

Entering Refractive Surgery Cases into the Case Log System

In order to better capture resident refractive surgery data in the Resident Case Log System, there are two additional choices when the 66999 (unlisted anterior segment procedure) code is entered. Residents will be prompted to select between LASIK/PRK, Peripheral Corneal Relaxing Incision, and Other when they enter 66999.

As a reminder, if a resident completes an operation which involves multiple procedures, the resident may record all the procedures as separate cases, provided that the resident performs the majority of the critical portions of the procedures, and the procedures fall within different subspecialty categories (e.g., Cataract, Cornea, Strabismus, Glaucoma, Retina/Vitreous, Oculoplastics/Orbit, Globe Trauma).

For example, if a resident performs a peripheral corneal relaxing incision to correct pre-existing astigmatism in conjunction with cataract extraction, the resident may record both procedures as surgeon cases.

For more details visit the Ophthalmology Review Committee webpage at www.acgme.com and click on the Definition of a Surgeon link under Program

Resources.

ACGME Resident Survey

Every two years, all programs with four or more residents complete the ACGME Resident Survey. Results of this survey are made available to the program and the DIO for programs with a 70% or greater response rate. Programs with less than 70% response rates are resurveyed the following year.

The Resident Survey is used by the site visitor to spotlight key areas of concern as well as program strengths that the residents identified. The site visitor also uses the Resident Survey to help determine serious non-compliance with duty hour standards. Increasingly, compliance with duty hours, adequate supervision, and limiting excessive service are noted as key factors that contribute to a high-quality learning environment for residents.

The RRC has requested that site visitors provide more detailed information regarding the verification of negative comments made in the numerical or comment sections of the Resident Survey, specifically, when the site visitor records that a concern is “not an issue” or “could not be verified.”

Results of resident surveys can be used as heuristic tools by program directors to improve the quality of training for residents. National averages of resident surveys can be viewed on the ACGME website, www.acgme.org within the

ADS section, and should be reviewed by individual programs during annual and mid-cycle internal reviews so that resident issues are identified and addressed in a timely manner.

Best Practices in Ophthalmology Residencies

Programs across the country have developed innovative methods of complying with program requirements. The following list highlights some of these programs, and includes links to articles, samples, and further descriptions about how these programs enhance their residents' learning experiences.

- [Program Evaluation Form](#)
Emory University - Maria Aaron, MD
- [The Iowa Ophthalmology Wet Laboratory Curriculum for Teaching and Assessing Cataract Surgical Competency](#)
University of Iowa - Andrew G. Lee, MD
- [Model Curriculum for Health Management Courtesy of Mayo Ophthalmology Program](#)
Mayo Clinic - J. Douglas Cameron, MD
- [Mayo Ethics Curriculum](#)
Mayo Clinic - John M. Pach, MD

Internal Reviews

The sponsoring institution is required to conduct an internal review of each residency program under its purview at approximately the midpoint of the accreditation cycle (the time between the date of the most recent accreditation action and the next scheduled site visit). The institution assembles an internal review committee, which must include at least one faculty member and at least one resident, who cannot be from the program that is being reviewed. The process involves interviews with the program director, key faculty members, peer-selected residents from each level of training, and other

individuals as appropriate. Frequently it includes review of data, such as how the program has addressed the citations from the last accreditation survey.

The goal of the internal review is a thorough and candid review that identifies the program's strengths and opportunities for improvement, and allows resolution of any concerns or problems before the program's next accreditation site visit. The responsibility for timing and conduct of the internal review lies with the sponsoring institution. At the same time, program directors and residents should be familiar with the process as they may be asked to participate in internal reviews.

Neither the site visitor nor the RRC reviewer sees the data from the internal review, which is not included with the program information form (PIF). Verification of the internal review during the site visit covers the date, the participants, and then the review presented to the institution's graduate medical education committee (GMEC). This information is obtained verbally or in writing. The site visitor does not look at the results of the internal review, to ensure a review that honestly assesses the program's strengths and opportunities for improvement.

The Next Step in the Outcomes-Based Accreditation Project

by Thomas Nasca, MD, CEO

The following contains excerpts from Dr. Nasca's article in the May 2008 ACGME Bulletin. The full article is available at: http://www.acgme.org/acWebsite/bulletin/bulletin5_08.pdf

Seven years ago the GME community embraced the Competencies and began the challenging task of elaborating them in each accredited specialty and its subspecialties. The ACGME convened groupings of leaders from the educational community in each specialty, called the Quadrads, and charged them with

developing a description of the specialty specific competencies within the six broad domains of clinical competency of all physicians. The Quadrads comprised four individuals representing the ABMS member Board, the Program Directors' Association, the Residency Review Committee and a resident representative. With the Competencies described in each specialty, it was hoped that the community, through decentralized research efforts, would define the tools required to systematically evaluate the Competencies in each discipline, and the ACGME, through its RRCs, would then "harvest" this research to create standards and core methods for evaluating the Competencies in each specialty. In that fashion, each specialty would create the "outcomes" in the competencies desired, and the metrics by which the Review Committee in each specialty would evaluate the effectiveness of each program in assisting their residents in achieving desired educational outcomes.

If we are to move forward, two events must take place to fulfill our promise to each other and the profession. First, we must agree on the "Milestones" of Competency development in each discipline. Second, we must agree on and implement common evaluation tools in each discipline to document our residents' achievement of these milestones. At the completion of the educational program, the Milestones are the articulation of the level of performance expected at entry into the unsupervised practice in each specialty, and are the levels of clinical competence required to gain eligibility for ABMS certification.

The establishment of a formal project to develop and seek endorsement of the Milestones will bring about an opportunity to discuss topics with our colleagues in undergraduate medical education that have, to date, been difficult to frame. The logical extension of the Outcome project will be to

ask the fundamental formative questions (as related to an individual resident). Where do they start (as medical students) in each of the domains of the competencies? If one makes the assumption that medical students graduate with "Advanced Beginner" status in some domains, and "Competent" in others (and perhaps "Novice" in Systems-Based Practice or Operative Skills), more specific descriptions of the requirements for entry into residency may be possible. Furthermore, rational discussions with our Undergraduate Medical Education colleagues could then be undertaken regarding reasonable expectations in each of these domains. Perhaps most importantly, development of these Milestones will lead, in my opinion, to systematic evaluation of each entry level resident in order to establish a customized, Individual Educational Plan (IEP) which will permit assessment of the trajectory of growth of each resident. This is not possible, especially during the first year of residency, without an entry level assessment. The opportunities for early identification of learning needs, and prompt preventive remediation, will enhance the quality and effectiveness of our educational programs, and produce higher quality outcomes.

Clarification of the Accreditation Review Process

Procedure logs should be maintained for or by each resident in the program and should document direct participation by each resident in any and all surgical procedures. Direct participation may include the resident actually performing the procedure or assisting in a significant way in performing the procedure. These logs can be maintained in the ACGME case log system. Site visitors are asked to verify the presence, the process for entering data, and completeness of these procedure logs.

The closure date for the case logs 2007-2008 academic year is August 1, 2008.

Preparing for a Site Visit

To help ensure a successful site visit, program directors are advised to prepare thoroughly. The ACGME Field Staff recommend that program directors should be aware of changes in requirements and the site visit process; the ACGME web site, DIO News, E-Update, ACGME Bulletin, and the RRC/IRC Executive Director are good resources for the most current information. Program directors should also ensure that an internal review occurs at the mid-point between the last review and the next visit date. This candid feedback can help improve and strengthen the program.

Further pre-planning for a site visit should ensure that the program director, Chair, Chief, DIO, key faculty and peer-selected residents (as a group) are available for interview. Program directors should plan appropriately for the site visitor to review documents, tour the facility, and allow time for clarification and concluding the session. Site visitors expect that the education in the competencies is aligned, and that goals and objectives for the program and for each rotation are sequenced in competency format.

Ultimately, program directors are encouraged to invest time and effort to produce a consistent, fully completed, and accurate PIF.

Description of a DIO

DIO refers to the Designated Institutional Official. This individual has the authority and responsibility for all ACGME-accredited GME programs in an institution. The DIO signs PIFs and also receives copies of accreditation results. The DIO is required to co-sign most correspondence between the institution and the ACGME.

Program Accreditation Statistics 2007

118	Accredited programs
1417	Total Approved Resident Positions
1362	Total on Duty Filled Positions
112	Programs with Continued Accreditation
2	Programs with Initial Accreditation
4	Programs on Probation

Updating the Ophthalmology Program Information Form

by Kathleen Holt, PhD

Beginning in December, 2007, RRC members and ACGME staff began work on the Program Information Form (PIF). They eliminated open-ended or free text items, checked that PIF questions parallel the program requirements, and reframed questions to be more outcomes-based. ACGME programmers are now converting the PIF questions into a web-based environment so that it may be completed by program directors just as annual updates and common PIFs are done now. The newly edited PIF (in Word format) will be available in July, 2008. Work has begun on the electronic version of the PIF, and it should be available for program directors by late Fall 2008.

Having a fully electronic PIF (e-PIF) is a crucial step towards the ACGME's goal of a fully Electronic Accreditation System (EASy). EASy will allow all parts of the program review (PIF completion, SV interviews and report, review by the committee, and program notification) to be completed and available within the ACGME's web-based system.

Minimum Procedures

The RRC will review minimum numbers at the November 2008 meeting. After reviewing the 2007-2008 data, the RRC will decide whether to continue using the 20th percentile nationwide for each category as its minimum. Any changes will have a proactive effective date of July 1, 2009.

Evaluation of Competencies during the Preliminary Year

The RRC requests that all program directors of ophthalmology receive a Summative Evaluation of Competencies from all preliminary year program directors for those residents entering the ophthalmology residency.

Ophthalmic Pathology Fellowship

The Committee determined that it would not pursue developing subspecialty education in ophthalmic pathology under the aegis of the RRC for Ophthalmology.

360 Evaluations

The RRC notes that in many cases patients have been excluded from the evaluation of residents. Patients should be included when evaluating resident competency.

Accreditation Data System: Reminders and Updates

The ACGME's online Accreditation Data System (ADS) alerts the RRC to changes in programs. Program directors should update the ADS to:

- Notify the RRC of any changes in their program (i.e., new program director or adding or deleting a site)
- Request a change which needs RRC approval (i.e., an increase in resident complement)
- Submit the academic year "Annual Update" (ADS staff will e-mail the deadline for updating faculty and resident rosters)
- Prepare for an upcoming site visit (the ADS will populate many sections of the PIF with the data entered)

The ADS is a historical resource for programs, and includes recent notification letters and previous citations.

ADS allows accreditation statuses to be emailed within 2-3 days after the RRC meeting; propose and confirmed adverse actions cannot be emailed to the program director/DIO following the RRC meeting but are posted in ADS as a pdf letter within one month of meetings. Notification letters are no longer printed or mailed; program directors/DIOs are notified via email that the pdf letter is available within ADS.

Address questions or concerns about ADS to the ADS representative for Ophthalmology, Emilio Villatoro, 312/755-7117, evillatoro@acgme.org.

ACGME Educational Conference 2008 Recap

Each year, the ACGME Annual Educational Conference provides a venue for graduate medical educators to learn more about the accreditation process and ways to enhance residency program quality related to ACGME initiatives, such as general competencies, educational outcome assessment, and duty hours. This year's conference theme "Building Community, Improving Quality" emphasized how better education and better patient care can occur when individuals in diverse roles work together toward shared goals.

Post-conference information is available at: http://www.acgme.org/acWebsite/meetings/meEducConf_08.asp

Save the date for the 2009 ACGME Annual Educational Conference, March 5-8, in Grapevine, TX.

RRC Welcomes New Resident Member

The RRC welcomed its new resident member, Todd Mondzelewski, MD to the Committee. Dr. Mondzelewski is a resident at the Navy Medical Center in San Diego, CA. At the same time, the Committee appreciated the contributions and commitment of Taliva Martin, MD who graduated and will start a pediatric fellowship at

the University of Michigan. Dr. Martin served on the Committee for two years.

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RRC Meeting and Agenda Closing Date

Meeting: November 21-22, 2008

Agenda Closing: October 1, 2008

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We invite your comments:

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