

Spring 2008

Updates to the Program Information Form

The ACGME has revised the Common PIF to make it less redundant, more efficient, and less time consuming. The RRC is currently completing the revision of the specialty-specific PIF to achieve the same goal. The RRC expects to complete the revision by May 2008.

Evaluating Primary Care Education

In January 2007, the RRC appointed a subcommittee led by Peter Schwartz, MD to reevaluate how obstetrics-gynecology residency programs are evaluated. The subcommittee focused on the types of metrics utilized, procedural-based competency, and the evaluation of primary and preventive care training. The subcommittee concluded that the measurement of primary care education should focus on the following twenty categories:

- Allergies
- Medications
- Blood pressure
- Smoking history
- Immunizations
- Alcohol use
- Substance use

- Depression
- Diet/Nutrition
- Exercise
- Sexual dysfunction
- Seat belt use
- Contraception
- History of abuse
- Menstrual history
- Pap smear screening

The following were specified for women over 50 years of age:

- Osteoporosis
- Lipid Screening
- Mammography
- Colonoscopy

The RRC will develop a format for examining these categories, and will approve an appropriate template at the May 2008 meeting.

Changes to Program Requirements

Patient Care

The subcommittee made the following recommendations to the patient care competency section of the program requirements. These changes were approved by the RRC in October 2007, and will be effective July 1, 2008.

For **Obstetrics**, residents will no longer

track amniocentesis on the OPLOG. Total operative vaginal deliveries will be added to the OPLOG.

For **Gynecology**, laparotomy, urogynecology, conization of the cervix, surgical sterilization, and endocrine/infertility surgery procedures will be eliminated from the OPLOG. Laparoscopic assisted hysterectomy will be added, and induced abortion (medical or surgical) will be substituted for abortion. In addition, the following will be changed: operative laparoscopy to other laparoscopy, hysteroscopy to operative hysteroscopy, incontinence and pelvic floor to incontinence and pelvic floor (urogynecology), and vaginal ultrasound to transvaginal ultrasound.

Institutions

Provided below are the revised requirements for Institutions, effective January 1, 2008.

I. Institutions

A. Sponsoring Institution

1. One sponsoring institution must assume the ultimate responsibility for the program as described in the Institutional Requirements, and this responsibility extends to the resident assignments at all participating sites.
 - a. The program director must have a minimum of 20 hours per week of administrative time (non-clinical) and must receive full financial support from the institution for this time. Increased administrative time will be required based on the number of residents, the number of training sites, and other local factors.
 - b. At a minimum, a full-time program coordinator is required for all programs,

and must receive full financial support from the institution.

2. The program must exist in an educational environment that should include at least two other relevant graduate medical education programs such as internal medicine, pediatrics, surgery, or family medicine. The program director must obtain teaching commitments from the other departments involved in the education of obstetrics-gynecology residents.

Complete program requirements are located on the RRC webpage at:

http://www.acgme.org/acWebsite/RRC_220/220_prIndex.asp.

Current Issues at the RRC

The ACGME, CREOG and the RRC are examining procedure-based competency in order to emphasize focused observation of the surgical procedures, with a minimum number of required procedures, to assure that the resident is competent. The RRC is also currently evaluating the role of simulation in the training of resident physicians.

Timing of Internal Reviews

Each program should have an internal review conducted by their sponsoring institution at approximately the midpoint between site surveys. This review is to be used by the program director, department chair, and the institution to identify real or potential problems, (that can result in citations or a recommendation for a possible adverse action) and have time to rectify them before the next survey. Programs should work with their DIOs to make certain that the internal review is completed.

ACGME Resident Survey Results: How Are They Used?

The ACGME Resident Survey asks residents to respond to questions about their clinical and educational experiences, duty hours, and their program. Initially, the resident survey results are only seen by the site visitor. The site visitor verifies the information at the time of the site visit, and forwards the information to the RRC. The comments by the residents are seen only by the site visitor.

The RRC uses the results confirmed by the site visitor, along with other data, to help make fully informed accreditation decisions. Residents are required to participate in this online survey developed and administered by the ACGME. The survey is completed every other year, and a 70 percent compliance rate is expected before the results are available to the program director.

Criteria for Five-Year Accreditation Cycles

To receive a five-year accreditation cycle, programs should demonstrate a well-balanced program. There should be sound administration that focuses on the breadth and depth of resident education, rather than service. Residents should have experiences in obstetrics, gynecology, and primary and preventive care, as well as innovative educational opportunities. There should be a high Board pass rate, as well as high resident satisfaction as captured in the program evaluations and resident survey. Residents should have thorough institutional support and the competency-based evaluation should be strong.

Request for Increase in Resident Complement

In accordance with ACGME Policy of July 2006, all requests for changes in resident complement must be submitted through the Accreditation Data System (ADS) and have

DIO approval.

The RRC also specifies that an increase in resident complement has to be accomplished on a “phase-in” basis, beginning with the PG-1 year. A request for a greater increase would need a special educational rationale.

ACGME Learning Portfolio

ACGME staff have developed a number of resources for programs that want to become more familiar with the ACGME Learning Portfolio (ALP). The Frequently Asked Questions (FAQs) include a description of the portfolio and its benefits to both residents and program directors, in addition to information about how ALP can be used and the timeline for development with special emphasis on the beta testing and alpha prototype.

http://www.acgme.org/acWebsite/portfolio/cbpac_faq.pdf

Also, a sample portfolio is included on the ACGME website.

http://www.acgme.org/acWebsite/newsreleases/newsRel_5_24_07.pdf.

CI Pilot Projects

The Committee on Innovation (CI) announced a set of duty hour and competency pilots in Fall 2007. Ingrid Philibert, Senior Vice President, Department of Field Activities, quoted from the first formal report of the committee, which was approved at the September 2007, meeting of the ACGME Board of Directors: “The ultimate aim of these pilots is to test proposed revisions to the common duty hour standards and refinements to the approaches for teaching and assessing the general competencies to ensure they are based on valid and ‘actionable’ evidence of their effectiveness.”

A listing of the pilots was sent to the Review Committee Chairs and Executive Directors (ED) in early August 2007. Chairs are being asked to confer with their EDs to discuss

which pilots would be of interest to the RRC.

Among the incentives for pilot participation are:

- waiver of selected program requirements;
- exempting programs from a site visit during the period of the pilot (unless the program requests a site visit for a specific reason such as a request for a complement increase); and,
- contributing to improving the evidence base for the accreditation standards and process.

More information regarding the pilot projects will be available from the ACGME website under Innovation/CI. For questions, contact Mary Joyce Johnston in the Department of Field Activities at 312/755-5013.

Program Director Guide to the Common Program Requirements”

To help clarify the meaning and expectations of the common program requirements, there is a “Program Director Guide to the Common Program Requirements” available on www.acgme.org. The guide has been very helpful to both new and current program directors. Please email comments and suggestions to: Guide@acgme.org.

Voluntary Withdrawal Requests

Programs must now enter requests to voluntarily withdraw accreditation (VW) using ADS only.

Programs initiate the request by answering a series of questions, including the proposed effective date, the reason for program closure, and presenting a plan to place any active residents in other programs. The request is emailed to the DIO for approval. After the DIO/GMEC

approves the request, the RRC staff designee is emailed. After the program receives official notification from the RRC and the accreditation status is changed to VW, the request will automatically be removed from the report.

Accreditation Data System

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

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

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

Email is now the ACGME’s major form of communication. Please ensure that e-mail addresses in the ADS are correct.

Address your questions or concerns about ADS to the ADS representative for Obstetrics and Gynecology, Emilio Villatoro at 312/755.7117, evillatoro@acgme.org.

ACGME Welcomes New CEO

Thomas J. Nasca, MD, MACP, was named chief executive officer of the Accreditation

Council for Graduate Medical Education in September 2007.

Dr. Nasca comes to the ACGME from Thomas Jefferson University in Philadelphia where he was dean of the Jefferson Medical College, senior vice president for academic affairs, and president of Jefferson University Physicians. Dr. Nasca is a board-certified internist and nephrologist, and brings 26 years of graduate medical education experience to the ACGME.

"I am honored to have the opportunity to join the ACGME and to succeed its outstanding and visionary leader for the past 10 years, David C. Leach, MD," said Dr. Nasca in an ACGME news release announcing his appointment. "I hope to enhance the ACGME's legacy of excellence and sustain our commitment to improve the health of the public through outstanding graduate medical education for the future physicians of the United States."



He succeeds Dr. Leach, who retired in Fall 2007.

ACGME Educational Conference 2008 Recap
Each year, the ACGME Annual Educational Conference provides a venue for graduate medical educators to learn more about the accreditation process and ways to enhance residency program quality related to ACGME initiatives, such as general competencies, educational outcome assessment, and duty hours. This year's conference theme "Building Community, Improving Quality" emphasized how better education and better patient care can occur when individuals in diverse roles work

together toward shared goals.

Post-conference information is available at: http://www.acgme.org/acWebsite/meetings/me_EducConf_08.asp

RRC Meeting and Agenda Closing Dates

In order to ensure an orderly and efficient RRC meeting, we must establish cut-off dates for requested agenda items. Please note these deadlines if you have submissions for future RRC meetings. The dates and deadlines are as follows:

Meeting: Oct 2-4 2008
Agenda Closing: Aug 15, 2008

We understand that emergencies occur and we will be sensitive to your needs in these situations. However, routine agenda items will be held for the next meeting after these cut-off dates.

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