August 2008

ACGME e-Bulletin

ACGME

Accreditation Council for Graduate Medical Education

The ACGME e-Bulletin is published several times per year by the ACGME and distributed to individuals in residency education. It is also available from the ACGME Web site at http://www.acgme.org/acWebsite/bulletin-e/ebu_index.asp

Ingrid Philibert
Editor

ACGME Guidance on Entering and Selecting Participating Institutions and Sites

Ingrid Philibert, PhD, MBA, Rebecca Miller, MS

The ACGME has received a number of questions about the listing of participating institutions in the Accreditation Data System (ADS), related to the requirement that programs *"submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS)."*

RRCs differ somewhat in their interpretations of this requirement. Several specialties have added requirements for participating institutions and other sites, which require the tracking of all required rotations regardless of the number of residents and time spent at the site (Diagnostic Radiology, Anesthesiology, Nuclear Medicine, Radiation Oncology, Transitional Year, Orthopaedic Surgery, Dermatology, Pathology, and Medical Genetics). The RRCs for pediatrics and family medicine do not require continuity clinics and experiences at private clinic offices to be included. Irrespective of an RRC requirement, a given site may be entered in ADS, but only sites with required rotations will appear on the program information form (PIF). Sites are defined as all organizations that provide educational experiences or educational assignments/rotations for residents or fellows. Examples of sites include: a teaching hospital and its ambulatory clinics and related facilities, group and private medical practices, nursing homes, health departments, federally qualified health centers and similar settings.

The ACGME enables programs to enter participating institutions into ADS after the sponsoring institution has listed them as a rotation location. In response to questions from sponsoring institutions, a recent clarification is that ambulatory sites under common ownership and in a common location with the sponsoring institution or a major participating site do not need to have a separate ADS institution number or "ID." Instead, the sponsor's or participating institution's ID should be used. If it is important to the program or sponsoring institution to separately identify its ambulatory sites, a single separate ID may be created in ADS for all on-site and satellite ambulatory sites located within 10 miles of the sponsoring institution. This single ID, to be used by all programs that use an ambulatory site, should be named to reflect the association with the inpatient clinical sites, such as "St. Luke's Hospital Affiliated Ambulatory Clinics." For sites located more than 10 miles away from the sponsoring or affiliated inpatient site, a separate ADS ID needs to be created for each location. A single separate ID may also be created in ADS for private ambulatory sites (not affiliated with an inpatient clinical site) located within 10 miles of the sponsoring institution.

The benefits of this approach include reducing the number of site IDs the program and its sponsoring institution need to create and maintain in ADS, and simplifying the process for program staff to select the appropriate ambulatory site ID.

A related question is whether all sites with a separate ADS ID are required to have on file program letters of affiliation (PLAs). When the ACGME issued a clarification to changes in its expectations for PLAS in 2007, this FAQ specified that "if the two sites operate essentially as one entity (when they are governed by one governing body), neither a master affiliation agreement nor a program letter of agreement is necessary." A recently added response option to the PLA question ("PLA not applicable") allows a program to indicate that a given site does not need a PLA because it is under common ownership with the sponsoring institution or one of its affiliates. This information will be automatically loaded into the common PIF.

ACGME Expectations for Evaluations in Residents' and Fellows' Files

Ingrid Philibert, PhD, MBA

The ACGME periodically receives questions about the information to be included in individual resident files and the period of time during which documents in resident files need to be retained. The context is the review of randomly selected resident files during the accreditation site visit, to assess documentation related to a number of program requirements, including procedural volume in surgical specialties and documentation of the periodic evaluation of residents.

Content of Resident Files

Although review of resident files is an important component of the site visit, the ACGME does not narrowly specify the content of residents' files and has just a small number of common program requirements that directly relate to resident files, such as the requirements that residents receive formal documented evaluations every six months, and that residents have access to their evaluations, irrespective of whether they are in paper or electronic form. A prior clarification in the *e-Bulletin* (February 2005 and September 2007) focused on expectations for documentation to be included in the files of residents who transferred into the program, and maintenance of documents when programs use electronic evaluation systems. It did not provide general guidance on the documents to be included in resident files.

The brief list below provides the expectations for the minimum content in current residents' "educational files" maintained by the program:

- written evaluations from the faculty and others;
- periodic evaluations (at minimum every six months) by the Program Director, his/her designee and/or a resident evaluation committee;
- records of resident physician's rotations and other training experiences, including surgical and procedural training as applicable;
- records of disciplinary actions, as pertinent to the given resident;

- for residents engaged in moonlighting, a prospective, written statement of permission from the program director (as specified by the institutional requirements);
- materials required by ACGME institutional and special program requirements; and
- other content as determined by the Program Director and/or the sponsoring institution.

For residents successfully completing the program, the permanent file should contain a succinct summary of the resident's evaluations and/or a letter documenting the resident's ability to practice competently and independently.

The term "files" in this context is not limited to paper formats. The resident files in a given program may be paper-based, retained in electronic storage or a combination of the two. It is important that for all media, secure storage is used to prevent loss of the records, and that for electronic storage, the program has file back-up and recovery protocols that are consistently followed.

Document Retention

The ACGME does not have standards for document retention, which specify the period for which records need to be kept after a resident's graduation. It defers to institutional document retention standards. Legal experts recommend that the period for which files need to be retained is at least seven (7) years after the resident has graduated.

The following core files should be kept indefinitely by the sponsoring institution, to accommodate requests for primary source verification for residents who have completed the program:

- a summation of the resident's evaluations and/or the final letter by the program director;
- records of resident physician's rotations, training experiences and procedures; and
- documentation of disciplinary action, if any.

For residents who do not complete the program or who are not recommended for Board certification, most programs will keep the entire file indefinitely in case of subsequent legal action.

Additional information about resident evaluations can be found in the Program Director Guide to the Common Program Requirements (http://www.acgme.org/acWebsite/navPages/nav_commonpr.asp). Programs with specific questions about what documents to include in their resident files and for how long they should be retained also should consult with their designated institutional official and, as needed, institutional general counsel.

Learning Portfolio Testers Share Experiences at the 2008 ACGME Annual Educational Conference

Julie Jacob

The 2008 ACGME Annual Educational Conference was held February 28 through March 2 at the Gaylord Texan in Grapevine, Texas. Based on the large crowd of people who packed the meeting room for a portfolio update that was part of the conference, interest is high in the ACGME Learning Portfolio. An alpha prototype of an electronic portfolio for residents is currently undergoing testing. Residents can use the portfolio to store and organize information about their learning, request and receive evaluations, and reflect on their progress. After continued testing and refinement of the portfolio over the next few years, the ACGME hopes to make the portfolio available to residents in all programs.

The session presenters, all of whom are testing the portfolio in their programs, spoke about their experiences using it and fielded questions from the audience. Richard M. Schlenk, MD, associate program director of the neurosurgery residency program at the Cleveland Clinic, noted that it is easy to upload various types of files to the portfolio, including .jpg and .pdf files. Resident attitudes toward reflection vary widely, he said, with about one-third of residents eagerly entering their reflections on learning in the portfolio, one-third doing so with prompting from faculty members, and the remainder of residents showing some reluctance to logging reflections on their learning.

Mariah E. Capurso, residency manager of the Leadership Preventive Medicine Program at Dartmouth-Hitchcock Medical Center commented on the benefits of the portfolio for managing resident evaluations. "The portfolio system has really decreased the amount of time needed to track evaluations," said Ms. Capurso. In addition, since residents began to use the portfolio, faculty members have been receiving more requests from residents for feedback, she said. Nan Garber, MD, an assistant professor of critical care pediatrics at the University of Maryland School of Medicine, said the portfolio system has gotten high marks from faculty members. "Even the most difficult to please attending thinks it is a user-friendly system," said Dr. Garber.

Rebecca S. Urunga, MD, a resident in the obstetrics and gynecology residency program at Dartmouth-Hitchcock Medical Center, gave the resident perspective on the portfolio. Dr. Urunga uses the online portfolio to store her curriculum vitae, research proposals, evaluations, and reflections, noting "The portfolio is a place where I can organize my facts, my experiences, my thoughts." She added that some residents were skeptical about the portfolio at first, and that she has encouraged her peers to try using the portfolio, and found many who have liked it.

More information on the ACGME Learning Portfolio, including frequently asked questions and an annotated bibliography, is available on the ACGME website at http://www.acgme.org/acWebsite/portfolio/learn_cbpac.asp.

Multidisciplinary Rounding Helps to Improve Patient Safety, Team Communication

Julie Jacob

Patient care improves when residents, nurses, faculty, case managers and other health professionals work together to coordinate the care of inpatients, said two speakers who presented a session on multidisciplinary rounding at the 2008 ACGME Annual Educational Conference. Two physicians at the Henry Ford Hospital in Detroit, Peter Watson, MD, and Anna Lukowski, MD, discussed the launch of a multidisciplinary rounding program at the hospital. Dr. Watson is chief of hospitalist medicine and an associate director of the internal medicine residency program, and Dr. Lukowski is program director for the transitional year program and associate program director for the internal medicine residency program.

The multidisciplinary rounding program was developed as a project for the Residency Review Committee for Internal Medicine Educational Innovation Project, which allows strong internal medicine programs to develop innovative ways to advance resident education and patient care. Dr. Watson and Dr. Lukowski listed the barriers to maintaining good patient care in hospitals: limited time, silos of care that divide physicians, nurses, and case managers; and a lack of standardized communication among members of health care teams. These obstacles can result in missed lab results, adverse reactions to medications, and reduced patient compliance with discharge instructions, among other things.

The internal medicine program began a collaborative multidisciplinary rounding program in fall 2005, designed to address some of the barriers to maintaining quality patient care. The collaborative rounding consists of four parts:

- The residents' review of quality and safety issues during daily patient assessments;
- A discussion among senior staff and health care team members of patient issues, and completion of a standardized physician review checklist;
- A daily meeting of senior residents, staff, nurses and case managers to develop team plans for patients; and
- Collaboration between senior and junior residents to carry out the patient plans.

Preliminary results of the multidisciplinary rounding indicated that the average length of stay for patients before and after the introduction of multidisciplinary rounding decreased slightly, from 5.6% to 5.2%, and readmission rates dropped from 17.9% to 16.4%. Although there were no significant improvements in patients' overall satisfaction with the clinical unit or their perception of the physicians, there was a slight increase in the patients' readiness for discharge. In addition, noted Dr. Watson and Dr. Lukowski, there was anecdotal evidence of improved communication between residents and nurses, as well as feedback that fewer details of care are being overlooked.

Future goals for the program, noted Dr. Watson and Lukowkski, are to continue standardizing the rounding process, and to better educate patients about multidisciplinary rounding.

Department of Accreditation Committees (DAC) System Enhancements of Note to Program Directors and DIOs

Jeanne Heard, MD, PhD

ACGME Improves System for Facilitating Contact with the DAC Review Committee Staff

In 2007, the ACGME developed detailed 'contact lists for specific topics' for each of its Review Committees, with the goal of improving access to committee staff for constituents with questions or comments. These lists are located on each Review Committee web page and are intended to facilitate efforts by program directors, coordinators and DIOs to receive answers to inquiries in an efficient manner. In addition, all of the contact information for the Department can be found at www.acgme.org – click on "About ACGME", click on "Staff Listings", click on "Department of Accreditation Committees".

On occasion, constituents have indicated that they have difficulty in receiving timely responses. The following guidelines are offered to address this issue:

1. Access the Review Committee web page contact list to locate the person responsible for the topic;
2. Contact that person via phone or email;
3. If a response is not received within *seven (7) business days* of a phone call or email: send or resend the email to the person and copy the Senior Executive Director of the Group and/or the Senior Vice President for Accreditation Committees (see page 6), or call the Senior Executive Director of the Group and/or the Senior Vice President for Accreditation Committees.

Group 1: Family Medicine, Internal Medicine, Pediatrics			
William Rodak, PhD	Senior Executive Director	312.755.5497	wer@acgme.org
Group 2: Anesthesiology, Allergy and Immunology, Dermatology, Diagnostic Radiology, Medical Genetics, Nuclear Medicine, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Physical Medicine & Rehabilitation, Preventive Medicine, Radiation Oncology, Transitional Year			
Steve Nestler, PhD	Senior Executive Director	312.755.5025	spn@acgme.org
Group 3: Colon & Rectal Surgery, Emergency Medicine, Neurological Surgery, Neurology, Plastic Surgery, Psychiatry, Surgery, Thoracic Surgery, Urology			
Larry Sulton, PhD	Senior Executive Director	312.755.5027	lds@acgme.org
Group 4: Institutional Review Committee, Obstetrics/Gynecology			
Pat Surdyk, PhD	Executive Director	312.755.5005	psurdyk@acgme.org
Department of Accreditation Committees			
Jeanne K. Heard, MD, PhD	Senior Vice President	312.755.5040	jkh@acgme.org

Redesigning Review Committee Web Pages Continues

In 2007, the ACGME began a major initiative to redesign the Review Committee web pages. To date, the web pages for thirteen Committees have been updated. The remaining sites will be completed this year. Each updated web page includes detailed staff contact information, a list of Review Committee members, access to the requirements and accreditation information forms, guidelines and other program resources, frequently asked questions (FAQs), the PD Virtual Handbook, newsletters and links to other information within the ACGME website.

Deadlines for Notification of Accreditation Information

In 2005, ACGME implemented email notification to program directors/DIOs about the results of program/sponsoring institution accreditation reviews. About one week following the meeting, the program director/DIO receives an email informing him/her of the accreditation status. The exception is that the e-mail notification is not sent for a proposed adverse action or adverse action. The 'status' e-mail is sent to the following individuals:

1. For the results of a specialty program review, notification is sent to the program director with a copy to the DIO of the sponsoring institution;
2. For the results of the review of a dependent subspecialty, notification is sent to its program director, and copies are sent to the core specialty program director and the DIO;
3. For the results of the review of a dependent sub-subspecialty, notification is sent to its program director, and copies are sent to the subspecialty and core specialty program directors and the DIO;
4. For the results of an institutional review, notification is sent to the DIO.

Six to eight weeks after the Review Committee meeting, the program director and DIO will receive notification that the letter of notification (LON) with the complete accreditation information has been posted in ADS. Beginning with Review Committee meetings that occur after July 1, 2008, the ACGME will adhere to the following deadlines for these notifications:

1. Status e-mails will be sent five (5) business days after the review committee meeting to the individual noted above.
2. Letters of notification will be posted within 60 days of the review committee meeting taking place.

ACGME Publishes Key to the ACGME's Standard Notification Letter for Continued Accreditation

One of the major initiatives of the ACGME Department of Accreditation Committees was to standardize the notification letter programs receive after the RRC has made an accreditation decision. To further enhance transparency, the ACGME has published a key to the standard notification letter for programs receiving continued accreditation. It is available from the ACGME web site at http://www.acgme.org/acWebsite/utility/KeyStandard.pdf

The key to the standard letter offers explanations for important points of the standard letter, such as accreditation status, length of training, the maximum number of residents and residents at each level, the effective date of accreditation, and the approximate date for the next site visit of the program. The section concerning areas not in substantial compliance (the citation section) also is addressed in the key to the standard letter; this section references the program requirements for each citation listed. For programs without citations and for programs with an accreditation cycle length of 4 or 5 years, this section also includes a statement of commendation to the program or institution for demonstrating substantial compliance with the requirements.

The standard letter notes that for all adverse actions for established programs (probation, withdrawal of accreditation or RRC initiated reductions in resident complement), the ACGME provides the program director with an opportunity to respond to the citations by submitting written information to the Review Committee. The response must be reviewed and approved by the sponsoring institution's Graduate Medical Education Committee and co-signed by the Designated Institutional Official (DIO).

Standard letters also may include additional information that communicates the RRC's decision on such matters as a change in participating institutions or other changes in the program. Letters also may include a listing of areas that will be given close attention during the next accreditation review, sometimes referred to as areas for improvement. These are typically areas in which the program or institution is marginally in compliance and the Review Committee is concerned that the program or institution is in jeopardy of falling below the threshold of compliance. These are not citations, because the program/institution is in compliance. However, the program or institution may be advised to monitor compliance in this area and, and the Review Committee will follow up at the time of the program/institution's next review. At the end of the letter, all regular participating sites listed in the ACGME Accreditation Data System (ADS) are shown.

Selected Winning Posters from the 2008 ACGME Annual Educational Conference Marvin R. Dunn Poster Session

The 2008 ACGME Annual Educational Conference was held in Grapevine, Texas, and was attended by more than 1,200 program directors, designated institutional officials, faculty and program coordinators. The Marvin Dunn Poster Sessions have been conducted annually since 2004. The 2008 session featured high-quality posters on topics of interest to program and institutional leaders and other constituents. The abstracts for selected winning posters are presented to offer samples of the breadth and depth of the topics addressed. The ACGME also is inviting submissions of abstracts for the 2009 poster session. Detailed information will be provided in the upcoming issue of the *ACGME Bulletin.*

Mayo Practice-Based Improvement Log: Assessing Residents' Perceptions of Adverse Events

Jason Post, MD, Bryan Krajicek, MD, Colin West, MD, Furman McDonald, MD, Joseph Kolars, MD, Kris Thomas, MD, Mayo Clinic Rochester, Rochester, MN

Background: The landmark report "To Err is Human" has lead to significant change in the approach to quality improvement and healthcare delivery. Recognition of errors is an essential step in the quality improvement process and is an integral component of competence in systems-based practice (SBP) and practice-based learning and improvement (PBLI). Our program is currently working through the Educational Innovation Project (EIP) to study ways to teach and assess competency in SBP and PBLI

Objective: The purpose of this study is to describe residents' perceptions of adverse events encountered during internal medicine training as collected using the Mayo Practice-Based Improvement Log (MPBIL).

Methods: The MPBIL was developed through an iterative process by a core group of medical educators at Mayo Clinic Rochester. This group consisted of the internal medicine residency program director, associate program directors, and chief medical residents. The MPBIL was released to all 169 categorical and preliminary internal medicine residents at Mayo Clinic Rochester in an electronic form in February 2006.

Results/Outcomes/Improvements: One-hundred forty-six (86%) of 169 residents completed the MPBIL. Residents frequently reported events resulting in significant clinical consequences (25% moderately severe, 6% severe, 14% death), with the majority of events identified as preventable (80%). Overall, 42% of the respondents reported the event to someone that they identified as a leader in quality improvement. PGY-3 residents were more likely to have reported the event to leadership than PGY-1 residents (50% vs. 35%). Residents were more likely to identify personal (37%) and team factors (16%) than systems factors (12%) as contributors to an event. Of the personal factors identified, PGY-1 residents were more likely to report knowledge (PGY-1: 51%, PGY-2: 39%, PGY-3: 35%), experience (PGY-1: 65%, PGY-2: 44%, PGY-3: 43%), and judgment (PGY-1: 60%, PGY-2: 39%, PGY-3: 25%) as important contributing factors. PGY-1 residents were also more likely than PGY-3 residents to report fatigue as a contributing factor (24% and 15%, respectively).

Significance: These data illustrate that residents can recognize opportunities for improvement in healthcare delivery. Residents are able to identify and report clinically significant adverse events that are often perceived to be preventable. The MPBIL provides a mechanism to review residents' perceptions of adverse events. As such, this instrument can be used to illustrate residents' ability to identify and characterize improvement opportunities as one component of competence in PBLI and SBP.

Hospital-Wide Entry and Second Year Multi-Station Clinical Exams for Residents

Julie G. Nyquist, PhD, Stephanie E. Gates, MEd, Jeffrey M. Ring, PhD, University of Southern California and White Memorial Medical Center Family Medicine Residency Program, Los Angeles, CA

Background: The Accreditation Council for Graduate Medical Education (ACGME) is moving the emphasis in accreditation review to focus more on outcomes. In addition to teaching and assessing the competencies listed in the common and specialty-specific requirements, all residency programs are expected to show evidence of how they use educational outcomes data to improve individual resident and overall program performance (ACGME, July 2007). To accomplish this requires expertise, faculty time and residency resources. Many individual programs lack expertise. Additionally, these requirements are being mandated at a time of increasing strain on the resources of most training programs, particularly in terms of faculty time. Combining resources to produce hospital-wide multi-station clinical examinations (MSCE) to assess ACGME competencies may be a partial solution for many academic health centers.

Objective: To develop collaborative MSCEs to track achievement of ACGME competencies and assist programs in using outcome data to improve individual resident performance and overall program performance.

Methods: White Memorial Medical Center (four residencies – Family Medicine, Internal Medicine, Pediatrics, and Obstetrics and Gynecology) is implementing an Entry MSCE for all beginning residents and another MSCE 1.5 years into training. The program directors collaborated to develop the test outline and select cases. An evaluation consultant assisted the directors in developing the rating scales, and training faculty raters and the standardized patients. The first Entry MSCE was implemented in June 2007 during resident orientation. The exam included 12 stations, 20 minutes per station with most having five minutes for faculty raters to provide feedback. The 12 stations included at least one station related to each ACGME competency except Medical Knowledge and specifically included issues of cultural competence and patient safety. Scores were computed for each resident and each program as well as the grand mean (by station and overall performance). Program Directors met to review the findings. This resulted in remediation of individual residents, as needed, and in plans for specific training sessions based on programmatic and hospital-wide resident performance needs. The Entry MSCE will be repeated each June. The first second-year MSCE will be administered in January 2009 for this same group of residents.

Results/Outcomes/Improvements: This was the first joint project undertaken by the program directors and program coordinators and all phases went smoothly. Resident overall performance had a mean=76/100 (SD=4.9). The station means ranged from 64/100 (data review station) to 87/100 (back pain history and physical exam station). Only two stations had overall means below 70%, the data review station and the fever/cough history and diagnosis. The means for the 24 learners ranged from 62/100 to

86/100. Only two residents had means below 70%. Individual plans for improvement were developed and implemented for each of those residents and for others as needed. The programs are coordinating to provide a training session on data review skills. Each program is also developing learning activities to address individual areas of need.

Significance: Collaboration among training programs, to meet new accreditation requirements and enhance program excellence, is a potential solution to increased requirements and decreased resources.

A Program Improvement Process Based on Clinical Outcomes

John Buckley MD, MPH, Barbara Joyce, PhD, Eric Scher, MD, Henry Ford Hospital, Detroit, MI

Background: Program evaluation methods in Graduate Medical Education (GME) have been predominantly based on the design and content of curricula, aggregate scores on standardized exams and 360-degree evaluations, and participation in research and quality projects. Such aggregate data are surrogate markers for clinical outcomes. Phase 3 of the Outcome Project mandates programs use external measures (i.e. quality of care indicators; patient satisfaction data) to assess a residency program's educational effectiveness. Swing, et al (2007) concluded that quality of care indicators may serve as indicators of the effectiveness of the educational training program. This abstract describes the use of a modified Plan-Do-Study-Act (PDSA) cycle using patient outcome data to measure educational effectiveness of a Pulmonary/Critical Care Fellowship.

Objective: Our objective was to apply a modified PDSA cycle to improve training in the Pulmonary/Critical Care Medicine fellowship using patient outcome data as a measure of educational effectiveness.

Methods: A modified PDSA cycle that incorporated educational components, quality improvement components, and discussion of program-specific environmental factors was applied to a Pulmonary and Critical Care Medicine Fellowship. An example of this modified PDSA cycle used patient outcome data on central vein catheter complications from the Institute for Healthcare Improvement (IHI) and National Nosocomial Infection Surveillance system (NNIS) as educational outcome measures.

1. *Plan:* A retrospective review of departmental performance on central vein catheter complications as completed prior to institution of curriculum and simulator-based training on insertion technique.
2. *Do:* Curriculum and simulation training focusing on known techniques to reduce pneumothorax and infection rates during central line placement was implemented.
3. *Study:* After implementation of curriculum and simulation training, errors on insertion and infection rates of central line placement decreased. Our complication and infection rates were compared to national benchmarks. We discussed the program-specific environmental factors impacting this process.
4. *Act:* Educational training of fellows was modified to increase the use of ultrasound-guided vein cannulation and we reinforced established effective infection control behaviors.

Significance: Linking residency and fellowship program performance with clinical outcomes is possible using existing or accessible quality improvement databases. Comparison with regional and national standards permits program directors and institutions to prioritize subsequent educational activities. Isolating the individual role of trainees in the clinical outcome may be difficult given the collaborative nature of delivered patient care. Additional mechanisms for linking individual performance with clinical outcomes are needed.

References: Swing, S., Schneider, S., Basov, K., Chapman, D., Graff, L., Hobgood C., Lukens, T., Radford, M., Sanders, A., Smith-Coggins, R., Spillane, L., Hruska, L., Wears, R. (2007). Using Patient Care Quality Measures to Assess Educational Outcomes. Academic Emergency Medicine, 14(5), 463–473.

Joint Commission Aims to Stop Bad Behavior Among Health Professionals

Ingrid Philibert, PhD, MBA

Rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a threat to patient safety and quality of care, according to a new Joint Commission standard that will go into effect January 1, 2009. It will affect 15,000 accredited health care facilities, including hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities, and behavioral health care facilities. Activities considered under the new standard are verbal outbursts, condescending attitudes, refusing to take part in assigned duties and making physical threats, based on the Joint Commission's belief that these behaviors have a negative effect on communication, collaboration and teamwork vital to a good patient care environment.

The recent Joint Commission's *Sentinel Event Alert* recommends that hospitals and other organizations educate members of the health care team about professional behavior, enforce the code of conduct consistently and equitably, and establish a comprehensive approach to addressing intimidation and disruptive language and actions. The Joint Commission expectations include applying a zero tolerance policy, involvement and support from physician leaders, and reducing fears of retribution if a physician reports a colleague for this type of behavior. Related ACGME standards include the professionalism competency standards in the common program requirements, and the institutional requirements requiring the Sponsoring Institution and the programs to provide an environment in which residents may raise and resolve issues without fear of intimidation or retaliation. This includes issues related to intimidating and disruptive behaviors directed at or witnessed by residents.