American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery

Otolaryngology/FPS Program Director's Annual Report of the Program

Program Name: _____ Specialty: _____

Program Director: _____ Director of Medical Education: _____

Review Period: _____ OPTI Academic Officer _____

Instructions:
To monitor the progress of otolaryngology/facial plastic surgery residency training programs, the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOCOO-HNS) requires all program directors to complete an annual evaluation report of the program. Please submit the report within thirty (30) days of completion of the academic year. Failure to submit the report may affect the program's accreditation status.

Program Director Responsibilities			*If a "NO" is indicated, an explanation is required*
1. The Quarterly and Annual Evaluations of the Residents are completed by the program director.	Yes ☐	No ☐	
2. The program director provides oversight of the residents' scholarly activity.	Yes ☐	No ☐	
3. There is a process to evaluate and monitor quality of teaching faculty.	Yes ☐	No ☐	
4. Does the program follow/implement the model curriculum?	Yes ☐	No ☐	
5. Program complies with all the patient care and educational course requirements.	Yes ☐	No ☐	
6. Program complies with the outside rotation standard.	Yes ☐	No ☐	
7. Date last ACA Program Director Workshop attended:			
8. Date last Faculty Development Program attended:			

Board Pass Rates	In-Service Exam Scores
a. # Graduates Eligible _____. b. # who sat for Boards ____; # who passed ____ c. Status of those who failed:	Total mean raw score for program and nation for the past three years: 2016 ____ Program ____ Nation 2015 ____ Program ____ Nation 2014 ____ Program ____ Nation
Fill Rate	**Segregated Totals**
a. I filled ____% of my approved/authorized/funded training slots last July. b. Total number of filled positions ____ c. Total number of approved positions ____	Average cumulative amount of procedures completed by the residents for the last three years ____ 2016 ____ 2015 ____ 2014

Site Visit	
Date of last Site Visit:	**Number of years granted for accreditation:**
List deficiencies from last site visit and how/when the deficiencies were corrected:	
List attributes and shortcomings of the program as you see them and provide the AOCOO-HNS with a Five-Year Improvement Plan for the program:	

Resident Information			
Name	**OGME Level**	**E-Mail**	**AOA Number**
List the names of residents who left the program (i.e. transferred/withdrew) and the reason for the departure.			
Provide a Resident Status Report to indicate residents who were denied advancement and any remediation plans instituted for residents:			

Program Changes	
If applicable, please describe any substantive changes to the program in the following areas:	
Faculty	
Administration/Staff	
Training Sites	
Rotations	
Other (concerns, challenges, accomplishments)	

Support			
Are you receiving the necessary support from your OPTI?	Yes ☐	No ☐	Comments:
Are you participating in mid cycle reviews with your OPTI?	Yes ☐	No ☐	Comments:
Are you receiving the necessary support from your institution?	Yes ☐	No ☐	Comments:

Program Director Evaluation of Residents			*If a "NO" is indicated, an explanation is required*
1. The institution and program fulfilled all of its responsibilities to the residents.	Yes ☐	No ☐	
2. All unfulfilled responsibilities to the residents have been addressed.	Yes ☐	No ☐	
3. The residents' academic projects (research, scientific paper, statistics course or poster for credit) were reviewed and approved.	Yes ☐	No ☐	
4. Residents participated in the annual inservice examination.	Yes ☐	No ☐	
5. The inservice examination results were discussed with the residents.	Yes ☐	No ☐	
6. Residents have established the required panel of patients in the ambulatory setting and have followed patients throughout the academic year.	Yes ☐	No ☐	
7. Did any residents require special counselling for deficiencies?	Yes ☐	No ☐	
8. Were resident counselling sessions documented?	Yes ☐	No ☐	
9. Program complies with all patient care and educational course requirements.	Yes ☐	No ☐	

Program Director comments in any other areas not specifically mentioned above.

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information on this form is correct and accurate.

Signature of Program Director	
Date	

I certify that the information on this form is correct and accurate.

Signature of DME or OPTI Academic Officer	
Date	

Otolaryngology/FPS Resident Caseload Form

SUBMIT ONE PAGE FOR EACH RESIDENT

As outlined in Standard VII-Resident Requirements, paragraph 7.4, residents are required to maintain surgical logs that must document the fulfillment of the requirements of the program describing the scope, volume and variety and progressive responsibility of the resident.

The program director, as part of the annual report of the program, must include a compilation of the major surgical cases completed* by each resident in each OGME year.

Resident's Name _____

Program Director's Assessment of the OGME-1		
Were the OGME-1 training year rotations as outlined in the basic standard completed and approved? If no, include a corrective action plan to incorporate the required OGME-1 rotations.	Yes ☐	No ☐

_____

_____

Program Director's Assessment of the Resident's Case Load								
	OGME-2		OGME-3		OGME-4		OGME-5		
	Total	Required	Total	Required	Total	Required	Total	Required	TOTALS
Congenital	_____	3	_____	3	_____	3	_____	3	**12**
Endoscopic Sinus	_____	15	_____	20	_____	30	_____	35	**100**
Endoscopy	_____	5	_____	15	_____	25	_____	45	**90**
Head and Neck	_____	10	_____	20	_____	30	_____	40	**100**
Laser	_____	5	_____	10	_____	10	_____	15	**40**
Otologic	_____	5	_____	15	_____	25	_____	45	**90**
Plastic & Recon.	_____	20	_____	35	_____	35	_____	50	**140**

*A major procedure in which the resident performs greater than 50% of the surgical case will be counted as a completed surgery.

PROGRAM DIRECTOR MUST OUTLINE CORRECTIVE ACTION PLAN FOR THE REMEDIATION OF MINIMUM CASE DEFICIENCY.

_____

_____

_____

SCHOLARLY ACTIVITY REPORT			
Title of Project	Type of Project	Points Awarded	Cumulative Points

I certify that the information on this form is correct and accurate.

Signature of Program Director	
Date	

I certify that the information on this form is correct and accurate.

Signature of DME or OPTI Academic Officer	
Date	