

RRC NEWS

OPHTHALMOLOGY



ACGME

Accreditation Council for Graduate Medical Education

FEBRUARY 2011

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RRC NEWS PROVIDES REVIEW COMMITTEE AND ACGME UPDATES. PLEASE CONTACT THE EDITOR WITH QUESTIONS OR COMMENTS ABOUT THIS NEWSLETTER: MSCHWAB@ACGME.ORG.

Accreditation Data System (ADS): Change in Faculty Roster

To make the Common PIF consistent for all specialties, the ACGME continues to improve the faculty roster. A standard faculty definition now appears in ADS and on each PIF. The subspecialty definitions are unchanged.

As announced in the ACGME's weekly *e-Communication*, all physician faculty members who devote **15 or more hours per week for the year** to the residency program have automatically been designated as 'core faculty' on the faculty roster in ADS. Programs will need to review and edit this information in the "Core Faculty" column. Additionally, every program director should be designated as core faculty.

A "Core Faculty" column has been added to the PIF and all faculty members on the "Physician" and "Non-Physician" tabs are considered active. If faculty members are not active, a new feature is now available that prompts the user for the date when a given faculty member became inactive or left the program, but no other faculty details need to be entered.

If you have any questions or concerns, please e-mail WebADS@acgme.org.

Update on Impact of Approved Revisions to the Common Program Requirements on Specialty-Specific Program Requirements

Revisions to the ACGME Common Program Requirements related to duty hours in the learning and working environment were approved by the ACGME Board of Directors on Monday, September 27, 2010 with an effective date of July 1, 2011. The revised Common Program Requirements include several sections that necessitate further specialty-specific definitions. Several of these areas, as denoted by an asterisk below, required immediate action by the Review Committees; others may be developed over the next year for implementation in July 2012. No other additions will be made to the duty hour section or other sections of these requirements.

MEETING AND AGENDA CLOSING DATES

MEETING: MAY 12, 2011

AGENDA CLOSING: MARCH 3, 2011

MEETING: NOVEMBER 17, 2011

AGENDA CLOSING: SEPTEMBER 8, 2011

NOTIFICATION DEADLINES

5 DAYS AFTER MEETING:

E-MAIL NOTIFICATION OF REVIEW STATUS/
CYCLE LENGTH AUTOMATICALLY SENT TO
PROGRAM DIRECTOR AND DIO.

60 DAYS AFTER MEETING:

E-MAIL ALERT SENT STATING THAT LETTER
OF NOTIFICATION IS POSTED IN ADS.

UNTIL THE OFFICIAL LETTER IS POSTED IN ADS, REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/NOT PERMITTED TO DISCUSS THE COMMITTEE'S ACTION OR SPECIFIC DETAILS OF THE AREAS OF NON-COMPLIANCE.

(cont. p.2)

Areas that Require Specialty-Specific Definitions to be Developed by Each Review Committee:

1. Define licensed independent practitioners who may have primary responsibility for patient care (VI.D.1).
2. Describe achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available (VI.D.5.a.1).
3. Specify optimal clinical workload (VI.E).
4. Define elements of teamwork that must be present in each specialty (VI.F).
5. Define Intermediate level residents and residents in the final years of education (senior level residents) (VI.G.5.b and c).*
6. Define circumstances when "senior residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty (VI.G.5.c.1).*
7. Review Committees may specify the maximum number of consecutive weeks of night float and the maximum number of months of night float per year (VI.G.6).*

** must be defined or specified by the Review Committees for review at the February 2011 ACGME Board meeting.*

Review Committees have developed these definitions, and submitted them to the ACGME for review and approval at the February 2011 ACGME meeting. The approved definitions will be posted shortly after the ACGME meeting and, as already mentioned, will become effective July 1, 2011.

Case Log Review

On occasion, the Committee requests a review of a program's case logs at the end of the academic year. A request to review the program's case logs might be made if the Committee notes that the volume and variety of procedures available for resident education may be marginal or insufficient at the time of a program's review. An accreditation cycle may be shortened if the Committee determines that a program is not in compliance for the required number of procedures and associated educational experiences.

Should such a request be made, it will be noted in the Letter of Notification sent to the program following a review, under "Other". The responsibility for obtaining the case logs for the Committee's review rests with the ACGME Committee staff. However, the program's accurate and up-to-date operative logs from the academic year in question, (i.e., 2010-2011), must be in ADS and available to the staff by September 1 of every academic year. After case logs are reviewed by the Committee at a meeting, the program director is

notified of the Committee's assessment and whether or not a change to the program's accreditation cycle was determined to be necessary.

Stats from the last Review Committee Meeting

The most common (*top 1-5 categories*) citations identified during the Review Committee's November 2010 meeting are listed below. These citations resulted from the Committee's review of program information forms (PIFs), site visitor reports, Resident Survey results, case logs, and programs' past histories. The most common citation categories were:

1. the competency of professionalism
2. program resources
3. responsibilities of the program director
4. scholarly activity
5. procedural experience

There were 17 full program reviews and four progress reports considered at the meeting.

Resident Members on Review Committees Add an Important Perspective

For a number of years all ACGME Review Committees have included at least one resident among their membership. These residents are full members of the Review Committees, participating in accreditation reviews, offering important perspectives during the reviews, and during deliberations on standards revisions, and other Committee business.

Resident members are also members of the ACGME's Council of Review Committee Residents (CRCR), which meets twice each year and advises the ACGME Board, providing valuable input and feedback about resident matters, education, and accreditation.

To be eligible for resident membership on a Review Committee, the Transitional Year Committee, or the Institutional Review Committee, individuals must be enrolled in a residency or fellowship program at the time of appointment, and may not serve more than one year beyond completion of the residency or fellowship.

The resident member's Committee term is a minimum of one year; reappointment is permitted. The current resident member of the Review Committee for Ophthalmology is Jordan Lubahn, MD, from the ophthalmology program at University of Texas Southwestern. His term ends June 30, 2012.

The appointment process for new resident members begins more than one year before the expiration of the current resident's term. The deadline for the nomination of the next resident member of the Review Committee for Ophthalmology is September 1, 2011.

Nominees cannot be from any programs with which the other current Review Committee members are affiliated. The full Review Committee considers all nominations and makes a decision on one individual. Residents or individuals interested in nominating a resident should consult the guidance on Review Committee member nominations, appointments, and responsibilities on the ACGME website, at: www.acgme.org/acWebsite/resInfo/ri_residentSelection106.pdf.

A Pilot to Increase Resident Input during Site Visits

To explore whether textual comments from residents could be introduced into the site visit interview process, eight members of the ACGME field staff are participating in a small pilot to ask residents (through a note to the program director) to compile a single, program-level list of up to five topics (strengths and areas for improvements) they would like to discuss during the interview. Residents are asked to bring this list to the site visit interview for further discussion.

To date, the lists received have included strengths, problems, and a surprising mix of general questions, ranging from questions regarding upcoming changes in American Board of Medical Specialties (ABMS) Member Board requirements, to questions about the ACGME and how it functions, to questions about the upcoming revisions to the duty hour standards.

The ACGME's Department of Field Activities is evaluating the pilots and will continue to explore this mechanism for increasing resident input.

Resident Survey

A new version of the Resident Survey was made available on January 12, 2011 for participation by all programs with four or more residents. There are now 34 questions, and the duty hour questions appear first. All forced *yes/no* questions were eliminated, and every question has been re-worded by the survey research team at the University of Wisconsin. There are two new questions related to teamwork. Duty hour-related questions are placed first in the survey. Any areas highlighted by residents as non-compliant with program requirements are specifically addressed by the site visitor. If the site visitor confirms a pre-identified area of concern, the Review Committee will cite that as an area of non-compliance with the ACGME standards in a program's Letter of Notification following the formal review. If the site visitor cannot verify a potential area of non-compliance per the survey results, the Review Committee considers all of the program's

accreditation materials, and while a formal citation may not be given, the Committee may still provide a comment to the program that this is an area to be monitored.

Programs should be aware that survey results contribute to national annual compliance data. Among other important benefits of collecting such data, thresholds for non-compliance are established based on this information. Programs across specialties that are identified as having a series of non-compliant responses (either annually or in consecutive program reviews) may be required to submit a duty hour or progress report to their Review Committees.

National Level Data on the Website

The Review Committee for Ophthalmology has agreed to place the national level aggregate data related to the minimum number of procedures from the case log data on its web page on the ACGME website. There are three reports available in ADS: the national, program, and individual resident operative reports.

It is important to remember that the data from the Resident Level Operative Report in ADS are used by program directors to monitor individual residents' educational experience, and to document specific surgical experience at graduation. In addition, the Committee reviews this information along with the program report.

Program Level Summary Report data are used by programs for self-evaluation and are also used by the Review Committee in the accreditation process. The ACGME Case Log System serves both of these purposes very well for most residents and programs.

The link to the data will be on the [Review Committee's web page](#) on the ACGME website. Look for this link around February 2011.

Update on Resident Operative Minimum Requirements

Maria Aaron, MD, FACS, Review Committee Vice Chair

The Review Committee for Ophthalmology believes that the surgical minima should reflect the minimum clinical volume of these procedures which is acceptable per resident for program accreditation. It should be recognized that the surgical minima are not meant to convey acquisition of resident competence, but are viewed as a marker of a program's overall surgical volume, and the depth and breadth of clinical experience available to the residents. While it is not currently explicitly required that each resident meet the stated minima, the Committee will evaluate

individual programs' and residents' numbers with regard to the equality of the educational opportunity afforded to each resident in each program. Citations may be considered for very large variations in resident surgical experience, or if individual residents do not meet the minima of procedures even if the program average is above the minimum.

The minima were originally set at the 20th percentile based on annualized national data, and are reviewed annually by the Committee with attention to changes in surgical technique and standards of care. The current surgical minima have remained unchanged for the past two years, and in general, now reside at approximately the 10th percentile nationally. Recognizing that surgical retina and refractive surgery are often performed by fellows only, the Committee modified the surgical minima for these areas to reflect a total of cases as surgeon and observer. The recent changes (effective July 1, 2010) in the categories of Refractive (minimum six combined surgeon and assistant cases) and Retina/Vitreous (minimum 10 combined surgeon and assistant cases) were made to promote resident familiarity with these procedures as opposed to the ability of the resident to perform such procedures.

With the changes in minimum numbers for these categories, minor changes will therefore be made with regard to the code category listings in the Case Log System. Refractive cases will be coded under a separate category, called Keratorefractive Surgery, and will not count toward the requirement of three surgeon cases for Cornea. This category includes all procedures that involve laser and/or incisional refractive surgery on the cornea (i.e., LASIK, LRI, etc.) but will not include toric or multifocal intraocular lenses. The cornea subcategories will be: (1) Keratoplasty (i.e., PK, DSAEK, DALK, etc.), (2) Conjunctival procedures/Pterygium excision, and (3) Other Cornea. There will now be three retina categories: (1) Retina/Vitreous (subcategories will be RRD repair and Posterior Vitrectomy), (2) Retinal Lasers (subcategories will be Photocoagulation and cryotherapy), and (3) Other Retina (subcategories will be Vitreous tap/inject and other retina). In addition, a number of CPT codes have been identified and will be added to the list of codes so that numbers can accurately reflect programs' experience within each of the categories, and so that residents are able to select the codes that best reflect the procedures that have been performed. The list of CPT codes and corresponding categories is accessible by running the report in the System called "Available CPT Codes by Area and Type". The Review Committee strongly encourages everyone involved in resident education

to review the CPT code listings and to provide the Committee with feedback.

In summary, it is the goal of the Review Committee to provide residency programs with reasonable, rational, surgical minima. In the future, the Committee will collaborate with the Department of Applications and Data Analysis at the ACGME on a special project to assess and potentially revise the operative minima currently in place for our specialty. The goals of this ongoing project are to establish a standard methodology which will provide rational minimum numbers for ophthalmology residency programs, and to provide a model for other Residency Review Committees.

Ophthalmology Milestone Project

Anthony Arnold, MD, Review Committee member

The ACGME Milestone Project was outlined by Dr. Thomas Nasca, CEO of the ACGME, in two articles in the *ACGME Bulletin* (May and September 2008), with the stated goal of producing outcomes-based accreditation requirements. Developmental milestones define the level of performance required for each specialty-specific, competency-based educational objective at designated intermediate and final points during residency education. Several of the core medical specialties, including internal medicine, pediatrics, and surgery, have been working over the past several years to produce documents which outline the process for integrating milestones into residency education. The Ophthalmology Milestone Project, a joint venture of the American Board of Ophthalmology and the ACGME, has been in development over the past year. The Ophthalmology Milestone Working Group convened its initial meeting December 11-12, 2010 at the ACGME Headquarters in Chicago. The group reviewed the various existing milestone documents and developed an approach to be tailored to education in ophthalmology. This will involve identification of the essential domains of practice, the key sub-competencies within them, and the levels of performance (with specific descriptive language linked to a scale of proficiency) expected at specified points in residency. The milestones will be linked to assessment tools and integrated into an overall blueprint for outcomes assessment. The Working Group began the task of developing topic-specific milestones documents in core areas such as glaucoma, macular degeneration, optic neuritis, and cataract, as examples of the processes which might be adopted locally. The short-term goal for the group is to develop an initial draft of a milestones document for ophthalmology within the next six months, which may be reviewed by the Association of University

Professors of Ophthalmology (AUPO) leadership and then further refined. The Working Group plans to meet again in May 2011. Updates throughout the process will be communicated via this newsletter, and the ACGME's weekly *e-Communication*, when appropriate.

Faculty Roster in Program Information Forms Includes Four Educational Activity Categories

In order to be consistent among all specialties, the ACGME has revised the Faculty Roster in the Common PIF, by expanding the 'Average hours/week devoted to Resident Education' to include four categories - clinical supervision, administration, didactic/teaching, and research. The PIF for Ophthalmology already includes these areas so no modification is necessary, but it is important that all programs be aware of the change in the current version of the PIF. For each faculty physician listed in the PIF roster, the program must insert the hours for each category of resident education according to the following legend (in the future this information will appear in the PIF as a 'mouse over').

Category of Resident Education	Examples of Resident Educational Activities
Clinical supervision	Bedside rounds; outpatient precepting; operative supervision
Administration	Program oversight; curriculum development; faculty, resident and program evaluation; career counseling
Non-clinical didactics/teaching	Lectures; simulation; case discussions; preparation time for and participation in: journal clubs, conferences, lectures, simulation, case discussions, manuscript editing with resident
Resident research	Mentoring and/or working with residents/fellows; peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; participation in national committees or educational organizations

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