

Accreditation Council for Graduate Medical Education



ACGME and Operative Log Update

ARCS Residency Coordinators Meeting

April 16, 2008

Peggy Simpson, EdD

Executive Director

Residency Review Committees for Surgery

Tom Richter, MA

Systems Manager

Applications and Data Analysis

Agenda—Surgery RRC Update

- RRC responsibilities
- Resident duty hours
- Accreditation decisions
- Progress reports
- RRC Surgery agenda timelines
- RRC Surgery data
- Common surgery citations
- Program change requests
- Updates - Surgery RRC
- Resources
- Staff contact information

RRC Functions/Responsibilities

Responsibilities:

- *Develop and approve training standards*
- *Review and accredit residency programs*

Functions:

- *Develop competency tools and assess program compliance*
- *Monitor compliance with duty hour policy and procedures*

Navigating the Requirements*

- 1. Must:** A term used to identify a requirement which is mandatory or done without fail. This term indicates an absolute requirement.
- 2. Shall:** (See must)
- 3. Should:** Term used to designate requirements so important that their absence must be justified. A program or institution may be cited for failing to comply with a requirement that includes the term 'should'.

*From ACGME "Glossary of Terms" (acgme.org)

Resident Duty Hours

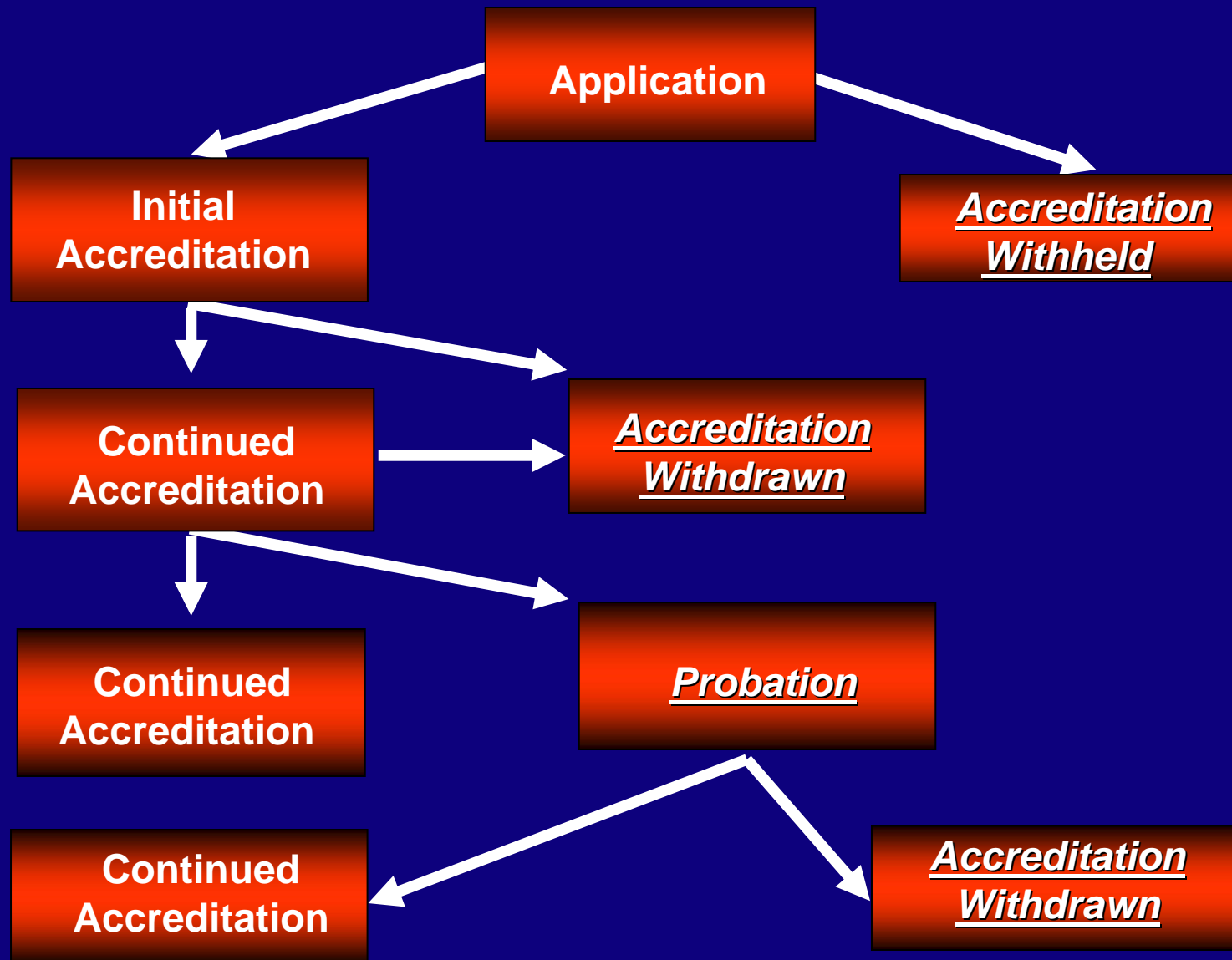
80 hour limit - averaged over 4 weeks, includes in-house call

1. One day out of seven free
2. In-house call no more than 1 day in 3 averaged over 4 weeks
3. 24-hour duty maximum
4. Provide at least 10 hours for rest between duty periods
5. In-house moonlighting counts

Monitoring Duty Hour Compliance

- ❑ Non-compliant Programs Identified through:
 - *Program Self-reports*
 - *Resident Questionnaire*
 - *Resident Complaints*
- ❑ Actions taken by RRCs:
 - *Additional Monitoring*
 - *Requests for Progress Reports*
 - *Shortened Accreditation Cycle*

Accreditation Options



Defer

- ❑ RRC needs clarification of major issues
- ❑ Accreditation decision remains “open”
- ❑ Result: Additional information will be requested. RRC will consider request after information has been received.

Progress Reports

- ❑ RRC needs a response to major concerns
- ❑ Report must be:
 - *Responsive*
 - *Reviewed/signed by the institution's DIO*

Progress Reports: *Reasons to Request*

- ❑ RRC seeks improvement/attention to an issue and believes site visit is not necessary to bring issue to a state of compliance with program requirements.
- ❑ RRC sees an issue has reoccurred over time and believes progress report will focus program and institutional attention on the issue

Surgery RRC Agenda Timelines

- ❑ February 21, 2008 meeting
 - *Agenda closing date: December 7, 2007*

- ❑ June 26, 2008 meeting
 - *Agenda closing date: April 11, 2008*

- ❑ October 23, 2008 meeting
 - *Agenda closing date: August 5, 2008*

Notification of RRC Decisions

- ❑ 2-4 days after RRC meeting (informal notification via e-mail)
- ❑ 8-10 weeks after RRC meeting (formal Letter of Notification (LON) posted)
 - *LONS are never mailed*

Accredited Programs - Surgery

| | Total Programs | Cont. Accred. | Initial Accred. | Other |
|-------------------|----------------|---------------|-----------------|-------|
| Core | 251 | 245 | 6 | 0 |
| Pediatric Surgery | 34 | 30 | 4 | 0 |
| Critical Care | 88 | 79 | 9 | 0 |
| Vascular | 96 | 92 | 4 | 0 |
| Hand | 1 | 1 | 0 | 0 |

RRC-Surgery 2006-2007

Frequent Areas of Non-Compliance

- The Education Program - Procedural Experience
- Program Personnel & Resources
- Institutional Support
- Evaluation
- Scholarly Activity

Average Citations Per Program Review

- Core programs - 4.25 citations
- Sub-specialty programs - 1.06 citations

RRC Surgery Updates

- ❑ New program requirements:
 - *Surgery (effective 1/2008)*
 - *Vascular (effective 7/2007)*
- ❑ Operative log changes: Vascular (Fall 2007 newsletter)
- ❑ Operative log report formats (AY 2007-2008)

RRC Surgery Resources

- ❑ www.acgme.org
(Review Committee Surgery page)
 - *Program requirements*
 - *PIFs*
 - *Newsletters*
 - *Program format change information*

When to Contact ACGME via ADS

- Upcoming changes in program - All requests must be made through ADS
 - *Notify change in Program Director and/or PD contact information*
 - *Request temporary increase in resident complement*
 - *Request participating site changes (add or delete)*
 - *Request changes to approved rotations*
- Response to Citations
- Annual Updates

When to Contact Staff

- Any time you need clarification/consultation
- Any time requested change would trigger a site visit
 - *Requesting a permanent change in resident complement*
- Any time major changes are occurring
 - *Change in sponsorship/ownership*

RRC Surgery Staff Contact Information

- ❑ Peggy Simpson, EdD, Executive Director
312.755.5499 psimpson@acgme.org
- ❑ Louise King, MS, Associate Executive Director—Core
312.755.5498 lking@acgme.org
- ❑ Sara Thomas, Accreditation Administrator—Sub-specialty
312.755.5495 sthamas@acgme.org
- ❑ Debra Martin, Accreditation Assistant
312.755.7471 dmartin@acgme.org

Agenda—Case Log System

- Year End Process
- Data Sharing with Board
- Pediatric Defined Category
- Preliminary Residents
- New (Modified) Reports
- Changes
- Where to Get Assistance

2008 Year End Process

- ❑ Deadline is August 1, 2008 (Anyone completing by 08/31/2008)
 - Categorical Grads
 - All preliminary positions (1-3)
- ❑ Update Online Case Log System
 - Set Current Graduating Class (2007-2008)
 - Verify grads and print reports (Operative and defined category for categorical grads)
 - + Signed by program director and graduates
 - + Working on implementing electronic signature
 - Letter indicating who categorical and preliminary grads are
 - Mail to ACGME

Data Sharing With the Board

- ❑ 3rd Year of Agreement to electronically transfer data to the Board
- ❑ Resident Must sign off on Agreement
- ❑ Aggregate File sent 3 times
 - May 1st
 - June 1st
 - Fall after data finalized



[Login](#)

[Case Entry](#)

[Program Setup](#)

[Year End](#)

[Reports](#)

[Handheld](#)

[Help](#)

Welcome to Resident Operative Case Log for General Surgery

Last Updated 03/14/2007:

The process for adding new residents to the Case Log System has been updated. Now, all new residents must be entered into ADS first. After adding them into ADS, there are two options for completing their addition to the Case Log System.

One is to wait for the next day. Each night, newly added residents to ADS will be automatically transferred to Case Logs. To complete their addition, simply assign them an ID and password for the Case Log System.

Otherwise, after adding them into ADS, you can log back into Case Logs and go to the 'Add/Update' link under resident on the 'Program Setup' tab. On the top part of the page, newly added residents from ADS will be listed, and any residents previously entered into the Case Log System will be on the bottom part of the page. Simply click on 'Add' and the data will be transferred. Alternatively, click on 'Synchronize Residents with ADS' and all new residents will be entered and their year in program synchronized with ADS.

The CPT descriptions have been updated to reflect the CPT 2007 publication by the AMA. The most notable change is that all the CPTs medium descriptions has been abbreviated to a maximum length of 48 characters. This change affects all 'handheld device' users.

General Surgery

- Corrections/Enhancements:
 - You have accepted the access terms click Review Agreement to review [Review Agreement](#)
 - Added an agreement page that will allow ACGME to share the residents operative log with the American Board of Surgery for its use.
 - Upon login all the General Surgery Residents will be asked to respond to an agreement with the ACGME.
 - If you disagree with the agreement you will be allowed continue. Please note that the ACGME will not share your case log experience with the American Board of Surgery.
 - Also, if you disagree, the agreement will display every time you log into the Case Log System.
- Known Issues:
 - Netscape users:
 - If all of the fields do not display on the procedure entry screen, try to reload the page. Use the Reload function on the View pull down menu.
 - There are two ways to view reports: The Java viewer and the HTML viewer. These options are listed at the bottom of the report tab. When using the Java Viewer in Netscape you may see unpredictable results. If the Java Viewer is not working right for you, try the HTML viewer. However, the HTML viewer will only print the current page you are viewing. ACGME is researching other options for reporting.

While this application is viewable under all major internet browsers it is best viewed using Internet Explorer 5.0.

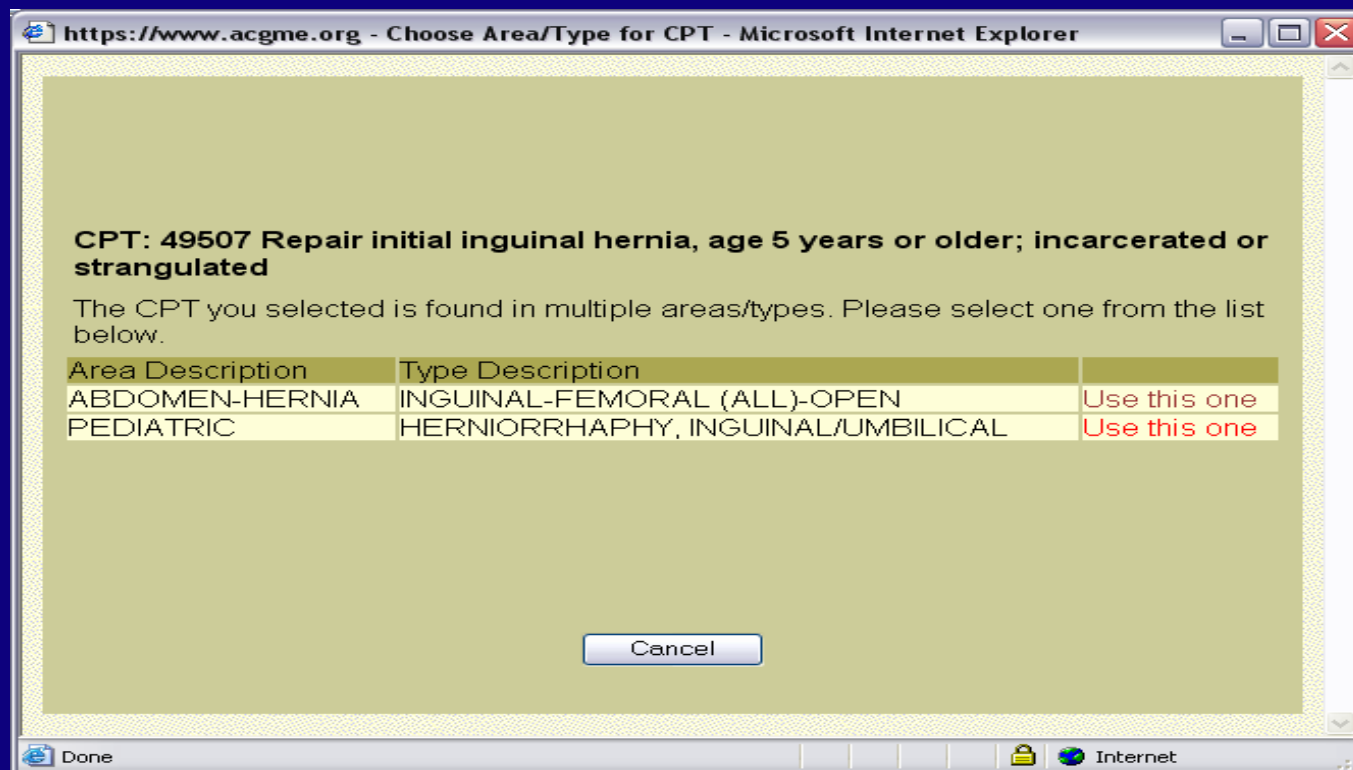
Notice:

- Are you experiencing an excessive amount of "Session Timeout Error pages"?

Pediatric Defined Category

- Vast majority of cases did not change
- Most procedures determined by the RRC and its corresponding CPT code
 - If adult and pediatric get screen asking to choose adult/pediatric
 - Searching by area & type will automatically assign correctly
- Hernias did not change; reported as subtotal
- Appendectomy was most significant change, use regular code and patient age dropdown box

Adult/Pediatric Code



https://www.acgme.org - Choose Area/Type for CPT - Microsoft Internet Explorer

CPT: 49507 Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated

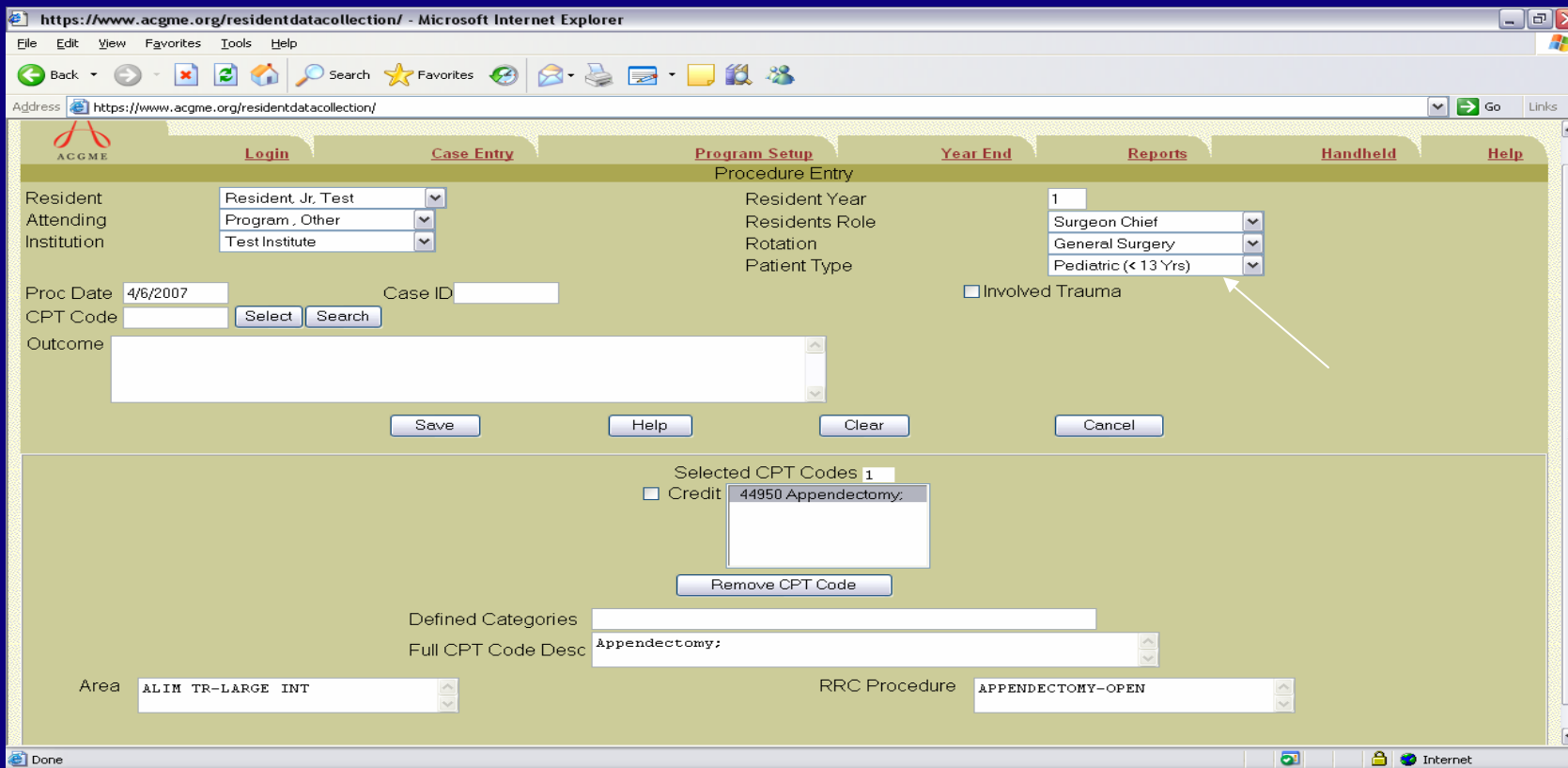
The CPT you selected is found in multiple areas/types. Please select one from the list below.

| Area Description | Type Description | |
|------------------|-----------------------------------|--------------|
| ABDOMEN-HERNIA | INGUINAL-FEMORAL (ALL)-OPEN | Use this one |
| PEDIATRIC | HERNIORRHAPHY, INGUINAL/UMBILICAL | Use this one |

Cancel

Done Internet

Pediatric Appendectomy



The screenshot shows a web browser window with the URL <https://www.acgme.org/residentdatacollection/>. The page has a navigation menu with tabs: Login, Case Entry, Program Setup, Year End, Reports, Handheld, and Help. The 'Case Entry' tab is active, and the 'Procedure Entry' sub-section is selected.

The form contains the following fields and controls:

- Resident:** Resident Jr, Test (dropdown)
- Attending:** Program - Other (dropdown)
- Institution:** Test Institute (dropdown)
- Resident Year:** 1 (text input)
- Residents Role:** Surgeon Chief (dropdown)
- Rotation:** General Surgery (dropdown)
- Patient Type:** Pediatric (< 13 Yrs) (dropdown, highlighted with a white arrow)
- Involved Trauma:** (checkbox)
- Proc Date:** 4/6/2007 (text input)
- Case ID:** (text input)
- CPT Code:** (text input) with 'Select' and 'Search' buttons.
- Outcome:** (text area)
- Buttons:** Save, Help, Clear, Cancel.
- Selected CPT Codes:** 1 (text input)
- Credit:** (checkbox) next to 44950 Appendectomy: (text input)
- Remove CPT Code:** (button)
- Defined Categories:** (text input)
- Full CPT Code Desc:** Appendectomy: (text input)
- Area:** ALIM TR-LARGE INT (dropdown)
- RRC Procedure:** APPENDECTOMY-OPEN (dropdown)

Close

| | | | | |
|---|-----------|----------|----------|----------|
| GASTROSTOMY (ALL TYPES)-LAPAROSCOPIC | | | | |
| GASTRIC RESECT, PARTIAL-LAPAROSCOPIC | 1 | | | |
| VAGOTOMY, TRUN/SEL W/DRAINAGE/RES-LAPAR | | | | |
| PROX GAST VAGOTOMY, HIGHLY SELECT-LAPAR | | | | |
| ENTEROLYSIS-LAPAROSCOPIC | | | | |
| ENTERECTOMY-LAPAROSCOPIC | 1 | | | |
| ILEOSTOMY (NOT ASSOC W/COLECTOMY)-LAP | | | | |
| APPENDECTOMY-LAPAROSCOPIC | 4 | 2 | 1 | |
| COLECTOMY, PARTIAL-LAPAROSCOPIC | | 1 | | |
| COLECTOMY, TOTAL/SUBTOT W/ILEOSTOMY-LAP | | | | |
| EXP LAP EXCLUSIVE OF TRAUMA-LAPAR | | 1 | | |
| MAJ RETROPERIT/PELVIC NODE DISSEC-LAPAR | | | | |
| OTHER MAJOR AB-GENERAL-LAP SIMPLE - DEF CAT CREDIT | 1 | | | |
| OTHER MAJOR AB-GENERAL-LAP COMPLEX - DEF CAT CREDIT | 1 | | | |
| CHOLECYSTECTOMY W/WO OPER GRAMS-LAPAR | 10 | 1 | 1 | 1 |
| COMMON BILE DUCT EXPLOR-LAPAR | | | | |
| SPLENECTOMY FOR DISEASE-LAPAR | 2 | | | 2 |
| INGUINAL-FEMORAL (ALL)-LAPAROS | | | | |
| EXPLOR THORACOTOMY W/WO BX-THORACOS | | 1 | | |
| PLEURODESIS-THORACOSCOPIC | | | | |
| LOBECTOMY/SEGMENTAL RESECT LUNG-THORACOS | | | | |
| WEDGE RESECTION LUNG-THORACOSCOPIC | | | | |
| PERICARD WINDOW FOR DRAINAGE-THORACOSCOPI | | | | |
| SYMPATHECTOMY, THORACOLUMBAR-THORACOSCOPI | | | | |
| ESOPHAGOMYOTOMY (HELLER)-THORACOSCOPIC | | | | |
| ANTIREFLUX PROCEDURE-LAPAROSCOPIC (PEDS) | | | | |
| EXPLOR THORACOTOMY-THORACOSCOPIC | | | | |
| EXPLOR LAPAROTOMY-LAPAROSCOPIC | | | | |
| Total Laparoscopic/Thoracoscopic Procedures | 18 | 9 | 1 | 4 |
| Pediatric Defined Category | | | | |
| APPENDECTOMY | 9 | 4 | | 1 |
| HERNIORRHAPHY | 6 | 2 | | |
| ADDITIONAL PROCEDURES | 1 | 1 | | |
| Total Pediatric Defined Category | 16 | 7 | | 1 |

Preliminary Residents

- ❑ Data is archived from System when residents complete
- ❑ Preliminary training
 - Data for residents who enter training in another specialty do not get transferred
 - If they later get categorical position, depends on position level if preliminary data counts
- ❑ ACGME is generating national level comparative statistics for
- ❑ Preliminary residents for the RRC

Preliminary Data Counts

- ❑ Resident enters categorical training beyond Program year 1
- ❑ If going to another program, data can and will be transferred
 - New program initiates the process
 - If archived, contact ACGME we will transfer data
- ❑ If remaining in new program don't submit at year end, let us know if they were archived

Preliminary Data Does Not Count

- Resident begins categorical training in program year 1
- Should report as preliminary graduate
- Data will be archived
 - Create download and save copy of data
 - ACGME will save copy and remove from production database
- Resident is entered as if a new categorical resident with no prior data

Reports for the PIF

- ❑ Every year, ACGME generates reports based on that years graduates
- ❑ Resident and national level comparative data
- ❑ Reports are be posted in ADS
 - **Back to 2002-2003 academic year**
- ❑ For PIF, attach reports to PIF as documentation of resident experience



ACGME Accredited Data Collection Application - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Print Print Preview

Links ADS ADS-Test Case Logs Case Logs - Test OpLog Secure - Production SECR - Test

Address <https://www.acgme.org/ads/main/default.asp> Go

- Update Program Information
- Update Faculty Information
- Resident Information**
 - Update Resident Information
 - Quick Update
 - Add New Resident/Fellow
- Site Visit Information**
 - Competency and Assessment Form
 - PIF Part 1 (For Site Visit)
 - PIF Part 2
 - Site Visit Evaluation Survey
- Resident Survey**
 - Aggregate summary report
 - Resident Survey Report Guide
- Tools**
 - Case Log Reports
 - CV Cover Sheet
 - Download My Data
 - World Directory of Medical Schools
 - Notification Letters
 - Duty Hour FAQ
 - ADS Main Glossary
 - Competency and Assessment Glossary

Your browser is: Microsoft Internet Explorer: 6.0;
Windows NT 5.1;
Your OS is: Win32

For the academic year 2005-2006, DIOs will no longer need to verify their sponsored programs duty hour responses. Please ensure that all information is accurate and complete.

Program Information Forms with New ADS Part 1 and Part 2 Format

At this time, the PIFs for several specialties have been re-organized and now follow the Part 1 (from ADS) and Part 2 format. Part 1 of the PIF is electronically populated from data provided annually by programs and sponsoring institutions. Using ADS, programs can retrieve Part 1 of the PIF under the Site Visit Information Section. After Part 1 is updated and complete, proceed with the completion of Part 2, a word processing document, that can be found under the Program Information Form Section on the ACGME website (www.acgme.org). The specialties with the converted PIF can use the ADS system to review Part 1 of the PIF at any time.

The revised PIFs include all core specialties (with the exception of Internal Medicine which is using CAAR). Subspecialties using the revised PIF include: Pediatric Anesthesiology, Critical Care Medicine (Anesthesiology), Pain Medicine (Anesthesiology), Procedural Dermatology, Dermatopathology, Medical Toxicology (Emergency Medicine), Endovascular Surgical Neuroradiology (Neurological Surgery), Pain Medicine (Neurology), Neuromuscular Medicine, Child Neurology, Neurodevelopmental disabilities, Clinical Neurophysiology, Adult Reconstructive Orthopaedics, Foot and Ankle Orthopaedics, Hand Surgery (Orthopaedics), Orthopaedic Surgery of the Spine, Orthopaedic Sports Medicine, Musculoskeletal Oncology, Neurology, Pediatric Otolaryngology, Pathology, Selective Pathology, Blood Banking/Transfusion Medicine, Pediatric Physical Medicine and Rehabilitation, Undersea and Hyperbaric Medicine, Medical Toxicology (Preventive Medicine), Addiction Psychiatry, Child and Adolescent Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Psychosomatic Medicine, Abdominal Radiology, Endovascular Surgical Neuroradiology (Radiology-Diagnostic), Vascular and Interventional Radiology and Cardiothoracic Radiology.

Some specialties are also including the program faculty data on the electronic PIF-Part 1 (see below). Programs are encouraged to initially log the faculty members who are directly and regularly involved in resident education and provide any additions and deletions on an annual basis. Within the next several months, more specialties will begin to generate the faculty data electronically on Part 1 of the PIF.

Requests in ADS by Program Director which require DIO/GMEC Approval

The ACGME Institutional Requirements specify that the Designated Institutional Official (DIO) or a designee review and cosign (hard copy or email) any correspondence or document submitted to the ACGME by program directors that requests changes in the program that would have significant impact, including financial, on the program or institution. In addition, the GMEC must review and approve, prior to submission to the ACGME, applications for accreditation of new program or subspecialty; changes in resident complement; major changes in program structure or length of training; additions and deletions of participating institutions used in a program; appointment of new program director. ACGME is in the process of transitioning to electronic submission, through ADS, these requests to RRCs. In order to facilitate documentation of DIO/GMEC approval, and therefore, compliance with the Institutional Requirements, program directors should submit the requests in ADS and submit a letter from the DIO/program director via



Browser navigation bar with address bar (https://www.acgme.org/ads/main/default.asp), search bar (Google), and multiple tabs including ADS, Case Logs, and SAS - WebReportStudio.

- Home/Annual Update Status
- Contact ADS Staff
- Log Out
- Update Program Info
- Update Resident Info
- Request Changes
- Resident/Fellow Survey
- PIF Preparation
- Case Log Reports**
- Site Visit Results
- Tools/Reference

Case Log Reports

Select an academic year: 2006-2007

| View Report (requires Adobe Acrobat Reader) | Report Title |
|--|-----------------|
| | National Report |
| | Program Report |
| | Resident Report |
| 3 Reports Found | |

GENERAL SURGERY: PROGRAM REPORT (Main Table)
 Reporting Period: Total Experience of Residents Completing Programs in 2006-2007
 Residency Review Committee for General Surgery

Program=440XXXXXX - Sample Program

| [PART 1] Programs in the Nation: 248 Residents in the Nation: 1004 Residents in this Program: 4 | | | | | | | | | | | | |
|---|---|---------------|----------------|--------------|--------------|---------------|----------|----------|-----------|--------------|-----------------|---------------|
| | | Surgeon Chief | Surgeon Junior | Teach Assist | First Assist | Surgeon Total | | | | | | |
| | | Prog AVE | Prog AVE | Prog AVE | Prog AVE | Prog AVE | Prog MIN | Prog MAX | Prog PERC | Prog Z-Score | Prog AVE Change | Natl Prog AVE |
| RRC Area | RRC Procedure | | | | | | | | | | | |
| SKIN/SOFT TIS | MAJ LYMPHADENECTOMIES | 0.0 | 1.3 | 0.0 | 0.0 | 1.3 | 0 | 4 | 9 | -1.0 | -1 | 4 |
| | MAJ EXC & REP/GRAFT FOR SKIN NEOPLASM | 1.0 | 7.3 | 0.0 | 0.0 | 8.3 | 7 | 9 | 66 | 0.3 | 4 | 7 |
| | SENTINEL LYMPH NODE BIOPSY FOR MELANOMA | 0.0 | 1.8 | 0.3 | 0.0 | 1.8 | 0 | 4 | 34 | -0.5 | 1 | 3 |
| | RAD EXCIS SOFT TIS TUMOR | 0.5 | 1.0 | 0.0 | 0.0 | 1.5 | 0 | 2 | 34 | -0.5 | 1 | 2 |
| | OTHER MAJOR SKIN/SOFT TIS | 4.5 | 34.0 | 1.8 | 0.3 | 38.5 | 35 | 47 | 94 | 2.3 | 19 | 19 |
| | Subtotal - SKIN/SOFT TIS | 6.0 | 45.3 | 2.0 | 0.3 | 51.3 | 47 | 56 | 88 | 1.2 | 24 | 35 |
| HEAD/NECK | RESECT LESION-LIPS/TONGUE/MOUTH | 0.0 | 0.3 | 0.0 | 0.0 | 0.3 | 0 | 1 | 53 | -0.2 | 0 | 0 |
| | PAROTIDECTOMY & RESECT OTHER SALIV GLND | 0.0 | 1.0 | 0.0 | 0.0 | 1.0 | 0 | 2 | 56 | -0.2 | 0 | 1 |
| | RADICAL NECK DISSECT & RESECT MAND/MAX | 0.0 | 0.8 | 0.0 | 0.0 | 0.8 | 0 | 3 | 39 | -0.5 | 1 | 1 |
| | TRACHEOSTOMY | 0.8 | 3.8 | 1.0 | 0.3 | 4.5 | 2 | 7 | 7 | -1.1 | -2 | 13 |
| | OTHER MAJOR HEAD/NECK | 0.5 | 6.3 | 0.0 | 0.3 | 6.8 | 5 | 9 | 80 | 0.7 | 4 | 5 |
| | Subtotal - HEAD/NECK | 1.3 | 12.0 | 1.0 | 0.5 | 13.3 | 8 | 20 | 22 | -0.8 | 3 | 21 |
| BREAST | BREAST BIOPSY | 2.5 | 24.8 | 0.0 | 1.0 | 27.3 | 21 | 32 | 48 | -0.3 | 7 | 32 |
| | BREAST BIOPSY-STEREOTACTIC | 0.0 | 4.3 | 0.0 | 0.3 | 4.3 | 1 | 9 | 81 | 0.7 | 4 | 2 |
| | SENTINEL LYMPH NODE BIOPSY BREAST | 0.3 | 5.5 | 0.0 | 0.3 | 5.8 | 0 | 16 | 41 | -0.4 | 3 | 8 |
| | MASTECTOMY - ANY & AXILLARY SAMPLING | 1.5 | 12.8 | 0.3 | 0.3 | 14.3 | 6 | 26 | 23 | -0.7 | 3 | 19 |
| | BREAST RECONSTRUCTION | 0.0 | 19.3 | 0.3 | 0.0 | 19.3 | 11 | 28 | 96 | 2.1 | 2 | 5 |
| | OTHER MAJOR BREAST | 0.3 | 1.5 | 0.0 | 0.3 | 1.8 | 0 | 5 | 49 | -0.2 | -0 | 2 |
| Subtotal - BREAST | 4.5 | 68.0 | 0.5 | 2.0 | 72.5 | 70 | 76 | 64 | 0.2 | 18 | 69 | |
| ALIM TR-ESOPHAGUS | ESOPHAGEAL RESECTION/BYPASS | 1.8 | 0.3 | 0.0 | 0.5 | 2.0 | 0 | 5 | 60 | 0.0 | -0 | 2 |
| | ANTIREFLUX PROC-OPEN | 1.5 | 0.8 | 0.0 | 0.0 | 2.3 | 0 | 6 | 72 | 0.2 | -1 | 2 |
| | ANTIREFLUX PROC-LAPAROSCOPIC | 4.3 | 0.0 | 0.0 | 0.0 | 4.3 | 3 | 5 | 59 | -0.1 | 2 | 5 |
| | REPAIR OF PERF-ESOPH DISEASE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 | 0 | 41 | -0.4 | 0 | 0 |
| | OTHER MAJOR ESOPHAGUS | 1.3 | 0.8 | 0.0 | 0.0 | 2.0 | 2 | 2 | 86 | 1.1 | 0 | 1 |
| | Subtotal - ALIM TR-ESOPHAGUS | 8.8 | 1.8 | 0.0 | 0.5 | 10.5 | 8 | 13 | 63 | 0.1 | 1 | 10 |

Note: Percentiles of 15 or less are highlighted in red while those 97 and above are in green. Z-Scores of -1 or less are in red while those 2 and above are in green.

GENERAL SURGERY: PROGRAM REPORT (Defined Categories Table)

Reporting Period: Total Experience of Residents Completing Programs in 2006-2007
Residency Review Committee for General Surgery

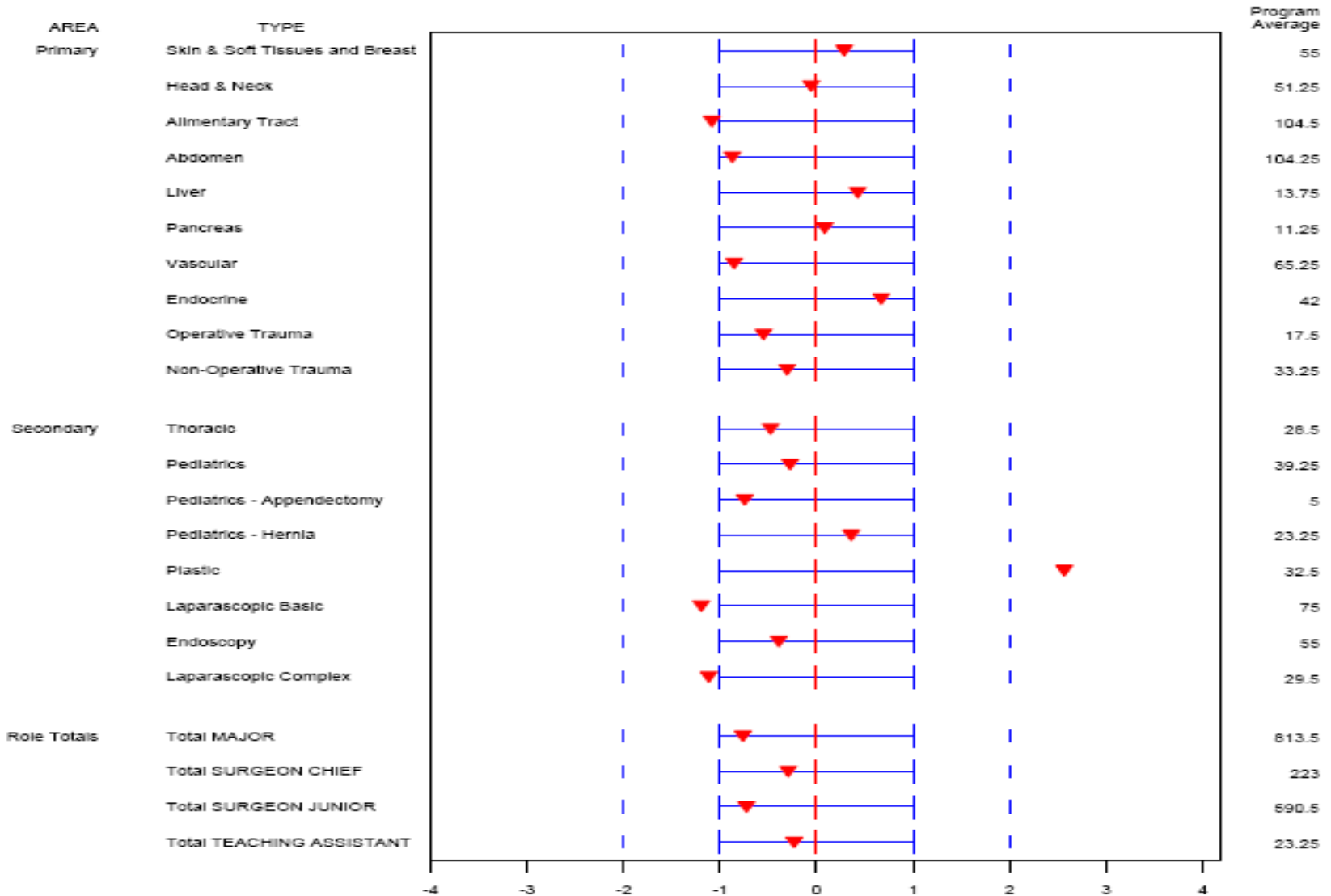
Program=440XXXXXXX - Sample Program

| [Part 1] | | Programs in the Nation: 248 | Residents in the Nation: 1004 | Residents in this Program: 4 | | | |
|-------------|--------------------------------|-----------------------------|-------------------------------|------------------------------|--------------|-------------|---------------|
| | | Defined Categories | | | | | |
| | | Prog AVE | Prog MED | Prog PERC | Prog Z-Score | Res Bel Min | Natl Prog AVE |
| RRC Area | RRC Procedure | | | | | | |
| Primary | Skin & Soft Tissues and Breast | 55.0 | 55 | 68 | 0.3 | 0 | 51 |
| | Head & Neck | 51.3 | 51 | 55 | -0.1 | 0 | 52 |
| | Alimentary Tract | 104.5 | 99 | 13 | -1.1 | 0 | 142 |
| | Abdomen | 104.3 | 102 | 16 | -0.9 | 0 | 138 |
| | Liver | 13.8 | 13 | 73 | 0.4 | 0 | 12 |
| | Pancreas | 11.3 | 11 | 68 | 0.1 | 0 | 11 |
| | Vascular | 65.3 | 67 | 21 | -0.9 | 0 | 91 |
| | Endocrine | 42.0 | 44 | 80 | 0.7 | 0 | 31 |
| | Operative Trauma | 17.5 | 17 | 35 | -0.5 | 0 | 24 |
| | Non-Operative Trauma | 33.3 | 28 | 52 | -0.3 | 0 | 43 |
| Secondary | Thoracic | 28.5 | 25 | 37 | -0.5 | 0 | 35 |
| | Pediatrics | 39.3 | 35 | 48 | -0.3 | 0 | 44 |
| | Pediatrics - Appendectomy | 5.0 | 6 | 20 | -0.7 | 2 | 9 |
| | Pediatrics - Hernia | 23.3 | 20 | 73 | 0.4 | 0 | 20 |
| | Plastic | 32.5 | 29 | 96 | 2.6 | 0 | 13 |
| | Laparoscopic Basic | 75.0 | 76 | 9 | -1.2 | 0 | 130 |
| | Endoscopy | 55.0 | 41 | 47 | -0.4 | 0 | 76 |
| | Laparoscopic Complex | 29.5 | 31 | 7 | -1.1 | 0 | 58 |
| Role Totals | Total MAJOR | 813.5 | 839 | 22 | -0.8 | 0 | 924 |
| | Total SURGEON CHIEF | 223.0 | 220 | 43 | -0.3 | 0 | 238 |
| | Total SURGEON JUNIOR | 590.5 | 597 | 26 | -0.7 | 0 | 686 |
| | Total TEACHING ASSISTANT | 23.3 | 15 | 53 | -0.2 | 0 | 30 |

Note: Percentiles of 15 or less are highlighted in light red in the table while percentiles of 97 and above are highlighted in green.

GENERAL SURGERY: PROGRAM REPORT (Standard Deviations Summary Graph for Defined Categories)
 Reporting Period: Total Experience of Residents Completing Programs in 2006-2007
 Residency Review Committee for General Surgery

PROGRAM-440XXXXXXXX - Sample Program




 National Average \pm One and Two Standard Deviations
 
 Program Average

Upcoming Changes 2008 Grads

- ❑ Laparoscopy – Basic
 - Minimum increased to 60 total cases
 - Procedures comprising the category have not changed
- ❑ Laparoscopy – Advanced
 - Minimum is now 25 total cases
 - Once again, procedures comprising the category did not change

Upcoming Changes 2009 Grads

- ❑ Total Majors – minimum increased to 750
 - Up to 50 teaching assistant cases can be counted towards the 750
 - Teaching assistant do not count toward meeting an individual defined category minimum
- ❑ Endoscopy
 - Minimum increased to 85 total cases
 - Upper endoscopy 35
 - Colonoscopy 50 procedures

If You Need Assistance

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Q & A

