ACGME Plans to Cut First-Year Resident Hours

BY ALICIA AULT

The Accreditation Council for Graduate Medical Education has revisited its standards for resident duty hours and determined that some modifications should be made, mostly for first-year residents. All other residents should still be subject to an 80-hour work week and up to 24 hours of continuous duty, according to an article published online in the New England Journal of Medicine.

The 16-member ACGME task force that wrote the standards will review public comments and make any modifications considered necessary before July 2011, when the new standards will go into effect.

A task force suggests first-year residents should not be on duty for longer than 16 hours continuously and should have 10 hours off and 8 hours free of duty between scheduled duty periods.

The American College of Surgeons Task Force on Resident Duty Hours has analyzed the recommendations and submitted its comments to the ACGME, said Dr. L.D. Britt, chairman of the task force and chairman of the Dept. of Surgery at the Eastern Virginia Medical School, Norfolk, Va. The 34-member task force represented a variety of organizations and specialties. Dr. Britt said that the task force would discuss its comments after the ACGME had a chance to review them.

The original ACGME standards, established in 2003, have been the subject of much consternation in the medical community, with opinions differing over whether they have been too restrictive or too loose to properly protect patients and ensure a good quality of life for residents.

According to the latest report, written by Dr. Thomas J. Nasca, Dr. Susan H. Day, and Dr. E. Stephen Amis Jr. on behalf of the ACGME task force, the 2003 standards had the following three "problematic" elements, as identified by the educational community and the public:

► The limits on duty hours may have created a shift mentality among residents, which tends to conflict with the duty to serve patients.

► Many academic programs began focusing on meeting the duty hour restrictions, perhaps at the expense of education.

► The 80-hour work week, with up to 24 hours of continuous duty, was seen by many as compromising patient safety.

In 2008, the Institute of Medicine took a hard look at the ACGME standards and, among other things, recommended that no residents should exceed 16 hours of continuous duty.

The ACGME convened the task force to consider the IOM recommendations. One of the biggest challenges, according to the authors, was to reconcile the IOM's suggestion for an across-the-board restriction on duty hours with the continuing plea from academic programs that duty hours needed to be tailored to each specialty (N. Engl. J. Med. 2010 [doi:10.1056/NEJMsb1005800]).

For surgery, in particular, it would be difficult—and contrary to learning—to have a resident leave in the midst of a procedure because his or her duty hours had been reached.

The ACGME panel also had to weigh whether there was sufficient evidence to show that working more than 16 hours or up to 30 hours continuously led to more medical errors, as has been suggested by many critics of the duty hour standards.

According to the ACGME panel, the data thus far indicate only that first-year residents are more prone to mistakes as a result of sleep deprivation. Therefore, the task force urged a new paradigm for the first year of residency, whereby residents cannot be on duty for longer than 16 hours continuously and should have 10 hours off and 8 hours free of duty between their scheduled duty periods. First-year residents are not allowed to moonlight, and they must have direct, in-house, attending-level supervision.

All residents are allowed to work up to an additional 4 hours to facilitate patient handoffs—an area of concern for patient safety.

The panel decided not to tailor duty hours to specialties "because studies have not shown that the safety effect of current standards varies with specialty," said the authors.

The IOM had also criticized the ACGME for not properly enforcing the duty hours. The task force said that enforcement is an "inherent" challenge, partly because there are some 9,000 accredited programs.

However, the ACGME is now undertaking annual site visits and analyzing whether institutions can comply. Eventually, the organization will give each institution a report on its compliance status and recommendations for resolving problems. The reports will be made available to the public, said the authors.

Wake Up Doctor, a coalition of public interest and patient safety groups that has been pushing the ACGME to further restrict resident hours, said that the new standards don't go far enough. The group gave the ACGME an "F" for failing to comply with the IOM recommendation that continuous duty be restricted to 16 hours for all residents.

The coalition also gave a failing grade to the ACGME's plans for better monitoring compliance with the standards. However, the recommendation for greater supervision of first-year residents got higher marks.

The revised standards represent an important step, but "I think the acid test will be in the details," Helen Haskell, founder and president of Mothers Against Medical Error, and a coalition member, said in a statement. "We need to be sure that residents of all levels have sufficient backup and reasonable limits on their workloads." ■

Insurers' Report Card Deems Claims Process More Accurate

BY SUSAN BIRK

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION'S HOUSE OF DELEGATES

CHICAGO — Twenty percent of health insurance claims are processed inaccurately, according to the American Medical Association's third annual National Health Insurer Report Card, which rates the nation's largest commercial insurers on timeliness and accuracy of claims processing.

Eliminating discrepancies in expected payment amounts would save doctors and insurers $15.5 billion annually, according to the report, which is based on a random sample of 2 million claims for 3.5 million services filed electronically February through March 2010 by 200 practices in 43 states.

Each year, claims processing costs as much as $210 billion and takes up 10%-14% of physicians' gross revenue and the equivalent for each physician of 5 work weeks, Dr. Nancy H. Nielsen, then immediate past president of the AMA, said in an educational session. "Physicians are drowning in this."

To remedy the problem, the AMA urges the creation of a single, transparent insurance industry standard "so that everybody knows in a seamless way how those claims are to be submitted and processed," Dr. Nielsen said, adding that such a standard would reduce errors and free physicians to focus more on patients and less on administrative red tape.

The report card "has actually turned out to be not just a 'gotcha' against the insurers, but an actual 'win win' between national payers and the AMA" because the insurers appear to be using the feedback to improve, Dr. Nielsen said.

Insurers made gains in some areas, including accuracy in the reporting of contract fees to physicians. They correctly reported contract fees 78%-94% of the time in 2010 versus 62%-87% of the time in 2008.

They also increased the transparency and accessibility of their fee schedules, according to Mark Rieger, chief executive officer of National Healthcare Exchange Services Inc. of Sacramento, which conducted the research.

Physicians' electronic access to complete fee schedules plays a major role in processing accuracy, he said. "Where the payer makes the fee schedule available, we have higher match rates."

"We've got a long way to go," he said. "There's still a need for better transparency. But we're optimistic that if payers continue to demonstrate some of the improvements that they've shown" additional efficiencies can be gained.

Coventry Health Care Inc. had the highest overall accuracy (88%), while Anthem Blue Cross Blue Shield had the lowest (74%). Other insurers addressed by the report were Aetna, CIGNA, Health Care Services Corp., Humana, and UnitedHealth Group.

Mr. Rieger said that every 1% increase in the match rate for claims would generate a conservatively estimated $777.6 million for physicians and payers. A 100% match rate would yield an annual savings of $15.5 billion.

The AMA asked physicians to do their part to improve the claims process by working to submit claims correctly the first time and implementing practice efficiencies such as an effective electronic practice management system, Tammy Banks, director of practice management and payment advocacy for the AMA, said.

"There's a lot going on in the next 5-10 years. Make sure that your vendor is willing to notify you of changes and upgrades" in federal and state mandates and transaction codes, she emphasized.

Administrative portals for claims processing "are a great short-term solution—they're getting us where we need to be," but they are not a long-term replacement for a direct relationship with payers through an effective electronic practice management system, Ms. Banks said. ■

The National Health Insurer Report Card is available at www.ama-ssn.org/ama1/pub/upload/mm/368/2010-nhirc-results.pdf.

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