Plastic Surgery Residency Review Committee

4th Annual American Council of Academic Plastic Surgeons
Program Coordinator’s Symposium
Denver, Colorado
September 23, 2011

Rod J. Rohrich, MD
Chair, RRC for Plastic Surgery

Peggy Simpson, EdD
Executive Director, RRC for Plastic Surgery
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- Robert A. Weber, Jr., MD
  Texas A&M University Health Science Center
- Resident Member
  Donald Buck, MD
- Ex-Officio Members (non-voting)
  R. Barrett Noone, MD
  ABPS Executive Director
  Patrice Blair, MPH
  American College of Surgeons
Agenda

- RRC Update
- Process for Converting Independent programs to Integrate programs (optional)
- New CPRs (eff. 7/1/2011)
- Integrated Program Transfer Criteria
RRC Update
Plastic Surgery Residency Training Programs

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>NUMBER OF PROGRAMS</th>
<th>RESIDENTS ON DUTY</th>
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<tbody>
<tr>
<td>Plastic Surgery-Independent</td>
<td>71</td>
<td>48</td>
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<tr>
<td>Plastic Surgery-Integrated</td>
<td>32</td>
<td>366</td>
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<tr>
<td>Craniofacial Surgery</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Plastic Surgery-Hand</td>
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<td>21</td>
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<td><strong>Total</strong></td>
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<td><strong>741</strong></td>
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<tr>
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<th>Initial</th>
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<th>Avg. Cycle</th>
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<tr>
<td>Integrated</td>
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<td>4.53</td>
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<tr>
<td>Craniofacial Surgery</td>
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<td>4</td>
<td>0</td>
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<tr>
<td>Hand</td>
<td>2</td>
<td>13</td>
<td>0</td>
<td>3.73</td>
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Site Visit Results: 7/1/2010—6/30/2011

- 27 programs were surveyed
- 19 administrative requests at meetings
- 43 interim decisions requests (PD changes, participating site change, temporary increases)
- 28 citations issued by RRC
  - (1.03 citations per program)
- Common Citations
  - Procedural Experience
  - Scholarly Activity
Resident Complement

- RRC approves by level and type
- Any changes **must** be approved in advance
- All requests must be submitted through ADS and include DIO approval
New Common Program Requirements

- Effective 7/1/2011
- Specialty Specific language for Plastic Surgery approved
- FAQs will be posted on ACGME Surgery RRC webpage
Process for Converting Independent programs to Integrate programs (optional)
Eliminating the “Combined” Format

• To support of the American Board of Plastic Surgery’s (ABPS) decision to eliminate the “combined” program format

• PR Int.B.1.a) “At least three years of clinical education with progressive responsibility in a single ACGME- or RCPSC-accredited surgery residency program. A transitional year or rotating internships may not be used to fulfill this requirement.”
Options for “Combined” Programs

“Combined” programs may:

• request that their programs be converted to an integrated format;

OR

• remain an independent program (no action required).
• Conversions may begin as early as July 1, 2012.
• The last conversion request will have a start date of July 1, 2015.
• The last start date for residents permitted to finish a “combined” format will have a start date of July 1, 2018.
Requests for Conversion

Submit the following to ACGME Offices:

1. Information regarding proposed new complement (positions by PGY-level), educational rationale, new block diagram, response to most recent citations, and summary of major changes since the last site visit.
2. List of new participating sites, not part of the current independent program.
3. Goals and objectives for any new rotation (e.g., PGY-1-3 rotations).
4. CV for any new faculty members.
5. Cover letter, co-signed by DIO and PD, describing implementation timeline, and commitment to current residents.
6. Signed letters noting support for and cooperation with the integrated program from involved program directors/division heads/department chairs of new departments.
Conditions

- If not all Positions will be converted: an application (PIF) for the integrated format must be submitted and a site visit will be required.
- If programs in the “combined” format wish to convert to the integrated format, the independent format would be discontinued.
- Residents currently in the “pipeline” will finish their educations under the format promised when they entered the institution.
Integrated Program Transfer Criteria
Transfer Criteria for Integrated Programs

- Transfer into PGY-1, PGY-2, or PGY-3 levels
- The last 4 years must be completed within the same program.
- Prior PD must certify completed years of education.
- Transfers into PGY-1 & 2 must transfer from an ACGME-accredited surgery, neurological surgery, orthopaedic surgery, otolaryngology, or urology residency program.
- Transfers into PGY-3 year must have competed an ACGME-accredited general surgery, thoracic surgery, urology, orthopedic surgery, neurological surgery, or oral/maxillofacial residency. or will require individual consideration by the Review Committee.
Transfer Criteria for Integrated Programs (cont.)

- The receiving program director must verify the completed curriculum of the transferring resident.
- A letter of support from the “transferring out” program director must be provided.
- Block diagrams of all completed rotations must be provided.
- The transfer must receive ABPS approval.
- If a temporary increase in complement is needed, the request must be entered into ADS.
- Approval from RRC must be received before the resident enters the program.
New CPRs (eff. 7/1/2011)
VI.D.1. - In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.
• 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.
New Common Program Requirements

• VI.E. - Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
VI.F. - Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.
New Common Program Requirements

• 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.

• For independent programs, Y-1-3 residents are considered to be in the final years of education.

• For integrated programs, Y-2 and -3 residents are considered to be at the intermediate level.
New Common Program Requirements

- 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

- For independent programs, Y-1-3 residents are considered to be in the final years of education.
- For integrated programs, Y-4, -5 and -6 residents are considered to be in the final years of education.
VI.G.5.c). (1) - 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.

• FAQ-1
New Common Program Requirements

- **continuity of care** for patients, such as for:
  - a patient on whom a resident operated/intervened that day who needs to return to the operating room (OR);
  - a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;
  - a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;
  - a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by the resident; or,
  - a patient or patient’s family with whom a resident needs to discuss the limitation of treatment/DNR/DNI orders for a critically-ill patient on whom the resident operated.

- a **declared emergency or disaster**, for which the residents are included in the disaster plan; or,

- to perform **high profile, low frequency procedures** necessary for competence in the field.
New Common Program Requirements

• VI.G.6. - Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

• Residents must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year.
Agenda Closing Dates

• Meeting: May 20-21, 2011
  • Agenda Closing: March 11, 2011
• Meeting: October 13-14, 2011
  • Agenda Closing: August 18, 2011
• Meeting: May 10-11, 2012
  • Agenda Closing: March 1, 2012
• Meeting: October 11-12, 2012
  • Agenda Closing: August 2, 2012
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THANK YOU