Chapter 14 Promoting Compliance With the Standards to Advance Patient Safety and Physician Competence

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The ACGME 2011 common duty hour standards emphasize that professionalism and supervision are overarching and necessary companions to the duty hour standards, to promote patient safety in settings where residents participate in care and in the care they will provide after completing their training.[1] This is in keeping with ACGME's role as the accrediting organization for graduate medical education, and the importance of accreditation as a measure of the quality for residency programs and their sponsoring institutions.

The ACGME's Approach to Promoting Compliance

The ACGME monitors compliance with the duty hour standards through a combination of approaches that include the following:

1. Monitoring through an annual ACGME Resident Survey, with follow-up for programs with responses suggesting potential areas of noncompliance;
2. Implementing an accreditation review with onsite visits and interviews with residents, program directors, and faculty;
3. Responding to complaints about potential duty hour violations;
4. Promoting sponsoring institutions' oversight and monitoring of resident hours; and
5. Increasing residents' and the education community's knowledge of the adverse consequences of sleep loss, and of preventive and operational countermeasures, and through the 2011 standards, affirming residents' responsibility for managing alertness and fitness for practice as a component of their professional obligations as physicians.[1]

The ACGME uses a concept of substantial compliance, in which residency programs and sponsoring institutions are expected to essentially meet the spirit of all program and Institutional Requirements, including those pertaining to resident hours. Substantial compliance distinguishes between individual residents in a program working beyond the duty hour standards and instances in which several residents report they exceed the limits. The ACGME promotes compliance by using external assessments and an increasingly data-driven approach, which uses submission of data at regular intervals between site visits and contributes to ushering in a new model of accreditation, with longer cycle lengths and added focus on residents' meeting specialty-specific educational milestones.[2]

The 27 Review Committees that have accreditation authority in the 26 accredited core specialties and the transitional year (a year of preparatory education for specialties that accept residents at the second postgraduate year) annually review 40% to 45% of all accredited programs. Review Committees monitor and cite programs that fail to meet the standards and take adverse actions when programs fail to comply substantially with the requirements, after appropriate due process. At present, the percentage of programs annually cited for duty hour noncompliance hovers around 7%, with evidence that citations lead to improvements in most programs.[3] The first step in promoting compliance with the duty hour standards entails collecting detailed, accurate information about residents' hours.

When it implemented the common duty hour standards in 2003, the ACGME's aim was to advance compliance with the new standards by broadening the data sources.[3] Soon after the 2003 implementation, the ACMGE incorporated

direct input from residents via the ACGME Resident Survey.[4] After piloting a Resident Survey in 2003, the ACGME surveyed all programs between 2004 and 2006.[4] It again surveyed all programs between 2007 and 2008, and since 2009 it has annually surveyed all core programs and all subspecialty programs with 4 or more fellows. For the approximately 5% of programs for which responses suggest a noncompliance with several standards, the ACGME follows up by requesting information on how the problem is being addressed, and in serious cases, conducting site visits of the programs with annually recurring (''continuous'') and multiyear (''significant'') noncompliance.[4] The validity of the Resident Survey has been demonstrated, although significant correlations with site-visit findings warrant added scrutiny for programs meeting the thresholds of potential noncompliance found in the group targeted for follow-up.[5]

The ACGME assigned oversight of compliance to its Monitoring Committee, which tracks duty hour citations issued by Review Committees, and monitors programs with potential duty hour problems identified via the Resident Survey.[4] Follow-up activities for multiyear, potentially serious noncompliance identified via the Resident Survey may include a ''targeted'' site visit.[4]

Accreditation site visits continue to be an important component of the compliance assessment process. During their site visits, the members of the ACGME field staff annually interview 12 000 to 15 000 residents about their educational experience, including duty hours, supervision, and other elements of their program. Together with the site visit, both the ACGME Resident Survey and a planned faculty survey are critical for assessing compliance with the duty hour, supervision, and related standards. A trained ''site visitor'' visits the program and confirms the information submitted by the program in the program information form. The Review Committee's assessment of the program is based on the information contained in the site visitor's report, the program information form, and history and other relevant information, such as case and experience logs for residents. Areas of noncompliance with the common or specialty-specific requirements are cited after discussion and concurrence by the entire Review Committee. The Review Committee sets the accreditation status of the program (full accreditation or a proposed adverse action) by the number and severity of citations, the accreditation cycle, and next survey date.

The ACGME also receives and follows up on complaints related to alleged noncompliance with the Institutional and Program Requirements, including the requirements for duty hours. Complaints may originate from residents, program staff, and others with knowledge of the residency program. Experience with these complaints has shown that duty hours are often a symptom of inadequate attention to the educational demands of residency, as complaints often pertain to the interface between duty hours and the learning environment for residents.

Key elements of enhancing compliance with the duty hour standards entail requesting progress reports and action plans from programs that have been cited and involving their sponsoring institution. Because institutional support will often be critical to a program's ability to address these citations, the sponsoring institution is involved in formulating the progress report and needs to sign off on the document. Simultaneously, the Institutional Review Committee reviews sponsoring institutions for patterns of duty hour noncompliance. The Review Committees and the Institutional Review Committee may conduct repeated surveys and/or focused reviews to reevaluate compliance. The aim is to foster compliance and program improvement, while allowing correction of citations made in error.

The Effectiveness of Accreditation

The Institute of Medicine's report, ''Resident Duty Hours: Enhancing Sleep, Supervision, and Safety,''[6(p.4)] included a critique of the ACGME's

effectiveness in enforcing the duty hour standards implemented in 2003. Independent of the IOM report, the ACGME identified the need for enhanced compliance monitoring, along with inherent challenges of enhancing the frequency and intensity of duty hour surveillance at the program level, given the nearly 9000 programs it accredits. Out of this rose a plan for enhanced measures to promote compliance at the institutional level and for annual site visits to sponsoring institutions, focusing on duty hour compliance, supervision, and provision of a safe and effective environment for care and learning. The dual aim of the planned sponsor visit is (1) to promote enhanced institutional oversight of duty hours and of the ability of the learning environment to provide safe high-quality health care; and (2) to assess the institution's effectiveness in involving residents in institutional efforts to enhance safety and quality in their learning environment and to benefit their professional development and future practice.

The ACGME has convened experts in safety, sleep medicine, and graduate medical education to suggest data elements for the institutional site visit and to ensure the data collected will provide a thorough and realistic analysis of institutions' ability to provide a safe and effective learning environment. Using a set of data elements suggested by this group, the ACGME will gather data from all sponsoring institutions and will conduct onsite visits for institutions with 4 or more core residency programs. Interpretation of the data also will involve experts in patient safety, sleep medicine, and graduate medical education, and the ACGME plans to provide each institution with a report that details its compliance status and identifies noncompliance issues for timely resolution. In addition to institutional reports, the monitoring process will generate aggregated reports (national, regional, hospital type) with 3 objectives: (1) public release of data on institutions' achievements to assure the public of teaching hospitals' adherence to practices important to safe and effective care; (2) dissemination of best practices for adoption and adaptation; and (3) through the aggregation of deidentified data, identification of common safety threats and risks in settings where residents learn and participate in care. ACGME information-sharing activities may include safety alerts, sharing of information on best practices and, potentially, enhancements to its standards in selected areas. The expert panel will provide ongoing guidance to refine the process and ensure currency with scientific evidence and state-of-the-art practice. Once the institutional site visit program is established, data from the process will be available to the public.

A comparison of the approaches to address patient safety by the Agency for Healthcare Research and Quality (AHRQ)—by highlighting their respective advantages and drawbacks when compared to legislation, regulation, and accreditation—finds that accreditation has the advantages of greater flexibility and input and opportunities for implementation at the organizational level.[7] One drawback cited—the fact that participation in the accreditation process is voluntary—is not entirely true for the accreditation of graduate medical education, because the American Board of Medical Specialties requires completion of an ACGME-accredited program as a prerequisite for board certification in all basic specialties; moreover, programs must be accredited to receive federal support for graduate medical education, which creates additional strong incentives. Finally, another drawback of accreditation mentioned by AHRQ—infrequent assessments—also applies to existing regulatory solutions to address duty hours.

The data for individual states show that noncompliance with the duty hour standards is distributed approximately equally among all states, including New York State, which has an 18-year history of state regulation of resident hours, and Puerto Rico, the only other jurisdiction that regulates resident physician hours. ACGME data show that compliance for programs in New York State is comparable to that in other states. New York State accounts for 9% of sponsoring institutions and accounts for

approximately 9% of institutions cited for duty hour noncompliance, and 9% of all duty hour citations between 2003 and 2009. Institutions in New York State account for 11.4% of institutions whose programs meet criteria for Review Committee follow-up on Resident Survey results that suggest duty hour violations.[8]

The Responsibility of Programs and Sponsoring Institutions

The ACGME traditionally has emphasized the responsibilities of programs and sponsoring institutions for creating an environment that promotes safe patient care and high-quality resident education.[3] During the past decade, the ACGME's standards have expanded to include new important areas of focus, including competency-based education, development and codification of the role of the designated institutional official, more rigorous common program requirements that include the duty hour limits, efforts to minimize resident hours spent on activities that do not contribute to the acquisition of competence for independent clinical practice, and a more data-based approach to accreditation with web-based reporting and tracking systems.

The Outcome Project and the Milestone Project have further affirmed that the obligation of residency education programs and sponsoring institutions goes beyond the safety of patients in teaching hospitals, where residents participate in providing care, and includes the safety of patients that residents will care for in independent practice after completing their formal education.[2,9] This requires further attention to the curriculum and experiences that maximize resident education and to meaningful assessment with feedback for all residents, to maximize the educational value of the hours in the program, and to ensure residents meet all educational milestone expectations by the time they complete their training.

References

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