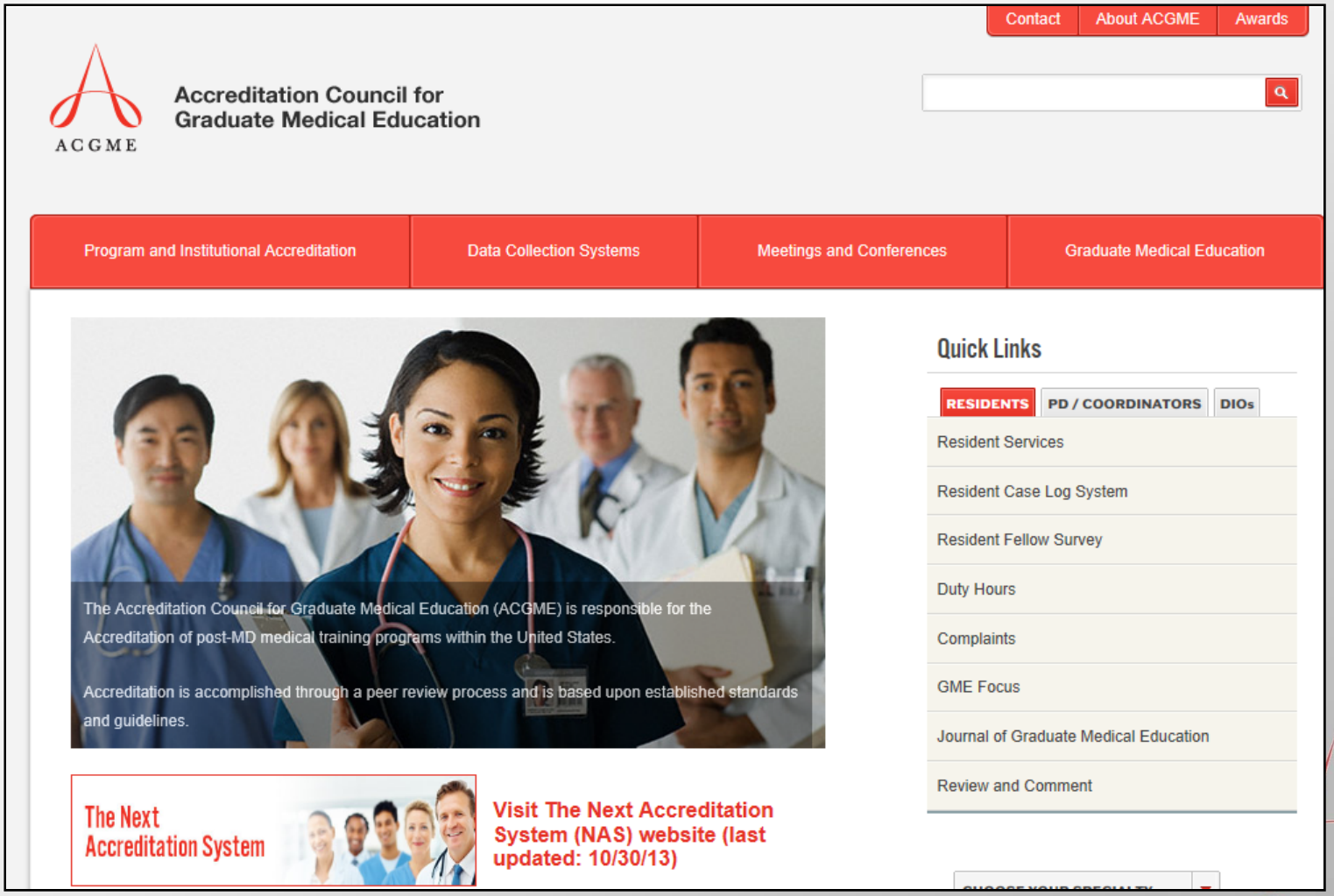
Policies on ACGME Website



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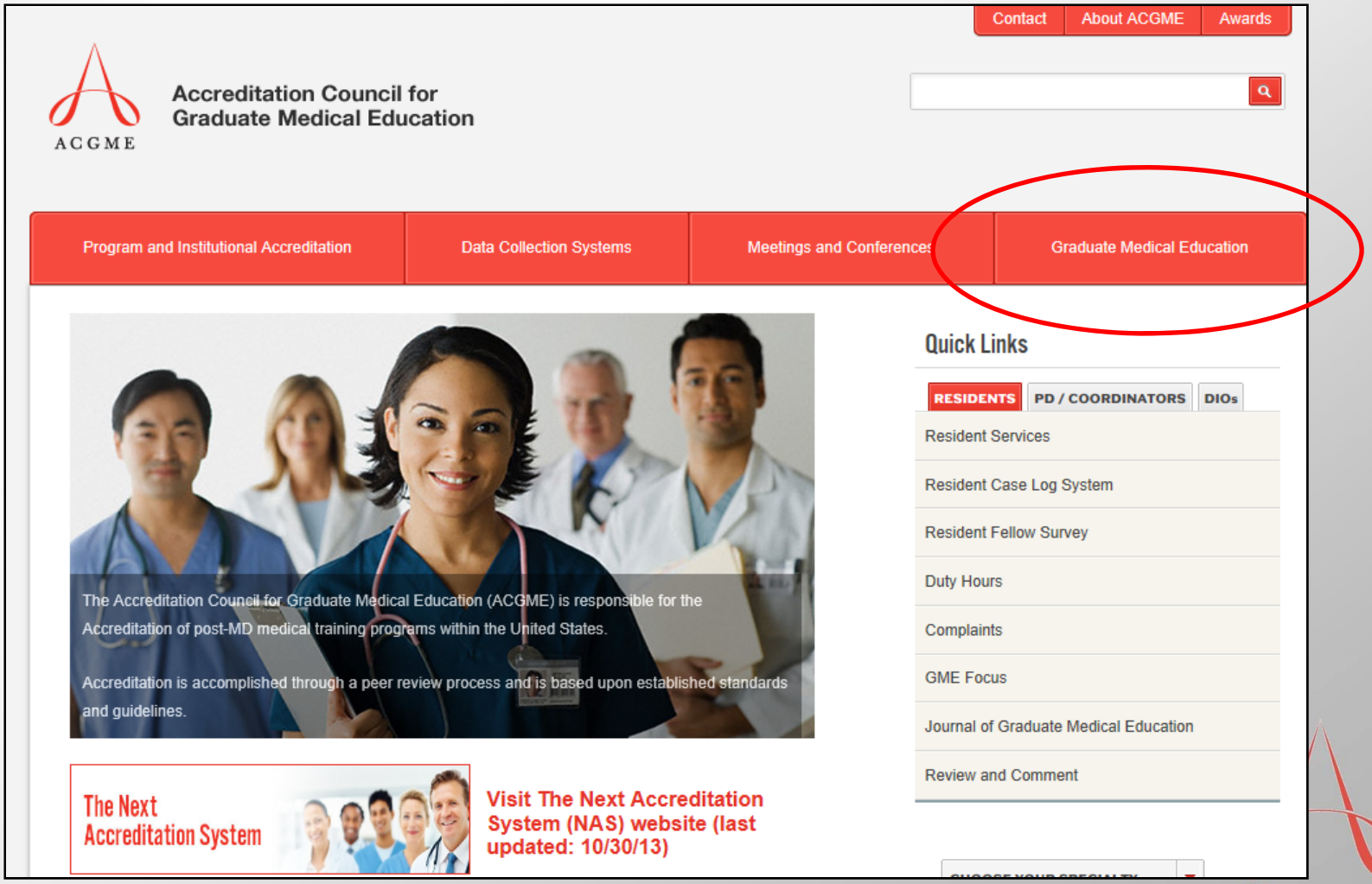

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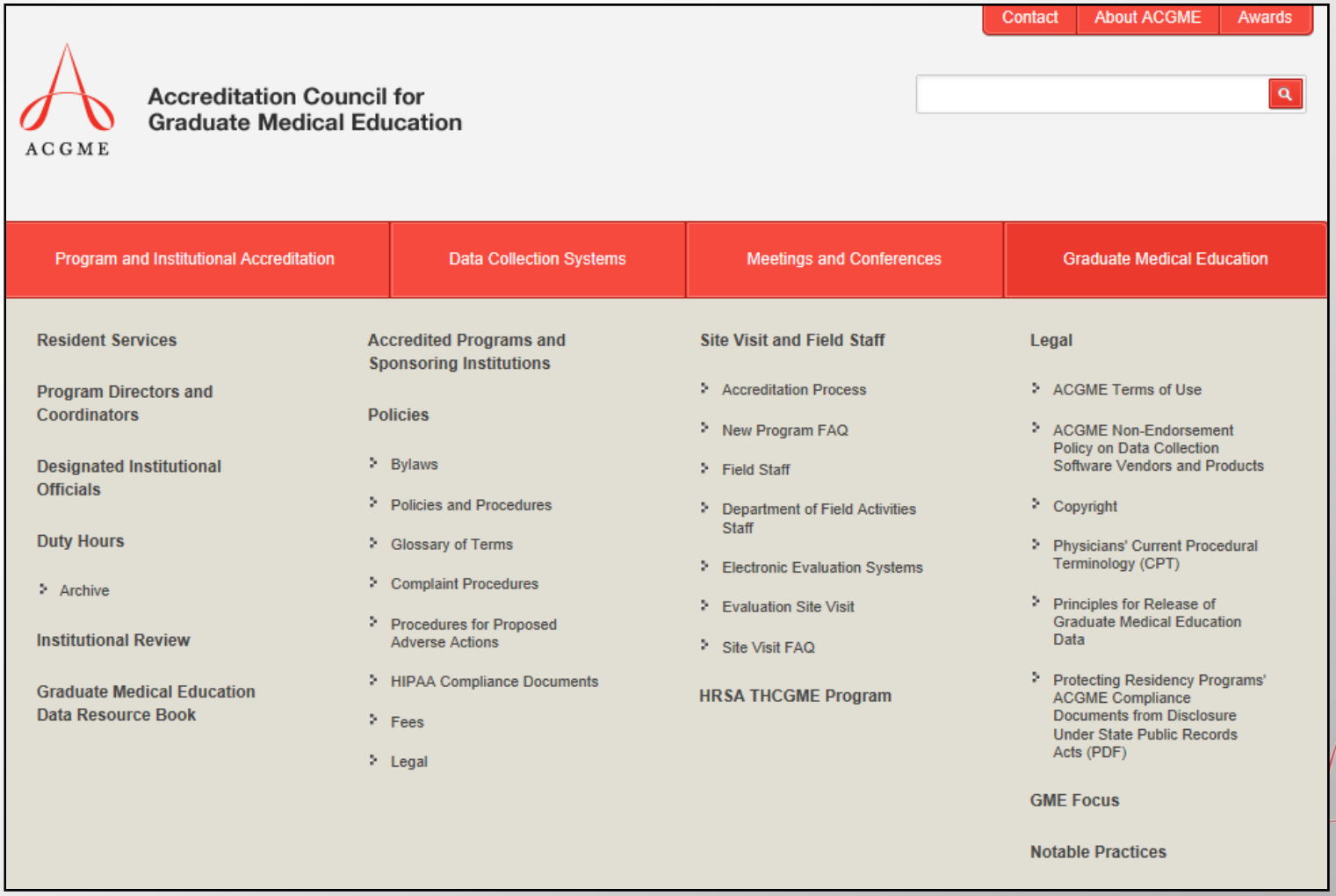

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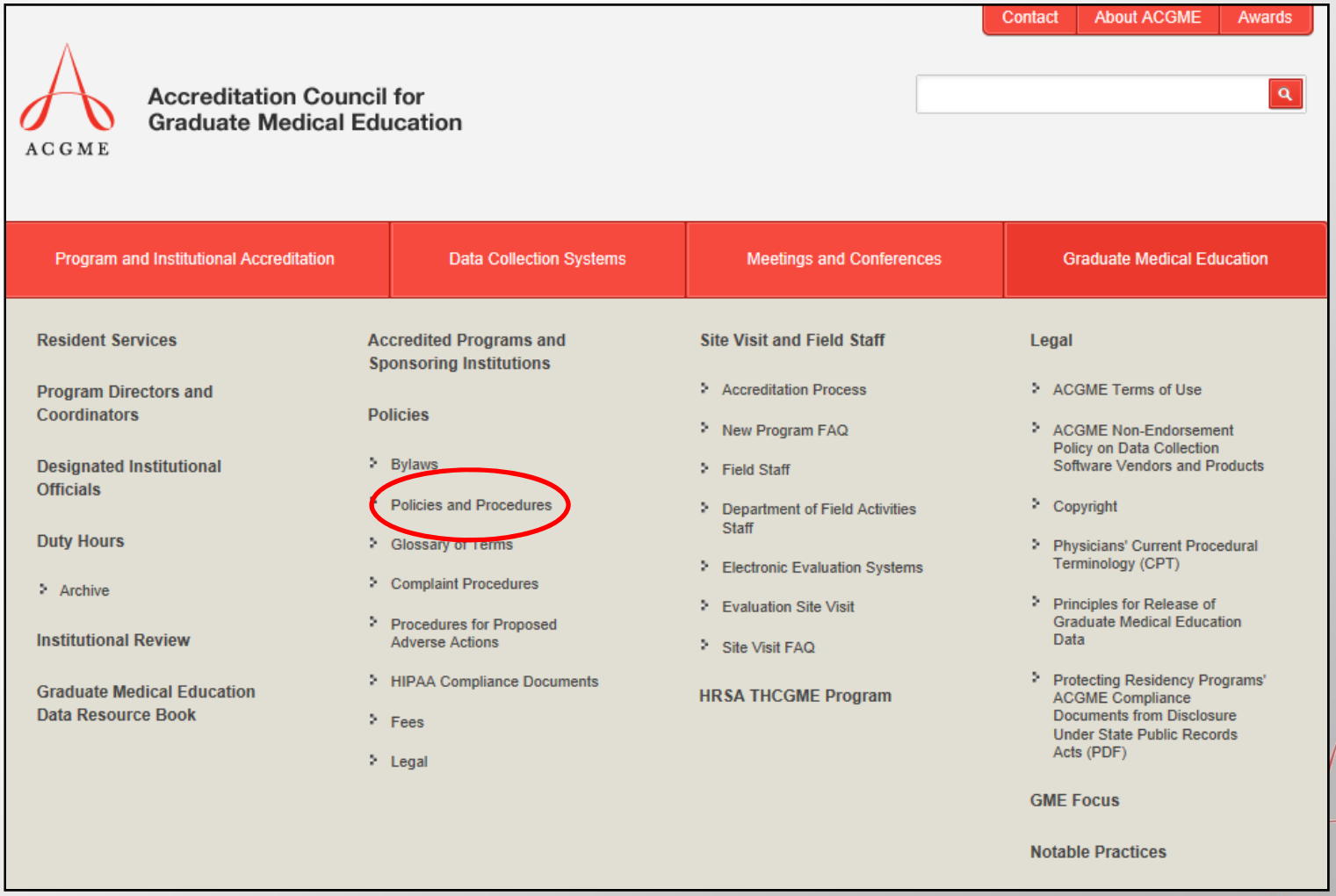

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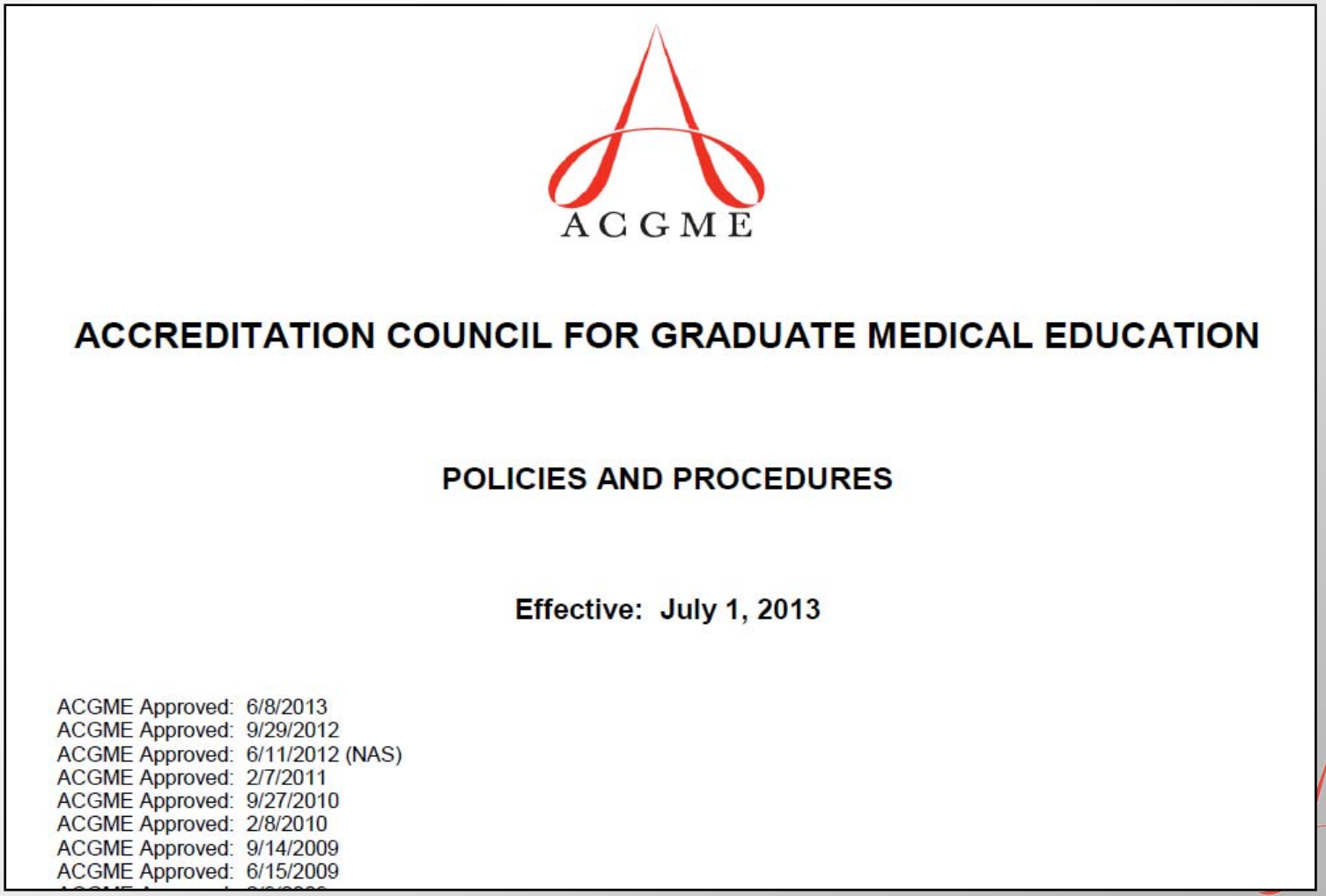

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ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

Effective: July 1, 2013

ACGME Approved: 6/8/2013
ACGME Approved: 9/29/2012
ACGME Approved: 6/11/2012 (NAS)
ACGME Approved: 2/7/2011
ACGME Approved: 9/27/2010
ACGME Approved: 2/8/2010
ACGME Approved: 9/14/2009
ACGME Approved: 6/15/2009

http://acgme.org/acgmeweb/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf

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NAS & Milestones

- **NAS: Structural overview**
- **NAS: What's different?**
- **Milestones**

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NAS & Milestones

- **NAS: Structural overview**
- **NAS: What's different?**
- **Milestones**

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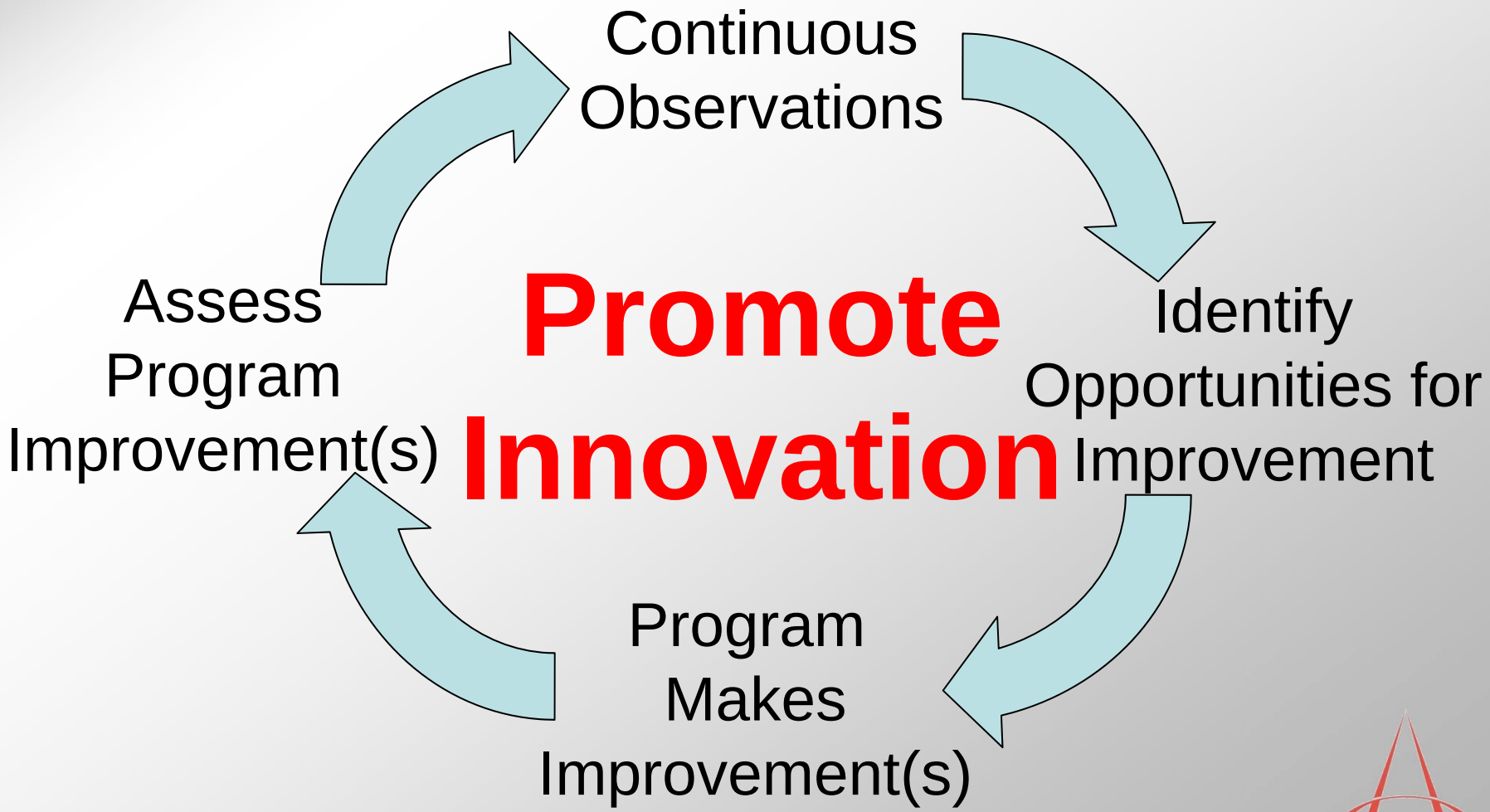
The Next Accreditation System



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NAS & Milestones

- NAS: Structural overview
- **NAS: What's different?**
- Milestones

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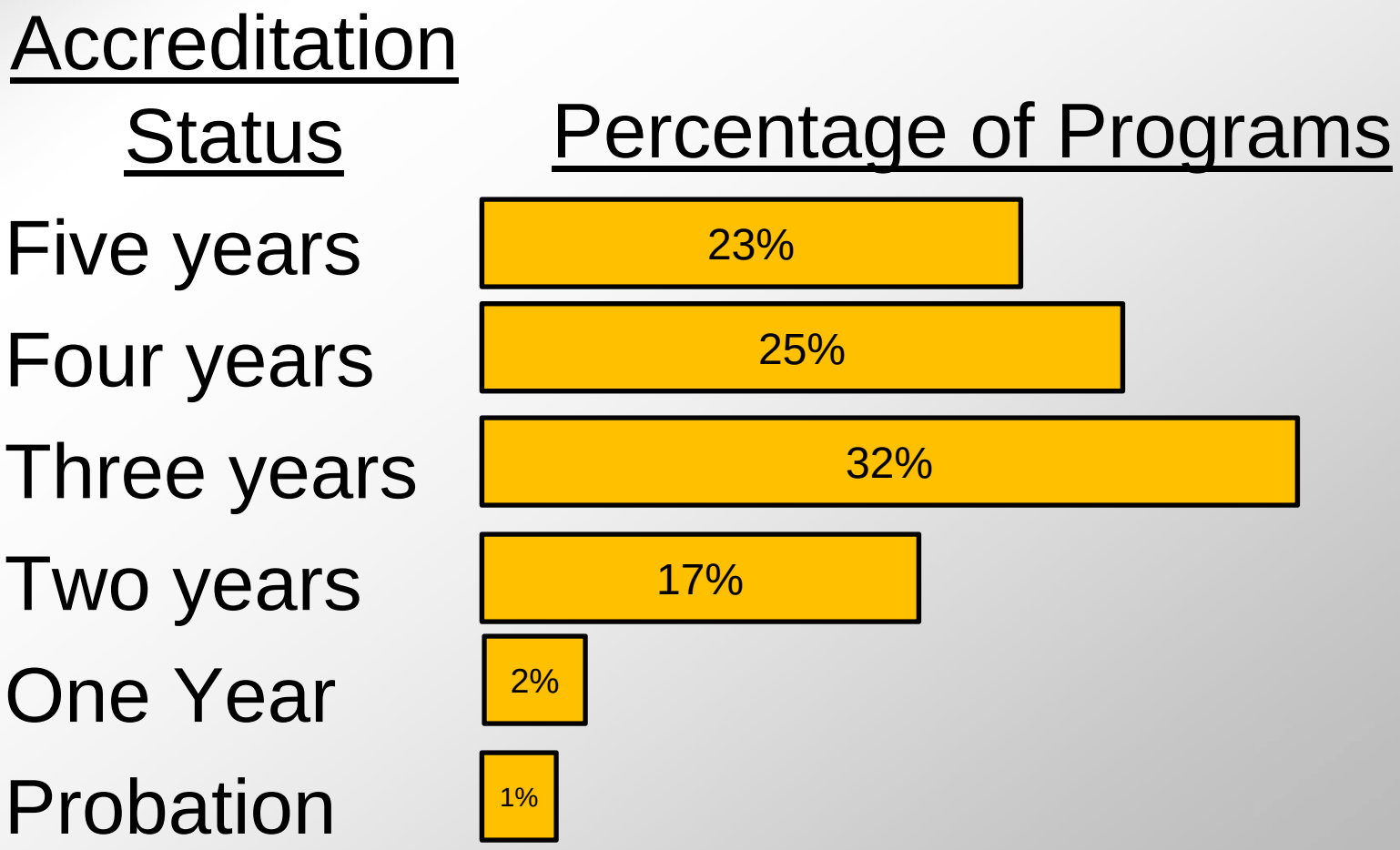
The Old Accreditation System- Sample of RRC Data



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NAS: What's Different?

- Continuous accreditation model
- No cycle lengths

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NAS: What's Different?

- No PIFs
- No Internal Review
- Programs notified of status *at least* annually
- Requirements revised every ten years

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NAS: What's Different?

- Citations *can* be levied annually by RRC
- But, *could* be resolved based upon:
  - New annual data from program
  - Progress report
  - Site visit (focused or full)

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NAS: What's Different?

- No site visits (as we know them)

  but…

- Focused site visits for an "issue(s)"
- Full site visit
- Self-study visits every ten years

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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

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Full Site Visits

- Minimal notification given (60 days)
- Minimal document preparation expected
- Team of site visitors

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Ten Year Self-Study Visit

- *Not* fully developed
- *Not* a traditional site visit
- Will be implemented in 2015

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Self Study
A Departmentally Coordinated Effort

- Respond to any Active Citations
- Evaluate Programmatic Performance against Goals (written plans of action)
- Review Previous 10 year “Annual Program Evaluations”
- Demonstrate effectiveness of modifications of the Program over time
- Establish Programmatic Goals for the future

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Ten Year Self-Study Visit

- Assess a broader unit of the GME educational environment
- Will review core and any affiliated sub programs together
  - General Surgery
    - Surgical Critical Care
    - Pediatric Surgery
    - Vascular Surgery-Independent
    - Vascular Surgery-Integrated
    - Complex General Surgical Oncology

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Self Study Visit *(Draft)*

- Team of site visitors
- Review the Self Study of the Departmental Educational Effort (Core and Subs)
- Validate most recent Annual Data submitted
- Potentially serve as a vehicle for:
  - Description of Salutary Practices
  - Accumulation of Innovations in the field

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Ten Year Self-Study Visit

- Review 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 and Outcome Requirements

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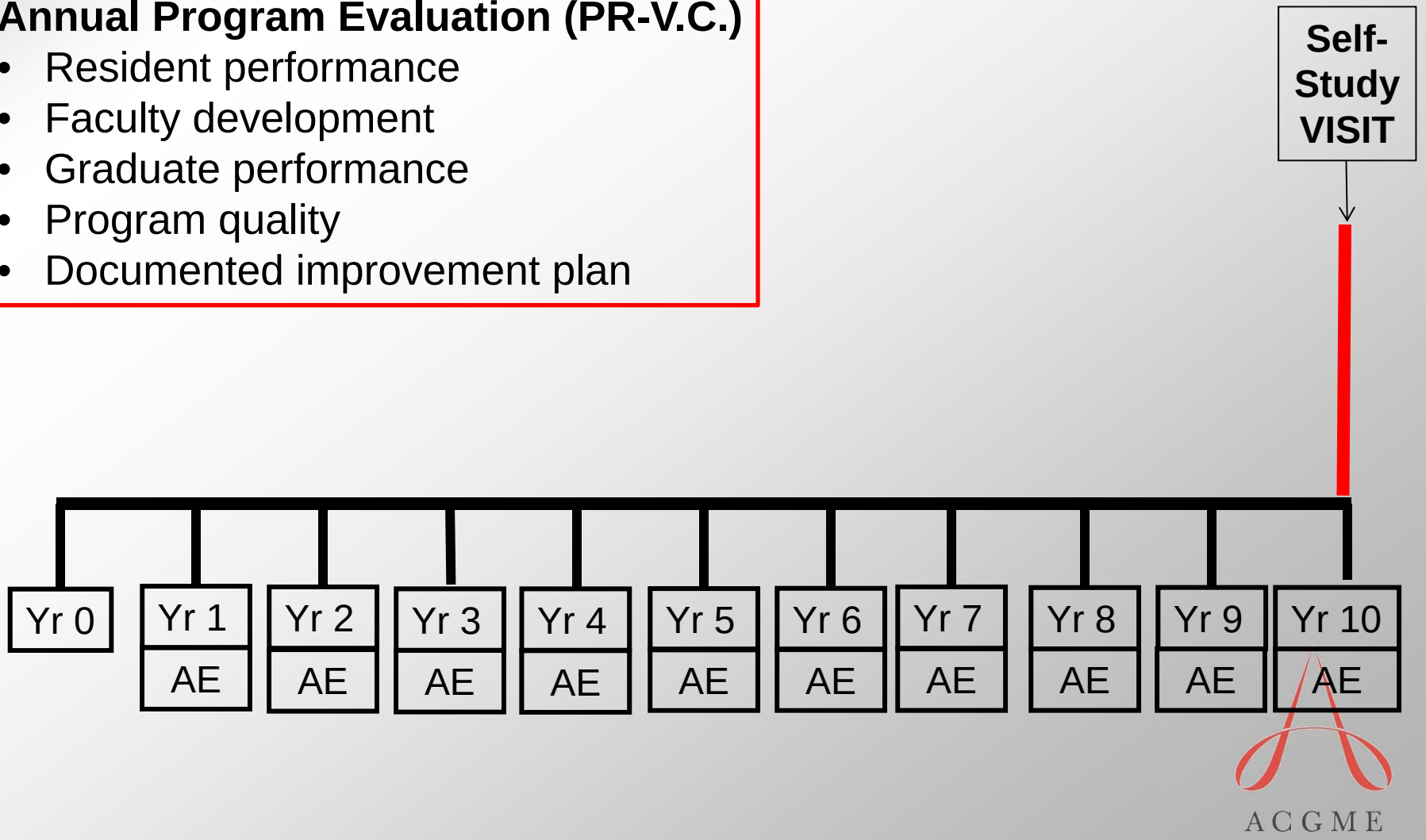
Ten Year Self-Study Visit

Annual Program Evaluation (PR-V.C.)

- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan



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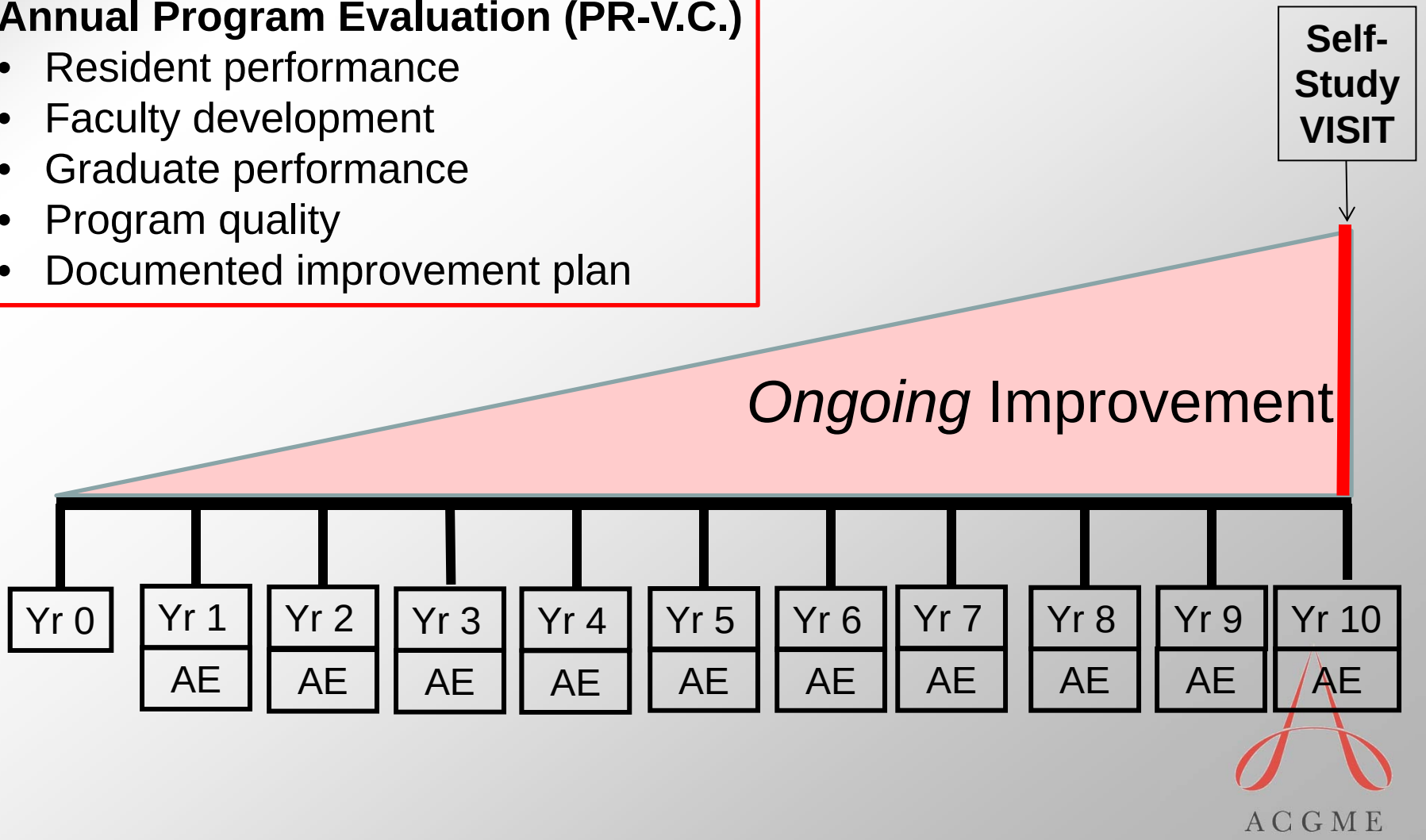

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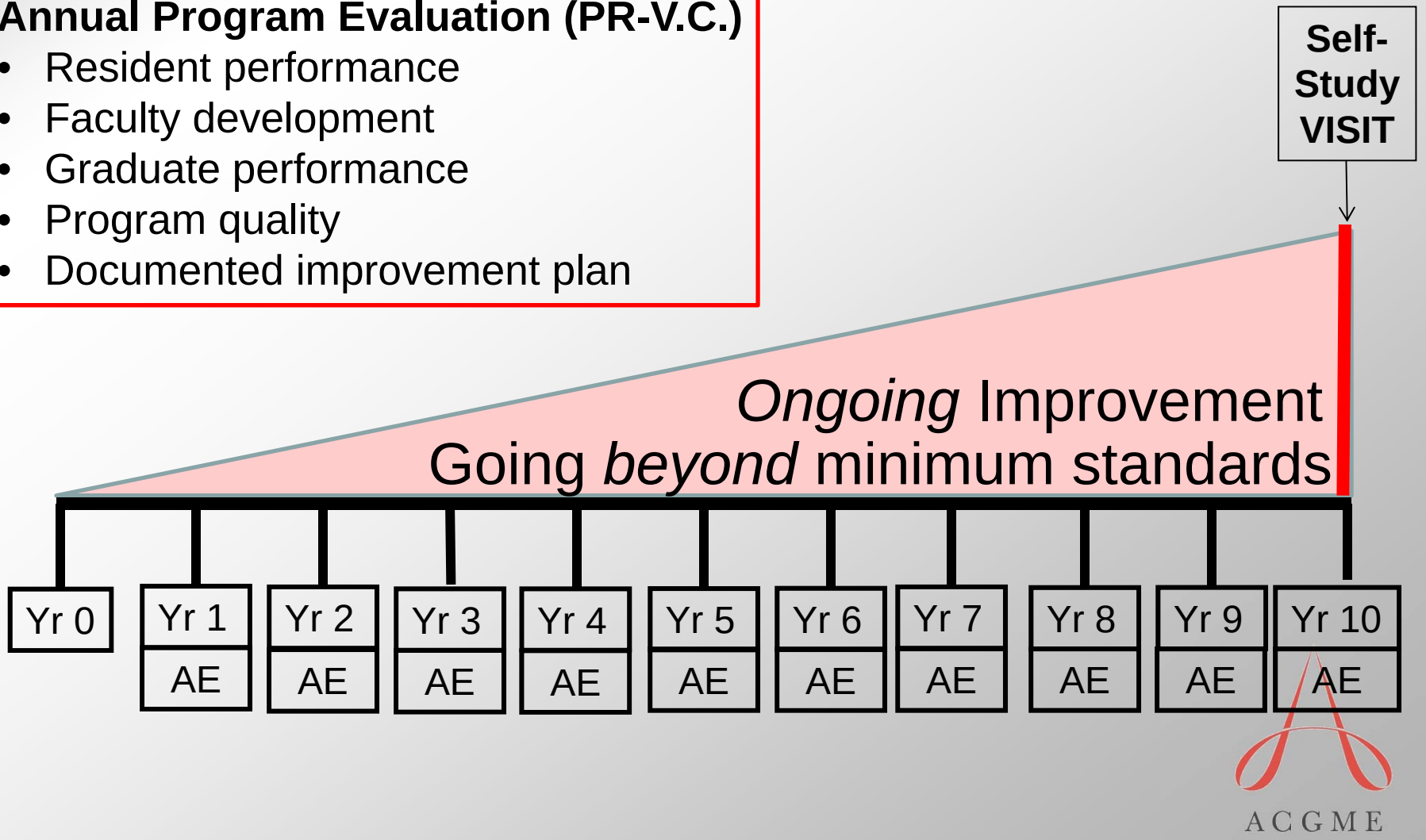

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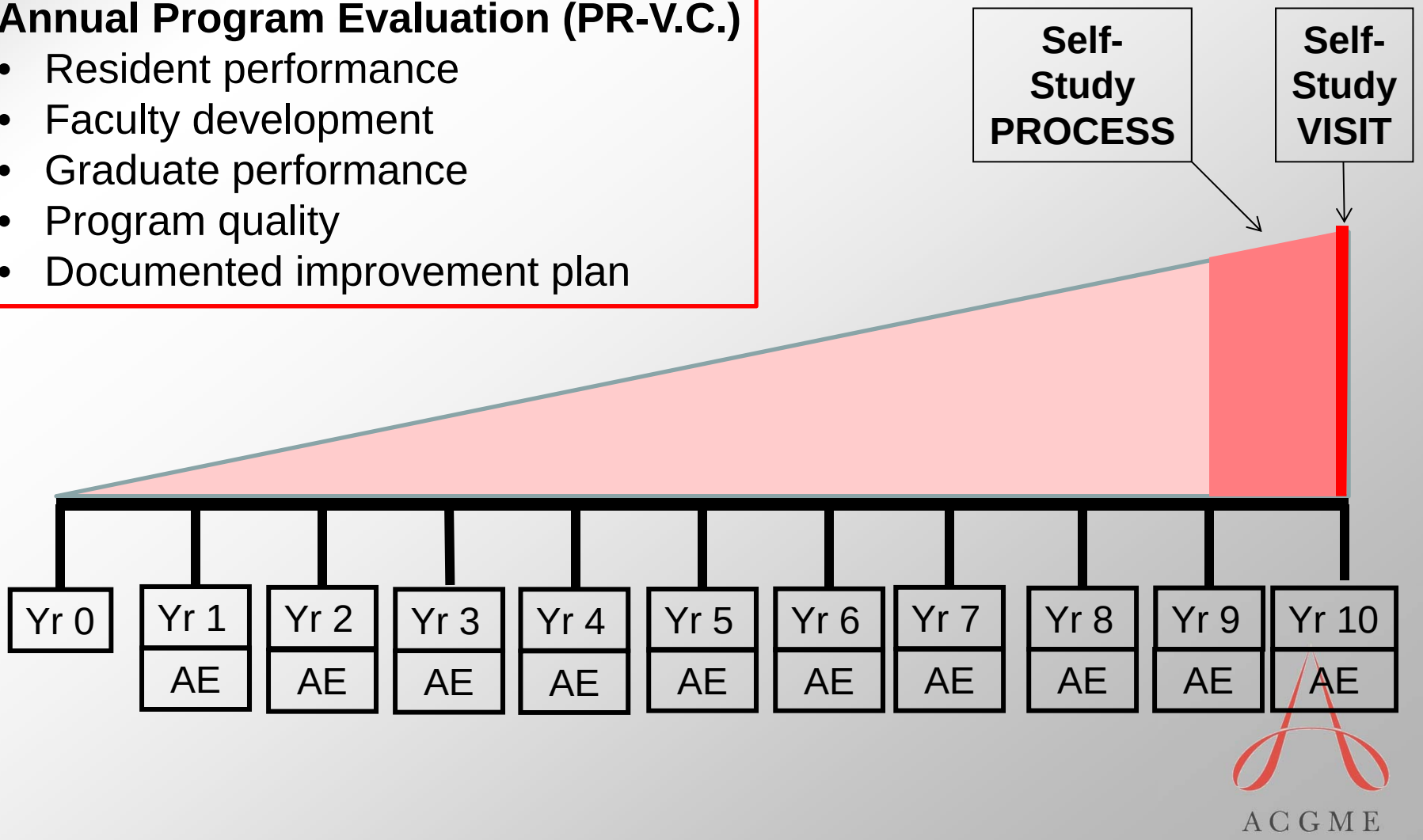

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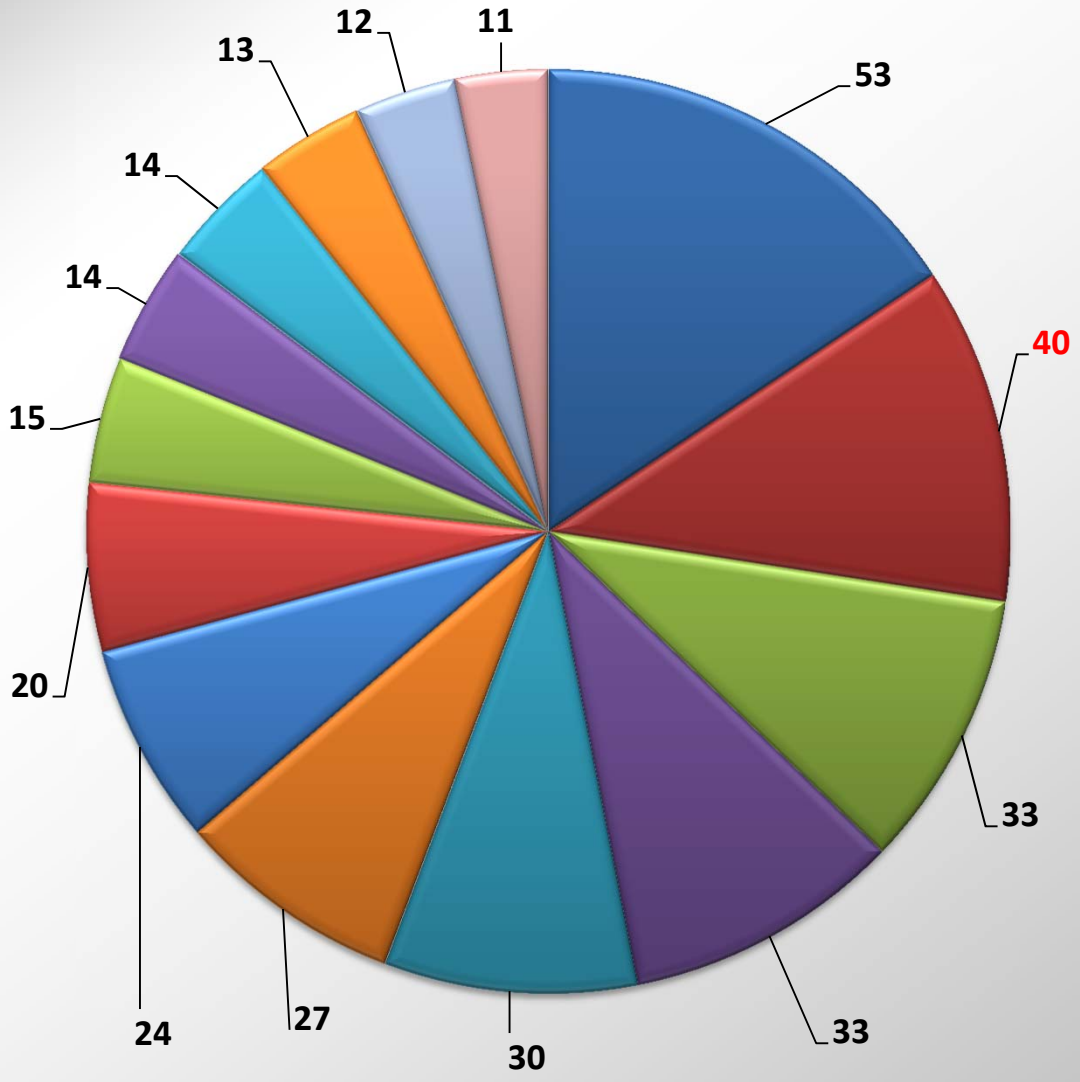
AY 2013 Top Areas of Citation



- Procedural Experience
- Program Evaluation
- Duty Hours & Work Environ.
- PD Responsibilities
- Faculty Qualifications
- Continuity of Care
- Resident Evaluation
- Faculty Responsibiliteis
- Professional Respons Culture
- Resident Appointment
- Scholarly Activities
- Service /Education Imbalance
- Performance on Board Exams
- Curricular Development

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Program Requirement Categorization

- Program Requirements revised every ten years
- *Each* standard categorized:
  - Outcome
    - All programs must adhere
      - *Results*
  - Core
    - All programs must adhere
      - *Resources*
  - Detail
    - Good programs may innovate
      - *Processes*

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Accredited Programs 2013-2014

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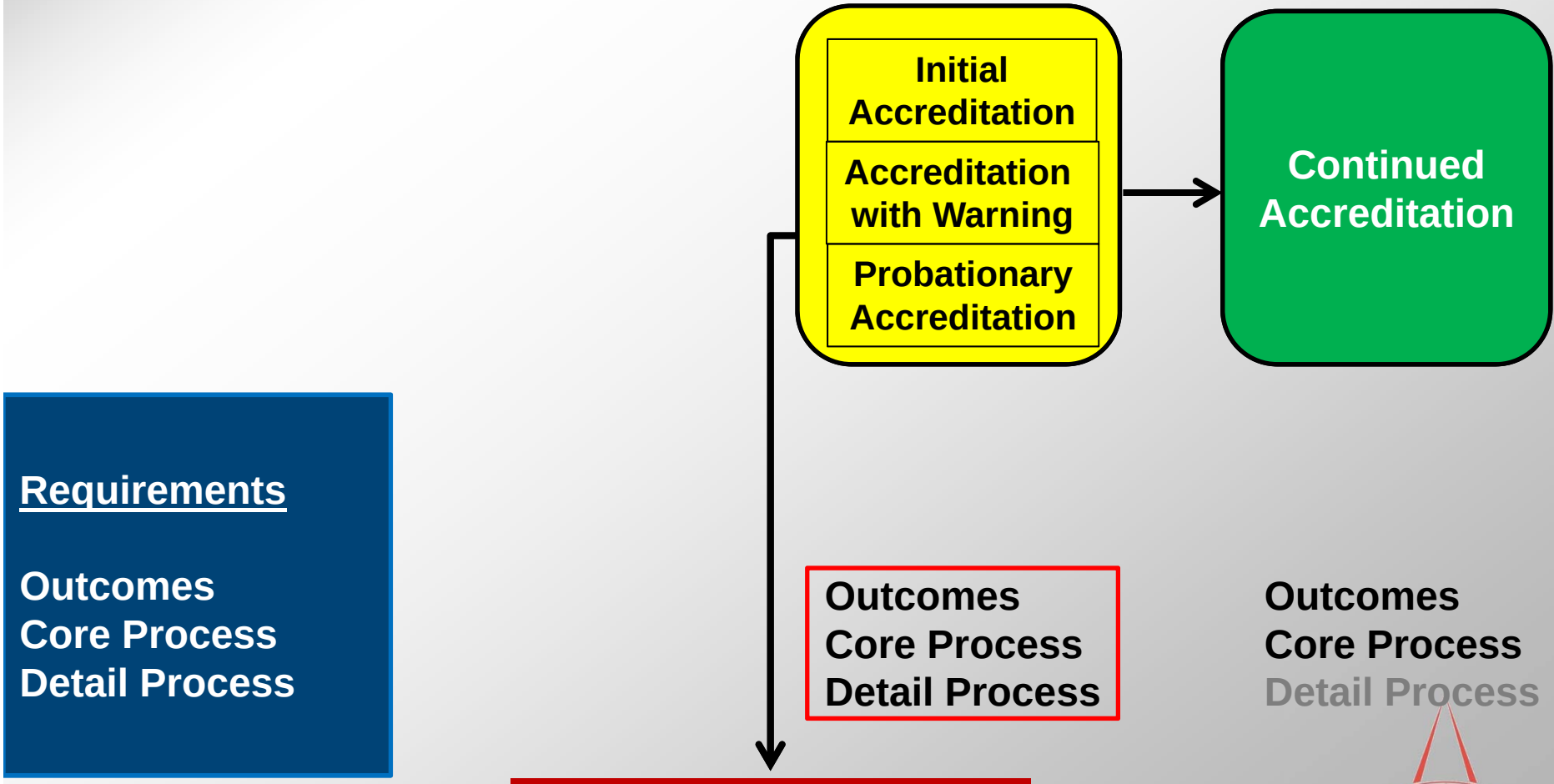
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



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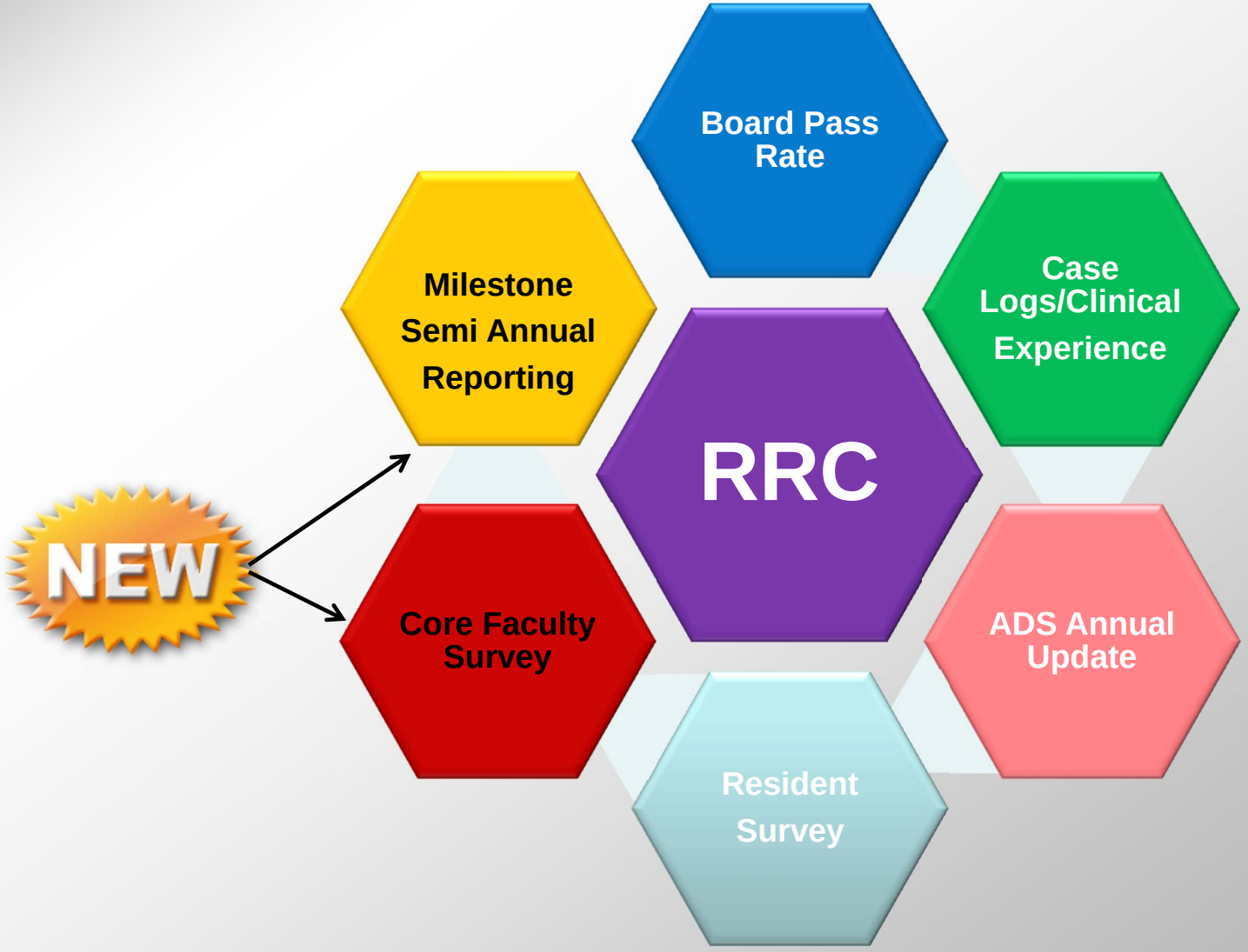
Review of Annual Data



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After Review of Annual Data RRC *can*…

- Request Progress Report
- "Resolve" Citations
  - Need to continue to respond is removed
- "Continue" Citations
  - Need to respond with updates continues
- Change Accreditation Status, e.g.:
  - Continued Accreditation with Warning →Continued Accreditation
- Require Focused or Full Site Visit
  - All Site Visits are PIFLess

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After Review of Annual Data RRC *will*…

- Post a letter to every program annually
  - Confirming accreditation status
    - Self-Study Visit Dates do not change
  - Indicated which citations are continued and which citations are resolved
  - Indicated if additional information is needed
    - Via a progress report
    - Clarifying report
    - Interim Site Visit
      - Focused visit (Letter will specify areas of focus)
      - Full visit

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NAS & Milestones

- NAS: Structural overview
- NAS: What's different?
- **Milestones**

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Milestones

- What?
- Who?
- When?

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Milestones

- What?
- Who?
- When?

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Milestones

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

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ACGME Goals for Milestones

- Track what is important
- Uses *existing tools* for *observations*
- RRCs track aggregated program data
- Clinical Competency Committee triangulates progress of each resident
  - Essential component of a valid and reliable clinical evaluation system
  - ABMS Board has the opportunity to track the identified individual
  - ACGME Review Committee tracks unidentified individuals' trajectories

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ACGME Goals for Milestones

- Specialty specific normative data
- Common expectations for individual resident progress
- Development of specialty specific evaluation tools

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Uses for the Milestones

- Program Director
  - Provide feedback to residents
  - Benchmark her residents to program mean
  - Determine program strengths
  - Determine program opportunities for improvement
  - Benchmark her residents nationally
  - Benchmark her program nationally

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Uses for the Milestones

- Resident
  - Get specific feedback
  - Benchmark herself against peers in program
  - Determine individual strengths
  - Determine individual opportunities for improvement
  - Benchmark herself against peers nationally

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Organization of Surgery Milestones

Practice Domains

- Care for Diseases and Conditions (CDC)
- Performance of Operations & Procedures (POP)
- Coordination of Care (CC)
- Improvement of Care (IC)
- Teaching (TCH)
- Self-directed Learning (SDL)
- Maintenance of Physical & Emotional Health (MPEH)
- Performance of Assignments and Administrative Tasks (PAT)

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Milestones: Domains Mapped to Competencies

Domain	Patient Care & Proecdural Skills	Medical Knowledge	Practice-based Learning & Improvement	Interpersonal & Communication Skills	Pro-fessionalism	Systems -Based Practice
CDC	PC1, PC2			ICS1		
POP	PC3	MK1,MK2		ICS3	PROF1	
CC				ICS2		SBP1
IC			PBLI3			SBP2
TCH			PBLI1			
SDL			PBLI2			
MPEH					PROF2	
PAT					PROF3	

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Milestones: Domains Mapped to Competencies

Domain	Patient Care & Procedural Skills	Medical Knowledge	Practice-based Learning & Improvement	Interpersonal & Communication Skills	Pro-fessionalism	Systems-Based Practice
CDC	PC1, PC2			ICS1		
POP	PC3	MK1,MK2		ICS3	PROF1	
CC				ICS2		SBP1
IC			PBLI3			SBP2
TCH			PBLI1			
SDL			PBLI2			
MPEH					PROF2	
PAT					PROF3	

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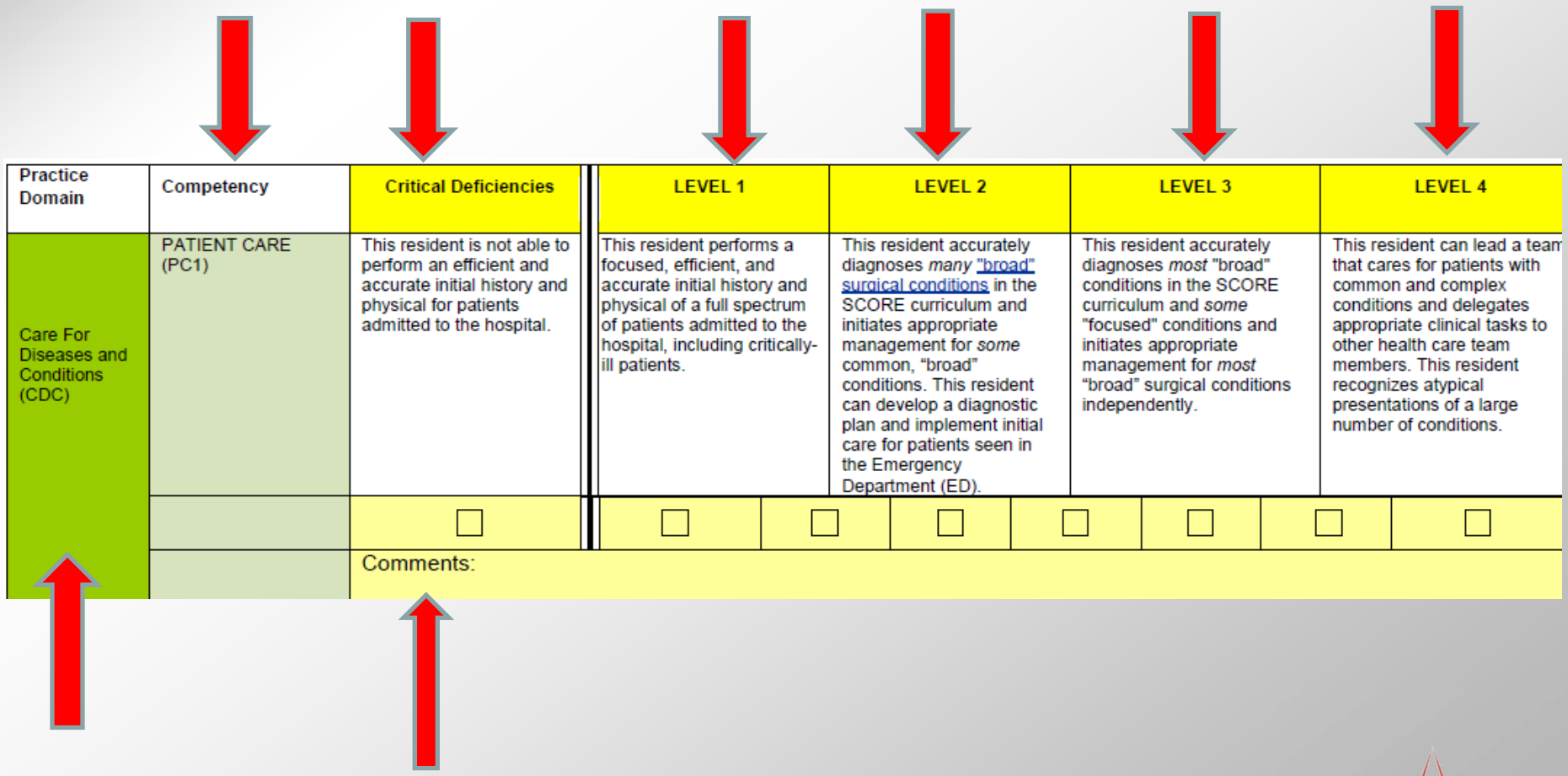
Surgery Milestones PC1



Practice Domain	Competency	Critical Deficiencies	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Care For Diseases and Conditions (CDC)	PATIENT CARE (PC1)	This resident is not able to perform an efficient and accurate initial history and physical for patients admitted to the hospital.	This resident performs a focused, efficient, and accurate initial history and physical of a full spectrum of patients admitted to the hospital, including critically-ill patients.	This resident accurately diagnoses *many* "broad" surgical conditions in the SCORE curriculum and initiates appropriate management for *some* common, "broad" conditions. This resident can develop a diagnostic plan and implement initial care for patients seen in the Emergency Department (ED).	This resident accurately diagnoses *most* "broad" conditions in the SCORE curriculum and *some* "focused" conditions and initiates appropriate management for *most* "broad" surgical conditions independently.	This resident can lead a team that cares for patients with common and complex conditions and delegates appropriate clinical tasks to other health care team members. This resident recognizes atypical presentations of a large number of conditions.
		☐	☐	☐	☐	☐
		Comments:				

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Milestones

- Why?
- What?
- Who?
- When?

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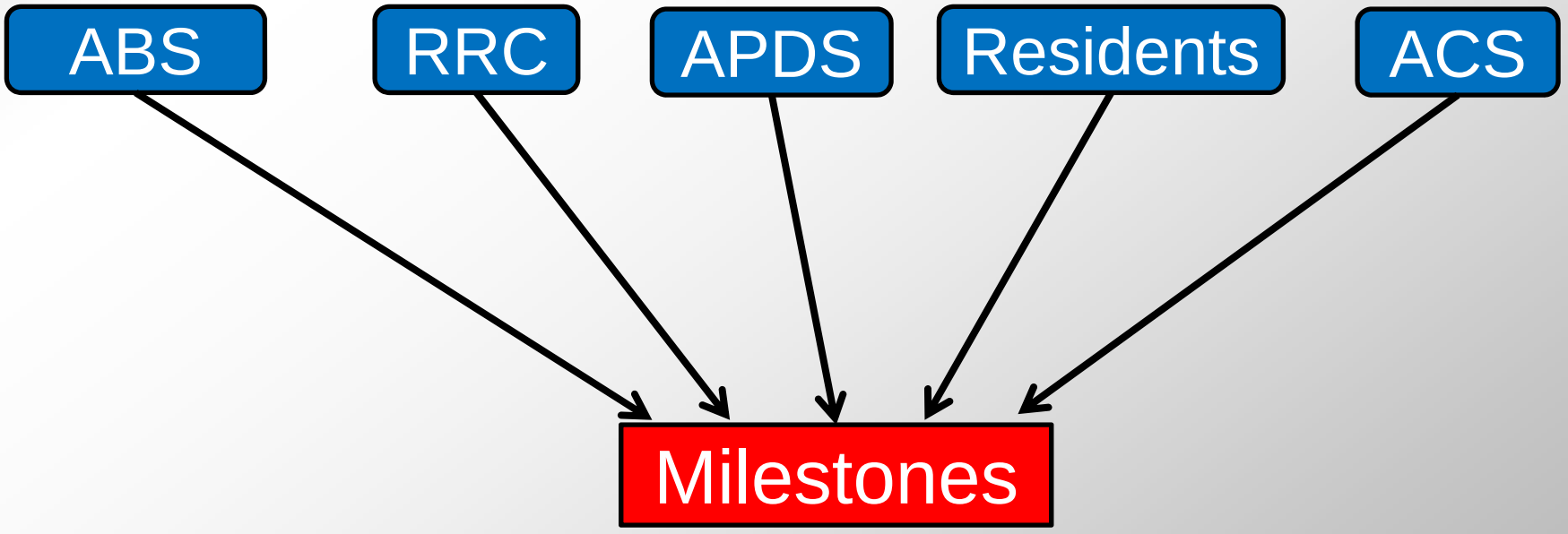
Creation of Milestones



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GS Milestones Working Group

- Dick Bell, MD[1,5]
- Tom Cogbill, MD[1,3,5]
- Stan Ashley, MD[1,5]
- Karen Borman, MD[1,3,5]
- Jo Buyske, MD[1,5]
- Joe Cofer, MD[1,3,5]
- Adeline Deladisma, MD[6]
- Mark Friedell, MD[3,5]
- Jim Hebert, MD[2,4,,5]
- Mark Malangoni, MD[1,2]
- Paula Termuhlen, MD[3,5]
- Jim Valentine, MD[1,3,5]
- Reed Williams, PhD[4]
- Charles Van Way, MD[3]
- Peggy Simpson, EdD[7]
- Susan Swing, PhD[7]

[1] American Board of Surgery
[2] RRC-Surgery
[3] Association of Program Directors in Surgery
[4] Association for Surgical Education
[5] American College of Surgeons
[6] Resident
[7] ACGME Staff

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Milestones

- Why?
- What?
- Who?
- When?

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Milestones: When?

Publication:

General Surgery: July 2013

Implementation (data collection):

General Surgery Programs: AY 2014-15

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Milestones												

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The Clinical Competency Committee (CCC)

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Goals

- How do we assess for Milestones?
- What does the ACGME expect for CCCs?
- How can CCCs work?

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Milestones Assessment

- A desire for objective methods of assessment and provide better feedback
- Provide a process for early identification of residents that are having difficulties
- A desire to encourage innovation

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Milestones Assessment

- Several evaluators are better than one
- Size, composition, frequency, workflow may have to vary and is difficult to regulate

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Clinical Competency Committee

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee.(Core)

ACGME Common Program Requirements
Approved: February 7, 2012; Effective: July 1, 2013
Approved focused revision: June 9, 2013; Effective: July 1, 2013

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Clinical Competency Committee

V.A.1. The program director must appoint the Clinical Competency Committee.(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.(Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team.(Detail)

ACGME Common Program Requirements
Approved: February 7, 2012; Effective: July 1, 2013
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Clinical Competency Committee

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

ACGME Common Program Requirements
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Clinical Competency Committee

How the CCC does its work may be decided by the Program Director

- Subcommittees
- Assigning residents to faculty members for pre-review
- Pre-review work will vary
- Some CCCs meet more than twice a year

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Clinical Competency Committee

- The program director's role on the CCC
- The program coordinator's role on the CCC
- Residents and fellows **cannot** be members of the CCC

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Reporting the Milestones

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME (Core)

- Milestones are reported directly through ADS
- Reporting windows are:
  - November 1-December 31
  - May 1-June 15

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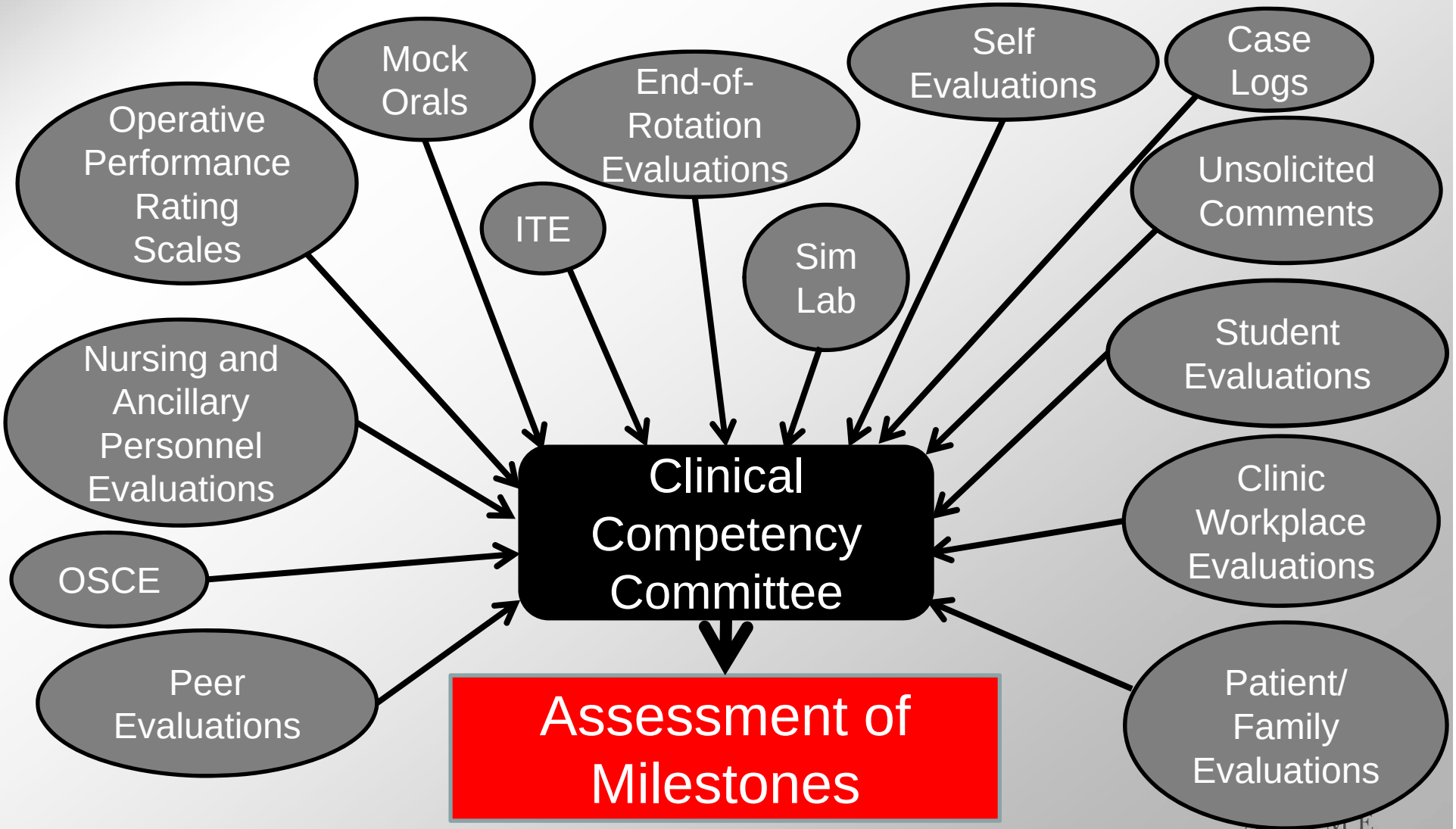
Clinical Competency Committee



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What Should a CCC Do First?

- Learn the Milestones
  - Posted on acgme.org
- Ensure at least one Program Goal or Objective can be mapped to each Milestone
- Decide how to assess the Milestones
- If necessary, identify new evaluation tools from program director associations, societies, colleges, etc.
- Faculty members should:
  - Discuss definitions and narratives
  - Agree on the narratives
  - Learn about assessment tools

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The Program Evaluation Committee (PEC) and the Annual Program Evaluation

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PEC Program Requirements

V.C.1. The program director must appoint the Program Evaluation Committee (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

ACGME Common Program Requirements
Approved: February 7, 2012; Effective: July 1, 2013
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PEC Program Requirements

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

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PEC Program Requirements

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation. (Core)

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Approved: February 7, 2012; Effective: July 1, 2013
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PEC Program Requirements

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.d) program quality; (Core)

ACGME Common Program Requirements
Approved: February 7, 2012; Effective: July 1, 2013
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PEC Program Requirements

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)

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PEC Program Requirements

The program must monitor and track:

V.C.2.e) progress on the previous year's action plan(s). (Core)

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PEC Program Requirements

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

ACGME Common Program Requirements
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PEC Function

- There are no requirements on *how* the PEC should carry out its duties
- The PEC and/or the PD may carry out the improvement plans
- The work of the PEC can go beyond meeting minimum standards→ continous improvement model

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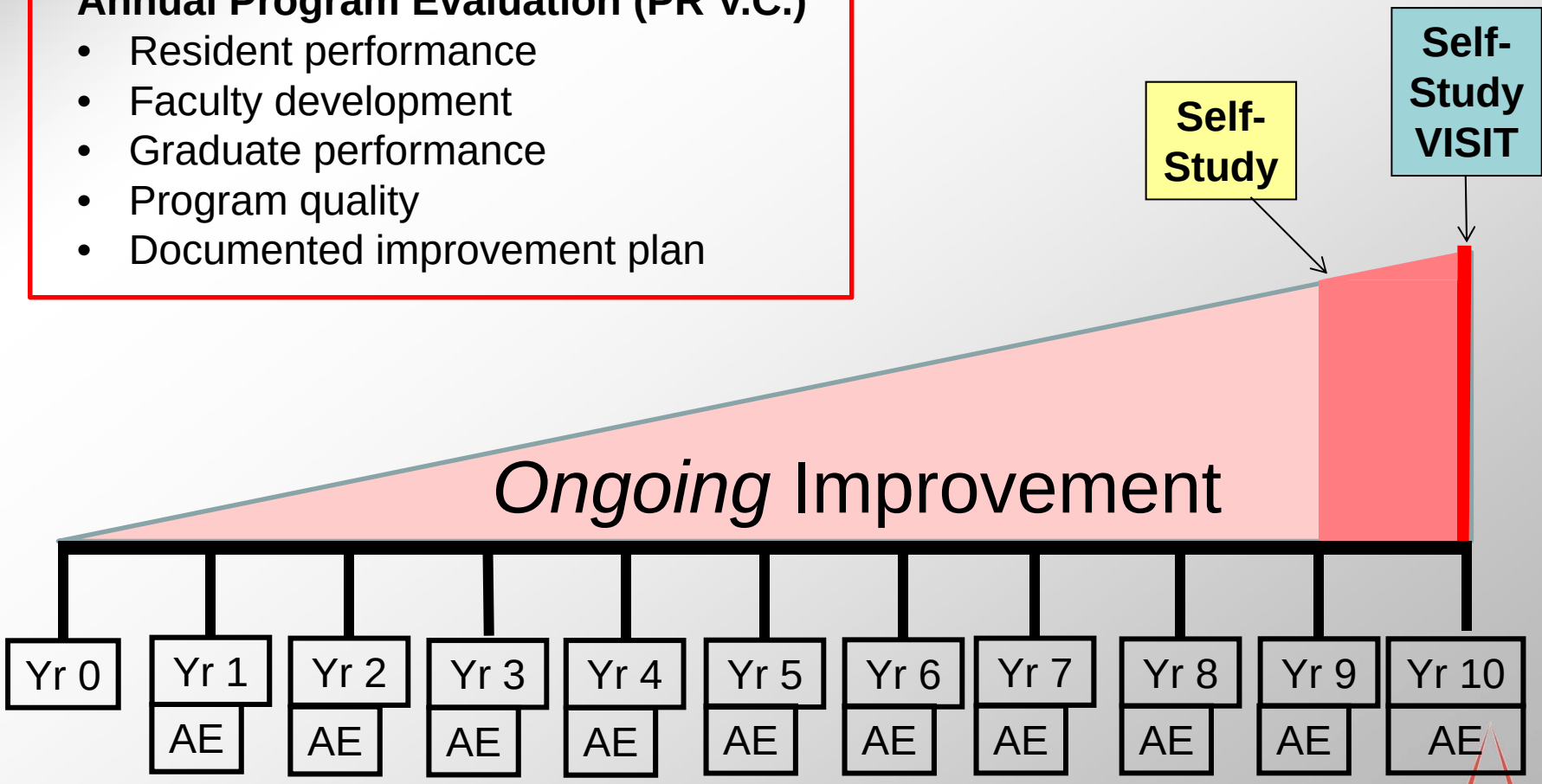
Ten Year Self-Study Visit

Annual Program Evaluation (PR V.C.)

- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Documented improvement plan



AE: Annual Program Evaluation

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PEC Summary

- Program evaluation requirements are not new
- Specific functions in the Program Requirements
- Flexibility in carrying out duties

ACGME Common Program Requirements
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Resources

- Webinar Information
  - Past
  - Future
- Faculty Development Resources
- Contact Information

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Previous Webinars

- Previous webinars available for review at:

  http://www.acgme-nas.org/index.html under

  "ACGME Webinars"

  - CLER
  - Milestones, Evaluation, CCCs
  - Specialty specific Webinars (Phase 1&2)
  - Coordinators Webinars (Phase 1)

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Upcoming Webinars

- Self-Study Process (what programs do)
- Self-Study Site Visit (what site visitors do)

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Faculty Development PPTs

- On ACGME's Website for download by PDs and GME community:
  - NAS
  - CLER
  - CCC/PEC
  - Milestones
  - Update on new ACGME policies
  - Self Study
- <20 min each

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Contact Information

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  Accreditation Assistant
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THANK YOU!!!!

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Getting a 2nd Chance "Coulda, Woulda, Shoulda"

Juanita Braxton
University of California, Davis
Surgical Education Administration

Why Do I Care?

- Why Do You want to Grow?
- What is a Second Chance to you?
- Do you want to a Second Chance to grow both in:

Personal development and/or for Career Advancement?

(Professional Development Handout)

Why Should You Care?

- You spend more waking hours at your place of business than you do at home during the day, make it enjoyable and personable.

- Do You Want a Job or a Career, Both or Neither?

GME – Who Knew?

- Graduate Medical Education
  - MY, MY, MY, has it changed over the last 20 years
  - The Second Chance to Get it Right
    - No PIF (still plenty of paperwork..lol)
    - More focus on Resident Responsibilities
    - More Responsibilities for Program Administrators
    - Collaborative Efforts between Hospital, GME and the Programs

NAS and Me – Professional Growth

- Is the Next Accreditation System a Second Chance Career?
- If not GME, how about CLER?
- If not CLER, how about Global Health and International Rotations

- ***If Not Any of the Above, then WHAT!***

Second Chance – Blah, Blah, Blah

"Sometimes life gives you a second chance, or even two! Not always, but sometimes. It's what you do with those second chances that counts."

Second Chances are for those that realized the first chance was a missed opportunity!

Professional Perspective

Perspective is as simple as answering this question: If I had 12 months to live would I do what I am doing right this minute or do I wish I was doing something entirely different?

How would I improve my personal development to fit with my career advancement.

Top 10 Deathbed Regrets

1. I wish I'd had the courage to live a life true to myself, not the life other people expected of me.

2. I wish I took time to be with my children more when they were growing up.

3. I wish I had the courage to express my feelings, without the fear of being rejected or unpopular.

4. I wish I would have stayed in touch with friends and family.

5. I wish I would have forgiven someone when I had the chance.

6. I wish I would have told the people I loved the most how important they are to me.

7. I wish I would have had more confidence and tried more things, instead of being afraid of looking like a fool.

8. I wish I would have done more to make an impact in this world.

9. I wish I would have experienced more, instead of settling for a boring life filled with routine, mediocrity and apathy.

10. I wish I would have pursued my talents and gifts.

Professional Development and Me?

- What is Professional Development?
  - *Wikipedia*
    - In workplaces, **professional development** refers to the acquisition of skills and knowledge, both for personal development and for career advancement.

It's All About What You Want!

This is what it is all about:

Is what I am doing right now helping me in my Personal Development and/or in my Career Advancement?

Thank You

Thank you President Mary Burda and the Executive Committee for allowing me to participate in this year's conference. It is my hope that each of us in Program Administration will do our very best each and every day to uphold the tradition and mission of excellence of ARCS!

GREENVILLE
HEALTH SYSTEM

Jenni and Darlene

HAVE NO CONFLICT OF INTEREST TO REPORT

Modernizing the interview process for the preliminary candidate:

"The evolution from face-to-face and airline rewards to *FaceTime™* and to *Skype™*"

Jenni Shieck, MBA
Afshin Molkara, MD
Riverside County Regional Medical Center
Moreno Valley, California

S. Darlene Norton, C-TAGME
Dane E. Smith, MD
Greenville Health System
Greenville, South Carolina

Goals and Objectives:

- Share the experience of 2 programs that changed the traditional method of interviewing preliminary candidates
- Communicate alternate methods for interviewing preliminary surgery candidates using internet based systems
- Describe how using an internet based system in the interview process can save the program and candidate time, money and resources.

Points to Ponder

- How many of you have preliminary residents in your program?
- How many of you hold separate interview days for preliminary candidates?
- How many of you conduct your preliminary interviews only on the phone?
- How many of you don't interview preliminary candidates, you match them all through SOAP?
- How many of you have used Skype™ or Facetime™ for interviews?

The 2013 Match

- NRMP results:

Surgery	Programs	Positions	Unfilled positions
Categorical	246	1185	3
Preliminary	293	1278	139

RCRMC Department of Surgery

2013-14 Interview season

- NRMP Quota – 2 Preliminary Residents
  – 4 Categorical Resident
- 72 Interviews slots
- 4 dates (Monday)
- Meet and Greet on Sunday night
- Interview 18 candidates per day
- 406 applications for training (174 applications for preliminary interviews – some of those applied for categorical positions as well)

GHS Department of Surgery

2013-14 Interview season

- NRMP Quota – 4 Preliminary Residents
  – 6 Categorical Resident
- 60 Interviews slots
- 10 dates (FRIDAY) – lodging/dinner provided the night before
- Interview 6 candidates per day
- 647 applications for training (259 applications for preliminary interviews – some of those applied for categorical positions as well)

Comparison:

	Categorical Residents	Preliminary Residents	Number of Interview Days	Categorical Applicants Interviewed	Preliminary Applicants Interviewed
GHS	6	4	10	65	11*
RCRMC	4	2	4	72	9*

*This is in addition to the candidates we interviewed for categorical who also selected preliminary

Why change?

- Saves the preliminary candidate and the hospital the expense of travel, room, meals

  GHS ($93 room/tax + $40 meal / allowed per candidate) = $133/candidate – total $1,596

  RCRMC (no room– $54 meal/allowed per candidate) = $54/candidate – total $486
- All interview slots can be used for categorical candidate interviews
- Skype™ and FaceTime™ are free to download – no cost involved for program or individual!
- Preliminary candidates are most likely to cancel interview – sometimes at the last minute

Easy connection around the United States!

Easy Connection around the World!

Cost for faculty

- GHS – 4 faculty interview
- Clinic – 15 patients x 10 interview days = 150 pts rescheduled
  (numbers reflect PD only)

- RCRMC – 7 faculty interview
  - 5 Faculty from County Hospital
    - On average 16 operative cases not done during interview day (rescheduled to later in the day or the next day)
    - No Outpatient clinic responsibilities on interview days
  - 2 Faculty from Kaiser
    - Clinic time postponed: 30 patients rescheduled

Be Prepared:

- Get your program director, faculty and residents on board
- Check out the internet at your hospital, do you get a good connection
- Does your IT department support these internet options
- Will you have to use the PD's personal computer and connect to wi-fi
- Get the program director a Skype™ address
- Practice ahead of time
- Have a back-up plan

FaceTime™ vs Skype™

- FaceTime is for Mac available to use with iphone, ipad, ipod or “apple” computer
- Skype can be used on android devices or the above as well (little more cumbersome on apple device)

Method Selected

- RCRMC = Skype
  - Facetime as back-up
- GHS = Facetime (9)
  Skype (2)

The GHS Way

- Review preliminary candidate files in ERAS
- Goal – to identify residents with residency appointments: Anesthesia, Radiology, etc.
- Ensure they meet program criteria, program director's approval
- Blocked 2 afternoons on PD's calendar
  - Need date/times to offer interviewee(s)
- Invite for an interview

The RCRMC Way

- Review preliminary candidate files in ERAS
- Goal – to identify residents with residency appointments: Anesthesia, Radiology, etc.
- Ensure they meet program criteria, program director's approval
- Blocked 1 afternoon on PD's calendar
  - Need date/times to offer interviewee(s)
- Blocked 1 afternoon for 2 residents to participate in interview with PD
- Invite for an interview

Invitation to Interview – email

- Send an email to those PD wanted to invite:
- Dear
-
- After review of your application, I am happy to offer you an interview with the Greenville Health System, Department of Surgery Residency Program in Greenville, South Carolina!
-
- This year we plan to interview all preliminary candidates using internet based system(s) to save you time, money and resources. We will use *Skype*™ or *FaceTime*™ for this purpose. Both are free to you and can be downloaded from the internet with ease. In your interview, you will have the opportunity to interview with the Program Director. A resident or two will follow-up with you to ensure all of your questions have been answered. This will be our first year using this method for interviewing, but think it will be beneficial for our preliminary candidates.
-
- Please contact Mrs. Darlene Norton, our residency coordinator, to arrange an interview at your earliest convenience. You can email Darlene at dnorton@ghs.org or call 864 455 1435. We look forward to hearing from you soon!
-
- Sincerely,
-
-
-
-
-
- Dane E. Smith, MD, FACS
- Program Director
- Greenville Health System
- 701 Grove Road, 3rd Floor Support Tower
- Greenville, SC 29605
-
- DES:dn

Confirmation – email

- Dear
- We are delighted that you are interviewing with us for a preliminary internship here in Greenville! Your interview is scheduled for Monday, November 18th, 2013. The time for your interview is listed below.
- Dr. Dane Smith will contact you using the phone number, email or address that have you have provided. Let me know if you have any questions, or if I may assist you in any way. This is our first year offering our preliminary candidates an alternative method like FaceTime© or Skype©. Hopefully, this will save you time, money and resources, as well as giving us the opportunity to meet and discuss what our program has to offer for your continued, successful medical career training. Following your interview, one of our residents will follow-up with you to see if they may be able to answer any questions you may have remaining.
- I have attached some information about our hospital and the Greenville community that may be of interest to you. Thank you again for your interest in our program,
- Date: 11/18/2013

Jessie Smith	1:10 pm	SKYPE
Peter Paul	1:40 pm	FaceTime
Matthew Jones	2:10 pm	FaceTime
Sue Henry	2:40 pm	FaceTime

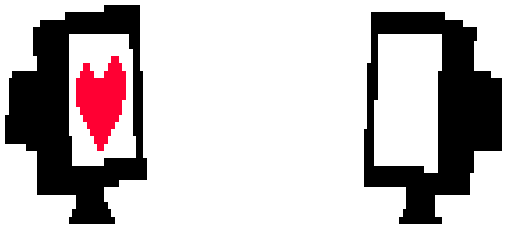
- For more information about our benefits and community, check out the websites below:
- www.ghs.org/

  http://www.iwasblownaway.com/
- http://www.greenvillecvb.com/
- http://towngreenville.com/
- Greenville & GHS Pinterest Boards

- **S. Darlene Norton, C-TAGME I General Surgery Residency Program Coordinator**
- Greenville Health System
- 701 Grove Road I 3rd Floor Support Tower I Greenville, SC 29605
- Office: 864 455 1435 Fax: 864 455 1320

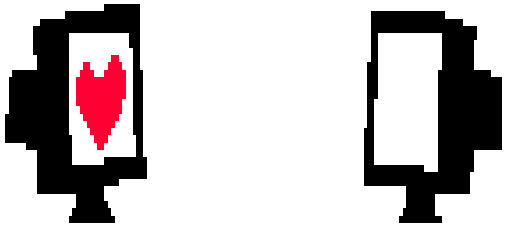
GHS System

- Block time on PDs schedule
- Allot 30 minutes for each interview (interview 20- 25 min)
- Schedule 3 or 4 interviews at one time
- Resident to follow-up within "the week" with email and phone call
  - Candidates were very receptive and appreciative – no cancellations!

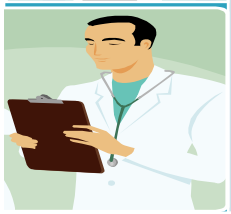


RCRMC System

- Block time on PDs schedule
- Allot 30 minutes for each interview (interview 20- 25 min)
- Scheduled 9interviews for the same day
- Residents participated in the interview with PD and then given private time to answer questions, about 10 additional minutes
  - Candidates were very receptive and appreciative – no cancellations



Schedule for PD

Date of Interview 11/18/2013 Picture of Candidate	Name / Time of Interview	How to Contact	School	Phone / email	Notes
	Jessie Smith **12/8** **1:10 pm**	SKYPE Please video call her SKYPE Name: Jessie.Smith	USC School of Medicine Program: Anesthesia	773 895 3801	Overall rating: _____
	Peter Paul **12/8** **1:40 pm**	FaceTime pls call 888 999 7779	Medical Univ of South Carolina Program: Radiology	888 999 7779	Overall rating: _____
	**Matthew Jones** **12/8** **2:10 pm**	FaceTime pls call 888 999 7777	Univ of Texas SW Med Center Program: Oral Surgery	888 999 7777	Overall rating: _____
	Sue Henry **12/8** **2:40 pm**	FaceTime pls call 888 999 7778	Quillen College of Medicine Program: Ortho	888 999 7778	Overall rating: _____

Pros to alternative interview methods

- Cost savings to the program and candidate
- Time saved for program and candidate
- Can add last minute or late applicants with ease
- Can reach applicants around the US or the world
- Easy to set up
- No cancelations!
- Program Director and Residents loved it!
- Applicants very appreciative of process

Cons to alternative interview methods

- Need to get Program Director on board
- Program Director must be willing to explore alternative interview methods. Step out of comfort zone
- Need good IT support
- Resident doesn't follow-up with phone call or email
- Case added to PD's schedule or runs longer than scheduled
- Need back-up plan

Program – First Impressions

Candidates very professional

- Dressed appropriately
- Great attitude
- Took process seriously, as though it was face to face
- On time and ready to go (no problems if we had to push back time)

Candidates prepared

- Reviewed items sent prior to interview
- Candidates appreciative
- No cancelations due to flight delays or weather!

Candidate First Impressions

Comments from candidates:

- GREAT idea!
- This is a wonderful thing – thank you!
- Even though I did not get to visit your program in person, I felt that the interactions that we had gave me a great view of what being an intern at your program would be …
- Researched your website and feel that your institution would offer me the type of preliminary year that I am looking for!
- This was a great idea – you can't imagine how much time and money you saved me

Other ways to use this system

- Second Looks
- SOAP
- Long distant interviews (out of the country)
- Lectures for residents off site
- Conferences with off site faculty
- …… do you have suggestions

Learning Points

- Program Director after review liked idea – agreed to the plan (did want to think about it for a while)
- Faculty were not so resistant to change after all
- Residents jumped on-board
- Candidates were impressed that a program would break tradition and offer a modern method to communicate with a text savvy generation
- Cost saving to candidate and the program

Improvements for next year

- GHS – Send out PD program overview PowerPoint
- RCRMC – Virtual Tour link (coming soon)

Our Experience

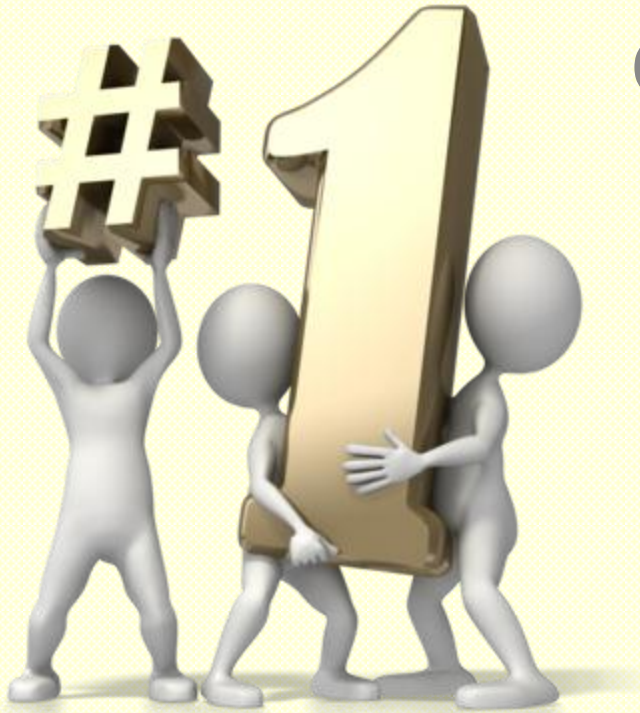
- Great opportunity to network with another ARCS Member
- Learned from each other
- Helped our Program Director(s) try something new – see something another way
- Chance to collaborate with another program
- Opportunity to affect change – make a difference
- Moved out of comfort zone a little
- It was FUN!!!

Who's Number 1?

ARCS

Chicago, Illinois

April 2014



Historical View

- Was the match process the same ~ 50 years ago?
- Did the candidates choose programs based on salary, location, prestige, fit?
- How do students choose today?

Walk Down Rank Order List Lane

Start 48 years ago…End with today…

Dr. W. Kirt Nichols

- Graduated from University of Michigan Medical School 1966
- Year of rotating internship 1966-1967
- General Surgery at the University of Missouri
- There was NO match

Dr. Brent Miedema

- Graduated from Cornell 1979
- General Surgery at New York Hospital 1979-1984
- Staff Surgeon VA Hospital in Wyoming, 1984-1988
- Fellowship, Gastroenterology, Mayo 1988-1990

Dr. Debra Koivunen

- Graduated from University of Michigan Medical School, 1978
- Completed Residency at University of Missouri-Columbia, 1978-1984
- Completed Endocrine Fellowship at Penn State, 1984-1986

Dr. Stephen Barnes

- Graduated from University of Alabama 1997
- General Surgery University of Kentucky, Lexington 1997-2002
- Critical Care/ACS Fellowship 2002-2004 University of Kentucky, Lexington

Dr. Jeffrey Coughenour

- Graduated from University of Missouri-Kansas City 2001
- Preliminary year at University of Kentucky, Lexington 2001-2002
- General Surgery at the University of Missouri-Kansas City 2002-2006
- Critical Care/ACS Fellowship 2006-2008

  University of Kentucky, Lexington

Dr. Christopher Nelson

- Graduated from University of North Dakota, Grand Fork 2005
- General Surgery at the University of Missouri 2005-2010
- Critical Care Fellow, University of Missouri 2010-2011

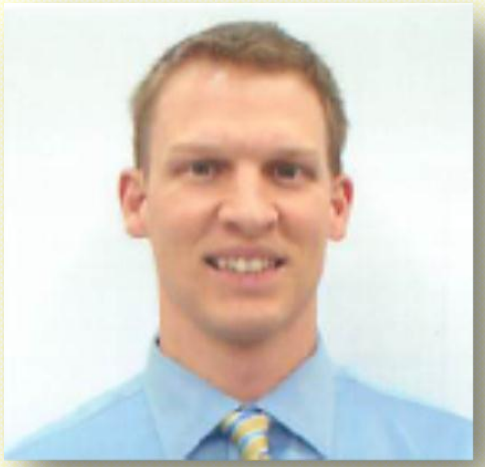
Dr. Arthur Rawlings

- Graduated from University of Illinois-Peoria 2004
- General Surgery at the University of Illinois, Peoria 2004-2009
- Fellowship in MIS, Washington University,

  St. Louis, Mo 2009-2010

Dr. Christopher Cooper

- Earned M.D. from The Brody School of Medicine at East Carolina University, 2004-2008
- Current Resident at University of Missouri-Columbia General Surgery, 2008-2014
- Matched into #1 Fellowship Choice, UCLA Trauma Fellowship beginning July 2014



Dr. Jacob Quick

- Earned M.D. from the University of Missouri-Columbia, 2004-2008
- Currently Administrative Chief Resident at University of Missouri-Columbia General Surgery, 2008-2014
- Completed Surgery Critical Care Fellowship in 2012 at University of Missouri-Columbia
- Accepted Faculty Position at University of Missouri-Columbia beginning July 2014

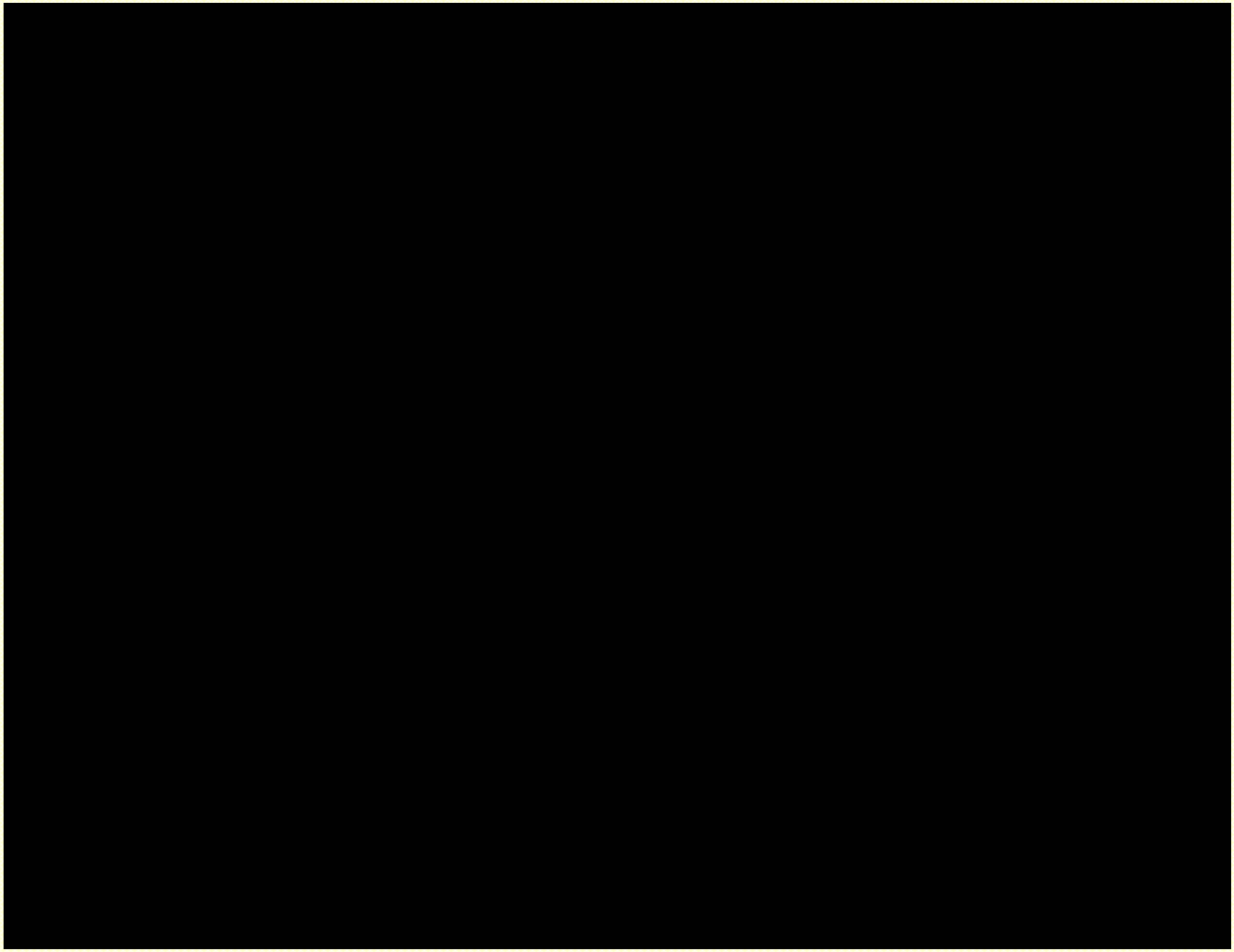
Dr. Nicole Tuve-Nelson

- Completed medical school at Nova Southeastern University (Osteopathic), 2009
- Currently a Chief Resident at University of Missouri-Columbia General Surgery
- Plans to remain in Columbia after June 2014

Consensus After 50 Years?

Top Factors Cited by Faculty/Residents at MU

1. Connected with Faculty/Chair/Chief
2. Happiness of Residents
3. Location and lifestyle fit (significant others)
4. Gut Feelings



Match List

Location								
Commute								
Faculty								
Residents								
Warmth								
Respect								
Gut								
Specialties								
Fit								
Number of Residents								
Call/Early operate								

Rank/Match 2014

1. Location
2. Commute/Traffic
3. Diversity of Residents/Faculty
4. Warmth
5. Structure of Program
    a. All specialties
    b. Away requirements
    c. Electives
    d. Research requirement
6. Respected
7. Family proximity
8. Gut
9. Lifestyle
10. Resources
11. Where do you see yourself in 10 years
12. People
    a. Residents
    b. Faculty
13. Cost of living
14. Salary
15. Moonlighting availability
16. Benefits
17. Are you a fit?
18. How early do you operate?
19. Call schedule/night float?
20. Number of residents

Disclaimer

- Bethany and I would like to thank the Executive Committee from ARCS for allowing us to use the programs for this session. We appreciate the opportunity. Please know the information we have is limited to the program site and web search.
- Again, thank you.

Who's number 1?

- Now, let's make a list
- Bethany and I are going to show you 8 programs, give you information about them and ask you "who's number 1"?
- We will work through this with you
- Going from table to table
- Then discuss

University of Toledo General Surgery Residency Program

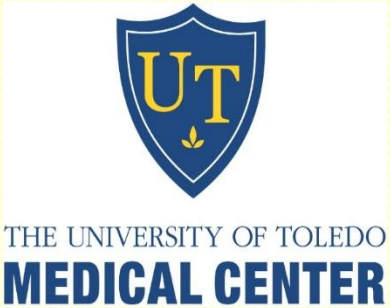
A. Program Information
   A. Residents
      A. Current: 4 Categorical Residents per year with 2 PGY-1 Preliminary Spots
      B. Graduates 2012: 4 to fellowship (Surgery Critical Care, Plastics, Transplant (x2)),
      C. Faculty: 2 CT, 1 Surgical Oncology, 1 Colorectal, 4 General Surgery, 1 MIS, 2 Breast, 2 Trauma Critical Care, 4 Vascular, 4 Surgical Research, 5 Surgical Education
   B. Structure
      A. 6 year program, 1 year spent in research
   C. Other Information
      A. Simulation: Maintains a simulation lab for computerized laparoscopic simulation and training as well as real-time dry laparoscopic lab.

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Quick Facts on Toledo, OH

- The city proper had a population of 287,128
- 100 miles west of Cleveland and 50 miles south of Detroit
- Home to a zoo, the Toledo Speedway, and the Toledo Metroparks System

University of Toledo General Surgery Residency Program



Schedule

PGY-1	PGY-2	PGY-3	PGY-4	PGY-5
Blue Service (UTMC)	Blue Service (UTMC)	Gold/Trauma (UTMC)	Gold Service (UTMC)	Blue Service (UTMC)
White Service (UTMC)	Gold/Trauma Surgery(UTMC)	Breast Surgery (UTMC)	Night Float (UTMC)	White Service (UTMC)
Gold/Trauma Surgery(UTMC)	Breast Surgery (UTMC)	Vascular Surgery (UTMC)	Pediatric Surgery (SVMMC)	Night Float (UTMC)
Breast/Plastic Surgery(UTMC)	Vascular Surgery (UTMC)	Transplant (UTMC)	Vascular Surgery (TTH)	General Surgery (SVMMC)
Night Float (UTMC)	General Surgery (SVMMC)	General Surgery (SVMMC)	General Surgery (SL)	General Surgery (SL)
Trauma Surgery (TTH)	Night Float (SVMMC)	Night Float (SVMMC)	Colorectal Surgery (SL)	
Cardiothoracic Surgery (UTMC)	General Surgery (SL)	Trauma Surgery (TTH)		
Neurosurgery (UTMC)				
Surgical Critical Care (UTMC)				
Urology (UTMC)				
Orthopeadics (UTMC)				

Case Numbers

The data listed below represents the average number of cases the 2008-2009 graduates performed during their residency.

Defined Category	Minimum Numbers	University of Toledo
Soft Skin Tissue and Breast	25	**76**
Head and Neck	24	**59**
Alimentary Tract	72	**132**
Abdomen	65	**122**
Liver	4	**9**
Pancreas	3	**10**
Vascular	44	**181**
Endocrine	8	**20**
Trauma - Operative	10	**24**
Trauma Non-operative	20	**27**
Thoracic	15	**41**
Pediatrics	20	**30**
Plastics	15	**20**
Laparoscopic - Basic	60	**113**
Endoscopy	54	**131**
Laparoscopic - Complex	25	**58**
Total Major Cases	500	**1017**
Total Chief Cases	150	**223**

Vanderbilt University General Surgery Residency Program

VANDERBILT UNIVERSITY MEDICAL CENTER

A. Program Information
   A. Residents
      A. Current: 8 Categorical Residents, 2 Preliminary PGY- 2 Residents
   B. Faculty: 17 General Surgery, 5 Hepatobiliary and Liver Transplant, 4 Kidney and Pancreas Transplant, 21 Surgical Oncology and Endocrine, 10 Trauma and Surgery Critical Care, 4 Thoracic, 3 Vascular, 9 Pediatric
   C. Structure
      A. 5 Year Program but encouraged to participate in a research fellowship
   D. Schedule: Rotations are crafted for each year and residents
   E. Other Information
      A. International Surgery Elective Rotation Available for PGY 4 residents
      B. Offers the Vanderbilt Center for Experiential Learning and Assessment for simulation using standardized patients and other resources

Quick Facts on Nashville, TN

- Capital of Tennessee
- Located on the Cumberland River
- Nickname “Music City”
- Population 1,589,934 (entire metropolitan area- 13 counties)
- Fifth largest city in Southeastern US

UCLA General Surgery Residency Program

A. Program Information
   A. Residents
      A. Current: 7 categorical positions
      B. Graduates: 7 to fellowship (1 Colorectal, 1 MIS/Robotics, 2 Plastic Surgery, 1 Vascular, 1 Thoracic, 1 Critical Care)
      C. Faculty: 37 General Surgery (incl. Breast, Colorectal, Critical care, Endocrine, Esophagus, GI, hernia, Pancreas, metabolic/bariatric, trauma), 7 Transplant, 4 Pediatrics, 5 Surgical Oncology, 3 Thoracic, 10 Vascular
   B. Structure
      A. 7 Year Program, 5 years clinical with 2 years research
   C. Schedule: 5 Rotation sites
   D. Cases: Residents graduate with an average of 1100 major cases during training
   E. Other Information
      A. Center for Advanced Surgical and Interventional Technology is a UCLA-designated research facility using simulation

UCLA Ronald Reagan Medical Center

Quick Facts on Los Angles, CA

- Population 3,857,799
- 2nd biggest US City
- Economy drivers: international trade, entertainment, aerospace, technology, tourism
- One in six residents work in the “creative industry”
- Extensive public transportation and transit systems
- Major Airport
- Coastal Climate

University of Kansas at Wichita General Surgery Residency Program

A. Program Information
    A. Residents
        A. Current: 6 Categorical Residents a year
        B. Graduates: Over the last 10 years (2003 through 2013), have entered postgraduate programs in the following subspecialties: advanced laparoscopy, colorectal surgery, plastic and reconstructive surgery, Transplant surgery, trauma, critical care, vascular surgery, burn, and cardiothoracic surgery.
    B. Faculty: 4 full time faculty, 46 part-time faculty
    C. Structure: University affiliated community based program, 3 major rotation sites
    A. Schedule: 5 Year Program
    B. Other Information
        A. ABS Pass Rate: During the past five years 93% of our residents who sat for the Qualifying and Certifying Examinations of the American Board of Surgery have passed. The percent rate for passing these examinations on the first attempt was 97% for the Qualifying Examination (QE) and 96% for the Certifying Examination (CE)

Quick Facts on Wichita, KS

- Largest City in Kansas
- Population 382,368
- Located on the Arkansas River
- "The Air Capital of the World"
- Aircraft manufacturing is primary industrial sector
- Second Largest IMAX
- Midwest, Small Tight Community Feel

University of Kansas at Wichita General Surgery Residency Program

Rotation Schedule

PGY 1	
Trauma / Critical Care	1 month
Plastic Surgery	1 month
Hepatobiliary / Colorectal Surgery	2 months
General Surgery	6 months
General / Vascular Surgery	2 months
PGY 2	
Trauma / Critical Care	4 months
Breast Surgery	2 months
General / Vascular Surgery	2 months
General Surgery	4 month
PGY 3	
General Surgery	6 months
General / Vascular Surgery	2 months
Cardiothoracic / Vascular	2 months
Burn Center / Critical Care	2 month
PGY 4	
General Surgery	2 months
General / Vascular Surgery	2 months
Hepatobiliary / Colorectal Surgery	2 months
Trauma / Critical Care	4 months
Elective Rotation	2 Months
PGY 5	
General Surgery	8 months
General / Vascular Surgery	2 months
General / Colorectal Surgery	2 months

Case Information

Surgeon - as chief resident	266 cases
Surgeon - as junior resident	837 cases
Surgeon - 1st year resident	146 cases
Total	1249 cases
First assistant	314 cases
Endoscopy	256 cases
Laparoscopy - Basic & Complex	213 cases

Guthrie Robert Packard General Surgery Residency Program

A. Program Information
    A. Residents
        A. Current: 3 Categorical per year, 3 Preliminary PGY 1
        B. Graduates: Program reports half go the fellowship and half go to private practice
    B. Faculty: Hospital
    C. Structure: 5 year program including rotations at University of Rochester Medical Center, ideal for those interested in practicing in rural settings
    D. Other Information
        A. Surgical Skills lab and curriculum with both high and low fidelity simulation
        B. Relocation Allowance for PGY 1 Residents

Quick Facts on Sayre, PA

- Population 5,587
- Within 40 minutes of the cities of Binghamton and Elmira, New York as well as within 4 hours to New York City, Philadelphia, and Niagara Falls, 2 hours from Rochester and Syracuse, and 5 hours from Boston
- Small town feel with a close community

Guthrie Robert Packard General Surgery Residency Program

Schedule

PGY-1

The "Intern" year. This year is primarily aimed at learning the art of pre-, peri-, and postoperative care of the surgical patient. The majority of the year is spent on the General Surgery service. Rotations on the Subspecialty Surgery service are also included in this year. Preliminary residents complete the same General Surgery and Subspecialty rotations.

PGY-2

Residents in their second year will see increased clinical responsibilities in General Surgery and Subspecialty Surgery. The primary focus is on critical care with rotations on the ICU service. Rotations in Pediatric Surgery, Transplant Surgery, and Trauma will be completed at the University of Rochester Medical Center.

PGY-3

In the third year, General Surgery residents will serve on the General Surgery and Subspecialty Surgery services. A rotation on research is included in this year where the resident has the opportunity to research areas of special interest.

PGY-4

This year is characterized by increased clinical and operative responsibilities in General Surgery and Subspecialty Surgery. During the Subspecialty Surgery rotation, the 4th year resident will act as Chief for the service. This year hones the surgical skills learned in previous years and career plans are established and/or finalized.

PGY-5

The "Chief" year. The surgical experience culminates in this year. The Chief residents have the ultimate responsibility for the General Surgery service as well as administrative and educational duties. The surgical skills learned throughout the residency are fine-tuned and career plans are set. By the end of this year, the resident has become a well-trained, competent general surgeon.

Robert Wood Johnson General Surgery Residency Program

RUTGERS
Robert Wood Johnson Medical School

A. Program Information
   A. Residents
      A. Current: 6 Categorical per year
      B. Graduates: 1 Plastics, 1 Thoracic, 1 Surgery Critical Care, 1 Colorectal, 1 MIS, 1 Transplant
   B. Faculty: 8 General Surgery, 8 Acute Care, 7 Cardiothoracic, 2 Pediatric, 10 Surgical Oncology, 7 Surgical Sciences, 7 Vascular
   C. Structure: 6 year program, 5 year clinical program with 1 year as Surgical Investigator (Research)
   D. Other Information
      A. Very few fellows, so residents not challenged for cases

Quick Facts on New Brunswick, NJ
- Population 55,181
- Robust medical community
- Diverse population
- Served by the New Jersey Transit System and Amtrak
- North Eastern Climate

Mount Carmel General Surgery Residency Program

A. Program Information
   A. Residents
      A. Current: 3 Categorical positions per year and 3 Preliminary PGY 1
      B. Graduates: Over the last five years, 7 private practice, 3 Vascular Fellowship, 1 Critical Care Fellowship, 2 Colorectal Fellowship
   B. Faculty: 17 Core Faculty with an additional 3 in General Surgery, 3 in Vascular, 2 Pediatric Surgery, and 1 Transplant
   C. Structure: 5 year program operating out of 2 main hospitals and an outpatient surgery facility
   D. Other Information
      A. Extensive Didactic opportunities

Quick Facts on Columbus, OH

- Capital of Ohio
- Population 787,033
- Big Ten University City
- Small town quality with Big City feel
- Home to world's largest private research and development foundation, Battelle Memorial Institute
- 2012 *Business Week's* 50 best cities in America
- Transitional weather between hot, muggy summers and cold, dry winters

Mount Carmel General Surgery Residency Program

Schedule

PGY I (Categorical and Preliminary)

General Surgery	5-6 blocks
Pediatric Surgery	1 block (Categorical only)
ICU East	1-2 block(s)
Trauma/Critical Care	1-2 block(s)
Vascular	1 block
GI (Other)	1 block
Acute Care Surgery	2-3 blocks

PGY II (Categorical)

General Surgery	7 blocks
Vascular Surgery	1 block
Colorectal Surgery	1 block
Trauma/Critical Care	3 blocks
Thoracic Surgery	1 block

PGY III (Categorical)

Vascular Surgery	2 blocks
General Surgery	6 blocks
Colorectal Surgery	1 block
Trauma/Critical Care	1 block
Pediatric Surgery	2 blocks
Transplant Surgery	1 block

PGY IV

Vascular Surgery	2 blocks
General Surgery	7 blocks
Thoracic Surgery	1 block
Elective/Third World	1 block
Trauma/Critical Care	1 block
General Surgery Clinic	1 block

PGY V – 3 chief residents

MCW General Surgery Clinic	each =
MCE General Surgery Clinic	4-5 blocks
Float Chief/Gen Surgery	(Total 13 blocks of General Surgery)

Case Information

Category	Graduating 2013 Chief Residents' Major Procedure Averages	RRC Requirements
Skin, Soft Tissues and Breast	74.0	25
Head and Neck	70.3	24
Alimentary Tract	338.3	72
Abdomen	470.3	65
Liver	9.3	4
Pancreas	9.3	3
Vascular	130.7	44
Endocrine	27.7	8
TRAUMOP	19.7	10
TRNONOP	47.3	25
Thoracic	30.7	15
Pediatrics	33.0	20
Plastics	19.0	5
Endoscopy	136.0	85
Upper Endoscopy	46.7	35
Colonoscopy	84.7	50
Laparoscopic, Basic	302.7	60
Laparoscopic, Complex	110.0	25
Total Major Operations	1175.7	750
Total as Surgeon Chief	246.3	150
Total Teaching Assistant	28.7	0

West Virginia University General Surgery Residency Program

A. Program Information
   A. Residents:
      A. Current: 3 Categorical residents per year, 3 Preliminary PGY 1
   B. Faculty: 38 Faculty members over 11 Divisions
   C. Structure: 5 Year Program
   D. Schedule: 12 Services including experience in cardiovascular surgery for ischemic, valvular and congenital heart disease and pacemaker implantation; care of trauma and critically ill surgical patients; peripheral vascular surgery involving vessels of the head, neck, extremities and abdominal aorta; head and neck, endocrine and gastrointestinal surgery. Residents also participate in all aspects of surgical oncology and general pediatric surgery. Faculty surgeons perform and teach laparoendoscopic surgery, surgical endoscopy, laser surgery, thoracic surgery, plastic and reconstructive surgery
   E. Other Information
      A. High Research University as classified by the Carnegie Foundation for the Advancement of Teaching

WVUHealthcare

Quick Facts on Morgantown, WV

- Population 29,660
- Next to the Monongahela River
- Large seasonal resident population from September-May
- Morgantown Personal Rapid Transit System
- Transitional Climate with 4 distinct seasons

	Ohio	Vanderbilt	UCLA	University of Kansas Wichita	Guthrie	Robert Wood Johnson	Mount Carmel	West Virginia
Location								
Commute								
Diversity of Faculty								
Diversity of Residents								
Warmth								
Respect								
Gut								
Specialties								
Fit								
Number of Residents								
Call/Early operate								
Totals								

	Ohio	Vanderbilt	UCLA	University of Kansas Wichita	Guthrie	Robert Wood Johnson	Mount Carmel	West Virginia
Location	7	2	3	4	5	6	8	1
Commute	7	5	8	4	1	3	6	2
Diversity of Faculty	2	5	6	7	8	4	1	3
Diversity of Residents	2	1	4	3	8	7	5	6
Warmth								
Respect	3	1	2	4	8	5	6	7
Gut								
Specialties	6	5	8	2	3	7	4	1
Fit	4	3	6	1	7	8	5	2
Number of Residents	4	8	7	6	2	5	3	1
Call/Early operate	6	4	8	3	5	7	2	1
Totals								

	Ohio	Vanderbilt	UCLA	University of Kansas Wichita	Guthrie	Robert Wood Johnson	Mount Carmel	West Virginia
Location	7	2	3	4	5	6	8	1
Commute	7	5	8	4	1	3	6	2
Diversity of Faculty	2	5	6	7	8	4	1	3
Diversity of Residents	2	1	4	3	8	7	5	6
Warmth								
Respect	3	1	2	4	8	5	6	7
Gut								
Specialties	6	5	8	2	3	7	4	1
Fit	4	3	6	1	7	8	5	2
Number of Residents	4	8	7	6	2	5	3	1
Call/Early operate	6	4	8	3	5	7	2	1
Totals	**41**	**34**	**52**	**34**	**47**	**52**	**40**	**24**

Current Rank List Based on Score

1. West Virginia
2. Vanderbilt/University of Kansas-Wichita
3. Mount Carmel
4. University of Toledo
5. Guthrie
6. Robert Wood Johnson/UCLA

	Vanderbilt	University of Kansas Wichita
Location	2	4
Commute	5	4
Diversity of Faculty	5	7
Diversity of Residents	1	3
Warmth		
Respect	1	4
Gut		
Specialties	5	2
Fit	3	1
Number of Residents	8	6
Call/Early operate	4	3
Totals	**34**	**34**

Two Schools Have the Same Score

Break it down to see which has more versus less than ideal qualities for you

= High Scores in Each Category

= Low Scores in Each Category

We see Vanderbilt has more 1 and 2's than Wichita

Which qualities are most important to you? Which hold more weight?

	Ohio	Vanderbilt	UCLA	University of Kansas Wichita	Guthrie	Robert Wood Johnson	Mount Carmel	West Virginia
Location	7	2	3	4	5	6	8	1
Commute	7	5	8	4	1	3	6	2
Diversity of Faculty	2	5	6	7	8	4	1	3
Diversity of Residents	2	1	4	3	8	7	5	6
Warmth								
Respect	3	1	2	4	8	5	6	7
Gut								
Specialties	6	5	8	2	3	7	4	1
Fit	4	3	6	1	7	8	5	2
Number of Residents	4	8	7	6	2	5	3	1
Call/Early operate	6	4	8	3	5	7	2	1
Totals	**41**	**34**	**52**	**34**	**47**	**52**	**40**	**24**

Matt Alexander

- Graduate University of Missouri-Columbia May 2014
- General Surgery Resident

Joedd Biggs

- Graduate University of Missouri-Columbia May 2014
- General Surgery Resident

Abbie Jensen

- Graduate University of Missouri-Columbia May 2014
- General Surgery Resident

Christopher Nauser

- Graduate University of Missouri-Columbia May 2014
- General Surgery Resident

Matthew Roberts

- Graduate University of Missouri-Columbia May 2014
- General Surgery Resident

Thank you!

- Hope you have enjoyed your break out session during the 2014 ARCS meeting. We hope this makes sense.
- Please contact us if you have any questions

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Clinical Competency Committee – Merging Milestones

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Disclosures

Objectives

- 1. Review the formation of Clinical Competency Committees
- 2. Review the Proposed Educational Milestones in General Surgery
- 3. Provide an institution's systematic review of the current assessment tools for surgical residents
- 4. Provide examples of an institution's development of new assessment tools to match the Educational Milestones

Building A Clinical Competency Committee

BUILDING A CLINICAL COMPETENCY COMMITTEE

- V.A.1.) The program director must appoint the Clinical Competency Committee. (Core)
- V.A.1. a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)
- V.A.1. a) .1 Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)
- V.A.1 b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

BUILDING A CLINICAL COMPETENCY COMMITTEE

V.A.1.b). (1.) The Clinical Competency Committee should:

V.A.1.b). (1.).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and , (Core)

V.A.1.b).(1.).(c). Advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

BUILDING A CLINICAL COMPETENCY COMMITTEE

- The Program Directors Role on the CCC
- Residents and fellows cannot be members of the CCC
- The coordinators role of the CCC

Timeline

- Formation of team
- Develop format of committee

- Meet every other month (4 PGY/year)
- Review Interns, 2/3, 4/5.
- Review each resident twice per year.

Scheduled Review

	T	S	F	Br	D	Ba
Jon	x	x				
Pam			x	x		
Jen					x	x
Rick		x	x			
Frank				x	x	
Jim	x					x

- Review 2 PGY years
- Each members reviews 2 residents
- Different reviewers of each resident
- Change for next meeting

Scheduled Review

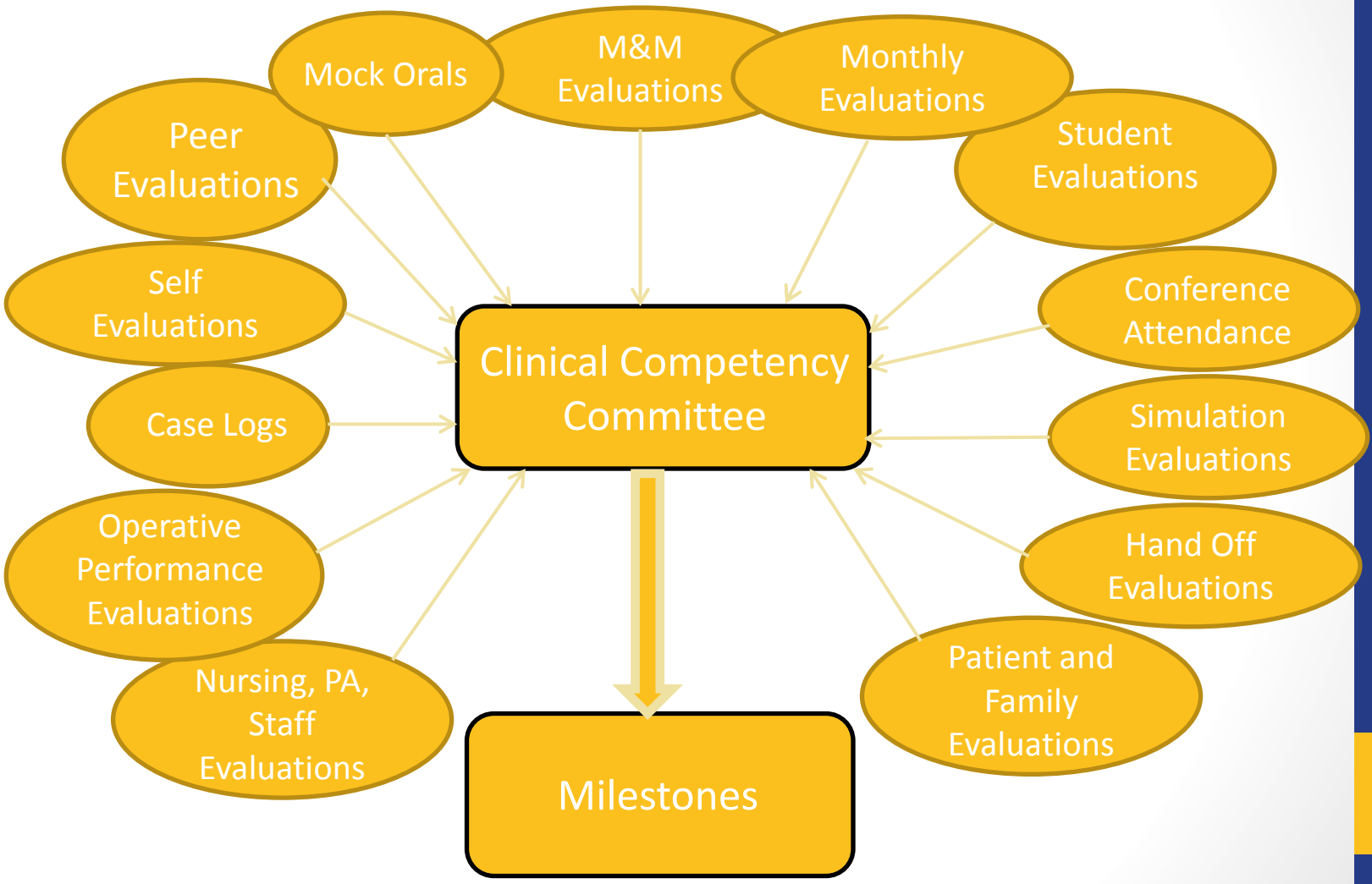
*	
August	4/5
Oct	2/3
Dec	Interns
February	4/5
April	2/3
June	Interns

*The first few meetings are going to take a while

Evaluations and Milestones

- Review Current Evaluation System

BUILDING A CLINICAL COMPETENCY COMMITTEE EVALUATION TOOLS



Assessment Tools

- Faculty evaluations
- Case logs
- ACS Operative Competency
- ABSITE Scores
- SCORE use
- Hand-off Conference

Evaluations and Milestones

- Review Current Evaluation System
- Review Milestones
- Compare how Milestones and Evaluation System Correspond
- Develop NEW tools to meet the Milestones

Assessment Tools

- Faculty evaluations – Complete REDO
- 360º evaluations - Developed
- Case logs
- Operative evaluations and ACS Operative Competency – NEW
- Morbidity and Mortality Evaluations - NEW
- ABSITE Scores
- SCORE use
- Program Director Report - NEW
- MD Content/QI Initiates - NEW
- Hand-off Conference - NEW

MILESTONE		Evaluation
ICS-1	Communication and Interaction with families	Patient Evals
		Faculty Evals
ICS-2	Communication and interaction with fellow residents	360
	Communication and interaction multidisciplinary team	Peer
		Hand-Off
ICS-3	Interaction with OR staff	360
	Informed Consent	Faculty Evals
PBL -1	Teaching/Presenting	Student Evals
		Faculty evals
		M & M
MK-1	Medical Knowledge- Broad/Focused Ds (SCORE)	Mock ABSITE
		ABSITE
		Monthly Quizzes
		Mock Orals
		Faculty Evals
MK-2	Medical Knowledge of Operative Steps/Options	Clinical Assessments
		Faculty Evals
		Operative Evals

MILESTONE		Evaluation
PC-1	Able to perform PE/Develop Plan/Diff Dx	Clinical Assessment
		Faculty Evals
PC-2	Post Op Complications	Faculty Evals
		Simulation Lab
		M&M Eval
		ICU Eval
PC-3	Able to perform Operative Skills	Faculty Evals
		Clinical Assessments
		Operative Eval
PBL-2	Reads Assignments	SCORE
	Uses Literature	M & M eval
	Self-Assessment	Faculty Eval
PBL-3	M&M	Faculty Evals
	Learns from Mistakes, Improves	M&M Eval
	QI	QI Project

MILESTONE		Evaluation
PROF-1	Respects Patients, Families	360
	Compassion, Composure	Faculty Evals
	Continuity of Care	
PROF-2	Duty Hours	PD/PC
	Time Management	
	Fatigue	
PROF-3	Administrative Tasks	PD/PC
	Punctuality	
	Leadership	
SBP-1	Coordination of Care, Discharges	360, Care Manager Eval
	Consults	
SBP-2	Understands Health Care Systems	MDContent
	QI	M&M Eval
		QI Project

Evaluations and Milestones

- Review Current Evaluation System
- Review Milestones
- Compare how Milestones and Evaluation System Correspond
- Develop NEW tools to meet the Milestones
- Distribute NEW tools/evaluations – to faculty and residents
- Implement changes as a trial

Evaluations and Milestones – Work in Progress

- Committee meets and reevaluates the new tools of evaluation
  - Ensure meeting the milestones
  - User friendly
  - Effective
- Discard the old!

Assignments

- Committee members assigned residents to review
- (Information sent 2 weeks ahead of meeting)
- Recommendations made by reviewers
- Entire committee discusses recommendations
- Summary of findings is generated
- Committee recommendation in writing to the Program Director
- Plan of action if necessary

Clinical Competency Committee Review

Resident:
Date of review:

The consensus milestone assessment based on the General Surgery Milestone Project by the ACGME and ABS is as follows below. These finding are from evaluation tools from _____

Milestone	Milestone Summary	Level	Comments
ICS -1	Communication and Interaction with families		
ICS -2	Communication and interaction with fellow residents and multidiscipline team		
ICS - 3	Interaction with OR staff and Informed consent		
PBL - 1	Teaching/Presenting		
PBL - 2	Reads Assignments, uses literature, self-assessment		
PBL - 3	M&M, Learns from mistakes, improves, QI		
MK -1	Medical Knowledge- Broad/Focused Ds (SCORE)		
MK -2	Medical Knowledge of Operative Steps/Options		
PC - 1	Able to perform PE/Develop Plan/Diff Dx		
PC - 2	Post Op Complications		
PC - 3	Able to perform Operative Skills		
Prof - 1	Respects Patients, Families, compassion, composure, continuity of care		
Prof - 2	Duty Hours, Time management, fatigue		
Prof -3	Administrative Tasks, Punctuality, leadership		
SBP - 1	Coordination of Care, Discharges, Consults		
SBP -2	Understands Health Care Systems; QI		

Based of these findings, it is recommended…

Clinical Competency Committee Review

Resident: [redacted]
Date of review: 1/27/14

The consensus milestone assessment based on the General Surgery Milestone Project by the ACGME and ABS is as follows below. These finding are from evaluation tools from: July – December 2013. Rotations on Gold and Vascular.

Milestone	Milestone Summary	Level	Comments
ICS -1	Communication and Interaction with families	1.5	Faculty evaluations
ICS -2	Communication and interaction with fellow residents and multidiscipline team	1.5	Faculty evaluations and comments
ICS - 3	Interaction with OR staff and Informed consent	1.5	Faculty evaluations and comments
PBL - 1	Teaching/Presenting	1.5	Faculty evaluations
PBL - 2	Reads Assignments, uses literature, self-assessment	1	SCORE, faculty evaluations
PBL - 3	M&M, Learns from mistakes, improves, QI	2	Faculty evaluations, QI project
MK -1	Medical Knowledge- Broad/Focused Ds (SCORE)	2	ABSITE scores, mock ABSITE, faculty evaluations
MK -2	Medical Knowledge of Operative Steps/Options	2.5	Faculty evaluations
PC - 1	Able to perform PE/Develop Plan/Diff Dx	2.5	Faculty evaluations
PC - 2	Post Op Complications	2.5	Faulty evaluations
PC - 3	Able to perform Operative Skills	2	Faculty evaluations
Prof - 1	Respects Patients, Families, compassion, composure, continuity of care	3	Faculty evaluations
Prof - 2	Duty Hours, Time management, fatigue	2.5	Duty hours, faculty evaluations
Prof -3	Administrative Tasks, Punctuality, leadership	3	Case logs, faculty evaluations
SBP - 1	Coordination of Care, Discharges, Consults	3	Faculty evaluations
SBP -2	Understands Health Care Systems; QI	2	SCORE, faculty evaualtions

Based of these findings, it is recommended more evaluation tools be used for assessment, improved use of SCORE curriculum by the resident, focus on communication skills.

HOMEWORK FOR THE CLINICAL COMPETENCY COMMITTEE

- Study your specialty Milestones
  - Found on the ACGME website – www.acgme.org
- Decide how to assess the Milestones
- Review and if necessary, identify new evaluation tools
- Faculty members should:
  - Conduct regularly scheduled meetings to review the progress of every resident in the program
  - Discuss definitions and narratives
  - Agree on the narratives
  - Learn about a variety of assessment tools

Report Card

- V.A.1.b.(1).(b) prepare and assure the reporting of Milestones evaluations for each resident semi-annually to ACGME (Core)
- Milestones are reported by entering data through ADS
- Reporting windows are:
  - November 1-December 31
  - May 1-June 15

Lessons Learned

- Time compensation for participation in CCC
- FOOD
- Break up the meetings or meet ahead of time.
- We had to completely redo our evaluations
- Meet in a room with computer support
- This is a work in progress

Questions