Updates: TS RRC, Common Program Requirements, and ACGME Case Log System Information and Demonstration

Peggy Simpson, EdD
Executive Director-RRC for Thoracic Surgery
TS-RACS
San Diego, CA
January 30, 2011
Thoracic Surgery Residency Review Committee
RRC—Thoracic Surgery Members

- R. Morton Bolman, III, MD (ACS)
  Brigham and Women’s Hospital
  (Vice Chair)

- Mark B. Orringer, MD (ACS)
  University of Michigan Health Systems

- Douglas E. Wood, MD (ABTS)
  (Chair)
  University of Washington

- Carolyn Reed, MD (ABTS)
  Medical University of South Carolina
  (Incoming Vice Chair)

- Walter H. Merrill, MD (CME)
  University of Cincinnati College of Medicine

- Michael R. Mill, MD (CME)
  University of North Carolina at Chapel Hill

  Resident Member
  Tom C. Nguyen

  Ex-Officio Members (non-voting)
  - William Baumgartner, MD
    ABTS Executive Director
  - Patrice Blair, MPH
    American College of Surgeons

  Incoming Member
  - Carl Backer, MD

  Ex-Officio Members (non-voting)
  - William Baumgartner, MD
    ABTS Executive Director
  - Patrice Blair, MPH
    American College of Surgeons

  Incoming Member
  - Carl Backer, MD
## Thoracic Surgery Residency Training Programs

<table>
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<tr>
<th>PROGRAM TYPE</th>
<th>NUMBER</th>
<th>RESIDENTS ON DUTY</th>
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As of 1/22/10
2010-2011 TS RRC Activity

- **38** programs reviewed (post site-visit)
- Average cycle length **3.25** years
- **18** administrative requests
- **45** interim requests (PD changes, participating site change, temporary increases)
2010 Top 10 Citation Types

- Institutional Support: 7
- Procedural Experience: 4
- Curricular Development: 4
- ACGME Competencies: 7
- Evaluation of Residents: 5
- Evaluation of Program: 5
- Performance on Board Exams: 5
- Resident Appointment Issues: 5
- Responsibilities of PD: 5
- Duty Hours: 5
Joint GS/Ts Training Programs

- Residents are eligible for “double boarding”
- Residents **must** use the ACGME case log system during the first *five* years of the program (required by ABS for certification)
- Residents report cases to CTSNet during PGY5, PGY6 and PGY7
- GS/Ts Commit to using one of pre-existing approved positions.
<table>
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<tr>
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<th>Program Description</th>
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<tr>
<td>1.</td>
<td>Brigham and Women’s Hospital/Children’s Hospital</td>
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</table>
Integrated Programs

1. An institution’s independent program must have a “Continued Accreditation” status and a cycle length of at least three years to be considered.

2. A completed application for initial application must be sent to the ACGME offices.

3. Institution’s whose independent programs have a targeted site visit date within 24 months of the dated signatures on the Initial Accreditation Program Information Form for the integrated program will receive a site visit as part of the application process.

4. Integrated programs, when approved, receive a separate program number, distinct from their independent program number.

5. The RRC expects institutions to maintain their independent program.
Relationship of Independent and Integrated Programs

• Independent program must be maintained until integrated programs matures to fill senior level positions

• Independent programs may continue in parallel with integrated program
  • Must not exceed total approved graduating positions without RRC approval
  • Provides program flexibility
Approved Integrated Programs

1. College of Medicine, Mayo
2. Medical College of Wisconsin Affiliated Hospitals
3. McGaw Medical Center of Northwestern
4. Medical University of South Carolina
5. Mount Sinai School of Medicine
6. New York Presbyterian Hospital (Columbia)
7. Stanford University
8. University of Maryland
9. University of North Carolina at Chapel Hill
10. University of Pennsylvania
11. University of Rochester
12. University of Texas Health Science Center at San Antonio
13. University of Virginia
14. University of Washington
Agenda Closing Dates

- **Meeting: July 15-16, 2011**
  - Agenda Closing: May 6, 2011
- **Meeting: January 6-7, 2012**
  - Agenda Closing: October 28, 2011
- **Meeting: July 13-14, 2012**
  - Agenda Closing: May 12, 2012
Common Program Requirements
New CPRs Roll-Out

- Effective July 1, 2011
- RRC Specific information permitted
- Recommendations from TS RRC to ACGME BOD considered at February 2011 meeting
- Publication of FINAL/BOD-Approved after February Meeting
Supervision of PGY 1 Residents

• VI.D.5.a).(1) - Supervision of Residents: In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

• The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program. The program must also define tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.
Minimum Time Off

- VI.G.5.b) - Minimum Time Off between Scheduled Duty Periods: Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

- Intermediate level is PGY2 and PGY 3
Minimum Time Off (cont.)

- VI.G.5.c) - Minimum Time Off between Scheduled Duty Periods: Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

- Senior Level: PGY 4 and above
Minimum Time Off between Scheduled Duty Periods: This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
Minimum Time Off (final years-cont)

- **Continuity of care for patients:**
  - Patient on whom they operated/intervened that day needs return to OR
  - Patient on whom they operated/intervened that day requires transfer to an intensive care unit (from lower level of care)
  - Patient on whom they operated/intervened that day in ICU is critically unstable
  - Patient on whom they operated/intervened during that hospital admission requires return to OR related to an operation or procedure previously performed by the resident
  - Patient or patient’s family need to discuss treatment of critically ill patient on whom the resident has operated or is responsible for care
- A declared emergency or disaster, for which the residents are included in the disaster plan
- To perform high profile, low frequency procedures necessary for competence in the field.
Maximum Night Float

- VI.G.6. - Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float.
- Night float rotations must be two months or less in duration and there can be no more than three months of night float per year. There must be at least two months between each night float rotation.
ACGME Case Log System Information
TS Integrated Residency
Index Case Requirements

- **Core Surgical Years (PGY 1-3)**
  - 375 operations averaged over 3 years
    - 125 cardiothoracic operations
      - up to 50 may be “component cases” that include sternotomy and closure, thoracotomy and closure, LIMA takedown, saphenous vein harvest, aortic and venous cannulation, proximal and distal anastomosis, other vascular anastomosis, gastric/esophageal mobilization)

- **150 ABS Index Cases (accrued over 6 years)**
  - Vascular 25, Skin/soft tissue/breast 10,
  - Head/neck 5, Alimentary tract 20,
  - Abdomen 30, Operative trauma 5,
  - Pediatric 10, Plastic 5,
  - Lap-basic 30, Lap-advanced 10

Proposal developed by Thoracic RRC, January 2010, modified and approved July 2010
TS Integrated Residency
Index Case Requirements

- Advanced Surgical Years (PGY 4-6)

  - Volume: 125 major thoracic cases for each year for a minimum total of 375

  - Distribution: Index cases as defined by ABTS

Proposal developed by Thoracic RRC, January 2010, modified and approved July 2010
ACGME Case Log Conversion

- Residents and fellows starting July 1, 2011 will use ACGME Case Log System
- Current fellow/residents continue using CTSNet
- Same Index Case Categories/framework
- Searchable CPT codes
- Same system used by general surgery, vascular surgery, pediatric surgery, plastic surgery
- Tools for tracking operative activity of residents, reporting for program directors, RRC
- Shared data with ABTS
ACGME Case Log System Demonstration
ACGME Case Log Help

• Oplog@acgme.org
• Telephone support: 312.755-7464
  • Andrew Turkington
  • Quinn White (backup to Andrew)
• Response time within 24 business hours
Sample RRC Report

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Program= 440XXXXXXX General Surgery Sample Program

Programs in the Nation: 242  Residents in the Nation: 1,040  Residents in this Program: 3

Total Experience of Residents Completing Programs in 2009-2010

Residency Review Committee for General Surgery
Report Date: October 8, 2010

ACGME
Contact Information

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Transitions in GME

2011
ACGME
Annual Educational Conference
Gaylord Opryland Resort Hotel
and Convention Center
Nashville, Tennessee
March 3-6, 2011

REGISTRATION NOW OPEN
(closing February 1, 2011)
For More Information: www.acgme.org
THANK YOU

FOR ALL OF YOUR
TIME AND EFFORT!!
Questions