

# ACOG ACM SASGOG

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Maintaining Procedural Competency in Academic Divisions of Specialists  
in General Obstetrics and Gynecology





University of Colorado  
Denver



*Dr. Christine Isaacs*

- 13 division members
- >25 providers to credential



*Dr. Mary Rosser*

- 36 division members
- > 46 providers to credential



*Dr. Chesney Thompson*

- 24 division members
- > 100 providers to credential

# Agenda

- Define Competency
- Review Fictional Case Scenarios
- Next Steps
- Workgroups to create a framework for competency measurement
- Key findings of work groups

# Defining Professional Competency

“Habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflections in daily practice for the benefit of the individual and community being served”

Epstein RM, Hundert EM. Defining and measuring professional competence. JAMA 2002

“Clinical competence exists when a practitioner has sufficient knowledge and skills such that a procedure can be performed to obtain the intended outcomes without harm to the patient”

Miller MD. Office procedures: education, training, and proficiency of procedural skills. Prim Care 1997





# How to Measure Competency?

Includes cognitive and technical aspects

“Knowledge of indications and contraindications related to the specific procedure, knowledge of specific complications and methods of recognizing and managing them, awareness of alternative therapeutic options, and the ability to effectively explain the risks and benefits of the procedure to the patient. Technical aspects that can be evaluated include knowledge of the different methods and approaches available for performing the procedure and possession of the skills needed to perform it properly”

Durning SJ, Cation LJ, Jackson JL. Are commonly used resident measurements associated with procedural skills in internal medicine residency training? *J Gen Intern Med* 2007;22(3):357–361.

# ACOG

“ACOG does not recommend a specific number of deliveries or other procedures per year per obstetrician/gynecologist to maintain competency or for any other purpose. Privileging should be based on training, experience, and demonstrated clinical competence of the individual physician. Numbers alone do not guarantee competency.”

American College of Obstetricians and Gynecologists. Guidelines for women's health care. 4th ed. Washington, DC: ACOG; 2014. p. 17-37.

# Fictional Scenarios

- The following are completely fictional scenarios. Any similarity to real or imagined providers is purely coincidental.

# Dr. Hawke



- Performed 80 LSC Hysterectomies during review cycle.
  - 2.5% complication rate
  - 1 required transfusion (started in ED when patient arrived with acute anemia)
  - 1 post operative DVT
  - Review of histology 45% of specimens revealed pathology and 55 < 85 gm uterus
  
- *Conclusion? ..... Talented busy surgeon with good skills.*
- *Do numbers tell the whole story? Are all surgeries indicated? Should other routes be considered?*



# Dr. Tortois



- Performed 3 TAH in review cycle
  - 1 re-admitted for a wound cellulitis and separation
  - 33% complication rate
  - Exceeds institution standards
  
- *What to do? Just a statistical effect?*
  
- This provider also performed 14 TVHs and 33 TLHs
  - Zero complications
  - 50 majors with a 2% complication rate

# Dr. Senior

- Did not perform any hysterectomies during review cycle
- Performed 1 uneventful TAH previous cycle
- Average 0.5 major surgeries in last 2 cycles
- Provider retired from group practice as prolific surgeon recognized for skills
- During 30 year tenure performed over 1500 hysterectomies
- *Should this person be allowed to maintain privileges?*



# Dr. Austin

- Residency completed 25 years ago and in busy group practice
- No longer performs gynecologic surgery, performed last TAH 7 years ago
- L&D generalist attending one day per week on busy labor floor
- Four 12-hour L&D calls per month which includes ER coverage
  
- *Should this person be allowed to maintain hysterectomy privileges?*
- *What about obstetrical privileges? Emergency situations?*



# What competency is being considered?

- Service
- Access
- Teaching/education
- Cost-effectiveness
- Resource utilization
- Clinical outcomes
- Complication rates

These are all capabilities, proficiencies, skills which can be measured.

# What is being measured?



## What metrics are used?

- Measurable Metrics- volume, outcomes, various complications, education assessment, costs, time
  - Specific examples used:
    - ❖ 3<sup>rd</sup>/4<sup>th</sup> degree lacerations, SSI, Transfusion, Re-admits, Return to OR
    - ❖ DVT, OR time, costs
    - ❖ Appointment availability, cancellations, documentation

# Where is the bar set?

- Peer benchmarks (too few if any reliable metrics and paucity of data on measuring or assessing competency)
- Arbitrary standards?
- Appraisal systems- certification, re-certification, privileging and credentialing, hospital requirements, insurance guidelines, pay for performance
- Thresholds- should be predicated by validity of analysis, data collection and abstraction
- JCAHO, IOM, ACGME regulatory efforts

# How does this happen ?

- Management- Anonymous, valid, objective, reasonable, transparent, effective, accountable, actionable, confidential
- Need buy-in, willingness, trust and agreement
- Understanding consequences and compliance

# What next?

- Division of labor - Balkanize General Ob/Gyn
- Re-train and remediate
- Limit of scope of practice.



# How does this start?

- **Training** - resident training and competency with ACGME/CREOG requirements, need to rethink training and certification beyond residency


**Minimum Procedure Numbers: Obstetrics and Gynecology**  
**Review Committee for Obstetrics and Gynecology**

<b>Category</b>	<b>Minimum</b>
Spontaneous vaginal delivery	200
Cesarean delivery	145
Operative vaginal delivery	15
Obstetric ultrasound <sup>1</sup>	50
Abdominal hysterectomy	35
Vaginal hysterectomy	15
Laparoscopic hysterectomy	20
Incontinence and pelvic floor procedures (excluding cystoscopy)	25
Cystoscopy	10
Laparoscopy	60
Hysteroscopy	40
Abortion	20
Transvaginal ultrasound	50
Surgery for invasive cancer	25

New recommendations- **70**

3/16/2018

ABOG Announces New Eligibility Requirement for Board Certification - Fundamentals of Laparoscopic Surgery

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# Fundamentals of Laparoscopic Surgery

...THE DEFINITIVE LAPAROSCOPIC SKILLS ENHANCEMENT AND ASSESSMENT MODULE.

- HOME
- ABOUT
- FLS REGISTRY
- TESTING INFORMATION
- DIDACTIC CONTENT
- INTERNATIONAL FLS
- CONTACT

You are here: [Home](#) / [FLS News](#) / ABOG Announces New Eligibility Requirement for Board Certification

## ABOG Announces New Eligibility Requirement for Board Certification

January 23, 2018

The American Board of Obstetrics and Gynecology (ABOG) announced today that it is adding a new requirement – **Fundamentals of Laparoscopic Surgery (FLS™)** – for physicians seeking board certification that will ensure that diplomates possess critical skills for the contemporary practice of obstetrics and gynecology (OB-GYN). **The new requirement will apply to residents graduating after May 31, 2020.**

Applicants for ABOG certification will be required to successfully complete the FLS™ program as a **prerequisite for specialty board certification**. Requiring completion of FLS™ is part of a broader initiative by ABOG to incorporate simulation and to standardize the knowledge and training obtained by OB-GYN residents. It also establishes an additional objective measure that all U.S. obstetricians, gynecologists and surgeons applying for primary specialty

### View the Interactive Demo

[Flash Demo](#)



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*Please use the menu below to jump to a section of your choice:*



# How does this start?

- **Training** - resident training and competency with ACGME/CREOG requirements, need to rethink training and certification beyond residency
- **Institution strategy**
- **Hospital requirements**
- **Department policy**
- **Division recommendations**
- **Insurance guidelines**
- **ACOG?, ABOG?**

# Existing physician certification and training tools

- Physician strengths and weakness: What are they good at?
- Physician interests and passions: What do they want to do?
- OPPE for new faculty, FPPE as required by institution
- Certification and Maintenance of Certification (MOC)
- External Review, Resident Review Committee (RRC)
- Renewal of privileges, M&M
- Formal reporting systems "PSN", Faculty evaluations (resident and students)
- Simulation exercises, Mock codes
- Provide rates on reportable metrics by division to Vice-Chair of Quality.

## Review Criteria (new)

Unplanned admission or readmission within 30 days of major surgery or any admission from ambulatory surgery (including retention for complication of surgery or anesthesia)  
Admission after a return visit to the emergency room (if seen by Gyn at the first visit)  
Unexpected death or cardiopulmonary arrest  
Any surgical site infection or other hospital acquired infection within 30 days of admission or surgery  
Unplanned admission to ICU or return to OR during same or subsequent admission within 30 days  
Intra- or perioperative transfusion of 2 or more units, post-op hgb <8/hct <24 (except radical cancer surgery)  
Unplanned removal, injury, or repair of organ during operative procedure  
Discrepancy between preoperative diagnosis and postoperative tissue report  
Removal of uterus weighing <280g for asymptomatic leiomyomas or in a woman <30yo except for malignancy  
Removal of follicular cyst or corpus luteum of ovary (if not incidental at the time of another surgery)  
Retained foreign body  
OR time greater than 6 hours  
Post-op venous thromboembolism  
Physician Request/ Other \*please specify

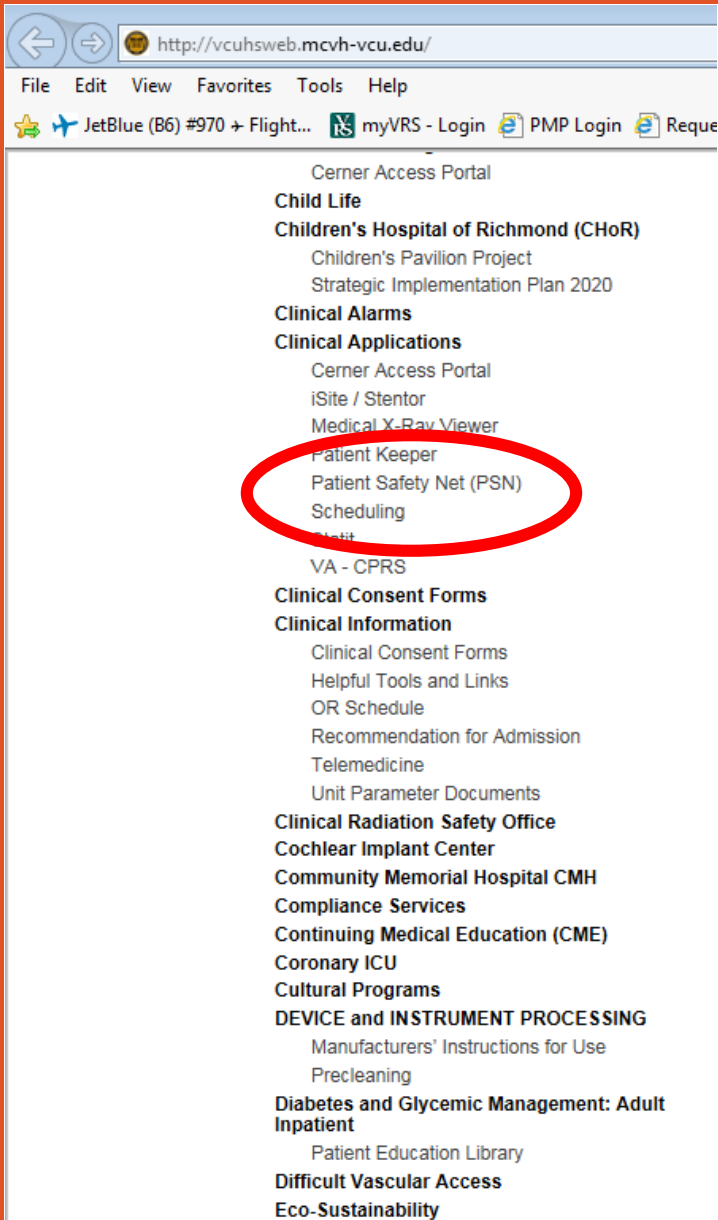
## GYN Q&A Committee

4 faculty members, 3 residents (PGY 2, 3, 4)

Every case submitted discussed & a review form completed

Summary & recommendations sent to the department chair





# Patient Safety Net (PSN)

- Anonymous reporting by any team member
- Sent to department chairs for departmental review and an action plan
- Opportunity: tracking system development

# Challenges

- **Measure numbers and frequency**
  - Probably insufficient and does not tell the whole story
  - Need outcomes data which is laborious
- **Resources include time, money and labor**
  - Consistent and reliable process
  - Validity of instruments and data
  - Statistics and sample size
- **Willingness, buy-in, participation and outcomes direction**
- **Safety** in numbers?



# Where do we go from here?

- **Important steps to improving care**
  - Continue to develop and implement competency-based assessment
  - Integrate into routine process and benchmarking
  - Explore different methodologies to assess competence
- **A tendency to become too focused?**
  - Are the metrics and competencies the bricks or building blocks?
  - Needs to be up to industry standards
  - What about the mortar between the bricks and the technique of laying the bricks?
- **Provider development**
  - Interact, communicate and integrate into the healthcare process?

# Do we have evidence based data to draw from?

- Literature suggests that increased surgical volume correlates with fewer complications and increased positive outcomes
- The significance and contributing factors are less clear

# Workgroups



# Key findings of workgroups

# References

- Wallenstein M, Ananth C, et al. Effect of surgical volume on outcomes for laparoscopic hysterectomy for benign indications. *Obstet & Gyn* 2012;119: 709-716
- Mowat, A, Maher, C, Ballard, E. Surgical outcomes for low-volume vs high-volume surgeons in gynecology surgery: a systemic review and meta-analysis. *Am J of Obstet & Gyn* 2016:02: 21-33.
- Wright, J. Measuring what matters: quality in gynecology surgery. *Am J of Obstet & Gyn* 2015:257-258