Minutes
Thoracic Surgery Admnistrator/Coordinators Section
Annual Meeting
Los Angeles Convetion Center/ Los Angels
Sunday, January 27, 2013

Marcie O'Reilly, President TS-RACS, opened the meeting at 8:45 AM, welcomed the attendees, reviewed agenda and announced the guest speaker.. See attached attendee list and agenda.

PCW Attendance: *(see attendance sheet)*

TOPIC/ SPEAKERS	DISCUSSION	ACTION/FOLLOW UP
Peggy Simpson, PhD **Next Accreditation System** • ACGME Updates • Operative Logs • Site Visits • Next Accreditation System • Milestones	• Reducing the burden of accreditation • Will still need Coordinators • Opportunity for new programs to innovate mad encourage progression. Promotes innovation. • Assist in structure to new programs • Move from process focused to outcomes focused • NAS update will look at: 1. Case log 2. Minimum Requirements 3. ADS Annual Update 4. Resident Survey's 5. Annual Date Collection-Core Faculty Survey 6. New- Mild Stones-expected report-all mild stone to move to an ADS online Program. • Site visitor hopefully every 10 years but may be as short as 5 years. Red flags can be addressed sooner and assistance from ACGME site visitor to give feedback and help. More consultative function of site visitors	

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	• RRC will look at programs on an annual basis. Every year RRC will look at board pass rate, case log/clinical experience, ADS annual update (if recommended corrections not made in 1 year ACGME will do site visit), core faculty survey, resident survey, and milestones (reported 2x year via ADS). • 10yrs Self Study Visit: Writing Analysis-Replacing PIF. Will include programs addressing areas they want to improve • Doing away with internal reviews at midpoint or routine. GMEC must demonstrate program oversight. • Annual update was streamlined. Will remove self-reported board pass rate. Will get this directly from boards. • Case logs should be finalized in July/August. PD certifies and ACGME closes out. • Resident survey in spring, faculty survey spring, ads fall. Milestones are semiannual. Dec/Jan and June. • Standards: outcomes (board pass, competency) core processes (things all programs must do); detail process (has conference each week).	• No PIFS • No Internal Review • 33 Question Removed • 14 Questions improved • Simplifying Faculty CV • PubMed ID # only- eliminates to input all articles

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	• Accreditation with warning or probationary accreditation, less than 1% of applications across all specialties are withheld. • Phase 1- Neurology, Orthopedic, and Urology • Phase 2 for NAS to start in Spring 2013 (programs with >2 year cycles moved to NAS) • 07/01/2014-WILL GO LIVE • CLER clinical learning environment review: Kevin Weiss is VP of this area. Site visitors different than regular site visitors will come in and review patient safety, QI, transition of care, supervision, dh oversight/fatigue management, professionalism. • Requesting volunteers for round 2 data testing, having webinars (must register), check NAS microsite on ACGME website often. www.acgme-nas.org. Can download CLER info from this website as well. • NAS is a continuous accreditation model. Program requirements will be revised every 10 years. Program requirements organized by outcomes (demonstrating competency), core processes, and detail processes. • Total of 95 accredited programs • New thoracic FAQ. Defines the core surgical education (24-36 months). Don't have to do all listed, but any combo of	• Will look at this across organization. Context of resources, faculty, residents, measures and improvement (how you choose plans of improvement). Include C suite, quality/safety officers, pds, faculty, residents. Site visitors can do walk around. A sort of like joint commission. • NAS in a nutshell: focus on outcomes, reduce burdens, and allow programs to innovate. • Case Logs: ACGME case log will be effective for everyone entering program July 1, 2013. Set up is required for sites, physicians, and rotations. Can do set up now in preparation for July start. Requirements report will be available starting July hopefully.

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	rotation areas counts. • January 2014 by Nov, 15 2013. July 2014 by May 1 2014. Site visitor reports must be in by those dates as well for programs to be reviewed at meetings. QA • Program director and residents must evaluate core faculty. • Bringing in do to ACGME spot who did AOA residency will result in resident citation • I6 bringing in resident to higher level. Make request to RRC and ABTS. If need extra spot, then apply for increase in resident compliment for that year • 4-3 program popularity. Currently 12 may have 13 as one program just applied. • ACGME will no longer have newsletter, but will have more interactive website that will be updated more frequently. RRC site will have more info in 4-6 weeks on website. • Will have more training and updates at AATS	• Top 5 citations: Duty hours, goals and objectives, responsibility of pd and faculty (following programs requirements for faculty or pd), evaluations (res evals not done, annual program review not documented, final eval doesn't say resident competent to practice independently), and performance on board exams
Business Meeting		
	• 2013 meeting minutes approved. Motion by Mitzi • Amendments approved. Motion by Patti • President-Elect: Honor Gifford. • Councilor-at-Large: Phyllis Weigum	• Suggestions: in future reports list programs that had a representative in attendance at TSRACS, invite program directors to attend TSRACS meeting, and question of what training will be offered at AATS and then notify coordinators and pds.

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Walter Merrill, MD: **Milestones**	• An integral part of NAS • Evolution started with 6 core competencies in 1999 • 2013 phase I implementation, and in 2014 NAS will be adopted for CT Surgery • Physicians as leaders of team-oriented care, literacy in info tech to improve care, cost effectiveness, involve patients in own care (empower), and physicians to possess skills/requisite clinical and 5rea5ll5nal attributes. • Limitations: requirements prescriptive, diminished ops for innovation, ^ burden • Measurement 5rea5 to assess/report Ed outcomes, close collaboration with RRC/ABTS/TADA/JCTSW and otero pro sovietices, trayectoria of pro development….see slides to list other points…. • ACGME goals • Ed milestones working group • Advisory group • Example of milestones. Hopeful that they can be refined through beta testing (pilot and phase 2) before released for all to use • Milestones are not meant to replace evals, but to complement/go along with.	• To enhance the ability of training programs to prepare physicians.

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		• Summary: 7/14 implementation, semi-annual assessment by CCC using milestones, goal for residents to reach level 4 by the end of training, and level 5 is desired goal for practitioner to be achieved later in practice. • Create a national framework for assessment, will reduce admin burden and eleminates focus on process, raise ceiling and floor and stimulate innovation. • Looking for 10 or so additional programs to participate in phase 2
Baumgartner: MOC	• **Started with: - Thanking all coordinators for all that they due and as a pd is acutely aware of who runs residency programs.** • ABTS has issues 8,000 certifications since 1949. Est in 1048. 4406 currently certified in us. • Part 1 professional standing (i.e. med license, part 2 lifelong learning and self-assessment (can get CME from annals and JTCVS at no charge), part 3 cognitive expertise (i.e. written exam), part IV practice performance assessment (STS/NY/none databases, patient safety module, QA projects. Assessing quality of care provided). • 5 year: professionalism (active med license,	• **History of MOC..** **1. One of few boards that have had decertification process for years.** **2. MOC has evolved to ensure competency maintenance....idea of lifelong learning.** **3. Started in 2008. 10 year cycle with 5 year milestone. No grandfathering - idea that you should be improving practice. 1800 Ct Surgeons have participated**

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	2 letters ref (VPMA/chief med officer, member on staff)' lifelong learning (150 CME prev 5 yrs, 1/2 must be I. Broad cat of ts)' cog exp (current version of SESATS. Each wrong answer has narrative. Can't move on until you get right answer. Refreshed every 3 yrs). • 10 year: professionalism same, cog is secured exam, Pract. Performance case summary of cases for last year and participate in database. • Database: Gold standard STS. This requirement starting 7/2014. Have other ABTS approved on website. Database provides benchmarks. • Goals of wab: process must be meaningful, improve some aspect of practice, and reasonable cost. 5 year SESATS given for free. Must have reasonable time commitment, reduce duplication of requirements. MOC will count for annual license requirements for medical license. • Facilitating process: New database and interactive website, continue providing a self-assessment learning tool (SESATS), catalog of CME opportunities, working with STS to develop required learning modules (patient safety, performance improvement CME (PI-CME) working with STS on this.	

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	• STS putting together patient safety module specific to thoracic surgery. • MOC is here to stay, self-regulation rather than CMS, lifelong learning 10yr cycle 5yr milestone, may change some sort of requirements every 2 years, meaningful and not onerous, Patient benefit • QA • Written and oral must be redone if let cert lapse or if don't do MOC	• **Q: Do you foresee split in cert for thoracic and cardiac? 2/3 of practicing Ct surgeons both TS and card. Thoracic relates to Pulm or GI and cardiac to cardiology. Every year will attach survey re practice patterns**
John Calhoon MD: **ABTS Update & Open Forum**	• New website for TSDA. Should be more user-friendly. • Coordinators need to be trained on online learning • I-6 group needs some form of interim testing cognitive and/or skill testing before 4th year. Want to know where residents are. Are there deficiencies?	

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George Hicks, MD	• Thoughts about milestones ill conceived. Now thinks project will be very helpful to us. • I-6 programs will continue to be responsibility. Need to aka sure skills developing and professionally developing. Want to have better trained and more mature ct surgeons. • Boot Camp: first Boot Camp funded by TSDA. Has become an important part of what TSDA does. Subsequent boot camps funded by JCTSE. Many want boot camps to become self-sustaining. July 25-28. Will target 32 residents. This year will have fee for residents. $1,000 first come first serve. Will give CME cert for 20hrs of assessable simulation. $110,000 total cost for • Boot Camp. Will be asking industry for help. • In training exam moved up a month. Proctor can be CT Faculty member, staff need not be board certified. Moved up so results out earlier so programs can use as part of resident assessment	• We will all be receiving simulators from chamberlain group. Program will provide pickups, castors or pickups, and sutures. Can get material for free from industry info on TSDA website. Model will be a part of competition. Funded by Ethicon. • **Q: is Boot Camp open to integrated residents? Has been open to first year traditional resident. May consider opening it up to some level of i6 perhaps 3rd or 4th year**
ADJOURNMENT		
Marcie O'Reilly Adjourned the meeting at 4:00 PM		