FLORIDA HOSPITAL
Graduate Medical Education
The skill to heal. The spirit to care.

2015-2016
GRADUATE MEDICAL EDUCATION MANUAL

Joseph D. Portoghese, MD, Designated Institution Official - Chief Academic Officer

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(Updated October 2015)
“Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.”

Accreditation Counsel for Graduate Medical Education

The American Osteopathic Association (AOA) is organized to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective healthcare within a distinct, unified profession.

American Osteopathic Association
The Florida Hospital (FH) Graduate Medical Education (GME) Manual is provided as a guide to and summary of the various policies, benefits, and services available and applicable to GME Trainees (Residents and Fellows) as of the date published.

The policies, benefits, and services described in this guide may be changed or discontinued at any time, with or without additional notice. Trainees are encouraged to consult the various booklets, summaries, and governing documents as appropriate, and to contact The Office of Graduate Medical Education for more detailed and up-to-date descriptions when necessary.

Information contained in any handbook, guide, manual, or document prepared for or relating to GME Trainees is for informational purposes only and shall not be construed as a contract.

This manual is renewed on an annual basis and posted on the FH GME website and in New Innovations, FH’s resident management system. Each training program is required to maintain its own program manual (resident manual) covering items specific to that program based on program requirements and items common to all programs as illustrated in the ACGME Common Program Requirements. Programs are expected to have sections regarding expectations for residents and faculty to participate in Quality Improvement, Patient Safety, Moonlighting, Fatigue Mitigation, and Supervision to name a few. Should any residency manual items come into direct conflict with stated policies and guidelines of the GME manual or FH Policy and Procedure, Office of GME and FH policies and guidelines will take precedence.

Should you have any questions or needs do not hesitate to visit or contact The Office of GME.

We are here to assist you and look forward to having you in our training programs.

Joseph D. Portoghes, MD
Chief Academic Officer/
Designated Institution Official
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GRADUATE MEDICAL EDUCATION DIRECTORY

Executive Administration:
David Moorhead, MD  
Chief Medical Officer  
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GME Program Directors & Coordinators:
Matthew Albert, MD  
Colon & Rectal Surgery  
Coordinator: July Jurado
Laura Bancroft, MD  
Radiology (diagnostic)  
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Louis Barr, MD  
General Surgery  
Coordinator: Maria Cepero

Lorna Brudie, DO  
GYN/Oncology Fellowship  
Coordinator: July Jurado
Dale Birenbaum, MD  
Emergency Medicine  
Coordinator: Katherine Bradford
Jay Bornstein, DPM  
Podiatric Medicine  
Coordinator: Karen Koster

Brian Browning, DO  
Family Medicine, Osteopathic  
Coordinator: Celina Diaz
Brian Browning, DO  
FM/NMM Integrated  
Coordinator: Celina Diaz
Ariel Cole, MD  
Geriatric Fellowship  
Michelle Stevenson

George Everett, MD  
Internal Medicine  
Coordinator:
Stephanie McLaughlin  
Michelle Stevenson
Jenni Keehbauch, MD  
Women’s Health Fellowship  
Coordinator:
Georgine Lamvu, MD  
GYN/MIS Fellowship  
Coordinator: July Jurado

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General Pediatric Residency  
Coordinator:
Francisco Hernandez, MBA  
Michelle Stevenson
Edward David Needham, MD  
Family Medicine, Allopathic  
Coordinator:
Sebastian DeLaFuente, MD  
Upper GI & HPB Fellowship  
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**Organizational Chart #1, Position of the GMEC:** I.A.5.a)-b) Organizational Chart 1 is an organizational chart that identifies the position of the Graduate Medical Education Committee (GMEC) in the Sponsoring Institution’s reporting structure, including its relationship to the Sponsoring Institution’s Governing Body.

**Med Exec and GMEC:** Since most of the GMEC participants are physicians, GMEC will continue to work with the Med Exec Committee in the best interest of the residents and the residency programs. GMEC will provide an annual update to the Med Ex as it would to the BoT.

**Resident Association and GMEC:** the Resident Association is an independent forum where residents can raise concerns and issues about their learning and work environment. The Resident Association has a Chairperson who participates in the GMEC meetings. At least two additional residents will be peer-selected to the GMEC to represent resident interests. Residents will also be peer-selected to participate on other GMEC sub-committees.

**Director, Quality/Safety and GMEC:** The Director of Quality and Safety sits on the GMEC. This role will chair a Resident Patient Safety/Quality Council to help engage residents in patient safety and quality projects/initiatives. Over time, 2 residents will be peer-selected to chair and co-chair this resident Q/S council with assistance and mentoring from the Director. This role will provide valuable guidance to the residents as well as recommendations for projects applicable to Florida Hospital.
Organizational Chart #2, Position of the DIO I.A.5.a)-b) Organizational Chart 2 identifies the position of the Designated Institutional Official (DIO), the position to which the DIO reports, and the positions that report to the DIO, including program director(s). (Note: Do not list the individual program director(s).)
MISSION

To extend the healing ministry of Christ
through the preparation of competent and compassionate physicians.

Florida Hospital’s (FH) Office of Graduate Medical Education (GME) strives to provide an organized system of educational programs with guidance and supervision of fellows/residents, facilitating their personal and professional development, firmly rooted in Florida Hospital’s mission and values, while ensuring safe and appropriate care for patients.

FH’S HISTORY

It’s hard to believe that mosquitoes were once far more prevalent than residents in Central Florida. But that was the case in 1908 when the leaders of the Adventist church put their boundless faith and limited funds into building their first healthcare facility in the region.

Originally the land that FH’s main campus stands on today had a farmhouse on it that an Orlando surgeon had converted into a facility for treating patients with tuberculosis. It was for sale, but the Adventist group only had $4.93 in the bank. Relying on commitment and prayer, a member of the group sold his own house to raise enough money to purchase the property. The offer of $9,000 was accepted and the roots of a new era in Central Florida healthcare began.

In October 1908, the Florida Sanitarium and Benevolent Association officially opened its doors with just four patients, a couple of employees and one doctor. A century later, this same institution has grown to become FH, with 2,188 beds, seven locations, 2,000 physicians and almost 20,000 employees.

Though the technologies and treatments have changed dramatically over the years, one thing remains constant: Our mission, “To extend the healing ministry of Christ.”
STATEMENT OF INSTITUTIONAL COMMITMENT

The Florida Hospital Leadership, teaching faculty, medical staff, and administrative staff are committed to excellence in medical education and providing the necessary financial support for administrative, educational, and clinical resources to support Graduate Medical Education (‘GME’). This commitment facilitates resident’s professional, ethical, and personal development, and is demonstrated through the leadership, organizational structure and the provision of resources necessary for FH to achieve substantial compliance with the Accreditation Council for Graduate Medical Education (‘ACGME’) Institutional Requirements, implement and develop sponsored programs, and enable all its training programs to achieve substantial compliance with appropriate accrediting body’s institutional requirements, common program requirements and specialty specific program requirements. An institutional Statement of Commitment is filed in the Office of GME Administration (herein referred to as “FH GME”).

INSTITUTIONAL RESPONSIBILITY

1. **FH GME residency/fellowship programs operate under the sole authority and control of FH**. In accordance with its mission, FH is dedicated to the preparation of competent and compassionate physicians. This Institutional responsibility extends to resident/fellow (herein referred to as ‘resident’) assignments at all participating sites and includes guidance and supervision of the resident while facilitating the resident’s professional and personal development to ensure safe and appropriate care for patients.

2. **FH GME is charged with the responsibility of ensuring that all GME programs are in substantial compliance with all accreditation standards.** This includes ACGME Institutional, Common and specialty-specific Program Requirements, and the ACGME Policy and Procedures, as well as requirements as defined by the other GME accrediting bodies including AOA, CPME, and AAGL.

3. **FH provides services and develops health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives.** This is done to ensure that resident experience is not compromised by a facility’s excessive reliance on residents to fulfill non-physician service obligations. These services and systems include:

   a. **Patient support services:** Peripheral intravenous access placement, phlebotomy, laboratory, pathology, radiology and patient transport services must be provided in a manner appropriate to and consistent with educational objectives and quality patient care.

   b. **Medical records:** A medical records system that documents the course of each patient’s illness and care must be available at all times and must be adequate to support quality patient care, residents’ education, quality assurance activities, and provide a resource for scholarly activity.

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1 ACGME Institutional Requirements, I.A.6.
2 ACGME Institutional Requirements, I.A.1
3 ACGME Institutional Requirements, I.A.2:
4 AOA Institutional Requirements, IV A 4.1 & IV A 4.3
5 ACGME Institutional Requirements, II.F.1: Resident education and work environment.
4. There must be a single program director with authority and accountability for the operation of the program based on ACGME & AOA accreditation standards\textsuperscript{6}.

5. Each institution with a base AOA training program must have an Osteopathic Director of Medical Education (DME) and an Institutional Educational Officer (IEO) who may be the same or separate individuals\textsuperscript{7}.

6. FH GME will ensure that, at each participating site, there is a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

   a. Faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents.

   b. Faculty must administer and maintain an educational environment conducive to educating residents in each of the competency areas.\textsuperscript{8}

\textsuperscript{6} ACGME Common Program Requirements, II.A.1.: Program Director.

\textsuperscript{7} AOA Institutional Requirements, VI A & B and VI C 6.1: DME and Program Director. AOA Postdoctoral Requirements, Section 6, C.

\textsuperscript{8} ACGME Common Program Requirements, II.B.1.a): Faculty.
INSTITUTIONAL AGREEMENTS

1. FH retains responsibility for the quality of GME including when resident education occurs at other sites.

2. Master affiliation agreements must exist between FH and all major participating sites and will be reviewed/renewed at least every five years.

3. FH will also maintain valid program letters of agreement (PLA)\(^9\) which identify:
   a. Responsibilities for teaching, supervision, and formal evaluation of residents;
   b. The faculty who will assume both educational and supervisory responsibility for the residents;
   c. Duration and content of the educational experience;
   d. Policies and procedures that will govern the resident education during the assignment.

4. The program director must submit any additions or deletions of participating sites\(^9\) 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).

\(^9\) ACGME Common Program Requirements, I.B.1. and 1.B.2. AOA Postdoctoral Requirements, Section C, 4.3.
RESPONSIBILITIES TO RESIDENTS

FH GME programs are designed to prepare the resident for the next phase of their professional careers, including advanced residencies or fellowships, practice or scholarship. FH GME programs will fulfill the following responsibilities to residents through an organized system of education.

1. FH ensures that residents have the opportunity to:
   a. Develop a personal program of learning to foster continued professional and personal growth with guidance from the teaching staff.
   b. Participate in safe, effective, and compassionate patient care, under the supervision of the program director and other faculty members, commensurate with their level of advancement and responsibility.
   c. Participate fully in the educational and scholarly activities of their programs and, as required, assume responsibility for teaching and supervising other residents and students.
   d. Participate as appropriate in institutional programs and medical staff activities and adhere to established practices, procedures, and policies of the Participating Institutions.
   e. Participate on appropriate institutional committees and councils whose actions affect their education and/or patient care.

2. In addition to the FH GME Manual, all programs must provide a program-specific manual to all residents prior to the beginning of the training program, outlining additional requirements and policies of the program.
FACULTY AND RESIDENT RESPONSIBILITIES (GENERAL)

Faculty Reporting:

1. **Faculty is responsible for the specific content and conduct of the resident’s education and training.** Each program will identify the means by which they will have residents report for all matters involving education, training, professional care and patient management.

2. **Faculty is responsible for resident supervision.** Medical staff concerns over residency competency in performing procedures or writing orders should be addressed with the attending faculty member of the service involved.\(^{10}\)

3. **FH, through the Chief Medical Officer, GMEC and, the Office of GME, is responsible for the administrative aspects of the education programs.** These include: pay, personnel benefits, legal matters, privileges, procedures concerned with admission and discharge of patients, medical records, consents for treatment, use of pharmacy, laboratories, x-ray and similar matters.

Residents Are Expected To:

1. Develop a personal program of self-study and professional growth with guidance from the faculty.

2. Participate in safe, effective and compassionate patient care under supervision commensurate with their level of advancement and responsibility.

3. Participate fully in the educational and scholarly activities of their program and, assume responsibility for teaching and supervising other residents and students.

4. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.

5. Participate in institutional committees and councils; especially those that relate to patient care activities.

6. Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect GME and of how to apply cost containment measures in the provision of patient care.

7. Cooperate with any reporting requirements in connection with the National Practitioner Data Bank and applicable state and federal requests for information pertaining to FH.

8. Comply with the ethical standards of the American Medical Association.


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\(^{10}\) AOA Postdoctoral Requirements, Section 6, D. Faculty.
10. Participate in evaluation of quality of education provided by the program.

Each program will assign additional expectations of their residents and faculty based on the specialty specific requirements.
TEACHING OF MEDICAL STUDENTS

FH GME hosts a number of medical students through its residency programs and private practitioner offices. Residents and faculty of all FH GME programs have a responsibility to contribute to the medical and professional knowledge of medical students.

Resident Responsibilities in Medical Student Instruction:

A. All residents in FH Sponsored Residency Programs are expected to provide guidance, instruction and evaluation for medical students and any other medical personnel or its students who may be in training on the service.

B. Residents may be delegated responsibility for medical student supervision by an attending physician appropriate for the residents level of training.

C. Residents may be delegated the responsibility by an attending to review, correct and countersign the medical records presented to them by medical students. The attending is ultimately responsible for the medical record and the care of the patient.

D. Residents in some programs may be eligible for appointment as junior faculty for the College(s) of Medicine with whom FH has affiliation agreements. Ongoing reappointment is conditional on student teaching performance.

Faculty Responsibilities in Medical Student Instruction:

A. Faculty is ultimately responsible for the supervision of a medical student. However, residents may be delegated such responsibility by a faculty member. The assignment of a student to a resident does not relieve the faculty physician of their ultimate responsibility for supervision.

B. Faculty should endeavor to remain aware of the activities and performance of all medical student(s) assigned to them for supervision.

C. The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners), in the program must not interfere with the appointed residents’ education.11

Medical student responsibilities:

A. To participate in clinical learning experiences, medical students must be credentialed through FH GME, enrolled in the specific course related to the clinical activity, and must be supervised by approved faculty at all times.

B. Medical students are expected to be appropriately dressed, and have an appropriate

11 ACGME Common Program Requirements, III.D: Appointment of Fellows and Other Learners.
name identification card, usually from their respective medical schools, in addition to their FH ID badge at all times.

C. Medical students are expected to properly identify themselves to the patients, clinical staff, faculty, and residents by name and level of training.

D. Medical students must communicate with the attending physician, or supervising resident, prior to initiating any procedure or implementing any changes in the treatment plans.

GME responsibilities:

A. The Office of GME has appointed a Clerkship Coordinator to coordinate the medical student process within the context of all established policies in reference to the teaching of medical students including student application, student identification while rotating in FH sites, preceptor registration and medical school affiliations.

B. These policies include rotating physicians, residents, and fellows as trainees in FH sites.

C. The Clerkship Coordinator shall also coordinate the process for all Advanced Practitioner students (e.g. nurse practitioner, physician assistant, student nurse anesthetists, nurse midwives), rotating at all FH GME program or clinical site. Advanced Practitioner’s are any person whose practice requires physician oversight and/or supervision.

PERFORMANCE IMPROVEMENT

FH has established protocols, processes, procedures, and other initiatives intended to improve patient care outcomes. It is the intent of FH GME and the programs to perform with 100% compliance. In keeping with that intent, the following guidelines are upheld:

A. Departments participating in GME training programs sponsored by FH must conduct formal quality assurance programs and review complications and deaths.

B. Program directors will provide opportunities for residents to participate in clinical quality improvement committees and activities

C. Programs must have a medical records system available at all times and accurately documents the course of each patient’s illness and care. The medical records system must be adequate to support the education of residents.

D. When applicable, residents will be provided with opportunities to participate in autopsies.

E. Program directors will develop a policy for medical records completion applicable to all residents and faculty of the program that is commiserate with FH Health Information Management policy.
F. Program directors and faculty will dedicate effort to performance and quality improvement initiatives, scholarly activity, and research.

**OFFICE OF GRADUATE MEDICAL EDUCATION**

*Chief Academic Officer/Designated Institutional Official:* Global oversight of all GME, Research, and CME. Acting FH representative for ACGME.

*Director, Graduate Medical Education:* Oversight of accreditation, GME operations, human resources and financial management for all GME programs.

*Medical Student Clerkship Coordinator:* Oversight of medical student and advanced practitioner student-related activities, student orientation, maintenance of student training records, facilitation of contracting specific to student needs, and housing.

*Administrative Assistant:* Assists DIO and Director with all activities related to GME, manages incoming requisitions, invoices and expense reports, monitors CME funds usage by faculty and residents and schedules standing meetings i.e. GMEC, CAO, Coordinator, PD/DIO meetings, and other meeting related to GME.

*Human Resources Coordinator:* Oversight of hiring and employment-related needs, orientation for all GME programs, contracting of volunteer faculty/preceptors, payroll, and graduation.

*New Innovations and Contracts Coordinator:* Oversight of New Innovations (residency management suite), daily monitoring of resident activities as related to duty hours, evaluations and procedure logs, and training of all GME personnel and residents. Prepares MAA and PLA’s, medical school affiliation agreements, and maintains contracts database.

*Research Director:* Assists with development of faculty and resident scholarly activity specific to each program’s requirements as approved by DIO.

*Research Coordinator:* Daily oversight and management of resident scholarly activity and research including submission of regulatory documents, monitoring of credentialing, resourcing for the development of resident and faculty projects, poster/publication completion, and maintenance of research-related information materials in the programs.

*CME Coordinator:* Daily oversight and management of FH CME activities and events, assimilates CME documents for review and approval of Category 1 CME credit, maintains CME database, interacts with the State of Florida for CME credit, and maintains accreditation standards directed by the ACCME.

The GME office is located in the medical plaza at:

2501 North Orange Avenue, Ste. 235, Mailbox 38
Orlando, FL 32804

The plaza faces Orange Avenue (west) and is located between Rollins Street (south) and King Street (north). Access to the medical plaza may be obtained from the hospital by taking the escalators west of
the cafeteria to the third floor and taking the raised crosswalk to the medical plaza. Entrances are also located at the north and south entrances on Orange Avenue as well as from Sanitarium Drive (east). The King Street parking garage houses physician parking (accessible from Sanitarium Drive with activated employee badge) on the ground floor and employee parking (accessible from King Street) on the fourth floor and above. Once in the medical plaza, take the north elevators to the 2nd floor to Suite 235, which is also the Internal Medicine Continuity Clinic. Walk through the waiting room and through the single door labeled, Graduate Medical Education. Go to the end of the hallway and turn left to the Office of GME.

**DESIGNATED INSTITUTIONAL OFFICIAL**

The Chief Medical Officer (‘CMO’) of FH appoints or may act as the Designated Institutional Official (‘DIO’). The DIO has the authority for oversight and administration of all GME training programs in collaboration with a Graduate Medical Education Committee (‘GMEC’) and has responsibility for assuring compliance with ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements.

**GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)**

FH GMEC holds the responsibility for oversight of the accreditation status of the Sponsoring Institution and each of its ACGME-accredited and AOA-accredited GME programs. Voting membership on the committee must include the DIO, a representative sample of program directors (minimum of two), a minimum of two peer-selected residents/fellows, a quality improvement or patient safety officer or designee. The GMEC may also include other members such as the Director of Graduate Medical Education, CMO, other faculty, or other members deemed necessary for the GMEC to function in the best interest of resident education.

GMEC must meet at least quarterly. FH GMEC currently meets every other month and maintains written minutes.

GMEC establishes and implements policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures include stipends and position allocation, resident status and selection, communication with program directors, resident duty hour policies, resident supervision, and other applicable Common and specialty/subspecialty-specific program requirements. GMEC is responsible for review of all ACGME program accreditation letters of notification and monitoring of action plans for correction of citations and areas of noncompliance.

GMEC provides an annual report to the Board of Trustees pertinent to the safety and quality of patient care. A report to the Organized Medical Staff can be provided annually at the discretion of the GMEC.

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12 ACGME Institutional Requirements, I.A.5.a): DIO must have the authority and responsibility for the oversight and administration of each Sponsoring Institution’s programs and responsibility for assuring compliance with ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements.

13 ACGME Institutional Requirements, I.B.4. Responsibilities of the GMEC. AOA Institutional Requirements, VI E 6.1 Each base institution must have a fully functioning Medical Education Committee.

14 ACGME Institutional Requirements, I.B.1. GMEC Membership
GMEC assures that each program provides a curriculum and an evaluation system enabling residents to demonstrate achievement of the ACGME general competencies as defined in the Common and specialty/subspecialty-specific Program Requirements. The GMEC ensures that each ACGME accredited program has an organized Clinical Competency Committee for the purposes of evaluating and reporting resident progress along the Milestone continuum.

The GMEC for FH includes programs from other accrediting bodies in its processes and requirements. GMEC will assure that all educational activities comply with ACGME, AOA, CPME, and AAGL competency guidelines.\(^{15}\)

GMEC is charged with the oversight of all phases of educational experimentation and innovations that may deviate from Institutional, Common, and specialty/sub-specialty-specific Program Requirements.

\(^{15}\) AOA Institutional Requirements, IV I: An Osteopathic Core Competency Program shall be integrated into all OGME programs and shall include an Institutional Core Competency Plan, Program Directors Annual Summary and Final resident Assessment as noted in AOA Basic Documents IV-I.
### ANNUAL INSTITUTIONAL REVIEW

ACGME 1.B.5. The Graduate Medical Education Committee (GMEC) must demonstrate effective oversight of the sponsored Florida Hospital Residency/Fellowship programs through an Annual Institutional Review.

### FLORIDA HOSPITAL

GRADUATE MEDICAL EDUCATION ADMINISTRATION

<table>
<thead>
<tr>
<th>Title: Annual Institutional Review (AIR) Performance Indicators</th>
<th>Policy # 1000</th>
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<tbody>
<tr>
<td>Issue date: August 2014</td>
<td>Developed by: Ava Fulbright</td>
</tr>
<tr>
<td>Revision dates:</td>
<td>Approved by: GMEC August 2014</td>
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### I. POLICY:

A. The Annual Institutional Review will include:

1. Results of the most recent institutional self-study visit to include [1.B.5.a).(1)] :
   
   a. The action plan and outcomes to correct any citations from the most recent self-study visit.
   b. The action plan and outcomes from any findings on the most recent AIR.
   c. A review of the six areas of CLER (patient safety, quality improvement, transitions of care, supervision, duty hours/fatigue mitigation, professionalism) to formulate an annual plan to promote opportunities for improvement and faculty/resident engagement in CLER activities.
   d. A review of the most recent CLER visit with the action plan to correct any recommendations from the visit and their outcomes.
   e. A review of all Sponsoring Institution policies and procedures to ensure they are in substantial compliance with ACGME institutional requirements.

2. Aggregate results of the annual ACGME resident and faculty survey to include [1.B.5.a).(2)]:

   a. Institutional aggregate of the survey results to form action plan(s) to correct the areas of noncompliance or lower than average scores measured against national norms.
   b. Individual program aggregate of survey results and comparison to national norms for each accredited program.
   c. Comparison of current survey results to any internal surveys, program evaluations, or other institutional assessments, which support or do not align with the ACGME survey as a means of understanding and addressing “best practice” indicators as well as those areas need improvement.
d. Design of an action plan for areas deemed non-compliant, below national benchmarks, or changes in one standard deviation below prior survey results.

3. Notification of ACGME-accredited programs’ accreditation status and self-study visits [1.B.5.a).(3)]:

   a. The action plan and outcomes to correct any citation(s) from the program’s most recent self-study visit.
   b. ADS data and/or GME scorecard data for each program i.e.
      i. Board pass rate
      ii. Resident/faculty attrition
      iii. Procedural volume/case mix/patient mix
      iv. Faculty development
      v. Faculty and resident scholarly activity
      vi. Milestones
      vii. Atmosphere for residents to raise concerns/issues; make inquiries
      viii. ACGME cycle length
   ix. Match data

4. Program response to GMEC the domains of ACGME CLER Review.

5. Compliance with up to date, signed institutional agreements i.e. Affiliation Agreements and Program Letters of Agreement (PLA).

6. Results/outcome of each program’s Annual Program Evaluation.

Any item listed above that is found to be out of compliance will be an agenda item for each Graduate Medical Education Committee (GMEC) meeting to monitor progress toward resolution. The program director will present a report on behalf of their program with status of correcting deficiencies for documentation into the GMEC minutes. The DIO will provide a written Executive Summary of the Annual Institutional Review to the governing body.
I. PURPOSE:

To establish a formal, systematic process by which the GME Committee demonstrates effective oversight of the Sponsoring Institution’s accreditation through an annual review and evaluation of institutional performance indicators in accordance with the Institutional Requirements of the ACGME (I.B.5) and any policies and procedures of the Florida Hospital Graduate Medical Education Committee.

II. POLICY:

The AIR Subcommittee of the GME Committee is charged among other things with the following responsibilities:

A. Review, monitor and assess accreditation status of sponsoring institution and its programs, and responses to citations, ACGME notifications and concerns

B. Review results of CLER visits, and review and approve responses to CLER visit reports

C. Address results of focused or special program reviews

D. On behalf of GMEC, demonstrate Sponsoring Institution oversight of accreditation through an annual institutional review (AIR)

This document describes the procedure by which the AIR Subcommittee of the GMEC will fulfill its charge in conducting an Annual Institutional Review.

III. PROCEDURE:

1. The AIR Subcommittee shall determine the number of meetings necessary to conduct the AIR at FH-Orlando, FH East, and Winter Park.

2. The AIR will be conducted in the spring (February- April) of each academic year to allow sufficient time for changes to be implemented for the start of the next academic year.
3. Beginning approximately one to two months prior to the review dates, the Designated Institutional Official (DIO) in collaboration with the Chair of the AIR Subcommittee will:

   a. Establish and announce the dates of the review
   b. Inform the standing membership of the AIR Subcommittee of the review dates and assure that the DIO, Chair of AIR Subcommittee, and Committee members consisting of program directors, assistant program directors, and/or core faculty from the three hospitals and at least one (1) peer-selected resident from each hospital to participate in the review (peer-selected residents will not include post-graduate chief residents such as those in Internal Medicine and Pediatrics).
   c. Identify staff assisting with organizing the data collection, coordinating the review process, and report development.
   d. Compile the data and information to include the performance indicators approved by the GMEC and include:
      i. Results of most recent institutional self-study visit (or most recent accreditation site visit letter of notification)
      ii. Results of ACGME surveys of residents/fellows and core faculty
      iii. Notification of ACGME-accredited programs’ accreditation statuses and self-study visits
      iv. Any other supporting information the committee may deem necessary
      v. Outcome of action plans resulting from prior AIRs

4. At the time of the meetings, the Committee will review its charges and responsibilities, the institution history including past citations and previous year’s action plans, responses to prior action plans, and current performance indicators and outcome data such as that described above.

5. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and improvement opportunities, and to make recommendations.

6. Written minutes will be taken of all meetings and submitted to GMEC.

7. As a result of the information considered and resulting discussion, the AIR Subcommittee will:
   a. identify any areas for improvement
   b. develop an action plan(s) to address areas for improvement
   c. include monitoring procedures for action plan(s) resulting from the review

8. The AIR final report, action plan and DIO executive summary will be presented to and approved by the GME Committee

9. The DIO will submit a written annual executive summary of the AIR to the Governing Body of the Sponsoring Institution.
I. PURPOSE:

To establish guidelines for the ACGME Institutional Requirement of I.B.4.a).(4) regarding GMEC oversight of the ACGME-accredited programs’ annual evaluation and improvement activities i.e. an Annual Program Evaluation (APE). AOA and CPME programs will follow the guidelines established for ACGME programs until such time their accrediting body requires a different process. All non-accredited programs will follow these guidelines until such time that the GMEC determines that no APE need be conducted.

At least annually, each program must conduct a self-review that includes the following:

ACGME Common Program Requirement V.C.2.- The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE). (Core)

1. resident performance using aggregated resident data;
2. faculty development;
3. graduate performance including performance of program graduates on the certification examination; and,
4. program quality

II. POLICY:

Each Program Director is responsible for appointing Program Evaluation Committee (PEC) to conduct an APE of the residency program. This process must include at least two faculty and one peer-selected resident(s). The evaluation will proceed according to the ACGME Common Program Requirements listed above using the representative check list of items to review at the end of this document.

All residents and faculty will be given the opportunity to participate by completing a confidential evaluation. The pooled information from these evaluations will be given due consideration by the PEC, and will be used to improve the program. Resident(s) will be peer-selected to participate in the review.

III. PROCEDURE:

A. The Program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).
B. The annual program evaluation will be conducted between ~April – May each year to allow programs the opportunity to assess the current academic year and potential changes for the upcoming academic year.

C. Approximately two months prior to the established review date, the Program Director will:

1. Facilitate the Program Evaluation Committee’s process to establish and announce the date of the APE meeting;

2. Request the residency coordinator to assist with organizing the data collection, review process, and report development; and,

3. Solicit written confidential evaluations from the Program faculty and Resident/Fellows prior to the review.

4. At the time of the initial meeting, the Committee should at least consider:

   a. Achievement of action plan improvement initiatives identified during the last annual program evaluation;
   b. Achievement of correction of citations and concerns from last accreditation site visit;
   c. Residency program goals and objectives;
   d. Faculty members’ confidential written evaluations of the program;
   e. The Residents’/Fellows’ annual confidential written evaluations of the program;
   f. The Residents’/Fellows’ evaluation of the rotations to date;
   g. Resident/Fellow performance and outcome assessment, as evidenced by:
      i. Aggregate data from general competency assessments;
      ii. Aggregate data from Milestones;
      iii. In-training examination performance;
      iv. Case/procedure logs;
      v. Graduate performance, including performance on the certification examination;
      vi. Faculty development/education needs and effectiveness of faculty development activities during the past year;
   h. Other data points collected by the ACGME in WebADS;
   i. Other items that are pertinent to the program/specialty;

   *Note*: a more comprehensive list can be found at the end of this document.

5. Additional meetings may be scheduled, as needed, to continue to the APE, discuss concerns and potential improvement opportunities, and to make recommendations. **Written minutes must be taken of all meetings.**

6. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:
   a. Resident/Fellow performance
   b. Faculty development
c. Graduate performance
d. Program quality
e. Continued progress on the previous year’s action plan if applicable.

7. The plan will delineate how those performance improvement initiatives will be measured and monitored and include a time-line.

8. The final report and action plan will be reviewed and approved by the program’s teaching faculty, and documented in faculty meeting minutes.

D. A final copy of the APE and action plan/time-line will be sent to the GME Office. Each APE will be on a future GMEC agenda. The GMEC will review and accept as written or propose changes in the action plan and/or time-line.

E. Using the GME Annual Program Evaluation format provided by the GME Office, the following areas should be analyzed to enhance program strengths and, in one or more areas, implement plans for improvement:

1. Resident performance:
   - In-training exam results
   - Resident assessment data
   - Resident research presentations/publications
   - Resident procedure/case log
   - Resident skills/simulation lab performance
   - On-line curriculum performance
   - Milestone achievement
   - Rotation evaluation
   - 360/multirater (patient, peer, nursing, etc.)
   - Oral exams(mock)
   - Resident self-assessment, goal setting, and individual learning plans
   - Skills/Simulation results
   - Chart audit
   - QI projects
   - Participation on hospital committees
   - Didactic/conference attendance
   - CEX observe patient encounter
   - Standardized patient
   - Evaluation of presentations
   - Technical skills and abilities
   - Compliance with administrative tasks

2. Faculty development
   - Results of annual confidential evaluation of faculty by residents
   - Review of updated CVs including faculty scholarly activity and publications
   - Teaching strategies/methods
   - Completion of educational modules
• Completion of courses on how to be a teacher
• Mentoring
• Faculty meeting attendance
• Local, regional and national meeting educational committee participation
• Participation in resident conferences/didactics
• Maintenance of certification
• Quality of providing formative feedback
• Participation on Clinical Competency Committee or PEC

3. Graduate Performance
• Board pass rate/how many sit for Boards
• Graduate survey
• Fellowship match results
• Graduate interviews vs positions offered
• On time graduation and program completion
• Scholarly activity
• Attrition
• Employment—academics, private, research, GME

4. Program quality
• Results of annual confidential evaluation of program by residents and faculty
• ACGME resident and faculty survey results
• Program rotation goals and objectives
• Program evaluations
• Resident evaluations/assessment methods
• Outcomes measures
• Conference topics/frequency
• Skills/simulation curriculum
• Survey data from recent graduates
• Review of status of any citations or concerns from previous accreditation letter
• Review of program policies and procedures and specialty-specific program requirements
• Program’s process on the previous year’s action plan(s)
• Resident/Faculty attrition
• Program board pass rate
• Match results
• Post-match survey
• Board pass rate
• Case logs/procedure logs
• Scholarly activity
• ACGME Web Ads/self-Study
• Clinical quality measures/pt care outcomes
• In service exams
• QI activities
• Milestones
I. PURPOSE:

This policy is to establish that each accredited Residency/Fellowship program sponsored by and/or funded by Florida Hospital establish a Program-specific policy to establish the composition and responsibilities of the training program’s Program Evaluation Committee. This Program-specific policy must also establish a formal, systemic process to annually evaluate the educational effectiveness of the Residency/Fellowship program in accordance with the program evaluation and improvement requirements of the ACGME, the program specific Residency Review Committee (RRC), other accreditation entities, and the Graduate Medical Education Committee (GMEC) policy.

AOA and CPME programs will follow the guidelines established for ACGME programs until such time their accrediting body requires a different process. All non-accredited programs will follow these guidelines until such time that the GMEC determines that no APE need be conducted.

II. POLICY:

Each Program Director is responsible for appointing Program Evaluation Committee (ACGME Common Program Requirement V.C.) to conduct an annual evaluation of the residency program. This process must include both faculty and residents. The evaluation will proceed according to the ACGME Common Program Requirements listed below:

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE).

The program must monitor and track each of the following areas:

V.C.2.a) resident performance;
V.C.2.b) faculty development;
V.C.2.c) graduate performance, including performance of program graduates on the certification examination;
V.C.2.d) program quality; and,
V.C.2.d).1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
V.C.2.d).2) The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.
V.C.2.e) progress on the previous year’s action plan(s).
V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored.

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Residents and faculty will be given the opportunity to participate by completing a confidential evaluation. The pooled information from these evaluations will be given due consideration by the PEC, and will be used to improve of the program. Resident(s) will be peer-selected to participate in the review.

PROGRAM EVALUATION COMMITTEE

A. In accordance with this policy, each Program Director shall appoint a Program Evaluation Committee (PEC) to participate in the development of the Program’s curriculum and related learning activities. In addition, the PEC will:

1. Annually evaluate the program to assess the effectiveness of the Program’s curriculum.
2. Identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

B. The Program Evaluation Committee shall be composed of at least 2 members of the Program’s faculty, and include at least 1 peer-selected Resident/Fellow.

1. Program Directors are generally discouraged from being a member of the PEC. However, in the case of a small Program, Program Directors may become members upon approval by the DIO.

2. Should there not be any Residents/Fellows enrolled in the program, the Resident/Fellow membership requirement will be waived until such time that peer-selected residents can be chosen.

C. The PEC will function in accordance with the written description of its responsibilities, as specified below and actively participate in:

1. Planning, developing, implementing, and evaluating all educational activities of the program;

2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
   a. Trainee performance;
   b. Faculty development;
   c. Graduate performance, including performance of program graduates on the certification examination and;
   d. Program quality, specifically:
i. residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually and;

ii. the program must use the results of the trainees' assessments of the program together with other program evaluation results to improve the program

iii. Progress on the previous year’s action plan(s).

D. Each residency program must use resident evaluations and feedback of the program including curriculum, working environment, scholarly environment, evaluation systems, and other items deemed important by the program. These evaluations are confidential.

E. Resident evaluations combined with faculty input are key to evaluating the educational effectiveness of the training program.

F. The program should prepare a written plan of action to document initiatives to improve performance in at least two areas. The action plan should document how improvement initiatives will be measured and monitored. The action plan must be reviewed and approved by the teaching faculty and documented in the meeting minutes.

G. All programs must submit a copy of the program evaluation agenda, minutes and a Program Evaluation and Improvement Plan to the GME office by August 15th of the academic year.
Title: GMEC Special Review Process

I. PURPOSE:

To ensure effective oversight from the GMEC and DIO of underperforming Graduate Medical Education programs within the Sponsoring Institution by (1) establishing the necessary criteria for identifying an underperforming program and (2) establish the procedure when a residency/fellowship program undergoes a Special Review.

II. CRITERIA:

A variety of informational and statistical information can be used to determine if a residency or fellowship program is underperforming. These items include, but are not limited to:

1. A significant change, as noted in the Annual Program Evaluation, in standard performance indicators such as:
   a. Board Pass Rate;
   b. In-training exam scores;
   c. Resident’s Clinical Experience (patient census, types, disease, procedural volume);
   d. Resident progress in the Competencies;
   e. Resident aggregate progress in the Milestones; Milestones assessment/reporting/results and program progress;
   f. Program Attrition (resident and/or faculty, program director);
   g. Resident or Faculty Survey Results (ACGME, program, or institutional surveys);
   h. Scholarly Activity (residents and faculty);
   i. Faculty Development;
   j. Significant changes in program educational content, structure and/or resources;
   k. CLER Site Visit results specific to a particular program that has not been resolved.

2. Evidence against a program indicating potential egregious or substantive noncompliance with the ACGME Common, specialty/subspecialty-specific Program, and/or Institutional Requirements; or noncompliance with institutional policy; or significant issue(s) as may be brought forth by the Resident Council.

3. A program’s inability to demonstrate success in any of the following Clinical Learning Environment Review (CLER) focus areas:
a. Integration of residents/fellows into institution’s **Patient Safety Programs**;
b. Integration of residents/fellows into institution’s **Quality Improvement Programs** and efforts to reduce Disparities in Health Care Delivery;
c. Establishment and implementation of **Supervision** policies;
d. **Transitions in Care**;
e. **Duty hours** policy and/or **fatigue management and mitigation**; and
f. Education and monitoring of **Professionalism**.

4. Self-report by a Program Director or Department Chair.

III. **PROCEDURE:**

1. **Designation:** When the GMEC has determined that a residency or fellowship program is deemed underperforming or failing, the DIO as Chair of the GMEC shall schedule a Special Review. The Special Review shall begin within 30 days of a program being designated as “underperforming” or “failing” with a final report and recommendations within 60 days of the start of the Special Review.

2. **Special Review Committee:** Each Special Review shall be conducted by a panel including at least one member of the GMEC who shall serve as Chair of the panel, at least one additional core faculty member, and one resident/fellow not from within the department of the program under review. Additional reviewers may be included on the panel as determined by the DIO/GMEC. Panel members shall be from within the Sponsoring Institution but shall not be from the program being reviewed or, if applicable, from its affiliated subspecialty programs.

3. **Preparation for the Special Review:** The Chair of the Special Review panel, in consultation with the DIO/GMEC and/or other persons as appropriate will clarify the specific concerns to be reviewed as part of the Special Review process. Concerns may range from those that broadly encompass the entire operation of the program to a single, specific area of interest. Based on identified concerns, the program being reviewed may be asked to submit documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

4. **The Special Review:** Materials and data for the review process shall include:

   a. The ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements in effect at the time of the review;
   b. Accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective RRC;
   c. Letters from the RRC with citations or areas of concern;
   d. Reports from previous internal reviews of the program (if applicable);
   e. Previous annual program evaluations;
   f. Results from the most recent internal or external resident surveys,
   g. Results from the most recent ACGME faculty survey, and,
   h. Any other materials the Special Review panel considers necessary and appropriate.
   i. The Special Review panel will conduct interviews with the Program Director, key/core faculty members, at least one peer-selected resident from each level of training in the program, and other individuals deemed appropriate by the committee.
5. **Special Review Report:** The Special Review panel shall submit a written report to the Program Director, Department Chair, the DIO and GMEC that includes, at a minimum, a description of the review process and the panel’s findings and recommendations. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns, a recommended time-line, and the process for the GMEC to monitor outcomes. The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.

6. **Special Review Follow-Up:** The program director will be required to submit a progress report to the GME Office addressing the findings and recommendations for improvement as designated by the Special Review Panel. The Special Review panel will review the progress/follow-up report for progress. The Chair of the Special Review panel will report all activities and progress at each GMEC meeting until such time that the GMEC is satisfied with the progress and compliance of the program. The program director from the underperforming program will participate in all GMEC discussions related to the Special Review.

7. **Monitoring:** The DIO and GMEC shall monitor outcomes of the Special Review process, including actions taken by the program and/or by the institution with special attention to areas of GMEC oversight, including:

   a. the ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited programs;
   b. the quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites;
   c. 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;
   d. the ACGME-accredited programs’ annual evaluation and improvement activities; and,
   e. all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.
Designation: When the GMEC has determined that a residency or fellowship program is deemed underperforming or failing, the DIO as Chair of the GMEC shall schedule a Special Review. The Special Review shall begin within 30 days of a program being designated as “underperforming” or “failing” with a final report and recommendations within 60 days of the start of the Special Review.

Special Review Committee: Each Special Review shall be conducted by a panel including at least one member of the GMEC who may also serve as the Chair of the committee. The committee shall include at least two additional core faculty members and, for a residency program review at least one resident in the PGY 2 year or higher or for a fellowship program review a fellow. Additional reviewers may be included on the panel as determined by the DIO/GMEC. Panel members shall be from within the Sponsoring Institution but shall not be from the program being reviewed or, if applicable, from its affiliated subspecialty programs.

Preparation for the Special Review: The Chair of the Special Review committee, in consultation with the DIO/GMEC and/or other persons as appropriate, will clarify the specific concerns to be reviewed as part of the Special Review process. Concerns may range from those that broadly encompass the entire operation of the program to a single, specific area of interest. Based on identified concerns, the program being reviewed may be asked to submit documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

The Review Process:
Approximately two weeks prior to the Special Review, the Chair of the Special Review Committee and the Director of Graduate Medical Education will meet with the Program Director and support staff to review the curriculum, policies and procedures, evaluation forms, Web ADS, milestone submissions, etc. This part of the review and the findings will be shared with the Special Review Committee members as well as the GMEC.

1. The day of the Special Review will be very similar to the ACGME site visit. The committee will meet, review the findings regarding the program surveys and documents, and spend the day interviewing the Program Director, faculty and residents from within the program. See example of the day’s events below:

   Committee discussion of the documentation – 1 hour
   Committee meets with the Program Director and Program Coordinator –1 hour
   Committee meets with PGY 1 residents – 30 minutes
   Committee meets with PGY 2 and PGY 3 residents – 30 minutes
   Committee meets with PGY 4 and PGY 5 residents – 30 minutes
   Committee meeting with program faculty – 45 minutes
Committee creates a preliminary list of findings – 45 minutes
Committee re-convenes with Program Director and Program Coordinator – 1 hour

2. A clear, concise summary of the Special Review will be completed with recommendations and a time-line.

3. The Special Review template (attached to the GMEC Special Review Process P & P) will be completed by the Committee and will include:

   The name of the program reviewed with the date the Special Review was completed

   Names and titles of Special Review committee members

   A brief description of how the review process was conducted including a list of those interviewed and documents reviewed

   Assessment of how the program has addressed previous citations

   Other issues or areas of concern noted by the Special Review committee in addition to previous RRC citations

   Final Recommendations/Requirements which may include a request for a progress report (timeframe to be determined by GMEC).

4. The summary report will be presented by the Special Review Committee Chair/ or DIO in his/her absence at the subsequent GMEC meeting. The GME Committee will review and discuss the findings. The Program Director will have the opportunity to respond to the findings in the report. A copy of the final report will be given to the Program Director with a copy on file in the Graduate Medical Education office.

5. Following the Special Review, the Program Director will be asked to provide a progress report to the GMEC addressing areas of concern. The timeframe for this report will be determined by the GMEC. The GMEC may continue to ask for the Program Director to report on areas of concern on a regular basis until the GMEC is satisfied that the issue(s) has/have been adequately addressed.

6. All residency programs supported by Florida Hospital will be reviewed when necessary in the same manner and expected to provide the same quality of education and clinical experience.
RESIDENT ELIGIBILITY AND SELECTION

I.V.A. The Sponsoring Institution must have written policies and procedures for resident/fellow recruitment and appointment and must monitor each program for compliance.

FLORIDA HOSPITAL
GRADUATE MEDICAL EDUCATION ADMINISTRATION

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<tr>
<th>Title: Resident/Fellow Eligibility and Selection Process - ACGME</th>
<th>Policy # 1005-A</th>
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<tr>
<td>Issue date: July 2015</td>
<td>Developed by: Ava Fulbright</td>
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I. PURPOSE:

To establish guidelines pertaining to the selection of residents and fellows who will participate in Hospital residency programs.

II. POLICY:

The Program Director is responsible for the selection and ranking of all candidate(s) that meet the programs eligibility and selection criteria. Input is gathered from other members of the teaching faculty and residents as an important part of the selection process. The Sponsoring Institution must ensure that all residents and fellows selected are eligible as defined below. Institutions and ACGME-accredited programs that enroll non-eligible residents are subject to non-appealable administrative withdrawal by the ACGME.

III. PROCEDURE:

Hospital residency programs will comply with ACGME standards when selecting Resident and Fellow applicants. Programs will participate in the National Resident Matching Program where applicable and will abide by its rules and regulations. All PGY I positions in each program will be listed with the NRMP as part of the All-In policy. There are no exceptions to this policy.

The program director is responsible to ensure that each resident or fellow who is considered for admission fully meets the standards and criteria.

A. Resident eligibility/qualifications - Applicants with one of the following qualifications are eligible for appointment to ACGME-accredited programs:

   1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME); or
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or,

3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   a. Holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or,
   b. Holds a full and unrestricted license to practice medicine in a US licensing jurisdiction in the ACGME specialty/subspecialty program in which they are in training; or,
   c. Graduates of medical schools outside the United States who have completed a Fifth Pathway* program provided by an LCME-accredited medical school.
   i. [*A Fifth Pathway Program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions:
      a) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school;
      b) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools;
      c) have completed all of the formal requirements of the foreign medical school except internship and/or social service;
      d) have attained a score satisfactory to the sponsoring medical school on a screening examination; and
      e) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Step 1 and 2 of the United States Medical Licensing Examination (USMLE).]

B. Resident selection:

1. Hospital will ensure that its ACGME-accredited programs select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. We shall not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.

2. In selecting from among qualified applicants, Hospital and its programs participate in an organized matching program, such as the National Resident Matching Program (NRMP).

3. Programs are not obligated, but may agree to accept a successful applicant for a J-1 Visa (Exchange Visitor). Program Director should be aware that sometimes a potential candidate will not qualify for J-1 status, therefore, the PD should determine whether the candidate
should be placed on the Match list by reviewing the criteria for J-1 status on the ECFMG website at www.ecfmg.org in advance of the rank meeting.

4. Programs are not obligated, but may agree to accept a successful applicant for a H1B Visa providing the candidate can meet the criteria for such Visa.

5. For programs that use the Electronic Residency Application Service (ERAS): candidates must submit all documents through ERAS as required by the program. Programs that do not use ERAS must provide application information directly to candidates that inquire. Those selected for further consideration by the department must appear for a personal interview.

6. If there is a question regarding the eligibility of an applicant, the final decision will rest with the Designated Institutional Official/Chief Academic Officer for Graduate Medical Education.

   a. The Hospital will conduct background checks on all residents and in some cases, fingerprinting. Other background checks will be conducted as determined by FH Human Resources.

   b. Program directors will obtain the following information about residents in other programs who plan to transfer to a Hospital residency:

      - Verification of previous educational experiences
      - A summative, competency-based performance evaluation of the transferring resident’s performance
      - The usual hospital background checks that may include fingerprinting

C. Financial Support for Residents:

1. Hospital will provide all residents with appropriate financial support and benefits.

D. Benefits and Conditions of Appointment:

1. Candidates for hospital-accredited programs (applicants who are invited for an interview) will be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the residents and their families. All of these elements may be found in the contract, GME P&P Manual, and the resident manual. Depending upon the timing of the interview, some of the data furnished are subject to change due to new or change in policy, laws, and other events that cannot be predicted at that time.
Title: Resident Eligibility and Selection Process - AOA

Policy # 1005-B

Issue date: July 2015

Developed by: Ava Fulbright

Revision dates:

Approved by: GMEC May 2015

I. PURPOSE

To ensure a consistent, fair and non-discriminatory process for the selection of osteopathic residents into the training program and to clearly define the minimum criteria for the selection of residents.

II. POLICY

A. Applications: The applicant applies to the residency program through the Electronic Residency Application Service (ERAS). The program director or designee shall review all applications received. Only candidates deemed eligible for residency as defined by the American Osteopathic Association (AOA) will be considered.

B. Interviews: The program director or designee reviews the applications, recommendation letters, and Dean’s Letter. Based on criteria specific to the program, a decision is made whether to invite the applicant to a personal interview with the program. The program director, faculty, and residents shall conduct the applicant interviews and shall follow the policies of the Intern Resident Registration Program (IRRP).

C. Resident Eligibility: Applicants with the following qualifications are eligible for appointment to the accredited osteopathic program at the Sponsoring Institution:
   1. The applicant must be a graduate of a college of osteopathic medicine in the United States accredited by the AOA.
   2. The applicant must have passed COMLEX I and maintain membership in the AOA.
   3. The applicant must submit three letters of recommendation, CV, personal statement, transcripts, and his/her Medical School Dean’s Letter.

D. Resident Selection:
   1. Interns/Residents are selected without regard to age, race, color, religion, sex, disability, veteran status, sexual orientation, national origin, or any other applicable legally protected status.
   2. The selection is based upon preparedness, ability aptitude, academic credentials, personal characteristics such as motivation and integrity, and the ability to communicate verbally and in writing.
3. The osteopathic program will assess all the applicants who have been interviewed and rank the applicants based on the recruiting criteria developed by the program. Applicants must have passed COMLEX II in order to be ranked.

4. The program prepares its match list and submits it to the AOA Intern Resident Registration Program (IRRP).

5. The program director, faculty, and applicants are to follow the policies of the AOA IRRP.

Applicants who are invited for an interview must be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the residents and their families; and the conditions under which the Sponsoring Institution provides call rooms, meals, laundry services, or their equivalents.
INTERNATIONAL MEDICAL GRADUATES AND VISAS

An International Medical School Graduate (‘IMG’) is defined as a graduate of a medical school located outside of the United States (‘US’). The Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of IMGs to enter US residency or fellowship programs that are accredited by the ACGME. The ECFMG certification is one of the eligibility requirements to take Step 3 of the United States Medical Licensing Examination (‘USMLE’), and is required to obtain a license to practice medicine in the US. To be certified by ECFMG, applicants must meet medical education credential requirements and examination requirements, including Step 1 and Step 2 of the USMLE.

The following visa classifications qualify for application to FH GME ACGME training programs:

- J-1: a non-immigrant visa available to aliens that fall under the designation of "Exchange Visitor";
- H-1B: a non-immigrant visa available to hired international employees in a specialty occupation.

FH will sponsor successfully matched IMGs to any GME training program for any of the above visa classifications at the discretion of the Program director. Through the FH GME Human Resource Coordinator, FH is equipped with a visa specialist that will guide the visa application process as necessary. Please allow 120 days for the processing of a J-1 visa.

VISITING RESIDENTS

All visiting residents must be approved by the applicable program director PRIOR to submission to FH GME. Residents wishing to spend elective time at an FH GME program or clinic should apply directly to the program in which the training will take place. Requirements for visiting residents may be found on the FH GME website, www.fhgme.com. The department and resident should allow at least 60 days for contracting when possible.

NATIONAL RESIDENT MATCHING PROGRAM

FH participates in the National Resident Matching Program (‘NRMP’) for PGY-1 positions. All positions shall be filled through the Match unless the DIO has approved the program to fill all accredited positions outside of the Match. The purpose of NRMP is to match medical students and other applicants with hospitals to obtain internships and residencies. Applicants submit a confidential list to the NRMP ranking their desired place of residency. Participating hospitals also enter a confidential list of most desired applicants. Each program’s proposed lists are subject to the approval of the DIO. All of the applicants and hospitals are informed of the result of the match. Programs are not allowed contact with ranked applicants until the national announcement of the match has taken place. Programs are expected to submit a list of Matched candidates to FH GME’s Human Resources Coordinator within 48 hours of the match. FH GME Administration will send employment contracts to all matched applicants.
RECOMMENDATION OF APPOINTMENT

All resident contracts will be issued by the FH GME Human Resources Coordinator. Execution of the contract by a resident indicates that the resident is familiar with the terms of the contract, is eligible and available to embark/continue residency and, has reviewed the GME Manual. The GME Manual outlining the Policies and Procedures will be posted to the FH GME website (www.fhgme.com) and in New Innovations (‘NI’).

Recommendation of appointment for continuing residents must be submitted to the FH GME Human Resources Coordinator no later than February 1st each year for the following July 1st. If a program director is unsure that a specific resident may not receive a contract for the next academic year, the program director or program coordinator should notify the GME office. The program and residents are responsible for verifying home addresses before submission of recommendation.

Program directors recommending a resident for continued appointment who are on (or will be placed on) remediation or probation must be reviewed with the DIO. Documentation for review should include: assessment of the basic competencies and milestones sub-competencies in total with emphasis on those for which the resident is on remediation or probation; remediation plan; and, re-assessment(s) completed to date. All recommendations are subject to review and final approval by the DIO.

LEVEL OF APPOINTMENT

A resident’s appointment is determined in accordance with the level recognized by their specialty/sub-specialty board in the residency-training program. Should a resident/fellow have questions as to their appropriate level, this may be resolved with the program before acceptance of appointment.

AGREEMENT OF APPOINTMENT

FH GME will assure that appointed residents are provided with a written agreement/contract, renewable on an annual basis, which outlines the terms and conditions of their appointment to a program16. A resident’s initial agreement and subsequent renewal agreement will be issued by the FH GME Human Resources Coordinator.

Following receipt of the initial agreement, residents will receive additional information about orientation, employee health appointment, mandated training, and other items in communications from the FH GME. It is important that you review and promptly respond to all communications received from FH GME in order to fulfill requirements before the first clinical day. Residents not completing all required materials and training may not start clinical training until successful completion of requirements.

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16 ACGME Institutional Requirements, IV.B.: The Sponsoring Institution and program directors must assure that residents are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program.
I. PURPOSE:

To establish a legally binding contract between residents and Hospital and to outline Hospital policies regarding resident non-renewal or non-promotion.

II. POLICY:

Hospital provides residents with a written contract outlining the terms and conditions of their appointment and monitors the implementation of these terms and conditions by the program directors. Hospital and its program directors ensure that residents adhere to established practices, policies, and procedures in all institutions to which residents are assigned.

The agreement of appointment must be provided to all applicants invited to interview. The agreement provided must be the agreement either in effect at the time of the interview or at the time of proposed appointment.

III. PROCEDURE:

1. Each resident receives a one-year employment contract. Each contract must be signed and returned to the GME Office by April 15th. The contract includes resident responsibilities and benefits, policies on academic probation, discipline and due process, and establishes pay level.

2. Non-renewal of agreement of appointment or non-promotion: In instances where a resident’s agreement will not be renewed, or when a resident will not be promoted to the next level of training, Hospital ensures that it’s ACGME and AOA-accredited programs provide the resident(s) with a written notice of intent not to renew a resident's agreement or give the promotion no later than four months prior to the end of the resident's current agreement. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the agreement, the ACGME and AOA -accredited programs will provide the residents with as much written notice of the intent not to renew or promote as the circumstances will reasonably allow, prior to the end of the agreement. This applies to other accredited programs and all non-accredited programs.
3. Residents must be allowed to implement the institution’s grievance procedure as addressed in the FH GME Grievance Policy if they have received a written notice of intent not to renew their agreement or of the intent to renew their agreement but not to promote them to the next level of training.

IV.B.2. The contract/agreement must directly contain or provide a reference to the following:

a. IV.B.2.a) Resident/fellows responsibilities;
b. IV.B.2.b) Duration of appointment;
c. IV.B.2.c) Financial support;
d. IV.B.2.d) Conditions for reappointment and promotion;
e. IV.B.2.e) Grievance and due process;
f. IV.B.2.f) Professional liability insurance, including a summary of pertinent information regarding coverage;
g. IV.B.2.g) Insurance (medical, dental, vision) and IV.B.2.h) disability insurance;
h. IV.B.2.i) Vacation and leave (parental, sick, personal);
i. IV.B.2.j) Effects of Leave;
j. IV.B.2.k) Board eligibility requirements;
k. IV.B.2.l) Duty hours; Moonlighting;
l. VII.7.2.d) AOA Conditions under which living quarters, meals, laundry are provided;
m. VII.7.2.f) AOA Mutual release clause;
n. VII.7.2.p) AOA Policy on other professional activities outside the program;
o. VII.7.2.q) AOA Counseling, medical, psychological support services;
p. VII.7.2.r) AOA Policy on physician impairment and substance abuse;
q. VII.7.2.s) AOA Policy on sexual harassment;
r. VII.7.2.t) AOA Policy on closure of hospital/training program or reduction

In institutions where both AOA and ACGME programs are present, a written statement of benefits must be attached to the contracts and a copy provided to the trainee.
EQUAL OPPORTUNITY FOR RESIDENT’S WITH DISABILITY

FH GME reasonably accommodates and promotes qualified residents with disabilities under the same guidelines and policies as all other residents\textsuperscript{17}. Essential trainee responsibilities and duties are defined in program manuals and reasonable accommodation will be made for the successful performance of those responsibilities and duties. FH GME will comply with accommodation parameters and arrangements as established by the accrediting board for the specialty / subspecialty program and those determined and established by FH. Each accommodation request will be handled on an individual basis. The process of evaluating and granting accommodation requests requires careful review and will be managed with full confidentiality. FH GME will assist any resident in obtaining appropriate auxiliary equipment, when deemed necessary and reasonable, to aid the resident in performing essential functions. Participants in this process include the resident, the faculty, the program director and the DIO; each with a set of basic responsibilities.

The resident is responsible for:

A. Indicating the need for the accommodation by a written notification to the Program Director;

B. Requesting the accommodation made well in advance of the need so that an appropriate needs evaluation may be completed. The request must be detailed enough to ensure that, if granted, the accommodation can be successfully implemented;

C. Identifying the specific nature of the condition supported by written medical documentation from an appropriate health care provider(s) which substantiates the presence of an impairment that supports the need for the requested accommodation. An accommodation request may require additional documentation and/or intermittent reevaluation. The resident is responsible for complying in a timely manner in such cases;

D. Fulfilling their responsibilities in conjunction with the granted accommodation by utilizing any device or equipment provided by FH as agreed upon, take due care to ensure its security and return the device or equipment in working order upon completion of training;

E. Maintaining regular contact with the program director or designee at least once during each rotation which requires the accommodation to provide feedback about its effectiveness or further evaluate any adjustment needs.

When request for accommodation has been granted and appropriate accommodation has been determined and established, the faculty member is responsible for:

A. Protecting the confidentiality of the information received regarding the resident’s disability. Information regarding the impact of the disability upon the resident’s participation in the training program can only be shared with those who have a legitimate educational need to be informed.

\textsuperscript{17} ACGME Institutional Requirements, IV.H.4.: Accommodation for disabilities.
B. Providing information to the resident regarding academic requirements and other related activities in ample time should further arrangements of accommodation need to be made for successful completion of the rotation.

On behalf of FH GME and the training program in which the resident is training, the program director or designee is responsible for:

A. Informing all teaching faculty and staff about their responsibilities in conjunction with accommodations.

B. Conducting an initial review of documentation form appropriate medical provider(s) regarding the nature and extent of the disability, restrictions and limitations, the nature of the accommodation and its expected duration.

C. Conducting the necessary research, the identification of appropriate equipment and the subsequent purchase of the equipment. The costs associated with this process are incurred by the training program in which the resident is participating.

D. Assuring that once an accommodation request has been reviewed and granted, the faculty will be required to accept and support the accommodation in their day-to-day tasks and responsibilities.

E. Implementing the delivery of the approved accommodation to the resident and deliberately assessing to assure the effectiveness of the equipment as expected.

F. Protecting the confidentiality of the information received regarding the resident’s disability. Information regarding the impact of the disability upon the resident’s participation in the training program can only be shared with those who have a legitimate educational need to be informed.

The DIO is responsible for:

A. Assuring that all FH GME training programs are in compliance with equal opportunity policies.

B. Monitoring publications of program related brochures, websites, program manuals and other pertinent documents to ensure appropriate disability information is included.

C. Acting as a liaison among all process participants to monitor appropriate role fulfillments for the duration of the resident’s course at FH GME.

D. Protecting the confidentiality of the information received regarding the resident’s disability.

Information regarding the impact of the disability upon the resident’s participation in the training program can only be shared with those who have a legitimate educational need to be informed.
PROGRAM CLOSURE/REDUCTION IN RESIDENT NUMBERS

The Sponsoring Institution must have a written policy that addresses a reduction in size or closure of a residency program or closure of the Institution. The policy must include the following:

1. The Sponsoring Institution must inform the GMEC, the DIO, and the residents as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution intends to close; and,
2. The Sponsoring Institution must either allow residents already in the program(s) to complete their education or assist the residents in enrolling in either a ACGME or AOA-accredited program(s) or, CPME accredited program as applicable, in which they can continue their education.

FLORIDA HOSPITAL
GRADUATE MEDICAL EDUCATION ADMINISTRATION

| Title: Program Closure and/or Reduction of Residency Programs/Positions-Sponsoring Institution | Policy # 1002 |
| Issue date: | Developed by: Ava Fulbright |
| Revision dates: | Approved by: GMEC |

I. PURPOSE:

To outline a written commitment to resident physicians in the event the institution determines that program closures(s) or reduction in size is necessary.

II. POLICY:

Hospital, as the Sponsoring Institution, through the Designated Institutional Official, will inform the GMEC, Program Directors, GME staff, and residents as soon as possible of any intention to reduce or close a residency program OR if the Hospital Board of Trustees determines that the hospital will close. Every effort will be made to allow residents currently in the program to complete their education or assist the residents in enrolling in a different ACGME, AOA or CPME accredited program in which they can continue their education.

Once the determination is made to reduce or close the residency program, the Sponsoring Institution must notify the ACGME, AOA and the National Residency Match Program (NRMP). The Sponsoring Institution must inform these entities of the method in which the institution will assist the residents in securing a position in another accredited program. Failure to notify these entities will be viewed as an egregious violation.
III. PROCEDURE:

1. If the institution intends to reduce the size of a residency program or close a residency program, or if the Hospital Board of Trustees determines that the hospital will close, the Sponsoring Institution will inform the residents as soon as possible.

2. Excepting the most dire, immediate fiscal crisis, residents already enrolled in programs will either be successfully placed in other programs, or will be permitted to finish the program during the phase out process.

3. Administrative assistance will be provided to assist residents in finding a new position for a minimum of 90 days.
RESIDENT ORIENTATION

In addition to the FH-mandated employee orientation the FH GME will conduct orientation specific to the requirements of GME at FH. In fulfillment of this responsibility, all new residents are mandated to attend orientation as outlined in hiring communication from the FH GME Human Resources Coordinator. Orientation days are paid for new residents. All residents are expected to attend each day and session, arrive promptly to the orientation site, wear appropriate attire for a casual business setting (no jeans, shorts, or flip flops), and be prepared to fully participate in orientation. Residents not attending orientation are subject to delay in the start of their clinical activity.

Each residency program will determine whether residents will complete ACLS, PALS, ATLS and NRP certification courses before orientation. Residents not completing required certifications may experience a delay in starting their residency training. These courses will be provided to new residents at no cost or the resident will be reimbursed at the program director’s discretion. All new residents must have a valid certification in any or all of these courses as specifically required by the training program. A new resident who possesses a valid certification (i.e. from medical school) should check their program’s requirements for certification and renewal to ensure they remain in compliance with the certification policies through the course of their residency.

New residents may be disqualified from the training program if they do not consent to any of the orientation activities, have significant positive findings on background checks, have illicit substances detected on drug screening without a bona fide medical indication or, otherwise do not meet the requirements for beginning their program at FH. Extraordinary circumstances preventing a new resident from participating fully, must be presented to the FH GME Human Resources Coordinator through a letter of approval from the program director before the date of orientation. In this circumstance, all orientation requirements must be fulfilled within 30 days of actual start date.

Each program will further define orientation specific to its requirements and clinical specialty/sub-specialty and will communicate those requirements to the resident through the program manual and/or specific written communication.

RESIDENT BENEFITS

Photo ID/Security Access:
Residents are issued an FH identification badge. The badge is for identification, access to secure areas, and purchases within the hospital. The badge is to be worn on the lab coat, scrubs, or other clothing at all times on the upper left hand side. Badges are not to be altered in any way including pictures, tape, or stickers. If a FH badge is ever lost or stolen it should be reported immediately to the FH GME Human Resources Coordinator. Remember that your badge can be used as a credit card in hospital food concessions and within gift shops or spa/salon. You are responsible for all charges. BADGES MAY NOT BE LOANED TO OTHER INDIVIDUALS FOR ANY REASON.

Radiation Badges (Dosimeter):
At the discretion of the program each resident may be issued a dosimeter in order to monitor his or her level of radiation exposure throughout the training period. Program coordinators will assist the resident in completing their application for a dosimeter and will manage the exchange of the monitoring device. The resident will be responsible for maintaining their dosimeter in proper working order and exchanging
the dosimeter quarterly. Should a resident suspect she is pregnant or become pregnant, she should immediately notify the program coordinator to obtain a second monitoring dosimeter to be worn on the waist throughout the pregnancy. Radiation monitoring data is cumulative and transfers with the resident throughout their career. Before graduation, the resident must complete a transfer form in order to transfer their record of radiation monitoring to their practice and/or employer. Any lost of damaged dosimeters should be immediately reported to the program coordinator.

**Stipend/Salary:**
All salary and/or stipend payments will be distributed through direct deposit as authorized by the resident and may be observed through the FH intranet system. No paper stub will be issued. Resident is responsible for checking the accuracy of their pay and any travel or expense reimbursements. Be aware that often “other” reimbursements will appear on the pay stub under various codes.

**Paid Time Off:**
**Personal time (vacation, sick, interview days, holidays):** Residency training is a 365-day a year activity and all days off service may be counted as vacation days. Since residents are employed by the hospital, Florida Hospital determines the number of PTO days for residents per year. Residents receive twenty (20) paid days off each academic year; AOA counts time off as “working days,” which is further defined in the Program Manual. Time off requests at the discretion of the program director and/or chief resident and must be requested in accordance with your program’s time off policy. Paid personal time is not subject to accumulation and may not be sold back by the resident and must be used within the academic year. Utilization of personal time is monitored through the program and must be entered as vacation time into NI.

Residents who are ill and unable to complete their duties must notify their program director and make the appropriate arrangements for their time away. Extended sick leave requiring leave of absence must be reported to the program director and the FH GME Human Resources Coordinator.

**CME Time:** Is determined by your program and is administered as outlined on the resident contract and may not exceed five (5) days. CME days (if available) are at the discretion of the program director and are monitored through the program. CME time is not subject to accumulation and may not be sold.

**Presentations:** The resident may, at the discretion of the program director and FH GME receive paid time off, which does not count against personal time off, to travel and present an accepted abstract, poster, or presentation or, to give an invited lecture.

**Professional Dues:**
In accordance with your resident agreement, professional dues for certifications and appropriate membership in organizations will be provided for through the program. Professional dues are outlined in the resident agreement.

**Malpractice:**
**Professional liability coverage**\(^{18}\): The Hospital shall at its own expense add the resident as a participant under the Hospital’s professional liability program which shall provide a minimum of one million dollars per incident, three million dollars aggregate on an occurrence basis with no deductible by the resident.

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\(^{18}\) ACGME Institutional Requirements, IV.B.2.f): Professional liability insurance.
Coverage shall not be available under the Hospital's professional liability program for services performed by the resident outside of assigned Program activities (e.g., when the resident is moonlighting, no coverage is afforded under the Hospital's professional liability program). Elective rotations away from FH will be reviewed with Risk Management and the Office of Graduate Medical Education in order to determine the applicability and/or extent of liability coverage available.

**Health Coverage and Medical Reimbursement:**

**Health Insurance**\(^19\): The FH Employee Medical Policy is the policy the residency complies with at all times (see FH Employee Handbook). Health insurance coverage for residents and their family will be effective on the first day of orientation. If coverage of a service is excluded, or partially excluded, by the FH Employee Medical Policy, the residency will exclude it as well. Please refer to your benefits package for more information.

**Prescription Plan:** The FH Prescription Plan (see Employee Handbook) is the policy the residency complies with at all times.

**Dental Insurance:** Please refer to your Employee Handbook for additional information regarding dental insurance.

**Meals:**

Meals/Food are made available during some conferences and at the physician lounge(s) at each campus \(^20\).

**Parking:**

The following parking facilities for physicians are available to residents (access requires the use of ID badge):

- **Orlando campus:** located in King Street parking garage 4\(^{th}\) floor or higher
- **East campus:** located behind Medical Plaza building and the hospital’s cafeteria.
- **Winter Park:** located by the Emergency Department.
- **Celebration:** located past ED second lot.

**Lab Coats:**

Two white lab coats will be furnished to Resident by the Hospital at the beginning of the first year of training to insure uniformity and identification of Residents. Replacement shall be the responsibility of the Resident. One new coat will be provided at the beginning of each subsequent training year. It is expected that each resident will comply with the hospital dress code to include nametag and appropriate Hospital affiliation identification. Lab coats with insignia or names of other institutions are not to be worn in hospital or while providing any patient care duties. **Residents may not wear lab coats or any FH identification when moonlighting or providing services not related directly to the residency program.**

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\(^{19}\) ACGME Institutional Requirements, IV.B.2.g) and IV.F and: Health Insurance

\(^{20}\) ACGME Institutional Requirement, II.F.2.a): Residents must have access to food while on duty at all participating sites.
Call Rooms:
Safe and secure call rooms are provided for residents on service\textsuperscript{21}. For those residents at the Orlando campus call rooms are located in the basement of the hospital and have been recently renovated to include sleeping quarters, bathrooms/showers, conference room, relaxation/TV area, and dining area.

Leave of Absence\textsuperscript{22}:
FH GME must ensure that each program provides its residents with a written policy in compliance with its Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program, and information relating to access to eligibility for certification by the relevant certifying board.

Family and Medical Leave: For all family and/or medical leaves, residents must notify their program director and the Office of GME Human Resources Coordinator. The following details apply:

A. If a resident takes family or medical leave as outlined below, there are certain restrictions specified by the accrediting body which must be adhered to. Please consult the appropriate program requirements.

B. Eligible residents may apply for or be placed on leave of absence by FH for the treatment of any illness, injury or medical condition, whether occurring on or off-the-job. Eligible residents may qualify for either a statutory family or medical leave or a Hospital medical leave for up to 12 weeks. If eligible residents exhaust these benefits and require additional time off from work for treatment of any on or off-the-job illness, injury or medical condition, they may apply for and extended leave.

The eligibility requirements and procedures for these leaves are outlined below:

(1) Residents must provide the Hospital with at least 30 days' notice before their leave, if possible. As soon as a Resident knows they will need to apply for a leave they must contact the GME HR Coordinator to arrange appropriate paperwork.

(2) Residents eligible for statutory family/medical leave may request a leave of absence for up to 12 weeks within any 12 month period for the following reasons:

i. The birth or placement (adoption or foster care) of a child ("child care leave"); or

ii. To care for a spouse, child or parent ("family member"); or

iii. For a serious health condition that makes the resident unable to perform the functions of his/her position.

\textsuperscript{21} ACGME Institutional Requirements, II.F.2.b) and II.F.2.c): Call rooms: Residents on call must be provided with adequate and appropriate sleeping quarters that are safe, quiet, and private; and, Security/safety: Appropriate security and personal safety measures must be provided to residents at all locations including but not limited to: parking facilities, on-call quarters, hospital and institutional grounds, and related facilities.

\textsuperscript{22} ACGME Institutional Requirements, IV.G: Leaves of absence. AOA Postdoctoral Requirements, Section VII, C.
C. Residents may take statutory leave for any combination of these reasons, but the total of all combined leaves may not exceed 12 weeks within a 12-month period. However, if a husband and wife are both employed by FH and either is entitled to leave for the birth or placement of a child, the aggregate number of workweeks of leave to which both are entitled may be limited to 12 weeks during any 12-month period.

D. A child-care leave must be taken within 12 months after the birth or placement of the child. A childcare leave can only be taken in consecutive weeks. Request for childcare leave on an intermittent basis or reduced work schedule must be approved at the sole discretion of the program.

E. When required by a doctor, due to the serious health condition of a family member or the resident, leave may be taken for consecutive weeks, intermittently or through a reduced work schedule.

F. If leave is requested because of a family member’s or a resident serious health condition, the resident must provide a certification from a doctor or health care provider. The Hospital will provide residents with a form describing the information to be included in the medical certification. The Hospital may require (at its expense) that the resident obtain a second opinion from a doctor or health care provider designated by the Hospital. Under certain circumstances, the Hospital may also require (at its expense) a third opinion by a mutually agreeable doctor or health care provider. Residents may also be required to provide recertification from the doctor or health care provider during the leave as well as certification that the resident is able to return to work upon completion of the leave.

G. All statutory medical leaves will be without pay; however, the Hospital may require that remaining vacation days leave be used for all or any part of the child care leave, family care leave or leave for a serious health condition of the resident.

H. Coverage under the Employee Health Care Plan will remain in effect during a statutory leave. Resident should contact the FH Employee Benefits office for more information.

I. It is the responsibility of the resident to reactivate medical coverage upon return from a Leave of Absence if it has been discontinued.

J. Residents must report to the Hospital no later than the work day following the expiration of their statutory leave. (See FH Time-Away Policy for non-compliance with this policy).

K. Residents with a serious health condition who exhaust their statutory leave benefits and need additional time off from work for treatment of an on or off-the-job illness, injury or medical condition may for extended leave.

Extended sick leave:
Residents may require additional time off from work for the treatment of an on or off-the-job injury, illness or medical condition after exhausting a statutory or Hospital medical leave.
A. To qualify for extended sick leave, residents must first exhaust their statutory (for personal medical reasons) or Hospital medical leave benefits. Residents must apply for extended sick leave through the Human Resources Department at least two weeks before expiration of their statutory or Hospital medical leave. Residents must provide certification from their doctor or health care provider on the form provided by the Hospital regarding the need for a continued medical absence from work. The Hospital may require (at its expense) a second opinion by a doctor or health care provider before granting an extended sick leave.

B. Extended sick leaves will be without pay. Residents who qualify for extended sick leave may continue their absence for an additional period of time. Resident should contact the FH Employee Benefits office for more information.

C. Residents will not accrue service credit or employment benefits during an extended sick leave. However, employment benefits accrued before the extended sick leave will not be forfeited. Coverage under the Employee Health Care Plan will remain in effect if the resident pays the full premium during an extended sick leave. Arrangements for continued payment of Employee Health Care Plan premiums must be made upon commencement of the extended sick leave.

D. Residents who have questions regarding their eligibility for leave of absence or the procedures which apply to a leave should speak with the FH Employee Benefits office.

Maternity Leave: Maternity leave plan must take into account the following:

A. Safeguard the health of the mother and infant.
B. Assure that the resident fulfills all educational requirements.
C. Assure that patient care is uninterrupted by the resident's absence.
D. The resident is allowed no more than one month per year away from the residency without make-up of that time to be eligible to take the Board exam (unless otherwise stated by the RRC). This month includes vacation and sick leave.
   (1) Under extenuating circumstances, the time taken may be limited by the residency director (i.e., as inadequate staffing of essential services).
   (2) When a resident acknowledges that she is pregnant, it is strongly recommended that the resident save any remaining vacation time (20 paid days per academic year) for maternity leave.
E. Pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled (1979 Amendment to the Civil Rights Act of 1964).
F. The duration of maternity leave for resident physicians should be based on the written recommendation of the physician(s) caring for the resident and infant.
G. The duration of the paid leave time will be made up of any remaining paid days off. Once paid days off are exhausted, (up to 20 days per academic year). Additional unpaid leave time would have to be made up by extending residency training. The additional leave time should be covered by a disability program, if medically indicated.

H. Residency programs are encouraged to allow residents to design home study or reading electives that comply with accrediting body’s requirements around the estimated delivery date (EDD) or after delivery to minimize the time needed away from the residency. Such home study electives would likely include some outpatient office time weekly in order to meet continuity requirements if applicable.

I. The pregnant resident should notify the program director and those responsible for the scheduling of rotations and call as soon as pregnancy is confirmed.

J. Efforts should be made to schedule the most demanding rotations earlier in pregnancy, allowing for the least strenuous rotations to be performed around the time of the resident's EDD.

K. The rotation performed around the time of the EDD should be one in which these residents are not essential to the service.

L. The resident call schedule should be arranged to have no call around the time of the EDD and while on leave. The resident should be expected to make up call before or after the time, so as not to disadvantage other residents currently in the program.

M. Residents should be able to return to the residency after leave without loss of training status.

N. Residents must call Human Resources within one month of delivery to enroll your newborn under health leave.

**Paternity Leave:**
Fathers are encouraged to take time off around the birth of their child.

A. The duration of paid leave time for a father is recommended to be made up of vacation and sick leave, which may be up to twenty working days per year. Under extenuating circumstances, the time taken may be limited by the residency director (i.e., inadequate staffing of essential services).

B. The father should be given time off while the mother is in labor.

C. The father should be entitled to take his paternity leave any time during the first month after delivery, at the discretion of the father and the program director.

D. The father should inform the program director and those responsible for the scheduling of rotations and call as soon as he finds out the mother is pregnant. Coverage of responsibilities during delivery and leave should be arranged as early as possible.
E. The rotation the father does around the time of EDD should be one in which he is not essential to the service.

F. Attempt should be made to allow the father to have minimal or no call around the time of the EDD and no call while on leave. However, he should be expected to make up his call at other times during the year, so as not to disadvantage other residents currently in the program.

G. The father should notify those who will cover his responsibilities as soon as the mother is in labor.

H. The resident must call Human Resources within one month of delivery to enroll your newborn under health leave.

**Adoption Leave:**

A. The duration of paid leave time for an adoptive parent is recommended to be made up of vacation and sick leave, which may be up to twenty working days per year. Under extenuating circumstances, the time taken may be limited by the residency director (i.e., inadequate staffing of essential services).

B. The adoptive parent should inform the program director and those responsible for the scheduling of rotations and call as soon as the time of adoption, even if only approximate, is known. Coverage of responsibilities during leave should be arranged as early as possible, with confirmation as soon as definite dates are known.

C. Attempt should be made to place the adoptive parent on a rotation in which the resident is not essential to the service around the time of the adoption.

D. Attempt should be made to allow the adoptive parent minimal or no call around the time of the anticipated adoption and no call while on leave, but call should be expected to be made up at other times during the year, so as not to disadvantage other residents currently in the program.

**Funeral Leave:** There is no formal leave for funeral attendance. Attendance is deducted from the paid days off (20 per academic year).
Expense Reporting:

Relocation Expense Reporting: Residents relocating to the Orlando area (from 50+ miles radius) at the start of their training are reimbursed up to $1,500.00 for moving expenses incurred three months before and up to one month after the start of training. Moving is defined as travel from one place of origin to one place of destination. This includes travel for the resident, immediate family and items from one address to another. This does not include purchase of new household items, apartment deposits or rent. Original receipts/documentations are required. Funds received for relocation expenses are taxed according to government regulations. Although taxation laws change, FH will comply with all applicable Federal and State taxation laws.

There are rules governing reimbursements, which ensure speedy and correct payment of expenses for travel, conferences, etc. To assist getting paid as quickly as possible, review the following:

Expense Report Processing:

A. Documentation – All Expense Reports submitted for reimbursement must include original, itemized receipts (must indicate clearly PAID) for expenses. Reimbursements without proper payment documentation will not be accepted. NOTE: Meal expenses must include an original itemized receipt for reimbursement.

Reimbursable Travel Expenses: The reasonable cost of the following expenses will be reimbursed:

A. Single hotel or motel accommodation shall be paid in accordance with FH guidelines. Reimbursement above this amount may be taxable to the employee unless allowed by the maximum Federal per diem lodging allowance for the specific location and season. Laundry, meals, movie, spa fee, safe charges are considered personal items and will not be reimbursed.

B. Air travel. Only coach rate fares will be reimbursed. Only the original ticket receipt (not itinerary or travel agency receipt) and/or boarding pass is acceptable for reimbursement—exception is an e-ticket receipt. E-ticket receipts are acceptable for reimbursement purposes. Reimbursements for unused tickets must have original tickets attached to the expense report. All travel should be well planned in advance to take advantage of savings. Last minute purchases that exceed the 3 week or more advance purchase price will be reimbursed at the lowest available fare.

C. Ground transportation. Employees should choose a shuttle van to move between the airport and hotel at the final destination. Limousine service is non-reimbursable.

D. Taxi fare with submission of original receipt.

E. Mileage. When driving your own car, reimbursement will be provided in accordance with Florida Hospital rates per mile. Please note that gas expense is included in the mileage rate so do not submit gas receipts. Travel exceeding 500 miles should be completed via air travel.
F. Charter plane or bus. A list of individuals taking the charter is required. This requires Vice President approval 60 days in advance.

G. Parking & tolls. Actual self-parking fees and tolls will be reimbursed to those traveling on Hospital business. Receipts are required. FH parking garage fees will not be reimbursed to employees.

H. Convention and registration fees. Receipt of paid invoice required. The front and back copy of the canceled check or the original credit card statement showing deposit by the payee is also acceptable. Convention fees can be paid by the attending employee and reimbursed via the Expense Report before the date of the seminar/convention or paid directly to the vendor with a Payment Authorization Voucher before the date of the seminar/convention.

I. Professional dues. Allowable professional dues paid by the employee will be reimbursed on the expense report in accordance with contracted amounts and, at the discretion of the residency director. Professional dues may also be paid directly to the organization by FH with a Payment Authorization Voucher.

J. Entertainment and business luncheons. All such expenses are to be submitted on the Expense Report. The explanation column must contain the names of all participants and the business purpose for the entertainment. No alcohol or tobacco expenses will be reimbursed. No pork or shellfish food items will be reimbursed.

K. Incidental/minor business expenses associated with normal hospital business or travel (faxing information, making copies, tips not associated with a meal, etc.) may be included on an Expense Report.

L. Package seminars. When hotel/convention fees are inseparable, the entire amount excluding airfare will be paid directly to the sponsoring organization through the payment authorization system. As with charter services, a list of attendees must be submitted.

M. Meals are reimbursed at the current per diem rate as outlined in FH Policy and Procedure 902.622-1.

N. Staying with Friends - FH allows $25 per night for a gift or dinner out for friends if the employee stays with friends in lieu of a motel when traveling on Hospital business.

O. One Employee Paying Expenses for Another – Expenses will be reimbursed to the individual who actually incurred the expenses, not the individual who paid (a signed copy of the paid receipt is required). Any repayment arrangement is between the individual parties involved. The Hospital discourages this practice and will not act as an intermediary.

P. Change of Plans/Hotel - According to Corporate policy, "no show" charges will not be reimbursed unless through no fault of the employee. "No shows" which are to be paid should be initialed at the item on the Expense Report by the authorizing signatory.
Q. Mixing Business and Personal Travel - For IRS purposes, the business reason for the trip must be clearly stated and dated. Separate business from personal receipts. The Hospital will not reimburse for personal receipts or per diem on personal days.

Non-reimbursable Expenses - The following items are not reimbursable:

A. Fines for traffic violations, parking tickets, and towing charges
B. Costs associated with legal defense of moving violations
C. Airline cabin upgrades
D. Security deposits of any type
E. Alcoholic beverages and smoking materials. No Exceptions.

Submit all receipts and paperwork at one time to the residency coordinator no later than 30 days from incurrence. Allow 4-6 weeks for payment. Employees will receive payment on their regular FH paycheck. If a submitted expense seems excessive, it will be questioned and possibly slow down and/or change the reimbursement. You are responsible for tracking your expenses and checking your pay stub for reimbursements.

Book Allowance: Residents may use part or all of the funds listed in the conference reimbursement section above toward medical textbooks or other program director approved educational materials.

National Holidays:
The following national holidays are recognized. Time off for Holidays is given at the discretion of the program director and not an entitlement. Holidays requested by accompanying time off requests will be counted as paid time off and will be deducted from your 20 day allowance.

  New Year’s Day
  Labor Day
  Memorial Day
  Independence Day
  Thanksgiving Day
  Christmas Day

Behavioral Health and Counseling Support:\n
The faculty psychologists are available for support and counseling to residents and their immediate family members. Additionally, FH has established a complimentary and confidential resource for the Medical Staff called Physician Support Services (‘PSS’). PSS may be accessed by calling 407.303.9674 or online at http://www.fhphysiciansupportservices.org/. PSS provides counseling and psychotherapy for individuals,

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23 ACGME Institutional Requirements, IV.H.1 Behavioral Health
couples and families, group counseling and psychotherapy, executive coaching, consultation and, physician development.

The Hospital’s Employee Assistance Program (‘EAP’) is also available at no cost to eligible employees, their spouses, and eligible dependents. Employees of FH are automatically enrolled. EAP services include face-to-face counseling, life coaching services (stress management, career planning, financial planning, motivation, time management) webinars, legal services, consultation, referrals and, financial services.

MHNet may be accessed by calling 1.800.492.4357 or online at www.mhneteap.com. A counselor will conduct a telephonic assessment with you to determine what services best will assist you. If a referral to a network provider is necessary, the assessment will include gathering your specific provider criteria such as location, day and time availability, and specialty. The network provider will conduct a formal, face-to-face assessment at your first session. Seeking help from MHNet is between you and the counselor or provider. No information may be shared with anyone else unless you give the counselor or provider written permission to do so.

Adventist Health System supports the MHNet policy of confidentiality.

Life Coaching Services may be accessed by calling 866.583.0119 to schedule an appointment Monday through Friday 7 a.m. — 6 p.m. Central Time.

RESIDENT FORUM

ACGME IR section II.C. Resident/Fellow Forum: The Sponsoring Institution must ensure availability of an organization, council, town hall, or other platform that allows residents/fellows to communicate and exchange information with each other relevant to their ACGME-accredited programs and their learning and working environment. Mechanisms to ensure this environment must include:

II.C.1.- 3 Any resident/fellow must have the opportunity to raise a concern to the forum; have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present and must have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.

In order to assure these requirements are met, the Office of Graduate Medical Education has established a Resident Forum that meets ~ 10x a year to allow residents from all FH GME programs to gather and address issues in a confidential manner.

The structure for these meetings is as follows:

A. The resident forum determines if they will be represented by a peer-selected resident, chief resident, or if they may all attend if there are no conflicts with patient care, duty hour requirements or didactic requirement;

B. Prior to the meeting, the President or Vice-president, or their designee, will call for agenda items.
C. The President or Vice-president, in the absence of the President, shall preside over the meeting.

D. The Secretary shall record the minutes.

E. The President and Vice-president shall be voting members of the GMEC and provide an oral report of the most recent meetings and any areas of concern or requests upon with the GMEC would vote or provide further information or guidance.

Meetings for academic year 2015 – 2016 are scheduled from 1p to 2p with food provided. The GME administrative assistant provides support in scheduling meetings and assisting with communication as requested by the President. The President and Vice-president of the Resident Forum is responsible for meeting communication, agenda, and the minutes. The resident forum has adopted their own bylaws for meetings and committee structure. The GMEC fully supports the resident association and encourages all program directors to provide protected time for resident representatives to attend these meetings.

COMMUNITY SERVICE

In keeping with the mission of Florida Hospital, residents may be asked to participate in mission trips and/or community service activities as determined by the program director. All community service performed is to be reported to the residency coordinator before the services is provided. Community Service will become part of the resident’s portfolio and must be documented in NI.

ACGME GENERAL COMPETENCIES

FH GME training programs are expected to be in full compliance of the prescribed competencies for resident development as set forth by their accrediting body. GME programs accredited by ACGME must integrate into the curriculum the ACGME Competencies as outlined in the Common Program Requirements as well as those further specified by the Review Committee. Additionally, FH GME applies the standard of ACGME competencies to all GME programs as a guide by which residents/fellows should train and conduct themselves. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

A. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

B. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

C. **Practice-Based Learning and Improvement** in which residents/fellows must

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24 ACGME Common Program Requirements, IV.A.5: ACGME Competencies
demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

D. **Interpersonal and Communication Skills** that result in effective information exchange and collaboration with patients, their families, and other health professionals.

E. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

F. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Compliance shall be demonstrated in terms of:

A. Evidence that each program has developed its curriculum that incorporates the teaching of required competencies as specified in the specialty’s Program Requirements. The program’s curriculum shall identify the goals and objectives based on the competencies.

B. Evidence that each program is utilizing a collection of evaluation tools to assess a resident’s competence in the various areas appropriate to the specialty.

C. Evidence of each program’s effectiveness in terms of competency based educational outcomes and their direct influence on program improvement.

D. Residents and Faculty demonstrating knowledge of the competencies and striving to achieve proficiency (at a minimum) in each of the areas outlined by the Common Program Requirements.

**AOA CORE COMPETENCIES AND PROGRAM REQUIREMENTS**

An Osteopathic Core Competency Program shall be integrated into all OGME programs and shall include an Institutional Core Competency Plan, Program Directors Annual Summary, and Final resident Assessment as noted in *AOA Basic Documents IV-I.*

A. Program Requirements

A program description including the following elements must be present:

1. Mission statement
2. Description of facilities

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25 AOA Institutional Requirements, IV I: Osteopathic Core Competency Program.
AOA programs require incorporation of osteopathic principles and practice only in the evaluation and care of patients of osteopathic attending physicians.

Residents must have passed COMLEX USA-3 before entry into the OGME 3 year.

**CORE CURRICULUM**

FH GME programs are based on a core curriculum that permeates all training programs and comply with the Competencies outlined in the Common Program Requirements\textsuperscript{26}. The core curriculum serves as the foundational guidelines for each training program in the formulation of specific curriculum objectives relevant to the nature of its specialty. All residents will acquire learning experiences in the core curriculum during their training as specified by the Program director. The curriculum must contain the following educational components:

A. Overall educational goals for the program, which the program must distribute to residents and faculty annually.

B. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. The resident at the start of each rotation should review these.

C. Regularly scheduled didactic sessions.

D. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program.

Additionally, the core curriculum includes the following areas:

A. Patient Safety: FH GME teaching faculty and its preceptors will develop and implement a patient safety curriculum that allow them to lead and teach patient safety concepts, tools and culture to all residents. Residents shall participate in various patient safety-focused learning activities such as M&Ms and case conferences, patient safety grand rounds, simulations for discussion of adverse events and lasting solutions, legal ramifications of patient safety issues, and any other subject matters appropriate to the training specialty.

\textsuperscript{26} ACGME Common Program Requirements, IV.A: Educational Program.
B. Practice Management: The curriculum in practice management is designed to meet the educational needs of physicians in training who will be working in an increasingly competitive and financially constrained market.

C. Citizenship: Residents must demonstrate a commitment to carrying out professional responsibilities within the guidelines of FH citizenship policies and its mission and values. FH GME training programs aim to help residents develop the skill, competence, and character expected in a physician. Expectations of citizenship are delineated in the citizenship section of this manual.

D. Ethics: FH GME programs will include longitudinal curriculum which will envelop the systematic and reasoned deliberation regarding values and best clinical practice that are made in the ever changing circumstances of personal and professional aspects of daily life, with the goal of fostering a full and noble existence. The curriculum specifically focuses on matters of health, life, and death that arise from the complex interrelationships between medicine, science and technology and society.

E. Diversity: Providing quality health care and helping people to change behaviors to achieve optimal benefits of healthy living are faced with unique obstacles due to the differing populations whose way of thinking, languages, backgrounds and experiences vary from their providers and each other. FH GME programs will include a core curriculum in cultural diversity that is designed to deepen the understanding of culture to further optimize health care that is accessible, effective, and cost-efficient to everyone.

F. Research / scholarly activities: FH GME programs are committed to promote and maintain an academic culture of excellence that is conducive to the transmission of knowledge and conduct of scientific inquiry to improve patient care with evidence based medicine. These scholarly activities are best expressed in rigorous research pursuits that do not violate established professional ethics pertaining to the health, safety, privacy, and other personal rights of human beings. FH GME programs’ expectations and training on research are delineated in the research policy section of this manual and are outlined in your specialties program manual.

G. Fatigue, Sleep Deprivation, Stress, and Burnout: FH GME programs fully recognize that the rigors and demands of residency training affect the quality of personal and professional lives of the residents.

H. Whole Person Care: Whole Person Care, a biopsychosociospiritual approach to health care which includes addressing the biological, psychological, social and spiritual needs of patients, is foundational to our institutional mission. FH GME Whole Person Care curriculum serves as a blueprint for all training programs and the teaching of medical students.

27 ACGME Common Program Requirements, VI.C: Alertness management/fatigue mitigation.
CONTINUING MEDICAL EDUCATION

Fundamental to the mission of FH GME is to develop the ethic for lifelong learning with a vital component of the continuum of medical education. FH GME is committed to provide its trainees with Continuing Medical Education (CME) activities that aid in the pursuit of lifelong learning that will contribute to their knowledge and skills in their journey to assume leadership in the community. All FH CME activities will be governed by the policies of the FH CME Committee chaired by the CME Director and the standards set forth by the ACCME.

TIME AWAY

All time away during the residency year must be requested and approved in accordance with the policies of FH GME and your program.

A. To request time off for any reason the resident must complete a Time-off Request form for all days off and submit to the appropriate Residency Program personnel.

B. No time-off requests are permitted during the last two weeks of a resident’s contract period unless specifically approved by the program director after careful consideration of the needs of the graduating residents and clinical coverage.

C. Time-off requests are considered individually by the Time Away Committee or program director and must have the appropriate approval. An approval or disapproval will be indicated on the Time Away request form and forwarded to the resident in their mailbox, and in some cases, via e-mail.

Time Away Committee or program director will operate based on the following guidelines:

A. Requests for leave are to be turned in at least forty-five (45) calendar days in advance.

B. It is the responsibility of the resident to provide coverage for shifts when assignments have already been scheduled. **Coverage may not negatively affect the duty hours or time off of the covering resident.**

C. The Resident must forward their EPIC in-basket to another identified Resident for coverage.

D. No request will be approved without the signatures of the Time Away Committee or program director.

E. No time off including CME, mission trip, Residency Retreat, and granted days for Boards are assumed.

F. The Resident must follow established procedure for approval.

(1) Actual days of Boards are granted days.
Any days before or after (including travel days), CME, and/or leave days will be considered personal time off.

The Resident is responsible for follow-up and confirmation of approval.

G. Time away for residents not in good standing is at the discretion of the program director.

For more specific requirements on Time Away policies, please consult your program’s Resident Manual.

**AWAY ROTATIONS (ELECTIVE)**

“Away” elective rotation is defined as a rotation lasting 30 or more days, at an institution not owned or operated by FH, and/or with a preceptor not contracted as a faculty member or preceptor of the requesting program. Florida Hospital GME does not approve away rotations outside of the U.S. due to lack of malpractice coverage from Adventist Health Systems, Inc.

Responsibilities:

A. It is the responsibility of the resident/fellow to obtain the approval and required information of the receiving institution and preceptor as well as obtain approval for the rotation from the program director;

B. It is the responsibility of the program director, or their designee, to notify the Director of GME of the request, provide rationale for the rotation, and forward the required documents as listed below.

C. It is the responsibility of the Office of GME to work with the receiving institution to negotiate terms and complete the required agreement as well as to work with the program to assure appropriate documentation specific to malpractice, salary, time off, etc., is in place.

Procedures:

A. Resident and Program

(1) Resident/fellow identifies site of away rotation meeting educational objectives as appropriate for their training program;

(2) Resident/fellow or designee obtains the following documents:

i. Preceptor:
   a. Curriculum vitae and copy of board certification;
   b. Complete contact information; and,
   c. Rotation curriculum, course objectives, or goals and
objectives indicating competency based training and/or didactics;

ii. Receiving Institution:
   a. Rotation agreement - *If Institution has no rotation agreement, please indicate and the FH PLA or appropriate Affiliation Agreement will be used; and,
   b. Complete contact information for the Institution’s representative

(3) Resident/fellow submits request for approval of time off (indicating request for salary, paid time off or unpaid time off), and rotation as per the program manual; and,

(4) Once approved through the program, all documentation and forms submitted to the Office of GME in care of the NI Coordinator. Email should indicate approval of the program director.

B. Office of Graduate Medical Education

(1) Once complete documents are received by Office of GME, DIO/CAO will review request and program documentation.

i. Questions or denial of approval will be discussed with the program director.

(2) DIO to review documents from program

i. If receiving institution has a rotation agreement, the NI coordinator shall negotiate changes with the institution and request authorization to execute the agreement through FH Legal Department as per FH policy;

ii. If the receiving institution has no rotation agreement, the NI coordinator will work with FH Legal and receiving institution to complete an agreement;

iii. Determination of malpractice coverage will be determined and/or confirmed through Risk Management, AHS Trust or other appropriate division; and,

iv. Determination of any employment or training-related impact will be reviewed and addressed as required.

(3) Once agreement and documents are determined complete, the NI coordinator will communicate such to the receiving institution, program and resident/fellow along with directions for execution of agreement.

B. Resident and Program
(1) Resident (or designee) will obtain signatures for agreement as directed in communication from DIO;

(2) Program will scan or provide a fully executed copy of agreement to the receiving institution AND to the DIO; and,

(3) Program will place a copy of the agreement and all associated documents in the resident/fellow’s training file - *It is preferable to also scan a copy of all documents into the resident/fellow’s NI Portfolio.
I. PURPOSE:
To establish an Institutional policy and set guidelines for GMEC to ensure all residents are provided appropriate supervision at all times during the course of the educational training experience and to ensure that patient care is delivered in a safe manner. Policy is in line with the ACGME Institutional Requirements; specifically addressing resident responsibilities for patient care, progressive responsibilities for patient management, and faculty responsibility for supervision. AOA programs must follow the AOA Section I: Trainee Supervision Policy. All program policies, regardless of accrediting body, must fall within the scope of this Institutional policy.

II. SCOPE
This policy applies to all FH GME programs, and all independent health care practitioners engaged in the supervision and teaching of residents enrolled in Florida Hospital post-graduate medical education programs.

III. DEFINITION OF TERMS:
Attending Physician refers to a member of the medical staff with a faculty appointment.
Program Director refers to a member of the active Medical Staff responsible for overseeing the program and its compliance with ACGME or AOA Institutional and program requirements.
Resident refers to an unlicensed or licensed intern, resident, or fellow enrolled in a Hospital post-graduate residency program.

IV. POLICY:
It is the responsibility of individual Program Directors to establish detailed, written policies describing resident supervision at each level and each assignment for their residency programs. These written descriptions of resident supervision must be distributed to all residents and faculty for each residency program. The requirements for on-site supervision will be established by the Program Director for each residency program in accordance with specific accrediting body guidelines and should be monitored through periodic departmental reviews. The type of supervision (i.e. physical presence of attending physicians, home call backup) required at various levels of resident training must be consistent with the requirement for progressively increasing resident responsibility during residency training and the applicable program requirements of the individual RRCs, as well as common standards of patient care.
Institutional oversight will occur through the GMEC annual Institutional review process to ensure that supervision is consistent with Institutional and Program-specific policies. Additional Institutional expectations for supervision are determined from the ACGME CLER Pathways for Supervision.

V. PROCEDURE:

Graduate Medical Education Administration requires resident clinical activities to be supervised either directly or indirectly at all times. Resident supervision is provided by faculty and to some extent by senior residents in each program. Each program must have established written descriptions of levels of responsibility for each post graduate year. Resident competency is based on faculty and senior resident observations and documented evaluation of competence.

1. Levels of Supervision

a. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

i. Direct Supervision: The supervising physician is physically present with the resident and patient.

ii. Indirect Supervision:

(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

iii. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

2. Supervision Guidelines

a. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.¹

b. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.²

c. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members.³ Criteria for each independent program must be outlined in the program policy, and must be based on the resident’s clinical experience, judgment, knowledge, technical skill, and capacity to function.
d. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

e. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

f. AOA programs shall provide resident supervision on a graduated basis as the trainee progresses through the training program, based on evaluation of individual knowledge and skill as well as Institutional policy, program and specialty college requirements.

g. On-call schedules for attending physicians shall provide for supervision that is readily available to the resident on duty 24 hours per day, 7 days per week.

i. Under circumstances, as determined by the program, in which urgent judgments by highly experienced physicians are typically required, faculty must be immediately available on site at all times.

ii. Under other circumstances, attending physicians can provide adequate supervision off site as long as their physical presence within a reasonable amount of time can be assured as needed.

h. Fellows in accredited programs, which lead to certification by an ABMS specialty board or AOA specialty board, may supervise residents at the discretion of the Program Director(s) of the residency and fellowship program(s).

3. Program, Faculty, Resident Responsibilities

a. All patients seen by a resident on an outpatient basis must be seen by, discussed with, or reviewed by the faculty responsible for the patient’s care.

b. Each program will determine how to best monitor and improve compliance with its supervision policy.

c. All faculty are responsible for and must be actively involved in the care of each patient, both inpatient and outpatient.

d. All faculty are responsible for fostering an environment of inquiry that encourages questions and requests for support or supervision from the resident, and encourages the resident to call or inform the faculty of significant changes in the patient’s condition.

e. The resident must be aware of his or her level clinical experience, judgment, knowledge, and technical skill, and their limitations. The resident must not independently perform procedures or treatments, or institute management plans that he or she is not deemed competent to perform or lacks the skill and training to perform.
f. The resident is responsible for communicating to the faculty any significant issues regarding the patient’s care.

4. **Resident Reporting of Inadequate Supervision**

   a. It is the responsibility of the Institution that residents/fellows have mechanisms by which to report inadequate supervision in a protected manner that is free from reprisal. These mechanisms include:

      i. The Annual Program Surveys reviewed by GMEC

      ii. Reporting to the Florida Hospital Resident Association, who would bring such concerns to the GMEC.

5. **Clinical Learning Environment Review (CLER) Pathways for Supervision**

   a. S Pathway 1: Education on Supervision

      i. Formal educational activities that create a shared mental model with regard to supervision are necessary for residents/fellows to work consistently in a safe manner.

   b. S Pathway 2: Resident/Fellow perception of the adequacy of supervision

      i. It is important to elicit resident/fellow perceptions as one indicator of the adequacy of supervision.

   c. S Pathway 3: Faculty member perception of the adequacy of resident/fellow supervision.

      i. It is important to elicit faculty members’ perceptions as one indicator of the adequacy of supervision.

   d. S Pathway 4: Roles of clinical staff members other than physicians in resident/fellow supervision.

      i. Awareness of and actions to ensure appropriate resident/fellow supervision are essential to patient safety.

   e. S Pathway 5: Patients and families, and GME supervision.

      i. For patients and families to participate appropriately in their care-related decisions, they need to be aware of the roles and responsibilities of and have access to the physicians providing their care.

   f. S Pathway 6: Clinical site monitoring of resident/fellow supervision and workload with regard to addressing patient safety.

      i. Periodic monitoring of resident/fellow supervision and workload is essential to identifying vulnerabilities and designing and implementing actions to enhance patient safety.
**DISTANCE POLICY**

FH bylaws mandate that all medical staff members shall be geographically available to fulfill their patient care obligations. Residence and office shall be within a 25-mile radius of one of the FH facilities. Medical staff members, whose patient responsibilities are primarily exercised at one campus, shall be located (both office and residence) within a 25-mile radius of that campus. Upon the recommendation of the Department Chairman, the Credentials Committee may consider requests for exception to this requirement on an individual basis.

FH GME physicians in training shall abide by the 25-mile radius requirement as well. The GME Office preference is that physicians in training reside within a 10-mile radius of the primary site where they train.
I. PURPOSE:

The ACGME and AOA requires all programs to have policies regarding duty hours for resident/fellows and to ensure each resident/fellow maintains a reasonable work schedule within his/her respective program. This Resident Duty Hours policy will ensure compliance with all ACGME, AOA, and CPME accreditation standards and requirements.

II. DEFINITION OF TERMS:

**Duty hours** are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, all activities associated with the transfer patient care, time spent in-hospital during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

III. POLICY:

Each program must have written policies and procedures consistent with the ACGME Institutional and Common Program Requirements, the AOA Basic Documents for Postdoctoral Training and/or the CPME Standards and Requirements for resident duty hours. The policy of the GME office is to provide residents with a sound academic and clinical education that is carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not in any way compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energies. Duty hour assignments must recognize that faculty and residents collectively have the responsibility for the safety and welfare of patients. It is the responsibility of the GMEC to monitor resident duty hours and the impact on quality of the educational program.
IV. PROCEDURE:

1. Resident duty hours for each GME program must not be excessive and must be consistent with the Program Requirements. While individual programs may impose more stringent duty hour policies no program should have policies less restrictive than the institutional policies.

2. On-call time and duty hours should be consistent with the educational needs of the resident/fellow and not be motivated by excessive reliance on the residents to fulfill institutional service obligations.

3. Duty hours must be limited to 80 hours per week, averaged over a 4-week period. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. Adequate time for rest and personal activities must be provided.
   a. “One day” is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
   b. At home call may not be assigned during the 24-hour free of all educational and clinical responsibilities.

4. All Moonlighting hours are counted toward the resident’s/fellow’s 80 hour work week.

5. All individual program policies must be in compliance with the ACGME Institutional and Common Program Duty Hour policies, or AOA Basic Documents Section VII. G. Trainee Duty Hours Policy.

6. All programs, including AOA & CPME accredited programs, are to follow the ACGME Duty Hour rules.

7. All residents must be required to log their Duty Hour time using the, web-based, New Innovations Residency Management Suite, Duty Hour module.

8. The GME office will monitor duty hours through the New Innovations Residency Management system.

9. The GMEC will monitor duty hour compliance for each program through duty hour reports presented at the GMEC meetings and through Annual Program Evaluations and resident surveys.

10. In keeping with the ACGME Clinical Learning Environment Review (CLER) Pathways for Duty Hours/Fatigue Management & Mitigation, Program Directors must maintain a culture of honesty in reporting of resident duty hours. Pathways relevant to this policy are:
a. **DF Pathway 1: Culture of honesty in reporting of duty hours**:  

   i. Prevention of fatigue-related harm to patients can only be accomplished in a culture in which candid reporting of duty hour/fatigue management-related issues occur.

Attachments:

1. ACGME Common Program Requirements, VI.G. Resident Duty Hours
2. AOA Basic Documents for Postdoctoral Training, Section VII: G. Trainee Duty Hours Policy

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28 CLER Pathways to Excellence v1.0. Duty Hours/Fatigue Management & Mitigation, Page 27
VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. (Core)

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)

Common Program Requirements NAS 18
VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

VI.G.4.b).(1) Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

VI.G.4.b).(2) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

VI.G.4.b).(3) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)

VI.G.4.b).(4) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. (Detail)

VI.G.4.b).(4).(a) Under those circumstances, the resident must:

VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and, (Detail)

VI.G.4.b).(4).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. (Detail)

VI.G.4.b).(4).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. (Detail)
VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee]

Common Program Requirements NAS 19

should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Core)

VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. (Outcome)

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (Detail)

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. (Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)
VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

Common Program Requirements NAS 20

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. (Detail)

***
G. Trainee Duty Hours Policy

Situations in which trainees work an excessive numbers of hours can lead to errors in judgment and clinical decision-making, and negatively impact the physical and mental well-being of trainees. These errors can impact on patient safety, as well as the safety of the physician trainees through increased motor vehicle accidents, stress, depression and illness.

7.1 The training institution, DME, and program directors must make every attempt to avoid scheduling excessive work hours leading to sleep deprivation, fatigue or inability to conduct personal activities.
   a. The institutional policy must be reported in the house staff manual and available for review at all program site reviews.
   b. Evidence of review of resident duty hours by the medical education committee (MEC) must occur quarterly.

7.2 The trainee shall not be assigned to work physically on duty in excess of 80 hours per week averaged over a 4-week period, inclusive of in-house night call and any allowed moonlighting. No exceptions to this policy shall be permitted.

7.3 The trainee shall not work in excess of 24 consecutive hours.
   a. Allowances for already initiated clinical care, transfer of care, educational debriefing and formal didactic activities may occur, but shall not exceed 4 additional hours and
must be reported by the resident/fellow in writing with rationale to the DME/program director and reviewed by the MEC for monitoring individual residents and program. These allowances are not permitted for OGME-1 trainees.

b. Trainees shall not assume responsibility for a new patient or any new clinical activity after working 24 hours.

7.4 The trainee shall have 48-hour periods off on alternate weeks, or at least one 24-hour period off each week and shall have no call responsibility during that time. **At-home call cannot be assigned on these free days.**

7.5 Upon conclusion of a 20-24 hour duty shift, trainees shall have a minimum of 12 hours off before being required to be on duty or on call again.

a. Upon completing a duty period of at least 12 but less than 20 hours, a minimum period of 10 hours off must be provided.

7.6 All off-duty time must be totally free from clinical, or assigned classroom educational activity.

7.7 Rotations in which a trainee is assigned to Emergency Department duty shall ensure that trainees work no longer than 12 hour shifts with no more than 30 additional minutes allowed for transfer of care and shall be required to report in writing to the DME/program director for review by the MEC, only any time exceeding the 30 additional minutes, for monitoring individual trainees and program.

7.8 In cases where a trainee is engaged in patient responsibility which cannot be interrupted at the duty hour limits, additional coverage shall be assigned as soon as possible by the attending staff to relieve the trainee involved. Patient care responsibility is not precluded by the duty hours policy.

7.9 The trainee shall not be assigned to in-hospital call more often than every third night averaged over any consecutive four-week period. Home call is not subject to this policy, however, it must satisfy the requirement for time off. Any time spent returning to the hospital must be included in the 80 hour maximum limit.

7.10 At the trainee's request, the training institution must provide comfortable sleep facilities or provide another mechanism for a resident to return home (e.g. cab fare) to trainees who are too fatigued at shift conclusion to safely drive.

7.11 The ACGME Duty Hours Policy may be substituted for the AOA Duty Hours Policy.
MOONLIGHTING

Florida Hospital
Medical Education Administration

Title: Moonlighting
Policy # 1011

Issue date: 7/1/2015
Developed by: Ava Fulbright, Dir. GME; James Jimenez, Manager, GME

Revision dates: Approved by: GMEC

I. PURPOSE:

To define the standards by which moonlighting will be monitored as required by Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA). The ACGME and AOA Institutional Requirements require the sponsoring institution to have policies regarding professional activities that take place outside of the educational program.

II. POLICY:

It is the policy of the Florida Hospital Graduate Medical Education Committee (GMEC) to assure moonlighting activities, whether internal or external, allow sufficient time for resident rest and relaxation to promote resident educational experiences and safe patient care. This policy applies to all Residents and Fellows, here in referred to as “Resident,” participating in any FH sponsored residency or fellowship program.

III. PROCEDURE:

1. Residents must not be required to engage in moonlighting activities. Program Directors may grant permission for a senior resident (senior resident is defined as a PGY 2 and higher) to participate in moonlighting activities under certain circumstances:

   a. The resident must be in good standing in the program.

   b. PGY 1 residents may not participate in moonlighting under any circumstances.

   c. Time spent by residents moonlighting, must be counted towards the 80-hour maximum weekly hour limit.

   d. Moonlighting activities may not interfere with performance of clinical or academic activities, including conference attendance. Each program director will monitor resident performance and fatigue and may withdraw moonlighting privileges at their discretion.

   e. A resident must have the following to participate in moonlighting activities:
i. An unrestricted, permanent license to practice medicine in each state where he/she moonlights. A permanent license is different from a training license and residents are not legally permitted to moonlight under a training license.

ii. A Federal DEA number. Residents are not legally permitted to moonlight under a training DEA number.

f. Residents moonlighting outside of Hospital (external moonlighting) are not covered by the Hospital’s Professional Liability Insurance policy and must make certain that the third-party employer provides adequate professional liability coverage OR the resident must purchase professional liability insurance on their own.

g. Resident benefit coverage, including coverage for any injury or disability incurred while moonlighting for a third party, do not apply during outside or unassigned activity.

h. The Program may revoke approval or initiate corrective action in the event of any unauthorized outside professional activity and/or if such activity interferes with the ability of the Resident to satisfactorily fulfill the obligations of the Program.

i. All approvals for moonlighting:

   i. shall remain in force for the current academic year unless terminated by the Program Director.

   ii. shall automatically expire on June 30 of each academic year.

   iii. are approved for a one-time moonlighting activity and expire at the end of that activity.

j. Renewal requests 90 days prior to the start of the next academic year must be processed and approved before undertaking additional moonlighting activities.

2. Program Director Responsibilities

a. Each program must have a written program-specific Moonlighting policy which meets the ACGME RRC and/or AOA requirements and which is consistent with the GME policy.

b. Prospective written approval from the Program Director is required for all moonlighting activity, in the form of a moonlighting request application.

c. Completed moonlighting applications must be sent to the GME office for final review and approval by the CAO/DIO, before any activities can take place.
i. Applications must include proof of malpractice coverage provided by third-party employer or purchased by resident.

d. The Program must maintain a copy of the completed and approved moonlighting request application as part of the resident’s personnel file.

e. The Program Director is expected to monitor all moonlighting activities, and is ultimately responsible for assuring that moonlighting activities do not interfere with the ability of the resident to meet the goals, objectives, responsibilities, and assigned duties of the program.

f. The program director may withdraw permission to moonlight if, at any time, if moonlighting activities are seen as producing adverse effects on the resident’s training experience.

g. The program director is responsible for ensuring that the resident reports all moonlighting hours toward the 80 hour limit.

3. Resident Responsibilities

a. All residents participating in moonlighting must first complete a Moonlighting Request application and obtain approval and signature from the Program Director and the CAO/DIO prior to undertaking such activity.

b. It is the sole responsibility of the resident to:
   
   i. Apply for and obtain a permanent license to practice medicine.
   
   ii. Apply for and obtain their own Federal DEA to support moonlighting activities.
   
   iii. Ensure coverage of malpractice and other insurances as applicable for moonlighting activities.

c. Duty Hour reporting: All moonlighting activities, internal and external, must be reported by the resident as duty hours within the residency management system.

d. Residents employed under a J-1 visa are strictly prohibited from participating in moonlighting activities.

e. Violation of these moonlighting rules and procedures by the resident may lead to disciplinary action up to and including termination.
**DUTY HOUR TRACKING AND VALIDATION**

Duty hours have a significant impact on the resident’s work performance, patient safety and, satisfaction with their training. Failure to comply with duty hours requirements may also jeopardize the program and institutional accreditation. All residents are responsible for tracking and validating their duty hours weekly. It is the responsibility of the resident to:

A. Monitor and validate duty hours in NI on a weekly basis (Sunday to Saturday). **All residents will complete the validation of their duty hours from the week before by 0900 every Monday morning.**

   (1) Residents whose hours are not validated by 0900 on Monday morning will receive a notice on Outlook to complete their duty hours by 0900 on Tuesday of the same week, which will be copied to the Program director and Residency Coordinator.

   (2) Residents whose duty hours are not validated by 0900 on Tuesday will be relieved of duty until they present to the DIO/Director and complete/validate their time.

      i. To relieve a resident of duty, the NI Coordinator will notify the DIO/Director that the resident is out of compliance.

      ii. The DIO/Director will contact the Program Director and Residency Coordinator to advise of non-compliance and request the resident be relieved.

      iii. Exceptions may only be made with the agreement of both the DIO/Director and the Program director.

   (3) Three (3) violations will result in written documentation by the DIO to the resident’s training file.

B. The GMEC requires Program Directors to report duty hour compliance at every GMEC meeting. Any violation identified must be addressed immediately along with a contingent plan for remedy.

   (1) The Program Director of concern shall submit a written report of evidence of resolution to the GMEC Chair within 30 days.

   (2) Program Directors should demonstrate back-up support systems in place in the event patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
EVALUATIONS

These policies are generally applicable to all residency-training programs. However, since programs vary from one department to the other programs should prepare policies that adhere to specific RRC requirement(s) and not conflict with GME or hospital policies. Such policies must be approved by the GMEC in advance.

A. Formative Evaluation:

(1) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

The program must:

i. provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on specialty-specific milestones;

ii. use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

iii. document progressive resident performance improvement appropriate to educational level; and,

iv. provide each resident with documented semiannual evaluation of performance with feedback.

(2) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

B. Summative Evaluation:

(1) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

i. document the resident’s performance during the final period of


education; and,

ii. verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

C. Faculty Evaluation\(^{31}\):

(1) At least annually, the program must evaluate faculty performance as it relates to the educational program.

(2) These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

(3) This evaluation must include at least annual written confidential evaluations by the residents.

D. Program Evaluation and Improvement\(^{32}\)

The program director must appoint the Program Evaluation Committee (PEC). The Program Evaluation Committee:

(1) must be composed of at least two program faculty members and should include at least one resident;

(2) must have a written description of its responsibilities; and,

(3) should participate actively in:

(a) planning, developing, implementing, and evaluating educational activities of the program;

(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

(c) addressing areas of non-compliance with ACGME standards; and,

(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

E. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). The program must monitor and track each of the following areas:

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\(^{31}\) ACGME Common Program Requirements, V.B: Faculty Evaluation.

\(^{32}\) ACGME Common Program Requirements, V.C: Program Evaluation and Improvement.
The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

i. resident performance;

ii. faculty development;

iii. graduate performance, including performance of program graduates on the certification examination; and,

iv. program quality. Specifically:

a) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

b) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.

v. progress on the previous year’s action plan(s).

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas as well as delineate how they will be measured and monitored. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. The Annual Program Evaluation and Action Plan must be submitted to the GME Office by July 1st each year.

**EVALUATION COMPLETION POLICY**

Evaluation Procedures:

A. Each department shall formalize procedures, which provide for standardized, regular and, timely evaluation and regular verbal and written notification of the evaluation to the resident regarding performance. During residency, evaluations should be discussed with the resident no less than every six (6) months. A resident whose performance is less than satisfactory should be notified at the conclusion, both verbally and in writing, as soon as possible after such determination is made.

B. An evaluation file must be maintained for each resident. Information in the file will be accessible to the resident. Supervisory faculty should submit written evaluations of each resident after each rotation. The Program Director should review each resident’s file on a routine basis. If the resident disagrees with statements in a written evaluation in the file, the resident has the right to submit a written response, which shall become part of the resident’s file.

C. Residents will participate in evaluation of the faculty and the program.
D. Upon receipt of satisfactory evaluations and compliance with all other terms of the program, each resident should expect to continue to the level of training agreed upon when the resident was recruited. Each residency program must provide a resident/fellow with a written notice of intent when that resident’s/fellow’s agreement will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed. Reasons for lack of advancement must be given to the resident both verbally and by written notification. Each department must establish a written remediation policy, which is approved by the GMEC, and communicated to all residents in the program.

E. **Residents will complete an evaluation of each rotation and the faculty/preceptor by 0900 on the Monday of the week following completion of the rotation.** For example, if the rotation begins on Monday, March 14th and ends on Friday, April 8th the resident must complete the evaluations before 0900, Monday, April 11th. For programs that have calendar month rotations, the resident must have the evaluations completed by the first Tuesday of the following month.

1. Residents who do not complete their evaluation of the rotation and faculty/preceptor will receive a notice to complete their evaluation by 0900 on Tuesday of the same week, which will be copied to the Program Director and Residency Coordinator.

2. Residents whose evaluations are not completed by 0900 on Tuesday will be relieved of duty until they present to the DIO and complete/validate their record.

   i. To relieve a resident of duty, the NI Coordinator will notify the DIO/Director that the resident is out of compliance.

   ii. The DIO/Director will contact the Program Director and Residency Coordinator to advise of non-compliance and request the resident be relieved.

   iii. Exceptions may only be made with the agreement of both the DIO/Director and the Program Director.

3. Three (3) violations will result in written documentation by the DIO to the resident’s training file.

**FACULTY/PRECEPTOR MATCHING POLICY**

It is the responsibility of the program director to select and approve the selection of program faculty to participate in the teaching program and to notify the GME office of such faculty for the purposes of resident learning and evaluation. The NI coordinator should receive detailed information on what faculty are assigned to what rotation(s) and ensure the appropriate PLA is in place. Residents may not start a rotation if the appropriate documents have not been secured.
RESTRICTIVE COVENANTS (NON-COMPETITION)

Medical Education Administration

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<tr>
<th>Title: Restrictive Covenants (Non-competition)</th>
<th>Policy #</th>
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<tr>
<td>Issue date: 7/1/2015</td>
<td>Developed by: Jay Jimenez &amp; Ava Fulbright</td>
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<tr>
<td>Revision dates:</td>
<td>Approved by: GMEC</td>
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I. PURPOSE:

This policy is to ensure appropriate institutional oversight required by the ACGME Institutional Requirements\(^ix\) and the AOA Basic Standards.\(^x\)

II. POLICY:

1. Neither the Sponsoring Institution nor any of its ACGME or AOA-accredited training programs may require residents to sign a non-competition guarantee (restrictive covenant).

2. The ACGME and AOA specifically prohibit the use of restrictive covenants in resident agreements.

3. This policy applies to all FH GME programs, including ACGME, AOA, and CPME accredited residency and fellowship programs.
**MEDICAL STAFF CREDENTIALING**

All residents will be processed through the FH Medical Staff Office for receiving admission and dictation numbers. Residents will not receive medical staff appointments and do not receive clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements and/or training manuals and protocols approved by the GMEC.

The one exception to the above is for residents who meet all of the following qualifications. They, at the discretion of their program director, can apply to the FH Medical Staff for appointment as Fellowship/Academic Staff (See Medical Staff Bylaws Article III Section F). Qualifications:

A. Enrolled in a GMEC approved training program in a surgical subspecialty.

B. Be board eligible or certified for the surgical specialty for which they are requesting privileges.

C. Have an unrestricted full medical license to practice medicine in Florida.

D. Have a active DEA.

**LINGERING AND DEA**

Florida law provides that medical school graduates in the first postdoctoral year may practice for that year without a Florida license, but must register with the Medical Board of Florida, which is accomplished before orientation. Residents are eligible for medical licensure in the State of Florida after successfully passing USMLE or COMLEX Boards Part III and successfully completing the first year of the residency.

The residency program pays for (or reimburses the resident for) licensing of residents eligible to be appointed to the second year of residency. Residents leaving the program after the first year will not be eligible for reimbursement of their Florida medical licensing fee.

A. All eligible first year Residents must take and pass Boards Part III before completion of their first year in the Residency Program.

B. All eligible second year Residents must provide evidence of licensure by the Board of Medicine of the State of Florida, or the Board of Osteopathic Medicine of the State of Florida, and the Drug Enforcement Agency (‘DEA’) certificate within six (6) months of commencing their second year of the residency program. We expect all interns to file the application no later than March 1st of their internship year.

C. After obtaining their State of Florida medical license and DEA in accordance with the above, all residents must maintain a license and DEA evidencing the eligibility of the resident to practice medicine in the State of Florida in accordance with the requirements of the State Board of Medicine, or the Board of Osteopathic Medicine of the State of Florida. Renewal fees will be reimbursed by the residency proportionally based on the time remaining in the training program.
D. Residents in the third postdoctoral or subsequent years without a valid Florida medical license will request/receive written documentation from their Program Director certifying that they will have no patient contact until the license is received. Documentation will be submitted by the resident and program to the Office of GME. Continuation in the program is at the discretion of the Program Director and the DIO. The resident will be placed on leave and may be subject to termination. Salary may be continued only in the amount of vacation time not used.

E. Incoming residents requiring a Florida medical license to start their training program, must demonstrate proof that an application has been submitted to the medical board of Florida with their registration materials. Please allow nine (9) months for processing of your application. Failure to promptly obtain a license and DEA certificate may result in suspension of training until they are obtained. Unreasonable delay in obtaining a medical license or DEA certificate may result in termination of the resident at the discretion of the Program director and the DIO. Waiver of the license or DEA certificate requirement is at the discretion of the Program director and DIO.

**PRESCRIPTION AUTHORITY**

Residents without Florida licenses are authorized only to prescribe medications for inpatients (chart orders). A licensed physician must countersign outpatient prescriptions and discharge prescriptions written by residents without Florida licenses and DEA numbers.

**COMMUNICATION MODES**

All residents have an FH Outlook email address (ex. John.doe.md@flhosp.org) and an Outlook calendar and are required to monitor their email and calendar for communications DAILY.

The Office of GME will utilize the resident’s FH email address exclusively.

FH utilizes New Innovations (‘NI’) for all residency training tracking. Important program and/or administrative announcements will be posted to the main page on NI, in addition to email and bulletin boards, as a means of assuring notice to all residents and faculty. Messages from NI and/or the NI Coordinator are pertinent to your training and accreditation requirements; therefore, all residents must monitor NI at least twice a week.

The programs will provide each resident a mailbox located in their respective resident area(s). It is the responsibility of the resident to check their mailbox at least every other day for notices, memos, schedules, etc. All mailboxes are to be kept neat and should be cleaned out at least once a week.

The programs will maintain bulletin boards specific to program needs, research, or other announcements in addition to those maintained in various areas throughout the hospital (i.e. call rooms, physician lounge areas, Office of GME, etc). Residents must check the bulletin boards at least every other day for notices from the hospital, Office of GME and FH for pertinent information and announcements. Notices may not
be posted on the bulletin boards without prior approval of the appropriate Program director or Residency Coordinator.

SOCIAL MEDIA POLICY

Weblogs and online social networks such as Facebook and others have become popular communication tools over the past several years. These forums offer unique opportunities for people to interact and keep in contact, and have great potential to augment friendships and professional interactions. As professionals with a unique social contract and obligation, all medical students, residents and practicing physicians must be cognizant of the public nature of these forums and the permanent nature of postings therein. While these sites offer terrific potential to bolster communication with friends and colleagues, they are also a potential forum for lapses of professionalism and professional behavior. These sites may give the impression of privacy, but postings and other data should be considered in the public realm and freely visible by many people.

FH GME has adopted the following policy for students, residents, faculty, and programs in safely and responsibly using these sites:

Professionalism:

A. Postings within social network sites are subject to the same professionalism standards as any other personal interactions. The permanence and written nature of these postings make them even more subject to scrutiny than most other forms of communication. Residents may be subject to disciplinary actions for comments that are either unprofessional or violate patient privacy.

B. Statements made by you within online networks will be treated as if you verbally made the statement in a public place.

C. You may not violate copyrighted or trademarked materials. Posting content, photos or other media indicates the resident owns or has the right to use these items.

D. In online social networks, the lines between public and private, personal and professional are blurred. Just by identifying yourself as resident and as a resident in an FH program, you are creating perceptions about yourself and FH by those who have access to your social network profile or weblog. All content associated with you must consistent with your position as a resident at FH and must be consistent with FH’s values and professional standards.

E. FH and FH GME logos may not be used on any social media site without the express approval of the FH media/marketing division. Any medically oriented weblogs should contain the disclaimer: “The posts on this site are my own and do not necessarily represent FH’s positions, strategies, or opinions.”

F. Use of social networking sites or weblogs can have legal ramifications. Comments made...
regarding care of patients or that portray you or a colleague in an unprofessional manner can be used in court or other disciplinary proceedings (i.e. State Medical Licensing Boards).

G. Unprofessional postings by others on your page reflect very poorly on you. Residents must monitor others’ postings on their profile and work to ensure that the content would not be viewed as unprofessional.

H. Residents are encouraged to alert colleagues to unprofessional or potentially offensive comments made online to avoid future indiscretions and refer them to this document.

I. Statements and photos posted within these sites are potentially viewable by future employers, and even if deleted can be recovered under certain circumstances. Be aware too, that images can be downloaded by and forwarded to others. It is not uncommon for potential employers to search for the social network profiles of potential hires, and there are many examples of people not being offered a job because of findings on social networking sites.

J. Relationships online with attending physicians, fellows, supervising residents, interns, and other medical students are all governed by the FH and FH GME policy against sexual harassment. Cyber stalking, requests from those who you supervise to engage in activities outside of work, and inappropriate postings to social networking sites while supervising trainees can all be considered forms of sexual harassment.

K. Avoid giving specific medical advice on any form of social media unless you are engaged in activities related to your program and at the request of your program.

Privacy:

A. Due to continuous changes in these sites all residents must closely monitor the privacy settings of your social network accounts to optimize their privacy and security.

B. It is advisable that you set your privacy profile so that only those people whom you provide access may see your personal information and photos.

C. Avoid sharing identification numbers on your personal profile. These would include address, telephone numbers, social security, passport numbers or driver’s license numbers, birth date, or any other data that could be used to obtain your personal records.

D. Others may post photos of you, and may “tag” you in each of the photos. It is your responsibility to make sure that these photos are appropriate and are not embarrassing or professionally compromising. It is wise to “untag” yourself from any photos as a general rule, and to refrain from tagging others unless you have explicit permission from them to do so.

E. Maintain the privacy of colleagues, doctors, and other FH employees when referring to them in a professional capacity unless they have given their permission for their name or likeness to be used.
F. Make sure that you differentiate medical opinions from medical facts. The world of medicine is foreign to many, so readers may take your words at face value. Residents must make clear what statements reflect your personal beliefs.

Confidentiality:

A. HIPAA regulations apply to comments made on social networking sites, and violators are subject to the same prosecution as with other HIPAA violations.

B. Patient privacy measures taken in any public forum apply to social networking sites as well.

C. Online discussions of specific patients should be avoided, even if all identifying information is excluded. It is possible that someone could recognize the patient to which you are referring based upon the context.

D. Under no circumstances should photos of patients or photos depicting the body parts of patients be displayed online unless specific written permission to do so has been obtained from the patient. Remember, even if you have permission, such photos may be downloadable and forwarded by others.

Patient Content:

A. Interactions with patients within these sites are strongly discouraged. This provides an opportunity for a dual relationship, which can be damaging to the doctor-patient relationship, and can also carry legal consequences.

B. Private patient information obtained on a social networking site should not be entered in the patient’s medical record without the patient’s knowledge and consent.

COMPUTER TRAINING

Residents will be required to complete computer training (Cerner, Epic, NI, Microsoft Office Suites, FH Intranet and electronic storage drives) in order to participate in educational and training activities at FH. Such training is mandatory and failure to complete required training may prevent the resident from obtaining privileges to train and/or beginning clinical activities.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Congress passed the Health Insurance Portability and Accountability Act (‘HIPAA’) in 1996 and subsequently enacted the Administrative Simplification provisions of HIPAA to regulate and standardize electronic transactions and billing codes and establishes standards for privacy and security of individually

33 Health Information Privacy:  http://www.hhs.gov/ocr/privacy
identifiable health information. All FH employees and residents are expected to strictly comply with all policies of FH, including the privacy and compliance policies and procedures. In addition, all residents are required to complete HIPAA training before starting clinical rotations at FH.

There are a number of resources to assist the programs and residents in identifying and protecting PHI through the FH intranet. The following identifiers are a partial listing only:

- Names
- Social Security Numbers
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code
- All elements of dates (except for year) that directly relate to an individual, including birth date, admission date, discharge date, date of death and all ages of 89
- Facsimile numbers
- Electronic mail addresses
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Full face photographic images and any comparable images

CONFIDENTIALITY AND MEDICAL RECORDS

The following applies to all patient information including paper and electronic medical records in addition to all conversations and business records. The HIPAA policy of FH governs all activities related to this area.

A. Medical Records

All medical records are to be kept strictly confidential.

Discussion of confidential patient information should be conducted in a secure location away from hallways or elevators where patients or visitors can overhear you.

All information contained in current or past medical records/charts is confidential and must not be shared in any manner with others including family members without the express permission of the patient.

Copies of reports, laboratory studies, or dictation must never be left in the cafeteria, conference room, stairwell, or other unsecured locations.

All employees and residents are required to secure their computer before leaving workstation. Logging out of all physician electronic access or pressing CTL-ALT-DLT on the keyboard accomplishes this.

B. Information Release. FH Policy and Procedure 715.109
There are many statutes governing the release of medical records and information to patients and others. If you receive written or verbal requests from patients or others to release medical records, you must check with the Attending, Practice Manager or the supervisor of information release in the Health Information Management (hospital medical records) Department (HIM) before complying. You may share medical information with another health care professional in an emergency. Refer all statements pertaining to law suits and/or subpoenas to the Office of GME who will inform HIM and Risk Management.

C. Computer Confidentiality. FH Policy and Procedure 760.009

All personnel share in the responsibility of maintaining the confidentiality of the medical record information accessed by computer for inpatients and outpatients. Computer accessed Medical Record information includes, but is not limited to the following:

1. Patient orders, both current and future
2. Order results
3. Documentation
4. Prior hospital and/or mental health records
5. Current face sheet information
6. Billing information

All residents and personnel with the right to review the patient’s medical record may access computer-generated information, on-line and printed, strictly during their “shift” and within their area(s) of responsibility. Any inappropriate or unauthorized retrieval or review or sharing of private patient information by or with hospital personnel (or with the assistance of hospital personnel) is considered a breach of confidentiality and will be considered just cause for immediate termination of employment at FH.

D. Paper Destruction.

Copies of confidential information may be taken to HIM or DME office to be shredded. In addition, there are security gray boxes marked for shredding throughout the hospital. You may put confidential information into these boxes. Never discard copies of confidential information in a trashcan or leave where it may be picked up or read by unauthorized personnel or visitors.

**BILLING FOR RESIDENT SERVICES**

All patient care performed by residents will be done under the supervision of qualified faculty (See Supervision Policy).

No bill for patient service rendered will be submitted to the patient or third party payor with the resident as the billing provider. All bills will be submitted using the supervising faculty as the billing provider and will comply with all compliance guidelines.
The only exception to the above is if the resident is in a GMEC approved training program in a surgical subspecialty, and the resident holds the FH Medical Staff status of Fellowship/Academic Staff.

In such a case, a bill for assistant surgeon will be submitted with the resident as the billing provider when the resident is the only assistant surgeon on the surgical case with the faculty member as primary surgeon and the surgical procedure qualifies as requiring an assistant surgeon. The utilization of this exception will require the resident to be credentialed with all contracted third party payors including Medicaid and Medicare.

**MANDATORY PROCEDURES**

All residents must meet certain specific requirements in the areas of medical records, employee health, and life support training. Failure to comply may result in delay in contracting, delay in the start of the training program, unpaid suspension of the resident from training, and/or delay of graduation pending satisfactory completion of any given requirement.

**Health Information Management (‘HIM’):**

Authentication:

A. FH requires that, at a minimum, entries of histories and physical examinations, operative reports, consultations and/or discharge summaries are authenticated and dated. Orders and progress notes must also include the time when they were written.

B. Medical Staff members and residents may use a signature stamp, but must, (1) Have a letter on file with the HIM Director requesting use of the stamp, (2) Retain the stamp in their possession at all times and, (3) Assure its use solely by themselves.

C. Entries in the medical record by residents and fellows that require countersigning by attending Medical Staff members include all dictated reports. The countersigning generally shall be completed by the faculty attending physician or Associate Director of the program for the specialty/sub-specialty area, or the co-admitting physician (e.g., Cardiologist, etc.). The attending physician must countersign all areas of medical student charting.

Other specified professional personnel entries shall be countersigned as designated by hospital departmental policies and procedures.

D. Physician signatures within a medical record must be readable and must have printed name legibly written if not using authorized stamp.

E. To avoid misinterpretation, symbols and abbreviations may not be used in the medical record. Residents must review the procedures for the management of medical records:

   1. Medical records must be completed within 15 days after the record has been assigned to a practitioner for completion.
2. Failure to complete delinquent medical records before 30 days after the record has been assigned may result in suspension of clinical/surgical privileges. Residents suspended from training due to delinquency of medical record completion may be placed on unpaid leave or may be required to continue their residency beyond the scheduled completion date without payment of an additional stipend. Repeated delinquencies may result in further disciplinary action including immediate termination.

3. Should suspension occur the resident may lose all clinical privileges and malpractice insurance at all affiliated hospitals and other training locations. Documentation of the suspension will become a permanent part of the resident’s institutional file.

4. Suspension and restoration of privileges will be coordinated through the Office of GME. The DIO and Program director will be notified of all suspensions and reinstatements of residents. Restoration of privileges will occur when the resident has completed the delinquent record(s).

5. In order to prevent delinquency and suspension actions by HIM, the resident or program should notify HIM of “away” rotations, mission trips, extended vacation, illness, or leave of absence.

Employee Health:

Employee Health: 407-303-7135

All residents are required to undergo physical examination and tuberculosis screening prior to the start of your training program. Failure to do so will delay your entry into the training program. Your employee health appointment will be scheduled for you during your employment document processing; instructions will be provided by the Human Resources Coordinator for the Office of GME.

TB screening with the Quantiferon blood test is the preferred TB screening test; however, traditional PPD’s may also be accepted.

A. In order to meet regulatory requirements, annual TB screening is required for all health care workers regardless of any previous results.

B. Persons with a positive result are required to have a chest x-ray and provide documentation of physician (or other acceptable method) consultation regarding the positive result and/or history of treatment for prophylaxis.

Residents will provide proof of valid testing, or will be tested, for antibodies against Hepatitis B. If you have not already been vaccinated against Hepatitis B, you should begin the three dose series of injections as soon as possible. If you refuse vaccination, you are required to sign a declination form with employee health.

Residents will be fit-tested for N-95 respirators (or others as determined appropriate by FH) and wear respirator for all patients with verified or suspected pulmonary TB, H1N1, SARS, or other disease as required.
**Life Support Training:**

Residents coming into the program will take Advanced Cardiac Life Support (‘ACLS’) and any other certification as required by the specific training program. Life support certification must be completed prior to beginning the program unless the resident holds an active certification. The residency program pays for new certification courses. The program does not reimburse residents whose certification is in effect before program contracting.

All residents must renew their certifications before their current certification expires. Failure to do so causes the resident to need retake the certification course rather than only the renewal course. Recertification of an expired certificate may result in proration of the reimbursement to the resident. The residency will pay fees associated with keeping these courses current when approved by GME (fees may be prorated for time remaining in the training program). Copies of all certifications shall be submitted to the program’s Residency Coordinators for placement in the resident’s file.

**Work-Related Injury and Needle Stick Policy:**

All work-related injuries must be reported to FH Employee Health. Residents requiring immediate first aid and/or medical care must proceed directly to the Emergency Department.

See Attachment 3 for Needle Stick Policy. **NEEDLESTICK HOTLINE 24-HOUR PHONE 407-741-4702**

**Exposure to Contagious Diseases (FH Policy 815.040):**

Residents exposed to, or diagnosed with any of the following diseases, must immediately advise their Program director or their designee:

- Chicken Pox/Herpes Zoster
- Conjunctivitis
- Ebola
- Hepatitis (all types)
- Lice
- Measles
- Mumps
- Pertussis
- Rubella
- Salmonella
- Scabies
- Shigella
- Tuberculosis

Upon assessment of the exposure, the Program director in collaboration with Employee Health (and other medical professionals as appropriate) will advise the resident as to management of the exposure. It is the responsibility of the Program director to:

A. Determine which resident(s) and/or personnel sustained a significant exposure;

B. Notify the Employee Clinic of the resident(s) and/or personnel who sustained significant
exposure immediately; and,

C. Instruct the resident and/or personnel to complete Employee Incident Report and call/report the incident to the Employee Clinic for evaluation and management.

Annual Educational Modules:

FH conducts intranet-based courses for annual requirements through Net Learning or the Physician portal on the FH intranet. Residents will be notified of the requirement and time frame for completing these annual requirements through email communication, NI notifications, notifications to the programs by the Office of GME and, through FH publications and media (e.g. Times, FH TV News). Residents not completing annual requirements may be subject to suspension from clinical/surgical duties until they demonstrate compliance with the requirements.

From the internet: [https://employees.floridahospital.org/](https://employees.floridahospital.org/)

Select Net Learning and enter your login access code then select Student Interface.
You will log in again on the following screen.

Then select the appropriate modules from the drop down menus.
NEW INNOVATIONS

New Innovations (‘NI’) is FH GME’s Residency Management Software program. NI assists with tasks such as scheduling, procedure logging, evaluations, monitoring conference attendance, duty hours and general personnel/portfolio tracking. The Office of GME NI Coordinator will train all residents in the use of NI upon orientation at FH. Additional training may take place as needed and may be accomplished through the Office of GME, program director, residency coordinator and residents appointed by their program to act as a resource for other residents and medical students.

All FH GME programs will utilize New Innovations as the primary tool for managing and coordinating duties and requirements.

Programs who must enter procedure logs into ACGME WebADS, or other accrediting body data management system, may refrain from logging procedures into NI. However, the resident must upload their procedure logs at least annually and, in the final year of residency, the procedure log should be updated in NI by the first half of the final year and monthly thereafter.

Users must be aware that each program dictates specific details regarding the use of NI and associated requirements.

Residents using NI are responsible for logging and validation of duty hours on a weekly basis (see Duty Hours for requirement). Residents are also responsible for validation of evaluations and preceptor (see Evaluations and Faculty/Preceptor Matching Policy). Validation of duty hours, evaluations and, preceptors is a resident responsibility and should not be delegated to the residency coordinator, department secretary, faculty member, or other resident.
PROFESSIONALISM, PERSONAL RESPONSIBILITY, AND PATIENT SAFETY

Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

The learning objectives of the program must:

- be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

- not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

- assurance of the safety and welfare of patients entrusted to their care;

- provision of patient- and family-centered care;

- assurance of their fitness for duty;

- management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers;

- attention to lifelong learning;

- the monitoring of their patient care performance improvement indicators; and,

- honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

FH GME Department further defines patient safety as the prevention of adverse events and harm to patients. It is the intent of the GME Department to sustain and monitor a culture of safety in all its training programs with the prevention of errors as the ultimate goal. It is a culture where we shall seek to understand the causes of errors without placing blame, but through open and supportive communication to learn and prevent medical errors. It is fully recognized that responding to the challenge of medical errors requires a comprehensive, multidisciplinary, systematic approach with continuous identification,
communication, understanding, and timely responses to problems in order to alleviate the conditions that are conducive for error.

Each training program is expected to develop and implement a patient safety culture, both in its inpatient and outpatient experiences, by at least the following means:

A. Develop program specific patient safety indicators.

B. Conduct patient safety focused M&Ms and case conferences.

C. Integrate patient safety discussion in rounds, chiefing, and journal clubs, incorporating evidence-based medicine and patient empowerment.

D. Educate both faculty and residents on the patient safety indicators and the SBAR (Situation-Background-Assessment-Recommendation) situational briefing model.

E. Conduct regular faculty development workshops for teaching patient safety to the residents.

F. Develop a Policy and Procedures on the monitoring, evaluating, and ensuring patient safety in the training program.

**INFECTION PREVENTION**

Patient safety and infection prevention is everyone’s responsibility. FH uses the MedMined Infection Surveillance System, which using computerized artificial intelligence to filter out patterns of hospital-borne infections and antibiotic resistance from the hospital’s lab results and patient data. This program helps infection control staff to detect and track hospitalized patients with significant contagious infections. Continuous surveillance, investigations into unusual patterns, and aggressive prevention programs not only serve as the first line of defense for controlling hospital infections, but also help reduce risk for all patients.

Det Norske Veritas Healthcare (DNV) accreditation requires proactive reporting and prevention of medical complications. Hospital-required infections have a direct impact on the quality of care a hospital provides and, by extension, on the hospital's accreditation. Each hospital-acquired infection is an unexpected outcome.

The following are a few smart reminders will keep you, your family and, your patients safe.

A. Perform hand hygiene before and after every patient contact, before and after you use the restroom, before and after you eat, before and after you leave any facility before going to the next and, before you leave the hospital/clinic for the day.

B. Do not wear artificial fingernails, rings, or jewelry or clothing that hang beyond your person.

C. Wear personal protective equipment (‘PPE’) for contact with blood/body fluids.
D. Have immunity to Hepatitis B, measles, rubella; know your varicella antibody status; have annual TB screening.

E. Do not report to work if you have a fever, flu symptoms, or eye or skin lesion drainage.

F. Report “Reportable Diseases” and conditions to Infection Control or the County Health Department.

G. Speak with Infection Control before discharging any patient with verified or suspected TB.

H. Residents will be fit-tested for N-95 respirators (or others as determined appropriate by FH) and wear respirator for all patients with verified or suspect pulmonary TB, H1N1, SARS or other disease as required.

**NON-SMOKING POLICY**

Smoking is not permitted anywhere within FH, including private offices, call rooms, lounges, lobbies, walkways, breezeways, parking facilities or on the grounds. This non-smoking policy extends to all affiliated properties and businesses owned or operated by FH.

**DRESS CODE**

Professional dress will be adopted by all residents (see FH policy). Residents will appear neat and observe the Florida Hospital dress code at all times while on duty in the hospital, on rotations, or at the office. Faculty may send a resident home to correct Dress Code infractions.

A white jacket and FH badge must be worn at all times while on duty at the hospital, on rotations, and at the office. Your FH badge is to be worn on the upper left portion of your body; if the badge covers FH logo, it can be worn on the upper right. No lanyards are to be worn. Jewelry will be limited and discreet as defined by FH standards. FH jackets and badges may not be worn when the resident is Moonlighting or otherwise working and/or volunteering for a non-FH entity unless otherwise approved through the Office of Graduate Medical Education.

Male residents are to wear dress shirt and tie, and clean, unwrinkled slacks that comply with a professional appearance and align with the dress code as set forth in the Program Manual for the residency. Hair should be cut above the neckline, off the ears and without long side burns. Ponytails on men are not acceptable. Open-toed shoes, athletic footwear, or sandals are not allowed.

Female residents are to wear a dress or pants consistent with modesty and a professional appearance and align with the dress code as set forth in the Program Manual for the residency. Shoes and socks conducive to comfort and a professional appearance are to be worn (no sandals, athletic footwear, or open-toed shoes). Hair should be neat and well groomed. T-shirts and jeans are not acceptable professional dress.
Scrubs may be worn in the hospital when appropriate (ED, ICU, OB, Anesthesia, Surgery, Night rotations). FH scrubs are not to be worn outside of the hospital. Athletic footwear may be worn in the hospital if the resident is wearing surgical scrubs. Scrubs are not allowed in the outpatient office.

The program, Office of Graduate Medical Education, and FH’s dress codes will determine what constitutes a professional appearance.

It is the responsibility of FH GME programs to enforce the Florida Hospital Dress Code. All faculty members will insist that each resident and medical student to abide by the regulations.

**MEDICAL LIBRARY**

Library Manager: Nancy Aldrich
Phone: 407-303-1860

The Medical Library at FH provides information for patient care, continuing education, management, and research. The library has approximately 1500 books, 1000 reference books, and subscriptions to 319 journals to help fulfill this responsibility. There is a card catalog and a journal holdings list to acquaint patrons with the library holdings. There is interlibrary loan service available for materials not available in this library.

A virtual library is available at the FH website. To log on to this site from outside the FH network, a token is required. The Physician Informatics Team will provide this token to you during orientation.

To access the virtual library from the internet:

[www.floridahospital.com](http://www.floridahospital.com) → Click on “Physicians” → Click on the FH MD logo

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34 AOA Postdoctoral Requirements, Section 4, H.
To log on from the intranet, click on Department link then Medical Library.

The Medical Library is located in the basement of the Orlando Campus, around the corner from the Barker Conference Rooms (below the cafeteria).

**Hours:**

Monday-Thursday 8:00 AM - 4:30 PM/Friday 8:00 AM - 1:00 PM

**After Hours:**

The library is available to physicians and other designated FH healthcare professionals on a 24-hour basis, with an ID badge security access system. The resources and services of the library are continually being evaluated and assessed as to how they fulfill the mission of the hospital and the needs of the FH medical staff and administration.

In addition to FH’s medical library, residents are encouraged to submit their current curriculum vitae to the University of Central Florida through the Office of Graduate Medical Education in order to become eligible to utilize their online library resource.

**COPYRIGHT MATERIALS**

The unauthorized copying of copyrighted material is illegal and unethical. FH Corporate Compliance department maintains an annual license with the Copyright Clearance Center that eliminates the need to obtain individual copyright permission for portions of books or journal articles used within the organization. Before distributing a document internally, it is your responsibility to check the Copyright
Clearance Center website to see if the book or journal is included in their permissions database and covered by the annual license.

If the title is not covered under FH's annual license, and/or you will be using the materials (including figures, diagrams, charts, graphs and photographs) outside of FH, you MUST obtain individual copyright permission from each publisher or author. FH's Copyright Clearance Center annual license covers use with team members only.

You may request individual copyright permission using the Copyright Clearance Center website. Or, if you find an article on the Internet, you can click on the permissions link in the menu to the right of the article and follow the instructions. In some cases, as with the New England Journal of Medicine, you can send an email directly to the author of the work you want to use. The author’s email and instructions on obtaining permission are usually located at the end of the article.

**DISASTER POLICY**

A disaster is defined as a calamitous event or a series of events that brings great damage, loss, or destruction. If, because of a disaster, an adequate educational experience cannot be provided for each resident FH will attempt to:

A. Arrange temporary transfers to other programs/institutions until FH can re-establish an adequate education experience for each of its residents.
   
   (1) Programs/institution will inform the resident of the minimum duration of transfer and will continue to inform the resident of any changes in duration. If transfer continues to and/or through the end of the residency year, the programs/institution must inform each transferred resident.

B. Cooperate in and facilitate permanent transfers to other programs/institutions in the event FH is unable to re-establish an adequate education experience. Programs/institution will make the decision expeditiously to maximize the ability of the resident to complete the resident year with the least amount of interruption.

If, despite a disaster, an adequate education experience can be provided for each resident FH will attempt to:

A. Ensure a safe, organized and effective environment for the educational experiences, which allow the resident to continue training without interruption of the residency year.

B. Recognize the importance of physicians at all levels of training in the provision of emergency care in the case of a disaster of any kind.

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35 ACGME Institutional Requirements, I.B.8: The Sponsoring Institution must have a policy that addresses administrative support for GME programs and residents in the event of a disaster or interruption in patient care. This policy should include assistance for continuation of resident assignments.
C. Assure the health and safety of the residents and their families.

In the event of a disaster, the DIO will contact the ACGME Institutional Review Committee Executive Director with information about the disaster and resident planning. Program directors will contact the appropriate Review Committee Executive Director with information about the disaster and resident planning. Similarly, residents will contact the appropriate Review Committee Executive Director with information about the disaster and resident planning. Within ten (10) days after the declaration of a disaster, the DIO will contact ACGME to discuss due dates that ACGME will establish for the affected programs in the event:

A. Program reconfigurations are required.

B. Notification is to be made specific to resident transfer decisions.

In preparation for a disaster and potential interruptions to FH GME training programs, the following policies are observed:

A. Each FH GME training program will maintain a disaster contact list that includes cell phone and pager numbers, organized with pathways to maximize expediency of communication, and regularly update (annually and with any changes in leadership, residents or staff).

B. Each affected Program director will assess the impact the disaster may have on the health and welfare of the program’s personnel and resources available to support the program’s educational experiences by:

(1) Making contact with all program personnel to gather information on their health and welfare;

(2) Referring any affected personnel to available resources for care as necessary;

(3) Assessing the functionality of facilities and institutions that support the program’s educational experiences;

(4) Preparing a summary to brief the DIO and/or Director of Graduate Medical Education/Academic Affairs on assessment results; and,

(5) Assessing their ability to maintain sufficient protection and redundancy for all personnel, training, and clinical records.

C. The DIO, or the Director of Graduate Medical Education/Academic Affairs when the DIO is not available (herein collectively referenced as DIO), will assess the impact of the disaster on the educational experience of the affected training program(s). If none of the aforementioned individuals are available, the Senior Vice President over Medical Education will act as or appoint a pro tem DIO. In assessing the impact of the disaster, the DIO will:

(1) Debrief with the program directors to determine the availability and condition
of faculty and residents and determine the feasibility for training within affected hospitals and offices;

(2) Assess the feasibility of providing an adequate educational experience;

(3) Notify the ACGME Institutional Review Committee Executive Director of the disaster with an assessment of impact on the affected program(s).

D. Disseminate as soon as possible any accreditation information received including any notification for site visit(s) that will be required. Site visits that were scheduled prior to a disaster may be rescheduled; and,

E. Assure salaries and benefits will continue to accumulate until such times that utility restoration allows for fund transfer.

In the capacity of assignment by Florida National Guard and/or Department of Homeland Security, FH GME physicians become temporary employees of Health and Human Services (HHS), therefore are subject to, and protected by the Federal Tort Claims Act. It is preferred, whenever and wherever possible, that notwithstanding other capacities, they also act within their FH function when they participate in disaster recovery efforts. While acting within their FH function, physicians will maintain their personal immunity to civil actions.

**MASS CASUALTY AND MASS CASUALTY DRILL**

In the event of a mass casualty or a mass casualty drill, resident will be called or paged to 911 by your program as defined by the Program’s Disaster Call list. Residents will report to, or phone, the appropriate disaster team leader immediately and advise as to the time of travel should their presence be required. The team leader reports to the disaster committee on who responded, how long it took for each person to respond, or if they did not respond at all.

Procedure:

A. Residents and/or medical students in house during a disaster/mass casualty occurrence or drill:

   (1) Last names beginning with A – M are to report to the Emergency Department.

   (2) Last names beginning with N – Z are to report to Ambulatory Surgery.

   (3) Follow instructions given by the Team Coordinator at the assigned location.

B. During a drill, any actor who says “Emergency Stop” means that they are no longer acting and are experiencing some medical problem. Respond accordingly.
MEDIA CONTACT

All media questions and contact are to be referred to FH Public Relations Department. Residents are not to make statements to the press or media representatives without advance clearance from the Office of GME and Public Relations. Should the media contact you for information or come to the hospital and ask you for information, please refer to the following:

During business hours - Public Relations - 407-303-1917

After hours and weekends (until 11 PM) - Orlando - 407-303-6611 - page the PR person on call.

VENDORS

FH GME recognizes there are Federal and state laws that impose criminal and civil penalties for offering or receiving improper “inducements” to order, refer, or purchase a health care item or service. The purpose of these laws is to prevent personal benefit to a health care provider from encouraging over-utilization of medical items or services or otherwise overriding considerations of product or service quality or patient well being.

Access to all personnel of FH GME and its training programs is a privilege. As such, there is a responsibility of all suppliers/vendors/pharmaceutical representatives to conduct business in a professional, respectful, and courteous manner. The following guidelines have been established to insure the safety of patients, visitors, and staff, to protect patient confidentiality, and to afford clinicians access to the latest technological advances.

In general, subsidies or other non-contractual benefits received from vendors by FH GME as a department or by individual FH GME personnel should be modest in value and scope, directly tied to legitimate educational purposes, and must not improperly influence the decision making of any FH GME personnel or program. These benefits include but are not exclusive to gifts, meals, donations, and other related activities.

The FH GME policy on vendor relationship are delineated below to indicate the minimal expectations, is as follows:

A. Vendor representatives must be registered with FH and with the FH GME program in order to be granted the privilege for visits.

B. Vendor representatives are not permitted in patient care areas.

C. Promotion or detailing of drugs is restricted to drugs approved by the Food and Drug Administration and listed on the FH formulary. “Off label” detailing is prohibited.

D. Promotion or detailing of a drug by multiple representatives on the same visit is prohibited.

E. Vendors may furnish consultants to serve as expert speakers at FH GME or training
program specific conferences / meetings. Prior approval must be acquired by the vendor from any FH GME or training program personnel who is deemed the appropriate authority.

F. Appropriate FH GME or training program personnel must approve all clinical and technical materials or manuals furnished by vendors during vendor sponsored events.

G. FH GME shall fully comply with the FH established policies and procedures as delineated by the FH Materials Management / Purchasing: Sales Representatives Code of Conduct (Index Nos. 420.022.1 and 420.022.3, effective dates of 3-13-08).

H. Vendors and FH GME personnel may not attempt to circumvent the application of any part of this policy. Any perceived vague or ambiguous situations may be referred in writing to the Director GME for further clarification of policy compliance. The Director shall respond in writing within seven (7) working days.

I. Violations by any pharmaceutical or supplier/vendor representatives could result in sanctions including suspension of facility visitation privileges or requesting the company to replace the representative.

CITIZENSHIP POLICY

FH GME Department holds the integrity of the teaching faculty – resident relationship as central to its educational mission. Trainees include medical students, residents and, rotating physicians. This relationship confers considerable trust in the teaching faculty members who consequently bears authority and accountability as advisor/mentor, educator, and evaluator to the trainee. Part A of this section is applicable to the entire FH community of health care professionals and employees. Part B includes the disruptive conduct policy that applies specifically to the members of the FH Medical Staff. Part C refers specifically to physician trainees of FH GME. All policies (Parts A, B and C) are relevant to the expectations of citizenship by FH GME on all its personnel. FH GME policies and procedures take precedence over FH Policies wherever applicable.

A. FH Policy Statement

(1) The purpose of this policy is to emphasize the necessity for all individuals working in FH to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. Additionally, this policy protects individuals from behavior, which does not meet these standards.

(2) All members of the health care team, including administrators, the medical staff, nursing and clinical personnel, volunteers and all hospital employees are expected to conduct themselves and their activities in a manner that supports the mission of the hospital and enables the delivery of quality, efficient patient care. Professional behaviors that promote cooperation and teamwork are a priority.

(3) FH citizenship expectations include the following:
i. Respond to patient and staff calls and requests appropriately and timely;

ii. Treat others with courtesy and respect;

iii. Cooperate and communicate with other members of the health care team in a dignified, professional manner;

iv. Respect patient's autonomy, confidentiality, and welfare;

v. Address clinical concerns with colleagues in a direct and respectful manner;

vi. Manage disagreements with courtesy;

vii. Encourage clear communication;

viii. Assist in the identification of colleagues who may be in need of assistance;

ix. Address dissatisfaction with policies, practices, or behavior through appropriate medical staff and/or administrative channels;

x. Participate in clinical improvement activities;

xi. Maintain professional education and skills;

xii. Comply with accepted practice standards;

xiii. Seek and obtain appropriate consultation;

xiv. Arrange for satisfactory coverage when unavailable and communicate such to involved parties;

xv. Complete patient records in a timely manner; and,

xvi. Disclose potential conflicts of interest.

(4) Behaviors to be avoided include the following:

i. Engaging in physical, visual or verbal harassment;

ii. Indulging in disorderly conduct or abusive language, including profanity, shouting, and rudeness;

iii. Fighting, threatening, intimidating, attempting bodily harm or injury, or interfering with other individuals;
iv. Misconduct toward or abuse of others, including patients, visitors, employees, and colleagues;

v. Blaming, shaming, or publicly criticizing others for unexpected or negative outcomes; and,

vi. Engaging in dishonest or fraudulent practices.

B. FH Medical Staff Disruptive Conduct Policy:

Members of the FH medical staff who engage in disruptive conduct will be dealt with in accordance with this policy, as enacted by the FH Board of Directors. In addressing disruptive conduct, protection of patients, employees, physicians, volunteers, visitors and others in the hospital and the orderly operation of the hospital are paramount concern.

(1) Definition:

i. Disruptive behavior is defined as behavior that:

   a. Is perceived by others to represent or which constitutes acts of degradation, intimidation, or the threat of harm;
   b. Disrupts the orderly operations of the hospital;
   c. Interferes with and/or impairs the ability of others to accomplish their work safely and competently;
   d. Creates a hostile work environment; and/or
   e. Interferes with the individuals' own ability to function in a safe and competent manner.

ii. This policy is not intended to inhibit freedom of speech nor to restrain the right to redress grievances.

iii. Examples of disruptive behavior include, but are not limited to, the following:

   a. Threats, attacks, or abuse, in whatever form, which are personal, irrelevant, or outside the bounds of professional conduct and personal civility;
   b. Impertinent or inappropriate verbal communication or written documentation in medical records or other official documents that, by fact or design, compromise the effectiveness or reputation of the hospital;
   c. Public and/or non-constructive criticism, addressed in a manner so as to intimidate, undermine confidence, demean, belittle, or imply stupidity or incompetence;
   d. Harassment of any kind; and,
   e. Use of profanity or similarly offensive language, written or not,
signs or dramatics that are perceived to intimidate, degrade, embarrass or humiliate other persons or the hospital.

(2) Procedure:

i. Physicians, nurses, or other hospital employees who observe, or are subjected to, disruptive behavior by a member of the FH medical staff are to notify the supervisor of the affected unit about the incident. In the event that the supervisor is unavailable, involved in the incident, or is the individual whose behavior is at issue, the next senior administrator of the department or functional unit is to be notified. Any medical staff member who observes such an incident may notify the Chief Executive Officer or a designee directly.

ii. Upon notification, the incident is to be documented in writing by the individual who reported the incident or by the supervisor or administrator receiving the report. The documentation shall include:

a. the date, time and location of the behavior in question and names of involved persons;

b. a factual description of the behavior in question;

c. the names(s) of any patient or family members(s) involved in the incident or any other individual who was a witness to the incident;

d. the circumstances which precipitated the incident;

e. the consequences, if any, of the disruptive behavior as it relates to patient care, personnel, or hospital operations; and

f. details regarding any action taken to intervene in, or remedy, the incident and a factual description of any such action.

iii. The written report shall be forwarded to the Senior Medical Officer, who shall review that report, take necessary steps to confirm the details, and inform the members of the Citizenship Committee of any preliminary findings.

iv. The FH Medical Staff Citizenship Committee shall be constituted as follows:

a. Chief Executive Officer

b. Senior Medical Officer

c. President of the Medical Staff

d. President-elect of the Medical Staff, and

e. Chairperson of involved Department

The Citizenship Committee shall be responsible for reviewing incidents of alleged disruptive behavior; recommending corrective or remedial action; and reporting to the Medical Executive Committee and Administration of FH.
This policy procedure is designed to facilitate a progressive remedial and disciplinary approach to the management of allegations of disruptive behavior. The implementation of this process may be modified subject to the judgment of responsible medical staff leaders and senior hospital administrators, depending upon the specific findings in each case. Other factors, including repeated infractions and the response of the individual involved to prior suggestions and/or recommendations for correction and remediation, shall be considered. The Medical Executive Committee may, at any time in the process, consider other options or when deemed prudent to do so, refer the matter to the Board for resolution, without a recommendation.

Upon determination that an incident of disruptive conduct has occurred, a meeting will be arranged, including one hospital representative and at least one medical staff representative from the Citizenship Committee and the involved member of the medical staff. The initial meeting shall be informational and collegial, and designed to accomplish the following:

i. Advise the member of the nature of the reported incident;

ii. Obtain the members perspective of the incident;

iii. Emphasize that certain conduct is inappropriate and unacceptable;

iv. Educate the member regarding established administrative channels for resolving complaints or concerns;

v. Advise the member that retaliation against any person involved in the incident or reporting process shall constitute grounds for immediate exclusion from hospital facilities; and,

vi. Advise that a written response may be prepared by the member and included with the summary in the confidential portion of the member's medical staff credentials file.

If another report of disruptive conduct involving the same staff member is received, a second meeting with the involved staff member will be held. The purpose of this second meeting will be to:

i. Inform the member of the nature of the reported incident;

ii. Obtain the member's perspective on the incident;

iii. Advise the member that certain conduct is inappropriate and unacceptable, advise the member that any future documentation of disruptive conduct will be referred to the Medical Executive Committee for more formal action; and
iv. Inform the member that a letter documenting the substance of the meeting will be prepared and a copy will be retained in the confidential portion of the member's medical staff credentials file.

(6) In the event of a third reported incident of disruptive behavior, a meeting with the involved staff member will be arranged. The participants for such a meeting shall include:

i. Chairperson, Professional Affairs Committee or a designee;  
ii. President, FH or a designee; and,  
iii. A designated member(s) of the Citizenship Committee.

(7) The purpose of this meeting is to inform the member for the last time and in unmistakable terms that the disruptive conduct will not be tolerated. A letter will be sent to the member and will address at least the following:

i. A description of the disruptive conduct at issue;  
ii. An outline of the steps taken in the past to correct the conduct in question;  
iii. The details regarding the unacceptable behavior; and,  
iv. An explanation of the conditions applicable to continued practice at the hospital.

The member shall be required to sign this letter. Failure or refusal of the member involved to sign the letter will result in the letter becoming a part of the involved member's credentials file and the commencement of a formal investigation pursuant to the Medical Staff Bylaws of FH.

A single additional incident of disruptive behavior after the signing of the notice letter, by the member involved, shall result in an adverse professional review recommendation pursuant to Medical Staff Bylaws. Exclusion from hospital facilities may be appropriate pending this process. The Medical Executive Committee shall be fully apprised of the history and actions taken to address the concerns.

(8) In situations where the member continues to engage in disruptive behavior, the member may be excluded from the hospital’s facilities pending the formal investigative process and any related hearing and appeal that may result. Such exclusion is not a suspension of clinical privileges. Rather, the action is taken to protect patients, employees, and others on the hospital premises from inappropriate behavior and to emphasize to the member the serious nature of the hospital’s intolerance of such behavior. The involved member may submit a written response to the Medical Executive Committee about the exclusion action within three (3) days of being notified.
This policy outlines collegial and professional review steps that can be taken in an attempt to resolve complaints regarding disruptive conduct exhibited by medical staff members. However, there may be a single incident (or combination of incidents) of disruptive conduct that is so unacceptable as to make these multiple opportunities inappropriate and to require immediate adverse action. Therefore, nothing in this policy precludes immediate referral to the Medical Executive Committee (or to the Board), or the elimination of any step in the policy in dealing with a complaint about disruptive conduct.

In order to affect the objectives of this policy, and except as may otherwise be provided, legal counsel shall not be permitted to attend any of the informal meetings described in the paragraphs above.

C. FH GME Code of Conduct Policy:

The academic relationship between a teaching faculty member and Resident must be protected from influences or activities that can interfere with the educational environment consistent with the mission of FH GME. Whenever a faculty member is responsible for academic supervision of a Resident, a personal relationship between them that is abusive in nature or of a romantic or sexual nature, even if consensual, will never be tolerated.

Behaviors considered unacceptable include, but not exclusively, the following:

1. Perceived inappropriate comments directed at an individual related to the person’s gender, sexual orientation, racial background, religion, or physical ability;

2. Verbal abuse, derogatory or degrading remarks, or threats of retaliation. This also includes threat of/or actual physical contact of any kind when there is a perception of physical violence;

3. Assigning tasks for punishment rather than for educational benefit or denying equal educational opportunities as a punishment;

4. Use of public humiliation or intimidation as a method of teaching or use of derogatory terms when referring to another person;

5. Performance rating used to punish rather than as an objective evaluation of the performance;

6. Preferential treatment because of relationship;

7. Sexual harassment of any kind even in jest after the person responsible for the

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36 ACGME Institutional Requirements, II.D.4.m): The Sponsoring Institution must have written policies covering sexual and other forms of harassment.
behavior has been informed that they are embarrassing or offensive or that are by their nature reasonably known to be embarrassing or offensive;

(8) Initiating or maintaining intimate romantic or sexual relationships between faculty and residents or between physicians and patients;

(9) Any acts of dishonesty, falsification, plagiarism, misrepresentation or deception, whether deliberate or unintentional;

(10) Being under the influence of alcohol and/or drugs while on FH property; and,

(11) Any other acts not covered above but are deemed in opposition to FH mission and values.

FH GME procedures:

(1) This section is designed to outline the procedures to facilitate a progressive remedial and disciplinary approach to the management of allegations of violations to any of the above policies. The implementation of this outlined process is subject to modification upon the discretion of the DIO in consultation with senior administrators.

(2) Any individual who has observed or been the subject of an unacceptable behavior is to report the event immediately to the appropriate program director, either verbally or in writing. The report will be treated with confidentiality. Once a report has been received, the following procedures will be followed:

Step 1: Investigation of the allegation. Both the complainant and the alleged will be counseled informally on the results.

Step 2: Documented formal discussion with the program director with an action plan from the perpetrator within 3 days of the discussion.

Step 3: Program director presents the case in writing to the DIO/CAO who will take specific action in consultation with senior administration.

There may be a single violation that is deemed so severe and requires immediate action that any progressive and disciplinary approach is judged as inappropriate.

Sexual and other forms of harassment:

Sexual and other forms of harassment in FH are considered intolerable behavior. It is a violation of federal law, a violation of trust, and a violation of moral standards. Sexual and other forms of harassment and the guidelines for reporting and investigating harassment complaints are defined in the FH HR-Workplace Policies (800.242-1). Any resident who feels that he/she has been subjected to sexual or other forms of harassment should immediately advise the Program
director so that the matter can be investigated and action taken. As a general principle, the resident should inform the next higher administrator above the alleged perpetrator.

All reports of alleged sexual or other harassment will be investigated in a timely and confidential manner. Investigation will normally involve interviews with the complainant, the alleged victim, the alleged perpetrator, and any other persons who might have information related to the complaint. The administrator to whom the complaint is made will determine if the alleged harassment occurred and, if so, the consequent disciplinary and/or remedial actions deemed appropriate. If the complainant disagrees with the finding, he/she may refer the matter in accordance with the grievance policy as outlined in this manual.

Each FH GME training program shall provide an educational conference for its residents on an annual basis regarding policy against sexual and other forms of harassment, the procedure for reporting and investigating complaints, and the possible effects on the resident’s educational program if he/she engages in harassing activity.

The above (Parts A, B) FH established policies are relevant to FH GME although FH GME policies and procedures take precedence over FH Policies wherever applicable.

**IMPAIRED PHYSICIANS**

Residents are prohibited from being impaired or under the influence of illegal drugs or alcohol while on duty. Residents who exhibit a physical or behavioral impairment such as alcoholism, drug abuse, or a mental or emotional problem, which may affect their skill, attitude, or judgment, may refer themselves on a voluntary basis to the FH Physician Support Services or the Employee Assistance Program for an assessment and possible treatment.

Residents exhibiting signs of impairment may be subject to the following policies either for voluntary or for involuntary referrals in addition to, or as an alternative to, disciplinary action:

A. The resident will be required to submit to drug/alcohol or clinical screening tests. If a resident by virtue of his/her laboratory tests, behavior, deportment, or performance, raise concern that he/she is suffering from an emotional disorder including, but not limited to, substance abuse, he/she may, at the discretion of the program director of his/her program, be required to undergo clinical or drug/alcohol screening. Such examinations may be required periodically and/or randomly. Behaviors, which might indicate the necessity for evaluation, would include, but not be limited to the following:

   (1) Dereliction of normal duties;

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37 ACGME Institutional Requirements, II.D.4.i): The Sponsoring Institution must have written policies that describe how it will address physician impairment, including that due to substance abuse. ACGME Common Program Requirements, IV.A.5.e: Program director and Institution must ensure a culture of professionalism that supports patient safety and personal responsibility...to include recognition of impairment including illness and fatigue, in themselves and others.
(2) Inability to be aroused while on call and/or persistent tardiness;

(3) Disorganized thinking or memory impairment;

(4) Unprofessional or otherwise inappropriate behavior with peers, patients and their families, teaching faculty, or nursing staff;

5. Demonstration of a disorder of mood such as depression or anxiety of such severity that it places the patients under his/her care at risk; and,

6. Reporting for duty with the scent of drug/alcohol and/or its possession.

B. Any Resident with documented behavioral evidence that warrants a screening that refuses such testing will be treated administratively as though testing positive for drug/alcohol or other controlled substances. The program director with consultation with the DIO and the Director will formulate an administrative plan for the resident with the intent to maximize the resident’s probability of success in his/her education at FH GME.

C. If clinical evaluation and/or substance abuse screening determines that a disorder is present, depending upon the severity of the resident’s impairment, and at the discretion of the program director and DIO, the following actions will be taken:

(1) The resident will be monitored by the Health Professional Recovery Program (HPRP) and will participate in group or individual therapy or other (AA or NA) activities as recommended by the HPRR. Participation in the HPRP is confidential. If a licensee is referred to the program, has a qualifying diagnosis, and complies with HPRP requirements his or her name will not be disclosed to state regulatory authorities or the public. Provided there is no readmission, records of HPRP participants are destroyed five years after successful completion.

(2) The resident may be permitted to continue to function with modification in their service load and/or supervision as deemed appropriate by his/her program director.

(3) The resident may be suspended or placed on sick leave;

(4) The resident may be placed on a formal leave of absence; and,

(5) Malfeasance, dereliction of duty or lack of compliance with treatment recommendations could lead to dismissal from the program.

D. Due Process – Residents are entitled to due process as set forth in their contracts with respect to this policy.

E. A resident with documented substance abuse problem may be listed in the “National Practitioner Database” per the NPD rules.
GRADUATION CEREMONY

The individual residency program conducts graduation ceremonies. A Resident faced with extraordinary circumstances, which prevent participation in the graduation, must receive an approval from their program director. Other emergent situations will be considered without the time deadline for submission. Approval must be granted for the Resident to be excused from participation.

FH GME training programs will issue certificates of completion. Certificates are presented to those residents at graduation that meet the following criteria:

A. Successful completion of all requirements from an accredited program in which the resident is board eligible. The dates on the certificate will reflect the dates served at the training program.

B. Successful completion of all requirements in an institutionally approved non-standard program.

Any resident leaving a program without completion of the program in which they were enrolled will receive a letter from the program director stating their dates of training, status within the program, and rotations completed. This letter will be authenticated by the program director and DIO.

Should a resident misplace a certificate, replacement certificates will be created at a charge of $30.00 by the training program. Replacement certificates will be signed by the current Program Director and DIO.

RESIDENT PROMOTION AND DISMISSAL

FH as the Institutional Sponsor for GME programs requires training programs to provide residents with standards for promotion to each successive level of the residency training. As such:

A. There shall be evaluations for each resident, which shall be augmented by other evaluation methods, including a 360 evaluation, and other relevant observations.

B. Residents must meet standards for promotion as defined by the Residency Review Committee and the program.

D. If significant deficiencies in the resident's performance are identified, a remedial plan will be given to the resident in both verbal and written notification in accordance with the program’s remediation policy.

   (1) Resident failing to demonstrate satisfactory progress of performance or achieve specified performance goals may be dismissed from the training program with four (4) months notice (if possible).

E. If a resident will not be promoted, the program director will notify the resident in both
Resident dismissal procedures:

**A.** FH GME training programs subscribe to a policy that residents may be dismissed for cause including but not limited to:

1. Failure to fulfill probationary corrective actions;
2. Unsatisfactory academic and/or clinical performance;
3. Failure to appear for duty when scheduled without notification to the program;
4. Failure to comply with the rules and regulations of the residency program;
5. Revocation, suspension or restriction of license to practice medicine;
6. Theft;
7. Unprofessional behavior;
8. Insubordination;
9. Use of professional authority to exploit others;
10. Conduct that is detrimental to patient care; and,
11. Falsification of information in patient charts or other documents of the residency program.

**B.** The program director who is considering dismissing a resident shall consult with the resident’s Advisor/Mentor, the Director and DIO who will compose the Dismissal Panel. The process for dismissal shall be:

1. The resident will be notified in writing that the program is considering dismissal. The reasons dismissal is being considered must be included;
2. Upon notification, the resident will have an opportunity to meet with the Dismissal Committee to present oral and written support for his/her position in response to the reasons for the action set forth by the program director; and,
3. If after the meeting (or, if the resident declines to meet, after the opportunity to meet is provided), the program director determines that dismissal is still recommended, the resident will be informed of the dismissal in writing and offered a hearing regarding the dismissal.

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C. A resident has a right to a hearing regarding a non-promotion or a dismissal. The resident may request for a hearing in writing. Such a written request must be made to the program director within fifteen calendar days from the date of receipt of the document informing the resident of the non-promotion or dismissal. The hearing process will follow the process outlined in the Resident Appeal Policy section of this manual.

**DISCIPLINARY POLICY**

FH is committed to provide the highest quality of educational programs. The program director may take remedial and/or disciplinary actions including reprimand, suspension or, termination against the resident when there has been failure to attain a proper level of scholarship or professionalism including but not limited to:

A. FH’s Citizenship Policy;
B. FH’s Code of Ethics;
C. Competencies as specified by the appropriate accrediting body;
D. Breach of the Resident Contract;
E. Behaviors due to alcohol and/or substance abuse;
F. Violation of FH and GME policy.

To ensure the quality of care for patients and resident adherence to a standard of excellence in performance and conduct are never compromised, the hospital follows a procedure for corrective disciplinary action when necessary. In the event of a perceived need for formal discipline based on documented deficiencies, the resident will be notified verbally and in writing regarding the deficiencies and the steps outlined to correct these deficiencies:

A. If this corrective action fails to remediate the deficiencies, the program director shall take the problem to the program’s faculty group. The faculty will vote to recommend placement of the resident on a “probationary” status for a period of one to six months. Along with the probationary status, there will be a verbal discussion and a notification letter to the resident stating the corrective actions required. If the deficiencies are serious enough, immediate dismissal may be enacted.

B. If the resident fails to fulfill the corrective actions outlined in the notification letter, or continues activities contrary to those expected and defined by any of the documents referenced in this disciplinary action section, then the Program director will bring the issues again to the faculty. Disciplinary action of formal dismissal from the program, suspension (up to three months) or probationary status with remediation will be

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determined. All such recommendations shall be provided verbally and in writing to the resident when approved, and shall be implemented by the program director.

C. Should the resident be placed under suspension, the resident will not work or be in FH property other than for official activities approved or requested by the Program director.

D. In the case of an act or threat endangering the health, welfare or safety of any patient, visitor, colleague or employee, the program director may suspend or terminate the resident immediately.

The Resident may appeal any disciplinary action through the appeal mechanism outlined in the GME Manual.

GRIEVANCE PROCEDURES

The Sponsoring Institution must provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies and procedures must minimize conflict of interest by adjudicating parties in addressing:

A. Academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident’s agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident’s intended career development; and,

B. Adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty.

The procedures set forth below are intended to provide both residents and FH with an orderly means of resolving differences which may arise between them. It is the desire of FH that all disputes or other matter of concern to the resident’s be fully considered by medical professionals and the executive leadership team charged with the responsibility for achieving interprofessional resolution of disputes whenever possible.

This section delineates the procedures to be used for residents in filing a grievance alleging discrimination and/or a violation of FH GME Code of Conduct prohibiting such behaviors. In addition to these grievance procedures:

A. The Office of GME has the responsibility for the grievance procedures specific to sexual and other forms of harassment, which is a separate and distinct process;

B. The Office of GME has constructed a separate Resident Appeals policy, for residents

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40 ACGME Institutional Requirements, II.D.4.e.): Grievance procedures and due process. ACGME Common Program Requirements, II.A.4.h. Program director... ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution. AOA Postdoctoral Requirements, Section VII, F: Grievances, Complaints and Due Process.
who perceive that they have received an unfair, unjustified or unfavorable disciplinary ruling from the program director;

C. Residents filing a grievance for any reason will be treated with respect and confidentiality, and will be guaranteed protection from any intimidation or retaliation through the following measures:

(1) Establishment of a fair and reasonable, and readily available policies and procedures for adjudication of residents’ complaints and grievances related to the work environment or issues related to the program or teaching faculty;

(2) Implementation of fair and reasonable policies and procedures for academic or disciplinary action related to a resident or fellow taken against residents that could result in dismissal, non-renewal of a resident’s agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident’s intended career development;

(3) Institutional commitment to a fair and reasonable process for residents addressing Concerns; and,

(4) Establishment of a resident forum to address issues and exchange information relating to working environment, their educational program, and other residents.

D. Residents in a FH GME sponsored program initiating a grievance are required to use the delineated grievance process.

E. Good faith efforts shall be made to resolve problems through informal means between the parties. The program director should be included as part of this informal process.

F. Residents who feel that they have been improperly subjected to an adverse action and who have been unable to resolve the problem through informal discussion shall submit the matter in writing to the DIO/Director.

(1) A written grievance conveys the resident’s request for review of a grievance through the Office of GME.

(2) A grievance must be initiated within 90 days of the action that is being grieved.

(3) The DIO/Director shall attempt to investigate and mediate a resolution to the complaint within seven (7) calendar days of receipt of the filed written grievance.

i. Following the seven (7) day period, the DIO/Director will propose a resolution in writing to the resident with copies to the program director;

ii. All parties shall meet to discuss and affirm the resolution within seven (7) days of issuance of the proposed resolution, or as soon as reasonably feasible;
iii. Following the meeting, the resident has fifteen (15) calendar days to file an acceptance of the resolution or decline the resolution to the DIO/Director;

iv. Should the resident fail to notify the DIO/Director of their acceptance or decline of the proposal, the proposal shall be assumed to have accepted.

G. A resident who declines the proposed resolution may request, in writing, a formal hearing of the grievance.

(1) The resident must state the basis for the grievance and the request must be received by the DIO/Director no later than fifteen (15) calendar days after the date the resident receives the proposed resolution and/or meets with the DIO/Director.

(2) The DIO/Director shall assemble a grievance hearing committee within fifteen (15) calendar days of the receipt of the grievance letter.

i. The hearing committee shall consist of five (5) physician members, one (1) executive leader from the GME (DIO or Director) and, in the case of contractual dispute, one (1) member of the FH Legal Division whose purpose will be to provide clarity on any legal issue pertaining to the grievance and/or resolution. Physician members shall be as follows:

a) two physician faculty members from the involved clinical department;

b) one faculty member of the GMEC from a clinical department not involved in the action;

c) one senior resident from the involved program; and,

d) one senior resident from another FH Sponsored residency program.

ii. The DIO/Director will notify the resident and the individual grieved against (herein referred to as ‘respondent’) of the committee members upon acceptance of assignment by all committee members.

a) The Resident and the respondent will have the right to challenge any member of the hearing committee for bias. The challenge must be in writing. The executive leadership of GME shall confer and decide the validity of a challenge; the decision of validity shall be final.

iii. The hearing committee shall select a panel chair to chair the meeting(s) and draft the report of findings and the recommendation of the panel.
iv. Within fifteen days of assembly, in a confidential setting, the committee shall meet with the resident and the individual and/or program director (herein referred to as ‘respondent’) to investigate the grievance. The resident and respondent shall both be dismissed following the discussion.

   a) Following presentation of the grievance a report of the prior proposed resolution and the resident’s response shall be presented to the committee by the DIO/Director.

v. The hearing panel shall endeavor to establish a collegial atmosphere in the hearing. The Resident or the Respondent may choose to invite an advisor to be present during the hearing. Either the Resident or the Respondent may choose to have an attorney as an advisor. However, during the course of the hearing only members of the hearing panel, the Resident and the Respondent have the right to address the panel members, the Respondent, the Resident or other persons brought before the panel. No one else shall present the Resident’s nor the Respondent’s case.

   (3) A written report and recommendation of the grievance hearing committee shall be submitted to the DIO/Director in writing within seven (7) calendar days by the committee chair.

   4) The DIO/Director will inform the resident, the respondent and the resident’s program director of the hearing committee’s recommendation within fifteen (15) calendar days of receipt of the committee’s report and recommendation.

   (5) The recommendation of the grievance committee is final and non appealable.

**RESIDENT SUSPENSION/TERMINATION APPEAL POLICY**

This section delineates the appeal mechanism for residents who wish to appeal decisions pertaining to disciplinary action including suspension and termination from the program.

A. Residents who feel they have been unfairly suspended or terminated for causes determined by their program director must:

   (1) Provide a written “Petition for Further Review” to the resident’s program director within ten (10) calendar days from the date of suspension or termination or, the date the resident receives a written notice of the intended disciplinary action.

      i. The "Petition for Further Review" shall name a member of FH’s medical staff who will be the resident’s nominee to a Review Committee.

   (2) The program director shall convene the Review Committee made up of three members:
i. A medical staff member selected by the Program director;

ii. The medical staff member nominated by the resident; and,

iii. A medical staff member selected by the other two members of the Review Committee.

In the event that two members of the Review Committee cannot come to an agreement on the selection of the third member, the DIO/Director will make the selection, which shall be binding.

(3) The Review Committee shall have ten (10) calendar days to investigate the matter.

i. The Committee's investigation may include meeting with the resident and other parties having knowledge of the events causing the disciplinary action.

ii. Within ten (10) days following the Review Committee meeting, the Committee shall present a written recommendation to the program director that the action, suspension, or termination be affirmed, revoked, or modified.

   a) The Committee shall issue the recommendation only once and it shall have been approved by at least two committee members.

iii. If the Committee's recommendation is not to uphold the disciplinary action, then this recommendation shall be reviewed by the DIO and Director. The DIO shall issue a final decision in writing within ten (10) calendar days.

   a) The DIO's final decision is conclusive, non-appealable and binding on the resident.

**RESIDENT RESIGNATION POLICY**

This policy sets forth conditions under which a resident may voluntarily terminate participation in any of the FH GME training program:

A. Any resident wishing to voluntarily terminate participation before the termination of their agreement must submit a written request for release to their program director. The program director has the right to delay or specify the actual termination date to ensure coverage of services, up to the end of the term of the agreement.

B. A resident who resigns prior to the termination of agreement but is not released by the
program director will not be allowed a contract for another FH GME training program for the current or following year, unless the program director releases the resident from his/her contract in writing to both the resident and the Director.

C. The Director may, at his/her discretion, review resident releases from contracts, and may reverse approval for the release prior to the end of the resident's current contract.

D. The resident’s agreement will be considered terminated on the date agreed upon by the program director or, on the resident's last day of work if they are leaving without approval of the program director.

(1) The resident’s final paycheck will be issued on the next regular pay period, provided the resident has fulfilled all obligations as outlined by FH and FH GME.

E. A resident may choose to decline to accept an offered agreement for the following year by not signing and returning an agreement within two weeks of its offer. The resident will remain in good standing during the remainder of the current agreement without prejudice and will assigned tasks until the end of the term of the agreement.

**RESIDENT TRANSFER**

Residents are considered as transfer residents under one of the following conditions:

A. Moving from one program to another within the same or different sponsoring institution;

B. Entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school);

The term ‘Transfer Resident’ and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

FH GME outlines the following guidelines for resident transfers to ensure that accreditation requirements are met.

Resident transfer into an FH GME training program:

A. To be considered for a position in an FH GME training program, transfer applicants must meet the eligibility requirements as specified by the specialty/sub-specialty Review Committee and eligibility policy of the program.

(1) The program will follow the guidelines outlined in their selection policies to

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41 ACGME Institutional Requirements, III.C.2: Resident Transfers.
ensure consistent and nondiscriminatory practices when screening and selecting transfer applicants.

B. The FH program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

C. A sending program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

E. The transfer of an applicant that applies to an osteopathic program from a PGY-1 program not otherwise approved by the AOA:

(1) The applicant must secure and provide verification of AOA approval for their PGY-1 training.

(2) Based on review of the verification materials provided, the FH GME Osteopathic program director will approve or deny advance standing in the Osteopathic program beyond the OGME-1 training year.

Resident transfer from an FH GME training program:

A. For resident’s transferring out of an FH GME training program prior to completion, the FH program director will meet all requirements of transfer as outlined in the ACGME Common Program Requirements.

B. Additionally, the program director shall write, and retain in the resident’s file the following:

(1) Competency-based summative evaluation of the resident’s performance in the program;

(2) A statement of the resident’s standing in the program;

(3) A statement of the training years satisfactorily completed;

C. For a resident transfer, who also participates an FH GME Osteopathic training program, The summative evaluation and documentation will be prepared in collaboration with the Osteopathic program director of concern.

D. The program director will both discuss and provide a written summative evaluation and verification of training with the transferring resident.

E. Upon request for use by other residency programs, program director’s will provide a timely written or electronic information:

(1) Verification of a resident’s educational experiences in the program, including
resident standing, training years satisfactorily completed, rotations satisfactorily completed if the resident is currently still in the program, and assessment as to whether it is anticipated the resident will satisfactorily complete the training year.

(2) Competency-based summative evaluation of the resident's performance.

RESIDENT FILE CONTENT AND ACCESS

Program Responsibilities:

A. Programs shall maintain a file (paper or electronic) concerning each resident.

B. Programs must develop a policy specifically outlining the titles of the individuals in the program with access to the resident’s file.

(1) All residents should assume that all leadership and staff members of the Office of GME have access to the resident file.

C. Programs will maintain resident files with the following documents:

(1) Legal name of resident;

(2) Dates of training/employment;

(3) Information collected through ERAS (or application) if applicable;

(4) Correspondence with the resident prior to and after their start date;

(5) Mandatory education (program and FH employee requirements);

(6) Resident rotation tracking form;

(7) Program required certifications;

(8) Compass Point;

(9) Validated procedure Log(s);

(10) CME certificates;

(11) Evaluations (formative and summative);

(12) Time Away (resident time away request with program director approval);

(13) In-training Exam Results;

(14) Licensure documentation:
i. Training license application  
ii. While in residency  
iii. Licensure application  
iv. Licensure verification from board  

(15) Letters of Recommendation;  

(16) DEA application and certificate;  

(17) EBAHR application (if applicable);  

(18) Certificate of post graduate training copy to school;  

(19) National Practitioner Data Bank documentation;  

(20) Board application;  

(21) Miscellaneous  

i. Residency completion form with forwarding address  
ii. Malpractice coverage  
iii. Copies of diploma  
iv. Deferment papers  
v. AHS Add/Change/Termination paperwork  
vi. Questionnaire from school on resident  
vii. Delinquent medical records forms  
viii. Signed Criteria for advancement  
ix. Data maintenance  
x. Signed Code of Conduct  
xi. Signed Memo of Understanding  
xii. Physician signature form  
xiii. Intern fact sheet  
xiv. Specialty society membership  
xv. Test for color blindness  
xvi. 1st year internship completion certificate or letter  
xvii. Contract  
xviii. Other documents as deemed necessary  

D. Upon the Resident’s completion of training, the following records will be retained for ten (10) years:  

(1) Resident Name/Date of arrival;  

(2) ERAS information (or application) if applicable;  

(3) Mandatory Education;  


(4) Resident rotation tracking form

(5) Program required certifications;

(6) Compass Point;

(7) Validated procedure Log(s);

(8) CME certificates;

(9) Evaluations (formative and summative);

(10) Time Away (resident time away request with program director approval);

(11) In-training Exam Results;

(14) Licensure documentation:
   i. Training license application
   iii. While in residency
   iv. Licensure application
   v. Licensure verification from board

(15) All correspondence;

(16) Miscellaneous
   i. Residency completion form with forwarding address
   ii. Malpractice coverage
   iii. Copies of diploma
   iv. AHS Add/Change/Termination paperwork
   v. Physician signature form
   vi. 1st year internship completions certificate
   vii. Contract
   viii. Other documents as deemed necessary

E. After 10 years beyond completion of the Resident’s training, the following documents will be retained permanently:

(1) Resident Name/Date of arrival;
(2) ERAS information (or application) if applicable;
(3) Mandatory education;
(4) Resident rotation tracking form;
(5) Evaluations;
(6) Procedure Log(s);
(7) In-training Exams;
(8) Licensure while in residency;
(9) Miscellaneous
F. On reasonable request, the resident shall have access to their file under the direct supervision of the program director or appropriate residency coordinator. The resident may request copies of the file or its contents. Such requests must be approved by the program director.

G. Upon completion of a training program the resident’s file will be maintained by the Office of GME.

H. Files of residents failing to complete the training program will be retained indefinitely and accessible through the Office of GME.

Institutional Responsibilities:

A. The GMEC requires the resident’s file be regarded as confidential, maintained in a secure location and, available only to the program director, residency coordinator, Director and, DIO.

B. The GMEC authorizes the program director, Director and, DIO to disclose the file or portions thereof to others whom they deem to have a legitimate need for the information or as authorized in writing by the resident.

C. The GMEC requires that the exterior of each file, “Confidential Information - Access to this File and its Information is governed by the FH GME Policy on Resident File and Access”. Electronic files will have this statement on its opening or at a place within the file designated by the program director.

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i. ACGME Common Requirements, VI.D.1.
ii. ACGME Common Requirements, VI.D.2.
iii. ACGME Common Requirements, VI.D.4.
iv. ACGME Common Requirements, VI.D.5.
v. ACGME Common Requirements, VI.D.6.
vi. AOA Basic Documents, Section VII. I. 7.1.
vl. ACGME Institutional Requirements, III.B.4.b).
viii. AOA Basic Standards VII.A.7.6.
ix. ACGME Institutional Requirements IV.L