HOSPITAL COMPLIANCE WORK HOURS AND CONDITIONS OF POST-GRADUATE TRAINEES

Key Points of Clarification and Q & As

The following information is provided to assist facilities in understanding and achieving compliance with current Department of Health (DOH) requirements pertaining to resident work hours. The document is presented in two sections with the first portion outlining Key Points/Clarifications. This information is provided in a more abbreviated manner for those who wish to review key facts. The second section offers a more detailed question and answer format including many of the questions and/or scenarios that have been raised by facilities in the past. Although lengthy, the intent is to provide a reference document to meet the needs of facility staff and to provide an understanding of current requirements.

Key Points of Clarification

- The review process typically focuses on identifying the working hours for one workweek. In determining compliance, the average hours worked over four weeks is considered.
- Work hours include all hours accumulated through all on-site activities/responsibilities that are assigned or expected to be completed by post-graduate trainees (PGT).
- Working hours associated with moonlighting arrangements must be considered when computing total working hours.
- Up to a three-hour transition period is allowed following a 24-hour on-call assignment. The transition period is not intended for the assignment of new patient care activities but can be used to complete assignments, transition patient care, and for rounds/academics.
- A full 24-hour off period is required each week. This is a non-working period during which the PGT may not be assigned any on-site or home call responsibilities.
- Home call assignments are not typically counted as working hours except for hours associated specifically with on-site activities during that period. Facilities should consider/monitor the number and frequency of interruptions at home and the frequency and duration of on-site obligations. In addition, the 24-hour off requirement cannot be met if the resident is assigned home call responsibilities during that same period.
- Hospital policies/procedures must be realistic and reflective of current operations. Hospitals that elect to implement a policy more restrictive than State requirements will be expected to comply with that policy.
- NYS regulations require 24/7 on-site supervision. The basic requirement is that the hospital have attending-level on-site supervision at all times per the provisions under 405.4(f)(3)(iii). The code then goes on to say that for hospitals that can document that the patients' attending physicians are immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by postgraduate trainees who are in their final year of postgraduate training, or who have completed at least 3 years of postgraduate training.
- HIPPA does not restrict access to patient specific information necessary to fulfill surveillance activities. The HIPPA Privacy Rule provides that protected health information may be used and disclosed with the authorization of the patient for health oversight activities that are authorized by law. The Department of Health (DOH) oversees compliance reviews performed by an agency contractor, IPRO, Inc. In conducting all oversight and surveillance activities, they will exercise due diligence in maintaining the confidentiality of all information reviewed/collected, and protect against subsequent disclosure.

Questions and Answers

Question: How is the information that the residents communicate to the survey team verified?

Answer: On-site review activities are comprehensive in considering interview information, documentation, schedules, and information gathered through observation and record review. All data collected is carefully reviewed and analyzed to ensure that each finding is accurate. Any isolated or unusual circumstance that could impact work hours is also considered.

Question: There is concern with reviews being done in July, during the holiday season and/or on resident Match Day. Is IPRO making any accommodations in view of these time periods?

Answer: Throughout the year there are dates or periods of time where routine scheduling may be more difficult. Review staff are aware of this concern and will remain sensitive to each facility's competing priorities. While reviewers will consider any unusual circumstance identified during an on-site review, surveys will not be discontinued during such time periods.

Question: It is difficult to find room to accommodate the full survey team, and to locate key hospital personnel on short notice. Is the DOH committed to unannounced visits? Is it possible to get any advance notification of the survey?

Answer: The DOH is aware of the issues associated with unannounced visits; however, the nature of the reviews relies to a certain extent on that aspect. Review staff will document for the DOH information specific to initiating survey activity to identify any pattern of problems or obstacles to conducting an unannounced survey. In addition, review teams are directed to be sensitive to the problems facilities may have in regard to space and identifying staff to secure information for review. A formal entrance and/or exit conference is optional and is often unnecessary. Review staff can meet with the facility's representative to facilitate initiation of surveillance activities. All reviews should be carried out without disruption to patient care.

Question: The current review program calls for triennial on-site surveys and annual off-site compliance assessments. How will these be conducted?

Answer: One triennial on-site compliance survey will be conducted every three years for facilities with more than 10 PGTs. Compliance is assessed through a written compliance assessment document during the off years when an on-site visit is not conducted and for facilities with ten or fewer PGTs. Surveys are scheduled at random. Scheduling years run from April 1 – March 31 and surveys may be carried out at any time during the year. There could be 2, 6, or 12 months between surveys and the schedule will change every contract year.

Question: Are podiatry and dental residents being interviewed?

Answer: Reviewers may elect to interview residents or review records associated with any specialty or service. Often the information gathered through such interviews is useful in analyzing findings and determining how staff are assigned and utilized within the hospital. Specifically, if dental or podiatry residents are assigned on-call responsibilities or assigned to a surgical rotation, they would be interviewed.

Question: What do you do for subspecialties with only one or two residents in the program?

Answer: For review purposes, small programs/subspecialties would be folded into another specialty, such as orthopedics can be folded into surgery.

Question: If a resident is working in the lab during the week, and only does call on weekends, would you count this interview?

Answer: Each circumstance will be evaluated individually, and in this example, the resident would be interviewed. Anytime a resident is assigned patient care responsibilities there is an interest in documenting total working hours. In addition, it is important to document coverage within a program since that coverage would impact the working hours of other residents.

Question: How are upper level PGYs, fellows, and/or PGYs in non-accredited programs counted?

Answer: While the current contract is focused on PGY 1-3, reviewers may interview other individuals (i.e., PGY4 or above) to gather information regarding a program. However, data or specifically the work hour information collected, would not factor into any compliance determination.

Question: If a resident is completing an extended rotation will both sites (the program sponsor and the rotation site) be informed of the results of the review?

Answer: No. Each facility is responsible for the residents and the patient care activities associated with their own facility. Findings are reported separately to each facility.

Question: How do you determine work hour compliance for residents who rotate through multiple facilities?

Answer: Reviewers would consider the duration of the assignment or the rotation. For extended rotations, i.e. 3 to 4-month rotation, the site where the resident is assigned and providing patient care is responsible for assuring work hour compliance. Often residents are assigned and routinely rotate within a network or group of facilities/sites. In such cases, each site must give careful attention to documenting total working hours.

Question: If an institution routinely shares residents with other hospitals, does IPRO/DOH expect the institution to get schedules from other hospitals?

Answer: Typically, hospitals that routinely share residents would be expected to have copies of schedules or an accurate record of hours worked at all work sites. Such information is necessary to make an accurate compliance determination. IPRO would expect the hospital to produce a copy of all relevant schedules or an accurate record of hours worked that would contribute to total working hours. While schedules alone would not fully document working hours, it would be important for hospitals that routinely share residents to have accurate information on total hours worked. This would provide a basis for determining whether a resident is working in compliance with current requirements. At the time of each compliance visit, the facility will be advised of the documentation that should be submitted to the on-site review team.

Question: If residents do rotations out-of-state, what are the responsibilities of the director and/or hospital to ensure they work within the compliance of New York State regulations?

Answer: Residents traveling to another state for a committed rotation at an out-of-state facility would not be subject to New York's working hour limitations. For areas on the border of the state, where a resident routinely travels between states during a workweek, attention should be given to ensure the resident is working in compliance with current requirements.

Question: Why do reviewers need to collect schedules of academics/lectures?

Answer: All schedules/scheduled activities are considered in determining working hours. This would include on-call and clinic assignments, academics, etc. Work hours include all activities or assignments that a resident is expected or required to complete.

Question: In evaluating plan of correction implementation, if the same facility representatives are on the GME committee as on the quality assurance/improvement committee, do all corrective actions need to be reviewed by both committees?

Answer: No. If the members of the GME committee are designated as the quality improvement review agent, then such duplication would not be necessary. Each hospital's obligation is to ensure that its quality assurance program is fully operational and effective in carrying out its responsibilities. The hospital retains the flexibility to define how other programs/services/committees will relate to its ongoing QA/QI program. Survey staff will review all such activities to document actions taken to identify and correct problems.

Question: Are the entrance and exit conferences a mandatory and integral part of the process?

Answer: To clarify, entrance/exit conferences are not mandatory. The initial intent of the entrance and exit conferences was to facilitate cooperation and information sharing between IPRO and the facility and to serve as a formal introduction and conclusion to the survey process. In addition, if the hospital elects to schedule entrance and/or exit conferences, they can serve to bring the IPRO team in contact with key hospital personnel, such as program directors. The process of assembling an impromptu group of key personnel to attend the entrance and exit conferences, however, can be inconvenient, and is often unnecessary to expedite the survey process. Upon entering a facility IPRO will contact the designated facility representative and/or alternate, conduct a brief and informal entrance conference, and request assistance in facilitating the review team's access to patient care areas and in scheduling interviews. A more formal entrance conference is not necessary. IPRO review staff will contact personnel and schedule meetings as necessary during the course of the review. The exit conference is also an optional session that the facility may request, if desired. Often facilities find that gathering staff for an exit conference is time consuming and unproductive, particularly since reviewers are not in the position of sharing specific survey findings at that time. Survey findings are only released to facilities by the DOH upon submission of the on-site review documentation to the DOH by IPRO review staff.

Question: Is resident confidentiality protected?

Answer: Reviewers take great care to protect the confidentiality of all residents and information collected during the reviews. Resident names are not reflected in any survey findings or information discussed with the facility.

Question: How do you view the schedule using 7 days?

Answer: Hospitals have flexibility in developing their own scheduling cycle. Reviewers will gather information for as many days as possible. The intent is to collect accurate and verifiable information. In analyzing the data collected, reviewers will consider the interview information, the schedules set by the hospital, and other documentation to determine if the data collected is representative of a typical workweek.

Question: How do you determine the accuracy of resident information? How do you determine if the residents are being intimidated or coerced?

Answer: Careful attention is given to considering any information collected as part of the system in place at the facility. The DOH expects all parties in the interview process to be truthful and conscientious in providing accurate and complete information. Schedules and records are reviewed to confirm information gathered through interviews. Patterns of information may indicate a legitimate problem. Often an isolated occurrence or interview can be explained based upon an unusual circumstance or scheduling irregularity.

Question: How can reviewers validate the merits of a single complaint?

Answer: An individual complaint may result in an on-site survey; however, reviewers will focus on overall hospital compliance and not the alleged working hours of one individual. Complaint investigations typically focus on one program within a hospital and would evaluate working hour compliance for all residents in the program. The DOH receives complaints from many different sources. While each complaint is given full consideration, a careful and comprehensive review would be completed to validate any concern identified.

Question: Will review staff request/review medical records, operative reports/logs, etc?

Answer: Yes, such information will be reviewed and the information obtained from record reviews may impact working hours and could weigh in to the compliance determination.

Question: How will IPRO/DOH handle information collected during the survey that identifies quality issues?

Answer: Potential quality issues identified would typically be referred to the appropriate DOH regional office for review/consideration. Such issues might include specific infection control or confidentiality concerns identified while on-site. An issue that specifically contributes to the review of working hours, such as un-timed/un-dated progress notes or medical record entries may be cited with any working hour violation.

Question: In a smaller facility, how do you handle resident complaints and protect confidentiality, without skewing the data? What if a resident complains because the program is not to their liking?

Answer: Individual interviews even in small programs are not the sole basis for a compliance determination. Reviewers may conduct record reviews, interview supervisory personnel, and evaluate logs and schedules to validate the comments noted during an interview or to validate a complaint.

Question: If there is a compliance issue, i.e. working hours in excess of 80 hours/week, is there some way to find more specific information regarding the problem in view of confidentiality issues? More information would assist the hospital in developing an appropriate plan of correction.

Answer: Often more specific information can be shared with a facility, and, if a question arises during the development of a plan of correction, hospital staff should contact the DOH or IPRO.

Question: Once a survey is complete and a plan of correction is submitted, how long does it take until the facility receives the results of the plan of correction acceptance?

Answer: On average, upon receipt of a plan of correction, facilities are notified of the plan's acceptance within 5-7 business days.

Question: Does IPRO routinely conduct follow-up visits after a Statement of Deficiency is issued? If there is a follow-up visit, how are they scheduled and would that take the place of the next annual visit?

Answer: Once findings have been recorded, follow-up visits may be carried out at any time to ensure that appropriate corrective action has been taken to achieve compliance. A separate follow-up visit will not be conducted in every instance where findings are reported. A sample of hospitals will be selected for a follow-up visit, and that visit would be supplemental to the next annual visit. If a separate follow-up is not scheduled, then the hospital's plan of correction would be evaluated at the time of the next visit.

Question: Why are facilities being fined? Who determines the fines? What are the criteria for being fined? Is there a legal process if you are fined?

Answer: The legislation supporting the review process sets forth a progressive fine structure for non-compliance. The Department of Health carries out enforcement activities. Enforcement is a legal process and all enforcement activities are handled by the DOH Office of Legal Affairs.

Question: What is expected in regard to the routine maintenance of on-call rooms?

Answer: Hospitals are responsible for maintaining adequate working conditions for residents. This would include the necessary space and resources to provide accommodations for rest. Routine housekeeping and an adequate supply of linens, where beds are available, would be expected.

Question: If the resident is assigned to one hospital but goes to an off-site clinic for a few hours and works over 80 hours for the week, is the assigned facility responsible?

Answer: Reviewers would evaluate the circumstances of the assignment. If a resident from one hospital is assigned to a weekly three-hour clinic at an off-site location the assigning hospital is responsible for monitoring the total working hours of the resident and ensuring that the proper work separations are in place. The off-site clinic in this case would be unable to account for the working hours of the resident other than for the three hours of the clinic.

Question: Is there any repercussion against a resident for disparities between what was reported and what is documented? Mistakes can be made in reporting information over a multi-day period. How are such inconsistencies addressed?

Answer: The intent is always to accurately document working hours. In some cases, individuals forget specifics or timeframes; a record review can validate such information. A pattern of misrepresenting information or underreporting working hours could result in further review.

80-Hour Workweek:

Question: Is an average calculated to determine compliance with the 80-hour workweek? How is this being calculated?

Answer: Facilities have flexibility in how schedules are set. The regulations do not dictate one particular scheduling cycle. Reviewers will typically look closely at working hours for a 7-9 day period, ask questions about scheduling patterns, and review actual schedules. It is possible to determine from the information collected whether averaging over four weeks is a factor to be considered. If the number of overnight calls in one week is different from the next week, for example, that would be considered when determining the average working hours.

Question: When there is a pattern of residents working 83 hours per week, are hours still averaged out over 4 weeks?

Answer: The intent of the regulations was not to accommodate wide variations in hours worked each week. Residents working 84 hours one week and 74 hours the next week would average out appropriately. Typically, up to 85 hours is an acceptable variation when averaging.

Question: Does the transition time add into the 80 hours worked?

Answer: Yes. Hospitals have considerable flexibility in utilizing the transition period. The unscheduled transition hours must be considered/counted as part of total working hours.

24-Hour Work Assignment:

Question: Do DOH regulations outline the requirements associated with the transition period?

Answer: No. DOH policy has afforded facilities flexibility in scheduling staff to provide for continuity of patient care and the transition of patient care responsibilities to new staff. This has been a longstanding DOH policy although the regulations do not specifically address this issue.

Question: Is there any exception to the 24-hour rule for any department?

Answer: DOH has a long-standing policy to allow up to a three-hour transition period following a 24-hour on duty assignment to facilitate the appropriate transfer of patient information. Current requirements limit emergency departments to scheduled shifts of 12 consecutive hours. Surgical programs may utilize the surgical exemption, and, if properly implemented, may schedule work hour assignments of more than 24 consecutive hours. For the specialties/sub-specialties covered by the regulations, no other variations to this policy would apply. For specialties other than those specifically covered by the regulations, hospitals have flexibility to develop appropriate scheduling arrangements that meet specific needs.

Question: What can the transition time following a scheduled on-call assignment be used for? Is it OK for residents to work up to 27 hours?

Answer: Facilities may not schedule residents for 27 consecutive hours. Scheduled assignments (other than in the case of surgical programs appropriately utilizing the surgical exemption) may not exceed 24 consecutive hours. Following this on-call period, up to a three-hour transition period may be used. Transition time of up to three hours would count as part of the total working hours for the week. In addition, if the scheduled day off is to follow the on-call period, it is important to ensure that the resident receives a full 24-hour off period. If the scheduled day off routinely follows an on-call assignment and

residents are consistently getting 21-22 hours off, the scheduling practice would not meet current requirements. The primary restriction associated with utilizing this period is that no new patient care responsibilities may be assigned or assumed by the resident during this period.

Question: During the transition time, may a resident complete clinical care for patients with whom they are already involved, as long as no new patient care responsibilities are assumed? For example, a resident could be completing a history and physical, or completing a work up or treatment for a patient under the resident's care during the assigned shift?

Answer: Completing the history and physical which has been started would be part of transition time and considered completion of patient care responsibilities for that patient.

Question: Can a resident assigned a 24-hour shift use the transition time to write new orders and do patient notes?

Answer: As part of transition, the resident should complete all medical record entries and patient notes. Only orders related to care/treatment managed by the resident and provided during the assigned shift should be written by the resident completing the assignment. Transfer of patient information to incoming staff, i.e. incoming resident, should appropriately be carried out during this time period. The incoming resident should then write any new orders.

Question: What services may a resident provide during transition?

Answer: This time is primarily for the transfer of patient information, completion of medical record entries and patient notes. As part of transitioning patient information, residents may participate in rounds and grand rounds/education. Residents may not extend an assigned 24-hour shift to attend to patients in continuity clinic, for example.

Question: Could transition time be used in the emergency department?

Answer: Yes. Transitioning patient care responsibilities and completing assignments would be appropriate in any department. The transition period would count toward the total workweek and may not be a scheduled part of the residents working assignment.

Question: For anesthesia residents, can the transition time be used to set up the OR for the next case?

Answer: Yes, completing assignments from a scheduled work shift would be an appropriate use of transition time. The anesthesia resident may not, however, initiate any new patient care responsibilities, e.g. starting an OR case.

Question: A resident participates in a surgical procedure, completes a scheduled work shift, and returns later in the day to check on the patient. Is this resident in violation of working hour regulations?

Answer: Returning to the hospital following a scheduled work assignment would likely be in violation of one or more work hour rules. In this case, the resident would likely be in violation of proper work separation.

24-Hour Off Period:

Question: How is the 24 hours off per week determined? Can you work more than 6 days in a row?

Answer: Reviewers would consider the scheduling cycle used by the hospital, and would expect evidence that a resident has a full 24-hour off period each week. The sample days reviewed during a survey may or may not correspond to the scheduling cycle in place at the hospital. Questions will be asked as to time off periods, and schedules will be reviewed. It is possible for a resident to have a day off at the beginning of one week and at the end of the next week, and still be in compliance. This allows for hospitals occasionally to schedule for a full weekend off. Facilities should be cautious not to routinely schedule for more than 7 consecutive days without a day off since working hours can easily accumulate creating other violations.

Question: Can the 24-hour off period be Sunday of Week 1 and Saturday of Week 2?

Answer: Hospitals have flexibility in scheduling to meet needs. It is not expected that a resident have the same day off each week. The 24-hour off period may float to allow greater flexibility in scheduling and the above arrangement would meet current requirements. Hospitals should be cautious in establishing schedules to ensure that the scheduling system in place does not create compliance problems. For example, scheduling a 24-hour off period following overnight call can result in less than a full 24-hour off period if the resident remains in the facility for the full 3-hour transition period and then reports back to the facility in less than 24 hours.

Question: What if the resident is on-call at home on their day off?

Answer: A day off means not assigned or scheduled for work. If a resident were scheduled for home call, then the time would not be considered as a day off.

Question: Do residents have to physically be off the premises on their day off? What if they are in the hospital to attend a birthday party or conference?

Answer: Routinely it would be expected that residents be off the premises when scheduled off. Any unusual circumstances would be considered to determine the purpose of the visit, whether the resident is available to hospital staff by beeper, or whether the resident has participated in or attended to patient care needs.

Question: What if they are on the premises, but in the library?

Answer: If they cannot be called or beeped for patient care, or are not checking on a patient, we will not count these hours. Reviewers can typically validate such situations by reviewing patient charts, operative reports, and confirming that a resident was not in patient care areas.

Question: Would mandatory conferences or exams count as working hours? In addition, if a resident attended grand rounds or a mandatory conference or exam on a day off, would those hours count?

Answer: Typically, yes, the hours would count. There are options for videotaping conferences, and this is a recommended best practice to ensure that residents fully benefit from such sessions. This is looked at very closely and considered on a case-by-case basis when determining whether a resident benefited from a full 24-hour off period each week.

Question: Does this extend to other activities if they were on the hospital floor? Would you count these hours?

Answer: Yes. If the resident is in the hospital and specifically on a patient care floor, he/she is likely to interact with patients and/or staff, thus the time would be counted as working hours.

Question: What if a resident comes in for a trauma case and spends 4 hours?

Answer: Working hours in the hospital count toward the 80 hours. In addition, if a resident is on-call at home, the hospital must consider the frequency and duration of calls requiring the presence of the resident in the hospital. It is possible that home call is not an appropriate scheduling option if the number of calls are frequent and extensive in duration.

Question: Often residents work as part of a team. In a three-person team, if one individual is on vacation the other two will need to cover additional shifts to ensure full coverage. It may not be possible to provide for a full 24-hour off period. What accommodations are made for this circumstance?

Answer: Reviewers will document unusual and unexpected circumstances that might contribute to intermittent scheduling difficulties. Scheduled vacations, however, would not be considered unexpected or unusual, and, as such, each of the residents covering would be expected to have a full 24-hour off period during the workweek. Keep in mind, however, that a single occurrence/violation that occurs due to unusual circumstances would not typically be cited. Reviewers focus on identifying patterns of non-compliance.

Moonlighting:

Question: Can you clarify moonlighting?

Answer: Moonlighting means working outside of the accredited program. If a resident assumes additional work in an emergency department, and that work is not part of the accredited training program/curriculum, then that time is counted as moonlighting.

Question: What do you mean by moonlighting is not covered by an accredited program?

Answer: Residents practicing within the scope of their accredited programs are not required to be licensed or have a limited permit. Residents working outside of an accredited program must have a license or limited permit. In addition, it should be noted that current requirements specify that residents may engage in moonlighting only if the resident has completed the required years of post-graduate training. A resident who attended a U.S. medical school would require one year of clinical experience, while a graduate of a foreign medical school would require three years of clinical experience.

Question: What if a resident moonlights in the same facility of their residency, but moonlights outside of their accredited program?

Answer: The answer is the same. Working outside of an accredited training program, any resident must be licensed or have a limited permit. Hospitals should carefully establish such practices to ensure that adequate protections are in place in terms of legal liability.

Question: What if they are moonlighting outside of the patient care setting?

Answer: The intent of the dual employment (moonlighting) regulations is to limit additional clinical care work of post-graduate trainees. This would include clinical activities at any location.

Question: What is an effective mechanism to ensure compliance with the moonlighting requirements and limit residents from practicing outside of the facility?

Answer: In terms of best practices, many hospitals have included provisions in the resident's contract limiting opportunities for dual-employment.

Question: Do moonlighting hours count against the accredited program facility?

Answer: Yes, the moonlighting hours worked would count toward the 80-hour workweek and would be evaluated in determining compliance with the other work hour requirements (i.e., 8-hour separation, 24 hours off, etc.).

Home call:

Question: Do residents need an 8-hour separation if on-call at home and they are called into the facility?

Answer: Generally, no. There is some flexibility with this. It is recognized that the on-call at home resident will occasionally have to come into the facility. This is expected and while the on-site hours would count, the intent of the regulations is to provide the facility with some flexibility in terms of complying with other aspects of the regulations, such as the 8 hours off between assignments. If, however, there is a pattern where the residents who are on-call at home are frequently coming into the hospital or are staying for extensive periods of time, then the hospital should question whether the home call arrangement is reasonable and appropriate to their needs. If there is a consistent pattern of such residents returning to the hospital and/or staying for extended time periods in the hospital, then the situation would violate working hour requirements.

Question: If a resident is on-call at the hospital, but gets some sleep in the on-call rooms, do the sleep hours count toward a weekly total?

Answer: For surgical residents only, getting "some" sleep is not the same as establishing a system or pattern for rest that allows for 4-5 hours of sleep per night. In the absence of any organized or documented system for rest, the hours would count as work hours.

Question: A resident is scheduled for on-call at home, but opts to stay at the hospital to avoid a long distance commute if called in. How would this be handled?

Answer: On a case-by-case review of the specific circumstances, it could be acceptable for a resident to sleep on the premises. The facts and documentation associated with the situation would be considered in evaluating its acceptability.

Question: Is there a maximum number of hours residents can be on-call at home or a limit on the number of times a resident who is on-call at home can be called into the facility?

Answer: Not at this time. Considerable flexibility has been afforded to facilities in scheduling residents for home call. Caution should be taken in ensuring that home call is an appropriate and suitable means to meet hospital/patient needs. If residents are scheduled for home call and frequently are phoned and/or called into the facility, then this scheduling option is not a viable choice at this time. In validating interview information, reviewers will thoroughly review medical records, operative reports, etc., to determine if such residents are routinely in the facility and carrying out patient care responsibilities. When appropriately utilized, home call provides a legitimate scheduling option for facilities where residents at home are not frequently contacted and do not routinely report to the facility during the on-call period. Time spent in the facility will count in calculating working hours. Time spent at home, taking occasional phone calls would not count, for example, as part of the workweek. Residents must, however, have a full 24-hour period off each week. They cannot be assigned home call responsibilities during this 24-hour off period.

Surgical Exemption:

Question: Can you explain the surgical exemption?

Answer: The surgical exemption is intended to provide a scheduling option for surgical residents participating in night call where adequate rest can be documented. The intent of the surgical exemption was to promote the continuity of patient care and to provide increased opportunity for surgical residents to participate in morning OR. To provide for this scheduling flexibility, hospitals must ensure that residents receive 4-5 hours of uninterrupted rest, participate in call not more than once every third night, and benefit from a full 16-hour off period following an on-call period. In addition, hospitals must have a system in place to relieve residents from duty if fatigue or lack of rest becomes a factor. If a resident with night call documents a period of 4-5 hours of rest/sleep, he/she can then stay for morning OR. The goal is to ensure that the resident receives the full 16-hour off period following this work period, and is eligible to return to the hospital for morning OR the next day. To accomplish this, the resident who reported for duty at 6 a.m. would need to leave the hospital by 2 p.m. post-call (the next day) and return no earlier than 6 a.m. the following day.

Question: Does the surgical exemption apply to any other specialty area, for instance OB/GYN?
Answer: No, only the surgery department.

Question: Can the surgical exemption be implemented on an ad-hoc basis?

Answer: The expectation is that facilities have an organized and systematic approach to ensuring compliance. An ad-hoc arrangement whereby an individual may or may not benefit from adequate rest would not be sufficient to ensure compliance. Hospitals may, however, implement a scheduling system that includes utilizing the surgical exemption only for senior residents. Such an approach can be implemented in a consistent and systematic manner.

Question: What constitutes a rest period? Does it refer to aggregate time? If a resident does not leave the on-call room, and receives 4-5 calls during the night, is this considered "resting"? Is there a perfect system in place for using the surgical exemption?

Answer: Hospitals should carefully consider if the surgical exemption provides a reasonable opportunity to meet the hospital's specific needs. If a resident is going to be busy and experience frequent calls and interruptions, then use of the exemption may not be effective. In terms of best practices, it can be beneficial when alternative staffing is available during the night shift and the resident can be considered on second call during periods of rest/sleep.

Question: Surgical residents are concerned about missing OR when they comply with working hour limitations. How do residents meet GME requirements and not violate NYS regulations?

Answer: If a hospital is appropriately using the surgical exemption, the resident should not be missing morning OR cases. Scheduling in accordance with the flexibility allowed under the surgical exemption, and in consideration of the accreditation requirements, would allow residents to benefit from morning OR sessions.

Question: Do we have to use the surgical exemption?

Answer: No. Many hospitals elect not to use the exemption because it imposes additional documentation/oversight requirements. Surgical programs can adhere to the working hour requirements in place for all other programs, which would limit to no more than 80 hours per week, and no more than 24 consecutive hours, with 8 hours separating each work assignment. Often this works much better for programs. It is important that the hospital consider how best to meet its needs.

Question: In applying the surgical exemption, does the rest period need to be consecutive?

Answer: Yes. DOH/IPRO will evaluate the system in place to ensure that it provides for uninterrupted rest.

Question: When the surgical exemption is implemented properly, how should work hours be counted?

Answer: The intent of the surgical exemption is to provide an opportunity for surgical residents to remain on duty for more hours, thus ensuring continuity of patient care and participation in OR cases. As stated previously, when the surgical exemption is appropriately utilized, a resident could remain on duty following a 24-hour on-call period. The resident who reported at 6 a.m. would be available for morning OR post-call the next day, would leave the facility by 2 p.m., have 16 hours off and return to the facility at 6 a.m. the following morning for OR. Such on-call assignments are limited to no more than every third night.

Supervision:

Question: How is supervision reviewed?

Answer: Reviewers discuss access and availability of supervision with residents during the interview. In addition, medical records are reviewed for documentation of supervision. The intent is to assess the access to and availability of appropriate supervision in the required specialties, the standard for personal supervision by attending physicians is met for care provided to surgery patients, and that quality supervision is documented and evident in the care/services provided by post-graduate trainees as confirmed through review of patient records. Supervision issues, as they relate to quality, are referred to DOH survey staff for specific review.

Question: How will reviewers conduct medical record review in facilities with electronic medical records?

Answer: It is expected that facilities with electronic medical records provide the reviewers basic read-only access. IPRO's review staff have experience in navigating most EMR systems and can function independently. As with review of paper records, all confidentiality is maintained.

Question: What are you looking for in the medical records?

Answer: Ongoing evidence in the patients' record of attending/supervising physician's oversight and management of: patient care, care and services provided by post-graduate trainees, and in-person supervision of post-graduate trainees in the operating room. For example, documentation by the PGT in the progress notes indicating they have discussed with the attending/supervising chief, attestations from attending physicians, such as, "I have seen and examined the patient and agree with the resident note above/discussed with residents", and/or follow-up progress notes by the supervising physician, usually meet this requirement. For surgery patients, per NYS 405.4 code provisions, supervision by attending physicians must include as a minimum: personal supervision of all surgical procedures requiring general anesthesia or an operating room procedure, preoperative examination and assessment, and postoperative examination and assessment no less frequently than daily.

Question: When a resident rotates to other facilities, which facility is responsible for supervision?

Answer: Supervision is an on-site coverage issue. Therefore, the site where the resident is working is responsible for supervision.

Question: Can a Family Medicine PGY2 resident be the senior on-call on-site with the attending physician available by phone?

Answer: No. In this example it would have to be a PGY3 on-site with the attending physician available by phone. (Note that programs where training requirements are greater than 3 years, the on-site supervision must be provided by a resident who has completed 3 years of training, for example, a PGY4 in OB/GYN.) The basic requirement is that the hospital have attending-level on-site supervision at all times per the provisions under 405.4(f)(3)(iii). The code then goes on to say that for hospitals that can document that the patients' attending physicians are immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by postgraduate trainees who are in their final year of postgraduate training, or who have completed at least 3 years of postgraduate training. So we initially look to see what attending level supervisory physicians are on-site and then consider the alternative.

Question: Can a Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, or other mid-level practitioners provide the supervision?

Answer: No.

Question: How do the NYS regulations compare with ACGME for supervision?

Answer: NYS requires on-site supervision 24/7 by supervising or attending physician