Honor Sanderford, President TS-RACS, opened the meeting at 8:00 am, welcomed the attendees, reviewed the agenda and announced the guest speakers.

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<td>Continental Breakfast/Registration Welcome, Announcements, Board Introductions</td>
<td>Honor Sanderford, President Moment of Silence for the loss of STS Member Michael J. Davidson MD of Brigham and Women’s Hospital in Boston, Massachusetts</td>
<td>2015 Agenda and 2014 Minutes Distributed</td>
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| Richard J. Shemin, MD ABTS Update | American Board of Thoracic Surgery Pathways:  
- Pathway One—general requirement: 5+2/3  
- 4+3 Joint is popular for people who focus on general surgery  
- Pathway Two—RCPSC  
- Pathway Three—I-6, which is being watched carefully to see if it is successful. A large number of medical students want an I-6 slot.  
- New: Pathway Four—5 year Vascular and 2-3 years Thoracic Surgery  
All these pathways are approved programs and eligible for ABTS.  
Another important ABTS requirements:  
- No need to take the ABS board exams  
Residency Requirements:  
- 2012 Case Requirements  
Surgical Volume:  
- 3-year training requires a minimum of | Residents need to register for the ABTS board written exam by August 15 or they miss the window of opportunity.  
Public recognizes that ABTS requirements are high stakes.  
No exceptions.  
If a trainee is not ready for the ABTS board exams then they should go for another year of training.  
There are 3 chances to pass the Written and 3 chances to pass the Orals.  
Worst case scenario: residents should be board certified in 7 years.  
Additional training must be approved by the Board. |
375 cases
- I-6 training is more complicated – 125 cases per year with a total of 375
- No general surgery requirements for PGY1-3
See ABTS surgery volume I-6 after July 2011 for PGY1-3, 4-6, 1-6
- See I—6 list of required cases
- Close relationship with general surgery programs
- Vascular cases for last years can be a challenge
- New general surgery program directors can lead to more flexibility

4/3 Case Index Case requirements, 2012
- Choose a track
- Log first assistant/primary surg roles

Congenital cardiac surgery
- 10 cases are required as primary and
- 20 cases are required as first assistant
- Important that there’s no trainee competition

Changes:
- Myocardial revascularization has been reduced
- Adult cardiac cases from 50 to 25

Stringent requirements because of work force: training needs to be robust and to include multidisciplinary stuff
Interventional skills: Adult cardiac are needed to meet requirements.

ABTS recognizes that physician assistants reduce skills – lost by our fellows. So they need conduit dissection and aortic procedures, arrhythmia surgery, MAZE.

Board exists to certify competence. Public relies on the Board for scrutiny
Applications for ABTS certification will be online by the end of June 2015.
Program Directors need to submit to ABTS by August 15, even if they are away on vacation.
“Board Eligible” – see letter by David Molin in November 2014, important facts

Starting in 2016, program start dates will change from July 1 to August 1.
American Board of Surgery exams will be on July 19. Residents need to study and take exams, move to new location. This is going to be a painful transition in July 2016. Downside: resident’s healthcare, COBRA purchase and pay a premium, while losing a month.
Upside: August to August cycle. Incentivize them to stay another month – perhaps as junior faculty. Should pay for a month. Start a week earlier than August 1. Problem: orientation set up.

ABTS application date will be shifted to September 15. As Orthopedics already does this ask your Ortho coordinators how they make this transition work. Honor’s suggestion.

Online evaluations should have a required-by
Fellows need experience and understand perfusion and complications. Circulation assist treatment/therapy ECMO, IABP requirements Lung surgery – higher numbers including VATS Credentials Committee of ABTS wants these important requirements.

Esophagus, mediastinum, trachea bronchial are important too. Esoph – general thoracic numbers

Politics with General Surgery can be difficult in gaining experience

Mediastinoscopy is not as common as it used to be but residents need to get experience. ABTS is studying data to see if this can be reduced.

Consultation experience is required in working up new patients, which is essential in hospital and office practice. Have to know how to transfer patients and follow up patients one-on-one.

Multidisciplinary patient management

Critical Care cases are a very important training requirement. Questions on critical care are highly valued in both ITE and Boards.

Simulation: 20 hours per whole training program. These can be logged on the ABTS case log.

date.

Part I Written Exam
Part II Oral Exam (scenarios) 3x30 min. exams in June in Chicago.
Residents must pass both thoracic and cardiac exams.
ABTS directors discuss all scenarios and take everything into account. If a resident fails 2 out of 3 sessions, they will fail.

Supervision – experience is optimal, thoracic surgery training is ultimately for independent practice.

Credentials Committee – a candidate is rejected, Program Director will be advised if it is due to operative experience and the RRC-TS will be told. Added training must be approved by the Board.

Operative Credit – emphasis – candidate is held responsible for knowledge of perfusion, techniques, complications and operative experience.

Go to ABTS website to see how the board sets criteria and how RRC certifies programs.

Goals and objectives have to be there or your program will be in jeopardy.

CCC – overkill but essential. Shemin likes feedback to head off problems at the start. Each rotation – strengths, weaknesses of residents are to be discussed. There should be
| Must have FLS, ATLS, ACLS certifications. | no misunderstandings. |
| Q&A: DO – increased number of applicants. Where does ABTS stand on this issue? Osteopathic community desires to meet ACGME standards & approval. If you have a DO in your general surgery program, that program has to be certified by ACGME. This is not retroactive. ABTS wants to include DOs as there will be shortages in the workforce. DO schools can expand quicker than medical schools. |
| Q&A: Valve cases = TAVRS |

| Karen Muth, University of Colorado Educate the Educator: A Program Coordinator’s Perspective | Karen participated in a recent JCTSE Educate the Educator course, where she increased her appreciation of program coordinators’ role in teaching and administering the ACGME NAS Milestones. Dr. John Potts gave his philosophical overview of the milestones explaining how the narratives show exactly what a resident/fellow is doing right and how to fix what he/she is not doing right. Dr. Deb De Rosa explained how trainees are different today and faculty need to adapt to this change. The current generation of learners are surface learners and faculty need to seize faculty moments. Dr. Steve Yang noted that PCs drive the milestones by becoming experts in milestone feedback and they can encourage faculty to overcome obstacles. |
| There will be an on-road JCTSE EtE course coming soon to all programs. Program coordinators should attend the JCTSE EtE Course with their program directors to improve their communication skills. PCs can help residents/fellows by encouraging faculty to teach and by helping to build a feedback culture in their program. |

| Dana Saxton, Vanderbilt University Coordinator Description Task Force | Coordinator Description Task Force:  
- ACGME has evolved and changed  
- PC role has evolved and changed too  
- Thoracic Surgery residency program administrators/coordinators need a |
| Thoracic Surgery Program Coordinators were encouraged to:  
- contact Dana Saxton with their support and ideas to review and revise language regarding the Thoracic |
| Jill Rose, Oregon Health & Science University | Program improvement is required for continuing ACGME accreditation and simulation can improve your program. The American Board of Thoracic Surgery (ABTS) requires thoracic surgery residents to complete and log 20 hours of simulation over the course of their training. Simulation requirements are goals & objectives, a curriculum, didactics, demonstrations, perfect practice and evaluations. Simulation must include thoracic and cardiac procedures. | Steps to start a simulation program:  
1. Primary idea (see TSDA Boot Camp)  
2. Process planning (logistics, timelines)  
3. Research (see TSDA Boot Camp)  
4. Implementation (set up and practice)  
5. Result (continually improve process)  
Suggestions for simulation:  
Skills stations for specific procedures, which are portable using readily available materials, real tissue, anatomy, and instruments. |
| Walter H. Merrill MD, Chair, ACGME Thoracic Surgery Review Committee  
Donna Lamb PhD, Executive Director  
Cathy Ruiz MA, Associate Executive Director | 1. Milestones  
2. CLER  
3. NAS is outcome driven. There are no more PIFs or regularly scheduled site visits.  
4. Program data is now reviewed every year; previous accreditation cycles have gone. Programs enter data in WebADS and accuracy is essential. | As a result of ACGME webADS annual reviews, the TS RRC can change a program’s accreditation status and might request a progress report, clarifying information and/or request a focused or full site visit. TS Case Logs are new and will be looked at for graduates.  
TS RRC accreditation status decisions – |
High and low data indicators such as case logs are reviewed with the Chair by a screening committee. Outliers are determined. Data omission is a data outlier. Resident surveys are critical now, while milestones and faculty reviews are also important. Certain programs with citations or probationary issues will be reviewed and other programs will receive continued accreditation.

5. Faculty credentials, accreditation, licensure, justification for core faculty, names of all sites, scholarly activity are all now annually reviewed. Block diagrams need to be complete and partial block diagrams are not acceptable.

**Business Meeting**

<table>
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<tr>
<th>Order of Business</th>
<th>Thoracic Surgery Residency Administrators/Coordinators are invited to apply for executive board positions. None of the positions entail a significant time commitment. Expect to be contacted by Phyllis Weigum if you have volunteered to become a part of the mentoring program. Honor is working on a Thoracic Surgery Program Coordinators Handbook.</th>
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<td>1. Motion to approve 2014 TS-RACS Minutes TS-RACS By-Laws, Proposed By-Laws Revision Voting Privileges:</td>
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<td>2. Motion to change wording of By-Law Article III, Section 2. Voting Privileges:</td>
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<td>Each approved program is accorded one vote for transacting the business of the TS-RACS. This vote is executed by the Administrator/Coordinator. No proxies or substitutions are permitted without prior written notice to the Secretary-Treasurer by the Administrator/Coordinator. The TS-RACS Executive Committee may request voting via email. To: Each member of the TS-RACS is</td>
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3. Vote for Executive Board positions:
   a. Motion to Elect Jill Rose, OHSU, for Vice President; Seconded, All in Favor
   b. Motion to elect Catherine Cooper, UCSF, for Secretary; Seconded, All in Favor

4. Presentation by Phyllis Weigum, Executive Board Councilor-at-Large:
   New thoracic surgery program coordinators can face an awkward time orienting to their role in a thoracic surgery residency program. PCs interested in participating in a mentoring program were asked to complete provided index cards with their name, contact information, institution, city and state, program type (eg: 5+2/3, 4+3 Joint, 1-6), and years of TS PC experience. New TS PCs will be partnered with geographically close mentors.
Honor Sanderford, President TS-RACS, opened the meeting at 9:00 am, welcomed the attendees, reviewed the agenda and announced the guest speakers.

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| Stephen Yang MD | Milestones Assessments need to fit the Milestones.  
• Mock Orals  
• SESATS | See JCTSE Manual, TS RRC FAQs for Milestones, google TS Milestones. |
| Meeting Adjourned | | |