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

ACGME

Thoracic Surgery Residency Review Committee

ACGME

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-0fficio Members (non-voting)

- **William Baumgartner, MD**
  ABTS Executive Director
- **Patrice Blair, MPH**
  American College of Surgeons

Incoming Member

- **Carl Backer, MD**

ACGME

Thoracic Surgery Residency Training Programs

PROGRAM TYPE	NUMBER	RESIDENTS ON DUTY
Thoracic Surgery-Independent	72	228
Thoracic Surgery-Integrated	14	11
Congenital Cardiac Surgery	10	7
Total	96	236

	Initial Accreditation	Continued Accreditation	Probationary Accreditation
Independent	4	64	4
Integrated	12	2	0
CCS	9	1	0

As of 1/22/10

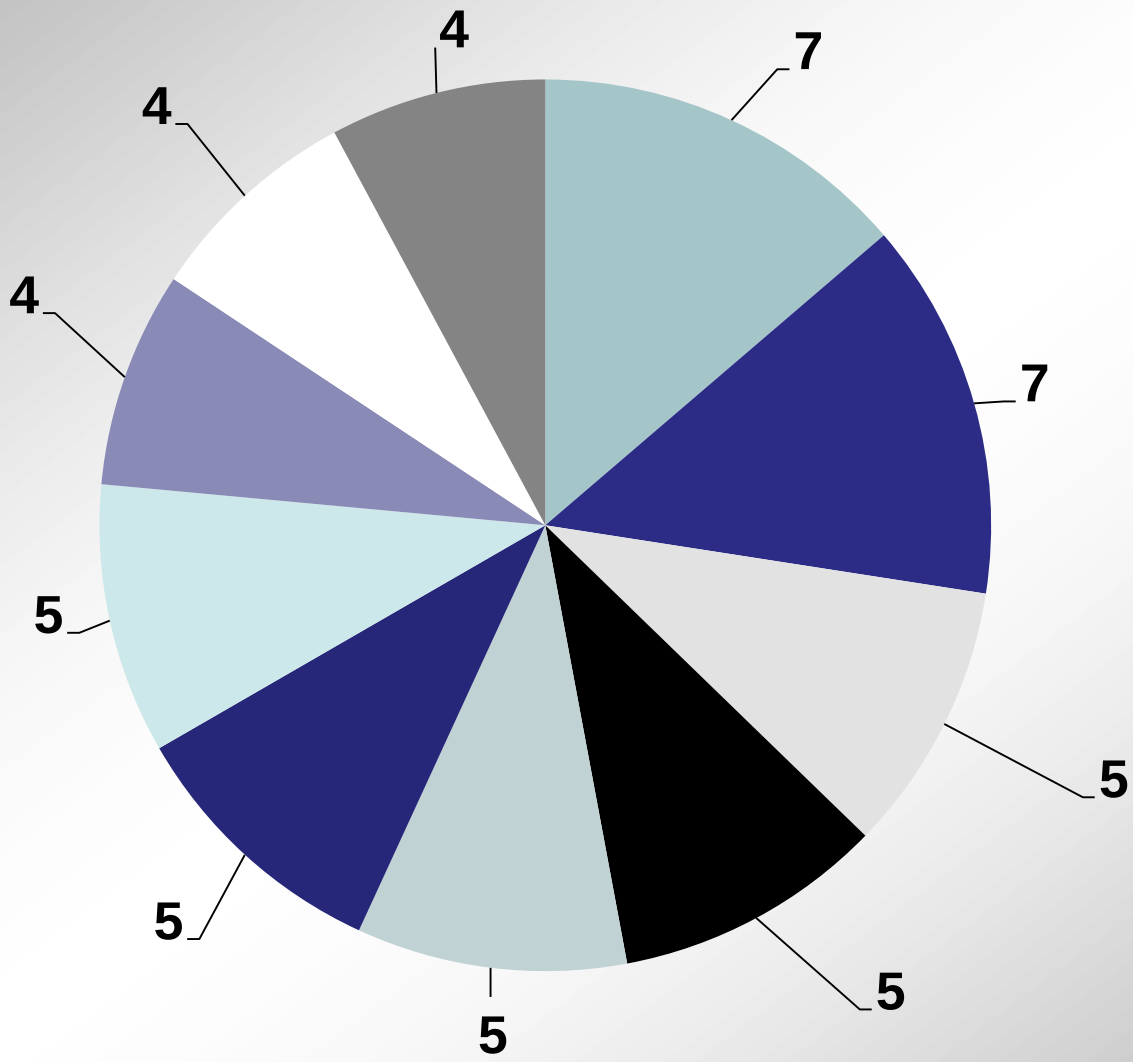
ACGME

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)

ACGME

2010 Top 10 Citation Types



- Institutional Support
- Procedural Experience
- Curricular Development
- ACGME Competencies
- Evaluation of Residents
- Evaluation of Program
- Performance on Board Exams
- Resident Appointment Issues
- Responsibilities of PD
- Duty Hours

ACGME

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.

ACGME

Approved Joint GS/TS Training Programs (4+3 format)

1. ***Brigham and Women's Hospital/Children's Hospital***
2. ***Duke University***
3. ***Indiana University***
4. ***Mayo School of Graduate Medical Education***
5. ***Massachusetts General Hospital***
6. ***New York University School of Medicine***
7. ***University of Maryland***
8. ***University of Rochester***
9. ***University of Texas Southwestern Medical School***
10. ***University of Virginia***
11. ***University of Washington***
12. ***Washington University School of Medicine***

ACGME

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.

ACGME

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

ACGME

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

ACGME

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

ACGME

Common Program Requirements

ACGME

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

ACGME

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.

ACGME

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

ACGME

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

ACGME

Minimum Time Off (cont)

- 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.

ACGME

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.

ACGME

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

ACGME Case Log System Information

ACGME

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 anatomosis, 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

ACGME

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

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

ACGME Case Log System Demonstration

ACGME

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

ACGME

Sample RRC Report

GENERAL SURGERY: NATIONAL REPORT (Defined Category Data Summary)
Reporting Period: Total Experience of Residents Completing Programs in 2009-2010
Residency Review Committee for General Surgery
Report Date: October 8, 2010

Program= 440XXXXXXX General Surgery Sample Program

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

		Principle										Secondary								Role Totals		
		SSB	HN	ALTR	AB	LV	PANC	VASC	ENDO	TRAU	NOT	THOR	PED	PLA	LAP B	ENDS	UEND	COL	LAP C	Tot MAJ	Tot CHF	Tot TA
		Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min	Min
		25	24	72	65	4	3	44	8	10	20	15	20	5	60	85	35	50	25	750	150	-
Program/Resident		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
440XXXXXXX	Prog AVE	67	73	209	258	6	1	137	31	28	24	52	31	21	143	90	29	48	66	843	167	2
	# Res Bel						2										2	2				
Res One	Res Proc COUNT	61	77	180	258	6	0	152	37	32	22	76	34	26	141	92	34	57	47	856	167	0
	Bel Min						* ! *										* ! *					
Res Two	Res Proc COUNT	66	84	221	248	7	0	134	30	30	23	61	28	20	143	85	15	44	56	859	161	5
	Bel Min						* ! *										* ! *	* ! *				
Res Three	Res Proc COUNT	74	59	227	269	4	3	124	25	21	26	18	31	17	144	93	38	43	95	813	174	2
	Bel Min																	* ! *				

ACGME

Contact Information

- Peggy Simpson, EdD-Executive Director
  psimpson@acgme.org / 312.755.5499

- Cathy Ruiz, MS—Senior Accreditation Administrator
  cruiz@acgme.org /312.755.5495

- Allean Morrow-Young, Accreditation Assistant
  amh@acgme.org /312.755.5038

ACGME

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

ACGME

THANK YOU

FOR ALL OF YOUR TIME AND EFFORT!!

ACGME

Questions

ACGME