New Coordinators’ Workshop

Jeannine St. Pierre
Judy Olenwine
June Cameron
Sandy DelCoglin
Donna Guinto
Kim Agretto
Barb Carter

Monday, April 14th, 2008
ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

Jeannine St. Pierre
University of Massachusetts
Worcester, MA
Established in 1981 to replace the Liaison Committee for Graduate Medical Education (est. in 1972).

- **Reason**: the academic medical community wanted an independent accrediting organization.
- **Purpose**: to evaluate and accredit medical residency programs in the US.
- **Mission**: to improve health care by assessing and advancing the quality of resident physicians.
In 2006-2007 8,257 accredited programs in 120 specialties and subspecialties existed with 106,377 filled positions.

Member organizations include:
- American Board of Medical Specialties (ABMS)
- American Medical Association (AMA)
- American Hospital Association (AHA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)
Every specialty with a certifying board approved by ABMS has a review committee.

Currently there are 26 specialty boards.

ACGME has a total of 28 review committees.
- One for each of the 26 specialty boards
- One for transitional year programs
- One for Institutional Reviews (2005)

All Review Committees operate under the auspices of the ACGME.
ACGME/RC

- Each RC is composed of volunteer physicians from organizations ex: (ACS) and specialty boards (ABS).
- The RC conducts accreditation reviews every 1-5 years depending on the program's degree of compliance.
- Failure to meet requirements can result in areas of concern, citations, probation, or the loss of accreditation.
- Residents must graduate from an ACGME accredited program to be eligible for board certification.
RC FOR SURGERY

- Composed of 4 members from each
  - American Medical Association
  - American Board of Surgery
  - American College of Surgeons
- Plus one resident member for a total of 13.
- All training programs have specialty requirements that must be met to maintain accreditation.
Site visitor conducts a one-day site visit.

An objective narrative report about the program, based on interviews with PD, residents, faculty, is submitted to the RC.

RC meets on average of 3 times per year.

Site visitor report is reviewed along with other program data.

RC members vote on appropriate accreditation action based on the site visitors report.
CORE COMPETENCIES

- Implemented July 2001
Refers to educational outcomes not clinical – “evidence showing the degree to which program purposes and objectives are or are not being attained, including achievement of appropriate skills and competencies by students”
THE COMPETENCIES

- Patient Care
- Medical Knowledge
- Practice-Based Learning
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice
Outcome Project

Enhancing residency education through outcomes assessment

Announcements:

- A new RSVP has been added to the Outcome Project website (7/31/07)
- A new RSVP has been added to the Outcome Project website (7/31/07)
- A new MODULE has been added to the Instructional Toolbox (5/1/07)
- A new RSVP has been added to the Outcome Project website (4/23/07)
- A new RSVP has been added to the Outcome Project website (3/9/07)
- Educating Physicians for the 21st Century: A 4 module educational resource for teaching and learning the competencies
For more information please go to www.acgme.org

QUESTIONS?
General Surgery Operative Log Management

Judith Olenwine, MS
Lehigh Valley Hospital
Resident Case Log System

- Internet based system utilizing CPT/ICD 9 codes designated by the ABS and ACGME to track resident operative experience

- [www.acgme.org](http://www.acgme.org) > Data Collection Systems > Case Log System

- All categorical, designated preliminary, & non-designated preliminary residents are required to enter their case data (per program requirements effective 01/01/08)

- The Op Log system was designed to allow residents to enter their own cases
### Data Entry Screen

**Resident**
- Doe, John Q.

**Attending**
- Attending, General S.

**Institution**
- Test Institution

**Resident Year**
- 3

**Residents Role**
- Surgeon Jr.

**Rotation**
- General Surgery

**Patient Type**
- Adult

**Proc Date**
- 4/4/2008

**CPT Code**
- Selected: Laparoscopy, surgical, gastric restrictive procedure.

**Outcome**
- 

**Case ID**
- 99999

**Involved Trauma**
- 

**Save**
- Help
- Clear
- Cancel

**Selected CPT Codes**
- 1

**Defined Categories**
- Laparoscopy, surgical, gastric restrictive procedure;

**Full CPT Code Desc**
- with gastric bypass and Roux-en-Y gastroenterostomy

**Area**
- Unassigned

**RRC Procedure**
- Unassigned
Credit Roles

SC = Surgeon Chief Year
- Only cases credited as surgeon during 12 months of chief year

Sj = Surgeon Junior Year
- All cases credited as surgeon prior to chief year

TA = Teaching Assistant
- More senior resident working with junior resident who takes credit as surgeon

FA = First Assistant
- Any instance in which a resident assists at an operation with another surgeon who is responsible for the operation
Definition of Surgeon

Significant role in the following:

- Determination or confirmation of diagnosis, provision of preoperative care
- Selection & accomplishment of appropriate operative procedure
- Direction of the postoperative care
- Sufficient follow-up to be acquainted with course of the disease & out of treatment

Participation in the operation only, without pre- and postoperative care, is
Your Role

- Maintain residents, faculty, rotations, and institutions in Op Log system
- Provide training to residents
- Be familiar with defined categories including minimum number required to graduate as a chief resident
- Monitor ACGME website for pending changes to the requirements
Yearly Tasks

- Enter new resident information into Web ADS; synchronize with your Op Log system
- Establish log in and password for each new resident
- Update faculty members, hospitals and/or rotations
- Inactivate residents who leave your program (other than graduates)
- Run final reports for graduating chief and preliminary residents; keep copies of all the final reports with original signatures for your files
- Submit GSOL to the ACGME by August 1st!
Semi-Annual Tasks

- Run Op Log reports for resident’s semi-annual evaluation
- Review each resident’s Critical Care Case Log (CCIC) for progress and accuracy
- Run defined category reports for your PD to review to ensure all residents are on-track for graduation (PGY3 or higher)
Weekly/Monthly Tasks

To ensure that resident Op Log information is current & correct, periodic monitoring by the coordinator & program director is necessary.

- Establish a weekly/monthly routine to monitor resident compliance with entering their cases & stick to it.
- Utilize reports to ensure residents are entering their cases correctly and in a timely manner.
- Monitor Op Log requirement changes through the ACGME website.
Things to Consider

# 1 RC Citation relates to operative experience

- Failure to meet minimum requirements in any defined category
- Failure to meet minimum requirements for total majors or total chief cases
- Imbalance of operative experience between residents
Things to Consider

- It should not be a surprise to your PD if a chief resident has not met the required minimums for graduation.
- Keep your PD informed of your residents’ progress!
Establish a policy for your program regarding Op Log accuracy & currency including consequences for non-compliance.

Establish consequences with the PD for those residents who are not current with their data entry.

Stick to it!
Use Reports to Help You

- Resident Operative
- Resident Full Detail
- Resident Brief Detail
- Resident Activity
- Defined Category Report
- Critical Care Index Cases Report
- Available CPT Codes by Code
- Available CPT Codes by Area and Type
- CPT Summary
- List Residents
- Resident Operative - Archived Data
# Resident Activity Report

**Primary Procedures**  
Program ID: 4401234567  
Program Name: General Surgery Program Name  
For All Attendings at All Institutes  
All Residents  
For Procedures In All Years  
For All Patient Types  
For All Rotations  
All Defined Ctgys  
For All CPTs in All Areas and All RRC Procedures  
As Of 4/4/2008

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Current Year</th>
<th>Cases</th>
<th>CPT Codes</th>
<th>Last Procedure Dat</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green, Mark</td>
<td>1</td>
<td>44</td>
<td>44</td>
<td>3/12/2008</td>
<td>3/13/2008</td>
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<tr>
<td>Resident, Jr, Test</td>
<td>1</td>
<td>10</td>
<td>10</td>
<td>4/30/2007</td>
<td>2/22/2008</td>
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<tr>
<td>Smith, John</td>
<td>1</td>
<td>73</td>
<td>73</td>
<td>2/6/2008</td>
<td>2/6/2008</td>
</tr>
</tbody>
</table>
# Sample Monthly Report

## ACGME OPERATIVE LOG

**Data as of: March 5, 2008**

<table>
<thead>
<tr>
<th>Yr</th>
<th>Resident</th>
<th>Records Added Since: 01/20/08</th>
<th>Total Records</th>
<th>Date of Last Op</th>
<th>Critical Care</th>
<th>Non-op Trauma</th>
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<tbody>
<tr>
<td>5</td>
<td></td>
<td>22</td>
<td>1689</td>
<td>02/17/08</td>
<td>37 (SC=0)</td>
<td>48</td>
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<tr>
<td>5</td>
<td></td>
<td>21</td>
<td>2072</td>
<td>02/26/08</td>
<td>33 (SC=13)</td>
<td>145</td>
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<tr>
<td>5</td>
<td></td>
<td>71</td>
<td>1423</td>
<td>03/03/08</td>
<td>21 (SC=3)</td>
<td>108</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>32</td>
<td>1496</td>
<td>02/29/08</td>
<td>21 (SC=0)</td>
<td>59</td>
</tr>
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</table>

**Concerns:**

<table>
<thead>
<tr>
<th>MD</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Must enter critical care as chief</td>
</tr>
<tr>
<td></td>
<td>Must enter critical care as chief</td>
</tr>
</tbody>
</table>
**Defined Category Report**

**Program Average and Totals for Each Resident of Procedures in Defined Categories**

**Primary Procedures**

Program ID: 4401234567  Program Name: General Surgery Program Name

For All Attendings at All Institutes

All Residents

For Procedures In All Years For All Patient Types For All Rotations

All Reporting Years

As Of 4/4/2008

<table>
<thead>
<tr>
<th>Resident</th>
<th>SSOB</th>
<th>HNAN</th>
<th>ALTR</th>
<th>AB</th>
<th>LV</th>
<th>FANC</th>
<th>VASC</th>
<th>ENDO</th>
<th>TRAMOP</th>
<th>TRN</th>
<th>THOR</th>
<th>MED</th>
<th>PLA</th>
<th>LAF-B</th>
<th>ENDSY</th>
<th>LAF-C</th>
<th>TTL Maj</th>
<th>TTL Chief</th>
<th>TTL TA</th>
</tr>
</thead>
<tbody>
<tr>
<td>дл, дл</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Dr. John Q.</td>
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<td>1</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<td>1</td>
<td>29</td>
<td>24</td>
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<tr>
<td>Green, Mark</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>0</td>
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<td>2</td>
<td>22</td>
<td>12</td>
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<td>Resident, General Surgery</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>11</td>
<td>2</td>
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<td>8</td>
<td>1</td>
<td>3</td>
<td>63</td>
<td>42</td>
<td>3</td>
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<td>Resident, Asian</td>
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<td>1</td>
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<td>7</td>
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<td>Resident, Egyptian</td>
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<td>0</td>
<td>6</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Smith, Alan</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>0</td>
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<td>34</td>
<td>14</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The data contained here reflects only procedures under the following Resident Roles: Surgeon Chief & Surgeon Junior
Special Requirements

- Ensure residents understand how to enter cases for their CCIC Log.
- Ensure residents understand how to enter trauma non-operative cases and “meet” the required minimum number.
- Ensure residents are aware of pediatric surgery requirements.
Each resident must document the care of at least 20 critically ill patients.

For a patient to qualify for the CCIC log, their care must fall into at least two of 7 areas.

Completed log should include experience with at least 1 patient in all 7 of the essential categories.

Use the CPT code 99292 to document these patients.

99292 is the ONLY code that will accept multiple entries for the same patient on
# Critical Care Index Cases (CCIC)

Program ID: 4404121280  
Program Name: Lehigh Valley Hospital Network/Pennsylvania State  
For All Attendings at All Institutes

For All Resident Years  
For All Resident Roles  
For All Patient Types  
For All Rotations  
For CPT: 99292 in SURGICAL CRITICAL CARE PATIENT MANAGEMENT area and All RRC Procedures  
As Of 4/3/2008

<table>
<thead>
<tr>
<th>Procedure Date</th>
<th>Institution</th>
<th>Ventilatory management</th>
<th>Eelecting (non-trauma patient) &gt; 3 units</th>
<th>Monodynamic Instability (inotropic/pressure mechanical support)</th>
<th>Organ Dysfunction</th>
<th>Dysrhythmias (drug management)</th>
<th>Invasive line management/monitoring</th>
<th>Parenteral/nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2006</td>
<td>Lehigh Valley Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>00727646</td>
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<td></td>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/4/2006</td>
<td>Lehigh Valley Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>00262624</td>
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<tr>
<td></td>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/22/2006</td>
<td>Lehigh Valley Hospital</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Major organ trauma, no operation required (99199)

- Patients with major organ trauma admitted to a specialty care unit
- Most senior resident should claim credit as surgeon
- Subsequent surgery that may be claimed in “Trauma, Operative” category should be recorded with operative code, not MOTNOR
### Resident Operative Log (Total Counts)

Also on Defined Category Report

<table>
<thead>
<tr>
<th>Total Counts</th>
<th>SC</th>
<th>SJ</th>
<th>TA</th>
<th>FA</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL MAJOR OPERATIONS</td>
<td>183</td>
<td>926</td>
<td>34</td>
<td>137</td>
</tr>
<tr>
<td>TOTAL ENDOSCOPY</td>
<td>20</td>
<td>186</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL MISCELLANEOUS</td>
<td>3</td>
<td>54</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>TOTAL ENDOVASCULAR DIAGNOSTIC</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>TOTAL PATIENT CARE:NON-OPERATIVE TRAUMA</td>
<td></td>
<td></td>
<td></td>
<td>61</td>
</tr>
</tbody>
</table>
Pediatric Surgery

- Patients up to 13 years of age
- Use drop-down box to identify pediatric from adult cases
- 20 total in following categories
  - 8 inguinal &/or umbilical herniorrhaphy
  - 6 appendectomy procedures (open or lap)
  - 6 additional procedures
## Resident Operative Log Report

(before Total Counts)

<table>
<thead>
<tr>
<th>Pediatric Defined Category</th>
<th>SC</th>
<th>SJ</th>
<th>TA</th>
<th>FA</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDECTOMY</td>
<td></td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>HERNIORRHAPHY</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL PROCEDURES</td>
<td></td>
<td>13</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Pediatric Defined Category</strong></td>
<td>1</td>
<td>25</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
New Requirements to Monitor

- **For chiefs graduating June 30, 2008**
  - Minimum # of cases to graduate: 750
  - Laparoscopy Basic: 60
  - Laparoscopy Advanced: 25

- **For chiefs graduating June 30, 2009**
  - Endoscopy total: 85
    - Upper endoscopy 35
    - Colonoscopy 50
EDUCATIONAL CONFERENCES

June Cameron, BA, C-TAGME
Maine Medical Center
Portland, Maine
Educational Program

A. The curriculum must contain
   1. Overall educational goals for the program
   2. Competency-based goals and objectives for each assignment at each educational level
   3. Regularly scheduled didactic sessions
   4. Resident roles and responsibilities
Educational Conferences

- Didactic = to instruct by communication
- Didactic methods include
  - lecture
  - conference
  - journal club
  - directed case discussion
  - Seminar/Symposium
  - or assigned online learning module
Didactic Component

● Required Conferences
  - A course or structured series of lectures providing education in the basic & clinical sciences fundamental to surgery.
  - Regular, organized clinical teaching, e.g., grand rounds, ward rounds, & clinical conferences.
  - A Weekly morbidity & mortality or quality improvement conference.
Basic Science Conference

- Formal review of basic & clinical sciences.

- Topics should include:
  - Applied surgical anatomy & surgical pathology
  - Wound healing
  - Homeostasis
  - Shock & circulatory physiology
  - Hematologic disorders
  - Immunobiology & transplantation
  - Oncology
  - Surgical endocrinology
  - Surgical nutrition
  - Fluid & electrolyte balance
  - Metabolic response to injury, including burns
Grand Rounds

- Formal presentations by faculty, local surgeons, residents and/or fellows, visiting professors.
- Topics related to general surgery and surgical specialties.
- May include other competency related topics needed for resident education, e.g., ethics, health policy, professionalism.
- Usually 1 hour, held weekly.
- CME’s given
M&M or Quality Improvement

- Morbidity & Mortality (M&M)
  - Review all complications & deaths with the objective of improved patient care.
  - Any event that deviates from the anticipated uneventful recovery from surgery is, technically, a complication.
  - Representatives from ancillary departments and/or risk management may be present.
Didactic Component

- Conferences should be scheduled to permit resident attendance on a regular basis.
- Resident time must be protected from interruption by routine clinical duties.
- Documentation of attendance by 75% of residents at core conferences must be achieved.
- Sole reliance on textbook review is inadequate.
Other Conferences

- **Journal Club**
  - Review evidence-based medicine and evaluate current surgical literature.
  - Assign residents to discuss selected articles.
  - Faculty or program director as moderator.

- **Teaching Rounds**
  - Performed by service.
  - Residents present patients to the team, synthesize plan of care, evaluate patients’ needs.
Other Conferences

- Vascular Conference
- Trauma Conference
- Surgical Oncology
- General Surgery Conference

- PIF requires documentation of Basic Science conferences including specific titles and presenters
Other Educational Programming

- Surgical Skills Labs
- Knot Tying/Wound Closure
- ABSITE Review
- Quality Assessment/Risk Management
- Discharge Planning
- Business & Debt Management
- Career Development
Educational Conferences

ANY QUESTIONS?????
RECRUITMENT

- Organization – Key to Success
- Important task
- Time consuming
- Never ending
- Constant planning, organizing & re-organizing
- Communication
- Greet each applicant with a smile
RECRUITMENT

ERAS (Electronic Residency Application Service)

- Service of AAMC (Association of American Medical Colleges)
  - Enhances medical students’ transition to residency
  - Reduces time required for application process
  - Partners with NBME and ECFMG

- Comprised of Four Main Components
  - The MyERAS Web Site
  - The Dean’s Office Workstation (DWS)
  - Program Director’s Workstation (PDWS)
  - The ERAS Post Office

- www.aamc.org/eras
RECRUITMENT

- **ERAS - 1996**
  - Only one speciality – OB/GYN

- **ERAS – 2000 – General Surgery Residency**

- **ERAS - 2007**
  - 36 Residency Specialties
  - 27 Fellowship Specialties

- **# of Applicants**
  - 2003 – 4,574
  - 2007 – 6,304
Prior to ERAS
## 2009 ERAS Timeline for Residency Programs

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-June 2008</td>
<td>Schools begin receiving DWS kits</td>
</tr>
<tr>
<td></td>
<td>Begin generating &amp; distributing tokens</td>
</tr>
<tr>
<td>July 1, 2008</td>
<td>MyERAS website opens to applicants</td>
</tr>
<tr>
<td>August 15, 2008</td>
<td>Residency programs begin receiving PDWS kits</td>
</tr>
<tr>
<td>September 1, 2008</td>
<td>ERAS Post Office opens</td>
</tr>
<tr>
<td></td>
<td>Begin downloading files</td>
</tr>
<tr>
<td>November 1, 2008</td>
<td>MSPE’s are released</td>
</tr>
<tr>
<td>December 2008</td>
<td>Military match results available</td>
</tr>
<tr>
<td>January 2009</td>
<td>Urology match results available</td>
</tr>
<tr>
<td>March 2009</td>
<td>Scramble</td>
</tr>
<tr>
<td>March 20, 2009</td>
<td>NRMP Match results available</td>
</tr>
<tr>
<td>May 31, 2009</td>
<td>ERAS Post Office closes</td>
</tr>
<tr>
<td>July 1, 2009</td>
<td>Residents begin their training</td>
</tr>
</tbody>
</table>
RECRUITMENT

NRMP (National Resident Matching Program)

- Provides uniform date of appointment
- Impartial venue for matching applicants and programs
- Approximately 34,000 applicants annually
  - 16,000 US medical students
  - 18,000 independent applicants

www.nrmp.org
## 2008 Main Match Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 15, 2007</td>
<td>Applicant registration begins</td>
</tr>
<tr>
<td>Sept 1, 2007</td>
<td>Institution/Program registration begins</td>
</tr>
<tr>
<td>Nov 30, 2007</td>
<td>Applicant registration deadline</td>
</tr>
<tr>
<td>Jan 15, 2008</td>
<td>Rank Order List entry begins</td>
</tr>
<tr>
<td>Jan 31, 2008</td>
<td>Quota change deadline</td>
</tr>
<tr>
<td>Feb 27, 2008</td>
<td><strong>Rank Order List Certification Deadline</strong></td>
</tr>
<tr>
<td>March 17, 2008</td>
<td>Matched/Unmatched info posted to Web Site</td>
</tr>
<tr>
<td>March 18, 2008</td>
<td>Scramble</td>
</tr>
<tr>
<td>March 20, 2008</td>
<td>Match Day</td>
</tr>
<tr>
<td>March 21, 2008</td>
<td>Send welcome letters to matched applicants</td>
</tr>
</tbody>
</table>
RECRUITMENT

March – August

- Match week
- Contact matched applicants
- Send out employment & informational packets
- Prepare for orientation
- Attend recruiting fairs
- Install ERAS updates
- Register with NRMP
RECRUITMENT

- September – October
  - ERAS Post Office opens
  - Download applications
  - Screen applications
  - Invite applicants
  - Begin to schedule interviews
RECRUITMENT

November – January

- Continue to download applications
- Continue to review applications
- Continue to schedule interviews
- Organize interview sessions
- Conduct interviews
- Organize rank list meeting
February

- Download any new supporting documentation for ranked applicants
- Conduct rank list meeting
- Prepare/enter/CERTIFY/ rank list
RECRUITMENT

 Summary
  - Organization – Key to Success
  - Communication – Know what PD wants
  - ERAS Time Line
  - NRMP Main Match Schedule
  - Institution Calendar/Dates
Evaluations

Noun:

An appraisal of the value of something.
Evaulations

- Why do we evaluate?
  - To provide useful feedback
  - Effective feedback is essential for resident/faculty/program effectiveness
  - Evaluations and effective feedback together tap the basic human need-to-improve, to compete and to be accurate.
  - Most importantly, because it is required by the ACGME
Evaluations

- Procedures for evaluation of residents are outlined in the Common Program Requirements.
- Mechanisms to evaluate each of the following must be in place:
  - Residents
  - Faculty
  - Program
Evaluation of Residents

- Faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and provide documentation at completion of their assignment.
Evaluation of Residents

- The program must:
  - Provide objective assessments in core competencies
  - Use multiple evaluators (e.g. faculty, peers, patients, self, other staff)
  - Document progressive resident performance improvement for educational level
  - Provide resident with documented semi annual evaluation of performance with feedback
Evaluation of Program

- Residents & faculty must have the opportunity to evaluate program confidentially in writing annually.
- Program must use results of residents assessments of program with other program evaluation results to improve program.
- Program should prepare a written plan of action to address deficiencies.
Rotation Evaluation

- Not required by the RC for Surgery.
- May be a useful component of program evaluation & improvement
- Resident evaluations of rotation must be confidential.
What This Means

- Add a strong statement that summarizes how you feel or think about this topic
- Summarize key points you want your audience to remember
Next Steps

- Summarize any actions required of your audience
- Summarize any follow up action items required of you
Accreditation Data System (WebADS) & ACGME – Site Visit

Kim Agretto, C-TAGME
Easton Hospital
Community Health Systems
Easton, Pennsylvania

April 14, 2008
ACGME
Accreditation Data System (WebADS)

What is ADS?

- ADS is the verification and update of critical accreditation program information
ACGME Accreditation Data System (WebADS)

Where is it located and how do I access the system?

- ACGME homepage under data collection systems
- A user name and password are required for access
ACGME Accreditation Data System (WebADS)

Why are we required to use this system?

- Current program information is collected and on file with the ACGME for all accredited programs

- Information from WebADS is converted to the Common Program Information Form (Common PIF)
ACGME Accreditation Data System (WebADS)

The annual update consists of two parts:

Resident Verification
- Resident Name
- Start Date
- End Date
- Year in Program
- Type of Position
- Prior GME Years (not in YOUR Program)
- Gender
- Ethnicity
- Medical School
- ECFMG Number (Foreign Graduates)
ACGME
Accreditation Data System (WebADS)

Verify Program Information

✔ Program Information
✔ Program Coordinator
✔ Approved/ Filled Positions
✔ Participating Sites
✔ Resident Duty Hours/ Board Pass Rates
ACGME Accreditation Data System (WebADS)

WedAds is also where you request changes such as:

- Resident Complement
- Participating Sites
- Voluntary Withdrawal
A new rule:

- Request for new Program Director must be initiated by the Designated Institutional Official (DIO). Program Directors will be notified via e-mail after the DIO has started the change process. Entry of additional information regarding educational experience and certification will then be requested of the Program Director/Coordinator.

Please contact your DIO to initiate your request.
The data in this system will be seen when printing out the Common PI F. You will combine the following for your inspection:

- ✅ Common PI F
- ✅ Continued Accreditation PI F
- ✅ Table of Contents

and now to the
ACGME - Site Visit

January 9, 2007
Easton Hospital Surgical Residency Program
When you see this

The Accreditation Council for Graduate Medical Education, in collaboration with the Residency Review Committee, has identified the following program as due for its periodic review.
ACGME - Site Visit

YOU DON'T WANT TO FEEL LIKE THIS
ACGME - Site Visit

You want to feel like this
ACGME SITE VISIT - TIMELINE
JANUARY 9, 2007

6 TO 18 MONTHS BEFORE THE VISIT:

- ACGME will ask residents to complete a survey on-line
- The ACGME expects 70% response rate
- Results are available to the program once the 70% response rate is reached
- Review results with faculty and residents as this survey is used by the inspector during faculty and resident interviews. It also identifies areas of non-compliance with the core competencies and resident duty hours

HELPFUL HINT:
PRINT OUT SAMPLE SURVEY AND REVIEW WITH RESIDENTS PRIOR TO ASKING THEM TO COMPLETE ON-LINE SURVEY
Notified by ACGME on 9/7/07, regarding inspection date.
Notified DIO, Faculty, Residents.
Searched ACGME website for Field Representative - printed bio.
Reviewed PIF-Part 1.
Reviewed competency assessment section.
Began work on PIF-Part 2.
Distributed CV copies to all faculty members with a deadline of October 31, 2006.
Contacted affiliated hospital coordinators for CV completion with a deadline of October 31, 2006.
Scheduled meeting with the RRC for review of inspection letter, competencies, duty hours, and to review agenda.
Reviewed ACGME checklist and began to prepare folders for inspection.
Reserved conference room.
Contacted by Site Visitor, Dr. Raines who discussed in detail what she wanted to review, who she wanted to meet, and how she wanted the day scheduled. She also asked to have all documentation delivered overnight prior to the holidays.

Reviewed discussion with Program Director with confirmation e-mail of discussion to Dr. Raines to clarify points reviewed.

Completed PIF-Part 2 with Program Director.

Combined all parts of the inspection document - PIF-Part 1, 2, and the competency assessment documentation. Inspection document was now ready for review and proofreading by the Program Director, Associate Program Director, and the Director of Surgery.

Reminded faculty members and affiliate sites that Curriculum Vitae documentation was due by 10/31/06.

Continued preparing documentation files as requested by Dr. Raines.
ACGME SITE VISIT - TIMELINE

INSPECTION - JANUARY 9, 2007

- Made suggested corrections/changes to the PIF
- Final contact made to faculty and affiliated sites for Curriculum Vitae submission
- Began page numbering
- Resident peer selection vote; 12 residents selected
- Final PIF reviewed by Program Director and Associate Program Director with Curriculum Vitae documentation
- Finalized agenda for inspection day
- Ordered breakfast and lunch
- Created a checklist and colored file folders for all documents requested by the inspector. Numbered the folders to coincide with checklist
- Reviewed checklist to ensure that all documentation requested was in place for inspection
Reviewed PIF final time.
Made final corrections and suggested changes to the PIF.
Final PIF reviewed by Program Director and Associate Program Director with Curriculum Vitae documentation
Completed page numbering.
Final PIF sent to DIO for review and signature.
Finalized agenda mailed to DIO, Director of Surgery, Faculty, and Residents.
Checked breakfast, lunch order, and room reservation.
Reviewed checklist and colored file folders for all documents requested by the inspector. Reviewed contents and check off documents as they were reviewed.
Prepared letter to Dr. Raines which included agenda, driving directions, a map of the hospital, and the inspection document.
Inspection documents mailed on December 12, 2006. Dr. Raines confirmed receipt of package with thanks that it was delivered early and well before the holidays.
Contacted Dr. Raines via e-mail to check if there was anything else she required.

Phone calls made as a reminder to DIO, Director of Surgery, faculty, and residents.

Reviewed ACGME checklist to ensure that all documentation requested was in place for inspection.
ACGME – Site Visit

Documentation required on the day of the Site Visit (ACGME Checklist):

1) Written curriculum with goals and objectives
2) Current Program Letters of Agreement
3) Files of current residents
4) Files of residents who have transferred into the program
5) Completed evaluations of residents by faculty
6) Completed evaluations of the faculty by the residents
7) Completed evaluations of the program by the residents
8) Documentation of program director’s twice yearly evaluation meetings with the residents
ACGME - Site Visit

What documentation will be required on the day of the Site Visit:

9) Program Policy Manual including duty hours, policy on moonlighting, and supervision
10) Final written evaluations for the most recent graduates including verification of training completion statement
11) Minutes of faculty meeting documenting review with resident participation
12) Duty hours documentation
13) Conference Schedule
14) Documentation of conference attendance
15) Documentation of Internal Review (single page with date, participants, type of data collected, and when reviewed by GMEC)
16) Completed procedure/case logs for prior year
ACGME - Site Visit

Suggestions

✓ Keep in mind that WebADS and the PIF go hand-in-hand
✓ Keep up with the ever-changing PIF on a yearly basis (don’t wait until you receive notification to study this document)
✓ Input data in WebADS as needed throughout the year
✓ Maintain duty hour logs for easy completion
✓ Maintain research and presentation list
✓ Know the program, common, and institutional program requirements
✓ Proof read, proof read, proof read
✓ Print final mailed copy of inspection documentation for the program and place in notebook for future reference
ACGME - Site Visit
Agenda - January 9, 2007

7:15am-7:30am - Met Dr. Raines at the Lobby Entrance

7:30am-8:00am - Dr. Raines reviewed all documents requested

8:00am-9:30am - Dr. Raines met with Program Director, Associate Program Director, and Coordinator

9:30am-9:45am - Institutional Director

9:45am-10:00am - Director of Surgery

10:00am-10:30am - Core Faculty Members

10:30am-12:30pm - 12 peer selected residents (box lunch was provided)

12:30pm-1:00pm - Wrap up with Program Director & Coordinator
ACGME - Site Visit

Best Advice:

- Be prepared and organize at all times, so when that site visit letter comes, you are ready!
- Ask questions and advice from fellow coordinators, this is the best place to gain an insight and knowledge as to what will happen during an inspection!
- No matter how long you have been a coordinator, you will still suffer from heart palpitations and anxiety before, during, and after the site visit!
- When you receive your accreditation letter reporting your great results, celebrate!
ACGME – Site Visit

Results of Site Visit - Notified:

Status: Continued Accreditation

• 4 year accreditation with commendation for demonstrated substantial compliance with the ACGME Requirements for Graduate Medical Education.

• Plus continuation of the Duty Hour Exception

However........................
The Committee cited the following areas as not in compliance:

- The program’s goals and objectives are not organized according to the resident’s level of experience. The goals and objectives are not level-specific for the Intensive Care, CT Surgery, and Urology experiences. In addition, no objectives are included for the research experience.

- In at least one case, appropriate documentation of a transferring resident’s prior training and verification of operative experience had not been received by the program.
ACGME - Site Visit ACGME
Three keys to a successful site visit

#1
First & Foremost
Your Residents
ACGME – Site Visit ACGME
Three keys to a successful site visit

#2
An Organized PI F
ACGME – Site Visit ACGME
Three keys to a successful site visit

#3
Board Pass Rates
RRC Accreditation Decisions

The Committee meets three times a year. Below is a summary of the most frequent citations for both core and subspecialty programs from July 1, 2006 through June 30, 2007.

**Core Programs:**

<table>
<thead>
<tr>
<th>Core Programs Reviewed in July 1, 2006 through June 30, 2007 for a Status Decision</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total of 440 Citations — about 1.425 citations/program</strong></td>
<td></td>
</tr>
<tr>
<td>1. Institutional Support</td>
<td>46</td>
</tr>
<tr>
<td>2. Resident Appointment</td>
<td>17</td>
</tr>
<tr>
<td>3. Program Personnel &amp; Resources</td>
<td>57</td>
</tr>
<tr>
<td>4. The Education Program—Goals and Objectives</td>
<td>16</td>
</tr>
<tr>
<td>5. The Education Program Curricular Development</td>
<td>22</td>
</tr>
<tr>
<td>6. The Education Program—Progressive Resident Responsibility</td>
<td>2</td>
</tr>
<tr>
<td>7. The Education Program—Didactic Experience</td>
<td>9</td>
</tr>
<tr>
<td>8. The Education Program—Patient Care Experience</td>
<td>11</td>
</tr>
<tr>
<td>9. The Education Program—Procedural Experience</td>
<td>53</td>
</tr>
<tr>
<td>10. The Educational Program—Service to Education Imbalance</td>
<td>4</td>
</tr>
<tr>
<td>11. The Educational Program—Scholarly Activities</td>
<td>32</td>
</tr>
<tr>
<td>12. The Education Program—Supervision</td>
<td>3</td>
</tr>
<tr>
<td>13. The Education Program—Duty Hours</td>
<td>31</td>
</tr>
<tr>
<td>14. Evaluation</td>
<td>37</td>
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</table>

**Subspecialty Programs:**

<table>
<thead>
<tr>
<th>Subspecialty Programs Reviewed in July 1, 2006 through June 30, 2007 for a Status Decision</th>
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</thead>
<tbody>
<tr>
<td><strong>Total of 161 Citations — about 1.46 citations/program</strong></td>
<td></td>
</tr>
<tr>
<td>1. Institutional Support</td>
<td>13</td>
</tr>
<tr>
<td>2. Resident Appointment</td>
<td>2</td>
</tr>
<tr>
<td>3. Program Personnel &amp; Resources</td>
<td>11</td>
</tr>
<tr>
<td>4. The Education Program—Goals and Objectives</td>
<td>6</td>
</tr>
<tr>
<td>5. The Education Program Curricular Development</td>
<td>10</td>
</tr>
<tr>
<td>6. The Education Program—Progressive Resident Responsibility</td>
<td>0</td>
</tr>
<tr>
<td>7. The Education Program—Didactic Experience</td>
<td>1</td>
</tr>
<tr>
<td>8. The Education Program Patient Care Experience</td>
<td>6</td>
</tr>
<tr>
<td>9. The Education Program—Procedural Experience</td>
<td>13</td>
</tr>
<tr>
<td>10. The Educational Program—Service to Education Imbalance</td>
<td>0</td>
</tr>
<tr>
<td>11. The Educational Program—Scholarly Activities</td>
<td>4</td>
</tr>
<tr>
<td>12. The Education Program—Supervision</td>
<td>2</td>
</tr>
<tr>
<td>13. The Education Program—Duty Hours</td>
<td>8</td>
</tr>
<tr>
<td>14. Evaluation</td>
<td>25</td>
</tr>
</tbody>
</table>
QUESTIONS?
INTERNAL REVIEW

- A self-evaluation process for ACGME accredited programs.
- Internal reviews must be in process and documented in the GMEC minutes by approximately the midpoint of the accreditation cycle.
- Must be in substantial compliance with specific

http://www.acgme.org
Development, implementation and oversight for the Internal Review process is the responsibility of your institution's GMEC.

An internal review committee must include at least one faculty member and at least one resident from within the Sponsoring Institution but not from within the program. Additional reviewers may be included as determined by your GMEC & within the ACGME guidelines.

A written protocol approved by the GMEC that incorporates, at a minimum, the requirements in Section IV of the ACGME Institutional Requirements.
Assess and Effectiveness

- Compliance with the Common, specialty / subspecialty-specific Program & Institutional Requirements. Educational objectives & effectiveness in meeting those objectives.

- The educational and financial resources.

- How areas of noncompliance and concerns noted in previous ACGME accreditation letters and previous internal reviews were addressed.

- Effectiveness of educational outcomes in the ACGME general competencies.

- Effectiveness in using evaluation tools and outcomes measures to assess a resident’s level of competencies in each of the ACGME general competencies.
Materials For Review Process

- The ACGME Common, specialty / subspecialty-specific Program, & Institutional Requirements in effect at the time of the review.
- Accreditation letters of notification from previous ACGME reviews and progress reports sent to the respective RC.
- Reports from previous internal reviews of the program.
- Previous annual program evaluations.
- Results from internal or external resident surveys, if available.
Program Improvement Efforts

- Resident performance using aggregated resident data.
- Faculty development.
- Graduate performance including performance of program graduates on certification exams.
- Program quality (refer to ACGME Common Program Requirements.)
The PD and Coordinator supply the information the IRC request. Some institutions require that you submit an abbreviated version of the ACGME Program Information Form (PIF).

The Sponsoring Institution must submit the most recent internal review as part of the Institutional Review Document.

When a program has areas of non-compliance, the GMEC recommends appropriate action. The DIO & the GMEC monitor the response by the program.
Written Report Must Contain

- Name of the program.
- Date of the assigned midpoint & status of the GMEC’s oversight of the IR at the midpoint.
- Names and titles of the internal review committee members.
- A brief description of how the internal review process was conducted, including the list of the groups/individuals interviewed and the documents reviewed.
- Sufficient documentation to show that a comprehensive review followed the GMEC’s internal review protocol.
- List of citations & areas of non-compliance or any concerns or comments from the previous ACGME accreditation letter of notification with a summary of how the program subsequently addressed each item.
Suggested List for Preparation

- Schedule a date, time, and location to meet with the GMEC, the residents, program director, faculty, and chairman.

- Prepare the data required well in advance for the committee to review.

- Keep copies of ALL internal reviews, reports from GMEC, and implemented actions on file.
Site Visit Requirements

- Your program must present documentation that an internal review took place.

- The site visitor, however, does not have access to the Internal Review Report.

- Note: the Annual Reports or Review DO NOT meet the requirements for a periodic internal review.

http://www.acgme.org
Programs must document formal, systematic evaluation of the curriculum at least annually.

The program must monitor and track resident performance, faculty development, graduate performance, including graduates on the certification examination.

Specifically program quality: Resident & faculty must have the opportunity to evaluate the program confidentially in writing at least annually; Programs must use the result of the residents’ assessments of the program together with other program evaluation results to make improvements.
The program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1 of the ACGME Program Requirements.

The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

At minimum, for the most recent five-year period, 65% of the graduates must pass each of the qualifying and certifying examinations on the first attempt.
Suggestion List for Preparation

- Prepare an agenda to include review of the evaluation process, evaluations, goals & objectives, conferences, teaching rounds, ABSITE results, ABS passing data, research, operative experience, etc.

- Work with PD to design and implement a plan of action for suggested changes.

- Maintain minutes of the meeting with any proposed
GREAT JOB, CHOOSE YOUR NEXT TASK?

A) ASK FOR A RAISE
B) DONE FOR THE DAY
C) OFF TO HAPPY HOUR
D) ALL OF THE ABOVE