AIAMC National Webinar
March 27th, 2020

# *Value of the Patient's Voice, and more*

**Kevin B. Weiss, MD**
Chief Sponsoring Institutions and the Clinical Learning Environments
Accreditation Council for Graduate Medical Education
Chicago, Illinois

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Disclosures: Professor of Medicine, Northwestern University Feinberg School of Medicine

Conflict of Interests:  none

# The voice of the Patient in

# CLER Pathways 2.0


# CLER Pathways to Excellence

- A guidance document; not a set of requirements
- *"…a **tool** for assessing the present and simultaneously envisioning and planning for the future."*

# CLER Focus Areas

Patient Safety


Health Care Quality


Supervision

Teaming

Well-being

Professionalism

# CLER Evaluation Committee Members

**John Patrick T. Co, MD, MPH, Co-Chair**
DIO, Brigham and Women's and Massachusetts General Hospitals
Director, Graduate Medical Education, Partners Healthcare
Director, Ambulatory Quality and Safety, MassGeneral Hospital *for* Children

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ACGME

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Associate Dean, GME, Professor of Anesthesiology
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**Tanya Lord, PhD, MPH**
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Foundation for Healthy Communities

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Resident, Obstetrics and Gynecology
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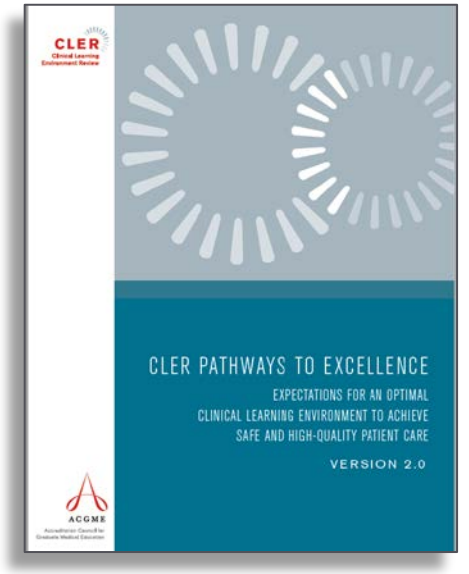
**Lucie E. Mitchell, DO, MS**
Educational Chief Resident
University of Alabama at Birmingham

# Teaming




## T Pathway 3: Clinical learning environment engages patients* to achieve high-performance teaming

### The clinical learning environment:

a. Maintains a strategy to engage patients as part of its effort to ensure high-performance teaming.

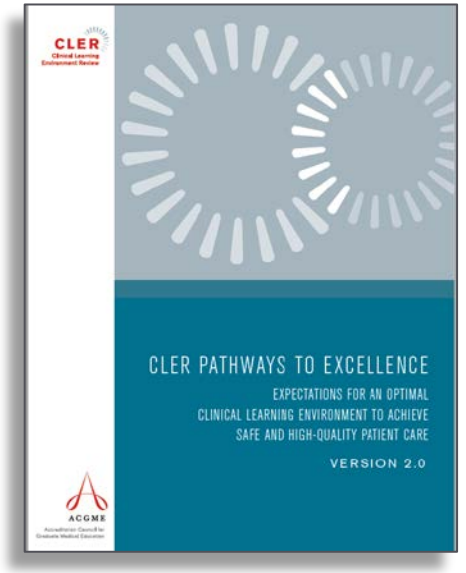
b. Ensures that patients are engaged with their clinical care team in decisions related to their care.

c. Engages patients in the development and revision of the clinical site's policies and procedures on patient care in which residents and fellows are involved (e.g., duty hours, supervision, informed consent).

d. Ensures that patients are involved, as appropriate, in resident and fellow care transitions (e.g., change-of-duty hand-offs).

* "Patient" can include family members, caregivers, patient legal representatives, and others.

# Supervision




## S Pathway 4: Patient* perspectives on graduate medical education supervision

### The clinical learning environment:

a. Ensures that patients understand the roles and are able to identify the names of attending physicians, residents, and fellows caring for them at the clinical site.

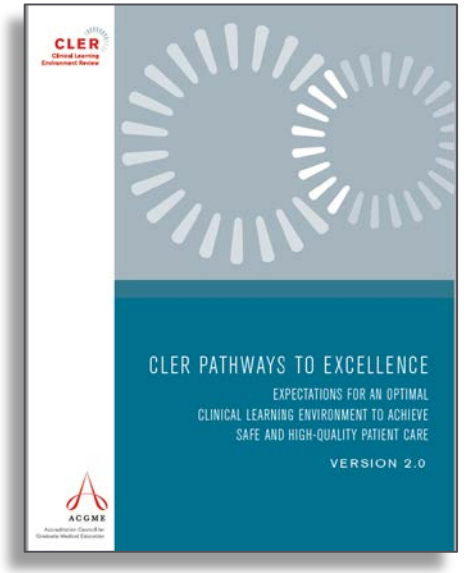
b. Ensures that patients have adequate contact with the resident and fellow team caring for them at the clinical site.

c. Communicates to patients the mechanism for them to directly contact the attending physician in charge of their care about concerns with supervision.

d. Includes patients' perceptions in monitoring adequate supervision of residents and fellows.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

# Professionalism




## PR Pathway 4: Patient* perceptions of professional care

**The clinical learning environment:**

a. Educates residents, fellows, and faculty members on how patient experience data on professionalism are used to improve patient care.

b. Routinely provides residents, fellows, and faculty members with patient experience data on professionalism at the clinical site.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

# Overview of Patient Perspective Subprotocol

# Patient Perspective Subprotocol

- Assesses patient perspective on how CLEs engage residents and fellows in the 6 CLER focus areas to improve quality of patient care
- Emphasis on brief interviews with patients
- Includes interviews with patient experience leader/officer, resident/fellow escorts, and nurses
- Subprotocol development led by Dr. Robin Dibner, CLER Field Representative

# Patient Perspective Subprotocol

- Series of cognitive interviews to test and improve questions that may be difficult to understand
- 3 field tests to date
- Official rollout planned for late 2020 in Cycle 4
- 25-30 visits in total
- For the initial set of visits, all subprotocol visits will be 2-day visits
- Webinar prior to official rollout, including publically sharing patient questions

# Selected Patient Questions

- Could you please tell me, who is the doctor in charge of your care during your stay at this hospital/medical center? Are there residents who assist your doctor?

- Do the doctor in charge and residents come into your room together each day to talk with you about your care? Do they also come into your room together with nurses each day?

- During your stay at this hospital/medical center, do your doctors go over the plans for your care in a way that you can understand?

- At this hospital/medical center, do you feel your doctors encourage you to ask questions?

- During your stay at hospital/medical center, have there been times when you felt that there was a lack of coordination between your doctors in planning your care?

- During your stay, have your doctors and nurses given you conflicting information about your care?

- Do you feel the residents are respectful to you and your family?

- Did anyone at the hospital/medical center explain to you what to do if you had a concern about your care?

# The voice of the Patient in

# COVID….it makes a difference

The New York Times

Opinion

# How the Coronavirus May Force Doctors to Decide Who Can Live and Who Dies

In the face of overwhelming demand and limited resources, health care would need to be rationed, with agonizing decisions.

**By Ezekiel J. Emanuel, James Phillips and Govind Persad**

Dr. Emanuel is vice provost of global initiatives at the University of Pennsylvania, Dr. Phillips is chief of disaster and operational medicine at George Washington University Hospital, and Mr. Persad is an assistant professor at the University of Denver Sturm College of Law.

March 12, 2020

How can health care officials ethically decide who gets scarce medical resources during this pandemic?

Building on our own past research on rationing medical resources, as well as American, British and Australian guidelines for a less daunting influenza pandemic, and just-released recommendations by the Italian intensive care unit physicians' group, we offer these suggestions.

The priority should be health care workers; police, firefighters and other emergency workers; and those who keep water, electricity and other necessary systems functioning, because they can save the lives of others. This primacy should not be abused. For instance, physicians who are not involved in patient care, such as researchers or administrators, should not get special treatment.

The New York Times

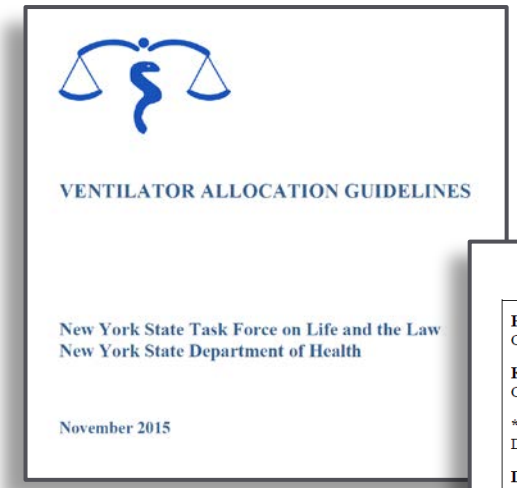
# *Whose Lives Should Be Saved? Researchers Ask the Public*

Mary Jo D'Amico, a nurse at Memorial Medical Center in New Orleans, fanned a patient waiting in the hospital's parking garage for helicopter transport after Hurricane Katrina in 2005. Doctors had to make life-or-death decisions on which hurricane victims to treat. Brad Loper/The Dallas Morning News, via Associated Press

August 21, 2016

For the past several years, Dr. Lee Daugherty Biddison, a critical care physician at Johns Hopkins, and colleagues have led an unusual public debate around Maryland, from Zion Baptist Church in East Baltimore to a wellness center in wealthy Howard County to a hospital on the rural Eastern Shore. Preparing to make recommendations for state officials that could serve as a national model, the researchers heard hundreds of citizens discuss whether a doctor could remove one patient from lifesaving equipment, like a ventilator, to make way for another who might have a better chance of recovering, or take age into consideration in setting priorities.

- Lottery
- Best chance to survive
- Longest potential lifespan
- Based on triage criteria



VENTILATOR ALLOCATION GUIDELINES

New York State Task Force on Life and the Law
New York State Department of Health

November 2015

**Members of the Task Force on Life and the Law**

**Howard A. Zucker, M.D., J.D., LL.M.**
Commissioner of Health, New York State

**Karl P. Adler, M.D.**
Cardinal's Delegate for Health Care, Archdiocese of NY

***Adrienne Asch, Ph.D., M.S.**
Director, Center for Ethics at Yeshiva University

**Donald P. Berens, Jr., J.D.**
Former General Counsel, NYS Department of Health

***Rev. Thomas Berg, Ph.D., M.A.**
Professor of Moral Theology,
St. Joseph Seminary

**Rabbi J. David Bleich, Ph.D.**
Professor of Talmud, Yeshiva University
Professor of Jewish Law and Ethics, Benjamin Cardozo School of Law

**Rock Brynner, Ph.D., M.A.**
Professor and Author

**Karen A. Butler, R.N., J.D.**
Partner, Thuillez, Ford, Gold, Butler & Young, LLP

**Carolyn Corcoran, J.D.**
Principal, James P. Corcoran, LLC

**Nancy Neveloff Dubler, LL.B.**
Consultant for Ethics, New York City Health and Hospitals Corporation
Professor Emerita, Albert Einstein College of Medicine

**Paul J. Edelson, M.D.**
Professor of Clinical Pediatrics, Columbia College of Physicians and Surgeons

**Joseph J. Fins, M.D., M.A.C.P.**
Chief, Division of Medical Ethics,
Weill Medical College of Cornell University

**Rev. Francis H. Geer, M.Div.**
Rector, St. Philip's Church in the Highlands

**Samuel Gorovitz, Ph.D.**
Professor of Philosophy, Syracuse University

**Cassandra E. Henderson, M.D., C.D.E., F.A.C.O.G.**
Director of Maternal Fetal Medicine
Lincoln Medical and Mental Health Center

**Hassan Khouli, M.D., F.C.C.P.**
Chief, Critical Care Section,
St. Luke's – Roosevelt Hospital

**Rev. H. Hugh Maynard-Reid, D.Min., B.C.C., C.A.S.A.C.**
Director, Pastoral Care, North Brooklyn Health Network,
New York City Health and Hospitals Corporation

**John D. Murnane, J.D.**
Partner, Fitzpatrick, Cella, Harper & Scinto

***Samuel Packer, M.D.**
Chair of Ethics, North Shore-LIJ Health Syste

***Barbara Shack**
Health Policy Consultant

**Robert Swidler, J.D.**
VP, Legal Services
St. Peter's Health Partners

**Sally T. True, J.D.**
Partner, True and Walsh, LLP

***indicates former member**

**Task Force on Life and the Law Staff**

**Susie A. Han, M.A., M.A.**
Project Chair of Guidelines,
Deputy Director, Principal Policy Analyst

**Valerie Gutmann Koch, J.D.**
Special Advisor, Former Senior Attorney

***Angela R. Star**
Former Administrative Assistant

***Beth E. Roxland, J.D., M.Bioethics**
Former Executive Director

***Tia Powell, M.D.**
Former Executive Director

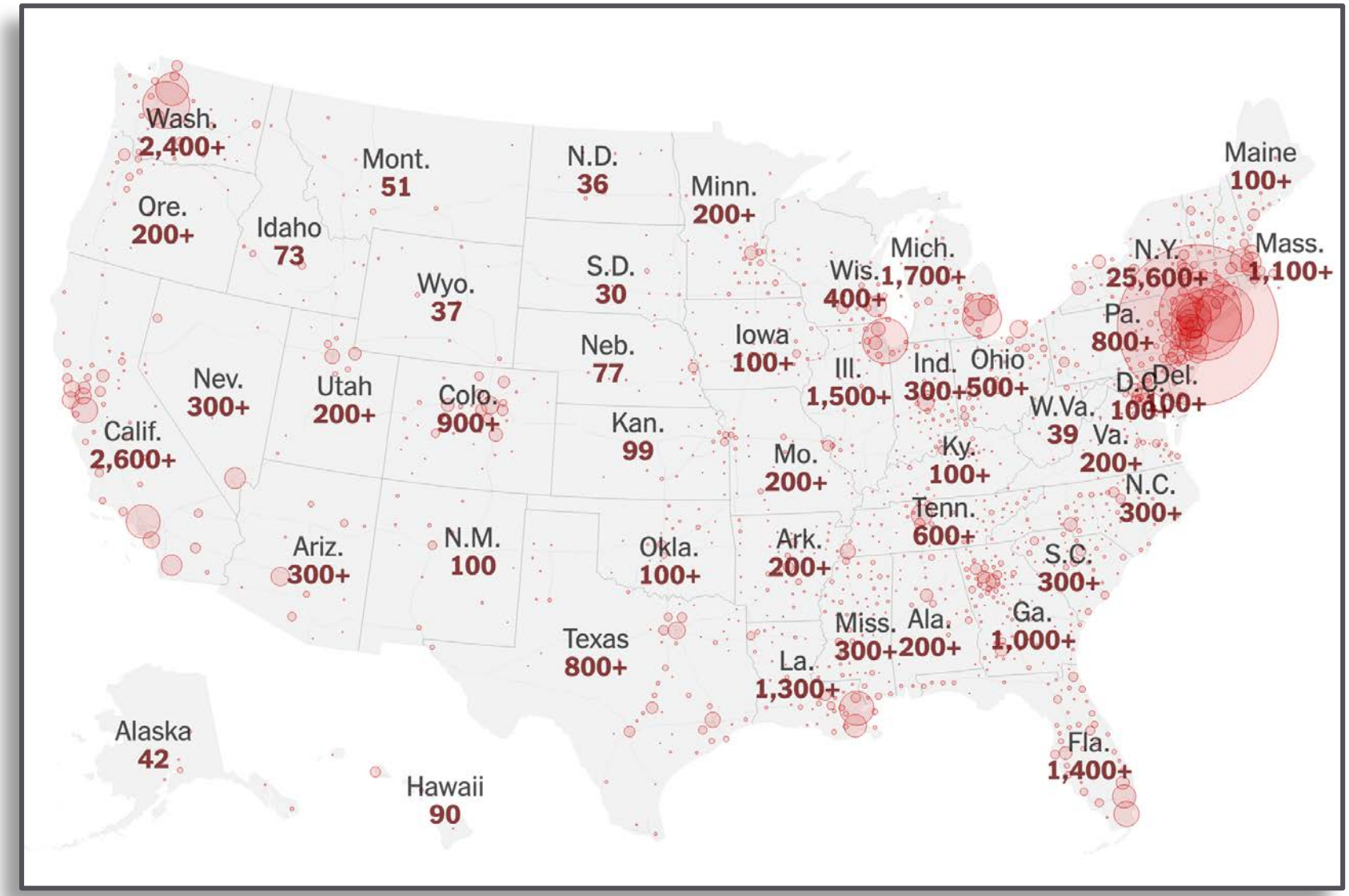
***Carrie S. Zoubul, J.D., M.A.**
Former Senior Attorney

*indicates former staff

The Task Force explored various non-clinical approaches to allocating ventilators, including distributing ventilators on a first-come first-serve basis, randomizing ventilator allocation (e.g., lottery), requiring only physician clinical judgment in making allocation decisions, and prioritizing certain patient categories (i.e., health care workers and patients with certain social criteria). However, the Task Force determined that these approaches would not be the best primary method to allocate scarce resources because they are often subjective and/or does not support the goal of saving the most lives. Furthermore, advanced age was rejected as a triage criterion because it discriminates against the elderly. Age already factors indirectly into any criteria that assess the overall health of an individual (because the likelihood of having chronic medical conditions increases with age) and there are many instances where an older person could have a better clinical outlook than a younger person. Thus, the Task Force concluded that a ventilator allocation protocol should utilize clinical factors only to give patients who are deemed most likely to survive with ventilator therapy an opportunity for treatment. After reviewing various clinical protocols, the Task Force developed New York's clinical ventilator allocation protocol for adults.

# ACGME and the rapidly evolving pandemic

# Coronavirus-19 in the US, March 25




Source: NYTimes

# Three selected issues

- Changing ACGME operations
- Adapting the Accreditation activities to meet current environment
- Communicating with the GME community


About Us | Contact Us | Newsroom | Blog | LEARN at ACGME
Type your search here...
Accreditation Council for Graduate Medical Education
LOG INTO
Accreditation Data System (ADS)
ACGME Surveys
Case Log System
Institution and Program Finder
What We Do
Designated Institutional Officials
Program Directors and Coordinators
Residents and Fellows
Meetings and Educational Activities
Data Collection Systems
Specialties
Response to Pandemic Crisis Section Added to Website
This new section provides information about ACGME activities during the pandemic and guidance for institutions and programs during this crisis.
LEARN MORE
ACGME NEWS UPDATE
Coronavirus (COVID-19)
WHAT'S NEW
ACGME Response to Pandemic Crisis web section now available
MARCH 24, 2020
ACGME response to COVID-19: Clarification regarding telemedicine and ACGME Surveys
MARCH 20, 2020
Letter to the Community regarding the ACGME response to the COVID-19 crisis
MARCH 18, 2020
ACGME shares Federation of State Medical Boards (FSMB) information on access to Physician Data Center
MARCH 17, 2020

Home > ACGME Response to Pandemic Crisis

# ACGME Response to Pandemic Crisis

The pressures of the COVID-19 (SARS COV2) pandemic are mounting across the country. Significant numbers of patients are arriving or being transferred to teaching hospitals. In contrast, some institutions are seeing very few of these patients, but are planning for the anticipated surge of patients infected with the novel coronavirus.

These circumstances, and their continued evolution, require a new conceptual framework from which graduate medical education (GME) can effectively operate during the pandemic.

Sponsoring Institutions and their participating sites are functioning at one of three stages along a continuum:

- Stage 1 – "business as usual"
- Stage 2 – increased but manageable clinical demand
- Stage 3 – crossing a threshold beyond which the increase in volume and/or severity of illness creates an extraordinary circumstance where routine care education and delivery must be reconfigured to focus only on patient care

| Stage 1: "Business as Usual" | Stage 2: Increased Clinical Demands | Stage 3: Pandemic Emergency Status |
|---|---|---|
| Governed by the Common and specialty-specific Program Requirements | Governed by the Common and specialty-specific Program Requirements and variances addressed in the Stage 2: Increased Clinical Demands Guidance | Governed by four overriding requirements |

The ACGME recognizes institutions and programs in the first two stages are also planning for the third stage of response to the pandemic.

## Quick Links

- Overview
- Three Stages of GME During the COVID-19 Pandemic
- Stage 2: Increased Clinical Demands Guidance
- Stage 3: Pandemic Emergency Status Guidance
- Pandemic Emergency Status Declaration Form

## Contact Us:

**General Inquiries**
For general questions about the ACGME's response to the COVID-19 crisis, or in response to communications sent by the ACGME.
ACGMECommunications@acgme.org

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**In Sponsoring Institutions that have self-declared Pandemic Emergency Status, the requirements below remain in effect. All other Common Program Requirements and specialty-specific Program Requirements are suspended for ACGME-accredited programs in those institutions.** This flexibility will allow Sponsoring Institutions and programs to increase the availability of physicians in clinical care settings.

The declaration of Pandemic Emergency Status lasts 30 days. A DIO may terminate this status in less than 30 days by notifying the ACGME via email dio@acgme.org. An extension beyond 30 days is subject to review by the Institutional Review Committee. All declarations and requests for extensions will be managed by the Executive Director for the Institutional Review Committee.

This declaration applies at the institutional level and involves all residents/fellows in all specialty and subspecialty programs at the Sponsoring Institution. This status cannot be requested for a subset of the institution's ACGME-accredited programs unless there are ACGME-accredited programs completely outside the affected service area that do not require the flexibility afforded through the declaration, e.g., a Sponsoring Institution that is a consortium functioning in multiple states.

In granting this flexibility, **the ACGME, in partnership with its ACGME-accredited programs, expects the Sponsoring Institution to fully comply with the following requirements** designed to protect its residents/fellows, health care teams, and patients.

The Sponsoring Institution and its programs must ensure the following:

**1. Adequate Resources and Training**

All residents/fellows must be trained in, and be provided with, appropriate infection protection for the clinical setting and situation. Appropriateness should consider the needs of the patient and the health care team, as well as the range of clinical care services being provided. Residents/fellows must only be assigned to participating sites that ensure the safety of patients and residents/fellows.

**2. Adequate Supervision**

Any resident/fellow who provides care to patients will do so under appropriate supervision for the clinical circumstance and for the level of education and experience of the resident/fellow. Faculty members are expected to have been trained in the treatment and infection control protocols and procedures adopted by their local health care settings.

**3. Work Hour Requirements**

The ACGME Common Program Requirements in Section VI.F. addressing work hours remain unchanged. Safety of patients and residents/fellows is the ACGME's highest priority, and it is vital all residents and fellows receive adequate rest between clinical duties. Violations of the work hour limitations have been associated with an increase in medical errors, needle sticks, and other adverse events that might lead to lapses in infection control. Deviations in this domain could increase risks for both patients and residents/fellows.

**4. Fellows Functioning in Core Specialty**

Fellows in ACGME-accredited programs can function within their core specialty, consistent with the policies and procedures of the Sponsoring Institution and its participating sites, if:

a. they are American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board-eligible or -certified in the core specialty;
b. they are appointed to the medical staff at the Sponsoring Institution; and,
c. their time spent on their core specialty service is limited to 20 percent of their annual education time in any academic year.

Abuse of residents, use of residents in areas in which they do not have the knowledge and skills to provide the services demanded, or failure to comply with any of the above four expectations may result in ACGME intervention.

The ACGME recognizes the serious challenges faced by the nation and its teaching hospitals. By instituting this policy clarification, the ACGME seeks to reduce the regulatory burden on Sponsoring Institutions and programs that care for patients affected by the pandemic. This flexibility is offered so that Sponsoring Institutions and programs can marshal their clinical enterprise to meet the surge of patients they must care for. The ACGME expects that this flexibility and relief will support Sponsoring Institutions and programs to protect their residents/fellows, and by doing so protect the patients under their care.

ACGME

# Pandemic Emergency Status Declaration Form

*Email completed and signed forms to dio@acgme.org. The ACGME will contact the designated institutional official (DIO) with any questions and will send confirmation of Pandemic Emergency Status declaration to the DIO and institutional coordinator.*

1. Sponsoring Institution Name

2. ACGME 10-Digit ID

3. Designated Institutional Official Name

4. Pandemic Emergency Status Requested Start Date

5. What is the term of the Sponsoring Institution's declaration of Pandemic Emergency Status?
   ☐ 30-day declaration ☐ Other end date (less than 30 days only) _____

6. The Sponsoring Institution may exempt programs from this declaration only if those exempted programs have no participating sites in common with other programs that are subject to this declaration. If the Sponsoring Institution wishes to exempt programs from this declaration, list the programs to be exempted and their participating sites. Add rows as needed.

| Specialty/Subspecialty | ACGME ID | Participating Site(s) |
|---|---|---|
| | | |
| | | |

*By signing the Pandemic Emergency Status Declaration Form, the designated institutional official:*

- *requests that the Sponsoring Institution and its ACGME-accredited program(s) be granted Pandemic Emergency Status through the ACGME's Extraordinary Circumstances policy;*
- *attests that this request for Pandemic Emergency Status has been approved by the clinical leadership of the primary clinical site(s) of the Sponsoring Institution's accredited program(s);*
- *attests that all voting members of the Sponsoring Institution's Graduate Medical Education Committee have been informed in writing of this request; and,*
- *attests that the Sponsoring Institution will ensure that its ACGME-accredited programs are compliant with specified ACGME Common Program Requirements that protect residents/fellows, health care teams, and patients throughout the term of the Pandemic Emergency Status declaration.*

_____ _____

Designated Institutional Official Signature Date

AIAMC National Webinar
March 27th, 2020

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