GETTING PRACTICAL WITH MEDICAL STAFF

GOVERNANCE, CREDENTIALING & PEER REVIEW

Graduate Medical Education:
Topics for the Medical Staff At Teaching Hospitals
Graduate Medical Education: Topics for the Medical Staff At Teaching Hospitals

The presence of graduate physician medical learners at hospitals adds another level of complexity for the medical staff.

Presented by
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Overview

• Scan of graduate medical education settings
• CMS has few specific requirements in the Medicare CoPs regarding graduate programs
• The Joint Commission refers to the role of the Graduate Medical Education Committee
• The GMEC is a function of the ACGME
• Moonlighting
• ACGME focus on Resident Wellbeing
Graduate Medical Education

• **CMS DID NOT ALWAYS ENSURE HOSPITALS COMPLIED WITH MEDICARE REIMBURSEMENT REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION**, OIG Report, November 2018, A-02-17-01017
  – OIG and CMS scrutiny is continuous, since Medicare pays teaching hospital collectively approximately $10 billion per year

• Accreditation Counsel for Graduate Medical Education – ACGME

• Clinical Learning Environment Review – CLER

• Graduate Medical Education Committee – GMEC

• Physicians At Teaching Hospitals – PATH
GME for the Medical Staff Is Often a Matter of Unscrambling, Untangling and Translation

Scrambled words are easily misunderstood. Most people will have little trouble reading this sentence.
Unscrambled, Untangled and Translated

Scrambled words are easily unscrambled. Most people will have little trouble reading this sentence.

What Is GME?

• GME begins in medical education after graduation from medical school (undergraduate medical education – UME) and continues through the completion of specialty and subspecialty graduate programs (internships, residencies and fellowships) up until a physician completes training and starts to practice independently

• Does not include continuing medical education – CME or maintenance of certification – MOC

• Often depicted as a pipeline
The Physician Pipeline

11 years

5.5-7 years

*While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor’s degree to enter some master’s programs.
990,688* Practicing Physicians
135,063** Residents and Fellows

• Approximately 12% of licensed physicians are learners in GME
• Graduate physician learners are an important clinical resource, but since they are not yet fully independent practitioners additional checks and balances are needed

* Kaiser Family Foundation, State Health Facts
https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

** ACGME Data Resource Book, 2017-2018
AMC Structures

- AMC Components
  - Medical School/College of Medicine
  - Faculty Practice Plan/Teaching Physician Organization
  - Teaching Hospital(s)
    - Medical Staff requirements apply directly only here
    - Overlay (sort of) all other AMC components
    - Core structure for AMC clinical enterprise

Figure 4.31
How Academic Health Centers (AHCs) Are Organized

AHCs take many organizational forms. Consolidation and growth of health systems and primary focus on system financial performance will put substantial stress on support of AHC education and research missions, support of which are critical to AHC success.

Loose  Degree of Integration  Tight

Independent
- University of Colorado School of Medicine
- University of Kansas Medical Center

Academic Enterprise Model
- Columbia University
- Washington University School of Medicine
- Weill Cornell Medical College
- Yale School of Medicine

Separate Practice Plan
- University of Alabama Medicine
- Duke Medicine
- University of Virginia Health System

Clinical Enterprise
- Indiana University Health
- Northwestern Medicine
- Partners Healthcare
- University of Pittsburgh Medical Center
- Stanford Health Care

Fully Integrated
- UCLA Health
- Emory Woodruff Health Sciences Center
- Johns Hopkins Medicine
- University of Michigan Health System
- Oregon Health & Science University
- Penn Medicine

Adapted by The Chartis Group from Levine31
Community Teaching Settings

• "Freestanding" programs: the teaching hospital or the health system is the accredited institution sponsoring its own programs

• Affiliations with medical schools, where the medical school is the ACGME accredited institution sponsoring the programs – an entirely different structure than the LCME accredited medical school itself

• Affiliations with GME consortia: collaborative arrangements among multiple institutions to sponsor GME programs
Little Specific Guidance from CMS for How the Medical Staff Should Address GME Learners

• CMS standard for residents: Appendix A, Restraint and Seclusion, A-0168
  – A *resident* who is *authorized by State law and the hospital's residency program to practice as a physician* can *carry out functions reserved for a physician* or LIP by the regulation. A medical school student holds no license, and his/her work is reviewed and must be countersigned by the attending physician; therefore, he or she is not licensed or independent. A medical school student is not an LIP

• Appendix A, Content of Records, Informed Consent, A-0466
  – Statement, if applicable, that physicians other than the operating practitioner, *including but not limited to residents*, will be performing important tasks related to the surgery, in accordance with the hospital's policies and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner

• No specific mention of residents in the Medical Staff CoPs, nor mention of the GMEC anywhere
Little Specific Guidance from CMS for How the Medical Staff Should Address GME Learners

• Appendix A, Informed Consent, A-0955
  – A well-designed informed consent process would include discussion of the following elements ... Whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies. Important surgical tasks include: opening and closing, dissecting tissue, .... (there is more in the text of a-0955)

• Appendix A, Medical Records, A-0450
  – When state law and/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules and regulations must address counter-signature requirements and processes.

• The need for the special treatment of residents occurs on limited sections of the CoPs, the above is not a complete list
Minimum Necessary for CMS Compliance at Hospitals with Limited GME Presence

• Resident on-boarding process: everyone involved in care of patients must have identity verified, health screen, etc., minimum, reasonable, "credentialing" as a resident learner/LIP, including coordination with supervising physicians and PDs

• General policy on what residents can order, can do under supervision, can document, etc., including specific provisions relating to residents and restraint/seclusion orders. See also next slide on surgeries

• Assessment of resident's role for the informed consent process and adjustment of consent forms as needed

• Mechanism for communication between the Medical Staff and the GMEC(s) overseeing the residents' programs; not a specific requirement but the only way to ensure that information the Medical Staff will need to oversee all patient care in the hospital can be obtained from the GME authority over the programs
CMS Deemed Status Through DNV

- DNV follows CMS CoPs closely, so no mention of GMEC
- When surgical/procedural residents are present, DNV adopts the residents and surgeries discussion almost verbatim from the CoPs: NIAHO SS.4, Version 18.1
- For surgeries in which residents will perform important parts of the surgery, discussion is encouraged to include the following:
  - That it is anticipated that physicians who are in approved post graduate residency training programs will perform portions of the surgery, *based on their availability and level of competence*;
  - That it will be decided at the time of the surgery which residents will participate and their manner or participation, and that this will depend on the availability of residents with the necessary competence; the knowledge the operating practitioner/teaching surgeon has of the resident's skill set; and the patient's condition;
  - That *residents performing surgical tasks will be under the supervision of the operating practitioner/teaching surgeon*; and
  - Whether, based on the resident's level of competence, the operating practitioner/teaching surgeon will not be physically present in the same operating room for some or all of the surgical tasks performed by residents
- **NOTE:** A "moonlighting" resident or fellow is a postgraduate medical trainee who is practicing independently, outside the scope of his/her residency training program and would be treated as a physician within the scope of the privileges granted by the hospital
- Whether, as permitted by State law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out; and that such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges by the hospital
Moonlighting – CMS perspective

• For purposes of Medicare Part B physician services billing, the term "services of moonlighting residents" refers to services that licensed residents perform that are outside the scope of an approved GME program. 42 CFR 415.208

• Since these services are outside the residency program, these moonlighting residents must be fully licensed, credentialed and have hospital privileges; limited appointments, not "members" but with privileges to do what they are doing in the hospital. Medical Staff Bylaws must accommodate this type of LIP with unique characteristics

• Considered full "physicians" for Medicare professional billing purposes, meaning must individually enroll in Medicare and PATH billing ideas do not apply: not "residents" while moonlighting

• CoP A-0045 For physician practitioners granted privileges only, the hospital's governing body and its medical staff must exercise oversight, such as through credentialing and competency review, of those other physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff
Moonlighting – ACGME

• Moonlighting Common Program Requirements, VI.F.5
  a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
  b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.
  c) PGY-1 residents are not permitted to moonlight.
TJC Medical Staff Standards and GME

- MS.04.01.01, Elements 6, 7 and 8

6. There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital)
   - The [GMEC] must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs
   - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs
   - Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization

7. There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants

8. Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC has with the governing board of the sponsoring hospital
   - Emphasis added.
TJC and ACGME

• What standard creates/defines the GMEC?
• Since nearly all physician GME programs need to be ACGME accredited for Medicare GME reimbursement to be paid, the ACGME structure also applies
• The GMEC is a function of the ACGME Institutional Requirements for the accreditation of GME programs
The ACGME GMEC Standard

• ACGME *Institutional Requirements*, I.B.1.
  – A Sponsoring Institution with multiple ACGME-accredited programs must have a GMEC that includes at least the following voting members:
    1) The DIO;
    2) A representative sample of program directors (minimum of two) from its ACGME-accredited programs;
    3) A minimum of two peer-selected residents/fellows from among its ACGME-accredited programs; and
    4) A quality improvement or patient safety officer or designee
The ACGME GMEC Standard

• Requirements, I.B.4.
  – GMEC responsibilities must include: Oversight of:
    1) The ACGME accreditation status of the Sponsoring Institution and each of its ACGME-accredited programs;
    2) The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites;
    3) The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements;
    4) The ACGME-accredited program(s)' annual program evaluations and self-studies;
    5) All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and
    6) The provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.
Coordinating the GMEC with the MEC

• The MEC and the GMEC are at the same level, but the final authority for the MEC is the hospital board and the final authority for the GMEC is the sponsoring institution's governing authority; might be the hospital GB, if the hospital is the sponsoring institution, but commonly it is another organizational structure: College of medicine or GME consortium sponsor
  — Can be confusing, since learning and clinical care delivery occur simultaneously
• The MEC is ultimately responsible for the quality of care of the patients
• A0049: The governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients. The governing body is responsible for the conduct of the hospital and this conduct includes the quality of care provided to patients
• A0338: The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital
ACGME Focus on Resident Well Being

• Previously, primary focus was on **Duty Hours**, focusing on resident fatigue and patient safety, all "balanced" with the need to learn as much as possible. Common Program Requirements Section IV.F.:
  
  – Clinical and educational work hours must be limited to no more than **80 hours per week**, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and all **moonlighting** [IV.F. 1]
  
  – Residents should have **eight hours off between scheduled clinical work and education periods**. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements [IV.F.2.b)and b).1]
  
  – Residents must have at least 14 hours free of clinical work and education after **24 hours of in-house call** [IV.F.2.c])

• In 2014, the focus changed
Physician Suicide

- On average, nearly 400 physicians commit suicide each year; a doctor a day
- 2x or more higher than the general population
  

- Average medical school class size is 120 students: 400 physicians = 3.3 *entire medical school classes* needed just to replace physicians who take their own lives annually
- Minimum 7 years of medical education: 4 medical school plus 3 graduate = 2,800 *person years* of medical education lost to society each year
- Profound personal tragedy
Physician Suicide

- Why Do Doctors Commit Suicide?, P. Sinha, September 2014


- ACGME Initiative, Improving Physician Well-Being, Restoring Meaning in Medicine
  https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being
ACGME Focus on Resident Well Being

The ACGME has been committed to exploring causes of and solutions for physician well-being for as long as the organization has been serving the graduate medical education (GME) community. The ACGME's Physician Well-Being initiative has expanded in recent years within the work of the organization and through partnerships in the medical community, with the ultimate goal of reducing burnout and helping physicians rediscover joy and meaning in work.

https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being

Next slide, Tia Drake, AHME Academy, Morehouse School of Medicine, February 23, 2018, slide 44

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<tr>
<th>Wellness Program Peer Institution Data</th>
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<tr>
<td><strong>Institution Size</strong></td>
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<td>2.25 FTE psychologist</td>
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<td>0.25 FTE psychiatrist only</td>
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<td>.3 psychiatrist, .3 Psychologist</td>
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<td>(Proposed) .6 FTE Psychiatry</td>
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<td>.5 FTE Psychology</td>
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<td>Coordinate with EAPs</td>
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<tr>
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<tr>
<td>Yes (ACGME requirement)</td>
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</table>
Physician Wellbeing

• ACGME Common Program Requirements, Section VI.C
  – In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. *Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence*

• Common Program Requirements, VI.F.5
  – And this includes moonlighting time and work
Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

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