



New York State Department of Health  
Hospital Compliance Review  
Working Hours & Conditions of  
Post-Graduate Trainees

Annual Report

October 1, 2010 – September 30, 2011

December 30, 2011



## TABLE OF CONTENTS

TITLE	PAGE
1.0 Program Summary .....	1
1.1. REPORT CHANGES DUE TO NEW REQUIREMENTS.....	2
1.2. DELIVERABLES.....	3
2.0 Year-10 Deliverables: Reviews and Investigations .....	4
2.1. ONSITE COMPLIANCE REVIEWS AND SURVEYS .....	4
2.1.1. Triennial Onsite Compliance Assessment Visits as % of Total Facilities .....	4
2.2. TRIENNIAL ONSITE ASSESSMENTS COMPLETED.....	7
2.3. ANALYSIS OF ONSITE COMPLIANCE ASSESSMENT VISITS .....	8
2.3.1. Statewide and Regional Visits.....	8
2.3.2. Statewide Distribution of Non-Compliance .....	9
2.3.3. Summary of Analysis of 30 Triennial Compliance Reviews.....	11
2.4. ANALYSIS OF ONSITE COMPLIANCE ASSESSMENT VISITS AND REVISITS.....	12
2.4.1. Proper Separation .....	15
2.4.2. <24-Hour Off Period.....	15
2.4.3. Supervision.....	17
2.4.4. Facility Revisits and Monitoring of Corrective Action Plans Results.....	17
2.4.5. Written (Off-Site) Assessments Results.....	17
2.4.6. Onsite Complaint Investigation Results .....	17
2.5. ONGOING QUALITY REVIEW MONITORING.....	18
3.0 Year-10 Deliverables: Facility Training and DOH Support.....	19
4.0 Year-10 Deliverables: Forms, Protocols and Database Development.....	20
5.0 Year-10 Deliverables: Analysis and Reporting .....	21
6.0 Facility Program Strengths .....	22
7.0 IPRO Continual Improvements .....	24



## EXHIBITS

<i>Exhibit 1. Contract Year vs. Triennial Review Year Periods.....</i>	<i>2</i>
<i>Exhibit 2. Distribution of Facilities by Region.....</i>	<i>5</i>
<i>Exhibit 3. Distribution of Facilities by Bed Size.....</i>	<i>5</i>
<i>Exhibit 4. Distribution of Facilities by Program (# of PGTs) Size.....</i>	<i>5</i>
<i>Exhibit 5. Thirty Visits as % of Total Facilities by Region.....</i>	<i>6</i>
<i>Exhibit 6. Thirty Visits as % of Total Facilities by Bed Size.....</i>	<i>6</i>
<i>Exhibit 7. Thirty Visits as % of Total Facilities by Program Size.....</i>	<i>6</i>
<i>Exhibit 8. Triennial Compliance Visits Completed by Month.....</i>	<i>7</i>
<i>Exhibit 9. Triennial Compliance Visits Completed by Quarter by Region.....</i>	<i>7</i>
<i>Exhibit 10. Triennial Compliance Assessment Visits Results-Percent Non-Compliance.....</i>	<i>8</i>
<i>Exhibit 11. Triennial Compliance Assessment Visits-Results by Region.....</i>	<i>9</i>
<i>Exhibit 12. Triennial Compliance Visits Conducted and Citations by Month.....</i>	<i>10</i>
<i>Exhibit 13. Triennial Compliance Visits-Non-Compliance Findings by Bed Size.....</i>	<i>11</i>
<i>Exhibit 14. Non-Compliance Findings Statewide and by Region.....</i>	<i>14</i>
<i>Exhibit 15. Statewide Non-Compliance Findings by Specialty, Proper Separation.....</i>	<i>15</i>
<i>Exhibit 16. Statewide Non-Compliance Findings by Specialty, &lt;24 Hours Off.....</i>	<i>16</i>
<i>Exhibit 17. Statewide Compliance Assessment-Supervision.....</i>	<i>17</i>



## APPENDICES

### Appendix A. Annual Off-site Compliance Assessment Tool



## 1.0 PROGRAM SUMMARY

New York State continues to be a leader in work hour requirements and monitoring of compliance with those requirements (NYCRR 405) for approximately 15,000 of the nation's 100,000 Post-Graduate Trainees (PGT). In conjunction with the New York State Department of Health (NYSDOH), IPRO has successfully conducted compliance assessments for the past ten years.

This Annual Report reflects Program operations under the contract period October 1, 2010 to September 30, 2011, all of which were conducted under new contract requirements. The current requirements for Program operations are:

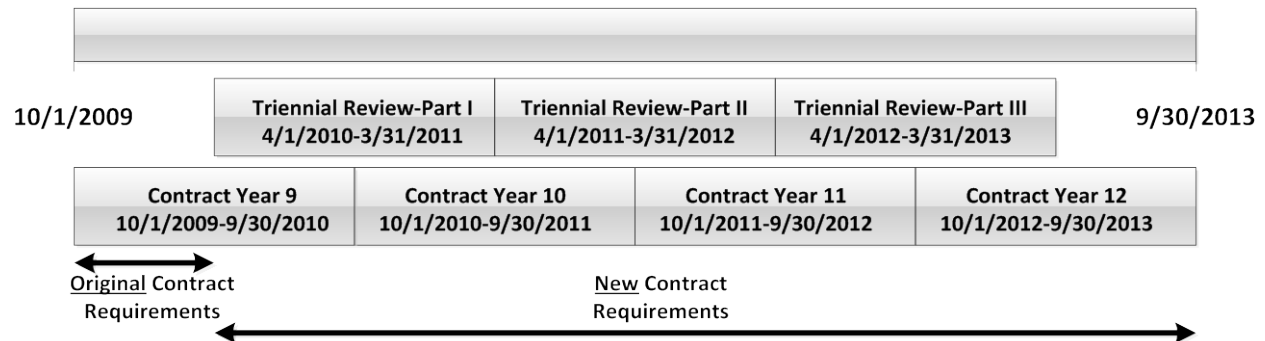
- Onsite compliance reviews to monitor compliance with requirements for work hour limitations and post-graduate supervision provisions to be conducted every third year (or approximately 30 onsite compliance reviews each year.)
- Written assessments utilizing a standardized assessment document for facilities not subject to a triennial onsite compliance review and for facilities with ten or less trainees (approximately 88 per year).
- Onsite complaint investigation and revisits (on average 10-15 per year.)
- Facility training initiatives.
- Development and implementation of a standardized written compliance assessment document for review of facilities not subject to an onsite visit.
- Development and implementation of onsite survey protocols for reviewing compliance with work hour and supervision requirements.
- Compilation and analysis of findings.
- Preparation of findings for Department review.
- Monitoring corrective action plans.
- Support of DOH enforcement activities (summary of findings and testimony/expert witness for hearings.)
- Development and maintenance of logs, statewide and regional database and tracking system for Program operations.
- Development of management reports, including statewide/regional findings, hospital specific reports and quarterly and annual reports.
- Ongoing quality review monitoring, including timeliness of conducting reviews, timeliness of submitting surveillance findings to DOH for approval, credibility of findings and provider feedback.



### 1.1. Report Changes Due to New Requirements

The activity and reporting requirements are complex due to the difference between the 12-month periods within the contract and the 12-month periods within the triennial review requirements, as illustrated in Exhibit 1, Contract Year vs. Triennial Review Year Periods.

**Exhibit 1. Contract Year vs. Triennial Review Year Periods**



This transition to reporting on the new requirements necessitates changes in the information included in the Annual Report. Some information is reported using the Contract Year-10 Timeline and some information is reported using the Triennial Review, Part 1 Timeline, which is made up of one-half of Contract Year-9 and one-half of Contract Year-10.

Under contract years 1-8, 100% of facilities were reviewed and results were presented as whole numbers as well as percentages of the whole. For example, if 10% of the facilities reviewed resulted in findings of non-compliance, the prior reports included that percentage since it represented a percentage of all facilities. Under the new requirements, facilities are reviewed only once every three years and the facilities to be reviewed are selected using a variety of factors that do not permit extrapolation of the findings to the universe of all facilities. Additionally, facilities are not subject to a triennial review if they have ten or less trainees. Therefore, if 10% of the facilities reviewed under the new schedule resulted in findings of non-compliance, this percentage cannot be reported as representative of the entire universe of facilities. It can only be presented as 10% of the facilities reviewed, with no attribution of that finding to the universe.

For this reason, in this year’s report, the findings are presented with the stipulation that the data applies only to the facilities reviewed. After all facilities are reviewed over the course of three full years, cumulative results will be reported. For the same reason, the comparison charts by year from the beginning of the program cannot be updated until the point at which review of the universe of facilities has been completed. Therefore, no comparison charts are included in this report.



## 1.2. Deliverables

For this Annual Report, the Program requirements have been grouped by type of “deliverable” and the report information is presented addressing each of those deliverables. The deliverable groups and the associated Program requirements are:

- **Program Operations Deliverables: Reviews and Investigations**
  - ✓ Onsite compliance reviews to monitor compliance with requirements for work hour limitations and post-graduate trainee supervision provisions to be conducted every third year (or approximately 30 onsite compliance reviews each year.)
  - ✓ Written assessments utilizing a standardized assessment document for facilities not subject to a triennial onsite compliance review and for facilities with ten or less trainees.
  - ✓ Onsite complaint investigation and revisits (on average 10-15 per year.)
  - ✓ Monitoring corrective action plans.
  - ✓ Ongoing quality review monitoring, including timeliness of conducting reviews, timeliness of submitting surveillance findings to DOH for approval, credibility of findings and provider feedback.
- **Program Operations Deliverables: Facility Training and DOH Support**
  - ✓ Facility training initiatives.
  - ✓ Support of DOH enforcement activities (summary of findings and testimony/expert witness for hearings.)
- **Program Operations Deliverables: Forms, Protocols and Database Development**
  - ✓ Development and implementation of a standardized written compliance assessment document for review of facilities not subject to an onsite visit.
  - ✓ Development and implementation of onsite survey protocols for reviewing compliance with work hour and supervision requirements.
  - ✓ Development and maintenance of logs, statewide and regional database and tracking system for Program operations.
- **Program Operations Deliverables: Analysis and Reporting**
  - ✓ Compilation and analysis of findings.
  - ✓ Preparation of findings for Department review.
  - ✓ Development of management reports, including statewide/regional findings, hospital specific reports and quarterly and annual reports.



## 2.0 YEAR-10 DELIVERABLES: REVIEWS AND INVESTIGATIONS

### 2.1. Onsite Compliance Reviews and Surveys

A total of 107 compliance assessments were conducted in the tenth year of the contract from October 1, 2010 to September 30, 2011, specifically:

- Thirty triennial onsite compliance assessment visits.
- Six onsite revisit assessments.
- Seventy-one written (off-site) assessments.

This total reflects the program changes made based on the new contract awarded in April 2010, which included (a) a change from annual onsite visits to triennial onsite visits for teaching hospitals with more than ten post-graduate trainees, (b) focusing on the working hours and conditions of PGT levels 1-3, and (c) overall assessment of PGT access to and the quality of supervision provided by supervising physicians. [Note that review of supervision is a new review category.] Facilities with ten or less post-graduate trainees and those facilities not scheduled for an onsite triennial visit are surveyed through a written compliance assessment.

In total, 1,666 Post-Graduate Trainees (PGTs) in the State were interviewed during this tenth year to assess compliance with working hour requirements. This year, there were no complaint investigations. Upon completion of each facility survey, a letter of findings was issued with a compliance determination. Non-compliance with current requirements was reported to facilities in a statement of deficiencies (SOD) by the NYSDOH. 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.

2.1.1. **Triennial Onsite Compliance Assessment Visits as % of Total Facilities**  
For program purposes, data is collected and reported by region, by bed size and by program size. The five regions include the counties/boroughs where teaching hospitals are located, as shown in Exhibit 2, Distribution of Facilities by Region. The distribution of facilities by bed size and by program size are shown in Exhibit 3, Distribution of Facilities by Bed Size and Exhibit 4, Distribution of Facilities by Program (# of PGTs) Size respectively.





***Exhibit 2. Distribution of Facilities by Region***

<b>Region</b>	<b>Counties/Boroughs with Teaching Hospitals</b>	<b># of Facilities</b>
Central	Broome, Jefferson, Oneida, Onondaga	10
Lower Hudson Valley & Long Island (LHVLI)	Nassau, Rockland, Suffolk, Ulster, Westchester	26
Northeast (NE)	Albany, Clinton, Otsego, Schenectady	6
New York City (NYC)	Bronx, Kings, New York, Richmond, Queens	56
Western	Cattaraugus, Erie, Monroe, Niagara, Steuben	16
<b>TOTAL</b>		<b>114</b>

***Exhibit 3. Distribution of Facilities by Bed Size***

<b>Bed Size Categories</b>	<b># of Facilities</b>
0-200	24
201-400	46
401-600	29
600+	15
<b>TOTAL</b>	<b>114</b>

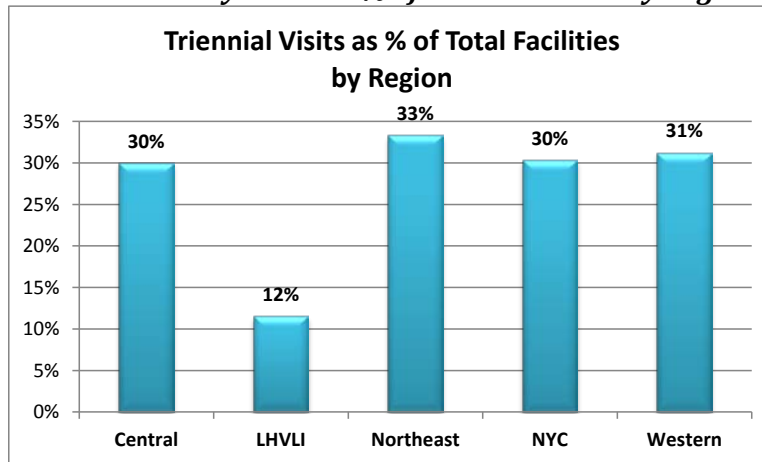
***Exhibit 4. Distribution of Facilities by Program (# of PGTs) Size***

<b>Program Size Categories</b>	<b># of Facilities</b>
0-10	26
11-100	45
101-300	38
301+	5
<b>TOTAL</b>	<b>114</b>

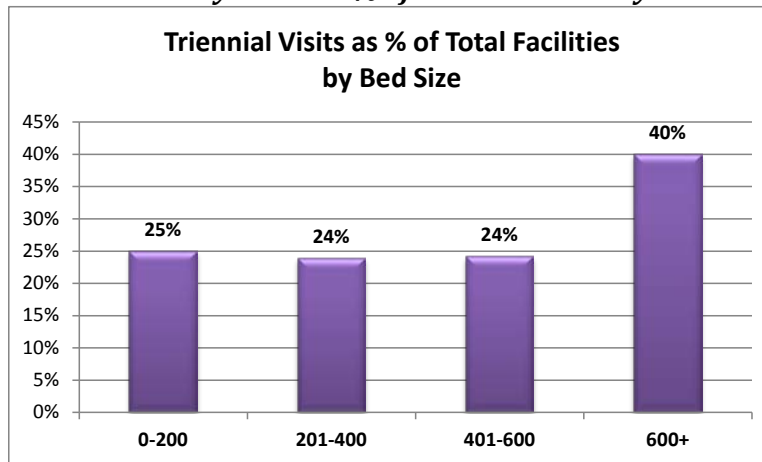
Under the new review requirements, the review plan calls for spreading reviews throughout the year by region, with a mix of small (<80 residents), medium (81-200 residents) and large facilities (>200 residents) scheduled each month. An average of three triennial onsite surveys and seven off-site compliance assessments have been planned each month.

As previously noted, the results of the 30 triennial compliance assessment visits conducted during Contract Year-10 can only be attributed to the facilities that were assessed, not to the universe of all facilities. The distribution of the 30 triennial assessments relative to the universe of 114 total facilities is shown in Exhibit 5, Thirty Visits as % of Total Facilities by Region; Exhibit 6, Thirty Visits as % of Total Facilities by Bed Size and Exhibit 7, Thirty Visits as % of Total Facilities by Program Size.

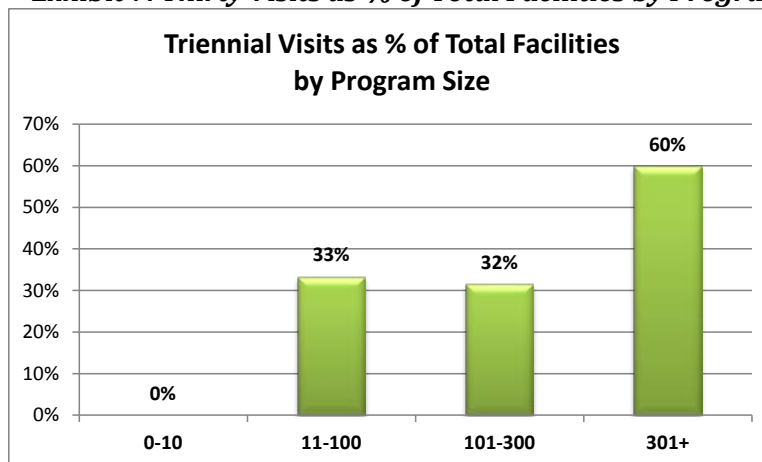
**Exhibit 5. Thirty Visits as % of Total Facilities by Region**



**Exhibit 6. Thirty Visits as % of Total Facilities by Bed Size**



**Exhibit 7. Thirty Visits as % of Total Facilities by Program Size**



## 2.2. Triennial Onsite Assessments Completed

Exhibit 8, Triennial Compliance Visits Completed by Month, shows the distribution of the 30 triennial reviews, by month, that were conducted during Contract Year-10 between October 2010 and September 2011.

**Exhibit 8. Triennial Compliance Visits Completed by Month**

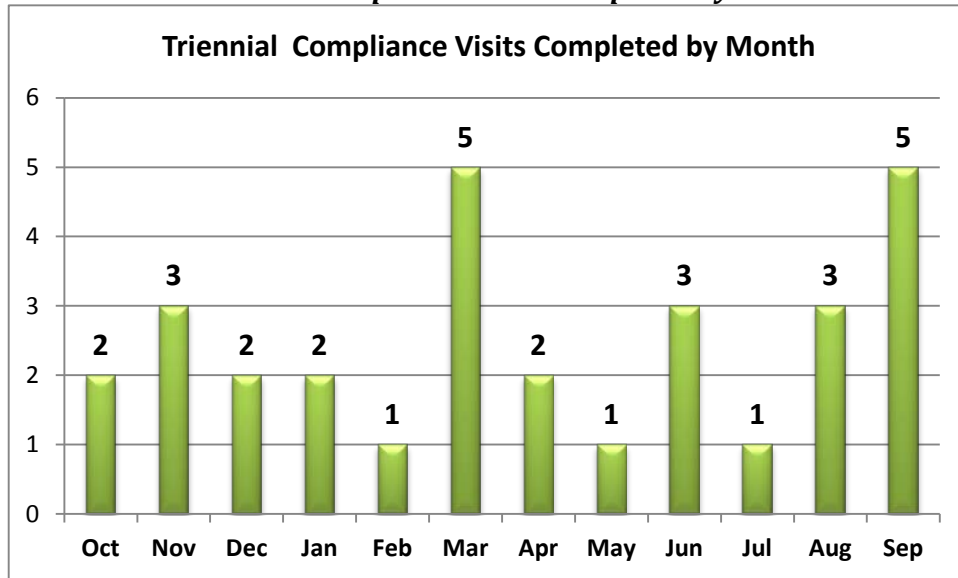
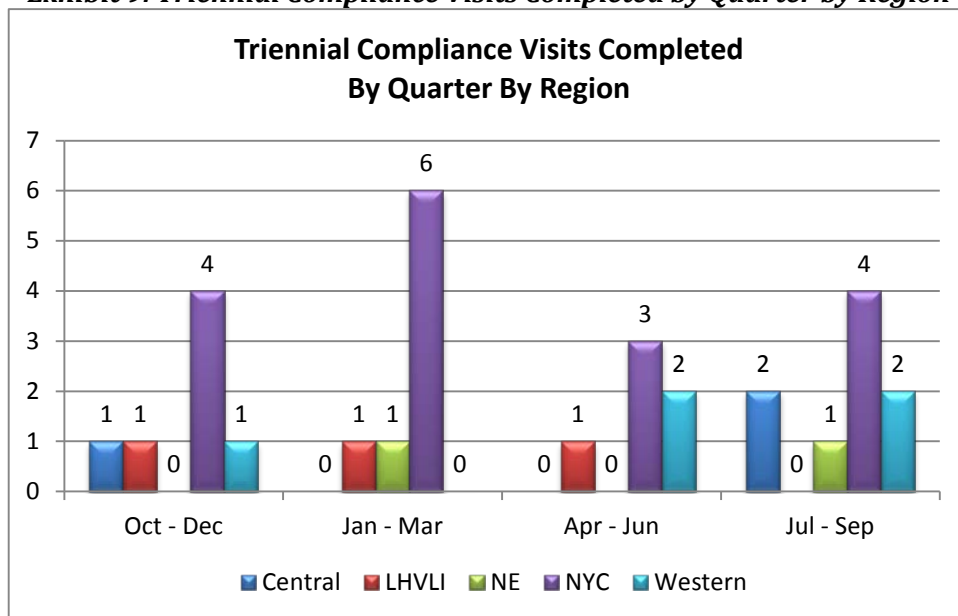


Exhibit 9, Triennial Compliance Visits Completed by Quarter by Region, shows the distribution of the 30 triennial reviews, by region across the state.

**Exhibit 9. Triennial Compliance Visits Completed by Quarter by Region**



## 2.3. Analysis of Onsite Compliance Assessment Visits

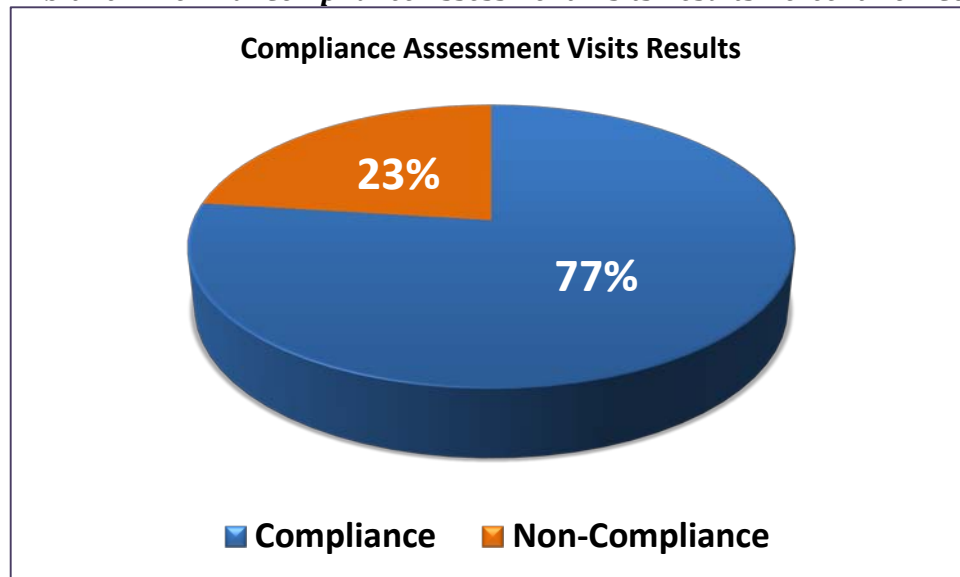
### 2.3.1. Statewide and Regional Visits

Thirty triennial compliance visits were conducted under the terms of the new contract, where each teaching facility receives an onsite compliance visit once in three years. Of these, seven evidenced some level of non-compliance at the time of the onsite review.

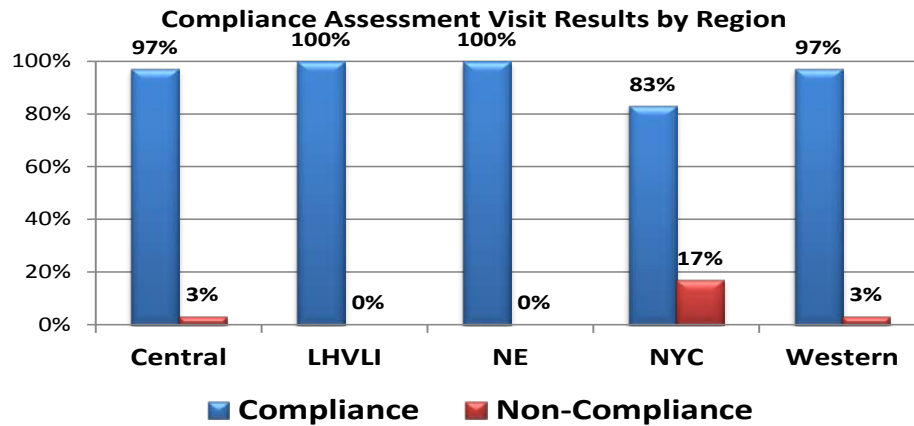
Exhibit 10, Triennial Compliance Assessment Visits Results-Percent Non-Compliance, and Exhibit 11, Triennial Compliance Assessment Visits-Results by Region, shows the distribution of the 30 triennial reviews, by compliance and non-compliance on a statewide and regional basis respectively. For reporting purposes, non-compliance means that one or more deficiency/finding was identified during the onsite review. Each deficiency/finding cited could result from an issue associated within one or more programs within the facility.

Of the seven facilities cited for non-compliance, five evidenced non-compliance in only one program area and two evidenced non-compliance in two program areas.

***Exhibit 10. Triennial Compliance Assessment Visits Results-Percent Non-Compliance***



**Exhibit 11. Triennial Compliance Assessment Visits-Results by Region**



As noted previously, the results of the triennial compliance visits for Contract Year-10 cannot be extrapolated to the universe of all facilities. The results apply only to the subset of thirty facilities reviewed.

### 2.3.2. Statewide Distribution of Non-Compliance

Exhibit 12, Triennial Compliance Visits Conducted and Citations by Month, illustrates the distribution of the 30 triennial visits compared to the findings of non-compliance for visits completed each month. The data reflects a fairly consistent correlation throughout the year between visits conducted and facilities found to be out of compliance with current requirements. It does not appear that survey outcome was significantly influenced by survey scheduling, which is consistent with the previous years' findings. While it is recognized that throughout the year there are dates and periods of time where routine scheduling for hospitals may be more difficult, compliance surveys continue to be scheduled throughout the full contract year.

**Exhibit 12. Triennial Compliance Visits Conducted and Citations by Month**

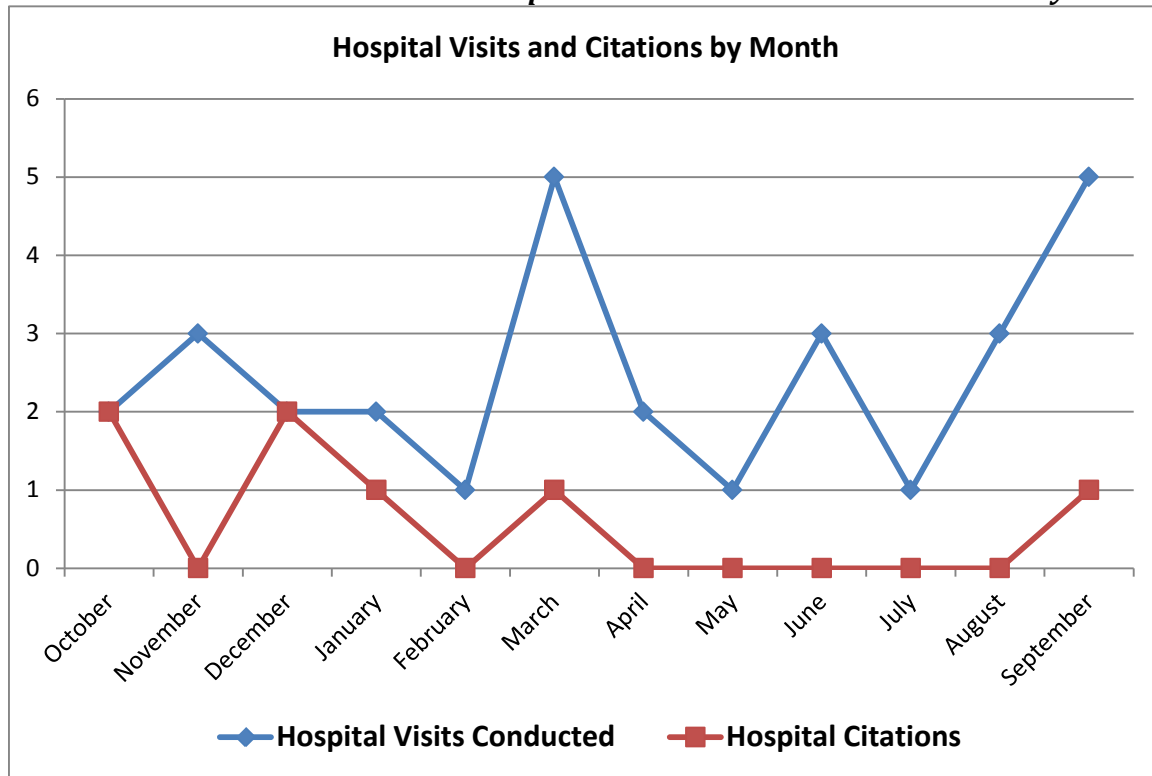
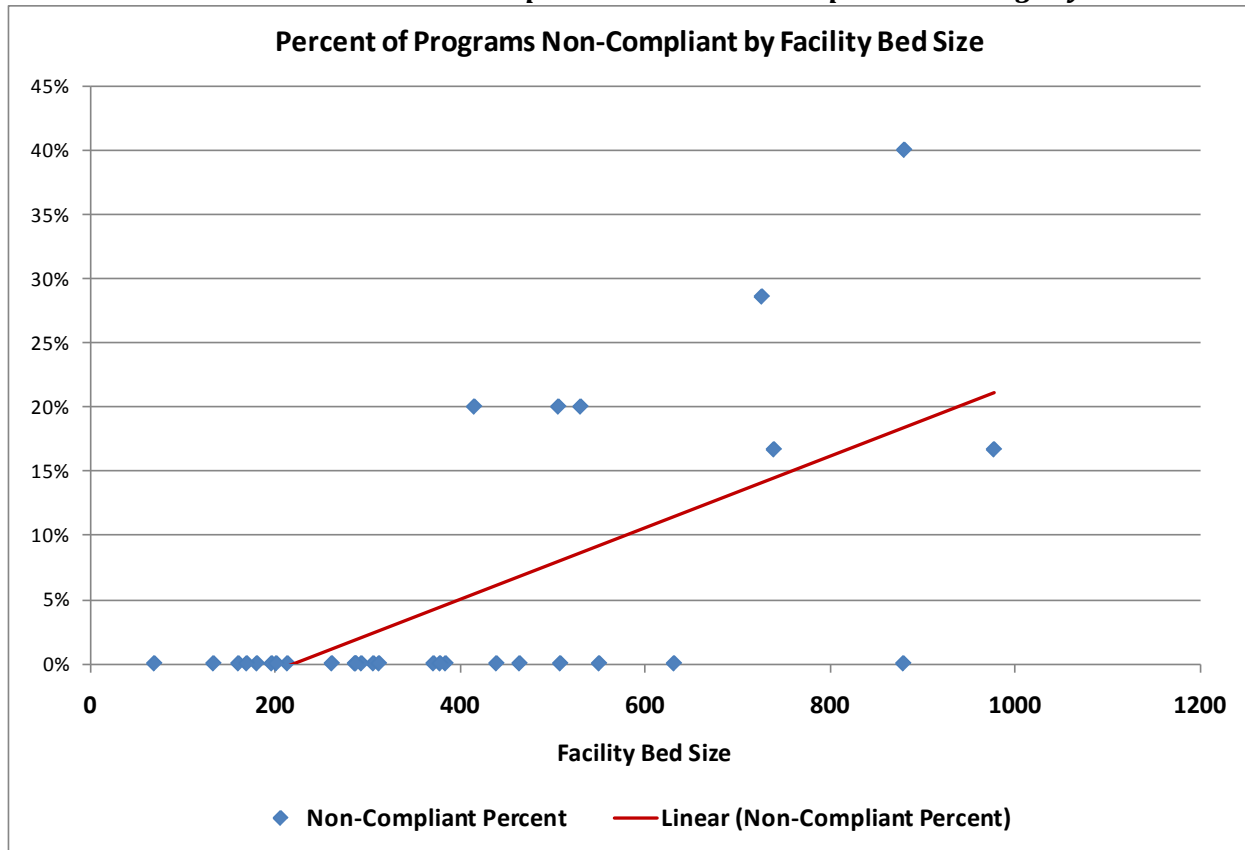


Exhibit 13, Triennial Compliance Visits-Non-Compliance Findings by Bed Size, presents a detailed assessment of compliance by bed size for the 30 triennial visits. Each facility is identified by its bed size, and is evaluated by the percent of non-compliance, as evidenced by the percentage of facility 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 13. Triennial Compliance Visits-Non-Compliance Findings by Bed Size**



None of the triennial visits conducted evidenced non-compliance in every teaching program reviewed at that site. Unlike prior annual reports, the non-compliance data for these 30 triennial reviews suggests a relationship between bed size and findings of non-compliance. However, since these reviews are a subset of the universe of facilities, no conclusion regarding the potential relationship can be made until the full three-year review cycle is completed.

2.3.3. Summary of Analysis of 30 Triennial Compliance Reviews

Compliance findings for the 30 triennial compliance reviews included the following:

- Twenty-three hospitals were found in substantial compliance with requirements, with no citations issued.
- Seven hospitals were cited for non-compliance in at least one program area:
  - ✓ In five of the facilities cited, only one program area within the facility evidenced non-compliance with at least one review criteria.
  - ✓ In two of the facilities cited, two program areas within the facility evidenced non-compliance with at least one review criteria.

- Of the seven hospitals that were cited for non-compliance:
  - ✓ One facility (surgery program) was cited for residents working more than 24 consecutive hours.
  - ✓ Three facilities were cited for residents not receiving one full 24-hour off period each week (internal medicine, OB/GYN and surgery programs).
  - ✓ Two facilities (internal medicine program) were cited for improper separation between working assignments.
  - ✓ Four facilities were cited for improper medical record documentation of post-graduate trainee supervision. One facility was cited in two programs (OB/GYN and surgery) and three were cited for one program (surgery).
  - ✓ One facility (internal medicine program) was cited for residents working greater than 80 hours per week.
  - ✓ One facility was cited for improper working conditions (ancillary services).

#### 2.4. Analysis of Onsite Compliance Assessment Visits and Revisits

A total of 36 visit types at 30 onsite visits were conducted during Year-10 of the contract. Of these, seven facilities evidenced some level of non-compliance with requirements.

As previously stated, new contract requirements were implemented in April 2010. These included (a) a change from annual onsite visits to triennial onsite visits for teaching hospitals with more than ten post-graduate trainees, (b) focusing on the working hours and conditions of PGT levels 1-3, and (c) overall assessment of PGT access to and the quality of supervision provided by supervising physicians. Facilities with ten or less post-graduate trainees and those facilities not scheduled for an onsite triennial visit are surveyed through a written compliance assessment.

The regional and statewide findings for the 36 total visit types at 30 facility onsite visits based on current program requirements include:

- 80 Hours Per Week. On average, over a four week period, the work week is limited to 80 hours per week. ***One facility was cited for working hours in excess of 80 hours each week.***
- 24 Consecutive Hours. Regulations limit scheduled assignments to no more than 24 consecutive hours. ***One facility was cited for residents working more than 24 consecutive hours.***
- 24 Hours Off Period. Scheduling must include one full 24-hour off period each week. ***Three facilities were cited for residents not receiving a full 24-hour off period during each week.***



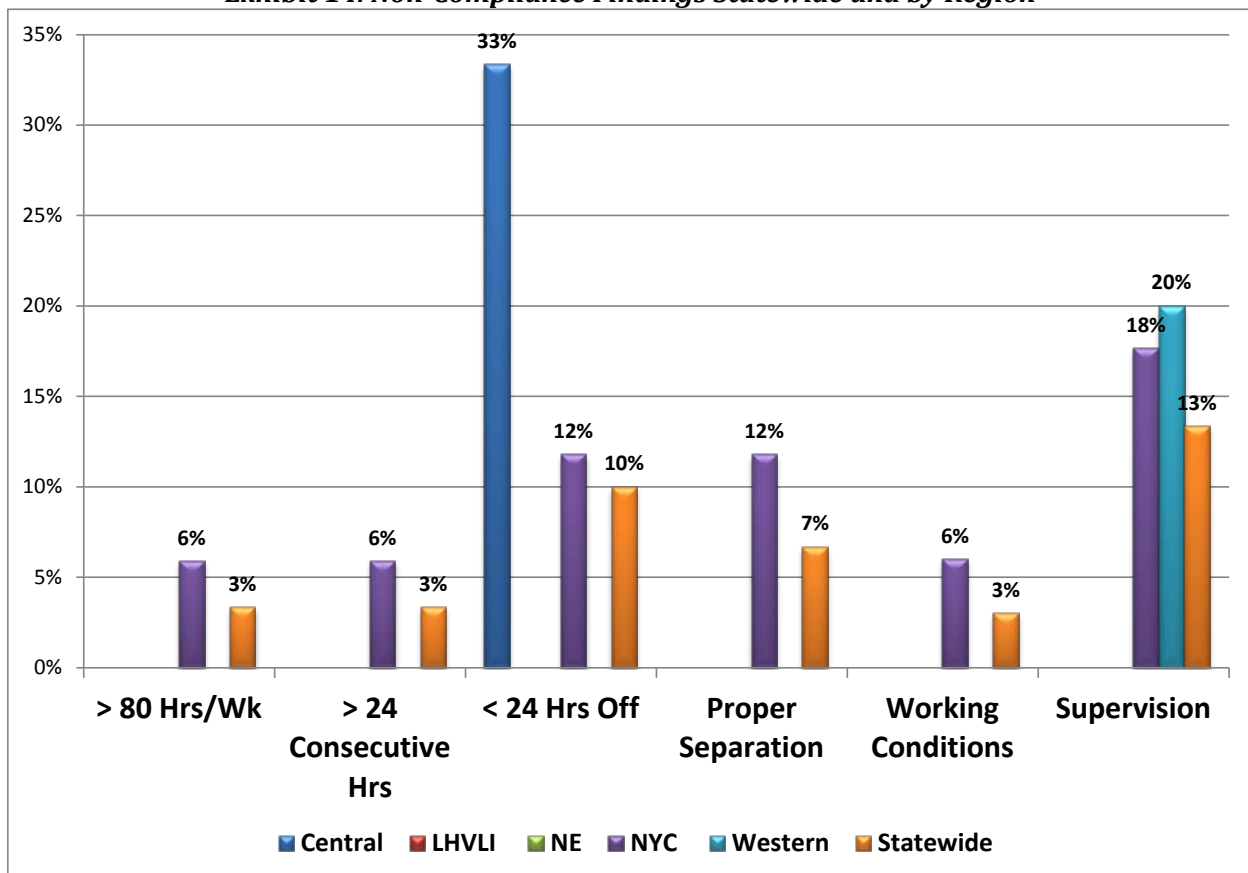
- Proper Separation. Assigned work periods must be separated by not less than eight non-working hours. **Two facilities were cited for working assignments not separated by required non-working time.**
- Working Conditions. This category includes consideration for sleep/rest accommodations, the availability of ancillary and support services, and the access to and availability of supervising physicians to promote quality supervision. **One facility was cited for failing to meet expected working conditions for residents.**
- Enhanced Monitoring of Supervision. Under the terms of the new contract, there is enhanced monitoring of supervision. The intent is to review for access and availability 24/7 by the attending physician to provide proactive supervision of all trainees with ongoing evidence in the medical record. Trainees in their final year or who have completed at least three years of training may perform supervision if it can be demonstrated that the attending is immediately available by phone and readily available in person. For surgical programs, the requirements are personal supervision of all surgical procedures requiring general anesthesia or an operating room, preoperative examination and assessment by the attending physician, and postoperative examination and assessment no less frequently than daily by the attending physician. **Four facilities were cited for improper medical record documentation of post-graduate trainee supervision.**
- Working Limitations. This category reflects documented inconsistencies in working hour information collected during interviews 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/QI. 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. No facilities reviewed during Year-10 were cited for deficiencies in their QA/QI performance. It should be noted that QA/QI would automatically be cited in Year-10 for any facility that had a repeat deficiency from Year-9 or in the case of a Year-10 revisit, a repeat of findings in Year-10.
- 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-10 of the contract, Governing Body was not cited as an area of non-compliance.
- 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 moonlighting as physicians providing professional

patient care services. No violations pertaining to moonlighting or dual employment requirements were identified in Year-10.

- Emergency Department (ED). For hospitals with more than 15,000 unscheduled emergency department visits, the ED assignments of trainees must be limited to no more than 12 consecutive hours. No violations were identified for this program area for facilities reviewed during Year-10.
- Medical Records. Medical record documentation and authentication regulations require that all medical record entries be signed, dated, and timed. All facilities visited in Year-10 were found to be substantially compliant with medical record entry requirements.

The most notable areas of non-compliance statewide and on a regional basis were medical record documentation of supervision (four facilities), residents not receiving a full 24-hour off period during each week (three facilities), and improper separation of work assignments (two facilities). These findings are illustrated in Exhibit 14, Non-Compliance Findings Statewide and by Region.

**Exhibit 14. Non-Compliance Findings Statewide and by Region**



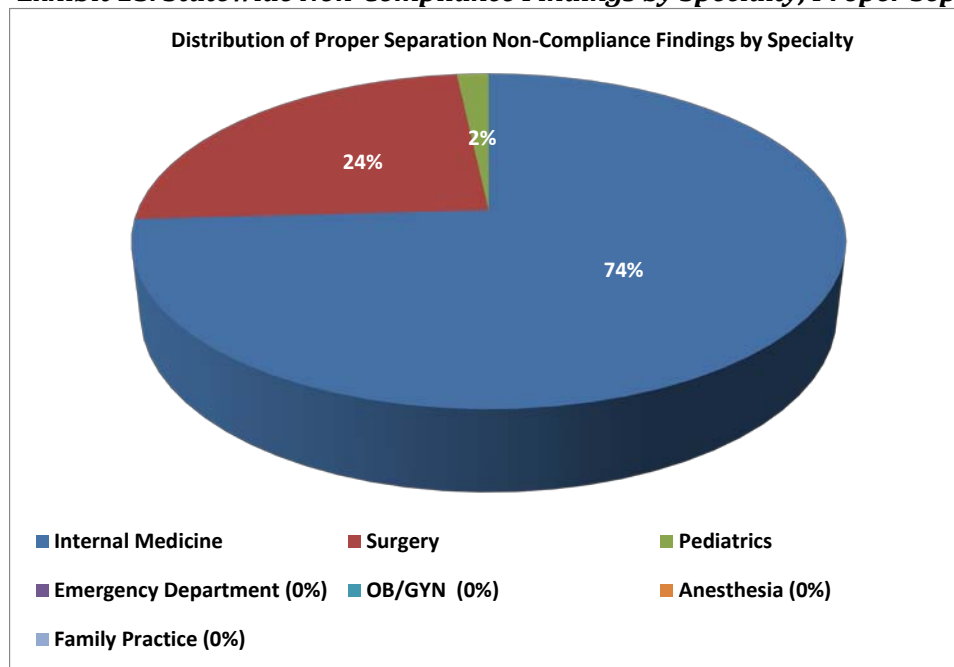
### 2.4.1. Proper Separation

New York State regulations require that scheduled on-duty assignments be separated by not less than eight non-working hours.

For all surveys conducted in Year-10 of the contract, non-compliance was evidenced in two facilities for 6% of the 36 total surveys conducted and 7% of the 30 triennial surveys conducted.

As illustrated in Exhibit 15, Statewide Non-Compliance Findings by Specialty, Proper Separation, based on the 36 total visits conducted (4 LHVLI, 3 Northeast, 21 New York City, 3 Central, and 5 Western) and the total residents identified as outliers, 24% of surgery and 74% of internal medicine residents were the most frequently identified, but not necessarily cited, for violating the proper separation requirement. This can, in part, be attributed to the fact that each category includes findings associated with numerous subspecialties and accounts for 43% of the programs in teaching hospitals throughout the state.

**Exhibit 15. Statewide Non-Compliance Findings by Specialty, Proper Separation**



### 2.4.2. <24-Hour Off Period

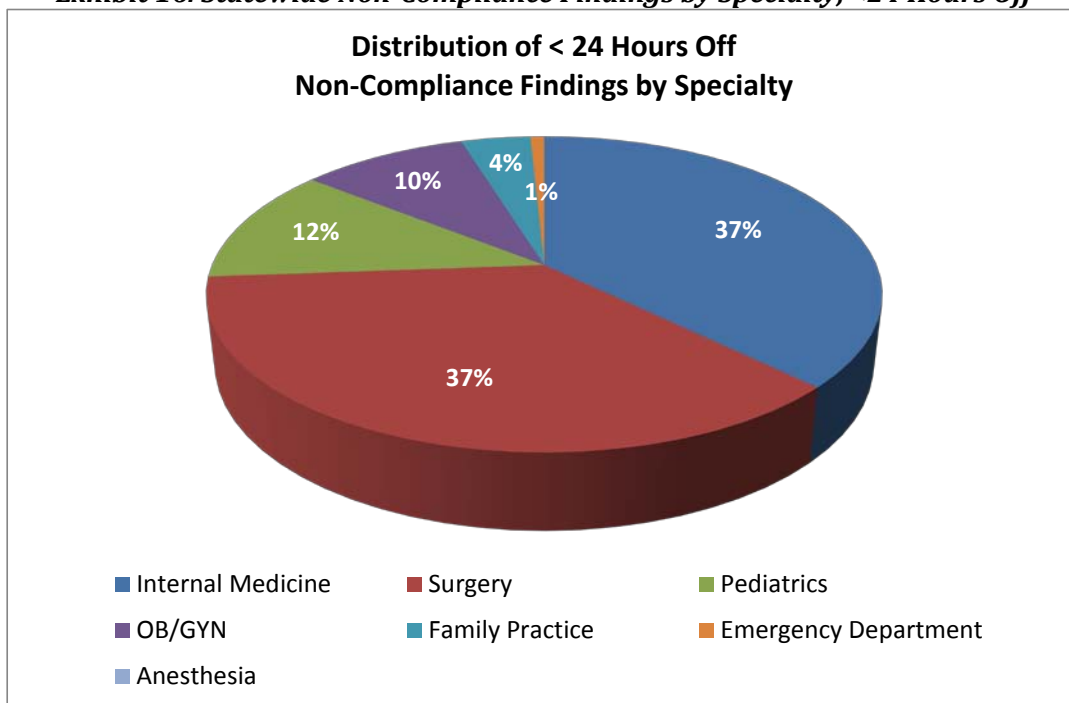
New York State regulations require that scheduling must include one full 24-hour off period each week free from patient care assignments or responsibilities. While programs may develop schedules that allow for a full weekend off or “Golden Weekend,” programs must be mindful that NYS regulations require a 24-hour off period each week, with no averaging. One difficulty that can present itself with providing a 24-hour off period each week is ensuring that there are 24 hours off post-call if this is the only day off for the week.

Sick, back-up, and/or jeopardy call, as well as home call systems can also result in non-compliance with the required 24-hour off period per week. Trainees under these call systems need to be available for coverage, and therefore, are not free from all patient care responsibilities even if they are not called back into the facility. If a trainee is scheduled for multiple consecutive days of call (i.e., back-up call every day for one month), the trainee would not have the required 24-hour off period per week.

For all surveys conducted in Year-10 of the contract, this area was one of the most frequently cited. Statewide, non-compliance was evidenced in three facilities for 8% of the total 36 surveys conducted and 10% of the 30 triennial surveys conducted.

As illustrated in Exhibit 16, Statewide Non-Compliance Findings by Specialty, <24 Hours Off, based on the 36 total visits conducted (4 LHVLI, 3 Northeast, 21 New York City, 3 Central, and 5 Western) and the total residents identified as outliers, 37% each of surgery and internal medicine residents were the most frequently identified, but not necessarily cited, for <24 hours off. This also can, in part, be attributed to the fact that each category includes findings associated with numerous subspecialties and accounts for 43% of the programs in teaching hospitals throughout the state.

**Exhibit 16. Statewide Non-Compliance Findings by Specialty, <24 Hours Off**

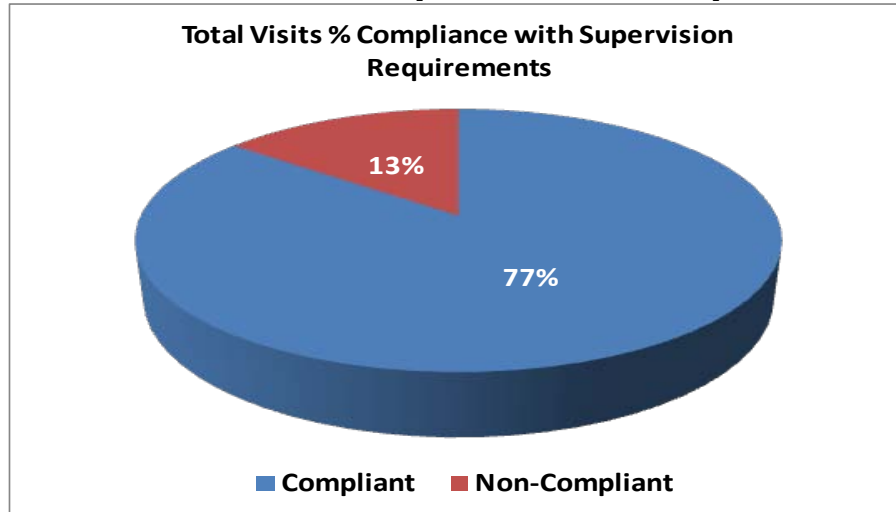


### 2.4.3. Supervision

Under the terms of the new contract, IPRO enhanced the assessment of compliance with the supervision requirements by asking residents additional questions to determine their perception of access, availability and adequacy of the supervision, as well as how they access their supervisor during both daytime and overnight hours. All respondents felt that supervision is adequate, accessible and available 24/7.

In addition, IPRO assessed whether quality supervision was documented and evident in the care provided by PGTs through review of patient records. For all surveys conducted in Year-10, this was the most frequently cited area. Statewide non-compliance was evidenced in four facilities for 11% of the 36 total visits and 13% of the 30 triennial surveys conducted. Exhibit 17, Statewide Compliance Assessment-Supervision illustrates the percentage of compliance/non-compliance with this requirement.

***Exhibit 17. Statewide Compliance Assessment-Supervision***



### 2.4.4. Facility Revisits and Monitoring of Corrective Action Plans Results

Six facility revisits involving eight resident programs were conducted to monitor the facility's plan of correction (POC) implementation for previously identified non-compliance:

- Revisits involved four internal medicine, two pediatric and two surgery programs.
- 100% of revisits evidenced substantial compliance with the POC.

### 2.4.5. Written (Off-Site) Assessments Results

No concerns were identified for the 71 off-site assessments.

### 2.4.6. Onsite Complaint Investigation Results

There were no onsite complaint visits conducted this contract year.



## 2.5. Ongoing Quality Review Monitoring

IPRO continues to conduct internal quality improvement and monitoring activities inclusive of staff performance, timeliness of all survey activities/processes and inquiries, as well as point-of-service feedback from facilities post-survey. Issues or trends are reviewed and improvements are made as needed to ensure program effectiveness and consistency. In addition, facility program changes and best practices are documented and tracked based on discussions with program representatives and/or survey findings. Trends noted are shared with facilities during inquiry or education sessions.



### 3.0 YEAR-10 DELIVERABLES: FACILITY TRAINING AND DOH SUPPORT

IPRO continues to provide training and updates as requested by facilities and other collaborators/special interest groups. During Contract Year-10, IPRO received three new requests and provided five training sessions (including two requests from the prior contract year), to facilities and collaborators. Based on the specific request, training was provided to residents, program coordinators, physicians, and special interest groups, and focused on regulation updates and changes with the new contract requirements.



#### 4.0 YEAR-10 DELIVERABLES: FORMS, PROTOCOLS AND DATABASE DEVELOPMENT

In cooperation with the Department, IPRO developed and implemented a standardized written compliance assessment tool which is used in the assessment of all facilities not subject to an onsite compliance visit. The tool is included in Appendix A.

Onsite survey protocols previously developed and implemented continue to provide a standardized and seamless approach to implementation of the new requirements as well as continuity of processes for facilities and staff.

IPRO modified the existing logs, databases and tracking system to accommodate the new program requirements when the new contract became effective. These tools are currently in use.





## 5.0 YEAR-10 DELIVERABLES: ANALYSIS AND REPORTING

In consultation with the Department, IPRO developed quarterly reports to reflect the new contract requirements. Data has been collected and the findings form the basis for quarterly and annual reports. Quarterly and annual reports are prepared and provided to the Department for their review. Following Department review, the reports are modified, if necessary, and finalized for submission to the Department. During contract Year-10 the following reports have been submitted:

- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, October 1, 2010 – December 31, 2010
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, January 1, 2011 – March 31, 2011
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, April 1, 2011 – June 30, 2011
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, July 1, 2011 – September 30, 2011



## 6.0 FACILITY PROGRAM STRENGTHS

During the ten years of IPRO's contract with the DOH, we have looked at changes facilities have made in response to the duty hours. This year we continued to track such changes based on discussion with program directors, program coordinators and/or chief residents. The majority of the changes centered on the revised ACGME regulations.

These changes can be grouped into five categories: schedule changes, staffing changes, new software, education/procedural changes and other. The following highlights summarize each category.

- **Schedule Changes**
  - ✓ Implemented or changed current night float systems to accommodate ACGME requirements for PGY 1s.
  - ✓ Changed hours of morning report and/or allowed post-call residents to present cases first.
  - ✓ Changed time of morning and/or afternoon sign-outs.
  - ✓ Changed time of last admit to allow residents to complete work and leave on time.
  - ✓ Increased or decreased upper levels using home call.
  - ✓ Rotation changes, such as added, deleted, length of rotation, etc.
  
- **Staffing Changes**
  - ✓ Hospitalists to cover patients at night or free up residents during the day.
  - ✓ Added Nurse Practitioners and Physicians Assistants for coverage.
  - ✓ Fellows on research to cover call.
  - ✓ More use of attending physicians for weekend days.
  - ✓ Increased number of residents used in call schedule.
  - ✓ Use of in-house moonlighting to cover call.
  - ✓ Re-allocated resources to cover busier services/times.
  
- **Education/ Procedural Changes**
  - ✓ Protected education time.
  - ✓ Changed clinic and/or conference times.
  - ✓ Increased or decreased rotations to facilitate education.
  - ✓ Conferences and presentations available on-line.
  - ✓ Attending available on-line.
  - ✓ More on-line simulation skills labs.



- Software Changes
  - ✓ Software for duty hour monitoring.
  - ✓ Software for handoffs.
  - ✓ Software for simulation.
  - ✓ Software for didactic education.
  - ✓ More Web-based education.
  
- Other
  - ✓ Use of binders to maintain all required survey information.
  - ✓ Well-written policies that capture both NYS and ACGME regulations.



## 7.0 IPRO CONTINUAL IMPROVEMENTS

IPRO continued to work with the NYSDOH during the transition by the ACGME to their new requirements and provided programs with information on how to be in compliance with the 405 code and the new ACGME regulations. In addition:

- IPRO staff collected facility contact and CEO information during both onsite visits and off-site written compliance assessments, and maintained an updated listing.
- IPRO reviewed schedules, as requested by facilities, to assist in achieving compliance.
- IPRO monitored survey processes, such as unannounced visits, staggered survey schedule, and site review protocols, as well as tracking and trending of program strengths, survey findings, feedback, and other QA/QI measures.
- IPRO provided onsite educational sessions.



## APPENDIX A. ANNUAL OFF-SITE COMPLIANCE ASSESSMENT TOOL

The off-site assessment form that follows was developed under the requirements of the new contract for facilities that are not subject to a triennial onsite assessment because they have ten or fewer Post Graduate Trainees or because they are not scheduled for a triennial onsite assessment during the contract year.



**Annual Off-site Compliance Assessment  
 Working Hours & Conditions of Post-Graduate Trainees**

INSTRUCTIONS	MAILING ADDRESS	EMAIL ADDRESS
Please submit the documents listed below and complete the Compliance Plan Update for the facility. Return all to the attention of Lois Piper, Director (email is preferred method)	Lois Piper IPRO 20 Corporate Woods Blvd Albany, NY 12211	lpiper@ipro.org <b>FAX</b> 518-426-3418
<b>Please submit the following documentation:</b>		
<ol style="list-style-type: none"> <li>1. List of all accredited and non-accredited programs that sponsor residents in your hospital.</li> <li>2. List of contact personnel (Program Director/Program Coordinator) and telephone number/extension for each department (including subspecialties).</li> <li>3. List of all post-graduate trainees by service and PGY level.</li> <li>4. Identify the Senior member of hospital administration who has oversight of compliance with work hour rules.</li> <li>5. Description of system and/or method for monitoring resident work hour compliance.</li> <li>6. Meeting minutes specific to monitoring results, such as GME, departmental, etc. These can be rolled up/summarized or include only sections relevant to working hours.</li> <li>7. For the past 12 months, please identify any issue, complaint or finding identified to the facility that raises concerns regarding compliance with work hour rules and/or supervision requirements. Indicate which actions were taken by the facility to review/address concerns raised and/or outcome of allegation.</li> <li>8. Indicate if any changes have been implemented in the past 12 months for education, scheduling/staffing, etc. to meet or maintain compliance with work hour rules.</li> <li>9. Describe or submit documentation outlining the process for handling internal complaints or concerns regarding resident work hours and/or supervision requirements.</li> <li>10. Indicate how you inform residents of an external process / option (such as ACGME, DOH, IPRO, etc.) if they have concerns regarding work hour and/or supervision requirement issues.</li> <li>11. Have any educational/ information sessions been held for trainees detailing work hours rules and the impact or effects of sleep deprivation and fatigue on work performance and safety? Please submit dates and agendas (if available).</li> <li>12. Any other supporting documentation/ information that you wish to submit for review.</li> </ol> <p><u>Note:</u> All information should be submitted in sections that correspond with the number/numbers above. The facility will receive confirmation that information has been received and will be notified if any additional information/documentation is required.</p>		