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

Annual Report

October 1, 2012 – September 30, 2013

November 21, 2013

TABLE OF CONTENTS

EXHIBITS

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 (PGTs). In conjunction with the New York State Department of Health (NYSDOH or Department), IPRO has successfully conducted compliance assessments for the past twelve years.

This Annual Report reflects Program operations under the contract period October 1, 2012 to September 30, 2013, 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 using 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 (an average of 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 NYSDOH 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 the Department for approval, credibility of findings and provider feedback.

1.1. Triennial Review Period vs. Contract Year

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 difference in triennial review period and the contract year requires recognition of the overlap between the two twelve-month periods. The full contract year (Contract Year-12) for this report encompasses part of both the first and second Triennial Review periods.

Under contract years 1-8, 100% of facilities were reviewed each contract year 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 as the total annual non-compliance rate since it represented a percentage of all facilities. Under the requirements that began on 04/01/10 during Contract Year-9, facilities are being reviewed only once every three years (triennial) 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. Mergers, closing facilities, and opening, expanding, or closing of residency programs also contribute to ongoing fluctuation of total facility and/or program counts. 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 annual 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, the findings in this annual report are presented with the stipulation that the data applies only to the facilities reviewed during this contract year timeframe. 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 using 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 (an average of 10-15 per year).
  - ✓ Monitoring corrective action plans.
  - ✓ Ongoing quality review monitoring, including timeliness of conducting reviews, timeliness of submitting surveillance findings to the Department for approval, credibility of findings and provider feedback.
- **Program Operations Deliverables: Facility Training and NYSDOH Support**
  - ✓ Facility training initiatives.
  - ✓ Support of NYSDOH enforcement activities (summary of findings and testimony/expert witness for hearings).
- **Program Operations Deliverables: Forms, Protocols and Database Development**
  - ✓ Ongoing maintenance of a standardized written compliance assessment document for review of facilities not subject to an onsite visit.
  - ✓ Ongoing maintenance of onsite survey protocols for reviewing compliance with work hour and supervision requirements.
  - ✓ Ongoing 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.
  - ✓ Preparation of management reports, including statewide/regional findings, hospital specific reports and quarterly and annual reports.

2.0 Contract Year-12 Deliverables: Reviews and Investigations

2.1. Onsite Compliance Reviews and Surveys

A total of 120 compliance assessments were conducted in the twelfth year of the contract from October 1, 2012 to September 30, 2013, specifically:

- Twenty-nine triennial onsite compliance assessment visits (one onsite survey was not conducted due to the October 2012 hurricane);
- Five onsite revisit assessments;
- Zero complaint investigations;
- Eighty-six 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. 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, 1,576 PGTs in the State were interviewed during Contract Year-12 to assess compliance with working hour requirements. 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. As indicated previously, differences in these charts from last year are due to mergers, closings, new and/or expanded programs.

Exhibit 2. Distribution of Facilities by Region

Region	Counties/Boroughs with Teaching Hospitals	# of Facilities
Central	Broome, Jefferson, Oneida, Onondaga	9
Lower Hudson Valley & Long Island (LHVLI)	Nassau, Rockland, Suffolk, Ulster, Westchester	28
Northeast (NE)	Albany, Clinton, Otsego, Schenectady	6
New York City (NYC)	Bronx, Kings, New York, Richmond, Queens	53
Western	Cattaraugus, Erie, Monroe, Niagara, Steuben	19
TOTAL		**115**

Exhibit 3. Distribution of Facilities by Bed Size

Bed Size Categories	# of Facilities
0-200	22
201-400	48
401-600	30
600+	15
TOTAL	**115**

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

Program Size Categories	# of Facilities
0-80	61
81-200	20
201+	34
TOTAL	**115**

Requirements of the new review plan call 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 are planned each month.

As previously noted, the results of the 29 triennial compliance assessment visits conducted during Contract Year-12 can only be attributed to the facilities that were assessed, not to the universe of all facilities. The distribution of the 29 triennial assessments relative to the universe of 115 total facilities is shown in Exhibit 5, Twenty-nine Visits as % of Total Facilities by Region; Exhibit 6, Twenty-nine Visits as % of Total Facilities by Bed Size and Exhibit 7, Twenty-nine Visits as % of Total Facilities by Program Size.

Exhibit 5. Twenty-nine Visits as % of Total Facilities by Region

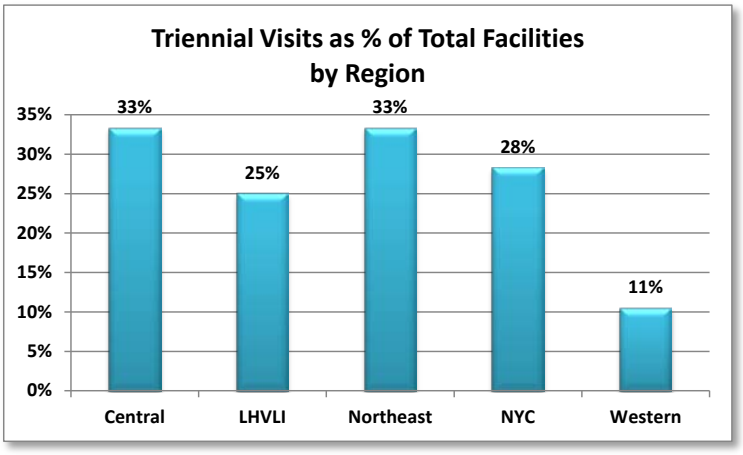


Exhibit 6. Twenty-nine Visits as % of Total Facilities by Bed Size

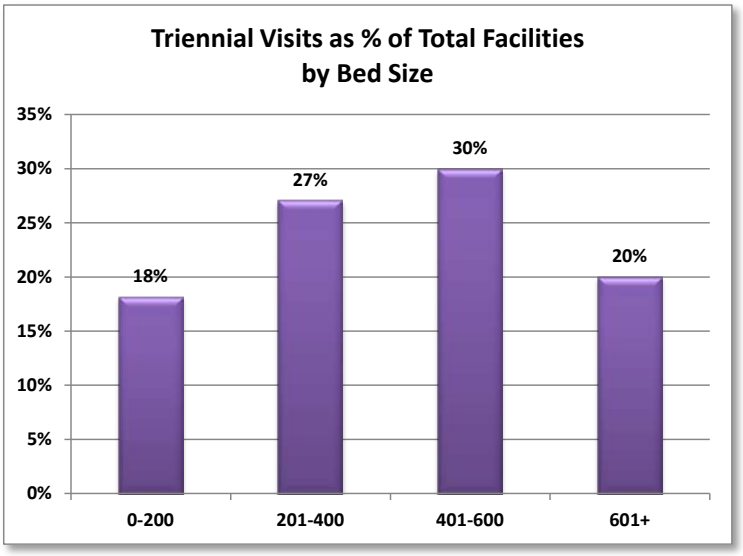
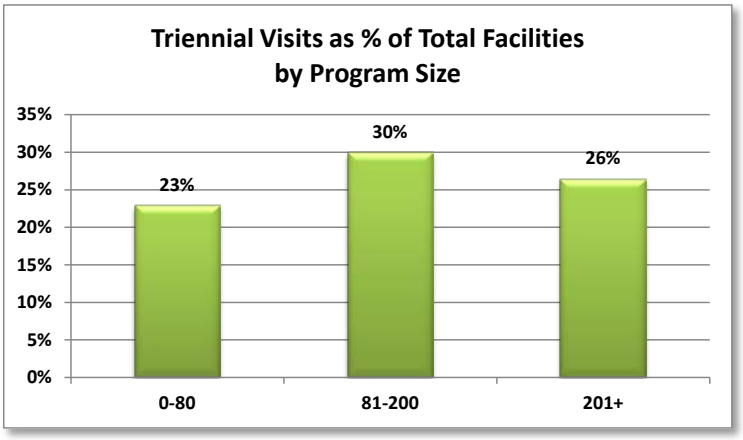


Exhibit 7. Twenty-nine Visits as % of Total Facilities by Program Size



2.2. Triennial Onsite Assessments Completed

Exhibit 8, Triennial Compliance Visits Completed by Month, shows the distribution of the 29 triennial reviews, by month, that were conducted during Contract Year-12 between October 2012 and September 2013.

Exhibit 8. Triennial Compliance Visits Completed by Month

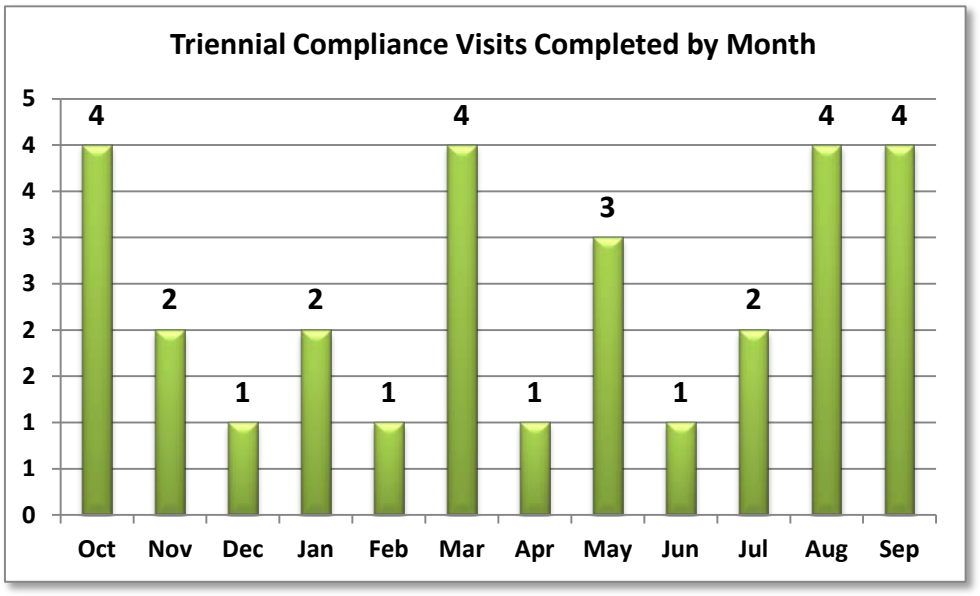
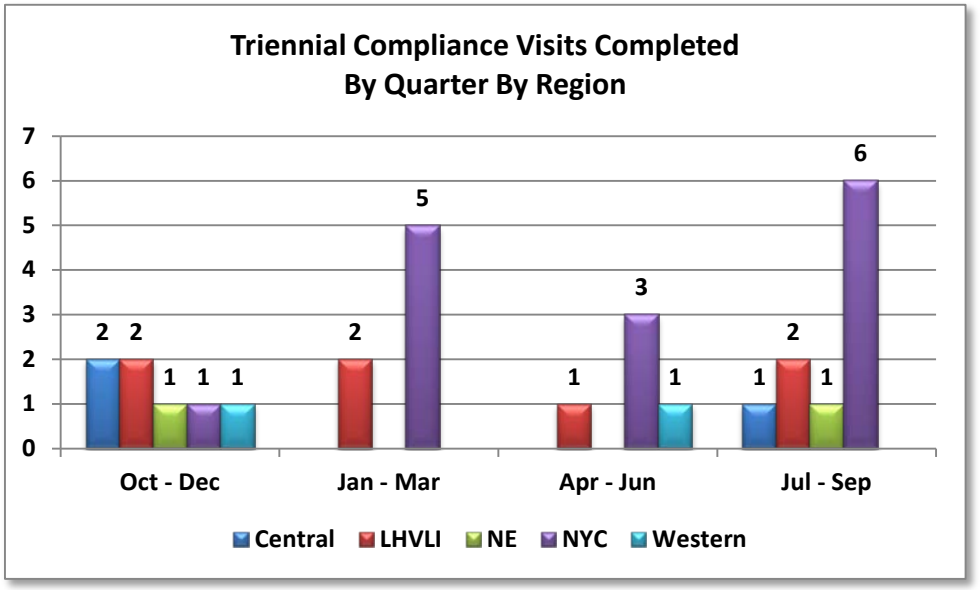


Exhibit 9, Triennial Compliance Visits Completed by Quarter by Region, shows the distribution of the 29 triennial reviews, by region across the state.

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

Twenty-nine 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 29 triennial visits, four evidenced some level of non-compliance at the time of the onsite review.

Exhibit 10, Contract Year-12 Compliance Assessment Visits Results shows the percentage distribution of the 29 triennial reviews, by compliance and non-compliance.

Exhibit 10. Contract Year-12 Compliance Assessment Visits Results

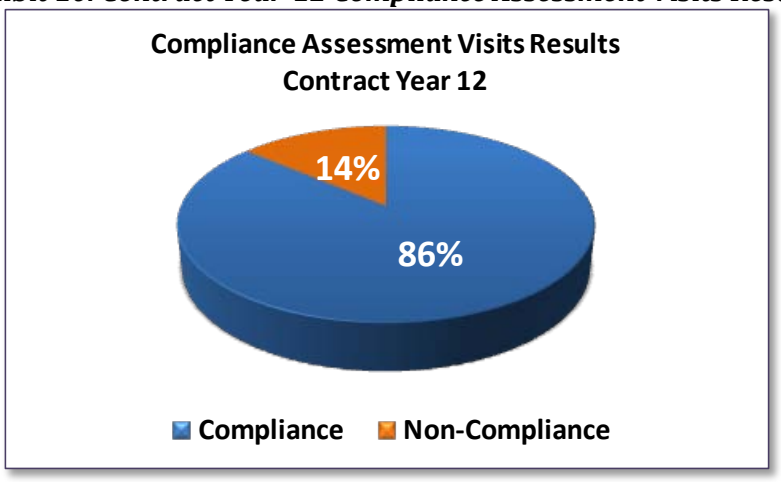
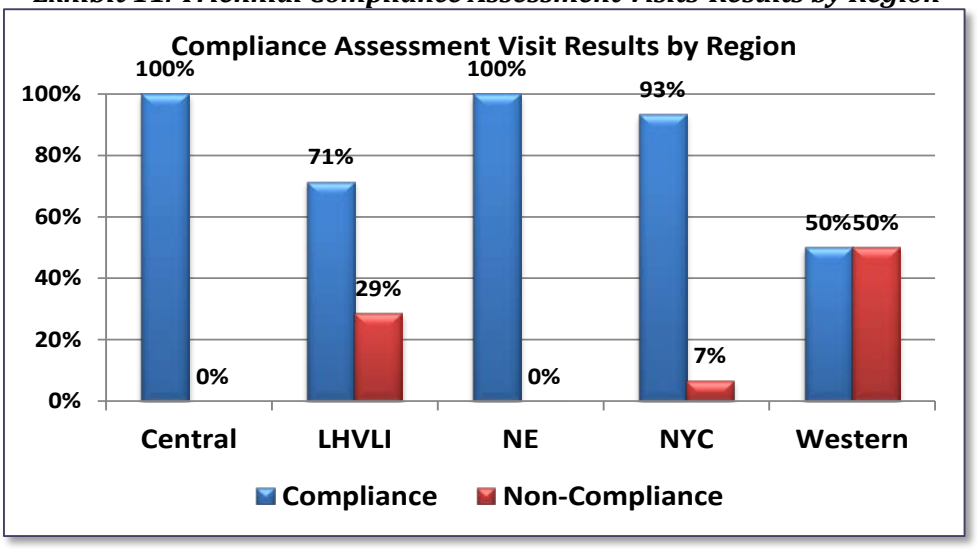


Exhibit 11, Triennial Compliance Assessment Visits-Results by Region, shows the distribution of the 29 triennial reviews, by compliance and non-compliance on a regional basis. For reporting purposes, non-compliance means that one or more deficiency/finding was identified during the onsite review. Each deficiency/finding cited could result from an issue associated within one or more programs within the facility.

All of the four facilities cited for non-compliance in Contract Year-12 evidenced non-compliance in only one program area, with one program receiving two citations.

Exhibit 11. Triennial Compliance Assessment Visits-Results by Region



2.3.2. Statewide Distribution of Non-Compliance

Exhibit 12, Triennial Compliance Visits Conducted and Citations by Month, illustrates the distribution of the 29 triennial visits compared to the findings of non-compliance for visits completed each month. It does not appear that survey outcome was 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

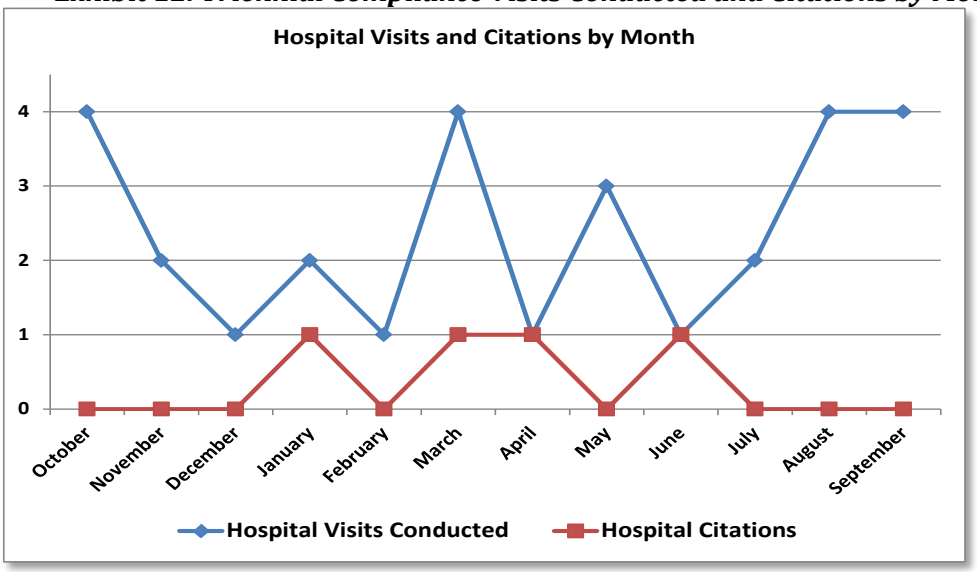
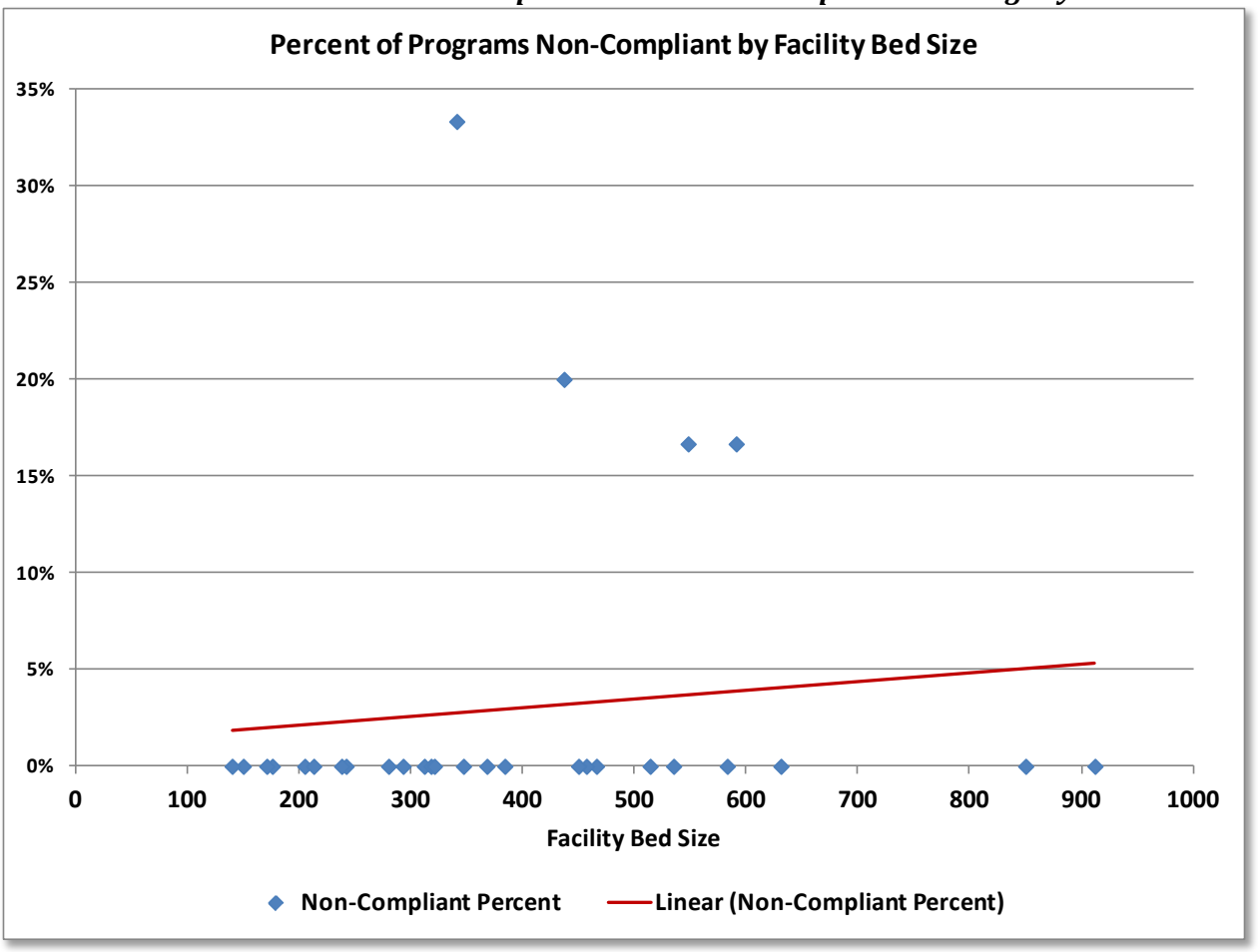


Exhibit 13, Triennial Compliance Visits-Non-Compliance Findings by Bed Size, presents a detailed assessment of compliance by bed size for the 29 triennial visits. Each facility is identified by its bed size, and is evaluated by the percent of non-compliance, as evidenced by the percentage of facility programs that were cited for non-compliance. For example, a facility review that included four teaching programs (i.e., 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. 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 Triennial Compliance Reviews

Compliance findings for the 29 triennial compliance reviews included the following:

- Twenty-five hospitals were found in substantial compliance with requirements, with no citations issued.
- Four hospitals were cited for non-compliance in at least one program area:
  - ✓ In three of the facilities cited, one program area within the facility evidenced non-compliance with one review criteria.
  - ✓ In one of the facilities cited, one program area evidenced non-compliance with more than one review criteria.
- Of the four hospitals that were cited for non-compliance:
  - ✓ Two facilities (family practice and internal medicine programs) were cited for residents working more than 24 consecutive hours,
  - ✓ One facility (family practice program) was cited for improper separation between working assignments,
  - ✓ One facility (OBGYN program) was cited for not having one 24-hour off period per week,
  - ✓ One facility (surgery program) was cited for improper medical record documentation of post-graduate trainee supervision.

2.4. Analysis of Onsite Compliance Assessment Visits and Revisits

A total of 34 visit types (29 triennials and 5 revisits) at 29 onsite visits were conducted during Contract Year-12. Of these, four facilities evidenced some level of non-compliance with requirements.

As previously stated, the new contract requirements implemented in April 2010 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 34 total visit types at 29 facility onsite visits based on current program requirements include:

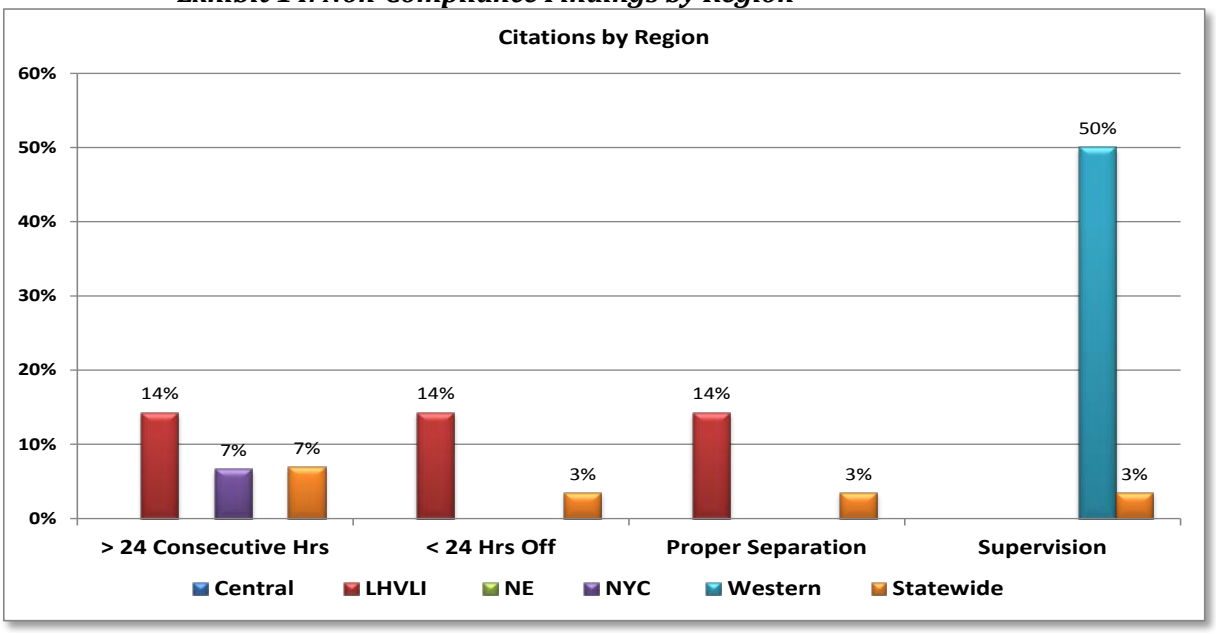
- 80 Hours Per Week. On average, over a four week period, the work week is limited to 80 hours per week. No facility was cited for working hours in excess of 80 hours each week.

- 24 Consecutive Hours. Regulations limit scheduled assignments to no more than 24 consecutive hours. ***Two facilities were cited for residents working more than 24 consecutive hours.***
- 24 Hours Off Period. Scheduling must include one full 24-hour off period each week. ***One facility was cited for residents not receiving a full 24-hour off period each week.***
- Proper Separation. Assigned work periods must be separated by not less than eight non-working hours. ***One facility was 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. No facility was cited for failing to meet expected working conditions for residents.
- 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 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 provide supervision if it can be demonstrated that the attending is immediately available by phone and readily available in person. For surgical programs, the regulations require 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. ***One facility was 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 Contract Year-12 were cited for deficiencies in their QA/QI performance. It should be noted that QA/QI would automatically be cited in Contract Year-12 for any facility that had a repeat deficiency from Contract Year-11 or in the case of a Contract Year-12 revisit, a repeat of findings in Contract Year-12.

- 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-12 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 Contract Year-12.
- 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 Contract Year-12.
- Medical Records. Medical record documentation and authentication regulations require that all medical record entries be signed, dated, and timed. All facilities visited in Contract Year-12 were found to be substantially compliant with medical record entry requirements.

The areas of non-compliance statewide and on a regional basis were residents working more than 24 consecutive hours, not receiving a full 24-hour off period during each week, improper separation of work assignments, and improper documentation of resident supervision. These findings are illustrated in Exhibit 14, Non-Compliance Findings by Region.

Exhibit 14. Non-Compliance Findings by Region



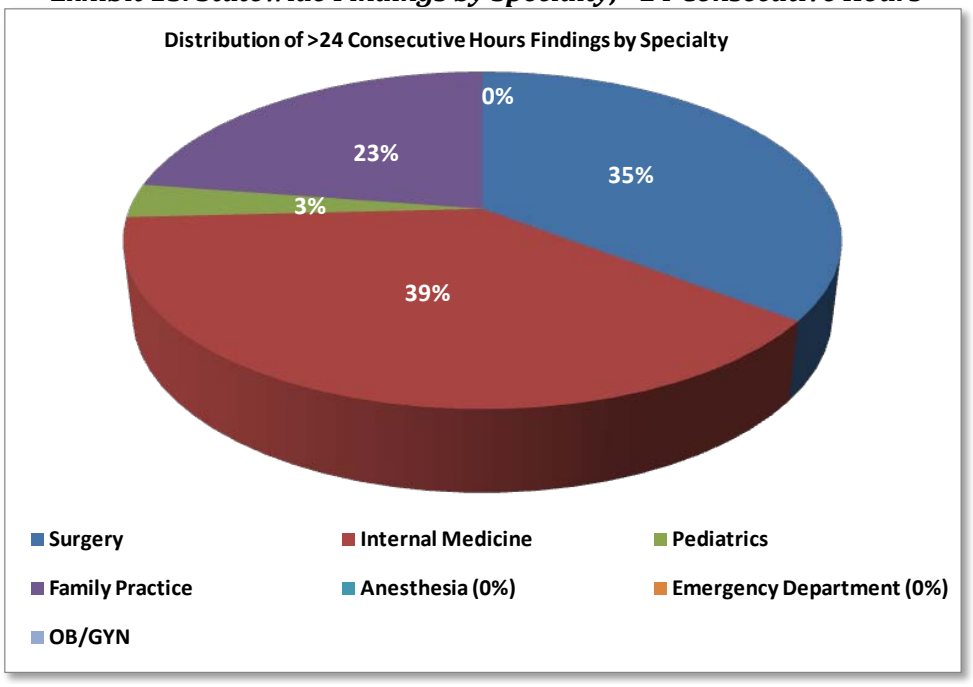
2.4.1. > 24 Consecutive Hours

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 used by facilities to provide for the appropriate transfer of patient information. Hospitals have some flexibility in using 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 Contract Year-12, non-compliance was evidenced in two facilities for 7% of the 29 triennial visits and 6% of the 34 total surveys conducted.

As illustrated in Exhibit 15, Statewide Findings by Specialty, >24 Consecutive Hours, based on the 34 total visits conducted and the total residents identified as having worked more than 24 consecutive hours, 35% of surgery and 39% of internal medicine residents were the most frequently identified, but not necessarily cited, for violating the >24 consecutive hours. This also can be attributed, in part, to the fact that each category includes findings associated with numerous subspecialties and accounted for more than half of the programs reviewed during this timeframe.

Exhibit 15. Statewide Findings by Specialty, >24 Consecutive Hours



2.4.2. <24-Hour Off Period

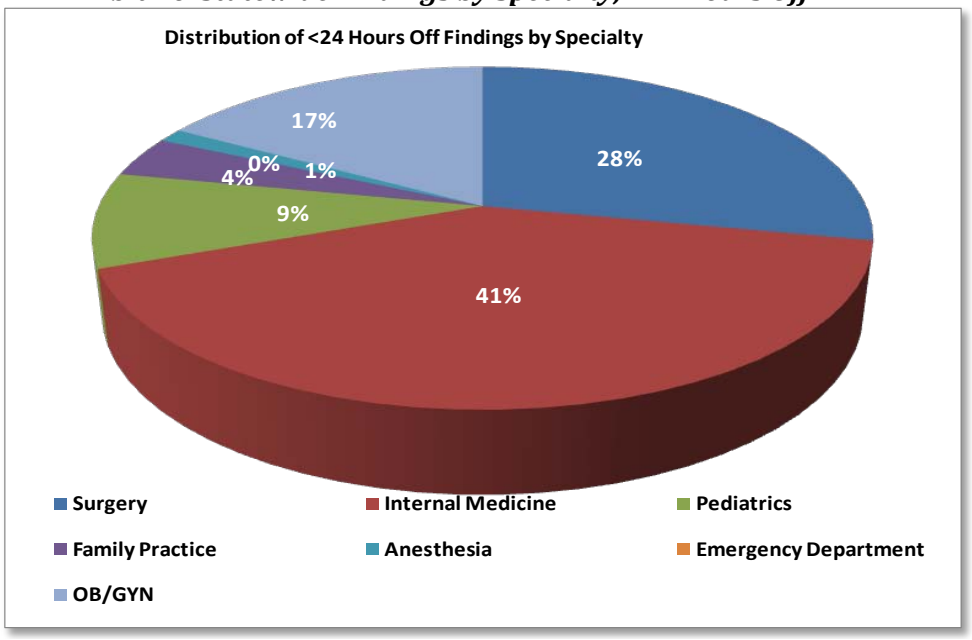
New York State regulations require that scheduling must include one full 24-hour off period each week free from patient care assignments or responsibilities. While programs may develop schedules that allow for a full weekend off or "Golden Weekend," programs must be mindful that NYS regulations require 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, for example, 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 Contract Year-12, statewide non-compliance was evidenced in one facility for 3% each of both the 29 triennial and 34 total surveys conducted.

As illustrated in Exhibit 16, Statewide Findings by Specialty, <24 Hours Off, based on the 34 total visits conducted and the total residents identified as not having one full 24-hour off period each week, 28% of surgery and 41% of internal medicine residents were the most frequently identified, but not necessarily cited, for <24 hours off. This also can be attributed, in part, to the fact that each category includes findings associated with numerous subspecialties and accounted for more than half of the programs reviewed during this timeframe.

Exhibit 16. Statewide Findings by Specialty, <24 Hours Off



2.4.3. 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 Contract Year-12, non-compliance was evidenced in one facility for 3% each of the 34 total and of the 29 triennial surveys conducted.

2.4.4. Supervision

As previously described above, New York State regulations require 24/7 access and availability by attending physicians to provide supervision of all post-graduate trainees. Compliance with the supervision requirements is assessed through interview data and review of patient records.

For all surveys conducted in Contract Year-12, statewide, non-compliance was evidenced in one facility.

2.4.5. Facility Revisits and Monitoring of Corrective Action Plans Results

Corrective Action Plans and implementation are monitored through revisits, which are conducted as a separate visit, at the time of the next onsite survey, or through the off-site written assessment.

- Facility plans of correction (POCs) and implementation for previously identified non-compliance were monitored through four facility onsite revisits and one off-site assessment.
- 100% of revisits evidenced substantial compliance with the POC.

2.4.6. Written (Off-Site) Assessments Results

No concerns were identified for the 86 off-site assessments.

2.4.7. Onsite Complaint Investigation Results

There were no onsite complaint investigations conducted in Contract Year-12.

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. Timeliness goals continue to be met. 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 Contract Year-12 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-12, IPRO received one new request and provided one training session. Based on the specific request, training was provided to surgical residents and faculty focused on the general work hour regulations.

IPRO developed a tips sheet based on frequently asked questions at exit conferences, and began email distribution to each facility along with individual facility specific reports, which compare the facility findings to statewide, regional and bed size results from contract year 1 through the first triennial cycle. Brochures continue to be distributed upon request and are given to residents during onsite survey interviews.

4.0 Contract Year-12 Deliverables: Forms, Protocols and Database Development

In cooperation with the Department, IPRO developed and implemented a standardized written compliance assessment tool in Contract Year-9. This tool continues to be 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 continues to use and modify as needed the existing logs, databases and tracking system to accommodate the program requirements.

5.0 Contract Year-12 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-12 the following reports have been submitted:

- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, October 1, 2012 - December 31, 2012
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, January 1, 2013 - March 31, 2013
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, April 1, 2013 – June 30, 2013
- Post Graduate Trainee Working Hours & Conditions, Quarterly Report, July 1, 2013 - September 30, 2013
- Post Graduate Trainee Working Hours & Conditions, Triennial Report, April 1, 2010 - March 31, 2013

6.0 FACILITY PROGRAM STRENGTHS

During the twelve years of IPRO's contract with the Department, we have looked at changes facilities have made in response to the duty hours. This year we continued to track such changes based on discussions with program directors, program coordinators, chief residents, and/or other program representative. The changes/program strengths remain consistent with previous years.

These changes are grouped into categories and summarized below:

- Schedule Changes
  - ✓ Implemented night float systems.
  - ✓ Changed time of morning and/or afternoon sign-outs to increase attendance while remaining compliant with work-hour regulations.
  - ✓ Changed time of last admit to allow residents to complete work and leave on time.
  - ✓ Increased or decreased upper level PGTs using home or on-site call to provide adequate coverage.
  - ✓ Use of a one-week clinic rotation which provides adequate and uninterrupted floor coverage, and improved clinic time and education.
- Staffing Changes
  - ✓ Use of Hospitalists, Nurse Practitioners and Physician Assistants for coverage.
  - ✓ 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 to allow attendance by night floats.
  - ✓ Conferences and presentations available on-line.
- Software Changes
  - ✓ Software for duty hour monitoring.
  - ✓ Software for handoffs.
  - ✓ Software for simulation.
  - ✓ More Web-based education.

- Other
  - ✓ Use of binders to maintain all required survey information.
  - ✓ Well-written policies that capture both New York State and ACGME regulations.

7.0 IPRO CONTINUAL IMPROVEMENTS

IPRO continues to work with the NYSDOH providing programs with information on how to be in compliance with the 405 code. In addition, IPRO:

- Collected facility contact and CEO information during both onsite visits and off-site written compliance assessments, and maintained an updated listing.
- Reviewed schedules, as requested by facilities, to assist in achieving compliance.
- 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.
- Provided onsite educational sessions.
- Developed and began distribution of a tips sheet to assist with compliance.

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 **FAX** 518-426-3418

Please submit the following documentation:

1. List of all accredited and non-accredited programs that sponsor residents in your hospital.
2. List of contact personnel (Program Director/Program Coordinator) and telephone number/extension for each department (including subspecialties).
3. List of all post-graduate trainees by service and PGY level.
4. Identify the Senior member of hospital administration who has oversight of compliance with work hour rules.
5. Description of system and/or method for monitoring resident work hour compliance.
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.
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.
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.
9. Describe or submit documentation outlining the process for handling internal complaints or concerns regarding resident work hours and/or supervision requirements.
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.
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).
12. Any other supporting documentation/ information that you wish to submit for review.

Note: 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.

QF-HC-IPRO 05/01/11