



Working Hours and Conditions
Post-Graduate Trainees
Annual Compliance
Assessment
Contract Year 5
10/1/05-9/30/06

Executive Summary

With approximately 15,000 of the nation's 100,000 post-graduate trainees working within New York State, considerable attention has focused on monitoring for compliance with the State's work hour requirements. In conjunction with a renewed five-year contract with the DOH, IPRO conducted compliance assessments at all teaching hospitals. A total of 146 compliance visits were conducted in the fifth year of the contract from October 1, 2005 to September 30, 2006, which included annual compliance visits at all 121 teaching facilities in New York State, 10 complaint investigations, and 15 re-visits. In total, the working hours of more than 9,079 residents in the State were reviewed to assess compliance with working hour requirements.

Upon completion of each on-site survey, a letter of findings was issued to each facility with a compliance determination. Non-compliance with current requirements was reported to facilities in a statement of deficiencies (SOD). All facilities with documented deficiencies were required to submit a plan for implementing corrective action. All facilities that submit a plan of correction (POC) are assessed for implementation and compliance with their submitted POC at their next visit.

Compliance findings for year five of the Post-Graduate Trainees Working Hour Compliance Assessment Program, include the following:

- Annual compliance reviews were conducted at all 121 teaching facilities, with 100 hospitals found in substantial compliance with requirements and 21 hospitals cited for non-compliance in at least one program area
 - In sixteen (16) of the facilities cited, only one (1) program area within the facility evidenced non-compliance
 - In four (4) of the facilities cited, two (2) program areas within the facility evidenced non-compliance
 - In one (1) of the facilities cited, the Graduate Medical Education department within the facility evidenced non-compliance
- 10 on-site complaint investigations were conducted with a 70% substantiation rate
 - Six (6) of the 10 complaints related to surgical programs with five (5) complaints substantiated
 - Two (2) of the 10 complaints related to internal medicine programs with both complaints substantiated
 - One (1) of the 10 complaints related to OB/GYN programs with the complaint not substantiated
 - One (1) of the 10 complaints was related to all programs at the facility with the complaint not substantiated

- In follow-up to identified non-compliance, 15 re-visits were conducted to monitor the facility's plan of correction (POC) implementation
 - 67% of re-visits evidenced substantial compliance
 - 33% of re-visits evidenced at least one element of continued non-compliance
 - 7 re-visits focused on surgical compliance issues with 57% continued non-compliance, and 3 revisits focused on internal medicine compliance issues with 33% continued non-compliance
- Twenty-six (26) of the 146 (18%) compliance reviews conducted evidenced residents working more than 24 consecutive hours
 - Programs in surgery (55%) and internal medicine (23%) were most frequently cited in this area
- Eleven (11) of the 146 (8%) compliance reviews conducted evidenced residents not receiving one full 24-hour off period each week
 - Programs in surgery (82%) and internal medicine (18%) were most frequently cited in this area
- One (1) of the 146 (1%) compliance reviews conducted evidenced improper separation between working assignments
 - Program cited was internal medicine (100%)
- Six (6) of the 146 (4%) compliance reviews conducted evidenced repeat violations and were cited for QA
 - Programs in surgery (57%), GME (29%), and internal medicine (14%) were most frequently cited in this area

Annual Compliance Assessment

Exhibits 1 – 2 / Implementation

Exhibit 1 illustrates the 121 annual reviews for the fifth year of the contract conducted between October 2005 and September 2006.

Exhibit 1

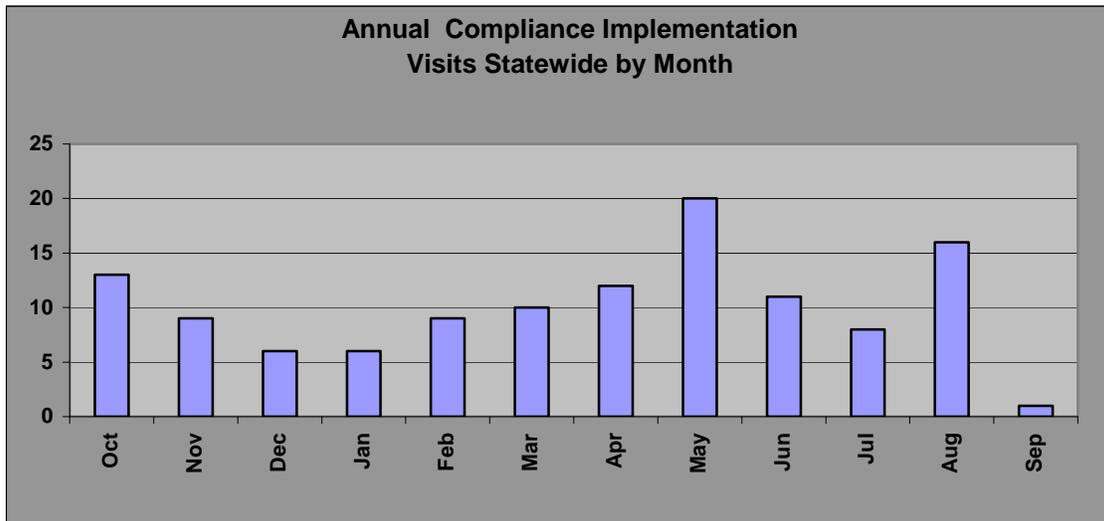
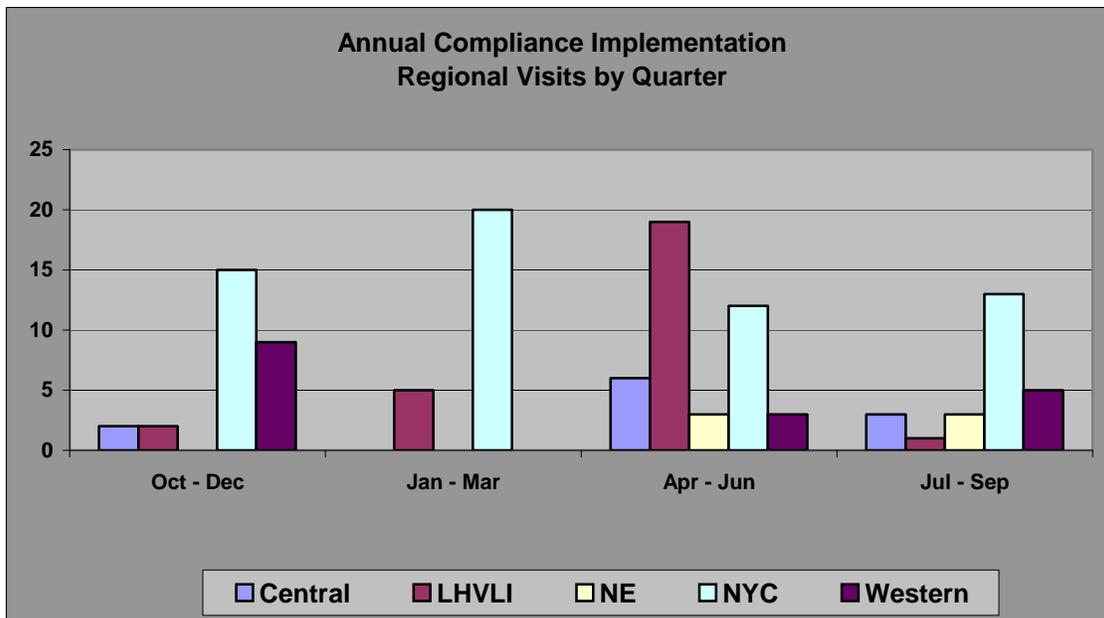


Exhibit 2 illustrates by quarter the distribution of the 121 annual visits by region across the state.

Exhibit 2



Exhibits 3 – 4 / Compliance Assessment- Statewide and Regional

Based on 121 annual compliance visits, 21 (17%) of the facilities evidenced some level of non-compliance at the time of the annual on-site review.

Exhibits 3 and 4 illustrate compliance/non-compliance on a statewide and regional basis respectively. For reporting purposes, non-compliance means that one or more deficiency/finding was identified during the on-site review. Each deficiency/finding cited could result from an issue associated within one or more programs within the facility.

Of the 21 facilities cited for non-compliance, sixteen (16) evidenced non-compliance in only one program area, four (4) of the facilities cited evidenced non-compliance in two program areas, and one (1) facility evidenced non-compliance in their GME program area.

Exhibit 3

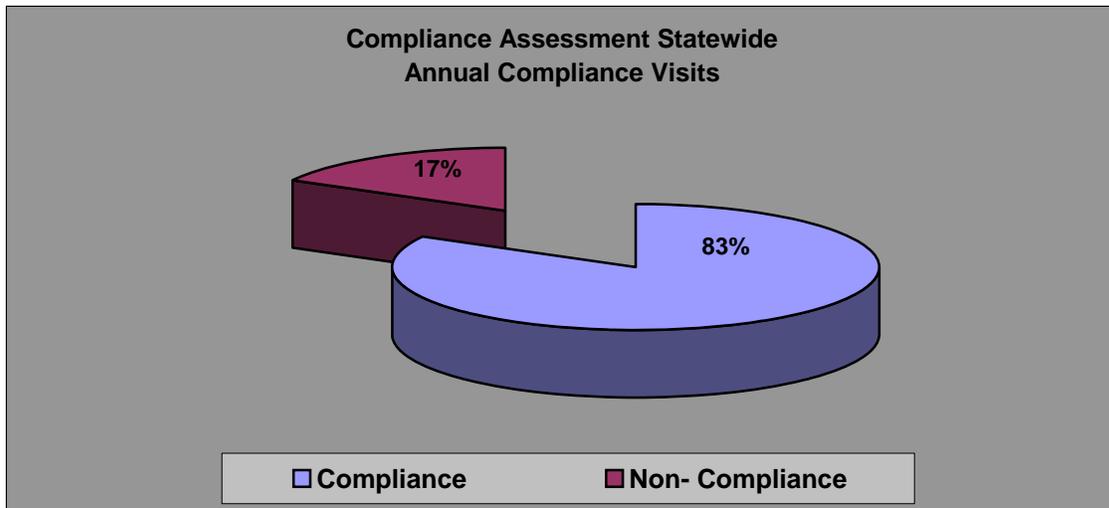
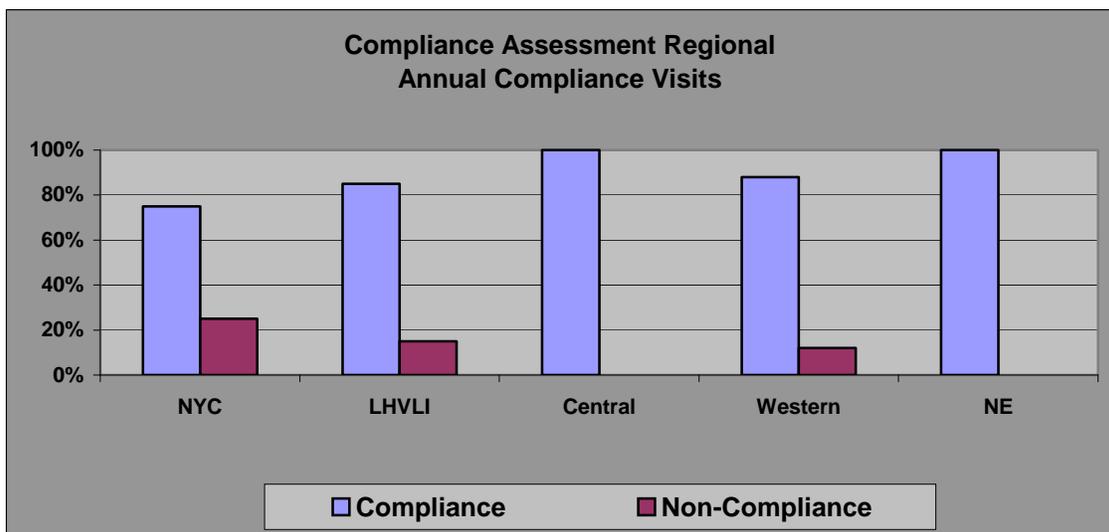


Exhibit 4

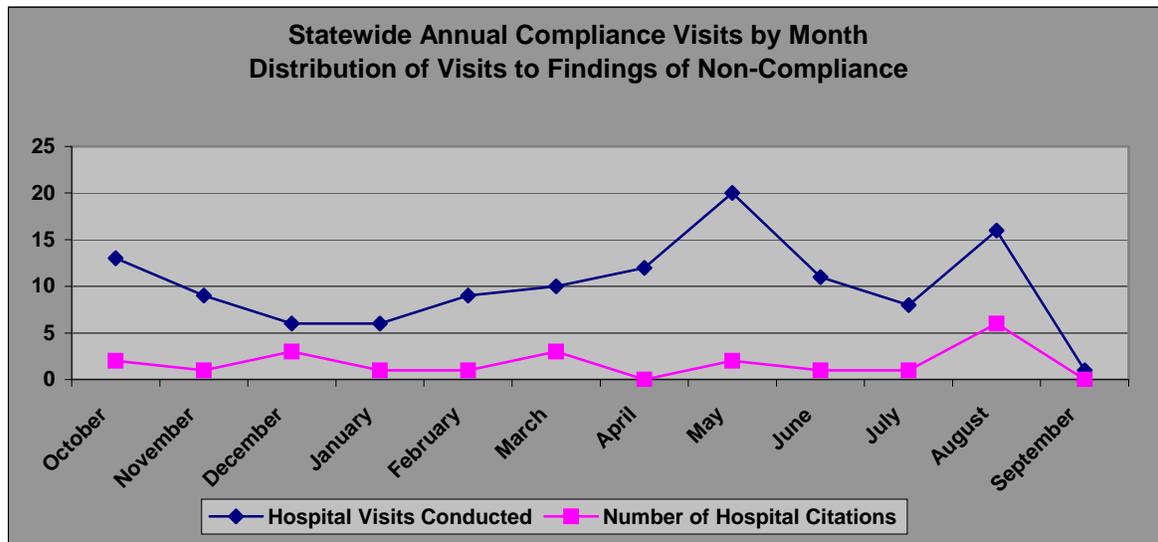


Exhibits 5 & 6 / Statewide Compliance – Distribution of Non-Compliance

Concerns continue to be raised regarding the scheduling of on-site visits in July and during the holiday seasons. While it is recognized that throughout the year there are dates and periods of time where routine scheduling for hospitals may be more difficult, due to the large number of surveys to be conducted, compliance surveys were carried out throughout the contract year. All 121 annual compliance surveys were completed between October 2005 and September 2006.

Exhibit 5 illustrates the distribution of the 121 annual visits to the distribution of non-compliance documented for visits completed each month. The information provided reflects a fairly consistent correlation throughout the year between visits conducted and facilities found to be out of compliance with current requirements. Upon review, the data does not appear to indicate that the time period the survey was conducted had a significant impact on whether a facility was found in compliance. In July, for example, the distribution of surveys conducted to findings of non-compliance does not indicate that survey outcome was significantly influenced by survey scheduling.

Exhibit 5



Exhibits 5a & 5b illustrates the comparison for contract years 1-5 for annual non-compliance for visits completed each month. The information provided reflects a fairly consistent correlation throughout the years for facilities found to be out of compliance for visits conducted each month of the contract year.

Exhibit 5a

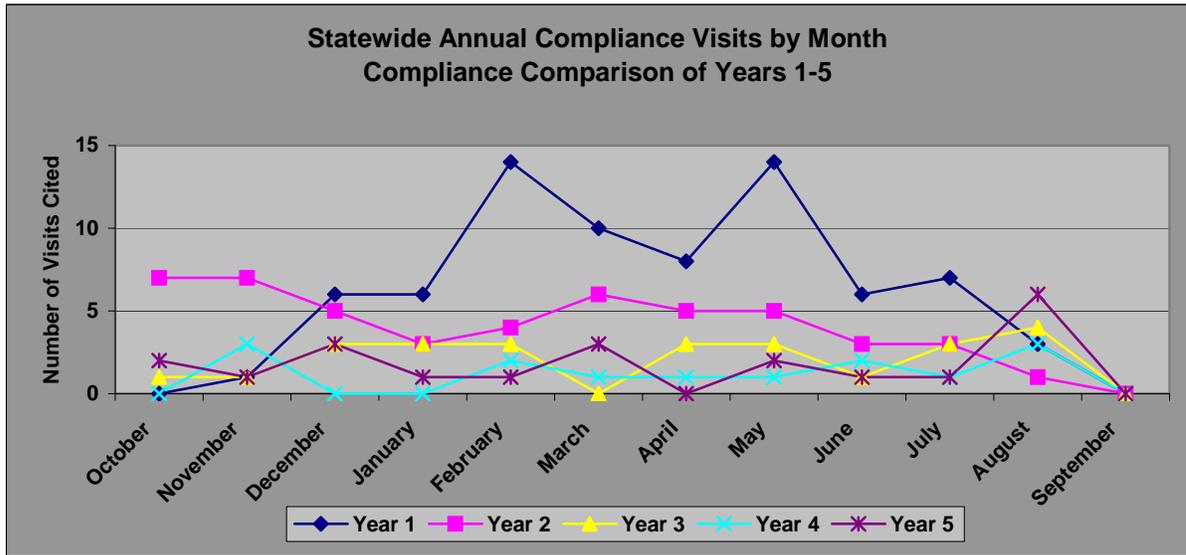


Exhibit 5b

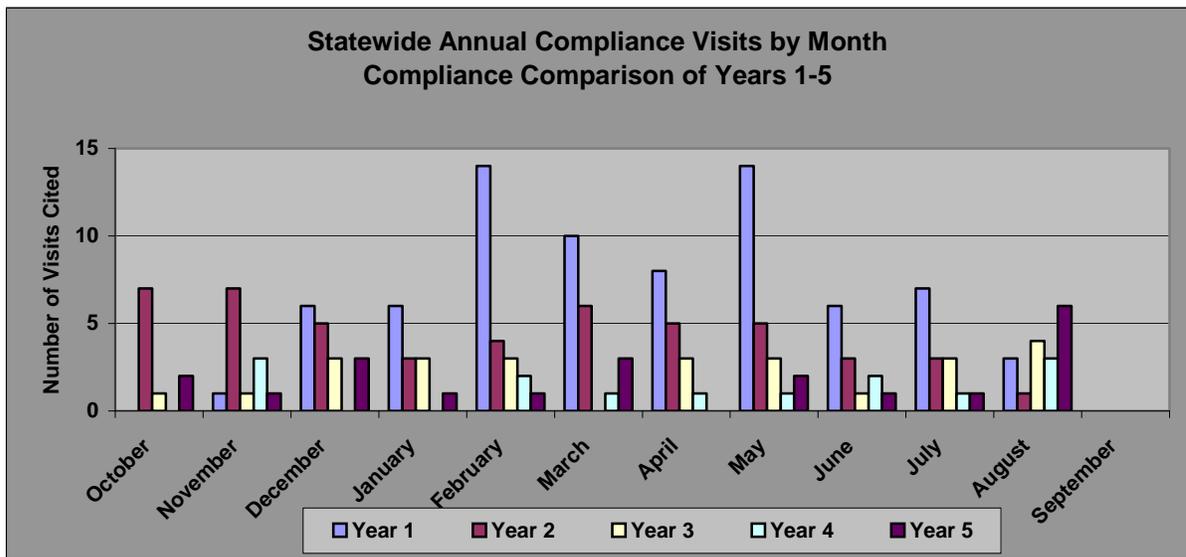
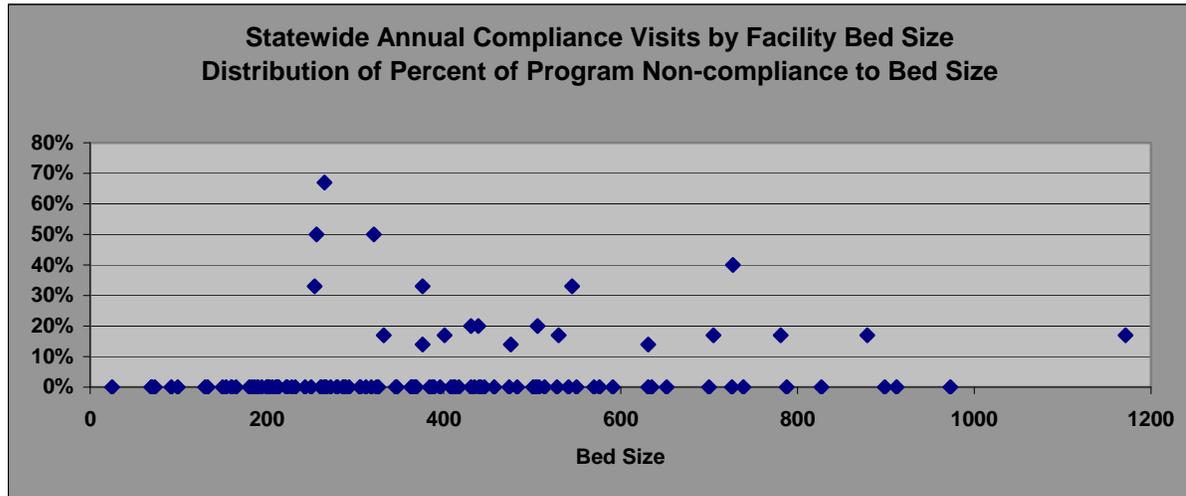


Exhibit 6 presents a detailed assessment of compliance by bed size for the 121 annual visits. Each facility is identified by its bed size, and is evaluated by the percent of non-compliance, as evidenced by the percentage of facility programs that were cited for non-compliance. For example, a facility review that included four teaching programs, surgery, internal medicine, OB/GYN, and pediatrics, and was found out of compliance in only one program, would be out of compliance for 25% of the programs reviewed. For analysis purposes, all sub-specialties were included under the primary program category.

Exhibit 6



- Working Limitations – this category reflects documented inconsistencies in working hour information collected during interview and through observation when compared to a review of documentation. To validate interview data, review staff screen facility documentation not limited to medical records, operating room logs or operative reports, delivery logs, and/or consult logs, to document the date and/or time certain services are provided and recorded. None of the visits conducted evidenced violations in this area.
- QA –each hospital is required to conduct and document ongoing quality assurance/quality improvement (QA/QI) activities for the identification of actual or potential problems in accordance with requirements set forth in statute. Four percent (4%) of facilities reviewed during year five were cited for deficiencies in their QA/QI performance. It should be noted that QA/QI would automatically be cited in year five for any facility that had a repeat deficiency from year four or in the case of a year five re-visit, a repeat of findings in year five.
- Governing Body – the responsibility for the conduct and obligations of the hospital including compliance with all Federal, State and local laws, rests with the hospital Governing Body. During year five of the contract, Governing Body was not cited as an area of non-compliance.
- Working Conditions - working conditions include consideration for sleep/rest accommodations, the availability of ancillary and support services, and the access to and availability of supervising physicians to promote quality supervision. In year five, no facilities were cited for failing to meet expected working conditions for residents.
- Moonlighting – regulations place responsibility with each hospital to limit and monitor the working hours associated with moonlighting or dual employment situations. Trainees who have worked the maximum number of hours permitted in regulation are prohibited from working outside the facility as physicians providing professional patient care services. No violations pertaining to moonlighting or dual employment requirements were identified in year five.
- Emergency Department (ED) – for hospitals with more than 15,000 unscheduled emergency department visits, the ED assignments of trainees shall be limited to no more than 12 consecutive hours. For the period of review, no violations were identified for this program area.

The most notable area of non-compliance statewide and on a regional basis continues to be working hours in excess of 24 consecutive hours (>24).

Exhibit 7

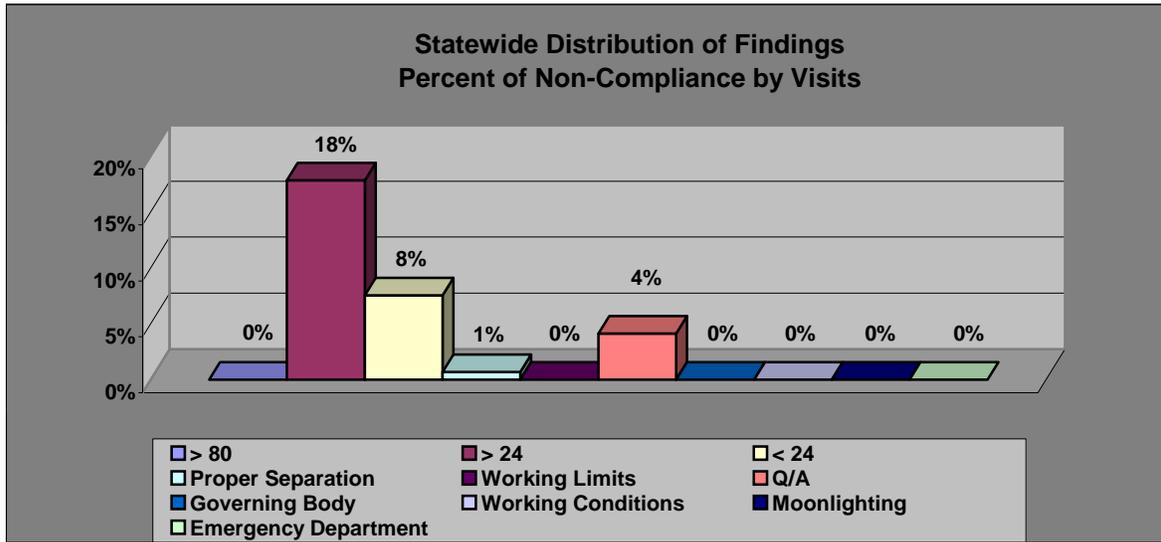


Exhibit 8

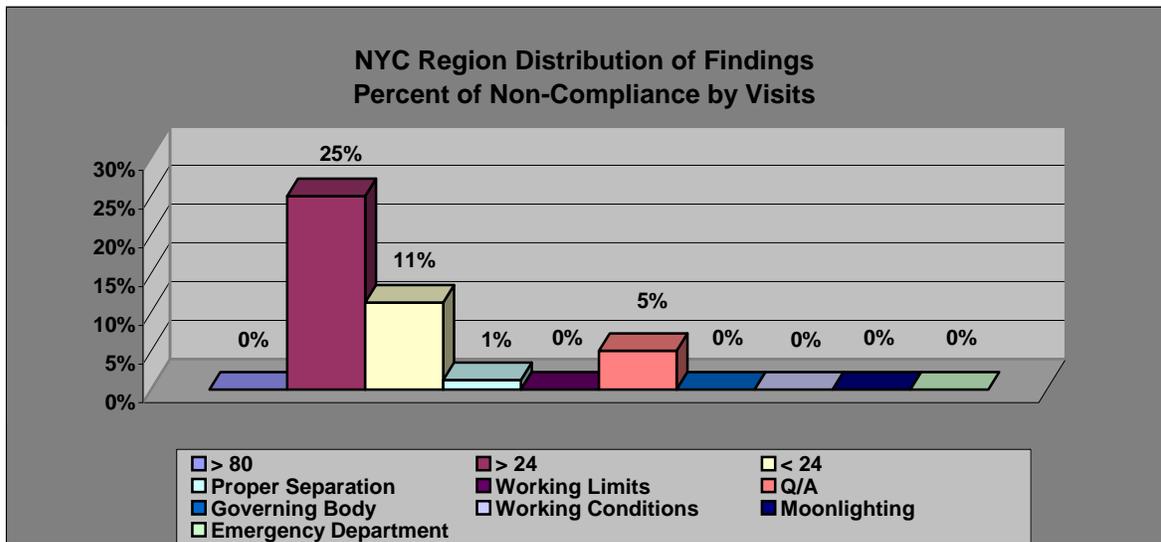


Exhibit 9

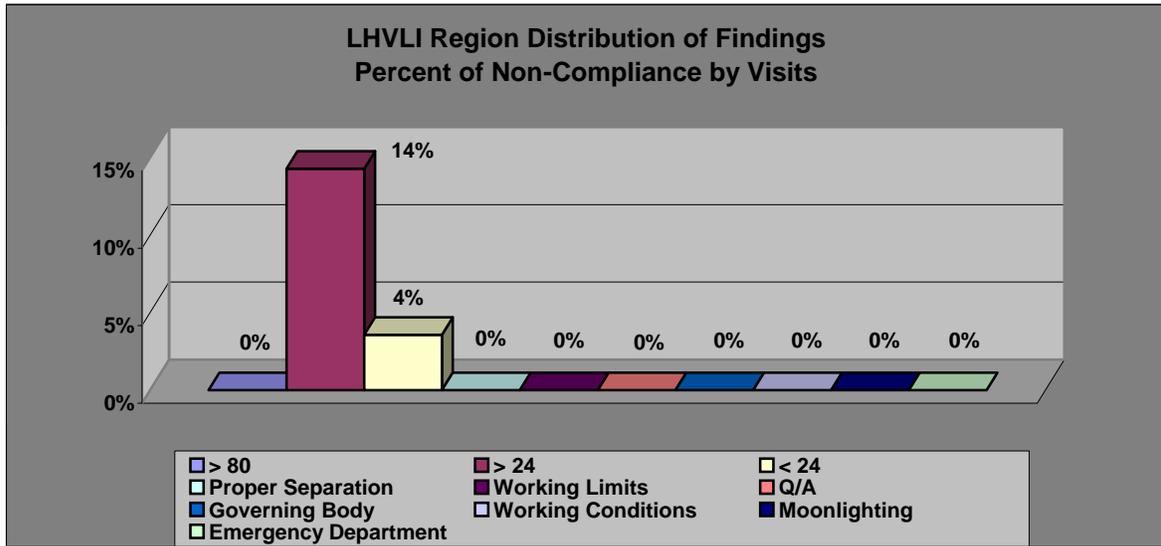


Exhibit 10

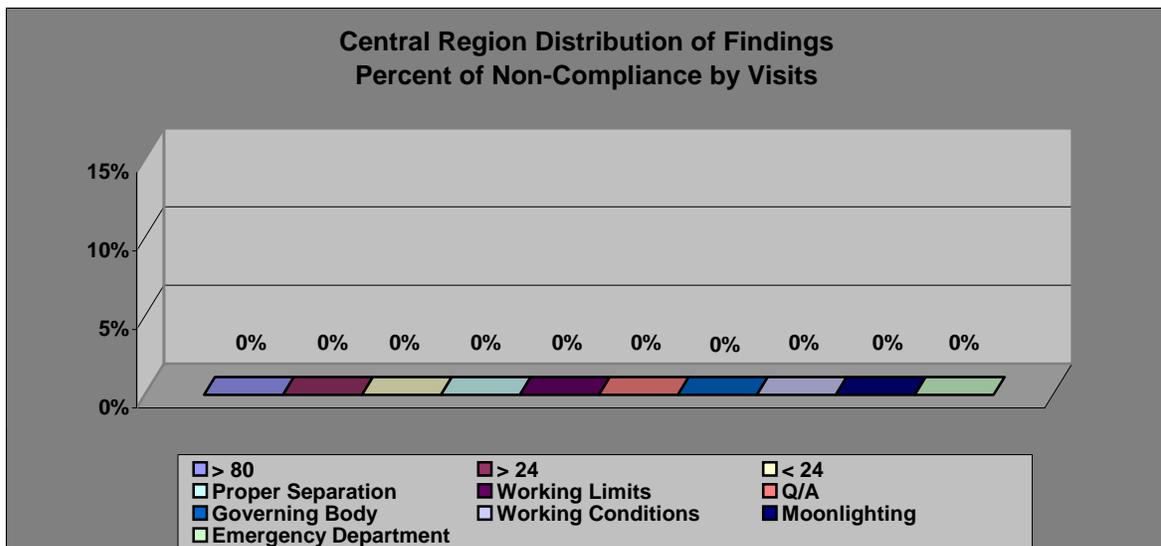


Exhibit 11

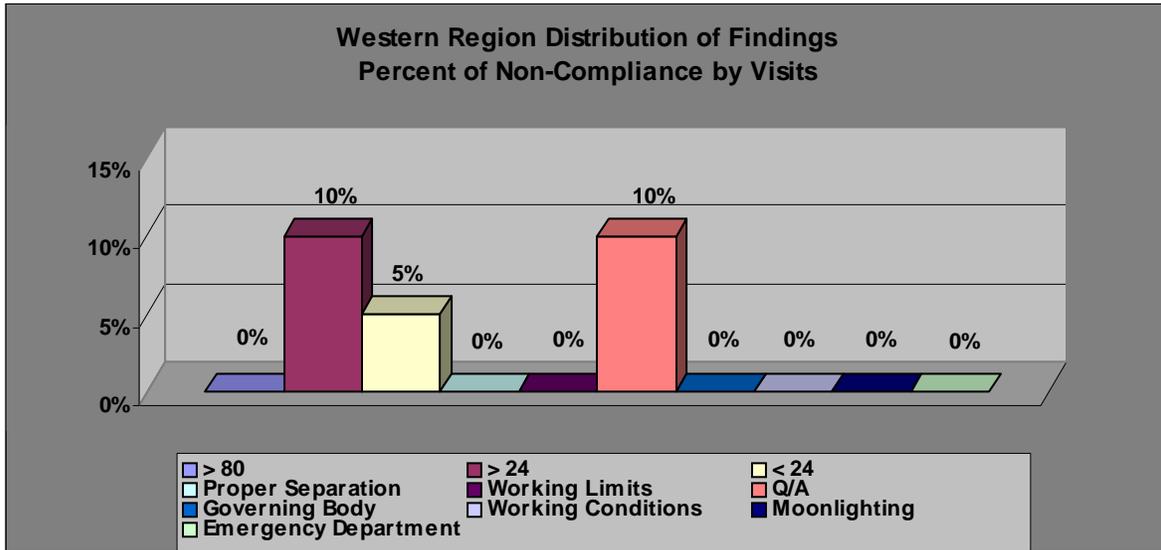
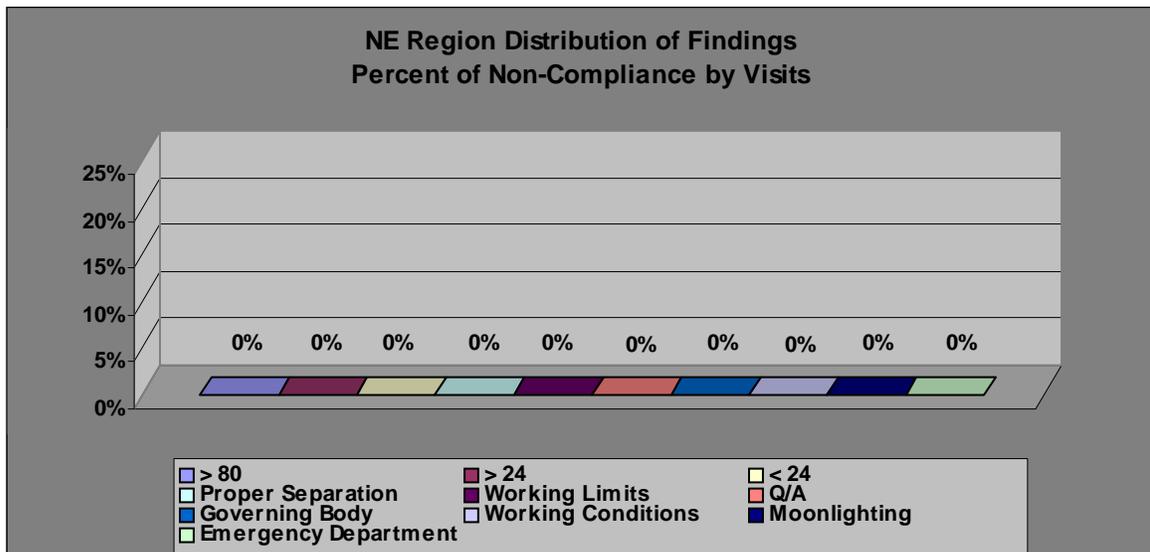


Exhibit 12



Exhibits 13 – 16 / Compliance Assessment – Working Hours > 24 Consecutive Hours

New York State regulations limit scheduled assignments to no more than 24 consecutive hours. In applying this standard and for determining compliance, an additional unscheduled transition period of up to three hours may be utilized by facilities to provide for the appropriate transfer of patient information.

Hospitals have some flexibility in utilizing the three-hour transition period to carry out rounds, grand rounds, and/or the transfer of patient information. New patient care responsibilities may not be assigned during the transition period, and the three-hour period, if used, is counted toward the weekly work hour limit of 80 hours.

For all surveys conducted in year five of the contract, this area was the most frequently cited. Statewide, non-compliance was evidenced in 18% of the surveys conducted. Exhibits 13 –16 further illustrate this finding by region, facility bed size, program size, and specialty.

Exhibit 13 – Based upon the 146 total visits performed, 25% of facilities in the New York City region were found to be out of compliance with this work hour regulation. The findings for the remaining regions are LHVLI at 14%, Western at 10%, and Northeast and Central at 0%.

Exhibit 13

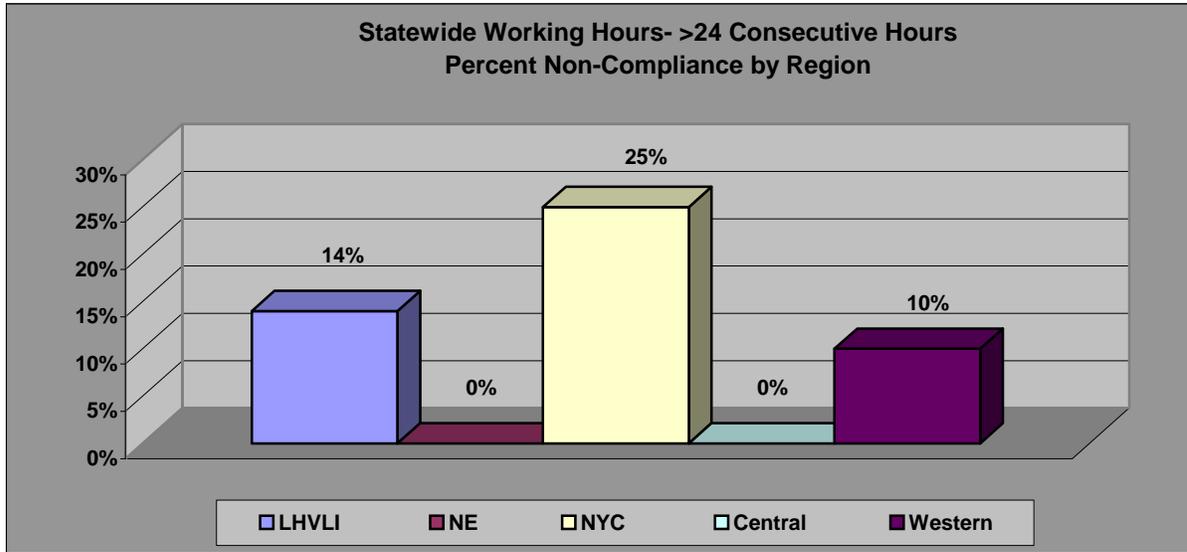
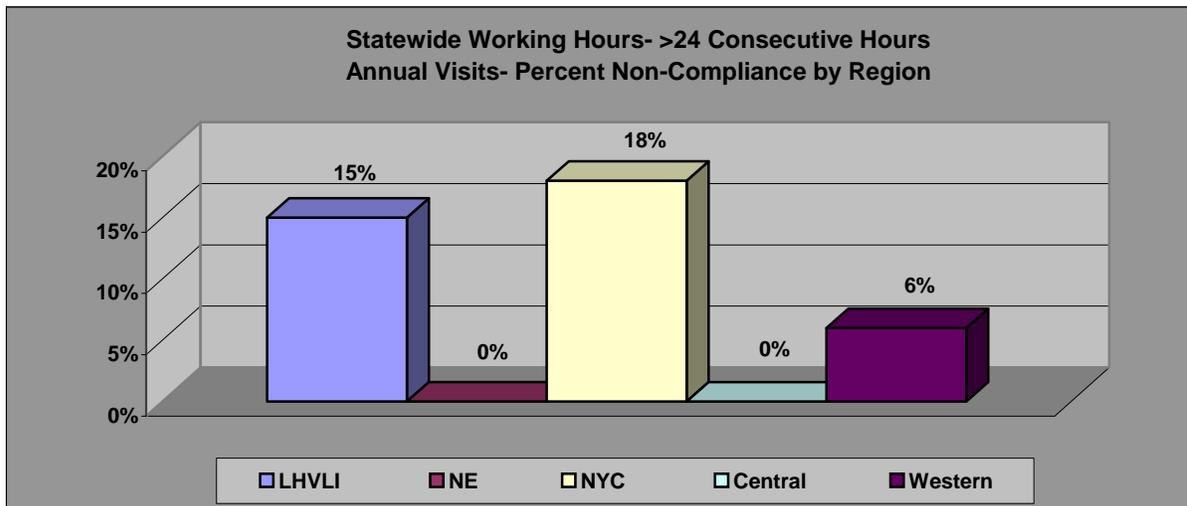


Exhibit 13a – In comparison, this exhibit is based upon the 121 annual visits performed. During the annual visit, New York City had 18% of facilities out of compliance with this work hour regulation. The findings for the remaining regions are LHVLI at 15%, Western at 6%, and Northeast and Central at 0%.

Exhibit13a



Exhibits 14 & 15 correlate findings to facility bed size and program size (number of residents) in a facility program. The highest percentage of findings for >24 hours was found in facilities with 601+ beds, followed by facilities with 401-600 beds and 201-400 beds for all visits and annual visits. The highest percentage of findings for >24 hours was also found in facilities with between 501+ residents in the facility teaching program, followed by facilities with between 101-300 residents and 301-500 residents at nearly the same rate of non-compliance for all visits and at the same rate of non-compliance for annual visits. Exhibits 14 & 15 are based on findings for the 146 total visits conducted. Exhibits 14a & 15a reflect findings for the 121 annual visits.

Exhibit 14

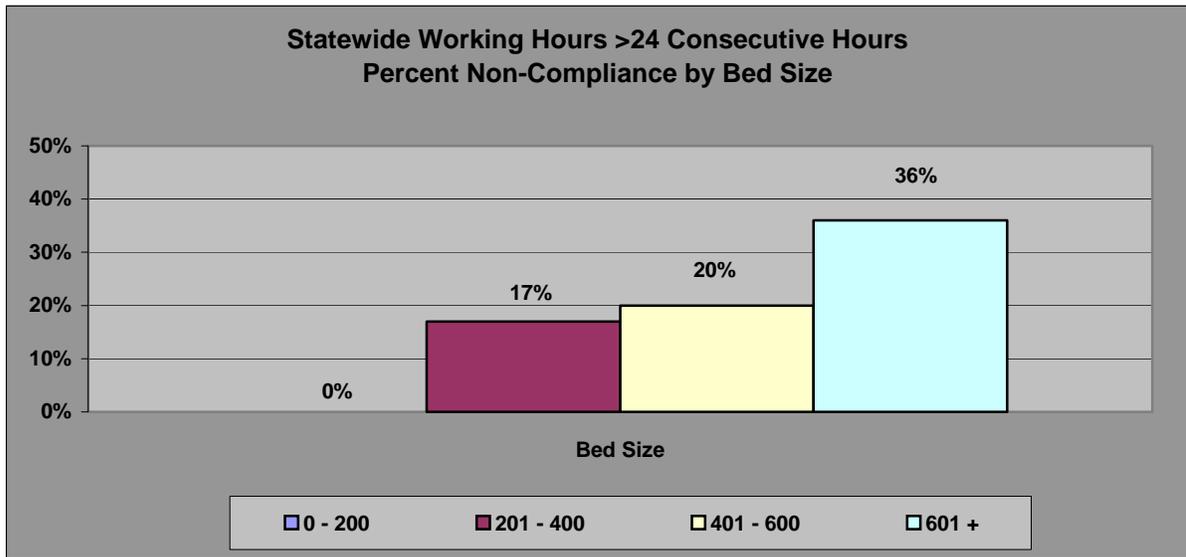


Exhibit 14a

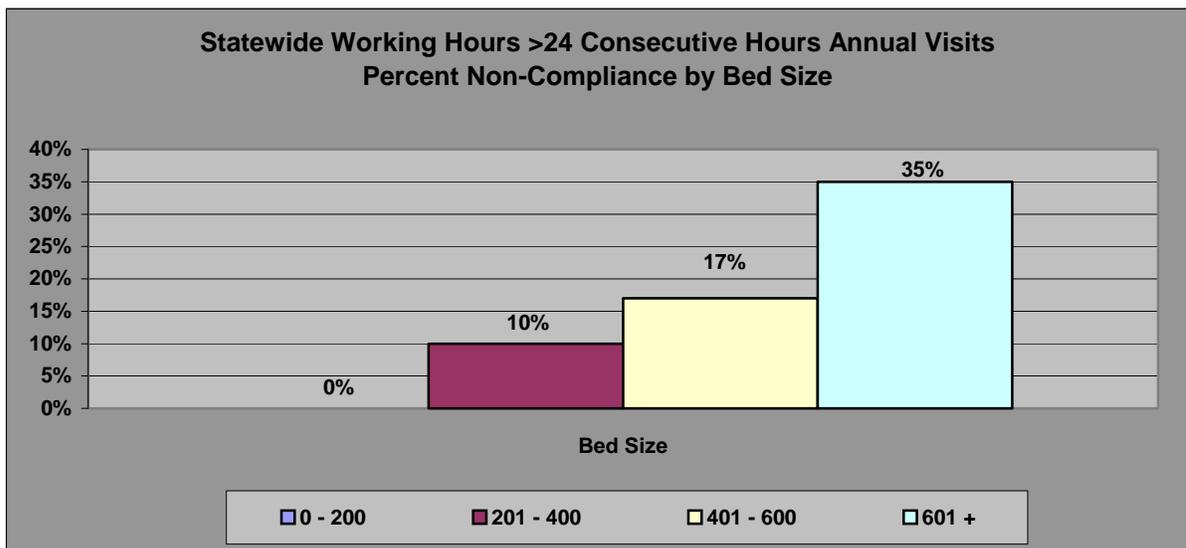


Exhibit 15

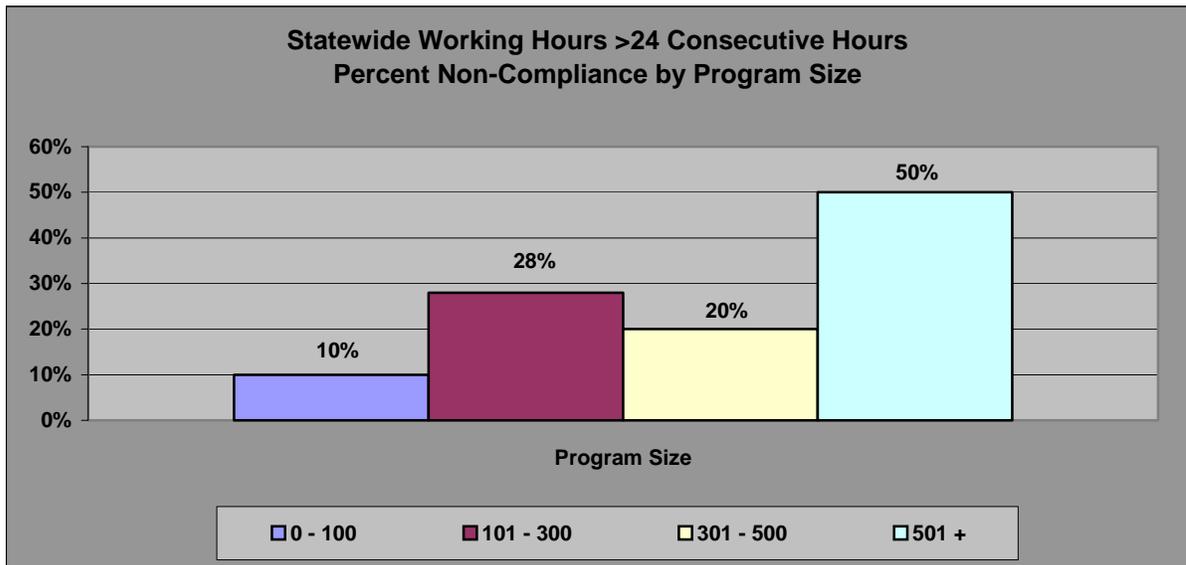
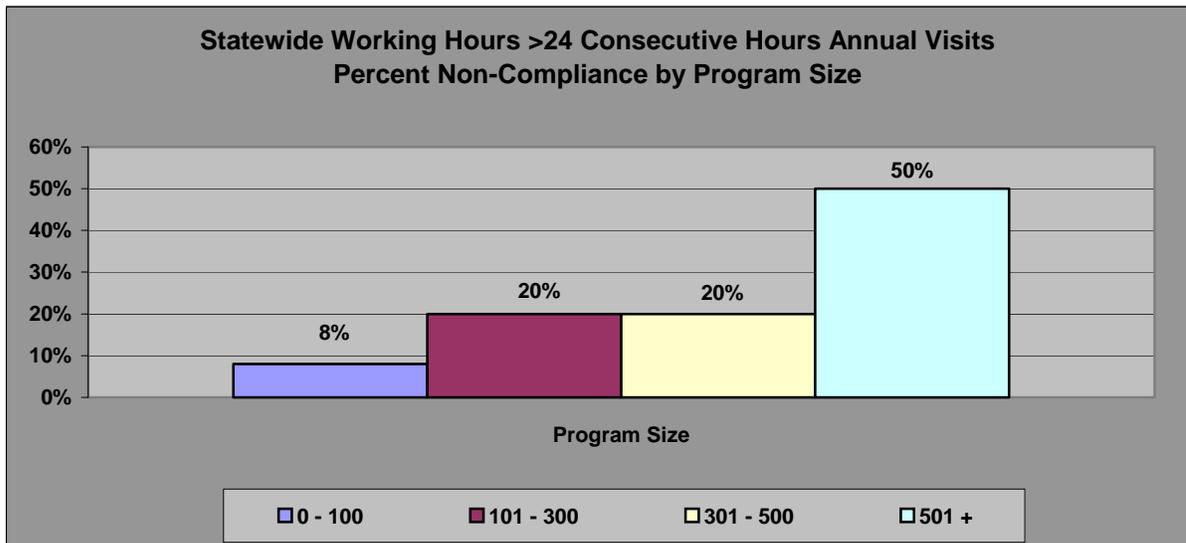
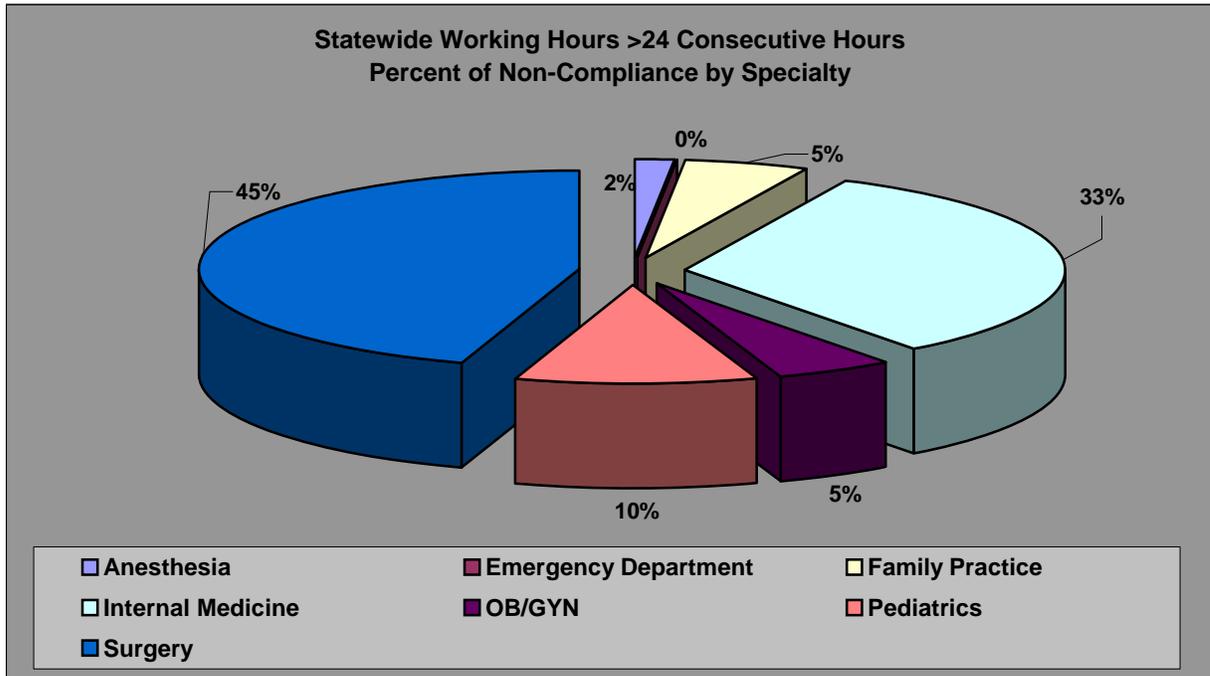


Exhibit 15a



As illustrated in Exhibit 16, based upon the 146 total visits conducted, there were 520 total outliers identified for non-compliance with regulations for >24 consecutive hours. Of the total outliers identified, surgery at 45% and internal medicine at 33%, were the most frequently identified specialty areas for > 24 consecutive hours. This can, in part, be attributed to the fact that each category includes findings associated with numerous subspecialties and account for 42% of the programs in teaching hospitals throughout the state.

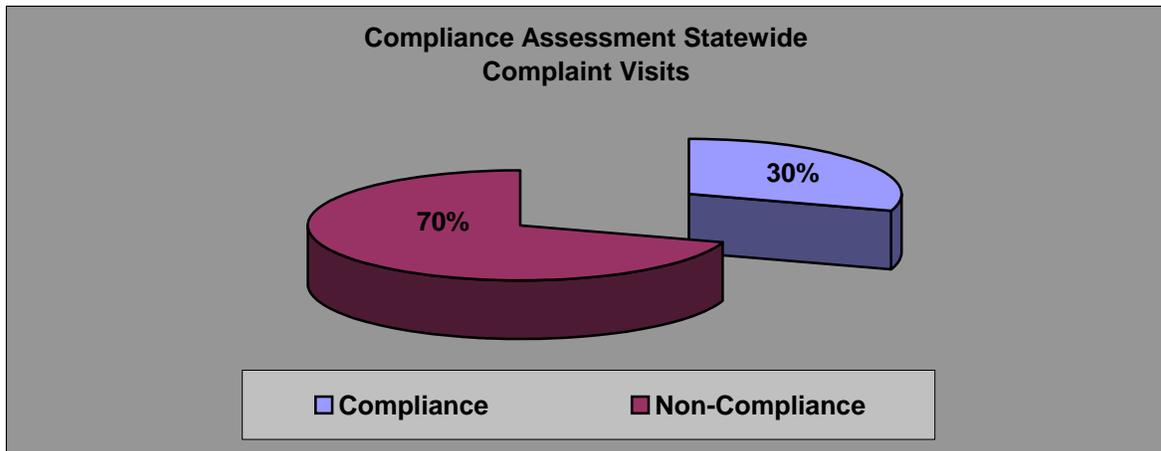
Exhibit 16



Exhibits 17 – 18 / Compliance Assessment – Statewide for Complaint Visits and Re-Visits

In accordance with program requirements, IPRO also evaluated and investigated complaints received by the DOH specific to resident working hours. In total, for year five of the contract, the DOH received 10 working hour complaints. Exhibit 17 indicates that 70% of complaints were substantiated following investigation. Six (6) of the 10 complaints related to surgical programs with five (5) of these complaints substantiated. Two (2) of the 10 complaints were specific to internal medicine programs and were substantiated. One (1) complaint related to an ob/gyn program, and one (1) complaint related to all programs in a facility, were not substantiated.

Exhibit 17



Revisits, focused reviews of previously identified issues, were conducted for a sample of facilities to monitor a facility's Plan of Correction implementation. In comparison to 17% non-compliance findings at annual compliance visits, at revisit, 67% of facilities were found in substantial compliance and 33% of facilities continued to evidence at least one element of non-compliance (Exhibit 18) at the time of the re-visit.

Exhibit 18

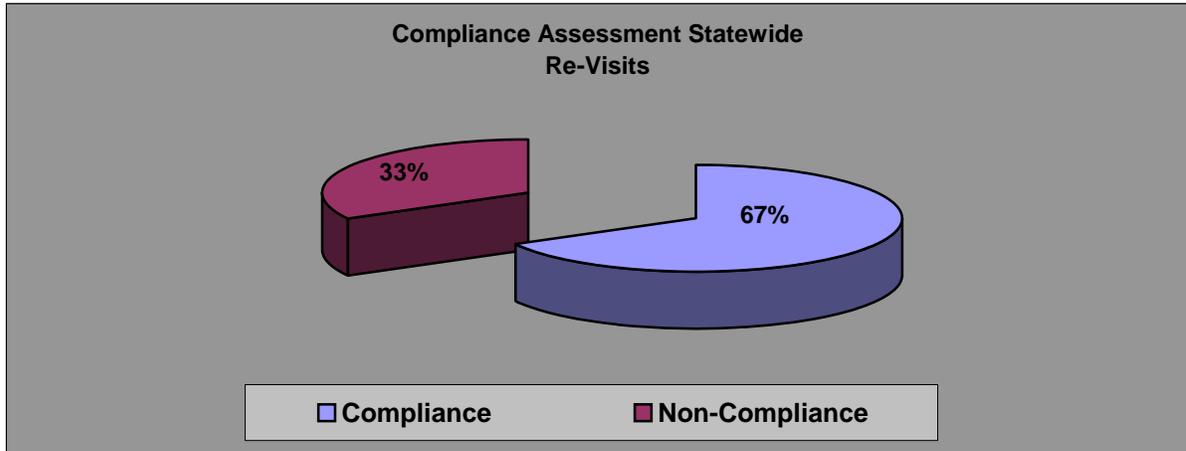
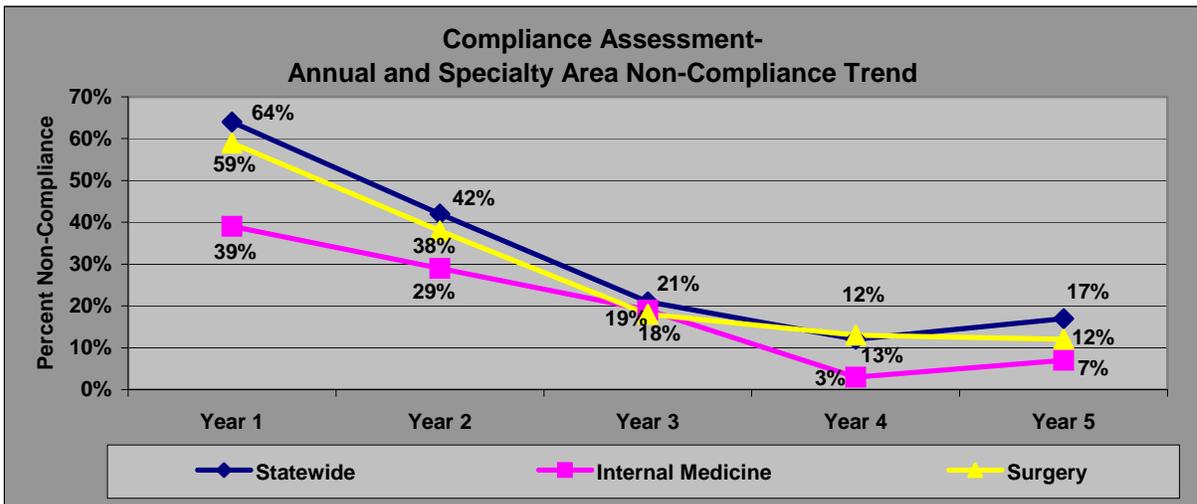


Exhibit 19 / Compliance Assessment – Annual and Specialty Area Compliance Trend

Throughout the five years of the contract, two specialty areas, internal medicine and surgery, were identified as the specialty areas most frequently cited for non-compliance with the regulations. IPRO has tracked these two specialty areas by specific citations.

Exhibit 19 demonstrates that as total annual visit compliance among facilities has improved statewide, compliance in these two specialty areas has improved at nearly the same rate.

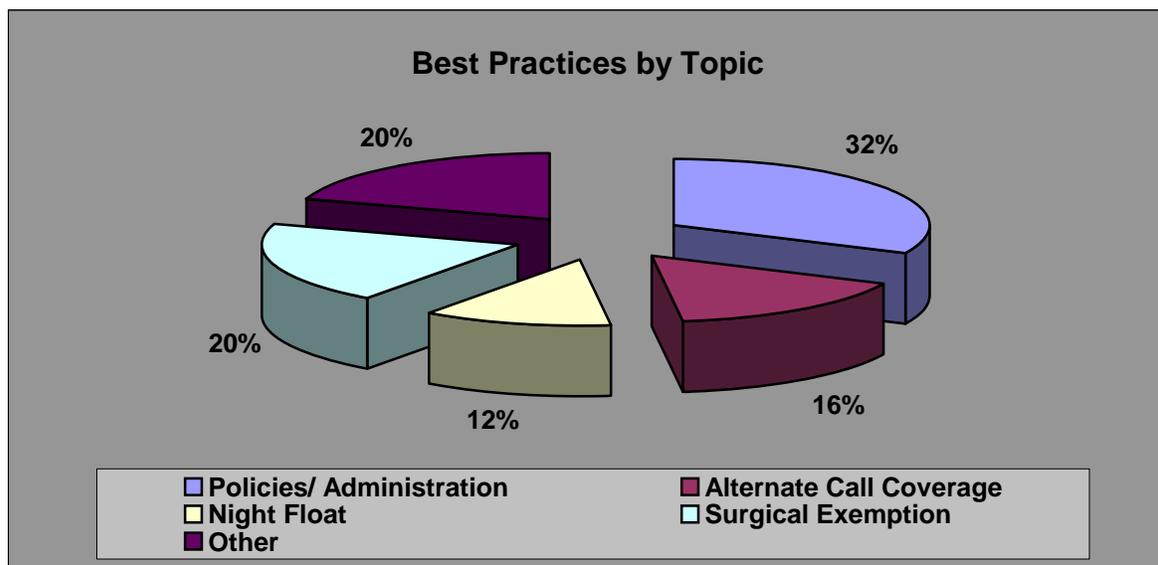
Exhibit 19



Program Strengths

Over a five year period of conducting compliance reviews, the most frequently noted compliance issue continues to be non-compliance with provisions that limit work hours to no more than 24 continuous hours + 3 hours for transition of patient care and/or education. Many facilities over the years have been innovative in taking steps to ensure compliance with this regulation as well as the other work hour limitations. IPRO has tracked these strategies and has frequently shared information with facilities during educational sessions or onsite reviews. It is important to provide a detailed list of these for review and discussion.

Below is a break out of program strengths by topic area. The largest changes have been in policies or administration at 32%, followed by surgical exemption at 20%, alternate scheduling at 16%, night float at 12%, and all other categories at 20%.



Policies and Administration:

- A strong GME office has been shown to facilitate the effective management of post-graduate training programs. Monitoring and collecting monthly schedules, including all rotations schedules, on calls schedules and rotators in from other facilities, promote sound management of the residency program. The GME office also, with the QI department monitors duty hours to ensure compliance with the work hour limitations and identify opportunities for improvement.
 - For example: One facility, schedules for 80 hours averaged over 4 weeks with only 10% variation per week.
- GME develops strong policies, which the facility and all departments adhere to including moonlighting, duty hours restrictions and QI activities.
- GME office has access to all schedules on a monthly or rotational basis, which include legends used to interpret the schedules.

- GME office performs work hour survey and develops the time frame for each including reporting structure for the survey results.
- GME office works with individual departments on use of monitoring tools such as time cards, compliance hotline, sign-in sign-out sheets and questionnaires;
 - For example: one facility uses a mock survey approach
 - Several facilities use an online survey system.
- GME office is able to interpret the difference between all regulatory requirements (State vs. ACGME) and assists individual departments in incorporating these into the scheduling practices of the individual departments.
- GME office has the ability to contact all program directors, program coordinators and / or residents to notify them of IPRO's arrival and need for access to them for completion of review.
- GME office confirms expectations for compliance to work hour limitations during facility orientation.

Alternate Call Schedule:

- Use of PA's for beeper call coverage
- Overnight attending coverage for call
- Use of team approach for coverage of call and for all team patients.
 - For example residents are placed on a team consisting of different PGY levels, this team then is responsible for 24- hour coverage of the team patients. If you have 6 residents 2 from each level 3 would work the day coverage and 3 would work the night coverage.
- Use of fellows to support call coverage

Night Float System:

- 6 surgical programs have initiated use of a night float system. While there has been much discussion on the negatives of using a night float system in surgery (i.e., lack of surgical observations, shift mentality, etc.), the residents in these programs express satisfaction with these systems and improved quality of life.
- Medicine has historically used night float system. We have seen unique use of these with long call or short call, many of which start at 9 pm which allows residents to attend morning report thereby meeting the educational component.
- Use of night float in medical ICU.

Surgical exemption:

- Many facilities that originally were using surgical exemption have stopped the use of it due to difficulties in the system. Those still using surgical exemption have:
 - Clear policies in place
 - Use PA's and/or fellows to cover call for sleep
 - Coverage of sleep by dental and OMFS residents
 - Clear documentation of required period of rest/ sleep
 - Clear system for relief if rest/ sleep is interrupted.

Other:

- Facility notification of IPRO's arrival.
- Education to residents during orientation and when changing rotations, on expectations for compliance.
- Facilities use Power point presentations placed on line for alternate education of post-call residents. These are accessible for review at any time allowing post call residents to go home, but still receive the educational component.
- Taping or video casting of grand rounds for post-call residents which allows for review at any time allowing post call residents to go home, but still receive the educational component.
- Plan of Correction binder system, which collects all documentation validating that, the steps highlighted by the facility to achieve compliance have been taken.

Future Opportunities

The program to conduct the focused review of working hours in teaching hospitals across New York State is supported by legislation and program funding. The fifth contract year was completed September 30, 2006. During the next contract period:

- DOH and IPRO staff will continue to work with the provider community to clarify program requirements and assist facilities in the development and implementation of strategies for ensuring compliance. IPRO will continue to identify and provide facility contact between programs requiring assistance and programs performing well.
- Continued attention in the review process will be given to ensuring that previously identified problems have been corrected. Data will be collected to evaluate facility QA/QI initiatives and assess the effectiveness of such measures. Review activities will recognize facilities that have exhibited a commitment to ensuring compliance. In addition, attention will focus on the obligations of each hospital's Governing Body to assure compliance and to address previously identified problems.
- Facilities that evidence repeat non-compliance will be closely monitored to ensure that each facility's plan of correction is fully implemented. The effectiveness of facility QA/QI initiatives will be documented.
- Efforts will continue to focus on identifying facility processes that improve compliance levels, while continuing to meet accreditation requirements. State requirements will be evaluated in the context of other national accreditation requirements to identify potential areas of inconsistency or concern. Information will be shared with all hospitals to assist in identifying and evaluating the impact of all applicable requirements. Of note, one of JCAHO's patient safety goals for 2007 focuses upon handoff of patient information. This affects both resident-to-resident and resident to attending handoffs.
- A staggered survey schedule will be used to ensure that scheduling alone does not impact compliance findings.
- Review staff will continue to evaluate the effectiveness of the unannounced visit by documenting actions taken during the first several hours of the survey. To facilitate the survey process, entrance and exit conferences will remain optional meetings to reduce concerns raised by facilities that surveys are disruptive to facility operations and that convening key hospital personnel on short notice is difficult. It is recognized that the process of assembling an impromptu group of key personnel to attend the entrance and/or exit conferences, can be inconvenient and may be unnecessary to expedite the survey process. Upon entering a facility, IPRO review staff will contact the designated facility representative and/or alternate, conduct a brief and informal entrance conference, and request assistance in facilitating the review team's access to patient care areas and in scheduling interviews. A more formal entrance and exit conference is not necessary, but can be scheduled at the request of the facility. Survey findings are only released to facilities by the DOH upon receipt/review of the documentation submitted to the DOH by IPRO.
- Alternative on-site review protocols will continue to be developed and implemented to promote the accuracy and legitimacy of survey findings. Compliance findings will continue to be based upon a wide range of review activities. Observation, interview and the detailed

review of policies/procedures, internal review activities, medical records, operative reports/logs, and other records/documents, currently serve as the basis of all review findings.

- IPRO will continue to identify other studies, which when complete can assist facilities with focus areas to accomplish the greatest impact. Two studies performed to date, the PGY >24 consecutive hours and surgical exemption study, provided such opportunity.
- Management staff will work with the facility's program organization staff; i.e., program directors, program support coordinators, etc., to clarify understanding of regulations and needs of the review staff during the survey process.
- IPRO will collaborate with the residency program's primary and affiliated rotation sites to ensure they understand their responsibility for ensuring compliance.
- Review staff will continue to update facility contact information during the entrance conference and IPRO will continue to keep an updated listing of facility CEO and residency program contacts.
- IPRO will continue to provide formal and informal education to assist facilities in achieving compliance.
- IPRO will continue to review schedules, as requested by facilities, to assist them in achieving compliance.

Summary of Exhibits

- Exhibit 1 Implementation –Annual Compliance Visits Statewide by Month
- Exhibit 2 Implementation – Annual Compliance Visits Regional by Quarter
- Exhibit 3 Compliance Assessment – Statewide / Annual Compliance Visits
- Exhibit 4 Compliance Assessment – Regional / Annual Compliance Visits
- Exhibit 5 Statewide Annual Visit Compliance– Distribution of Visits to Findings of Non-Compliance
- Exhibit 5a Statewide Annual Visit Compliance– Visits by Month Compliance Comparison Years 1-5
- Exhibit 5b Statewide Annual Visit Compliance– Visits by Month Compliance Comparison Years 1-5
- Exhibit 6 Statewide Annual Visit Compliance – Distribution of Non-Compliance to Bed Size
- Exhibit 7 Statewide – Distribution of Findings/ Total Visits
- Exhibit 8 New York City Region – Distribution of Findings/ Total Visits
- Exhibit 9 Lower Hudson Valley & Long Island Region – Distribution of Findings/ Total Visits
- Exhibit 10 Central Region – Distribution of Findings/ Total Visits
- Exhibit 11 Western Region –Distribution of Findings/ Total Visits
- Exhibit 12 Northeast Region –Distribution of Findings/ Total Visits
- Exhibit 13 Statewide - > 24 Hours by Region/ Total Visits
- Exhibit 13a Statewide - > 24 Hours by Region/ Annual Visits
- Exhibit 14 Statewide - > 24 Hours by Facility Bed Size/ Total Visits
- Exhibit 14a Statewide - > 24 Hours by Facility Bed Size/ Annual Visits
- Exhibit 15 Statewide - > 24 Hours by Program Size/ Total Visits
- Exhibit 15a Statewide - > 24 Hours by Program Size/ Annual Visits
- Exhibit 16 Statewide - > 24 Hours by Specialty/ Total Visits
- Exhibit 17 Compliance Assessment – Work Hour Complaint Visits

Exhibit 18 Compliance Assessment – Hospital Re-Visits

Exhibit 19 Compliance Assessment – Annual and Specialty Area Non-Compliance Trend

Appendices

Appendix A

Appendix A contains the following comparison exhibits based on total visits conducted at facilities in Year one and two:

- Exhibit 20 Year 1- 5 Comparisons Assessment - Annual Compliance Visits Statewide by Month
- Exhibit 21 Year 1- 5 Comparisons Compliance Assessment- Statewide Annual Compliance Visits
- Exhibit 22 Year 1- 5 Comparisons Compliance Assessment- Regional Annual Compliance Visits
- Exhibit 23 Year 1- 5 Comparisons Compliance Assessment- Statewide Distribution of Findings
- Exhibit 24 Year 1- 5 Comparisons Compliance Assessment- New York City Region Distribution of Findings
- Exhibit 25 Year 1- 5 Comparisons Compliance Assessment- Lower Hudson Valley & Long Island Region Distribution of Findings
- Exhibit 26 Year 1- 5 Comparisons Compliance Assessment- Central Region Distribution of Findings
- Exhibit 27 Year 1- 5 Comparisons Compliance Assessment- Western Region Distribution of Findings
- Exhibit 28 Year 1- 5 Comparisons Compliance Assessment- Northeast Region Distribution of Findings
- Exhibit 29 Year 1- 5 Comparisons Compliance Assessment- Statewide >24 by Region
- Exhibit 30 Year 1- 5 Comparisons Compliance Assessment- Statewide >24 by Facility Bed Size
- Exhibit 31 Year 1- 5 Comparisons Compliance Assessment- Statewide >24 by Program Size
- Exhibit 32 Year 1- 5 Comparisons Compliance Assessment- Statewide >24 by Specialty
- Exhibit 33 Year 1- 5 Comparisons Compliance Assessment- Statewide Complaint Visits
- Exhibit 34 Year 1- 5 Comparisons Compliance Assessment- Statewide Re-Visits

* Data reported reflects a compilation of information and data collected through routine surveillance activities. The information is based upon a sample of post-graduate trainees in New York State.

Exhibit 20

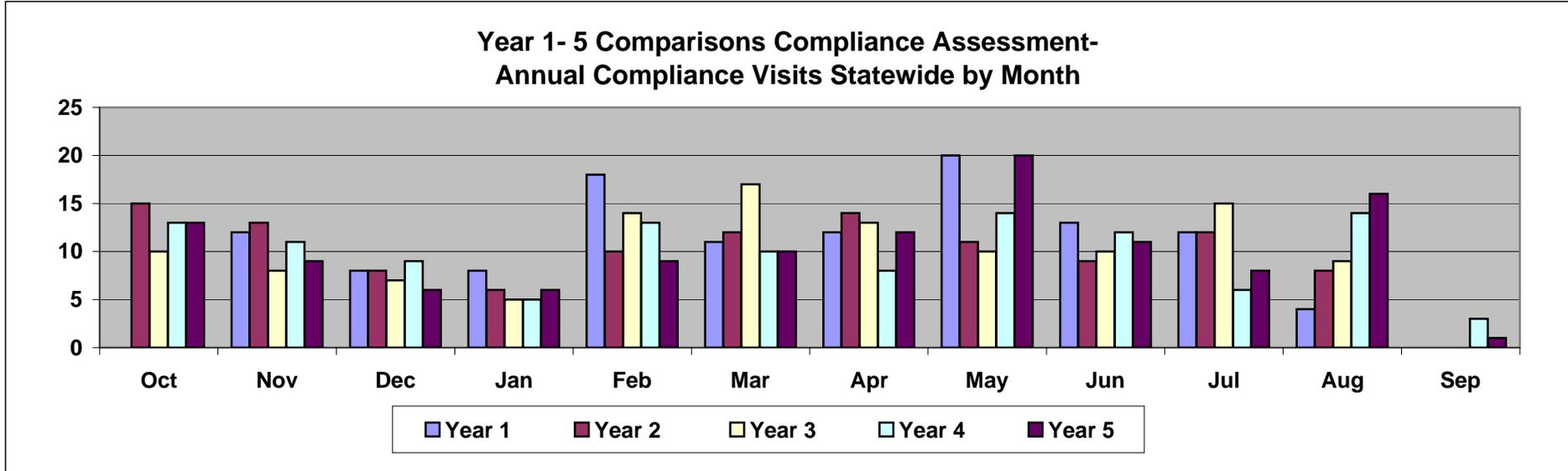


Exhibit 21

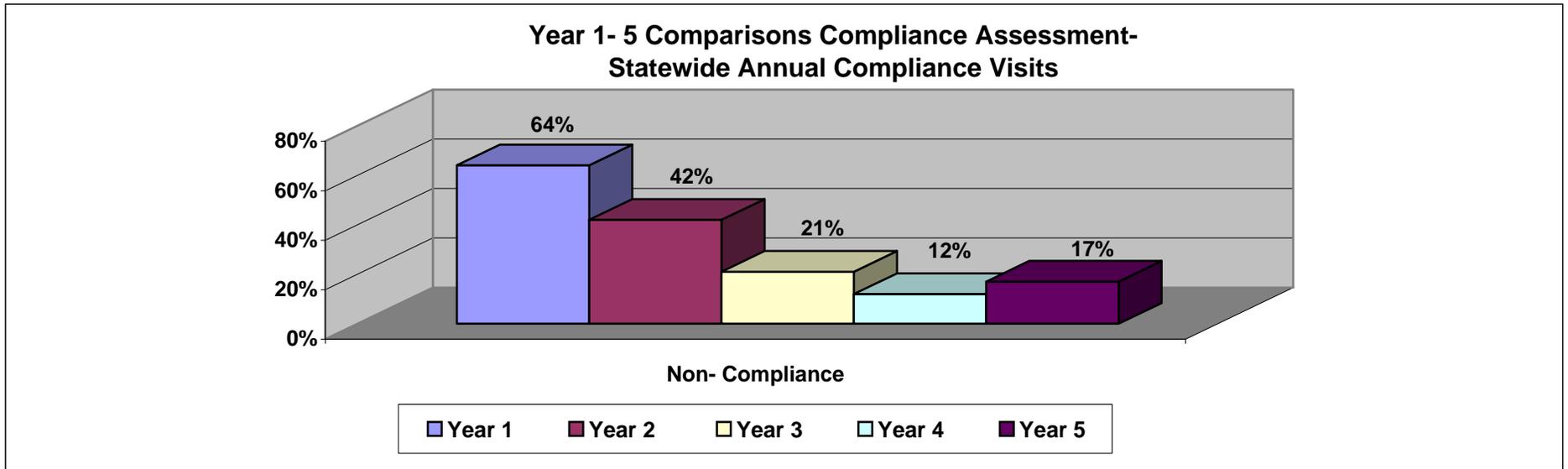


Exhibit 22

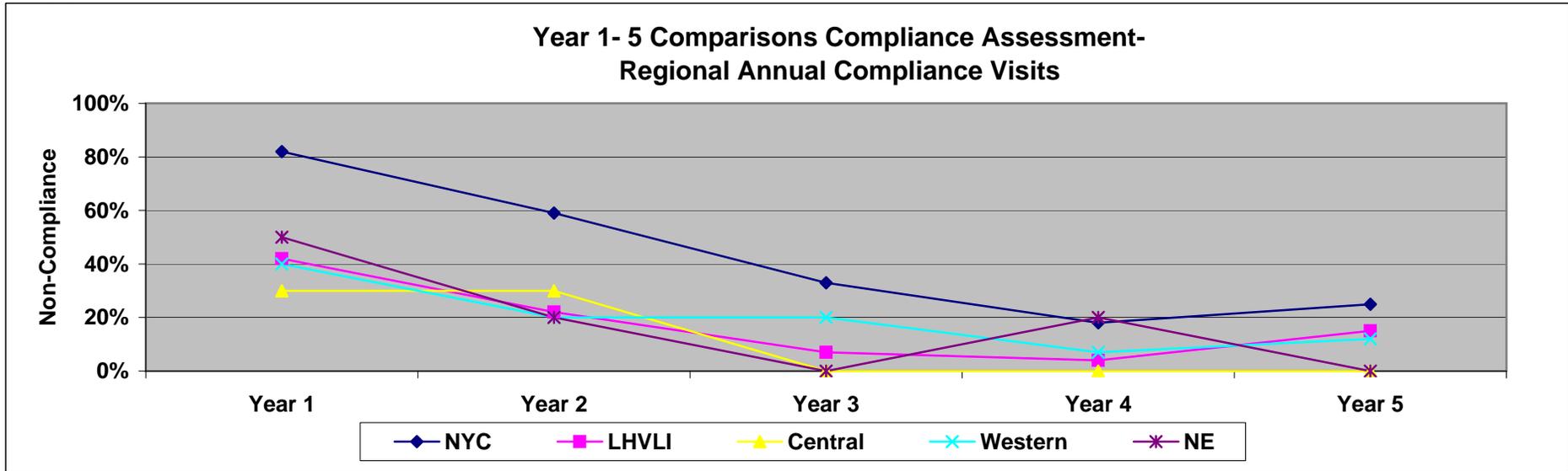


Exhibit 23

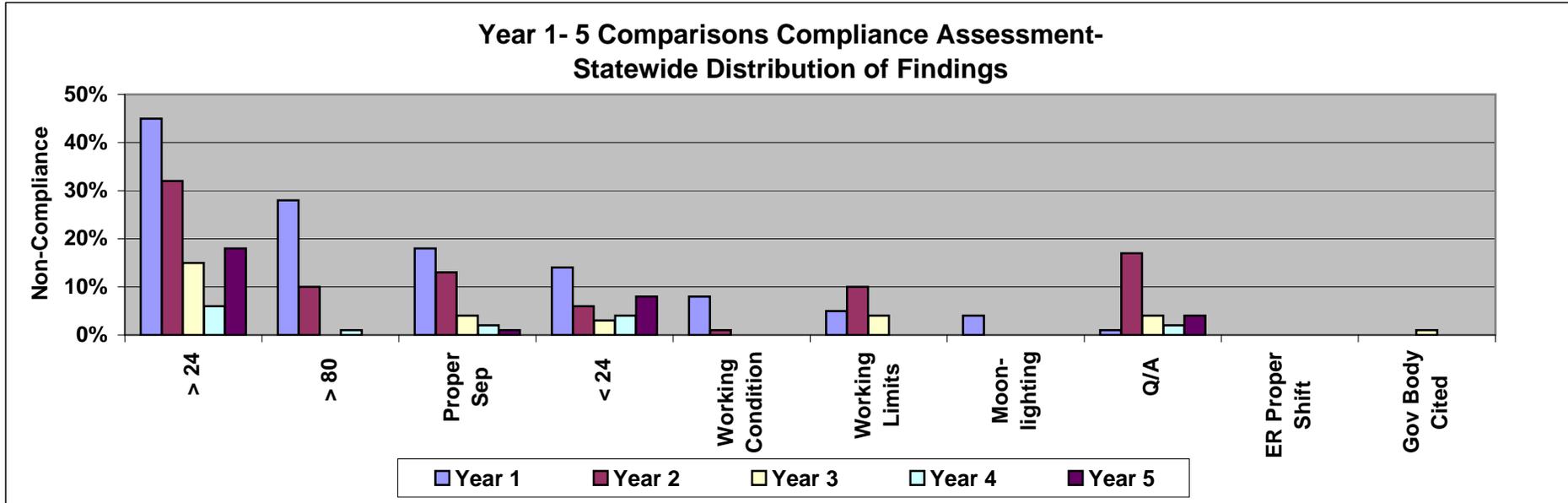


Exhibit 24

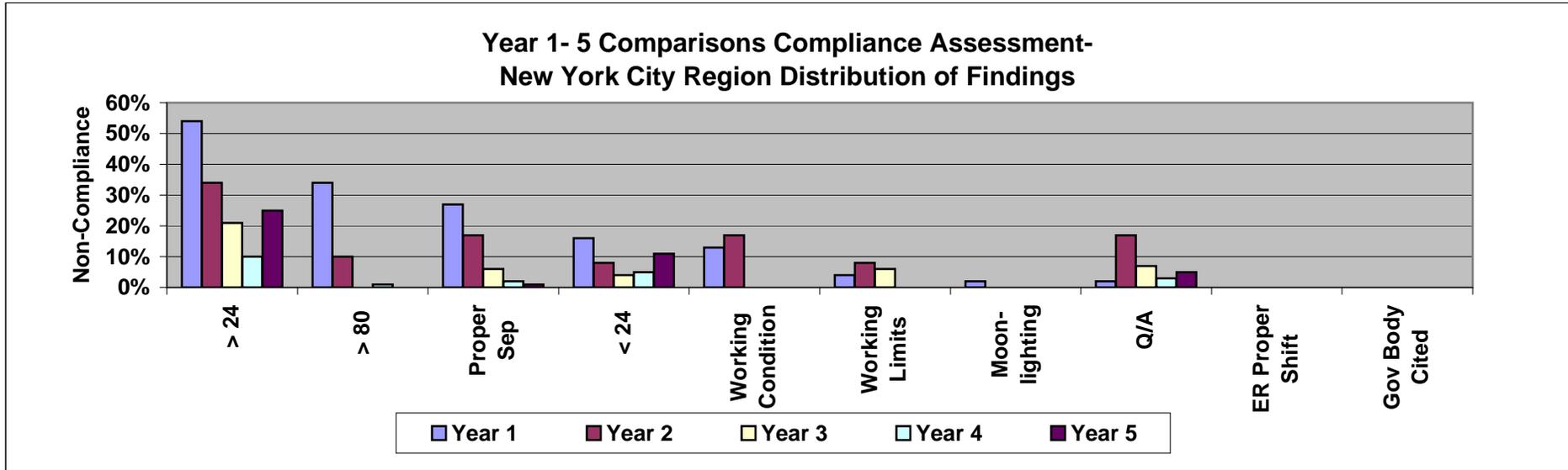


Exhibit 25

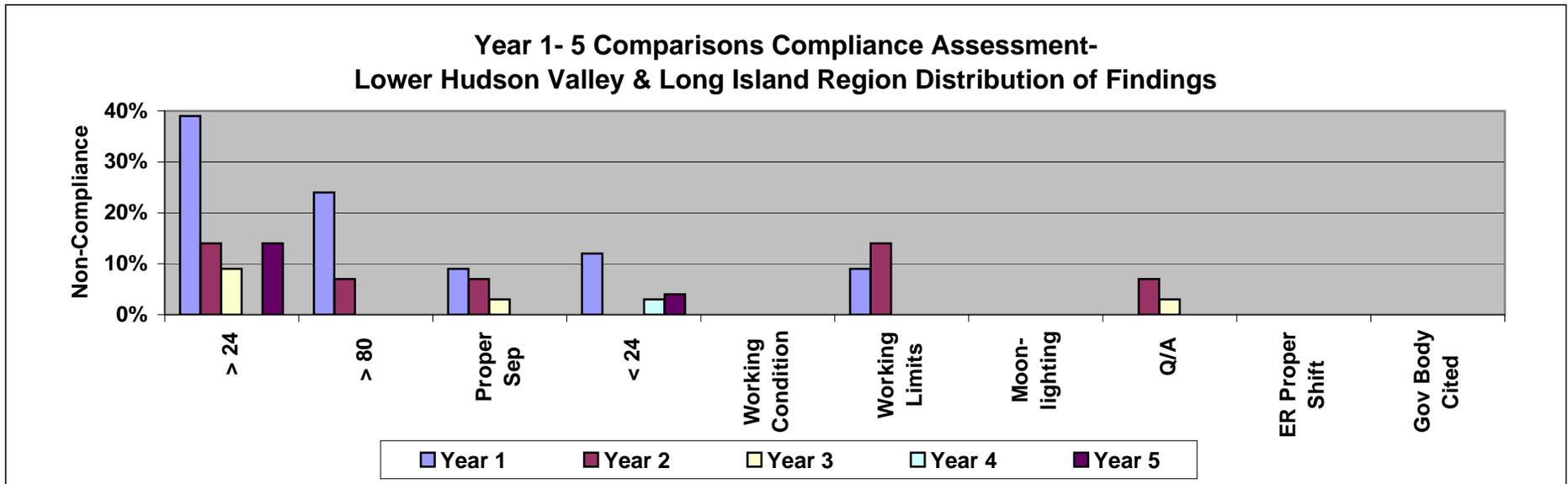


Exhibit 26

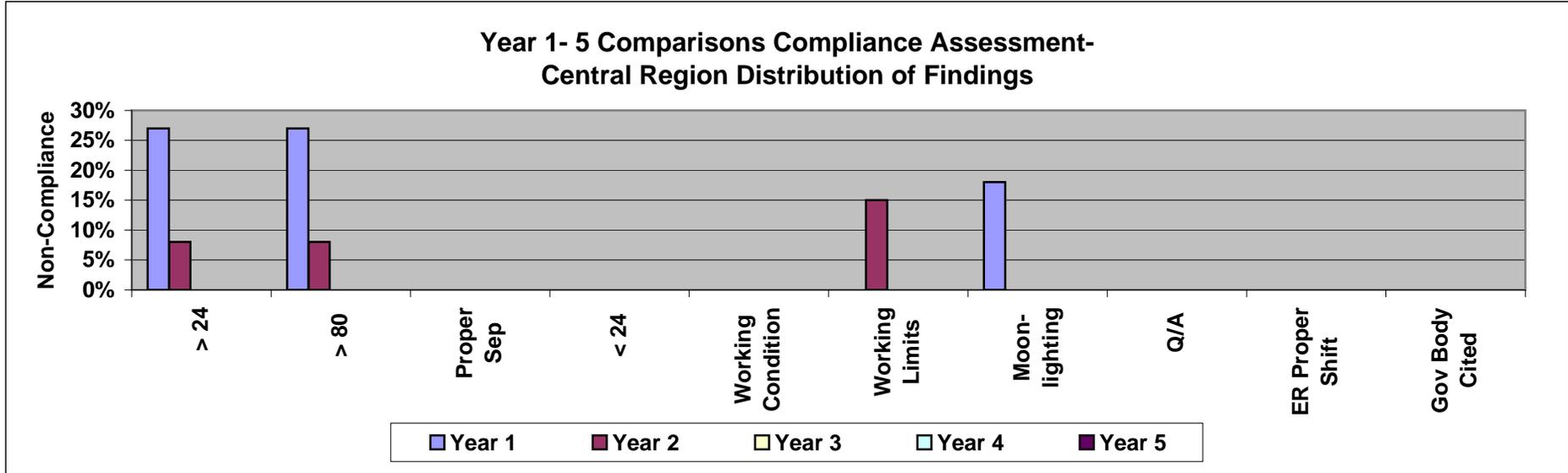


Exhibit 27

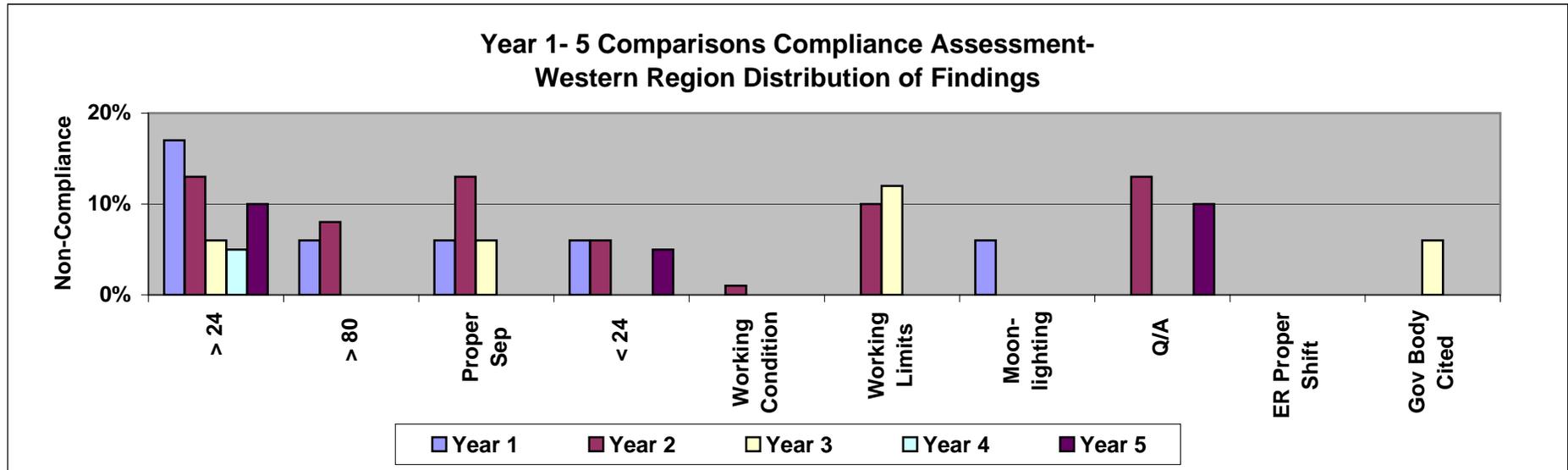


Exhibit 28

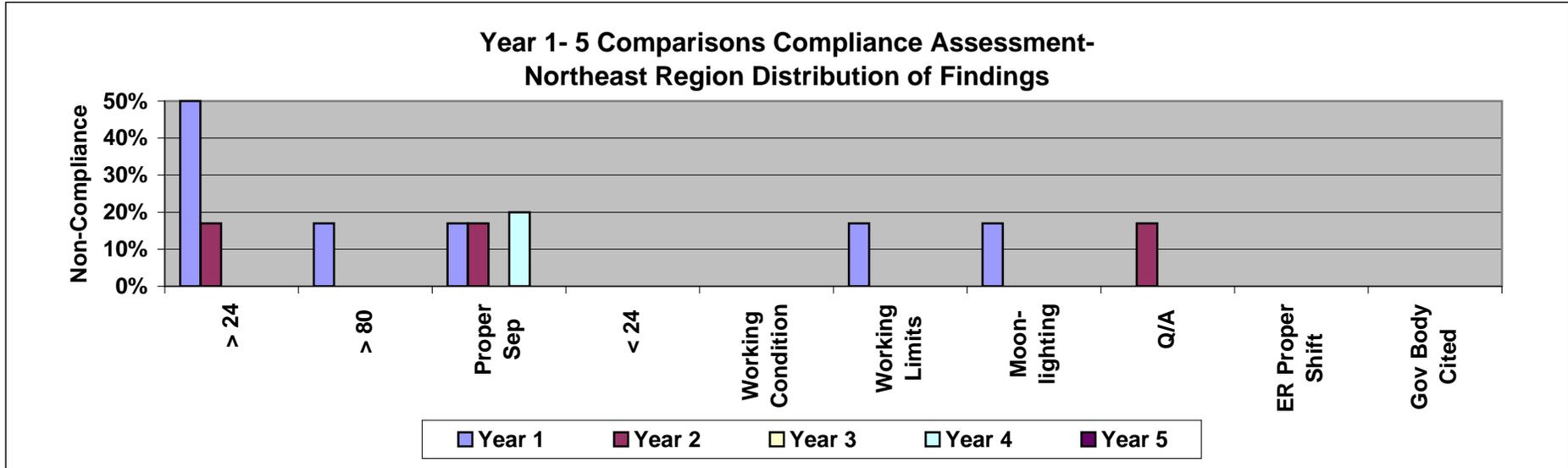


Exhibit 29

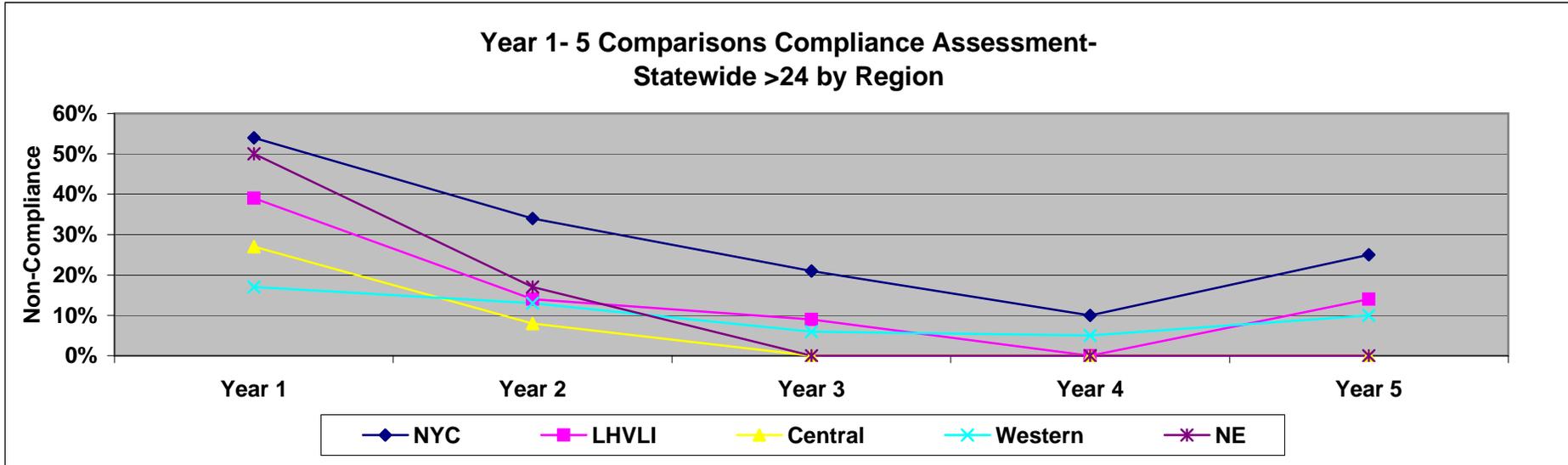


Exhibit 30

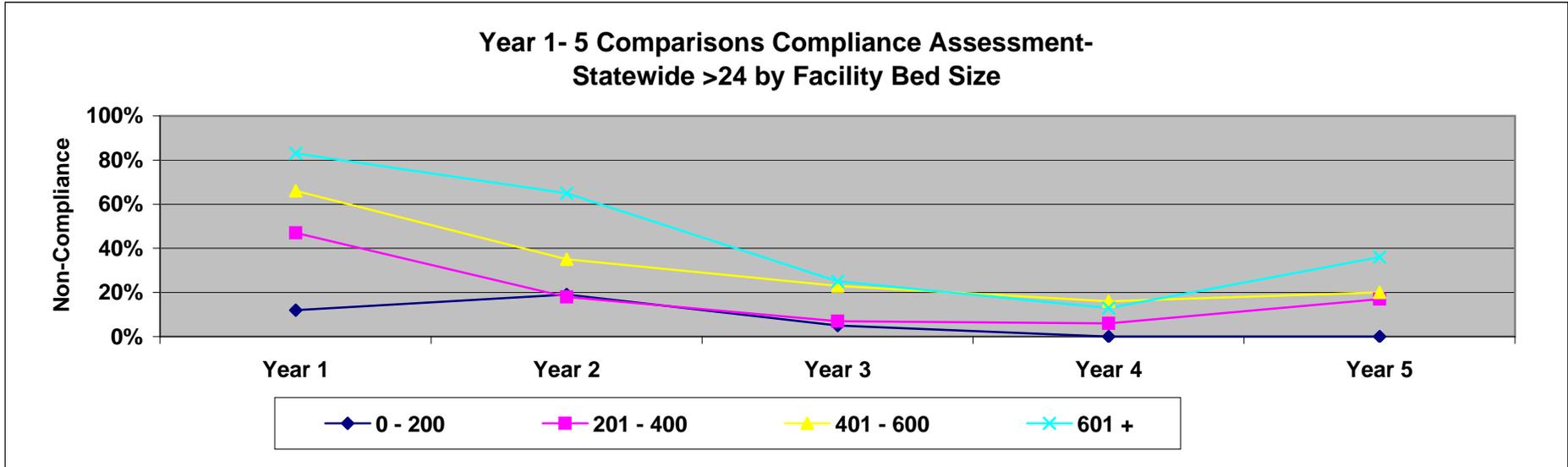


Exhibit 31

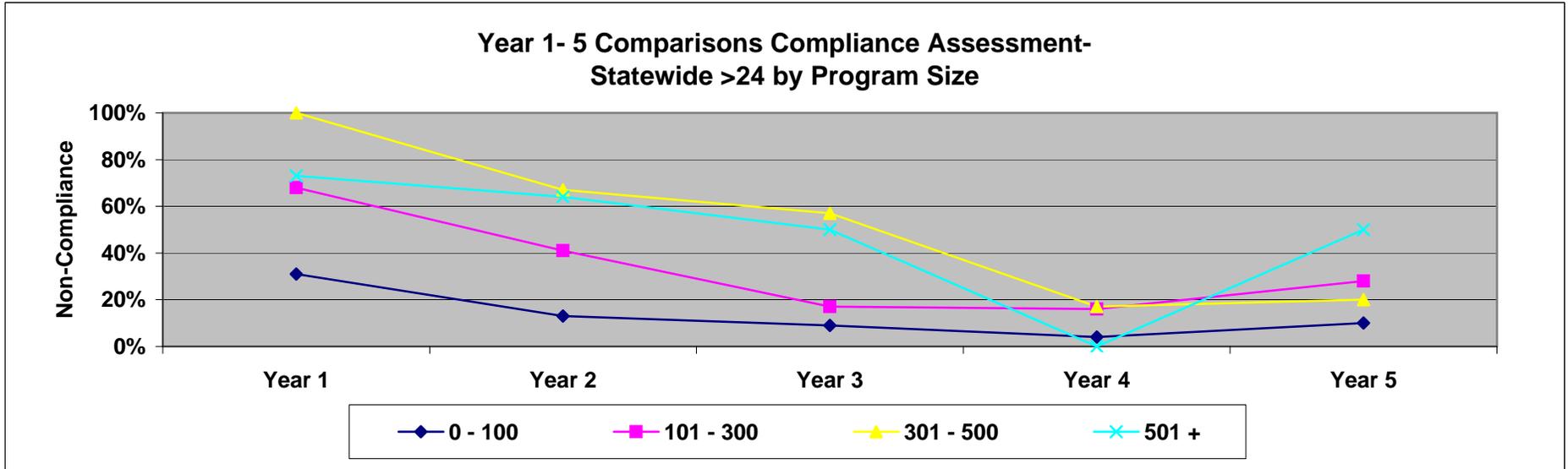


Exhibit 32

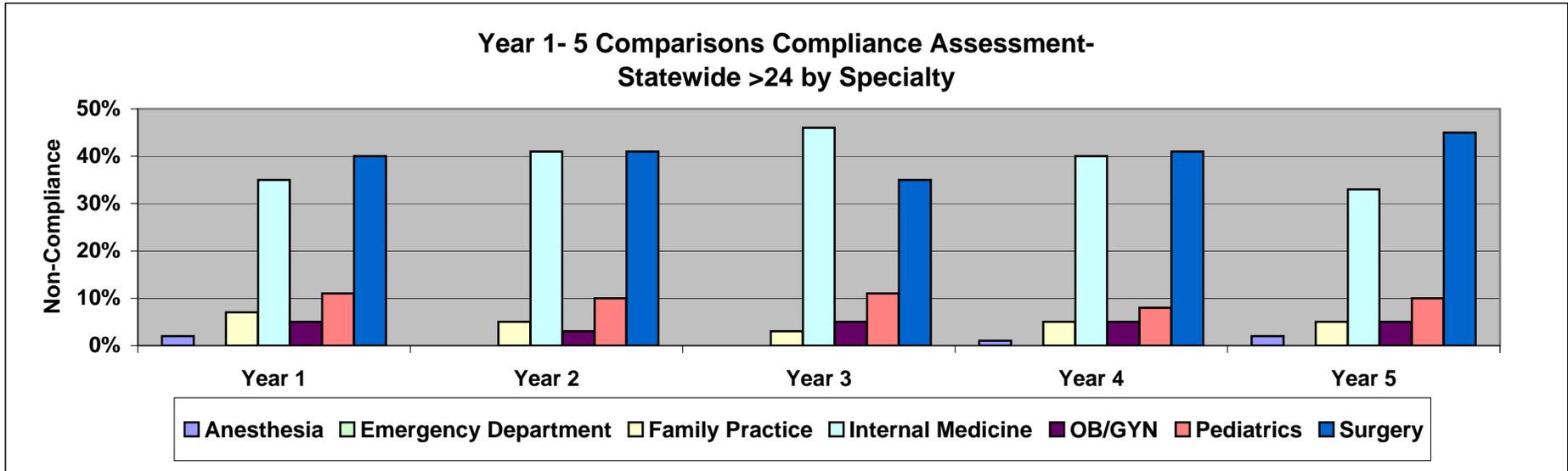


Exhibit 33

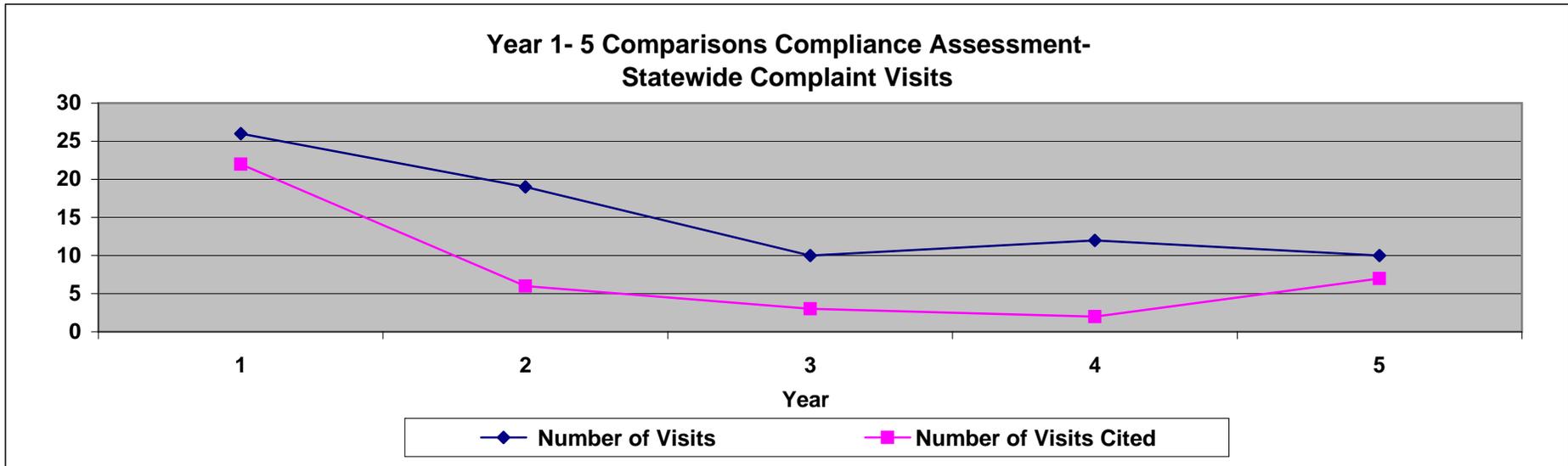


Exhibit 34

