ACGME Quality Care and Professionalism Task Force

Susan Day, MD and E. Stephen Amis, Jr, MD, Co-Chairs

Draft Standards Overview

AAMC Teleconference, July 14, 2010

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ACGME Duty Hours History

- 2003 - ACGME duty hours standards went into effect; committed to revisit in 5 years
- Feb. 2008 - Began review process
  - International Symposium on Resident Duty Hours and the Learning Environment, held March 2009
  - Task Force convened June 2009

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Task Force Background

- Co-chairs:
  - E. Stephen Amis, M.D., Chair CRC, University Chair, Department of Radiology, Albert Einstein College of Medicine and Montefiore Medical Center
  - Susan H. Day, M.D., Chair ACGME Board, Chair, Department of Ophthalmology, California Pacific Medical Center
- Vice Chair
  - Thomas Nasca, M.D., M.A.C.P, CEO ACGME

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Task Force Background

- 16 members
  - Medical, surgical & ancillary specialty representatives (all RRC chairs)
  - Three residents
  - One public member
- Combined 250+ years clinical education experience

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Duty Hours Task Force

E. Stephen Amis, Jr., MD - RRC Chair, Radiology, CRC Chair – Co-Chair
Susan Day, MD - Ophthalmology. Board Chair, ACGME – Co-Chair
Thomas J. Nasca, MD, MACP - Nephrology. CEO, ACGME – Vice Chair
Paige Amidon – ACGME Board Director, Public Director
Jaime Bohl, MD – CRCR Resident Member, Colon and Rectal Surgery
Lois Bready, MD – former RRC Chair, Anesthesiology
Ralph Dacey, Jr., MD – RRC Chair, Neurosurgery
Rosemarie Fisher, MD – RRC Chair, Internal Medicine. CRC Vice Chair
Timothy Flynn, MD – Vascular Surgery. ACGME Board Chair-Elect
Stephen Ludwig, MD – RRC Chair, Pediatrics
Robert Muelleman, MD – RRC Chair, Emergency Medicine
Janice Nevin, MD, MPH – former RRC Chair, Family Medicine
Meredith Riebschleger, MD – CRCR Resident Member, Pediatrics
William Walsh, MD, MPH – ACGME Board Director, Pulmonary & Critical Care
George Wendel, Jr., MD – RRC Chair, Obstetrics and Gynecology
Thomas V. Whalen, MD – RRC Chair, Surgery

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Task Force Process

- Extensive data-gathering
  - National Duty Hours Congress, June 2009
  - Commissioned 3 independent reviews of literature on sleep issues and patient safety
  - Conducted Web-based survey of DIOs, program directors, faculty & residents
  - Solicited position statements from member and constituent organizations, patient safety groups and individuals
  - 10 meetings of TF, both face-to-face and virtual, from July 2009 – April 2010

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Task Force Process - Expert Testimony in the Following Areas:

- History and impact of 2003 duty hours standards
- Report of Monitoring Committee on duty hours
- Sleep research and physiology
- Historical/political framework of IOM Report and duty hours
- Patient safety, quality, and the teaching hospital
- Safety net hospitals
- New York hospitals' experience (405 Regulations)
- Duty hours and the legal perspective
- Fatigue management strategies
- Public patient safety advocates

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Task Force Process

- Received written positions of more than 100 medical organizations
- Received testimony from nearly 100 individuals in the U.S., Canadian and U.K. medical communities
  - Including four IOM committee members
  - Invited three IOM members back for more in-depth discussions

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Task Force Objectives

- To ensure:
  - Patients receive safe, quality care in the teaching setting today
  - Graduating residents provide safe, high quality patient care in the unsupervised practice of medicine in the future
  - Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

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Guiding Principles

- Patient safety, quality care and an excellent learning environment are about much more than duty hours
- Draft standards should be a coherent package
- One size doesn't fit all--standards must match residents' level of experience and emerging competencies
- Medical profession has a moral responsibility to prepare residents to practice medicine safely and effectively beyond the GME learning environment

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Key Issues

- Need to address all aspects of the learning environment, **not just duty hours**
  - Professionalism
    - Accept personal responsibility for patient safety
  - Alertness management
  - Proper supervision
  - Transitions of care
  - Clinical responsibilities/workload
  - Communication/teamwork

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Additional Considerations

- Sleep physiology
  - Acute sleep deprivation
    - Decreased performance
    - Major studies were laboratory-based and not in a clinical environment
    - Fatigue is poorly self-assessed by residents
    - Decrement in performance tends to occur at about 16 to 18 hours of continuous wakefulness

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Additional Considerations

- Sleep physiology (continued)
  - Chronic sleep loss
    - Cumulative
    - Also poorly self-assessed
  - Individual variation
    - Some residents tolerate long hours better than others

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Additional Considerations - Evidence

- Work intensity/workload have greatest impact on least experienced
  - Only evidence connecting medical errors to lack of sleep is study of PGY-1s
- No definitive evidence to support a maximum of four consecutive nights of night float
- Evidence from other vocations (airline pilots, truck drivers) does not necessarily apply to physician work
- Techniques for detecting fitness for duty are under development, but not yet of generalized utility in the medical setting
- Concept of fatigue recognition and management is very important

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Additional Considerations - Evidence

- Large studies (VA and Medicare, Volpp et al.) demonstrated no connection between mortality and morbidity at hospitals and resident duty hours
- Other studies showed reducing duty hours does not greatly enhance residents' average sleep time (5.9 hrs. vs. 5.6 hrs.)
- Longitudinal research demonstrates that resident work hours per week have dropped since 2003 to less than 60 hrs. per week, on average (Staiger et.al. JAMA. 2010;303(8):747-753)
- Multiple studies have shown that transitions of care create the most risk of medical errors

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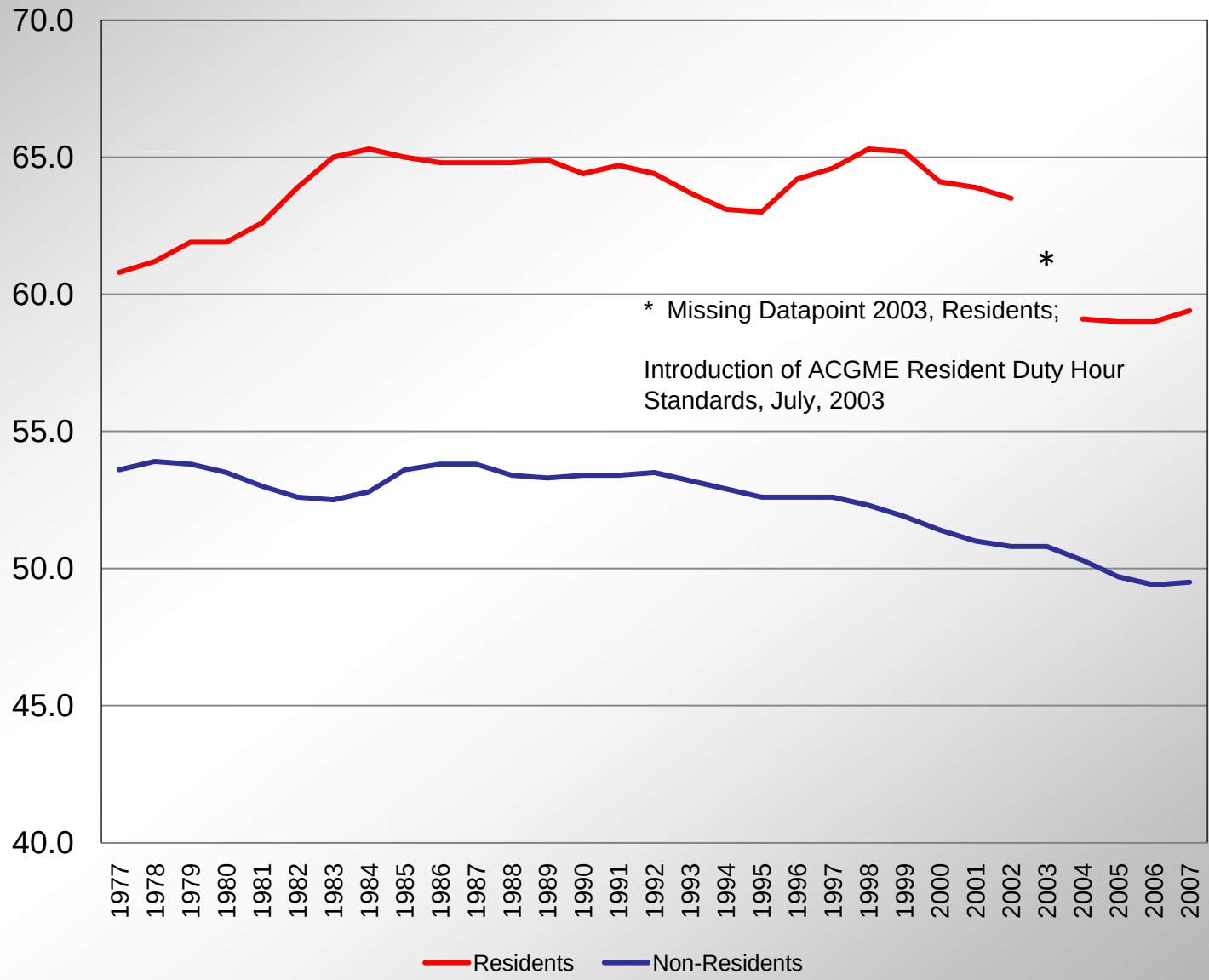
eTable 1.

Staiger DO, Auerbach DI, Buerhaus PI. Trends in the Work Hours of Physicians in the United States.
JAMA. 2010;303(8):747-753.
http://jama.ama-assn.org/cgi/data/303/8/747/DC1/1



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Draft Standards Highlights - Supervision

- Graduated levels of supervision

1. **Direct Supervision** —The supervising physician is physically present with the resident and patient
2. **Indirect Supervision**:
    a. **Direct supervision immediately available** – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision
    b. **Direct supervision available** – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone, and is available to provide Direct Supervision
3. **Oversight**-The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

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Draft Standards Highlights – Supervision *(cont.)*

- Supervising physician can be either a faculty member or more senior resident
- The program director must evaluate each resident's abilities based on specific criteria ("milestones")
- Supervising physicians should delegate portions of care to residents based on the needs of the patient and the skills of the residents
- Programs must set guidelines for circumstances and events in which residents must communicate with supervising faculty members
- **PGY-1 residents must receive either direct supervision (level 1) or indirect supervision with direct supervision immediately available (level 2a)**
  - *PGY-1s may not be alone on a hospital service*
  - *Supervision may be by upper level residents*

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Draft Standards Highlights - Clinical Responsibilities (Workload)

- The clinical responsibilities (workload) for each resident must be based on:
  - Patient safety
  - PGY level
  - Demonstrated resident skills/knowledge
  - Severity and complexity of patient illness/condition
  - Availability of support services

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Draft Standards Highlights - Teamwork

- Residents must care for patients in an environment that maximizes effective communication
- This must include the opportunity to work as a member of effective interdisciplinary teams that are appropriate to the delivery of care in the specialty

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Draft Standards Highlights – Professionalism, Personal Responsibility, Patient Safety

- Residents must take personal responsibility for, and faculty must model:
  - Assurance of their personal fitness for duty
  - Assurance of the safety and welfare of patients entrusted to their care
  - Management of their time before, during, and after clinical assignments
  - Recognition of impairment (e.g. illness or fatigue) in self and peers
  - Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

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Draft Standards Highlights - Transitions of Care

- Programs must design clinical assignments to minimize the number of transitions in patient care
- Institutions and programs must ensure and monitor effective, structured handover processes to facilitate both continuity of care and patient safety
- Programs must ensure that residents are competent in communication with team members in the handover process

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Draft Standards Highlights - Transitions of Care *(cont.)*

- Institutions must assure the availability of schedules that inform all members of the health care team of faculty and residents currently responsible for patient care
- Residents and faculty should inform patients of their role in the patient's care

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Draft Standards Highlights - Alertness Management

The Program must:

- Educate all faculty and residents to recognize the signs of fatigue and sleep deprivation
- Educate all faculty and residents in fatigue mitigation processes
- Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, e.g. naps, back-up call schedules

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Draft Standards Highlights - Alertness Management

The Program must: (cont.)

- Each program must have a process to ensure continued patient care in the event that a resident may be unable to perform his/her patient care duties
- Sponsoring Institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home

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Draft Standards Highlights - **Duty Hours**

- Maximum duty hours
- **Up to 80 hrs./week, averaged over four weeks**
  - Internal **and external** moonlighting must be counted toward the 80-hr. limit
  - **PGY-1 residents are not permitted to moonlight**

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Draft Standards Highlights - Duty Hours *(cont.)*

- Maximum continuous duty
  - **PGY-1 residents – no more than 16 hours (no additional transition time)**
  - **PGY-2 and up** – up to 24 hours plus **four hours** for transition of care
    - Strategic napping, particularly after 16 hours of continuous duty and between 10 p.m. and 8 a.m., is strongly encouraged
    - Residents, on their own volition, may remain with a single patient, after signing out all other patient care responsibilities.
      - This must be tracked by the Program Director

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Draft Standards Highlights- Duty Hours (con't.)

- Mandatory time off duty
  - **Minimum of one day free of duty every week, averaged over four weeks (same)**
    - **At-home call cannot be assigned on these free days**

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Draft Standards Highlights - Duty Hours *(cont.)*

- Minimum time off between duty periods
  - **PGY-1 residents** should have 10 hours and must have eight hours free of duty between scheduled duty periods
  - **Intermediate-level residents** (as defined by the RRC) should have 10 and must have eight hours free of duty between scheduled duty periods
    - Must have at least 14 hours free of duty after 24 hours of in-house duty

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Draft Standards Highlights - Duty Hours *(cont.)*

- Minimum time off between duty periods
  - **Senior level residents** (as defined by the RRC) *should* have eight hours between scheduled duty periods
    - Under circumstances defined by the RRC and approved by the ACGME, senior level residents may return to duty with fewer than 8 hours between scheduled duty periods
    - This early return to duty must be overseen by the program director

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Draft Standards Highlights- Duty Hours (con't.)

- Maximum consecutive nights on night float
  - **6 nights**
  - RRCs may limit amount of night float each year

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Draft Standards Highlights - Duty Hours *(cont.)*

- In house call frequency
  - PGY-2 residents and above must be scheduled for in-house call no more than every third night, **no averaging (new)**
- Home call
  - Time spent in hospital must count toward 80-hour limit
  - Returning to hospital does **not** restart the clock for a new required “off-duty” period

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Next Steps

- Draft standards posted for 45 days of public comment, until August 9, 2010 (www.acgme-2010standards.org)
- Awaiting results of economic impact assessment by UCLA/Rand group
  - Results will be posted on ACGME website
- All comments submitted will be taken into consideration by the Task Force and CRC

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Final Steps

- Final draft standards will be presented to the ACGME Committee on Requirements, September 2010
- If approved, the standards will be presented to the entire ACGME Board of Directors for approval, September 2010
- Goal is to implement standards July 2011

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Compliance

- Patient Safety and Quality Assurance review approved by ACGME Board
  - Every sponsoring institution would be visited annually
  - Examine institution's ability to integrate residency education, supervision and fatigue management standards into quality assurance initiatives
  - Results of surveys would be available to the public

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Proposed Standards

Questions?

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