



Program Coordinators in Colon and Rectal Surgery

**2008 Administrative Manual
Policies, Guidelines &
Reference Listings**

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Revised April 2008

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ACRONYMS

PURPOSE:

To define commonly abbreviated/series of letters to describe a function or organization.

SCOPE:

Applies to residents, program coordinators, program directors, nurses, etc.

DEFINITIONS:

AAMC

Association of American Medical Colleges

The AAMC is an association of medical schools and hospitals that, among other things, is responsible for administering the Medical College Admission Test (MCAT).

Association of American Medical Colleges

2450 N Street, NW

Washington, DC 20037-1126

Telephone: (202) 828-0400

Fax: (202) 828-1125

www.aamc.org

ABCRS

American Board of Colon and Rectal Surgery

Like the ABS, the ABCRS was developed to ensure a certain standard of excellence not only in general surgery, but also colon and rectal surgery for the American people.

The ABCRS determines which candidates qualify for certification, conducts examinations to determine the ability and fitness to practice the specialty of colon and rectal surgery and awards certificates to those candidates who fulfill its requirements.

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American Board of Colon and Rectal Surgery

20600 Eureka Road, Suite 600

Taylor, MI 48180

Phone: (734) 282-9400

Fax: (734) 282-9402

General E-Mail Address:

admin@abcrs.org

www.abcrs.org

ACRONYMS—Continued

ABMS

American Board of Medical Specialties

The ABMS, a not-for-profit organization, assists of 24 approximately specialty boards. The ABMS serves to coordinate the activities of its Member Boards and to provide information to be public, the government, and profession and its members concerning issues involving specialization and certification of medical specialists.

American Board of Medical Specialties
1007 Church Street, Suite 404 | Evanston, IL 60201-5913
Phone Verification (866) ASK-ABMS
Phone: (847) 491-9091 | Fax: (847) 328-3596

www.abms.org

ABS

American Board of Surgery

The American Board of Surgery was founded in 1937 for the purpose of certifying those found to be qualified after meeting specific requirements and completing an examination process. A major reason for establishing the specialty board was to identify the surgeon who has met a certain standard of excellence.

The American Board of Surgery
Suite 860
1617 John F. Kennedy Boulevard
Philadelphia, PA 19103 USA
Phone: (215)568-4000
Fax Number: (215) 563-5718

www.absurgery.org

ACGME

Accreditation Council for Graduate Medical Education

Responsible for the accreditation of graduate medical education programs in the United States.

www.acgme.org

ACS

American College of Surgeons

The ACS is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

The members of the ACS are referred to as “Fellows”. The letters FACS after a surgeon’s name mean that the surgeon’s education and training, professional qualifications, surgical competence, and ethical conduct have passed a rigorous evaluation and have been found to be consistent with the high standards established and demanded by the College.

ACRONYMS—Continued

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American College of Surgeons
633 North Saint Clair Street
Chicago, IL 60611-3211
Telephone: (312) 202-5000
Toll Free: (800) 621-4111
Fax: (312) 202-5001
Email: postmaster@facs.org
Website: www.facs.org

ACRONYMS—Continued

ADS

Accreditation Data System

AHA

American Hospital Association

The AHA was founded in 1898 and formed to aid in the communication between hospital administrators across the U.S.

AHA-Chicago Headquarters (CH)
One North Franklin
Chicago, Illinois 60606
Phone: 312-422-3000
Fax: 312-422-4796

AHA-Washington Office (WO)
325 Seventh Street, N.W.
Washington, District Of Columbia 20004
Phone: 202-638-1100
Fax: 202-626-2345
Toll Free: 800-424-4301
www.aha.org

AMA

American Medical Association

Founded more than 150 years ago, it is the AMA's commitment to standards, ethics, excellence in medical education and practice, and advocacy on behalf of the medical profession and the patients it serves.

American Medical Association
515 N. State Street
Chicago, IL 60610
800-621-8335
www.ama-assn.org

APDS

Association of Program Directors in Surgery

The APDS members are Program Directors from residencies in general surgery as well as other interested individuals.

APDS/ARCS Headquarters Office
640 Goldsboro Road – Suite 450
Bethesda, MD 20817-5846

or

P.O. Box 342260
Bethesda, MD 20827-2260
Telephone: 301-320-1200
or 301-263-9025
www.apds.org

ACRONYMS—Continued

ASCRS

American Society of Colon and Rectal Surgeons

The ASCRS is a professional society representing more than 1,000 board certified colon and rectal surgeons and other surgeons dedicated to advancing and promoting the science and practice of the treatment of patients with diseases and disorders affecting the colon, rectum, and anus.

American Society of Colon and Rectal Surgeons

85 W. Algonquin Rd., Suite 550

Arlington Heights, IL 60005

Phone: 847-290-9184

Fax: 847-290-9203

Email: ascrs@fascrs.org

www.fascrs.org

CME

Continuing Medical Education

CME is the third phase in medical education. This phase continues the specialty education begun in graduate training; it reflects the commitment to lifelong learning inherent in the medical profession.

CMSS

Council of Medical Specialty Societies

CMSS is a non-profit association whose members are 30 national medical specialty organizations representing more than 500,000 doctors nationwide.

In short, CMSS was established to provide an independent forum for the discussion by medical specialists of issues of national interest and mutual concern.

Council of Medical Specialty Societies

51 Sherwood Terrace, Suite M

Lake Bluff, Illinois 60044-2232

Phone: 847.295.3456

Fax: 847.295.3759

Email: mailbox@cmss.org

www.cmss.org

DHS

Department of Homeland Security

Comprised of divisions responsible for immigration policies, procedures and enforcement including US Citizenship and Immigration Services, US Immigration and Customs Enforcement and US Customs and Border Protection.

ACRONYMS—Continued

DIO

Designated Institutional Official.

DoS

United States Department of State

US government agency responsible for the administration of all Exchange Visitor Programs.

DS-2019

Certificate of Eligibility for Exchange Visitor (J-1) Status. The legal document necessary to obtain/maintain J-1 status (Formerly Form IAP-66).

D/S

Duration of Status, contingent upon valid Form DS-2019.

ECFMG

Educational Commission for Foreign Medical Graduates

Through a program of certification, assesses the readiness of International Medical Graduates (IMG's) to enter US residency or fellowship programs that area accredited by the ACGME.

ECFMG
3624 Market Street
Philadelphia, PA 19104-2685
Telephone: (215) 386-5900
Fax: (215) 386-9196
Email: Scheduling permits – permits@ecfmg.org
Credentials – credentials@ecfmg.org
General inquiries – info@ecfmg.org

www.ecfmg.org

ERAS

Electronic Residency Application Service

ERAS®—the Electronic Residency Application Service—is a service that transmits residency applications, letters of recommendation, Dean's Letters/MSPE, transcripts, and other supporting credentials from applicants and medical schools to residency programs using the Internet.

Association of American Colleges
2450 N Street NW
Washington, DC 20037
Help Desk: (202) 828-0413
Email: erashelp@aamc.org
<http://www.aamc.org/audienceeras.htm>

ACRONYMS—Continued

EVSP

Exchange Visitor Sponsorship Program

ECFMG Department responsible for J-1 sponsorship.

FRIEDA

Fellowship and Residency Electronic Interactive Database Access

An electronic information resource maintained by the AMA that assists medical students and residents in selecting GME programs.

You can update or look up your program by going online to www.ama-assn.org/frieda.

Telephone: (800) 266-3966

Email: frieda@ama-assn.org

GME

Graduate Medical Education

GME is the second phase of training for a physician. GME focuses on the development of clinical skills and professional competencies in a medical specialty. This learning process prepares the physician for the independent practice of medicine in that specialty.

GMEC

This is a committee formed by your institution or freestanding sponsor in order to vote on and implement policies, rules and general decisions about your program.

IMG

International Medical Graduate

A physician whose basic medical degree or qualification was conferred by a medical school located outside the United States, Canada and Puerto Rico.

US citizens who have completed their medical education in schools outside the United States, Canada and Puerto Rico are considered IMGs, while foreign national who have graduated from medical schools in the United States, Canada and Puerto Rico are not.

ACRONYMS—Continued

JCAHO

Joint Commission on Accreditation of Healthcare Organizations

An independent, non-for-profit organization who evaluates and accredits nearly 15,000 healthcare organizations and programs in the United States. JCAHO is the nation's predominant standards-setting and accrediting body in health care.

Headquarters and Conference Center - Oakbrook Terrace, IL
Written correspondence should be sent to:
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Telephone: (630) 792-5000
Fax: (630) 792-5599

Federal and External Relations - Washington DC Office
Joint Commission on Accreditation of Healthcare Organizations
601 13th Street, NW
Suite 1150N
Washington, DC 20005
Telephone: (202) 783-6655
Fax: (202) 783-6888

www.jointcommission.org

LCME

Accreditation of educational programs leading to the MD degree is the responsibility of the LCME.

NRMP

National Resident Match Program

This process matches GME programs and applicants to those programs and then the results are announced at a specific time. This is managed by the Association of American Medical Colleges (AAMC).

National Resident Matching Program
2450 N Street NW
Washington, DC 20037-1127

Telephone: (202) 828-0566
Fax: (202) 828-4797
Email: nrmp@aamc.org

www.nrmp.org

ACRONYMS—Continued

PDA

Program Directors Association

The PDA's Purpose and Objectives

- To provide a forum for the exchange of information and for discussion on a wide range of subjects related to post-graduate colon and rectal surgical education.
- To promote high standards for residency training and education in colon and rectal surgery by improving graduate education.
- To provide advice, assistance, and support to program directors on matters pertaining to surgical education or to accreditation.
- To encourage research in the education and training of colon and rectal surgeons.
- To represent the interests of program directors to other organizations, individuals, and governmental or regulatory bodies concerned with surgical education.
- To promote and develop an academic interest in teaching colon and rectal surgery.
- To provide a forum for the exchange of information and for discussion on a wide range of subjects related to post-graduate colon and rectal surgical education.
- To transmit to the American Board of Colon and Rectal Surgery (ABCRS) such suggestions, comments, or ideas as may be of value in furthering our mutual interests and purposes.
- To advance, promote, and develop training programs in colon and rectal surgery in concert with the RRC for Colon and Rectal Surgery.

PIF

Program Information Form

The PIF is the document completed by the Program Director in preparation for a site-visit. The document is a compilation of requested information that reflects the current status of the educational program. The PIF is organized in two parts: the Common PIF, which addresses the program's compliance with the Common Program Requirements, and the Specialty or Subspecialty specific PIF, which addresses compliance with the specialty or subspecialty specific program requirements. The Common PIF is electronically generated through the Accreditation Data System.

PLA

Program Letter of Agreement

A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education.

RRC

This is a Residency Review Committee (RRC) for each of the specialties in which certification is offered by a specialty board that is a member of the American Board of Medical Specialties (ABMS).

Each RRC is sponsored by the AMA's Council on medical education, by the board that certifies physicians within that specialty, and in most cases, by the professional college or other professional association within the specialty.

ACRONYMS—Continued

RRC (Continued)

Name	Phone (312)
Paul O'Conner	755-5039
Sheila Hart	755-5030
Pam Derstine	755-7444
Marsha Miller	755-5041
Ingrid Philibert	755-5003
Jim Cichon	755-5015
Tami Walters	755-5002

Program Requirements

Interpret Program Requirements – [Paul O'Connor](#), [Sheila Hart](#)
Revision of Program Requirements – [Paul O'Connor](#)
New Program Requirements – [Paul O'Connor](#)
Program Director Guide to the Common Program Requirements – [Pam Derstine](#) **Program Requirements**
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New Program Requirements – [Paul O'Connor](#)
Program Director Guide to the Common Program Requirements – [Pam Derstine](#)

ADS/PIFs

Subspecialty PIF – [Paul O'Connor](#)
Content for Part I of the PIF – [Sheila Hart](#)
Technical questions related to Part I of the PIF OB/GYN, CRS – webADS@acgme.org
Part II of the PIF – [Paul O'Connor](#), [Sheila Hart](#)
Revision of PIFs – [Paul O'Connor](#)
Program Director changes – [Sheila Hart](#)
Participating Sites – [Sheila Hart](#)
Increases in resident complement – [Sheila Hart](#) **ADS/PIFs**
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Revision of PIFs – [Paul O'Connor](#)
Program Director changes – [Sheila Hart](#)
Participating Sites – [Sheila Hart](#)
Increases in resident complement – [Sheila Hart](#)

Letters of Notification (LON)

Core and subspecialty letters of notification – [Paul O'Connor](#)
Administrative action letters – Progress reports, duty hours, etc – [Paul O'Connor](#), [Sheila Hart](#)
Administrative action letters – Progress reports, duty hours, etc – [Paul O'Connor](#), [Sheila Hart](#)
Administrative action letters – Progress reports, duty hours, etc – [Paul O'Connor](#), [Sheila Hart](#)

ACRONYMS—Continued

RRC (Continued)

Accreditation Process

Application Deadlines – [Sheila Hart](#)
Voluntary withdrawal of accreditation – [Sheila Hart](#)
Late progress reports and rebuttals – [Sheila Hart](#)
Increases in resident complement – [Sheila Hart](#)
Resident complaints – [Marsha Miller](#)
Rescheduling Site Visits – [Ingrid Philibert](#), [Jim Cichon](#)
Appeal Hearing – [Tami Walters](#)
Application Deadlines – [Sheila Hart](#)
Voluntary withdrawal of accreditation – [Sheila Hart](#)
Late progress reports and rebuttals – [Sheila Hart](#)
Increases in resident complement – [Sheila Hart](#)
Resident complaints – [Marsha Miller](#)
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Resident complaints – [Marsha Miller](#)
Rescheduling Site Visits – [Ingrid Philibert](#), [Jim Cichon](#)
Appeal Hearing – [Tami Walters](#)

RRC Meetings

Field staff attendance at RRC meetings – [Sheila Hart](#)
Post-meeting notification e-mails – [Sheila Hart](#)
Meeting dates – [Sheila Hart](#)
Staff schedules – [Sheila Hart](#) **RRC Meetings**
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Staff schedules – [Sheila Hart](#)

Communications

Program Mergers – [Paul O'Connor](#)
ACGME Learning Portfolio - [Pam Derstine](#)
Program Mergers – [Paul O'Connor](#)
ACGME Learning Portfolio - [Pam Derstine](#)
Program Mergers – [Paul O'Connor](#)
ACGME Learning Portfolio - [Pam Derstine](#)

Other Organizations

Board Eligibility and Certification contact the American Board of Medical Specialties (ABMS)
Medicare funding for your program contact the Center for Medicare & Medicaid Services (CMS)
Physician Licensure contact the National Board of Medical Examiners (NBME) **Other Organizations**
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ACRONYMS—Continued

SEVIS

Student and Exchange Visitor Information System

Government database that tracks immigration activities of all non-immigrant students and exchange visitors.

TPL

Training Program Liaison

Person at the host institution who coordinates the administrative details of the Exchange Visitor's training program.

USCIS

United States Citizenship and Immigration Services

Division of DHS responsible for the administration of immigration and naturalization adjudication functions and establishing immigration services policies and priorities.

USMLE

United States Medical Licensing Examination

This is an examination with set rules for what constitutes passing scores, that allows your resident or fellow to get his/her medical license. This test is also administered by many medical schools for promotion and graduation.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

PURPOSE:

The ACGME is a private, non-profit organization that accredits over 8,000 residency programs in 120 specialties and subspecialties affecting over 100,000 residents. Its mission is to improve the quality of patient care through improving and maintaining the quality of graduate medical education for physicians in training in the United States.

The ACGME established an Institutional Review Committee which is responsible for reviewing institutions sponsoring training programs in GME for compliance with institutional requirements.

SCOPE:

The ACGME has five (5) member organizations:

- American Board of Medical Specialties (ABMS)
- American Hospital Association (AMA)
- American Medical Association (AHA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)

The ACGME governance structure also includes an RRC Council, consisting of the chairs of the 28 residency review committees, and an RRC Resident Council, comprising resident members of the RRCs.

A Residency Review Committee (RRC) consists of representatives appointed by the AMA, appropriate specialty board to review the program in detail, evaluate the program, and determine the degree to which it meets educational standards.

The work of reviewing specific programs and making accreditation decisions is carried out by 28 residency review committees one for each major specialty, as well as one for transitional year programs. RRC members are volunteer physicians appointed by the appropriate medical specialty organization, medical specialty board and the AMA Council on Medical Education.

ACGME field staff representatives conduct one-day site visits to programs once every two to five years, depending on the strength of the program. About one-third of the programs are visited each year. The field staff representatives write objective narrative reports about the programs they visit, based on lengthy interviews with the program directors, faculty and residents, as well as a review of supporting documents.

The RRCs, which meet three times a year, review the site visitors' reports, along with data provided by the programs. The RRC members then vote on the appropriate accreditation action for each program on the agenda for that meeting.

New programs are given provisional accreditation, while continuing programs are given full accreditation if they substantially comply with the ACGME common and specialty-specific requirements. Programs that have deficiencies may be given accreditation with warning or probationary accreditation. Programs that fail to demonstrate that they have corrected their deficiencies and are in substantial compliance with ACGME requirements may have their accreditation withdrawn.

Programs can appeal adverse accreditation actions to an appeals panel composed of volunteer physicians in the appropriate specialty. Although withdrawal of accreditation is usually preceded by probationary accreditation, programs which have egregious violations of program standards, have experienced a catastrophic loss of resources or become inactive may have their accreditation administratively or summarily withdrawn.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (Cont.)

RESPONSIBILITY

Residents

The ACGME requires all residents to complete an online survey concerning their clinical and educational experience, duty hours worked, and the competencies.

The ACGME will notify programs directly when their participation is required. This notification will include detailed information on accessing the survey and a deadline for completion. The ACGME will not contact residents directly. It is the program's responsibility to ensure their residents complete the survey.

Web Accreditation Data System (ADS)

It is an internet based data collection system that contains the current data on file with ACGME for all sponsoring institutions and programs. Sponsors and accredited programs are required to verify and update general information annually in a secured environment. In addition, programs will be required to verify the accredited training of all residents and to communicate organizational changes as they occur (<https://www.acgme.org/ADS>).

Overtime, the PIFs for all specialties will be rewritten to exclude these common elements collected annually and prior to a site visit the program will print the web information and attach it to the specialty specific portion of the PIF. At this time, the PIFs for several specialties have been re-organized and now follow the Part 1 and Part 2 format. They are available in the Program Information Form Section of the ACGME website (www.acgme.org). The specialties with the converted PIF can use the ADS system to generate part 1 of the PIF. Contact WebADS@acgme.org to obtain the updated list of specialties with the new PIFS. Over the next several years, more specialty specific information from the PIF will be made available over the web. Other site visit related items are moved to the web for collection. Specifically, any program site visited after July 2002 must complete the Competencies and Assessment Form.

Data Collaboration with Other Professional GME Organizations

There are an increasing number of entrepreneurial GME data collection systems available. Some of these are tailored for a single discipline and others are quite broad. Because licensing data from an existing system would require post-collection primary source verification and due to the fact that many existing systems exceed the data needed for accreditation and may offer the data commercially, the ACGME will continue to collect and own the data needed for accreditation decisions.

You may be asked by several other organizations to provide program and resident data similar to the information provided in ADS, therefore, the ACGME has created a new feature in ADS that allows programs to require their completed information in file format for internal use or for submission to other organizations of your choice (download My Data).

Access to the Application

The Accreditation Council for Graduate Medical Education (ACGME) has provided each program and sponsoring institution with a User Identifier and Password to access the data system. The Designated Institutional Officials (DIOs) will be contacted each year and will be asked to log on and verify their institutional data, as well as monitor the progress of their programs making annual updates. All specialties and subspecialties are required to update their data annually.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (Cont.)

Resident Survey

Only your currently active full- and part-time residents are required to participate, and at least 70% participation is required. You may use e-mail to communicate with your residents and may wish to forward to them the notification you receive from the ACGME. To help your program manage this administration, you can view (on-line through the Accreditation Data System (ADS) a list of your residents who have not yet completed the survey.

Residents will complete the survey through the ACGME's website: <https://www.acgme.org/Surveys>. Residents will login using their program's 10 digit code and a password. This password is based on the resident's birthdate and the last two letters of their last name. Every resident is required to change his or her user id and password to ensure confidentiality.

Resident Case Log

The resident experience log is an Internet based case log system utilizing CPT codes or ICD-9-CM codes (ICD-9) to track resident experience. The Residency Review Committees have indexed these codes into categories for evaluation. Any valid CPT or ICD-9 code can be entered in the application but only those codes the RRC has selected will be evaluated for experience.

While some programs desire to have administrative help enter procedures this application was designed to allow residents to enter procedures on a regular basis at their convenience. Entry can be done from any PC connected to the World Wide Web.

The site is secured by encryption certificate obtained through the Verisign Corporation.

The process for adding new residents to the Case Log System has been updated. All new residents must be entered into Web Ads first. After adding them, there are two options for registering them into the Case Log System. Each night, newly added residents into Web Ads will be automatically transferred to the Case Log system. Or, if you prefer, you can assign them an ID and Password for the Case Log system.

ACGME Colon and Rectal Staff

Title/Name	Phone (312)	Email
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Senior Accreditation Administrator, Sheila Hart	755-5030	sah@acgme.org
Senior Secretary, Allean Morrow-Young	755-5038	amh@acgme.org

ACGME Program Requirements for Graduate Medical Education in Colon and Rectal Surgery

Common Program Requirements

Effective: July 1, 2007

Introduction

A. Duration and Scope of Training

Institutions offering residencies in colon and rectal surgery must provide the necessary education to qualify the resident as a colon and rectal specialist in the care of patients, in teaching, and in research. Surgeons admitted to each residency are required to have completed a minimum of five years of an accredited, graded program in general surgery. Thus, the residents should already have developed a satisfactory level of clinical maturity, technical skills, and surgical judgment which will enable them to begin a residency in colon and rectal surgery for the purpose of specializing in this field of surgery. The period of training must be one year and the program must comply with the institutional requirements for residency training.

I. Institutions

A. Sponsoring Institution

1. One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

2. The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

B. Participating Sites

1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

- b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- c) specify the duration and content of the educational experience; and,
- d) state the policies and procedures that will govern resident education during the assignment.

2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

3. Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and approved in advance by the Review Committee.

II. Program Personnel and Resources

A. Program Director

1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

- a) The program director should be a member of the staff of the sponsoring or participating site.
- b) There should be a minimum of two staff members, including the program director.

2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

3. Qualifications of the program director must include:

- a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

- b) current certification in the specialty by the American Board of Colon and Rectal Surgery, or specialty qualifications that are acceptable to the Review Committee; and,
 - c) current medical licensure and appropriate medical staff appointment.
4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:
- a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
 - b) approve a local director at each participating site who is accountable for resident education;
 - c) approve the selection of program faculty as appropriate;
 - d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
 - e) monitor resident supervision at all participating sites;
 - f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
 - g) provide each resident with documented semiannual evaluation of performance with feedback;

- h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- i) provide verification of residency education for all residents, including those who leave the program prior to completion;
- j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
 - (1) distribute these policies and procedures to the residents and faculty;
 - (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
 - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

- (1) all applications for ACGME accreditation of new programs;
- (2) changes in resident complement;
- (3) major changes in program structure or length of training;
- (4) progress reports requested by the Review Committee;
- (5) responses to all proposed adverse actions;
- (6) requests for increases or any change to resident duty hours;
- (7) voluntary withdrawals of ACGME-accredited programs;
- (8) requests for appeal of an adverse action;
- (9) appeal presentations to a Board of Appeal or the ACGME; and,
- (10) proposals to ACGME for approval of innovative educational approaches.

- o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

- (1) program citations, and/or
- (2) request for changes in the program that would have significant impact, including financial, on the program or institution.

B. Faculty

1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:
 - a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and
 - b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.
2. The physician faculty must have current certification in the specialty by the American Board of Colon and Rectal Surgery, or possess qualifications acceptable to the Review Committee.
3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.
4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.
5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

- a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
- b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

- (1) peer-reviewed funding;
- (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
- (3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
- (4) participation in national committees or educational organizations.
- (5) Faculty should encourage and support residents in scholarly activities.

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

- 1. The program should supply the necessary volume and variety of colon and rectal surgery to assure adequate training of residents. If there is insufficient volume or variety in the primary sites, arrangements should be made for an affiliation with a participating site to correct the inadequacy.
- 2. Adequate numbers of both diagnostic and therapeutic colonoscopies must be available either at the colon and rectal training program or through an appropriate institutional affiliation to satisfy this particular need.

E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

C. Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.
2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMCC in accordance with sponsoring institution guidelines.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;
2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;
3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

- (1) will have training in both diagnostic and therapeutic colonoscopy. The objective is to develop the necessary competence in the use of this procedure to qualify as an expert in the field;
- (2) will develop skills in patient evaluation, examination, office treatment, and surgical aftercare. Where feasible, such training should include work in the faculty member's office, as well as in the out-patient clinic of the hospital; and,
- (3) must have ample opportunity and responsibility for the care of patients with anorectal and colonic diseases.

b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

- (1) will obtain sufficient knowledge of those aspects of anesthesiology, radiology, and pathology that relate to colon and rectal surgery to develop overall competence as a specialist. Such training is best accomplished in cooperation with the departments of anesthesiology, radiology, and pathology.

c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

- (2) set learning and improvement goals;
- (3) identify and perform appropriate learning activities;
- (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- (5) incorporate formative evaluation feedback into daily practice;
- (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- (7) use information technology to optimize learning; and,
- (8) participate in the education of patients, families, students, residents and other health professionals.
- (9) teach to contribute to the educational process. Teaching should be a regular part of the training program. The resident should assist when possible in the instruction of general surgical residents, and medical students, as well as nurses, and other allied health professionals. It is important to include instruction in the care of intestinal stomas, especially in institutions that do not have enterostomal therapists.

d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- (2) communicate effectively with physicians, other health professionals, and health related agencies;
- (3) work effectively as a member or leader of a health care team or other professional group;
- (4) act in a consultative role to other physicians and health professionals; and,
- (5) maintain comprehensive, timely, and legible medical records, if applicable.

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- (1) compassion, integrity, and respect for others;
- (2) responsiveness to patient needs that supersedes self-interest;
- (3) respect for patient privacy and autonomy;
- (4) accountability to patients, society and the profession; and,
- (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- (2) coordinate patient care within the health care system relevant to their clinical specialty;
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- (4) advocate for quality patient care and optimal patient care systems;
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- (6) participate in identifying system errors and implementing potential systems solutions.

B. Residents' Scholarly Activities

1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
2. Residents should participate in scholarly activity.
3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

- a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

b) The program must:

- (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
- (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional

staff);

- (3) document progressive resident performance improvement appropriate to educational level; and,
- (4) provide each resident with documented semiannual evaluation of performance with feedback.
 - c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

- a) document the resident's performance during the final period of education, and
- b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

B. Faculty Evaluation

1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
 - a) resident performance;

- b) faculty development;
- c) graduate performance, including performance of program graduates on the certification examination; and,
- d) program quality. Specifically:

(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

- 2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
3. Didactic and clinical education must have priority in the allotment of residents' time and energy.
4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.
3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

E. On-call Activities

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
3. No new patients may be accepted after 24 hours of continuous duty.
 - a) A new patient is defined as any patient for whom the resident has not previously provided care.
4. At-home call (or pager call)
 - a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
 - b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
 - c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

F. Moonlighting

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

G. Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

*** ACGME Approved: June 1995 Effective: July 1996 Competencies: July 2001
Editorial Revision: July 2004 Revised Common Program Requirements Effective: July 1, 2007

**AMERICAN BOARD OF COLON AND RECTAL SURGERY
(ABCRS)
ASSOCIATION OF PROGRAM DIRECTORS IN COLON AND
RECTAL SURGERY (PDA)**

PURPOSE

The American Board of Colon and Rectal Surgery was established to promote health and welfare of the American people through the development and maintenance of high standards for certification in the specialty of colon and rectal surgery. To accomplish this, the Board:

- Determines that candidates possess proper qualifications before taking the examination for certification or recertification.
- Conducts examinations to determine the ability and fitness to practice the specialty of colon and rectal surgery.
- Awards certificates to those candidates who fulfill its requirements.

The American Board of Colon and Rectal Surgery appoints representatives to the Residency Review Committee. This is a Tripartite Committee which reviews and evaluates new and previously approved residency programs in colon and rectal surgery in order to maintain the high standards of graduate medical education. It is comprised of members representing the Board, the American College of Surgeons, and the American Medical Association.

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Program Responsibilities for Website Updates

The American Board of Colon and Rectal Surgery **(www.abcrs.org)**

As you are aware, a screen has been set-up on the American Board of Colon and Rectal Surgery website to retain program and resident information. **Maintaining this data is the responsibility of each individual program.**

➤ **Updating your Program/Resident Information**

Each residency program has been assigned an individual Username and Password for use by the director and/or coordinator. To update your program information, please go to www.abcrs.org, click on “Login Services” and use the Username and Password assigned to your program. This information should be kept in a safe place and used to make all future changes to your program and/or resident information. Should your program encounter a director and/or coordinator change, the originally assigned username will continue to be valid. Passwords should be changed by the new program director or coordinator

If for any reason your access is denied, please contact the Board office at (734) 282-9400, or admin@abcrs.org.

➤ **Resident Information**

In order to establish a file for incoming residents, programs must provide their names to the Board office via the ABCRS website. This will ensure that all residents are issued a username and password for our system and all information relating to the certification process is communicated to them in a timely manner. If this information is not provided, your residents may not receive important certification information. To add a new resident:

Log onto the ABCRS website using your username and password

Click on the “Resident Info” tab

Click “Add New Resident”

Fill in the information and hit submit

Add another resident or close that window

If the new resident’s name does not show in your program list, hit “refresh”

[Program Responsibilities for Website Update \(Continued\)](#)

Click on the "Welcome" button next to each new resident

A letter will automatically be generated for each resident, informing them of their username, password, and pertinent information regarding the application for certification process. Print the letter and give it to your resident. Please remind them to fill out their prerequisite form ASAP.

➤ [Automatic Program Updates](#)

Verify that all information on the "Program Information" tab is correct. Make any changes needed and hit the save button. Once changes are submitted, the program information automatically updates on both the ABCRS and APDCRS website. Keeping your information up-to-date will ensure that both websites are current and correct. The contact information will be used for all mailings, including US Mail and E-mail, sent from both organizations. Since the information is available to affiliated organizations as well as the public, it is essential that programs provide all necessary changes as soon as they occur.

Association of Program Directors for Colon & Rectal Surgery

20600 Eureka Road, Suite 600, Taylor, Michigan 48180 - (734) 282-9400 - (734) 282-9402 – Fax Pda@abcrs.org

September 15, 2005

Dear <PD>,

As you are probably aware, The American Board of Colon and Rectal Surgery has decided that all resident case log reporting will be completed using the ACGME software starting with the 2005-2006 residency year. The program is web-based and has been customized for colorectal surgery procedures. The web-based version is free; a PDA-based version is available for an additional cost of \$25 per resident. The basic architecture of the program should be familiar to all of the incoming residents, as the program is modified from the electronic case log system that has been used by the Surgery RRC for the past several years. The major difference in the colorectal surgery version is that the residents must input BOTH a procedure code AND a diagnosis code for each procedure performed. These codes are searchable both by category and by ICD-9 and CPT codes. Further information about the program is available via the user manual available on the ACGME's website (www.acgme.org). **The manual will be in place by Tuesday, July 5, 2005. It will be specific to colon and rectal surgery and will be found on The ACGME Homepage in the following place: Choose "Data Collection Systems" on the left hand side of the Homepage. Then click on "Resident Case Log System." Clicking on "Login" will take you to the login screen, clicking on "Manuals and CPT codes" will list each of the specialties using the Case Log System and have a link to the manual and list of codes being used by that specialty. The case log program can be accessed by following the above directions for the manual but select "Login" instead of "Information."**

Program directors have access to the resident case logs and can monitor operative and endoscopic experience throughout the year via their administrative access. Before the academic year begins, program directors should use this access to customize their local site by adding a list of affiliated institutions and staff surgeons. These features will enable you to track surgery volumes by hospital site and attending surgeon.

The program was beta tested with a subgroup of the 2004-2005 residency class, and no major glitches were encountered. We are hopeful that the transition to an electronic-based case log system will be a smooth one, and look forward to comments and suggestions about how to improve the system in the future. **I will be happy to answer any questions that I can. You can reach me at: (612) 625-7992; or you may contact the ACGME Support Center at (312) 755-7464.**

With best regards,

Robert D. Madoff, MD

AMERICAN BOARD OF COLON & RECTAL SURGERY OPERATIVE PROCEDURE STANDARDS POLICY

In September 2000, the Board instituted a Standards Policy with regard to acceptable operative performance by residents in colon and rectal training programs. It states:

A Minimum requirements within each of the 17 operative categories have been established. Accordingly, residents displaying insufficient numbers in five or more categories will not be allowed to enter the certification process until they are able to furnish sufficient case numbers to meet the requirements.

Residents should consult with their Program Directors for specific details about reaching the required numbers within his/her own institution. The Board recommends a periodic evaluation prior to the conclusion of training to ensure that the expected numbers are being met.

Operative Procedure Guidelines

#	Operative Procedures	Category Description	*Minimum Requirements
1	(1-2-3)	Procedures for Hemorrhoids	34
2	(4-5-11-15-16)	Abscess/Fistula	32
3	(6)	Procedures for Fissure	9
4	(8-9-10-60)	Pilonidal/etc.	12
5	(7-14)	Anoplasties	5
6	(13)	Transanal Excision/Tumor	7
7	(17-51)	Prolapse Procedures	4
8	(20-21-22-23)	Rigid Sigmoidoscopy	20
9	(24)	Flexible Sigmoidoscopy	25
10	(25-26-27-28-29-30-31)	Colonoscopy	138
11	(32-46-61)	Segmental Colectomy	37
12	(33-34)	Low Anterior Resection	11
13	(35)	Abdominoperineal Resection	4
14	(36-37-38-39)	Resections for Crohns	4
15	(40-41-42)	Resections of CUC/FAP	3
16	(43-44)	IPAA/Coloanal	7
17	(48-49)	Stoma Procedures	19

*When considering what the "Minimum Requirements" are, it should be stressed that these figures do not reflect what the Board Considers to be the ideal number of cases.

RESIDENT ASSESSMENT

At the end of the training year, the ABCRS will send to each program Resident Assessment forms for the teaching faculty to complete on each trainee (see attached). These forms serve as a performance tool rating the trainee in various areas of performance, knowledge, and personality in addition to stating the trainee has completed the one (1) year program and whether or not this individual is recommended for candidacy for examination in the American Board of Colon and Rectal Surgery. This form must be completed and signed by the Program Director and returned to the American Board of Colon and Rectal Surgery no later than July 15 of each year.

Name of Candidate:

Name of Residency Program:

Rating A = Outstanding/Superior B = Above Average C = Good/Average D = Below Average E = Poor *Please give details for any rating below a C in the space below					
PERFORMANCE	A	B	C	D	E
1. Initiative					
2. Cooperation					
3. Performance in emergencies					
4. Availability and punctuality					
5. Acceptance of responsibility					
6. Ability to work with others					
7. Leadership					
8. Utilization of full potential					
9. Effectiveness with patients					
10. Surgical judgment					
11. Evidence of progress					
12. Surgical skills: a. Anorectal surgical procedures					
b. Abdominal surgical procedures					
c. Endoscopic procedures					
KNOWLEDGE					
1. Fund of knowledge					
2. Application of knowledge					
3. Teaching ability					
4. Quality of verbal presentation					
5. Quality of written presentation					
6. Evidence of study					
7. English language ability					
PERSONALITY					
1. Adaptability					
2. Response to criticism					
3. Emotional maturity					
4. Integrity					
5. Respect					
6. Compassion					
* Comments (Attach additional sheet if necessary):					
I certify that the above named candidate has completed _____ months of an approved colon and rectal residency. I recommend this candidate for examination _____ I do not recommend this candidate for examination _____					

Name & Signature of Program Director _____ Date

Please mail or fax your completed form by **July 1st** to: The American Board of Colon & Rectal Surgery
20600 Eureka Rd, #600, Taylor, MI 48180; (734) 282-9402 Fax

ASSOCIATION OF PROGRAM DIRECTORS IN COLON AND RECTAL SURGERY—APDS

Purposes and Objectives

The purposes of the Association shall be as follows:

1. To provide a forum for the exchange of information and for discussion on a wide range of subjects related to post-graduate colon and rectal surgical education.
2. To maintain high standards of residency training and education in colon and rectal surgery by improving graduate education.
3. To provide advice, assistance, and support to program directors on matters pertaining to surgical education or to accreditation.
4. To encourage research in the education and training of colon and rectal surgeons.
5. To represent the interests of program directors to other organizations, individuals, and governmental or regulatory bodies concerned with surgical education.
6. To promote and develop an academic interest in teaching colon and rectal surgery.
7. To transmit to the American Board of Colon and Rectal Surgery (ABCRS) such suggestions, comments, or ideas as may be of value in furthering our mutual interests and purposes.
8. To advance, promote, and develop training programs in colon and rectal surgery in concert with the Residency Review Committee for Colon and Rectal Surgery.
9. To promote, foster, and further a cooperative fraternal spirit among training programs.
10. To obtain an adequate and fair distribution of the prospective residents in colon and rectal surgery among all the training programs.

AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS (ASCRS)

The American Society of Colon and Rectal Surgeons (ASCRS) is the premier society for colon and rectal surgeons and other surgeons dedicated to advancing and promoting the science and practice of the treatment of patients with diseases and disorders affecting the colon, rectum and anus. More than 1,000 of the Society's 2600+ members are certified by the American Board of Colon and Rectal Surgery.

Vision

The American Society of Colon and Rectal Surgeons is the recognized authority on conditions and diseases of the colon, rectum and anus.

Mission

The American Society of Colon and Rectal Surgeons is an association of surgeons and other professionals dedicated to assuring high quality patient care by advancing the science through research and education for prevention and management of disorders of the colon, rectum and anus.

Beliefs

The deeply held beliefs of the ASCRS are that diseases of the colon, rectum and anus are significant health problems; that people deserve the best quality care for these diseases; and improvement in recognition, treatment and ultimate eradication of these diseases as well as in the quality of patient care is enhanced by the professionalism, development of knowledge and dissemination of information fostered by the fellowship of Society members.

Membership

The American Society of Colon & Rectal Surgeons is large enough to represent your interests but small enough to hear your voice and meet your needs. All of the many benefits of membership are available to you for the low annual cost of only \$300. We invite you to complete a [membership application form](#) online or return it to the membership office of the American Society of Colon and Rectal Surgeons for approval. We look forward to receiving your application and hopefully welcoming you as an active participating member both at our annual scientific meeting and throughout the year. If you have any other questions or concerns, please feel free to call our office at 847-290-9184.

For additional information, contact:

American Society of Colon and Rectal Surgeons

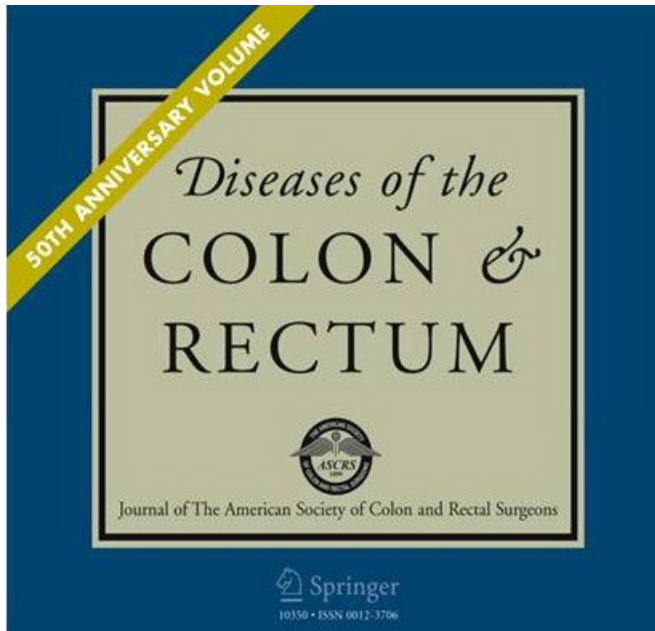
85 W. Algonquin Rd., Suite 550

Arlington Heights, IL 60005

Phone: 847-290-9184

Fax: 847-290-9203

Email: ascrs@fascrs.org



Diseases of the Colon & Rectum (DCR) is the official journal of the American Society of Colon and Rectal Surgeons and is mailed to members on a monthly basis as a member benefit. Non-member subscriptions also are available. In addition, members and non-member subscribers can access the online version of DCR:

ASCRS Members

ASCRS members have full text access to DCR Online and can find instructions on logging in [here](#).

DUTY HOURS

PURPOSE

Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent-in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

SCOPE

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

This verbiage was taken from the Program Requirements for Colon and Rectal Surgery.

All residents should accurately log their duty hours. There are many mechanisms/software programs available tracking. The ACGME is working with directors of residency programs and with designated institutional officials to ensure that resident duty hours comply with these standards. The ACGME monitors compliance through interviews with program directors, staff and residents during site visit. There are confidential internet resident surveys for programs with site visits and those with potential violations, and by receiving complaints from residents and others with knowledge about alleged violations.

ECFMG/VISA ISSUES

PURPOSE:

Through its program of certification, the Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of international medical graduates to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG certification is a requirement for international medical graduates who wish to enter such programs.

ECFMG certification assures directors of ACGME-accredited residency and fellowship programs, and the people of the United States, that international medical graduates have met minimum standards of eligibility to enter such programs. ECFMG certification does not, however, guarantee that these graduates will be accepted into programs, since the number of applicants frequently exceeds the number of available positions.

ECFMG is a private, nonprofit organization committed to promoting excellence in international medical education. ECFMG's aims and missions include providing information to international medical graduates (IMGs) regarding entry into graduate medical education and health care systems in the United States, evaluating the qualifications of IMGs, and providing international access to testing and evaluation programs.

ECFMG is sponsored by the following major medical organizations:

[American Board of Medical Specialties](#) (ABMS)

[American Medical Association](#) (AMA)

[Association of American Medical Colleges](#) (AAMC)

[Association for Hospital Medical Education](#) (AHME)

[Federation of State Medical Boards of the United States, Inc.](#) (FSMB)

[National Medical Association](#)

The Educational Commission for Foreign Medical Graduates (ECFMG®) is authorized by the U.S. Department of State (DOS) to sponsor foreign national physicians as Exchange Visitors in accredited programs of graduate medical education or training or advanced research programs (involving primarily observation, consultation, teaching or research). Exchange Visitors sponsored by ECFMG receive a Certificate of Eligibility for Exchange Visitor (J-1 Visa) Status (Form DS-2019). This document is used to apply for the J-1 Visa.

The objectives of the Exchange Visitor Sponsorship Program are to enhance international exchange in the field of medicine and to promote mutual understanding between the people of the United States and other countries through the interchange of persons, knowledge and skills.

The Program is administered by ECFMG in accordance with the provision set forth in a Memorandum of Understanding between ECFMG and the DOS and the Federal Regulations established to implement the Mutual Educational and Cultural Exchange Act. ECFMG is responsible to ensure that all Exchange Visitors and host institutions meet the federal requirements for participation.

SCOPE:

Applies to international medical graduates.

DEFINITIONS:

ECFMG/VISA ISSUES (Continued)

Types of visas most commonly seen by Graduate Medical Education personnel:

B-1 – Visitor for Business

Foreign visitors present in the U.S. on a B-1 visa may not be paid any salary, wage, honorarium, stipend, or other form of compensation for services rendered from a U.S. source. Only “reasonable” reimbursement for incidental expenses-including accommodations, meals, travel expenses – may be paid. May not engage in any employment in the U.S. including salaried work or services performed on an independent basis.

B-2 - Visitor for Tourism

Foreign visitors in the U.S. on a B-2 visa are prohibited from receiving payment of any kind from any U.S. source. Reimbursement of expenses is prohibited.

F-1 - Student

While maintaining valid F-1 status, may be employed on the campus of the school they are authorized to attend for a maximum of 20 hours per week while classes are in session. Part-time, on-campus employment is authorized by the school, and prior USCIS approval is not needed. During school vacations, students may work on campus for a maximum of 40 hours per week if otherwise eligible and intending to enroll for the next term. 2. While enrolled, visa holders in circumstances of “economic hardship” may work off campus if so recommended by DOS on form I-20. In such cases, EAD is required. 3. May participate in employment directly related to the field of study. This Employment may take the form of : Curricular Practical Training employment required for completion of the student’s degree program. Requires approval of DOS on form I-20. EAD not required. Employment authorization is job specific. Optional Practical Training. Employment during or after completion of studies. The total period of employment may not exceed 12 months. Requires recommendation of DSO and approval by USCIS. EAD is required.

J-1 Exchange Visitor (Short-term Scholar, Professor, Researcher, or Specialist)

Eligible to receive payment from the organization listed on Form DS-2019 (formerly IAP-66) as the source of funds and/or the Designated Program Sponsor for the period of validity as stated on the DS-2019. Under limited circumstances, may receive compensation from other institutions provided prior written authorization from the Responsible Officer of their Designated Program has been secured. DS-2019 Form authorizes employment. EAD is not required.

J-2 – Dependents of J-1 Visa Holder

Eligible to apply to USCIS for work permission. With EAD issued by USCIS, may work for any employer. Employer must verify employment authorization after expiration date on EAD.

H-1B Temporary Worker in Specialty Occupation

Employment permitted only with the sponsoring institution that obtained USCIS approval for the visa classification. Prohibited from receiving payments from other organizations. USCIS form I-797A authorizes employment. EAD is not required.

TN Trade NAFTA (for citizens of Canada & Mexico)

May be employed and compensated only by the sponsoring employer through whom the status was

ECFMG/VISA ISSUES (Continued)

obtained. Canadians require only an I-94 card as employment authorization. Mexicans require USCIS Form I-797A; EAD is not required.

Visa Waiver for Business (VWB) and Tourism (VWT)

Laws regarding study and employment for holders of VWB or VWT visa waivers for business and tourism are identical to their B-1/B-2 visa counterparts. Visa holders may not extend length of stay or change visa status.

O-1 Person of Extraordinary Ability, O-2 Accompanying Personnel

May be employed and compensated only by the petitioning employer or agency through whom the status was obtained. USCIS Form I-797A authorizes employment. EAD card is not required.

DS-2019

Formerly IAP-66. This is the Certificate for Eligibility for the "J" Exchange Visitor Visa.

Electronic Residency Application Service (ERAS)

PURPOSE

What is ERAS?

ERAS®—the Electronic Residency Application Service is a service of the Association of American Medical Colleges (AAMC) and was created to enhance medical students' transition to residency by reducing the amount of time spent on the residency application process. Using the Internet, ERAS transmits residency applications, letters of recommendation (LoRs), the Medical Student Performance Evaluation (MSPE), transcripts, and other supporting credentials from applicants and medical schools to residency program directors. ERAS also provides national statistics on applicant behavior by specialty.

Components of ERAS

ERAS is comprised of four main components:

- **MyERAS Web site.** This is where applicants complete their ERAS application, select programs to apply to, and assign documents to be received by those programs.
- **The Dean's Office Workstation (DWS).** This is ERAS software used by the designated dean's office. From this software, you create the ERAS electronic token that applicants use to access MyERAS. You also use this system to scan and attach supporting documents to the application, such as photograph, medical school transcript, dean's letter/MSPE, and LoRs. These documents are then transmitted to the ERAS Post Office.
- **Program Director's Workstation (PDWS).** This is ERAS software used by program staff to receive, sort, review, evaluate, and rank applications.
- **The ERAS Post Office.** This is a central bank of computers that transfer the application materials to programs. You can monitor the activity of your files on the ERAS PostOffice via the [Applicant Data Tracking System \(ADTS\)](#).

How does ERAS work?

- Applicants receive an electronic token from their designated dean's office, and use it to access the MyERAS Web site.
- Applicants complete their ERAS application, select programs, assign supporting documents, and transmit their application to programs.
- Schools receive notification of the completed application, and start transmitting supporting documents: transcripts, LoRs, photographs and MSPE/Dean's Letters.
- Examining boards receive and process requests for score reports.
Programs contact the ERAS Post Office on a daily basis to download application materials.

Supporting Documents for Applicants

This is a list of supporting documents that may be provided by the applicant when applying to programs.

- [MyERAS Application Worksheet \(CAF\)](#) (PDF, 15 pages)
- LoRs (applicants may assign up to four letters to a program)
- Personal Statement
- Medical School Transcript (provided by the medical school)
- Medical Student Performance Evaluation (provided by the medical school)
- Wallet-sized Color Photograph
- USMLE Transcript (transmitted by the NBME)
- COMLEX Transcript (transmitted by the NBOME)
- ABSITE Transcript (surgery applicants only)
- ECFMG Status Report (International Medical Graduates (IMGs) only)
- California Application Status Letter (International Medical Graduates (IMGs) only)

The most popular features of ERAS are:

- Filter/sort provides the ability to select and work with groups of applicants based on criteria selected.
- Bulk e-mail of selected groups of applicants.
- USMLE and COMPLEX transcripts delivered electronically.
- Electronic delivery of ECFMG certificate
- Automatic download of applicant files
- Access for multiple users to applicant data

Electronic Residency Application Service (ERAS) (Continued)

How to Get the Software?

To get the software from the Web site, you may visit <http://www.aamc.org/eras>. Select "For Residency and Fellowship Program Staff", and then choose the Software Downloads Link. You will be prompted for a user name and password.

INTERVIEW SELECTION PROCESS

STEPS

- Program Director and selection committee review candidates' credentials and invite them for interview
- The NRMP web site is currently quite sophisticated. All correspondence can be done through the NRMP workstation.
 - Interview Preparation
 - Send letter of invitation with interview dates, hotel information, map from airport to institution, and your contact information
 - Interview Schedule
 - Make a spread sheet with all your interview dates and applicants. This gives an overview of your interview schedule
 - Interview Day
 - Meet and greet residency applicants, answer any questions,
 - Due to NRMP requirements: provide sample contract and institutions selection process. Have applicant look over and sign and date confirmation that they have seen both of these items.
 - Schedule one-on-one interview meetings with the faculty members and each applicant
 - Appoint a current resident to mingle with the applicants as they are waiting for their interview to answer any questions the applicants may have. Applicants want to know what it is "really like" to be a resident in your program. It is important everyone receives the same message
 - Arrange for the applicants to spend time with current resident reviewing clinic procedures, Operating Room procedures, Hospital Rounds procedures etc. Applicants also like to see the operative log from past year. White out resident name and make copies for them to review.
 - Follow up after Interview Day
 - Program evaluation
 - Letter of thanks
 - Repeat visits?
- Completion of Interviews - Ranking Applicants
 - Ranking Committee meets to discuss applicants
 - Ranks applicants, sends rank list to National Residency Matching Program before date of Rank Order List closes. (See NRMP in manual)
 - Recommendation is to rank all your applicants (1 – 40 etc). You will only see the programs filled from your ranking applicant list.

INTERVIEW SELECTION PROCESS—(Continued)

- New Residents
 - Program Director telephones matched applicants to welcome them.
 - An official letter of welcome with a transitional timeline of requirements that is needed to enter the program is sent to matched applicants.

NATIONAL RESIDENT MATCHING PROGRAM (NRMP)

PURPOSE:

The NRMP provides a uniform date for decisions about fellowship selection for both applicants and programs, eliminating the pressure that may otherwise fall upon the applicants and programs to make decisions before all of their options are known.

SCOPE:

The National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME). It is governed by its board of directors. Five medical/medical education organizations and four medical student organizations nominate candidates for election to the board: the American Board of Medical Specialties (ABMS), the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), the Council of Medical Specialty Societies (CMSS), the AAMC Organization of Student Representatives, the American Medical Student Association (AMSA), the AMA Medical Student Section, and the Consortium of Medical Student Organizations. Each year, the NRMP conducts a residency match that is designed to optimize the rank ordered choices of students and program directors.

POLICY:

The NRMP is not an application processing service; rather, it provides an impartial venue for matching applicants' and programs' preferences for each other consistently. Each year, approximately 16,000 U.S. medical school students participate in the residency match. In addition, another 18,000 "independent" applicants compete for the approximately 24,000 available residency positions. Independent applicants include former graduates of U.S. medical schools, U.S. osteopathic students, Canadian students, and graduates of foreign medical schools.

Applicants must apply directly to residency programs in addition to registering for the Match. Most programs participate in the Electronic Residency Application Service (ERAS), which transmits residency applications to program directors via the Internet. **Applicants must register with both NRMP and ERAS to participate in the services of each.**

Colon and rectal surgeons diagnose and treat disorders of the intestinal tract, rectum, anal canal, and perianal areas that are amenable to surgical treatment. They are involved not only in operative treatment but also in diagnostic procedures, including colonoscopy and endoscopy.

Applicants must have completed a residency in general surgery.

Colon and rectal surgery fellowships are one year in length.

The American Board of Colon and Rectal Surgery, the sponsoring organization for colon and rectal surgery fellowships, has requested that the National Resident Matching Program (NRMP) conduct a match program. Please refer to the [Schedule of Dates](#) for the specific Colon and Rectal Surgery Match dates. Specialty Matches conducted by the NRMP are not centralized applications services. Candidates apply directly to the residency program that interests them.

A directory of programs participating in the last match is available in [Participating Programs in Previous Match](#). Once a match begins, registered participants have access to a real-time directory of registered programs located in the Match Site. Program Directors also will have access to a real-time listing of applicants registered for the current match. Another source of information is the *Graduate Medical Education Directory* published by the American Medical Association. This publication includes the names and addresses of all accredited programs regardless of whether the program participates in the Colon and Rectal Surgery Specialty Match.

NATIONAL RESIDENT MATCHING PROGRAM (NRMP) - (Continued)

For more information and statistics on Colon and Rectal Surgery fellowships, log on to the American Medical Association's interactive online program called [Fellowship and Residency Electronic Interactive Database Access \(FREIDA\)](#).

STEPS

www.NRMP.org

Before registering, please review the [SMS Match Participation Agreement](#). By registering with the match and submitting a certified rank order list (ROL), applicants and programs agree to abide by the outcome of the match. Failure to do so is a breach of the Agreement and violators may be subject to penalties under the NRMP's [Violations Policy](#). Both applicants and programs must follow the cardinal rule that neither must ask the other to make a commitment before the submission of ROLs. It is to be expected that one may express a high level of interest in the other; however, it is not acceptable for one to ask the other how one will be ranked.

Any verbal or written contract between an applicant and a program prior to the submission of the ROL is a material violation of the SMS Match Participation Agreement, and violators may be subject to penalties under the NRMP's Violations Policy. The final preference of program directors and applicants as reflected on the submitted ROLs will determine the offering of positions and the placement of applicants. Candidates must apply to the programs of their choice using the method accepted by the program. Beginning, July 2003, the Colon and Rectal Surgery Fellowship will participate in the [Electronic Residency Application Service \(ERAS\)](#). ERAS, a service developed by the AAMC, transmits application materials via the Internet to programs in residency and selected fellowship specialties. A few programs may use their own application or the [Universal Application for Residency \(PDF, 6 pages - 35KB\)](#). Do not send any program applications or the *Universal Application for Residency* to the NRMP.

Program directors review candidates' credentials and, if interested, invite them for interviews. Applicants also are responsible for ensuring that they meet all program prerequisites and institutional policies regarding eligibility for appointment to a fellowship position prior to ranking a program through the NRMP. Applicants who have not completed prerequisite training in an accredited ACGME program in the U.S., or a similar program in Canada accredited by the Royal Colleges of Physicians and Surgeons of Canada, must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). Program directors who do not wish to rank any applicant should certify their rank order list with no ranks so the NRMP knows it is not an oversight that no applicants have been ranked. Programs that fail to submit rank order lists and do not withdraw will appear in the Match Results as having unfilled positions available to unmatched applicants.

There is a registration fee which covers registration, submission of rank order lists, and access to Match Results.

Contact the NRMP at (202) 862-6077 or www.nrmp.org for any questions you may have regarding the match.

NATIONAL RESIDENT MATCHING PROGRAM (NRMP) - (Continued)

ACONYMS

NRMP – National Resident Matching Program
ABMS – American Board of Medical Specialties
AMA – The American Medical Association
AAMC – The Association of American Medical Colleges
AHA – The American Hospital Association
GME – Graduate Medical Education
ERAS – Electronic Residency Application Service
SMS – Specialty Matching Service
ROL – Rank Order List

Updated 08/13/2007

OPERATIVE CASE LOG SYSTEM (VIA ACGME)

The RRC has re-affirmed that it will require every program to use the ACGME on line procedure logs for data collection beginning July 1, 2005. All patients should be entered with one diagnosis and one procedure. The system is HIPAA compliant, and there are business agreements in place between the covered entities and the sponsoring institution, which were created by the ACGME. As it now stands, there are many inconsistencies as to how data is collected in specialties not using the ACGME site, and this is a frequent cause of concern and subsequent citations. The ACGME data depository thus provides a mechanism that allows for training programs to comply with program requirements and provides a uniform mechanism to verify the clinical training of residents among programs. PDA software will be available for a \$25 user fee. Residents will be asked to sign a waiver at the initiation of data collection.

Welcome to Resident Operative Case Log for Colon & Rectal Surgery

Last Updated 02/27/2008:

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.

Colon & Rectal Surgery

Corrections/Enhancements:

- You have accepted the access terms click Review Agreement to review [Review Agreement](#)
- Added the new report, 'Index Cases Report' to the Reports and Year End menus.
- Added CPT code 45999 to Abdominal - Transanal endoscopic microsurgery so these procedures can be entered in the 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"?

If you are a Windows 2000, ME or XP user, the cause could be:

Starting the Case Log System through the Favorites option on the toolbar in Outlook and the Windows File Explorer.

- The following message "Sorry, your session has timed out or you are not accepting cookies. You Must Login again." displays when searching for cases or CPTs and trying to request Reports.
- Workaround: Start Internet Explorer from the Programs option on the Start menu and use the Favorites option on the toolbar.
- Or you could be blocking popup windows through the Internet Security setting or a 3rd party software like the Google toolbar.
- The following message "Sorry, your session has timed out or you are not accepting cookies. You Must Login again." displays when searching for cases or CPTs and trying to request Reports.
- Workaround: Please allow this site (www.acgme.org) to display popup windows.
- If you are planning to purchase any of the new PALM 5.4.x and above devices (including PALM OS 6.0), please be aware that the mRDCS or mACLS applications are not compatible.
- This is due to Palm changing the files system.
- A new version compatible with Palm OS 6.0 is being developed.

Please report any problems or suggestions to the OPLog@acgme.org.

Handheld Activation Request Form

To purchase the handheld application your computers and handheld devices should meet the following requirements.

The handheld application will run on any handheld device using Palm OS 3.5, 4.x, 5.2 and below, or Pocket PC 2002 (WinCE 3.x), Pocket PC 2003 (WinCE 4.x), Windows Mobile 5.0 (WinCE 5.x), Windows Mobile 6.0 (Win CE 6.x)

Device with at least 4 meg of free memory

Desktop PC running Windows 95/98/2000/XP/NT

Vista supported for Win CE 4.x and above

Desktop PC with Internet access

ACGMESync (Win CE 4.x, 5.x, 6.x), Afaria 5.0 (Palm) or

Scout Client 4.2 (WinCE 3.x) provided by ACGME on first sync

The application is not compatible with Palm OS 5.4. We are not compatible with the Motorola Q and any device that does not utilize touch screen technology.

There is an annual \$25 fee for each resident using the handheld application. The institution will be billed through the standard ACGME invoicing policy. The Designated Institutional Official (DIO) will be receiving the invoice.

If your program meets the above requirements please fill out the below information. Please have the program director and Designated Institutional Official (DIO) sign the form and fax to our office at 312.755.7498, Attn: ACGME Helpdesk ACGME will then enable your program to use the Handheld application.

Contact the ACGME Support Center for any questions you may have: 312. 755-7464 or HelpDesk@acgme.org.

Please provide ACGME the following information:

Name of Program _____

Program Number _____

(10 digit ACGME #) _____

Program Director _____

Program Director Signature _____

DIO

(Designated Institutional Official) _____

DIO's Signature _____

Indicate the number of residents to use the handheld application _____

Indicate the number of additional users if your program

Is already using the handheld application _____

Purchase Order Number (If Required) _____

Once the program is registered, each resident using the handheld application should follow the setup instructions provided on the Handheld tab of the Resident Case Log System.

RECORDS RETENTION

Each program has either a sponsoring institution or individual practice that has some obligations to maintain records concerning the residents enrolled in its programs. Records of program graduates may be maintained by the sponsoring institution or the specific program. An important program responsibility is to define the “official personnel file,” its location and required contents. The sponsoring institution has a responsibility to develop a records retention policy which conforms to state, local, and national laws and meets the needs of the program. Components of the resident files and department documents should be retained in the office of the core program under the supervision of the core program coordinator/administrator and core program director.

Resident Personnel Files (one file for each resident):

Section 1 - Resident Graduation Requirement Checklist

List residency graduation requirements, include progress toward meeting required, selective & elective rotations, passage USMLE Step 3, research & presentation & other requirements

Rotations schedule completed for each year enrolled

Resident's individual learning plan for the residency (including change as goals are accomplished)

Documentation of performance in last period of training that the resident has demonstrated sufficient competence to enter practice without direct supervision.

Section 2 - Resident Performance

Monthly evaluations of rotation (completed by faculty members) that provide timely feedback to the residents, including rotation exam results (date sent to or signed by the resident)

Competency evaluation (incorporated into monthly, rotation or special activity evaluations)

Objective assessments (measures) of competency collected for each semi-annual evaluation

patient care,

medical knowledge

practice-based learning and improvement

interpersonal and communication skills

professionalism

systems based practice

Use of multiple evaluators (include faculty, patients, peers, self, and other professional staff.)

Documented (written) semi-annual evaluation with feedback to each resident (PR II A 4 g, PR V A 1 c)

Evaluation results demonstrate progressive improvement appropriate to educational level

Track summary of progress or achievement of core rotation objectives/ requirements

Documentation of procedures (procedure log)

Attendance record summary

Excused and unexcused absences from activities

Conference attendance rate

Case log summaries each rotation or six month period (including verification of accuracy)

End-of-residency evaluation summary including statement that reviews the resident performance during the final period of education and verifies that the resident demonstrated sufficient competence to enter practice without direct supervision.

Resident portfolio of grand rounds and Journal Club presentations

Resident portfolio of research project(s) or scholarly activity

Resident portfolio demonstrating competence at systems based practice

Resident portfolio demonstrating practice based improvement

Section 2 - Resident Discipline

Feedback and critical incident documentation

Copies of all correspondence regarding disciplinary incidents

Evaluation committee decisions*

Copies of any probationary terms and conditions

Documentation of successful remediation or dismissal from the program

Section 3 - Program and Hospital Papers

Signed contract(s) with hospital (sponsor) for each year of training

Hospital staff application and supporting documents

Hospital credentials committee actions concerning the resident

When a resident transfers into the program, documentation of previous educational experience and a summative competency-based performance evaluation of the transferring resident

Selected residency application materials necessary for credentialing (Admission files for enrolled residents contain these as well as other confidential materials)

Miscellaneous paperwork

Letter of recommendation for residents leaving program prior to graduation referencing competencies

Section 4 - Physician Licensure

Photocopy of License

Application materials (with checklist)

Follow up information (documentation of calls with licensing board)

Section 5 – Documentation

	Specialty Boards
ف	Board newsletters, bulletins, and other information
ف	Copy of current rules/requirements for certification (information booklet)
ف	Copy of roster of enrolled residents in the program (notes concerning changes)
ف	Annual resident evaluation reports sent to boards each year (if required)
ف	Correspondence with board concerning residents and their completion dates and required experiences

Permission to moonlight including moonlighting activities , if applicable
On-call activity (when, where, compliance with duty hours)
Certification (BLS, ACLS, etc.) including dates of recertification
In-training exam reports
Original papers (or photocopies) pertaining to license, transcripts, Visa, etc.
I-9 Employment Verification form
Loan deferment forms
Academy application / board information

Section 6 - Resident Scholarly Activities

Presentations, posters or abstracts presented at meetings
Attendance at professional meetings
Journal articles, publications
Resident scholarly portfolio

Section 7 - Correspondence with Resident

























Communication with Program Director or Academic Coordinator
Rotation and vacation requests
Verification of training documents
Correspondence from the central GME office
Miscellaneous correspondence

Section 8 – Resident outcomes after graduation

Board passage and scores
Fellowship
Location and type of practice
Honors and awards

Section 9 – Visa Paperwork

ECFMG Certificate
Offer of appointment
Program description (for J-1 visas)
Letter listing duties, responsibilities, minimum requirements & applicant's qualifications (H-1 visas)
Copies of
 Visa application
 I-94
 IAP-66 or DS-2019
 Passport
 SEVIS form
Letter of Need from Ministry of Health (for J-1 visas)
Applicant's statement of goals and objectives (for J-1 visas)
Labor Condition Application (for H-1 visas)
Related correspondence

<p>     </p>	<p>Specialty Boards Board newsletters, bulletins, and other information Copy of current rules/requirements for certification (information booklet) Copy of roster of enrolled residents in the program (notes concerning changes) Annual resident evaluation reports sent to boards each year (if required) Correspondence with board concerning residents and their completion dates and required experiences</p>
<p>     </p>	<p>Alumni Files – Verification of training (one file for each program graduate) Current contact information on all graduates of the program (alumni database) Demographic information and type of practice (alumni database) Requests for verification of training and responses Alumni database</p>
<p>        </p>	<p>Other Coordinator/Administrator Activities and Related Files Resident Orientation (schedule, handbook, office procedure guide, memos) Graduation ceremony and related activities Alumni association activities including meetings Program newsletter Resident Retreats Special projects or events Institutional policies concerning interactions between pharmaceutical/vendor/corporations/industry funding and residents/GME programs</p>
<p>          </p>	<p>Security and Access to Files Procedure to be followed by residents to gain supervised access to all documents in their file Records must be protected from fire, natural disasters, water damage Files protected from drop-in visitors, theft, vandalism Duplicate files maintained in a separate location or in digital format Access limited to no more than three people (coordinator, program director, dept administrator) Locks have a limited number of keys, no key number visible Resident and faculty personnel files are locked at all times - even during the day Files protected by a bar lock or security bar built in or attached to the file cabinet with a separate padlock (numbers removed) Program disaster preparation in place for multi-method communication with residents and their families, services responsibilities, communication concerning rotation changes, records recovery.</p>

٤٤ ٤٤ ٤٤ ٤٤ ٤٤ ٤٤ ٤٤	<p>Security and Access to Files</p> <p>Procedure to be followed by residents to gain supervised access to all documents in their file</p> <p>Records must be protected from fire, natural disasters, water damage</p> <p>Files protected from drop-in visitors, theft, vandalism</p> <p>Duplicate files maintained in a separate location or in digital format</p> <p>Access limited to no more than three people (coordinator, program director, dept administrator)</p> <p>Locks have a limited number of keys, no key number visible</p> <p>Resident and faculty personnel files are locked at all times - even during the day</p> <p>Files protected by a bar lock or security bar built in or attached to the file cabinet with a separate padlock (numbers removed)</p> <p>Program disaster preparation in place for multi-method communication with residents and their families, services responsibilities, communication concerning rotation changes, records recovery.</p>
٤٤ ٤٤ ٤٤ ٤٤ ٤٤ ٤٤	<p>Records Retention/Institutional Information to be Reported to DIO</p> <p>Copy of institutional policy/program policy regarding accommodation that would apply to residents with disabilities—documentation of accommodations made.</p> <p>Records retention policy of the sponsoring institution</p> <p>Documentation of resident participation in patient safety and quality care education.</p> <p>Summary of aggregate resident performance reported to the sponsoring institution</p> <p>Documentation that educational experiences lead to measurable achievement of educational outcomes in the ACGME competencies as outlined in common and specialty specific requirements</p> <p>Data collected and submitted to the DIO and/or GMEC documenting the program response to actions recommended by the GMEC in the internal review process.</p>

RESIDENT ORIENTATION

PURPOSE:

Preparing for resident orientation requires effective teamwork and planning on the part of the Program Director, Program Coordinator, teaching faculty, and various members of the institution's administrative staff.

It is essential to the success of our training programs that new residents be given attention and an orientation helping facilitate their first few weeks on the job.

SCOPE:

The orientation process is established to provide an overview of the division's/institutions' policies, goals and objectives as well as their roles and responsibilities of the residents, faculty preceptors and project staff. In addition, it creates a feeling of welcome to the organization, demonstrates positive perceptions about the organization by personal involvement from key staff members and teaching faculty.

Suggested agenda items for orientation:

- Mission/history and structure of the Division and/or institution.
- Biographical sketch and photograph of teaching faculty.
- Organizational chart.
- Review in detail the orientation manual allowing time for questions and answers.
- Arranging to drive residents to various hospitals to obtain parking/photo identification
- Overview of duty hour reporting/policies and procedures
- Overview of resident, program/faculty evaluation processes and procedures
- Welcome reception inviting Program Director, Program Coordinator, teaching faculty, visiting physicians, former residents, clinic coordinators/surgery schedulers, and key office administrative personnel
- Photographer for new residents

Suggested items to be included in your orientation manual:

- Agenda
- Teaching Faculty/contact information
- Institution/Division policies and procedures
- Teaching Plan (Goals and Objectives)
- Conference schedule/description
- Research guidelines
- Foundation/alumni information
- Administrative Chief Resident responsibilities
- Hospital/clinic information
- Rotation schedule/descriptions
- Instruction on logging resident activity (duty hours)
- Instruction on completing online evaluations
- Instructions on case log reporting/standards
- Instructions on dictation
- Electronic Medical Record
- HIPAA
- Parking card, keys, and pager distribution

RESIDENT/PROGRAM EVALUATION

PURPOSE

In accordance with the Program Requirements for Colon and Rectal Surgery, the faculty must evaluate the residents in a timely manner. The program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance. Residents must evaluate the educational program and faculty semi-annually the quality of the curriculum, performance of the members of the teaching staff and assessment of meeting educational goals.

SCOPE

Evaluation tools should produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.

Written evaluation of residents must occur at least semi-annually. Evaluations are to be communicated to each resident and maintained in a record that is accessible to each resident. Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

The Program Director must provide a final evaluation for each resident who completes the program. It must include a review of the performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record.

The performance of the faculty must be evaluated by the program annually. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

The educational effectiveness of the program must be evaluated at least annually. The Program Director, representative faculty and one resident must be organized to review program goals and objectives and their effectiveness. This group must conduct a formal documented meeting at least annually for this purpose. The group must take into consideration written comments from the faculty, the most recent report of the GMCC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

SITE VISIT PREPARATION

PURPOSE

To carry out the functions and preparations of a site visit.

RESPONSIBILITY

Most often the Program Coordinator is the one responsible for making the arrangements for the Site Visit and completing the Program Information Form but the involvement of the Program Director is strongly recommended. Assemble a team of key people to get involved early in the preparation process. (Program Director, Director Medical Education, Faculty, Residents etc.)

STEPS

Go to web site

www.ACGME.org

click on	Data Collection System
click on	ADS
complete	Update Program Information
complete	Update Resident Information
complete	PIF Preparation

Approximately four years ago, the ACGME developed an initial set of responses to frequently asked questions (FAQs) about the entire site visit process. The document below was updated in the fall of 2005, with new responses addressing areas such as the ACGME resident survey and the expectations for providing information on the general competencies in a selected number of subspecialty programs. The responses below offer general answers. Answers to specific questions should be addressed to the Department of Field Activities or the relevant Review Committee (RC) team.

When will our site visit be scheduled?

The notification (or accreditation) letter the program receives after the RRC has made an accreditation decision shows the approximate date of the next site visit (stating, for example, that “the program will be resurveyed after April 1, 2008”). Programs generally are scheduled in a 120- to 150-day window around this date. On occasion, a site visit may occur on a later date because each ACGME Field Representative visits three programs per week, and programs can be held back to allow three programs to be scheduled in a given city. In addition, Transitional Year programs and some subspecialties with one required year of residency are generally scheduled during the last nine months of the academic year in order to give their residents an opportunity to gain experience in the program prior to participating in the resident interview.

Programs generally receive at least 110 days of advance notice of the scheduled date of their site visit. If the approximate date of the visit is near and you have not yet received a letter from the ACGME, please contact Amy Dunlap (312/755-5009) or Penny Iverson-Lawrence (312/755-5014) in the Department of Field Activities to find out if a visit date has been set.

Who will conduct the site visit?

The ACGME uses two types of site visitors – Field Representatives and Specialist Site Visitors (SSVs). The ACGME Field Staff is made up of professional site visitors employed by the ACGME. SSVs are members of the discipline who conduct a small number of visits annually. Of the approximately 2,000 site visits conducted annually, more than 1,900 are performed by members of Field Staff, and around 80 are involve SSVs. [Biographical sketches for the ACGME Field Representatives](#), outlining their background, can be found on the ACGME web site. The RC in your specialty decides whether a member of the Field Staff or an SSV will do a given visit. A number of RCs do not use specialists, and others use them only for specific circumstances (such as new program applications).

The role of both types of site visitors is identical – to produce a report that verifies and clarifies the information the program submitted in the Program Information Form (PIF). To collect the information for this report, the site visitor interviews the program director, faculty, residents, and the designated institutional

official (DIO) and/or other administrative representatives. For some specialties, the site visit also includes interviews with representatives from other departments the program interacts.

What do I need to know about preparing the Program Information Form (PIF)?

An important aspect of preparing for a site visit is the preparation of the PIF. A well-prepared PIF describes the residency program accurately, completely and truthfully. It should be comprehensive, specific and concise, and answers all questions completely. An incomplete or inaccurate PIF can be a contributing factor in an unsatisfactory RC review.

To download the PIF for your program from the ACGME's web site, use the instructions provided in the site visit announcement letter (these instructions are also in the response to the FAQ, "How do I download the Program Information Form?"). Before preparing the PIF, you should review your program requirements and the institutional requirements. You should also allow sufficient time to gather the data needed for completing the PIF. In completing the PIF, remember that the RC members will not be familiar with the specifics of your program. Also, you should not rely on the site visitor to relate to the RC information that is relevant to compliance with the accreditation standards. If something is relevant to the review, you should include it in the PIF.

Call the staff of your RC if you need help with any questions in the PIF. If you have a technical problem with any aspect of the PIF, contact the ACGME Help Desk at 312/755-7464 or via e-mail to help-desk@acgme.org. Whether you complete the PIF yourself or delegate parts to others, a third party should review the entire document for consistency, accuracy and clarity before it is submitted to your DIO for final review and signature.

Can the date of the site visit be changed?

The ACGME surveys approximately 2,000 programs annually. Therefore, once the date of your site visit is set it generally cannot be changed. Exceptions may be made in certain circumstances. All requests to change the date of the site visit must be made by telephone to Jim Cichon, Associate Director (312/755-5015), Penny Iverson-Lawrence, Senior Survey Administrator (312/755-5014) or Ingrid Philibert, Senior Vice President (312/755-5003), all in the Department of Field Activities. Requests must be made within 14 calendar days of receipt of the site visit announcement letter.

The ACGME incurs significant costs in scheduling Field Representatives to conduct site visits, and requests for postponements of a survey received by the ACGME more than 21 days after the date of the site visit announcement letter must be accompanied by a letter from the institution's DIO or Chief Executive Officer (CEO). The letter must indicate that the institution agrees with the request for a change in the site visit date and is aware that it may be charged a fee of \$2,750 for late notice of their intent to postpone the visit.

Our program currently has no residents. Will we be site visited?

If a site visit is due, the ACGME may visit your program, even if there currently are no residents in the program. Please contact your RC team, or staff in the Department of Field Activities to discuss. If the program is not planning to take residents, most RCs allow a period of up to 24 months without residents. After that period, programs are expected to request voluntary withdrawal of accreditation without prejudice. Requests for voluntary withdrawal must be directed to the staff of your RC. In late 2007 and early 2008, the ACGME will begin to use an on-line function to allow you to make the request for voluntary withdrawal of accreditation. You may find this option under your Accreditation Data System menu. If you have been **notified of a site visit and are planning to seek voluntary withdrawal**, notify Jim Cichon (312/755-5015) or Penny Iverson-Lawrence (312/755-5014) in the Department of Field Activities as soon as possible of your plans. Failure to do so may result in the program being fined \$1,375 for late notice of seeking voluntary withdrawal.

How do I download the PIF?

To download the PIF for your site visit, on the ACGME's web site, access the menu option "Review Committees" to bring up a directory showing all RCs. Probing the line for the given RC will bring up a

menu that includes the option to download the program requirements, the PIFs for the core program and any subspecialties, and the instructions for downloading the document in WordPerfect or Microsoft Word. Follow the detailed instructions on the web page to download and complete the PIF and any associated documents. Programs in Internal Medicine and its subspecialties will have received specific software for completing the PIF and other site visit documents. For an institutional review, the Institutional Review Document (IRD) and the Institutional Requirements can be accessed by probing the option in the main menu entitled "Institutional Review" If you encounter problems in accessing or downloading documents from the web, contact the Computer Help Desk either by sending message to helpdesk@acgme.org or calling 312/755-7464.

When will our program complete the ACGME resident survey?

All core specialty programs and subspecialty programs with 4 or more residents/fellows will be surveyed every other year between January and May. Aggregate reports will be made available to programs if a 70% response rate is reached. This survey is not administered in conjunction with a program's site visit, although the information gathered will be used at the time of the program's site visit. The ACGME will notify programs directly when their participation is required. This notification will include detailed information on accessing the survey and a deadline for completion. Residents/fellows will have 4 weeks in which to complete the survey. More detailed information about the ACGME resident survey is available from the ACGME web site at:

[ACGME Resident Survey](#)

How should the program prepare for an assessment of the general competencies?

Programs in all core specialties, the Transitional Year Review Committee, the subspecialties of Internal Medicine and a few other subspecialties are required to provide information on the use of the six general competencies. Your site visit announcement letter will contain detailed instructions on how to download the Competency and Assessment Form from the ACGME's web site. If your subspecialty program uses the competencies in its curricula and evaluations, you may provide information on this on a voluntary basis. It should be placed in the PIF narratives that discuss your curriculum and evaluation process.

What should be done with the completed PIF?

After completing the PIF, you should print four (4) hard copies. One copy should be sent to the address of the Field Representative assigned to your program (shown in the ACGME's letter announcing the site visit date). This copy must be sent to arrive at the Field Representative's address a minimum of 14 days before the date of the site visit. The three remaining copies are turned over to the site visitor on the day of the visit. All four hard copies of the PIF must be identical and must be final. Draft copies are not acceptable to the Field Representative or the ACGME. Failure to send the copy to the Field Representative at least 14 days before the visit can result in cancellation of the site visit at the discretion of the Field Representative (the program is charged a \$2,750 fine for cancellation under these circumstances and the visit is rescheduled). All copies should not be bound or stapled and should be held together with a strong rubber band.

How do we set up the schedule for the day of the site visit?

Approximately 30 to 60 days before the scheduled site visit day, the site visitor assigned to your program will contact you by telephone, letter, fax or electronic mail to set up the schedule for the visit. You may also contact the Field Representative at the address listed on the scheduling letter to make the necessary arrangements (the best day to call the Field Representative is Friday). On the day of the visit, the site visitor will need to meet with faculty, residents and the DIO or another administrative representative. For a series in which two or more programs are visited at one sponsoring institution only one meeting with the DIO is necessary, and your site visit day may not include schedule time with the DIO. Some RCs also ask the site visitor to meet with other program or institutional representatives. The site visitor, in consultation with the program director, makes the final determination of the schedule and the individuals who will be interviewed.

You should remember that the site visitor might not be familiar with your town or your institution's facilities, and may appreciate directions to the institution and instructions for parking. You should arrange for

a place and time to meet the site visitor. The site visit (with exception of tours of on-call rooms and other facilities, as required) should take place in a well-lighted conference room with a table sufficiently large to allow the site visitor to do his/her work. If lunch is scheduled during the site visit, please keep the menu simple.

What happens on the day of the site visit?

On the day of the survey, be flexible and understand that schedules may be changed or be delayed to accommodate the information collection needs of the site visitor. At the conclusion of the visit, do not expect the site visitor to offer an opinion about your program. The RC evaluates the program and makes the accreditation decision, and the site visitor's role is to verify and clarify the self-study report you provided in the PIF.

If you expect a report at the end of the visit on how your program did, you may be disappointed. Site visitors are not able to give you detailed feedback, because they are not the decision-makers. Accreditation decisions are the purview of the RC. The site visitor may be able to offer preliminary suggestions regarding possible program strengths and opportunities for improvement, but these are solely based on the site visitors' experience with the review process in general.

Can I make changes to the PIF after it has been sent to the site visitor?

The PIF sent to the site visitor and the three copies provided on the day of the visit must be identical and in final form. Changing the PIF after a copy has been sent to the site visitor and before the day of the visit should be avoided at all cost. Minor discrepancies can be cleared up on the day of the visit. The rare exception is a major error or omission in the PIF that profoundly affects the review. In this case, do not send a new PIF. Send the site visitor only the pages that were changed, with the changes clearly highlighted. Notify the site visitor via voice mail or electronic mail that revised PIF pages are being sent. No revisions may be sent any later than 5 to 7 days before the date of the visit. The three copies of the PIF provided to the site visitor on the day of the visit for mailing to the ACGME must be in the revised form.

If errors are discovered on the day of the site visit, it is acceptable to make minor changes to selected PIF pages, provided that it can be done before the site visitor departs. Do not ask the site visitor to wait while you make extensive changes. Once pages have been changed, a copy of the revised pages should be given to the site visitor with the changes highlighted, and the pages with revisions should be inserted in the three copies to be sent to the ACGME before they are packaged for mailing.

How should residents be selected to meet with the site visitor?

The resident interview is crucial to the site visit. Please follow these guidelines: if the program has ten or fewer residents, the Field Representative will want to speak with all residents who are on duty on the day of the visit. If the program has more than ten residents, the Field Representative will want to speak with 10 to 12 residents. Residents must be selected by their peers, with representation from each year of the program. Chief residents beyond the required years of residency (e.g., a fourth-year internal medicine chief) may not participate in the resident interview (they may be included in the faculty interview). If your program operates a combined program track, such as internal medicine-pediatrics or internal medicine-psychiatry, residents from the combined program should be represented in the interview group. Residents should be made available for the entire interview period, with their pagers and cell phones turned off.

What happens during the resident interview?

The resident interview is an important component of the site visit. It generally opens with a brief overview of the accreditation process and the purpose of the site visit. Residents may be asked what instructions were provided about the resident interview. The residents are informed that if an adverse action results the site visit report may be shared with the program. Then the site visitor asks questions based on the information in the program's PIF and concludes with questions about the program's strengths and weaknesses. For the site visit report, answers have to reach consensus level to be reported, or are reported as "a single resident stated" or "the first-year residents as a group indicated." Individual residents

are not identified in the report.

Will the program be billed for the site visit?

Programs are not billed for the visit. Beginning in 2000, the ACGME has used an annual accreditation fee for all accredited programs, which eliminates the previous practice of charging site visit fees and annual resident fees. The annual fee is billed in January, separately from the site visit.

What happens after the site visit?

After the visit, the site visitor submits a written report to the ACGME, which is then forwarded to the RC team and sent to the RC reviewers. The RC's review of your program is based on your PIF and its attachments, and the site visitor's report. The site visitor does not participate in the accreditation decision. His/her job is completed when the finished site visit report is transmitted to the ACGME.

All RCs meet at least two times per year, some that review a large number of programs meet more frequently. The ACGME strives to get each program reviewed in as timely a fashion as possible after the site visit. RCs close out their agendas approximately 60 to 75 days before the meeting date. For a program site visited less than four months before a meeting date, there is no guarantee that it will be presented at the next meeting. Also, on occasion, the RC's agenda may be very full and programs may need to be delayed until the next meeting. The schedule of meetings for the RC and the Institutional Review Committee is available from the ACGME web site at:

RRC Meetings 2007 and
RRC Meetings 2008

How do I provide feedback on the site visit?

The ACGME sends a request for an anonymous electronic evaluation to all programs within two weeks of the site visit. The results are aggregated and used in the professional development of the site visitors, and the evaluation of the Department of Field Activities. The request to complete the survey will be in the form of an electronic mail message from the ACGME, with the web portal for the survey embedded in the message.

If you have a complaint or concern about the site visit, or if the site visitor was especially helpful or informative, in addition to filling out the electronic survey you should relate this information to the ACGME Department of Field Activities by contacting Ingrid Philibert , Senior Vice President, at 312/755-5003 or Jim Cichon , Associate Director, at 312/755-5015.

I want to increase my resident complement, but the RRC requires a review. Can I request an early site visit?

A number of RCs require a site visit and review prior to allowing a program to increase its complement. If you are not certain, please check with your RC team to see if a site visit is required. Based on the recommendation of the RC team, you may request an early review. You must contact Ingrid Philibert (312/755-5003) or Jim Cichon (312/755-5015) to ask for an early site visit. Please be prepared to provide the reasons for the early review.

My site visit will occur before the RRC determined next date. How should I time my internal review to be at the mid-point between site visits?

The ACGME also receives questions about the timing of the internal review when site visit dates are moved up at the request of the program or the ACGME. The Institutional Requirements state that the internal review should be conducted approximately at the midpoint between the last RC review and the next site visit. When the visit is moved up, and the internal review has not yet occurred, the Institutional Review Committee expects programs to perform an internal review as soon as possible, even when this places it in close proximity to the site visit date. When an internal review occurs under these circumstances, the reason should be documented in the summary that is included in the Institutional Review Document.

Tips & Tricks

- Be prepared – know the approximate date of next site visit
 - Review Institutional Accreditation Report
 - Make sure to address areas of concern and/or citations of last site visit
 - Contact the Director or Field Staff (Ingrid Philibert) at ACGME immediately if there is an avoidable problem with your site visit date.
 - Clear the Program Director and Program Chairman's schedule. They must be in town
 - Contact all faculty, residents, GME, administrators, coordinator and support staff about date of site visit
 - Cancel all patient care and committee responsibilities
 - Designate and schedule location of site visit (conference room)
 - If desired, arrange catering for a working breakfast or lunch for the day of the site visit. Identify food restrictions and preferences. Do NOT invite the site visitor to dinner
 - Approximately a month prior to site visit, contact the site visitor (if they have not contacted you) to outline the schedule, specify interviewees and to identify special requests for documentation / materials
 - Attend to details, i.e. map, directions, hotel recommendations
 - If needed, arrange for parking / security and offer to greet at front desk
- At the conclusion, don't ask or expect the site visitor to offer an opinion or suggestions for improvement

ACGME Recommendations

- Do not leave blanks or any questions unanswered
 - Do not submit information not specifically requested (recruitment brochures, public relations material, or institutional policies)
 - Do not use slang or abbreviations
 - Do not use hospital or program specific terms unless clarified, e.g. "red service", "Mr. Strong"
 - Submit on time as requested
 - Do not staple or bind your PIF. Use strong rubber bands and forget binders, report covers, fancy folders, etc.
 - Cannot substitute ABCRS form for PIF operative experience record
- Use caution when transferring numbers (check and double-check)

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