


APPENDIX E – MCH GME Policies
 (Access the Latest Versions of The Policies on: <http://policies/default.aspx>)

A. Hurricane Policy

 MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
ISSUED BY: Dept of Medical Education	POLICY NUMBER:
PAGE: 27 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE: 7/5/2012	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: Hurricane Policy	


<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: [why this policy and procedure was created and the intent of the policy]</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY:</p> <p>Residents who are assigned to work during the hurricane will make preparations for an oncoming hurricane at the time the HURRICANE WATCH goes into effect.</p> <p>When a HURRICANE WARNING goes into effect, all residents assigned to work during the hurricane must report to the hospital and the DME/Chief Resident.</p> <p>Residents who are working during the hurricane must be prepared to work at least 24 hours post hurricane.</p> <p>Employees who are to work after the hurricane when the HURRICANE WARNING has been lifted will report to the hospital and the DME/Chief Resident.</p> <p>All residents who are to work after the hurricane are expected to report to the hospital within 24 hours post hurricane and must be prepared to stay at least 48 hours.</p> <p>All residents must be available by beeper if the phone system is operable. Residents are to report to the hospital at 24 hours post hurricane and are to refrain from calling because communication will be limited.</p> <p>Determining the residents responsible for working during the hurricane.</p> <p>Prior to the hurricane season all residents will complete the proper hurricane information forms provided by the hospital. At least 50% of the residents must be prepared to remain in the hospital during the hurricane.</p> <p>Residents will be asked on a voluntary basis to sign-up for the before and after teams.</p> <p>The residents who are on the call schedule to work at the time of the HURRICANE WARNING are</p>

obligated to work on the Alpha Team. Residents should be prepared to be on-call every other day until the crisis has been resolved.

PROCEDURE: [description of principal tasks required for performance of an operation, usually constructed in a step-by-step format]

REFERENCES: [list of supporting and source documentation used to validate the policy and procedure]

B. GME Disaster Policy

MIAMI CHILDREN’S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Dept. of Medical Education	POLICY NUMBER: O7600018
PAGE: 29 of 53	REPLACES POLICY DATED: 11/10
EFFECTIVE DATE: 11/10	DISTRIBUTION: System wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: GME Disaster Policy	

<p>SCOPE: All employees and contractors or any and all personnel providing services at all MCH owned or operated facilities, including, but not limited to, hospital, ambulatory centers, physician practices and all departments contained therein.</p>
<p>PURPOSE: This policy addresses ACGME Institutional Requirement I.B.8 - <i>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.</i> This policy is meant to be a supplement to the MCH Emergency Operational Plan</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY: If Miami Children’s Hospital (sponsoring institution) must reduce the size, close, or substantially alter training in any of its sponsored programs due to a disaster, the following policies/procedures shall be implemented:</p> <ul style="list-style-type: none"> A. The Designated Institutional Official (DIO), working with the program directors, CMO, MCH administrators, and hospital leadership has the responsibility of determining when conditions exist that requires the relocation of residents so that their educational programs can continue. When this occurs, the DIO, working with MCH leadership, will establish a command center to provide information to the residents, staff and faculty. Depending on actual conditions this may be a physical location, website, call center or some other configuration that facilitates communication with the affected residents, staff and faculty. B. Once conditions prohibit maintenance of applicable ACGME standards and guidelines for graduate medical education (GME) for any program, the DIO shall notify the CMO and CEO of MCH, all involved Division Chiefs and Heads, Program Directors, the ACGME, and the applicable RRCs that there will be a need to relocate residents in order to continue their educational program. C. Division Chiefs and Program Directors must maintain operational awareness of the location of ALL residents and fellows within their programs as well as methods of contacting each individual during time of disaster. The following information shall be established on the resident’s arrival to the program and updated at least every six months. This information shall include all of: e-mail addresses (non-campus, if available), phone numbers both cellular and land line (if available), next of kin / family location information including addresses, email addresses and phone numbers. Each trainee shall provide a disaster evacuation plan to the program director which details where he / she will go including phone numbers, address, e-mail in the event an evacuation of the area is mandated. The program director shall maintain such information in a spreadsheet format on removable media which may be taken with the PD in the event of an evacuation. Likewise, all

program directors must provide up-to-date information to the MCH TM&E personnel system.

1. Upon notification of disaster status from the DIO, each PD will immediately determine the location and status of all trainees under his / her supervision and report this information back to the DIO
 2. The DIO will maintain communication with each PD regarding the need to relocate trainees either on a temporary or permanent basis. Once this decision is made, trainees will be notified immediately by their PD.
- D. The Office of GME will maintain a backup of all demographic and training information from the New Innovations Data Management System on removable media which may be easily transported in the event of an evacuation.
- E. In the event of program closure or reduction secondary to disaster:
1. short-term closure or reduction, the DME and PD shall assist the trainee to locate institutions which can provide short-term training.
 2. For longer-term or closure durations which will be expected to outlast remaining time in residency training, MCH will make every effort to assist trainees in identifying suitable programs for permanent transfer. The ACGME and individual RRCs will assist with this process (see below).
 3. All applicable records (rotations, evaluations, demographics, etc) from New Innovations will be made available to accepting programs.
 4. In addition each program is expected to have critical information about current and past residents stored electronically in at least two locations.
- F. Within 10 days of a disaster determined to necessitate program closure or reconfiguration, the DIO will contact the ACGME to discuss due dates for programs to submit requests for reconfiguration to the ACGME and to inform each program's residents of need to transfer to another program – either for brief or longer durations.
1. The DIO will also notify the IRC Executive Director to inform him / her of the situation necessitating program reconfiguration or closure.
 2. Each PD will notify the appropriate RRC Executive Director about the need to locate positions for each of his / her trainees and the expected duration of time needed for relocation.
 3. Residents will be given contact information (by their PD) about who in their RRC will be coordinating relocation efforts as well as a list of potential accepting programs. PDs will assist each resident in contacting the PD directors at each of these programs.
 4. Residents will continue to receive salary / benefits from MCH during this entire relocation process. If relocation is only temporary or brief, MCH will continue all salary and benefits. If relocation is long-term or lasts until completion of training, salary support will transfer to the accepting institution (also see below regarding transfer of GME funding) once the resident has relocated.

PROCEDURE:

SUMMARY INFORMATION

In the event of resident transfer, adherence to the following procedures will expedite the process. PDs must be familiar with these steps.

1. Current emergency contact information and disaster planning information for every resident / fellow must be on file on removable media and updated every six months.
2. Involved residents, PDs, Department Chairs, DIO and the GME office will share responsibility for locating a suitable program using ACGME resources.
3. Transfer letters will be completed by PDs using backup information available from NI.
4. Receiving hospitals / institutions are responsible for requesting temporary complement increases from the RRCs

5. In the event of permanent transfers, financial officials from MCH, affiliated hospitals and receiving institutions will work together to assess the process of transferring funded positions. Short-term transfers will continue to be paid by MCH.

C. Parking Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Medical Education	POLICY NUMBER:
PAGE: 31 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE: 7/5/2012	DISTRIBUTION: System wide
APPROVED BY: Chief Medical Officer, Sr. VP for Medical Affairs	
POLICY DESCRIPTION: Parking Policy	

SCOPE:

The MCH departments, including all employees and contractors or any and all personnel providing services.

PURPOSE: To provide equitable and efficient parking for residents, fellows, medical students and others associated with the Miami Children's Hospital Medical Education Department.

DEFINITIONS:

POLICY: Employed residents and sub-specialty residents (also known as fellows and referred to as residents this point forward) are to have access to the second floor of the physician's parking garage. Parking is available on a first-come basis; overflow parking for residents is on the floors above physician parking in the visitor's lot.

Rotating residents, Medical Students and Domestic/International Observers/Scholars are allowed to park in the visitor's parking garage only.

PROCEDURE: Employed residents: The Medical Education Department staff sends a report to the Security Department when there are changes in the employment status of any resident or other employed members of the Medical Education Department who have access to park in the physician parking areas. The report is to include name, employee number and employee badge number. All residents are given access to the second floor parking area for physician parking by the security office. At the end of employment, the residents' badge is deactivated by Security.

REFERENCES: Security Department, Medical Staff Office

D. Internal Review Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Medical Education	POLICY NUMBER: O7600015
PAGE: 32 of 53	REPLACES POLICY DATED: 5/20/02, 9/15/08 (GME approved), 8/2010
EFFECTIVE DATE: 8/2010	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Internal Review Procedure	

SCOPE:

The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.

PURPOSE: The purpose of this policy is to ensure that all ACGME accredited training programs undergo a comprehensive internal review which satisfies all the components of the ACGME Institutional Requirements.

DEFINITIONS:

ACGME General Competencies Definitions for Pediatrics

Patient Care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.

- Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records and diagnostic/therapeutic procedures.
- Make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgement, scientific evidence, and patient preference.
- Develop, negotiate and implement effective patient management plans and integration of patient care.
- Perform competently the diagnostic and therapeutic procedures considered essential to the practice of pediatric medicine.

Medical Knowledge – Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

- Apply an open-minded, analytical approach to acquiring new knowledge.
- Access and critically evaluate current medical information and scientific evidence.
- Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of pediatric medicine.
- Apply this knowledge to clinical problem-solving, clinical decision-making, and critical thinking.

Practice-Based Learning and Improvement – Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes and processes of care.

- Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient practice.
- Develop and maintain a willingness to learn from errors and use errors to improve the system or processes of care.
- Use information technology or other available methodologies to access and manage information, support patient care decisions and enhance both patient and physician education.

Interpersonal and Communication Skills – Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

- Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families, and colleagues.
- Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.
- Interact with consultants in a respectful, appropriate manner.
- Maintain comprehensive, timely, and legible medical records.

Professionalism – Residents are expected to demonstrate behaviors that reflect a commitment to professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

- Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues.
- Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities of patients, families, and professional colleagues.
- Adhere to principles of confidentiality, scientific/academic integrity, and informed consent.
- Recognize and identify deficiencies in peer performance.

Systems-Based Practice – Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

- Understand, access and utilize the resources, providers and systems necessary to provide optimal care.
- Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient.
- Apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management.
- Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care.

EXAMPLE OF MATRIX FOR THE GENERAL COMPETENCIES

General Competencies	Evaluation Tools Used or In Development by the Program
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Patient Care	Developing OSCE	Mini CEX	Patient Surveys	Procedure Logs
Medical Knowledge	Chart Stimulated Recall	Oral Exam	Written Exam-Multiple Choice	
Interpersonal and Communication Skills	Developing 360 Degree	Patient Surveys	Standardized Patients	
Professionalism	360 Degree	Checklist		
Practice Based Learning	Resident Portfolios	Developing Oral Exam	Record Review	
Systems Based Practice	Developing Resident Portfolios	Developing 360 Degree		

POLICY: The Accreditation Council of Graduate Medical Education (ACGME) states in Section IV of its Institutional Requirements that “the Graduate Medical Education Committee (GMEC) must develop, implement, and oversee an internal review process.” The internal review process is designed to assess the program’s compliance with the following parameters:

- a) Compliance with the Institutional, Common Program, and Specialty-specific Program Requirements;
- b) Educational Objectives and effectiveness in meeting those objectives;
- c) Educational and financial resources;
- d) Effectiveness in addressing areas of noncompliance and concerns in previous ACGME accreditation letters of notification and previous internal reviews;
- e) Effectiveness of educational outcomes in the ACGME general competencies (a description of the six general competencies is attached);
- f) Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the ACGME general competencies and,
- g) Annual program improvement efforts in resident performance (using aggregated resident data), faculty development, graduate performance, including performance of program graduates on the certification examination, and program quality.

The Director of Medical Education has been designated the responsibility for monitoring the quality of the institution’s graduate medical education. A written internal review protocol, which incorporates the requirements in Section IV of the ACGME Institutional Requirements, must be established and approved by the GMEC. The GMEC is charged with the responsibility of assisting the Director and the Office of Medical Education in carrying out the periodic internal review function.

PROCEDURE:

1. Each ACGME accredited training program sponsored by Miami Children’s Hospital must undergo an internal review at the **midpoint** of the accreditation cycle. The accreditation cycle is calculated from the date of the RRC meeting at which the final accreditation action was taken (‘effective date’) to the time of the next site visit.
2. The internal review will be conducted by an ad hoc review team which must include at least one faculty member (not counting the Director of Medical Education) and at least one resident from within the sponsoring institution, but not from within the program being reviewed. Additional internal or external reviewers and/or administrators may also be included as determined by the GMEC. The ad hoc review team customarily includes the Director of Medical Education as an additional reviewer.
3. Materials and data to be used in the review process must include:
 - a) The current ACGME Institutional, Common, and Program Requirements;
 - b) Accreditation letters of notification from previous ACGME reviews and progress reports sent to the respective RRC;
 - c) Reports from previous internal reviews of the program;

- d) Previous annual program evaluations;
- e) Results from internal or external resident surveys, if available; and
- f) A completed copy of current Program Information Form (PIF) (verbal approval given by ACGME IRC Associate Executive Director).

4. The ad hoc review team will conduct interviews with the program director, key faculty members, at least one peer-selected resident from each level of training in the program, and other individuals deemed appropriate by the committee. Upon the completion of the interviews, the ad hoc review team will meet in a debriefing session and a report is generated by the adhoc review team.
5. After the review, a written report stating the name of the program reviewed, the date of the assigned midpoint, the status of the GMEC's oversight, the names and titles of the ad hoc review team members, the individuals interviewed and documents reviewed, documentation to demonstrate that the review followed the GMEC's protocol, and a list of citations, concerns, or areas of noncompliance from the previous ACGME accreditation letter along with a summary of how each was addressed by the program will be drafted by the DME. This summary report will be submitted to the members of the ad hoc review team for review prior to its presentation to the GMEC for final approval and notification of the Program Director of the reviewed program.
6. The report must be presented to the GMEC. Concerns raised or actions recommended during the internal review must be addressed by the program director in the form of a response detailing the action plan implemented to correct the identified deficiencies. This response must be presented to the GMEC no later than six months after the submission of program's internal review summary report to the GMEC. The Director of Medical Education and the GMEC must monitor the response by the program to actions recommended by the GMEC in the internal review process. A copy of the summary report and program's response will be kept in the Department of Medical Education. It is recommended for the Program to keep a copy of the internal review summary to use during subsequent Annual Program Reviews and site visits.
7. The Sponsoring Institution must submit the most recent internal review report for each training program as a part of the Institutional Review Document (IRD). If the institutional site visitor simultaneously conducts individual program reviews at the same time as the institutional review, the internal review reports for those programs must not be shared with the site visitor.

**CHECKLIST OF DOCUMENTATION TO BE PROVIDED
FOR INTERNAL REVIEW**

	<u>Documentation</u>	<u>Attached</u>
<input type="checkbox"/>	Policy regarding resident supervision.	
<input type="checkbox"/>	Didactic program for residents.	
<input type="checkbox"/>	Copy of Resident Evaluation.	
<input type="checkbox"/>	Copy of Faculty Evaluation.	
<input type="checkbox"/>	Copy of Program Evaluation.	

<input type="checkbox"/>	Copy of policy for resident duty hours and on-call schedules.	
<input type="checkbox"/>	Copy of policy regarding moonlighting.	
<input type="checkbox"/>	Copy of policy regarding resident eligibility and selection process.	
<input type="checkbox"/>	Copies of any affiliation agreements.	
<input type="checkbox"/>	Copy of ACGME letter of accreditation.	
<input type="checkbox"/>	Copy of last internal review report.	
<input type="checkbox"/>	Copies of annual program review	
<input type="checkbox"/>	Duty hour logs or documentation	
<input type="checkbox"/>	Competency evaluation matrix	
<input type="checkbox"/>	Competency-based, level-specific, rotation specific goals and objectives	
REFERENCES: ACGME Institutional Requirements		

E. Duty Hours and Moonlighting Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Medical Education	
PAGE: 37 of 53	REPLACES POLICY DATED: 7/1/03; 9/04; 9/10
EFFECTIVE DATE: 07/11	DISTRIBUTION: System wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Resident Duty Hours and Working Environment	

SCOPE:

The MCH clinical departments, including all employees and contractors or any and all personnel providing services.

PURPOSE: To ensure the proper standards related to duty hours and the working environment, per the Accreditation Council for Graduate Medical Education (ACGME), are followed by all residency and subspecialty residency programs at Miami Children's Hospital (MCH).

DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]

POLICY:

Supervision

All patient care must be supervised by qualified faculty. The program director is responsible for ensuring, directing, and documenting adequate supervision of residents and subspecialty residents (or fellows, collectively referred to as residents) at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

Fatigue

Faculty and residents are educated by the Medical Education Department to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

Duty Hours

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, the provision for transfer of patient care, time spent in-house 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.

Duty hours must not exceed 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

Residents must be provided with a minimum of 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. At-home call cannot be assigned on these free days.

Adequate time for rest and personal activities must be provided. For PGY-1 residents, this should consist of a 10-hour time period provided between all scheduled ~~daily~~ duty periods. For intermediate level residents (as defined by the Review Committee), this should consist of 10-hour time period between scheduled duty periods and at least 14 hours free of duty after 24 hours of in-house duty. For residents in the final year of education (as defined by the Review Committee), in order to be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods, this preparation must occur within the context of the 80-hour maximum duty period length and one-day-off in seven standard. 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 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. These circumstances must be monitored by the program director.

Residents must not be scheduled for more than six consecutive nights of nightfloat.

Each resident is required to keep an electronic log of his/her work hours. It is the responsibility of the program director to monitor the residents' logs, address violations of the work hours, and report the results of the logs to the GMEC. Each individual program may chose to monitor continuously or periodically.

Duty Hours Exception: A Residency Review Committee (RRC) may grant exceptions for up to 10% of the 80-hour limit or a maximum of 88 hours, to individual programs based on a sound educational rationale. However, prior to submitting the request to the RRC, the program director must obtain approval of the MCH GMEC and DIO. Duty hour exceptions logged into New Innovations will appear as violations until clarified by the program director.

Residents/fellows exceeding the allowed hours must log the hours and may complete a notification form (see attached) to justify the reasons and obtain approval from the program director each time additional service beyond scheduled duty hours occurs.

On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences.

Duty periods of PGY-1 residents must not exceed 16 hours in duration.

In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution. In-house call of PGY-2 residents and above must occur no more frequently than every third night, averaged over a four-week period. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may be allowed to remain on-site to accomplish effective transitions in care, residents education, or to ensure patient safety; however; this period must be no longer than an additional four hours. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

At-home call (pager call) is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the every third night limitation; however, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Moonlighting

Moonlighting (Internal or external) is not permitted without the written approval of the individual program director of anyone of the MCH training programs. Because residency education is a full-time endeavor, the program director must ensure that moonlighting, if approved, does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. It is forbidden for any resident at MCH to participate in employment activities (working at other institutions or covering for other physicians) while under contract at MCH. Unauthorized moonlighting may result in dismissal from the program. All moonlighting activities (Both internal and external) approved by the program director may be discontinued at any time at the Program Director's discretion. MCH trainees' malpractice insurance does not cover any trainees' moonlighting activities particularly external moonlighting. A Trainee Moonlighting Approval Form must be completed and signed by the program director and the trainee.

Time spent by residents in external and internal moonlighting (i.e. within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s)) that occurs as part of the training program must be counted toward the 80-hour weekly limit of duty hours.

PGY-1 Residents are not permitted to moonlight under any circumstance.

Any MCH department/division who desire residents from a non-MCH sponsored training program moonlight in their department/division must obtain written approval by the resident(s) program director and follow the sponsoring institution's written policies and procedures.

GENERAL INFORMATION:

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being in a supportive educational environment. Each residency program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. MCH requires that all GME training programs, even if non-approved by the ACGME, maintain these same standards. The ACGME standards emphasize the responsibilities of programs, sponsoring institutions, and the accrediting body (ACGME) relating to safe patient care and an appropriate learning environment for residents.

PROCEDURE: Each program director for all approved and non-approved residency programs and sub-specialty residency programs is responsible for ensuring their residents are following the required ACGME requirements as described above. The GME Committee will ask the program directors to submit verification of compliance from time to time.

Residents who believe they are working over the 80-hour rule, have concerns regarding the supervision or other factors related to the working environment at MCH or their rotation sites, should first talk to the Program Director and/or Chief Medical Officer. The Resident also may call the MCH anonymous Employee Compliance Hotline (888-323-6248).

REFERENCES: ACGME



**GRADUATE MEDICAL EDUCATION
TRAINEE MOONLIGHTING APPROVAL FORM**

Dear Program Director: (Name) _____

RE: (Trainee) _____

The above named trainee is requesting credentialing for moonlighting activity. According to the MCH GME Policy on **“Residents Duty Hours and Working Environment”**, moonlighting (internal or external) is not permitted without the written approval of the individual program director.

Responsibility of the program director:

- ◆ Approve all moonlighting activity requests for their trainees
- ◆ Ensure that moonlighting, if approved, does not interfere with the ability of the trainee to achieve the goals and objectives of the educational program.
- ◆ Ensure that MCH-employed trainee does not engage in external employment activities (i.e. working at other institutions or covering for other physicians) while under contract at MCH.
- ◆ Monitor the trainee work hours, deterioration in academic performance, and signs of sleep deprivation and fatigue
- ◆ May discontinue moonlighting at any time at the program director’s discretion.

I have read and understand the Moonlighting Policy of the MCH Department of Medical Education. My signature below is an attestation of my willingness to approve this trainee for moonlighting and to abide by this policy and carry the responsibilities specified above.

Approved

Denied

Program Director Signature

Date

Responsibility of the trainee:

- ◆ Trainee must request approval for moonlighting from the program director prior to engaging in moonlighting activities
- ◆ Must log in their internal or external moonlighting hours and those hours are counted toward the 80 hour work week limit
- ◆ Must carry his/her own malpractice coverage in the event of external moonlighting (outside MCH entities).

I have read and understand the Moonlighting Policy of the MCH Department of Medical Education. I understand that I may be asked to terminate moonlighting duties if I fail to maintain the academic and professional standards, as well as expectations set forth by my training program at the discretion of my program director.

Trainee’s Signature

Date

PS: Signed copy of this document to be scanned in the trainee’s New Innovations file.



DEPARTMENT OF MEDICAL EDUCATION

Circumstances Necessitating Exceeding Scheduled Resident/Fellow Duty Period
Program Director Notification & Approval Form

A completed form should be submitted to the Program Director for review and approval for each time additional service beyond scheduled duty occurs.

Program: _____

Name of the resident/fellow: _____

Today's Date: _____

Date/Time on call started: _____

Date/time of scheduled time off: _____

Date/time actual time off: _____

Reason(s) for staying beyond scheduled duty period are pertaining to a single patient?

[] Yes (Patient MR# _____)

[] No

I handed over the care of all other patients to the team responsible for their continuity of care at the scheduled time of the end of my duty: [] Yes [] No

Reason(s) for remaining beyond scheduled period of duty related to the patient listed above: (Check all that applies)

[] Severely ill / Unstable patient

[] Patient safety

[] Effective transition of care

[] Academically important event (Learning)

[] Humanistic attention to patient/ family needs

[] Other: (Specify) _____

Resident/Fellow: _____
Name Signature Date

Supervising Attending: _____
Name Signature Date

Program Director: _____
(Approval) Name Signature Date

F. Residents Selection and Appointment Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Dept of Medical Education	
PAGE: 42 of 53	REPLACES POLICY DATED: 4/03, 9/04
EFFECTIVE DATE: 9/10	DISTRIBUTION: System wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Resident Selection and Appointment Policy	

SCOPE:

The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.

PURPOSE: To ensure that the selection and appointment of residents and sub-specialty residents (fellows, hereby referred to as residents) complies with the ACGME Institutional Requirements, the GME Committee and Miami Children's Hospital approved policies and procedures to ensure that excellent residents are selected in an equitable manner for training programs at Miami Children's Hospital.

DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]

POLICY: All MCH departments must follow these approved guidelines for hiring residents.

The process must ensure selection from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills and personal qualities (such as motivation and integrity) and the individual's potential contributions to pediatric medicine.

MCH is committed to ensuring that the resident selection process is free from discrimination. In compliance with all federal and state laws and regulations, no person shall be subject to discrimination in the process of selection on the basis of gender, race, age, religion, color, national origin, disability, sexual orientation, or veteran status.

A. Resident Eligibility:

- a. Per ACGME requirements, all medical resident applicants must meet one of the following criteria:
 - i. Graduate of medical school in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA).
 - ii. Graduate of an international medical school, meeting one of the following qualifications:
 1. Have a currently valid ECFMG certificate prior to appointment or
 2. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are training.
 - iii. Graduate of international medical school who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
- b. Participate in an organized matching program, such as the National resident Matching Program (NRMP), where such is available.
- c. If no match is available, applicants will complete and submit the Fellowship Application Form attached to this policy
- d. Be approved by the Residency Selection Committee or be approved by the respective fellowship program selection committee (i.e. individuals who interview the candidates).
- e. Fulfillment of all documents required by the Matching Program application or as required in the approved checklist (see policy "Required Resident Personnel Information" for details) when a

matching program is not available.

- f. If the program is not in the match, the program director will get a formal approval from GMEC or DME (pending GMEC approval due to time constraints).

B. Resident Selection:

- a. All documents submitted by applicants meeting the eligibility criteria will be reviewed by a program selection committee
- b. Eligible applicants are invited to interview
- c. Invited applicants who interview with the program are informed in writing or by electronic means, of the terms, conditions, and benefits of their appointment, including financial support; vacation; 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 MCH provides call rooms, meals, laundry services, or their equivalents. Applicants acknowledge in writing receipt of the above information.
- d. Resident ranking and selection is based on defined program-related criteria such as preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation, program fit, and integrity without discrimination with regard to gender, race, age, religion, color, national origin, sexual orientation, disability, or any other applicable legally protected status.

C. Resident Appointment:

- a. MCH Department of GME and program directors provide the matched/selected residents with a written agreement of appointment/ contract outlining the terms and conditions of their appointment to the program.
- b. MCH Department of GME and program directors ensure that appointed residents are informed of and adhere to established educational and clinical practices, policies, and procedures in all sites to which residents are assigned as outlined in their employment agreement, housestaff manual, and MCH employee handbook. (Refer to the attached copy of the agreement of appointment/ contract for further details)
- c. Appointed residents are employees of MCH and follow the Department of Talent Management and Employment (TM&E) rules and regulations related to employment and visas where applicable.
- d. Appointed residents have to successfully complete the Hospital credentialing process prior to beginning employment
- e. A resident who is ineligible to be employed due to a pending visa or for any other reason, may be approved to attend orientation, but is not eligible for compensation or benefits during orientation or beyond until employment is finalized. Clinical training time does not officially begin until resident employment process is complete. Making up time missed from training is discussed with the program director on an individual basis as delineated in the contract.

PROCEDURE: MCH GME Committee, sub-committees (e.g., Pediatric Resident Interview Committee), Medical Education Office and others involved with the selection and appointment of residents at MCH shall follow these guidelines.

REFERENCES: ACGME Institutional Requirements, MCH Employee Handbook, GME Housestaff Manual, and MCH TM&E Policies

ATTACHMENT: FELLOWSHIP APPLICATION FORM



Application for _____ Fellowship for _____ Year

PERSONAL DATA:

Name:	(type your name here)
Current Mailing Address:	
Permanent Mailing Address:	
Telephone Numbers:	Day:
	Evening:
Email Address:	
Social Security Number:	
Date of Birth:	
Place of Birth:	
<input type="checkbox"/> U.S. <input type="checkbox"/> Permanent <input type="checkbox"/> Other <input type="checkbox"/> J-1 <input type="checkbox"/> H-1	

EDUCATION:

<u>Degrees</u>	<u>School</u>	<u>Date Completed</u>
Undergraduate:		
Medical School:		
Other:		

POST GRADUATE TRAINING:

<u>Title</u>	<u>Institution</u>	<u>Date Completed</u>
PGY 1		
PGY 2		
PGY 3		
Other		

USMLE:	Step 1:	
(type in score)	Step 2 CK:	2 CS:
	Step 3:	
Licensure:	State:	Year:

Awards, Honors, and Memberships in Professional Societies:

Academic and Committee Memberships:

PROFESSIONAL REFERENCES: (List Three)

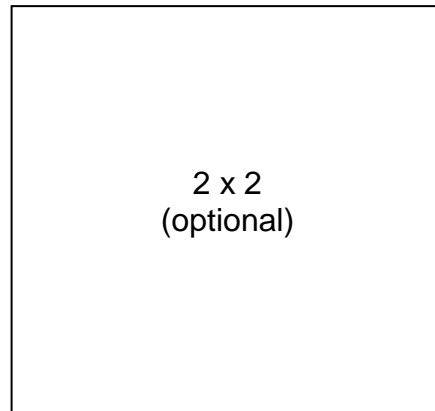
(1)
(2)
(3)

CHECKLIST FOR COMPLETION OF APPLICATION:

- Completed and signed application (including photo, optional – see space below)
- Curriculum Vitae (please include months and years)
- Personal Statement (one page)
- Medical School Diploma copy
- Residency Diploma copy (if applicable)
- USMLE Score copies
- Three (3) letters of recommendation (one must be written by the Director of your Residency Program or Chair of your Department; must be in sealed envelopes)
- Medical School Transcripts (unofficial or copies allowed)

Please have the previous documents and this signed form to:

Fellowship Program Director*
Miami Children’s Hospital
3100 S.W. 62 Avenue
Miami, FL 33155



* Adolescent Medicine
Emergency Medicine
Clinical Neurophysiology
Craniofacial Surgery
Critical Care
Pediatric Radiology
Pediatric Surgery

Lorena Siqueria, M.D.
Marc Linares, M.D.
Michael Duchowny, M.D.
S. Anthony Wolfe, M.D.
Bala Totapally, M.D.
Ricardo Restrepo, M.D.
Steven Stylianos, M.D.

Please complete the application online. Print, sign and mail the application to the appropriate program director and address above.

Signature of Applicant

Date



RECOMMENDATION FOR APPOINTMENT FORM

Purpose and use: Used by departments to recommend a physician to the Fellowship Sub-Committee for consideration. Submit completed form to Medical Education Department by March 1 prior to the beginning of the academic year (July 1st).

Today's Date: _____

I recommend the appointment of: _____

Effective date of appointment request (month/day/year): _____ Last Name _____ First Name _____ M.I. _____ Through: _____

To the position of: _____ (list program name)

PGY Level
(to be verified by MedEd Office): 1 2 3 4 4 5 6 7

Budgeted position? yes no Source of salary (be specific): _____

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Date of Birth: _____ Location: _____ Permanent Resident: yes no

If not a U.S. Citizen, Type of Visa: _____

EDUCATION:	Institution	Location	Degree Date (mo/yr)
Medical School			
Internship			
Previous Residency Training			

(use additional sheet if necessary)

Florida License: yes no

International Medical Graduates: ECFMG#: _____
(enclose copy of valid certificate) FL license # _____ List licenses in other states: _____

Signature of Program Director: _____

G. Closure of Residency Program

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Medical Education	
PAGE: 49 of 53	REPLACES POLICY DATED: 10/05
EFFECTIVE DATE: 9/10	DISTRIBUTION: System wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Closure of Residency Program	

<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: To provide a written institutional policy that conforms to the ACGME guidelines. When Miami Children's Hospital finds it necessary to reduce or close a training program due to unforeseen circumstances, these guidelines will be enforced.</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY: Miami Children's Hospital is committed to the mission of high quality training for all residents and fellows. However, if Miami Children's Hospital finds it necessary to reduce or close any or all of the training programs due to unforeseen circumstances, the following guidelines will be enforced:</p> <ol style="list-style-type: none"> 1. The Sponsoring Institution must inform the GMEC, the Director of Medical Education, and the residents as soon as possible 2. In the event of such a reduction or closure, Miami Children's Hospital as the sponsoring institution will either allow residents already in the program(s) to complete their education, or the program will assist the residents in enrolling in an ACGME-accredited program(s) in which they can continue their education. 3. Restrictive Covenants: Neither the Sponsoring Institution nor its programs may require residents to sign a non-competitive guarantee.

H. Resident Supervision and Teaching Standards

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Medical Education	POLICY NUMBER: O7600005
PAGE: 50 of 53	REPLACES POLICY DATED: 4/04, 9/04, 9/10
EFFECTIVE DATE: 7/11	DISTRIBUTION: System wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Resident Supervision and Teaching Standards	

SCOPE:

The MCH Clinical departments, including all employees and contractors or any and all personnel providing services.

PURPOSE: The purpose of this policy is to establish standards for the supervision and teaching of residents at Miami Children's Hospital as required by the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission (TJC) and other applicable organizations, including the level of supervision provided.

DEFINITIONS: A resident is defined as either of the following:

1. An individual who participates in an approved Graduate Medical Education (GME) program, including any residency program approved by the ACGME, American Osteopathic Association (AOA), the Council on Dental Education of the American Dental Association, or
2. A physician who is not in an approved GME program, but who is practicing under a teaching program at the Hospital (i.e., training program has a defined curriculum, goals and objectives and all ACGME guidelines are followed by the training program per MCH policy).

POLICY: This policy outlines the procedural requirements for Graduate Medical Education pertaining to the supervision of residents and subspecialty residents (or fellows, hereby referred to as residents) at Miami Children's Hospital (MCH). The provisions of this policy are applicable to all patient care services in inpatient and ambulatory care, and performance and interpretation of all diagnostic and therapeutic procedures on or behalf of MCH by any resident.

Teaching at MCH

Each residency training program will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. Program Directors will review each resident's performance and supervise progression during their training program based on ACGME guidelines and program curriculum. The responsibility given to residents in patient care activities should depend upon each resident's knowledge, problem-solving ability, manual skills, experience and the severity and complexity of each patient's status.

As the residents advance in their training, they may be given increasing responsibilities to conduct clinical activities with limited supervision or to act as teaching assistants for less experienced residents. Job descriptions and descriptions of rotations are available in the program-specific Residency Manual and are reviewed on an annual basis.

Supervision

Supervision of residents requires that within the scope of the residency training program, all residents will

function under the supervision of appropriately credentialed attending physicians. Every residency program must ensure that adequate supervision is provided for residents at all times. This is particularly critical for patients with severe and/or complex disease. Supervision requirements are the responsibility of the appropriate residency Program Director.

A MCH Medical Staff member must be immediately available to the resident in person or by telephone and, if needed, be able to come to the Hospital within a reasonable period of time. Each department/division will electronically publish and make available to the hospital operators their call schedules indicating the responsible attending(s) to be contacted. Such schedules are to be readily accessible in a prominent physical or electronic location. The availability of adequate supervision of residents must be documented. All patients admitted by residents are reviewed by the supervising attending within 24 hours during management/teaching rounds conducted seven days a week including holidays and an attending note is required daily.

Residents should be supervised by medical staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. This statement is true regardless of specialty or discipline. Medical Staff involved in this process must understand the implications of this principle and its impact on the patient and the resident.

All programs must delineate what level of supervision is required for each level of resident training and each resident experience, consistent with specific ACGME requirements. Levels of supervisions must be communicated to the residents.

The following classification of supervision levels must be used by the program as per the ACGME requirements:

- 1) **Direct Supervision** – The supervising physician is physically present with the resident and patient
- 2) **Indirect Supervision:**
 - a. **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
 - b. **With direct supervision available** – The supervising physician is not physically present within the hospital or other site of care, but is immediately available by means of telephonic and / or electronic modalities, and is available to provide Direct Supervision
- 3) **Oversight** – The supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.

In all instances, the resident (level as designated by each program) must notify the attending physician for:

- A. A patient death or adverse event
- B. An identified patient error
- C. Transfer of a patient to a higher level of care
- D. Consultation when the resident believes is a difference of opinion or concern about patient care that requires attending involvement
- E. A patient to be designated DNR/ DNI or end-of-life decisions

A program may designate additional times when their residents are required to notify the attending physician. All instances must be communicated to the residents by the program director.

PROCEDURE: Appropriately qualified Medical Staff must supervise all patient care services. The following procedures will be followed in the supervision of varying levels of residents:

Supervising Medical Staff must have the following qualifications:

- 1) Possess requisite specialty expertise as well as documented educational and administrative abilities and experience in their field


- 2) Be certified in the specialty by the applicable American Board of Medical Specialties (ABMS) Board or possess qualifications which must be approved through the Medical Staff Credentialing Committee
- 3) Physicians must be in good standing, credentialed and a member of the MCH Medical Staff
- 4) Non-physician supervisors must be appropriately qualified in their field and possess appropriate institutional appointments and credentials, and always function under the supervision of a credentialed medical staff member.

Emergency situation

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious health impairment to a patient. In such situations, any resident, assisted by medical care personnel, will, consistent with the informed consent provisions, be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate Medical Staff member must be contacted and apprized of the situation as soon as possible.

REFERENCES: ACGME, TJC standards, Pediatric Residency Manual

I. Impaired Resident Policy

MIAMI CHILDREN’S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Medical Education	
PAGE: 53 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE:	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affairs)	
POLICY DESCRIPTION: Impaired Resident Policy	

SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.
PURPOSE: This policy supplements the Impairment Hospital Policy
DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]
POLICY: This policy describes the procedure and measures taken in the event of a resident impairment. These measures are in addition to the procedure delineated in related hospital policy for all employees
PROCEDURE: When an unusual event such as an impaired resident occurs(inability to practice medicine due to mental illness or substance abuse), the program director convenes a meeting with the resident and a psychologist/ psychiatrist for the initiation of counseling and the consideration of several options. One option is participation in the Employee Assistance Program (EAP) at Miami Children’s Hospital Human Resources Department whereby the resident will have psychological services which are private, confidential, and anonymous available at no cost to the resident. This service will provide besides confidential evaluation, treatment planning, and monitoring for the residents who enroll in the program. This can be further complimented by the assignment of the resident to a faculty mentor and the creation of a panel of counselors which includes an attending and psychologist for regular meetings with the resident. This panel, in turn, will report the results of the resident assessment and an action plan to be implemented to the program director. The panel will also identify stresses and factors within the environment that could cause problems, and personality traits that could put the resident at risk. The resident may be given a leave of absence or may utilize sick leave while under the care of an approved treatment center.

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J. Dress Code Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE



ISSUED BY: Human Resources	POLICY NUMBER: H9510E18
PAGE: 54 of 53	REPLACES POLICY DATED: 5/00; 2/02
EFFECTIVE DATE: 1/88	DISTRIBUTION: System wide
APPROVED BY: Exec. VP/Chief Operating and Compliance Officer	
POLICY DESCRIPTION: Dress Code/Business Casual	

SCOPE:

All employees and contractors or any and all personnel providing services at all MCH owned or operated facilities, including, but not limited to, hospital, ambulatory centers, physician practices and all departments contained therein.

PURPOSE: To establish and clarify standards for dress code and business casual dress and grooming for employees to present a professional presentation to patients, families and visitors.

DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]

POLICY: Standards of cleanliness, suitability and good grooming, appropriate to our Hospital environment must be observed by all employees while on duty.

The Hospital requires certain employees to wear uniforms at all times while on duty. Employees are expected to wear their complete uniform as specified by their department. Uniforms are to be kept clean and in good repair at all times.

Badges, slogans or irrelevant items are not to be worn with uniforms while on duty, except those badges indicating professional or technical school graduation and Hospital identification badge. Only pins distributed by the Hospital may be worn.

Hospital employees who do not wear uniforms are expected to maintain a standard of dress appropriate to a business atmosphere reflecting the Hospital's serious mission to patients and visitors. Department heads and supervisors will discuss the uniform or department dress code with the new employees. Casual dress may be allowed on certain days, occasions or associated with Hospital programs. In no case, can employees wear T-shirts with wording except for Miami Children's Hospital T-shirts, nor are denim jeans allowed to be worn in the Hospital.

A business casual dress code has been developed to be in effect between the dates of June 1st. and September 30th, and also on Fridays of the remainder of the year. This dress code is based on four basic concepts:

1. Use good common sense.
2. Show good professional judgement
3. Exercise leadership.
4. Anything you would wear to the gym, beach, or trendy clubs does not constitute Business Casual Dress.

Business Casual Dress is defined as clean, neat and professional clothing.

CASUAL DRESS STANDARDS – MEN

1. Suits, ties, and sport coats will be optional unless the dress standard is professional business wear at the appropriate meeting or appointment.
2. Slacks, khakis or dress pants (no jeans or shorts).
3. Collared long or short sleeved dress shirts (no golf/polo shirts or T-shirts).
4. Belts, socks and polished leather shoes (no sandals, sneakers or hiking boots).
5. All clothes must be well pressed, tailored and in good condition.

CASUAL DRESS STANDARDS – WOMEN

1. Suits, dresses (short or long sleeve), and blazers will be optional unless the dress standard is professional business wear at the appropriate meeting or appointment.
2. Skirts, tailored pants, or dress pants (no jeans or shorts).
3. Blouse, skirt, sweater, or jacket (no golf/polo shirts, halters, tanks or T-shirts).
4. Hosiery is always recommended, except with pants.

PROHIBITED CLOTHING

1. Denim (jeans, dresses, skirts, jumpers, or shirts)
2. Tight fitting clothing or mini-skirts
3. Athletic attire or sweatsuits
4. Spandex
5. Capri pants
6. Sundresses with spaghetti straps
7. T-shirts or tank tops
8. Sleeveless blouses or shirts (unless under a blazer)
9. Running, tennis or hiking shoes.
10. Mules, clogs or backless slip-on shoes. (Summer shoes and sandals are appropriate, but **MUST** have a strap on the heel).

If your position currently requires a uniform, the Casual Dress Code Policy does not pertain to you.

PROCEDURE:**ENFORCEMENT OF DRESS CODE**

If an individual crosses the standards of the dress code, it will be the responsibility of the manager or director to address the situation. If the attire is deemed unacceptable, the manager or director will ask the individual to leave, change, and return to work appropriately dressed.

REFERENCES: [list of supporting and source documentation used to validate the policy and procedure]

K. Academic Discipline Policy

 <p style="text-align: center;">MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE</p>	
ISSUED BY: Dept. of Medical Education	
PAGE: 56 of 53	REPLACES POLICY DATED: 7/10
EFFECTIVE DATE: 9/2013	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: Residents'/Fellows' Academic Discipline: Monitoring and Remedial Measures	

<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: Miami Children's Hospital (MCH), Graduate Medical Education (GME), and individual training programs have an obligation to provide learning opportunities, adequate supervision, and regular monitoring for all trainees so that at the end of their training the residents/fellows are competent to practice medicine safely without supervision in their respective fields of training. It is important for the programs to identify residents/fellows with academic poor performance early in their training and provide appropriate remedial measures to ensure training competent physicians.</p> <p>This P&P outlines various monitoring procedures for academic poor performance among trainees at MCH and provides a list of remedial actions including extending the training, non-renewal of contract, and dismissal of the trainee.</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY:</p> <ul style="list-style-type: none"> • Academic poor performance is performance which is below the expectation for the level of training in one or more of the six core competencies and/ or a benchmark threshold of each competency's specialty-specific milestones. <ul style="list-style-type: none"> ○ Patient care ○ Medical Knowledge ○ Interpersonal/communication skills ○ Professionalism ○ Problem-Based Learning and Improvement ○ Systems-based Practice • The Clinical Competency Committee (CCC) of the individual program is responsible for the bi-annual review of each resident's performance and meeting the milestones. The outcome of the review is communicated to the Program Directors who are primarily responsible for reviewing

academic performance report with the trainees and designing a remediation and/or an individualized learning plan (ILP). The program directors may review the performance through personal engagement, periodic review of evaluations, formal/informal discussions with the faculty and hospital staff.

- Once the Program CCC and the Program Director determine academic poor performance in any trainee, he/she will initiate a close monitoring program tailored to the trainee based on the degree of poor performance and the progress shown by the trainee.

PROCEDURE:

Resident Status				
Resident Status	Reporting Requirements	Procedure	Monitoring	Outcomes
Normal	N/A	N/A	<ul style="list-style-type: none"> • Evaluations as per the Program policies • Semi-annual evaluation by the Program Director 	N/A
Review	None	<ul style="list-style-type: none"> • On-review status is used for trainees who are marginally deviate from the expectations for the level of training. • PD must meet with the trainee in person and explicitly present: <ul style="list-style-type: none"> ○ Area of poor performance ○ Measures to improve the performance ○ How the improvement is measured ○ Duration of monitoring ○ Mechanism of evaluation ○ Various outcomes of review status • Specific mentors/evaluators may or may not be assigned during the evaluation period • Written attestation is preferable but not mandatory • The written documentation may be purged from the trainee's file if he/she 	<ul style="list-style-type: none"> • PD must meet with the trainee at least every three months. • Mentors, if assigned, meet with the trainee periodically and report to the PD of the progress. 	<ul style="list-style-type: none"> • Shown significant improvement: progress to normal status • Show some improvement: extend review status • Not shown improvement: escalate to higher monitoring or remedial level

		improves and comes out of review status to normal status		
Warning	None	<ul style="list-style-type: none"> • On-warning status is used for trainees who: <ul style="list-style-type: none"> ○ significantly deviate from the expectations for the level of training ○ not shown improvement during review period or ○ shown some improvement during probation period • PD must meet with the trainee in person and explicitly present: <ul style="list-style-type: none"> ○ Area of poor performance ○ Measures to improve the performance ○ How the improvement is measured ○ Duration of monitoring ○ Mechanism of evaluation ○ Various outcomes of warning status • Specific mentor(s) need be assigned during the evaluation period • Written attestation is preferable but not mandatory <p>The written documentation may be purged from the trainee's file if he/she improves and comes out of review status to normal status</p>	<ul style="list-style-type: none"> • PD must meet with the trainee at least every two months. • Mentors meet with the trainee periodically and report to the PD of the progress. 	<ul style="list-style-type: none"> • Shown significant improvement: progress to normal status • Show some improvement: extend warning status or move to review status • Not shown improvement: escalate to higher monitoring or remedial level
Probation	Yes: <ul style="list-style-type: none"> • GMEC (trainees name should not be identified) • DME/DIO • Program CCC • Statutory Boards 	<ul style="list-style-type: none"> • On-probation status is used for trainees who: <ul style="list-style-type: none"> ○ significantly deviate from the expectations for the level of training ○ not shown improvement during review/warning period • PD must meet with the trainee in person and explicitly present: 	<ul style="list-style-type: none"> • PD must meet with the trainee at least every month. • Mentors meet with the trainee periodically and report to the PD of the progress. 	<ul style="list-style-type: none"> • Shown significant improvement: progress to normal status • Show some improvement: extend probation status or move to review/warning status • Not shown

		<ul style="list-style-type: none"> ○ Area of poor performance ○ Measures to improve the performance ○ How the improvement is measured ○ Duration of monitoring ○ Mechanism of evaluation ○ Various outcomes of probation status ○ Reporting requirements for the program and the trainee ● Specific mentor(s) need be assigned during the evaluation period ● Written letter with all the details is given to the trainee to sign (to acknowledge the receipt of the letter) ● PD needs to meet with DME/DIO to discuss the issue of probation and to review the documentation before meeting with the trainee. ● It is preferable to have a third party present during the discussions with the trainee. ● It is recommended to have written documentation of trainee's poor academic performance and remediation efforts (if any). In case of verbal report, it is advised that PD document the nature of the report, date and time, and the staff who reported. ● PD to document the duration and outcome of the probation period in trainee's file for future reference. ● PD needs to report to GMEC after placing any trainee on probation. No identification or minimal details need to be presented to GMEC. ● PD/DME may take legal help in 		<p>improvement: extend probation period/extend the training period/non-renewal of the contract/termination</p>
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		drafting the letter. <ul style="list-style-type: none"> The academic probation status is <u>NOT</u> subjected to Grievance Process. 		
Remedial Actions				
Remedial Action	Reporting Requirements	Procedure	Monitoring	Outcomes
Extend the Training Period	Yes: <ul style="list-style-type: none"> GMEC (trainees name should not be identified) DME/DIO Program CCC Statutory Boards 	<ul style="list-style-type: none"> Training period is usually extended for trainees with poor academic performance but shown improvement and have potential to become competent physicians at the end of the extended period of training. PD must meet with the trainee in person and explicitly present: <ul style="list-style-type: none"> Areas of poor performance Measures to improve the performance How the improvement is measured Duration of training extension Salary and benefits during extension Reporting requirements for the program and the trainee Hospital Grievance Process Written letter with all the details is given to the trainee to sign (to acknowledge the receipt of the letter) PD needs to meet with DME/DIO to discuss the issue of training extension and to review the documentation before meeting with the trainee. PD needs to secure financial support for the period of extension. It is preferable to have a third party present during the discussions with the trainee. PD needs to report to GMEC. No identification or minimal details need 	<ul style="list-style-type: none"> Monitoring frequency depends upon the monitoring status. 	<ul style="list-style-type: none"> Successful completion of training Failure to complete the training

		<p>to be presented to GMEC.</p> <ul style="list-style-type: none"> • PD may need to report to ACGME/respective boards as required. • PD/DME is advised to take legal help. • Extension of training period is subjected to Grievance Process. (See Academic Grievance and Appeal Policy) 		
Non-renewal of contract	<p>Yes:</p> <ul style="list-style-type: none"> • GMEC (trainees name should not be identified) • DME/DIO • Program CCC • Statutory Boards 	<ul style="list-style-type: none"> • Contracts are not renewed for next level of training usually for trainees with poor academic performance and have not shown sufficient improvement in spite of remedial efforts and have no potential to become competent physicians at the end of the training period in their field of training. • PD must meet with the trainee in person and explicitly present: <ul style="list-style-type: none"> ○ Areas of poor performance ○ Summarize remedial efforts and their outcomes ○ Reporting requirements for the program and the trainee ○ Hospital Grievance Process • Written letter with all the details is given to the trainee to sign (to acknowledge the receipt of the letter) • PD needs to meet with DME/DIO to discuss the issue of non-renewal to review the documentation before meeting with the trainee. • It is preferable to have a third party present during the discussions with the trainee. • Notice to be given at least 4 months before the end of the current training 	<ul style="list-style-type: none"> • Monitoring frequency depends upon the monitoring status. 	<ul style="list-style-type: none"> • Failure to complete the training • May give full or partial credit for future training (after discussion with the respective boards)

		<p>year.</p> <ul style="list-style-type: none"> • PD needs to report to GMEC after placing any trainee on probation. No identification or minimal details need to be presented to GMEC. • PD may need to report to ACGME/respective boards as required. • PD/DME is advised to take legal help. • Non-renewal is subjected to Grievance Process. (See Academic Grievance and Appeal Policy) 		
Termination	<p>Yes:</p> <ul style="list-style-type: none"> • GMEC (trainees name should not be identified) • DME/DIO • Program CCC • Statutory Boards 	<ul style="list-style-type: none"> • Termination is done usually for trainees with extremely poor academic performance with significant risk for patient safety even under supervised training conditions. • Trainee must be informed about: <ul style="list-style-type: none"> ○ Areas of poor performance ○ Reporting requirements for the program and the trainee ○ Hospital Grievance Process • Written letter with all the details is given to the trainee to sign (to acknowledge the receipt of the letter) • PD needs to meet with DME/DIO to discuss the issue of termination to review the documentation before meeting with the trainee. • PD & DME must to take the help of legal and Talent & Management for delivery of termination letter to comply with hospital rules. • PD needs to report to GMEC. • PD may need to report to ACGME/respective boards as required. • Termination is subjected to 	N/A	<ul style="list-style-type: none"> • Failure to complete the training

		Grievance Process. (See Academic Grievance and Appeal Policy)		
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NOTE:

This policy addresses Academic Discipline related to substandard academic performance. Other disciplinary measures related to resident/fellow's impairment, sexual harassment, complaints, patient-care related professional complaints are addressed by following the institutional/ employee policy

REFERENCES: [list of supporting and source documentation used to validate the policy and procedure]

L. Academic Grievance and Appeal Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Dept. of Medical Education	
PAGE: 64 of 53	REPLACES POLICY DATED: 7/10; 7/11
EFFECTIVE DATE: 9/2013	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: Residents'/Fellows' Academic Grievance and Appeal Policy	

<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: The purpose of this policy is to outline the process of timely, fair, and responsible resolution of academic grievance and appeal filed by a resident or fellow in response to an academic disciplinary action as a result of a resident/fellow's poor performance. This institutional policy conforms to the ACGME guidelines.</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY:</p> <ul style="list-style-type: none"> • The following academic disciplinary actions are eligible for grievance/appeal (see Residents'/Fellows' Academic Discipline: Monitoring and Remedial Measures Policy): <ol style="list-style-type: none"> 1. Extension of Training Period 2. Non-renewal of Contract 3. Termination • The process must ensure that all ACGME accredited programs will provide the resident(s) with a written notice of the disciplinary action as early as possible. • The resident/fellow may appeal one of the decisions above by filing a written appeal no later than fourteen (14) calendar days after the receipt of written notification of non-renewal or non-advancement, or termination to the appropriate Program Director. The Program Director shall respond to the written appeal within fourteen (14) calendar days following the receipt of the written appeal. • If the Program Director's response is adverse to the resident, the affected resident may file a written appeal to the DME/DIO within fourteen (14) calendar days following the receipt of the response from the Program Director. • The DME/DIO will review the situation and attempt to address the appeal and resolve the dispute if possible and seek resolution and notify the resident/fellow in writing of the outcome of the appeal. • If the DME/DIO were not able to resolve the situation to the resident's/fellow's satisfaction, the resident/fellow may file an appeal in writing to the GMEC for consideration by a Performance Dispute Resolution Committee. The letter should be filed within Fourteen (14) days from the receipt of the DME/DIO decision. • The DME/DIO shall forward documents and all relevant material including a statement of the program director's position and the resident's letter of dispute to the GMEC for subsequent consideration. • The GMEC shall designate a three (3) – person Performance Dispute Resolution Committee consisting of:

- One faculty member selected by the Program Director
- One Housestaff or faculty member selected by the resident/fellow
- A third member selected by the first two members. The third member cannot be a member of the involved clinical division or a division chief of any other division.
- The **Performance Dispute Resolution Committee** will permit the resident/fellow to submit whatever material the resident believes to have bearing on the dispute for the Committee's consideration. The Committee will arrange to meet with the resident/fellow to afford him/her an opportunity to make an oral presentation. The Committee will then review all material relevant to the dispute (including previous CCC reports and bi-annual evaluations and plans by the PD), interview individuals as selected by the committee, and issue written findings and a recommendation to the CMO. The CMO shall render the final decision.

Committee Meeting:

1. The resident will be given written notice of the time and place of the hearing before the Committee
2. The resident may bring an attorney, or other advisor, who can assist the resident, however, the attorney/advisor will not be allowed to represent the resident, attend, or participate in the deliberation of the Committee
3. If there are additional issues of fact or procedure in question, the panel may call for further investigation and meetings before rendering a final, written decision. The Committee shall render a decision to accept, reject, or modify the program's decision, such decision to be issued no later than fourteen (14) calendar days from the conclusion of the review.
4. Although evidence may be presented, the hearing is not a legal proceeding, does not follow the rules of law or of evidence, and is not subject to laws relating to the conduct of legal proceedings.
5. Since the Committee is advisory to the CMO and is not serving as the institutional official, the Committee report is not subject to appeal, cross-examination, or negotiation.
6. The CMO will render the final decision. The determination rendered by the CMO shall be final and binding on all parties and shall not be subject to grievance or arbitration.

PROCEDURE:

Appendix A

This Appendix supplements the Resident's / Fellows Academic Grievance Appeal Policy

Description of the Performance Dispute Resolution Committee Meeting:


1. This meeting is held to:
 - a. Allow the Performance Dispute Resolution Committee to review, assess, confirm, and Clarify information in the documents
 - b. Allow the resident to plead his/her case in front of members of the Committee
 - c. Allow the Committee to interview other individuals to substantiate the information provided in the records to be able to have all the information they need for deliberation
2. The resident will be given written notice of the time and place of the hearing before the Committee
3. The resident may bring an attorney, or other advisor, who can assist the resident, however, the attorney/advisor will not be allowed to represent the resident, attend, or participate in the deliberation of the Committee
4. The resident will be given up to 20 minutes to present his/ case in front of the Committee members if the resident chooses to do so.
5. Committee will follow with any questions or clarifications from the residents about the information.
6. The resident and whoever is accompanying him/her leaves the meeting.
7. The Committee has the option of calling on any other involved parties to interview them separately or ask questions or clarifications
8. If there are additional issues of fact or procedure in question, the panel may call for further

investigation and meetings before rendering a final, written decision.

9. The Committee shall render a decision to accept, reject, or modify the program's decision, such decision to be issued no later than fourteen (14) calendar days from the conclusion of the review. The Committee's recommendation will be forwarded to the CMO and copied to the GMEC.
10. Although evidence may be presented, the hearing is not a legal proceeding, does not follow the rules of law or of evidence, and is not subject to laws relating to the conduct of legal proceedings.
11. Since the Committee is advisory to the CMO and is not serving as the institutional official, the Committee report is not subject to appeal, cross-examination, or negotiation.
12. The CMO will render the final decision. The determination rendered by the CMO shall be final and binding on all parties and shall not be subject to grievance or arbitration.

REFERENCES: [list of supporting and source documentation used to validate the policy and procedure]

M. Educational Conference Travel and Expense Reimbursement Policy

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Medical Education	
PAGE: 67 of 53	REPLACES POLICY DATED: 1/16/2012
EFFECTIVE DATE: 9/2013	DISTRIBUTION: Departmentwide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: Educational Conference Travel and Expense Reimbursement Policy	
SCOPE: The MCH Medical Education department (Residents and Fellows in Training), including all employees and contractors or any and all personnel providing services.	
PURPOSE: To provide guidelines and establish procedures for time allowance and reimbursement of residents and fellows employed by MCH for expenses incurred related to attending educational conferences.	
DEFINITIONS: Residents and fellows refer to trainees employed by MCH Department of Medical Education	
POLICY: The Department of Medical Education encourages scholarly activity and lifelong learning. This policy is meant to supplement the MCH Travel and Expense Reimbursement Policy (policy # O9500023). The following are general guidelines for the training programs related to Educational Conferences. <ol style="list-style-type: none"> 1) Request for attendance of a national educational conference by residents/ fellows must be submitted <u>in writing</u> as soon as reasonably possible and is subject to approval of the trainee's program director. The program director is responsible for determining the appropriateness of the work presented, the number of times the same abstract is presented, or the appropriateness of the conference to submit to. 2) The cumulative time to attend an approved educational conference(s) must NOT exceed a total of 5 work days per resident/fellow per academic year (regardless if the resident is presenting or not). Any days over 5 work days are considered vacation time. 3) For educational conferences eligible for reimbursement (see below), a travel pre-approval form must be completed by the resident/fellow and submitted in advance to the Department of Medical Education for pre-approval by the Director of Medical Education and Program Director. 4) Only one abstract author (the presenting author) per abstract is eligible for reimbursable travel to present. For abstracts with more than one trainee as author, only one author is eligible to be reimbursed for the abstract presentation expense or the presenters might decide to split the reimbursed cost or share hotel room etc. 5) A Travel Pre-Approval Checklist (see attached) MUST be completed and cleared after obtaining the approval signatures (Program Director, Dept Director) and PRIOR to submission of the pre-approval form for processing. This checklist must be completed for all approved residents and fellows' travel regardless if the travel is for attending a conference or for presenting at a conference. 	
PROCEDURE: Expense and Travel Reimbursement:	

Residents and fellows must follow the MCH Travel and Expense Reimbursement policy in order to be reimbursed for any purchases or travel (policy # O9500023). All expenses must be submitted by the resident/ fellow by means of the Pre-Approval Form and must be approved in advance by the Director of Medical Education. Alcohol, special room/spa services, room charges or food for spouse/family members staying with you during an event and other items as specified in the travel policy are not reimbursable. Itemized, original individual receipts and a completed Travel/Expense Reimbursement Form must be submitted within 30 days for any reimbursement requests after travel. See MCH Travel Policy for more information or ask Medical Education Office for assistance.

This is a GME Institutional Policy. It is at the discretion of the Individual Program Director(s) to come up with a process of implementation of the policy taking into account schedules restrictions, allowed rotations from which to take educational leave, make-up and/or payback time, allowable specialty-specific conferences, and additional department rules. Refer to the individual training program manual for policy implementation details.

The following are guidelines related to reimbursement for expenses incurred during approved educational conferences:

Educational Conference	Eligibility for reimbursement	Resident/fellow responsibility
Resident/Fellow attending the conference	Not eligible for reimbursement	Obtain approval in writing from the program director (Conference must be sponsored by a major medical society as defined by the program director(s)) Complete and clear the Travel Pre-Approval checklist tasks
Resident/fellow presenting at a national conference	Eligible for reimbursement <ul style="list-style-type: none"> • Airfare • Registration • One night hotel (the night before the presentation) • Transportation • Meals (excluding alcohol) for 24 hours around the presentation time • Refer to the MCH Travel and Expense Reimbursement Policy (policy # O9500023). 	<ul style="list-style-type: none"> • Complete travel pre-approval form(s). The process MUST be started as soon as the fellow / resident receives the invitation letter • Attach invitation letter/ abstract acceptance letter • Obtain pre-approval from the Director of Medical Education and the Program Director (Travel outside the continental USA and / or International Travel require approval from the CMO and the CEO as per hospital policy) • Complete and clear the Travel Pre-Approval checklist tasks • Keep itemized receipts for meals (excluding alcohol) • If a poster is needed for the conference, the resident/ fellow must allow a minimum of 2 Weeks for ordering and printing of the poster through hospital vendors

REFERENCES:

- [Travel and Expense Reimbursement Policy](#)



Department of Medical Education Travel Pre-Approval Checklist

Resident/ Fellow Name: _____
 Program: _____
 Date Form is Completed: _____
 Date of Planned Travel: _____
 Purpose of Travel: _____

Prior to processing Pre-Approval form for the approved travel reimbursement of residents and fellows, the following checklist **MUST** be completed and cleared after obtaining the approval signatures (Program Director, Dept Director) and **PRIOR** to submission of the pre-approval form for processing.

REQUIREMENT/ JOB DUTIES	Complete	N/A	Signed off by:
1. Up to Date Duty Hour Logs	<input type="checkbox"/>	<input type="checkbox"/>	
2. Up to Date Procedure Logs	<input type="checkbox"/>	<input type="checkbox"/>	
3. Clear Medical Records Dictation List	<input type="checkbox"/>	<input type="checkbox"/>	
4. IPM Modules	<input type="checkbox"/>	<input type="checkbox"/>	
5. Up to Date on Evaluation Completion	<input type="checkbox"/>	<input type="checkbox"/>	
6. CHEX Modules	<input type="checkbox"/>	<input type="checkbox"/>	
7. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

A Completed Form must be attached to each Pre-approval form

N. Residents Educational Allowance Stipend Policy

 MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
ISSUED BY: Medical Education	POLICY NUMBER: [alpha-numeric]
PAGE: 70 of 53	REPLACES POLICY DATED: 9/ 2012
EFFECTIVE DATE: 09/2013	DISTRIBUTION: [system or department wide]
APPROVED BY: Graduate Medical Education Committee (GMEC), Deise Granado-Villar, MD; CMO	
POLICY DESCRIPTION: Residents Educational Stipend Allowance Policy	

<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: The Sponsoring Institution shall provide Residents and Fellows (Herein referred to as “Residents”) with educational support throughout each approved academic year. This policy does not include educational stipends related to CME meetings. For the institutional policy related to attending educational meetings (time and allowance), refer to the GME policy on “Educational Conference Travel and Expense reimbursement Policy”</p>
<p>POLICY: It is the policy of MCH to provide its residents with the equivalent of \$600 per training year as a stipend. In the first year of training, this stipend is allocated for the purchase of ipad + cover to be provided at orientation. The ipad will be used by the resident throughout their training for patient care and will be maintained and set up by MCH IT Department in accordance with the hospital policy. Upon completion of training, the ipad is for the resident to keep after IT clears its secured/ confidential information.</p>
<p>PROCEDURE: Effective in academic year 2013-2014, the educational stipend will be provided to the residents in the following manner:</p> <ol style="list-style-type: none"> 1) First Training Year: ipad + Cover (~ \$600 value) 2) Subsequent Training Year(s): \$ 600 / training year <p><u>Note:</u></p> <ul style="list-style-type: none"> • One year program trainees will only receive the ipad + cover • The cash stipend (Year 2 and beyond) will be issued via check (included in paycheck). This allowance is considered taxable income. • At the discretion of the individual program director, the cash stipend(s) (or part of it) might be allocated to either the purchase of specific educational material (e.g. books) or membership in specialty society (other than AAP and AMA as AAP and AMA memberships are covered by the institution for all residents). The program director will notify the GME office of the desired stipend allocation. The GME office will purchase the items and provide any remaining cash to the resident.
<p>REFERENCES:</p>

O. Clinical Competency Committees (CCCs)

 MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
ISSUED BY: Dept. of Medical Education	
PAGE: 71 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE: 9/2013	DISTRIBUTION: Department wide
APPROVED BY: Graduate Medical Education Committee, Granado-Villar, Deise (Chief Staff-SVP Medical Affair)	
POLICY DESCRIPTION: Clinical Competency Committees (CCCs)	

<p>SCOPE: The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: The intent of this policy is to describe the program's Clinical Competency Committees (CCCs), their formation, structure, membership, rationale, and roles.</p>
<p>DEFINITIONS:</p>
<p>POLICY:</p> <p>It is the policy of the MCH Department of Medical Education and its training programs to conduct meaningful assessments of its trainees. These assessments are based on multiple sources including formative and summative evaluations, milestones-based assessments based on direct observation, simulation, rating scale, evaluation of scholarly work, and 360 degrees evaluation in compliance with the ACGME requirements. The goal of the assessment is to provide the program directors and the trainees with meaningful performance evaluation and feedback to allow to the program director to design an individualized learning plan aimed at strengthening areas of weakness.</p> <p><u>Structure of the CCC:</u> <i>(New proposed ACGME Common Program Requirements for Resident Evaluation (V.A. 1))</i></p> <ul style="list-style-type: none"> • The program director appoints the Clinical Competency Committee. • CCC must have at least three program core faculty (excluding the program director) who have the opportunity to observe and evaluate the residents • CCC members may also include non-physician members of the health care team, non-MD educators, assessment specialists, or residents in their final year. For example, a small fellowship program may include faculty from the core program or from required rotations in other specialties. <p><u>Responsibilities of the CCC:</u> <i>(New proposed ACGME Common Program Requirements for Resident Evaluation (V.A. 1))</i></p> <p>Each program is expected to form a CCC. The CCC must:</p> <ul style="list-style-type: none"> • Meet at least semi-annually to review and discuss each individual residents' performance data (one year programs might need to meet more frequently to give meaningful assessments but they have less number of trainees) • Make a consensus decision on the progress of each resident by applying assessment data to the milestones. • Serve as an early warning system/ early identification if a resident fails to progress in the educational program and make recommendations to the program director for resident progress including promotion, remediation, and dismissal.

- Submit to the program director a written assessment of each resident's performance on the milestones

Role of the program director on the CCC:

The requirements regarding the CCC do not preclude or limit a program director's participation on the CCC. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. The program director role on the CCC includes:

- Attends the CCC meeting but he/ she may not chair the meeting
- Serves as a resident advocate, advisor, and confidante
- Receives the CCC's written report on each resident, meets with each resident individually to discuss the CCC's assessment, and provide the resident with individualized learning plan as needed.
- Has final responsibility for the program and trainees' evaluation and promotion.
- Reports the aggregate, de-identified information for all residents in the program to the ACGME in the ADS system.

Role of the Department of Medical Education:

It is the responsibility of the MCH Department of Medical Education to:

- Prepare the members of the CCC to their role through faculty development.
- Provide faculty with added training in the evaluation process, including how to aggregate and interpret data.
- Assist CCC members in understanding the milestone narratives to reach a common agreement of their meaning.
- Guide the faculty members' discussion about resident evaluation, including how many assessments are needed for any given milestone, data quality, and the application of quality improvement principles to the evaluation process.
- Support the program CCCs by providing them with the necessary data elements
- Monitor the process of all CCCs and their performance


PROCEDURE:

Description of CCC meetings:

- The program director (PD) and the GME department will prepare Milestones data summary on each resident through reports generated from various sources e.g. 360-degree evaluations, rotation evaluations, Simulations, etc...
- In some situations the residents' data will be divided among CCC members to review before the meeting and report on during the meeting
- While the PD is part of the CCC meeting, the PD must not chair the meeting and can be available for clarification, etc..
- Each resident is given a semi-annual assessment on a dashboard in one of the following 5 categories on each of the metrics set by the program: (No Data, Below Expected for training level, On Track for training level, Above Expected for training level).
- The CCC will generate a report/ recommendation letter to PD on each resident. The PD will meet with each resident and communicate the recommendation, design an improvement plan, etc..
- Thresholds will be set by the CCC. Interventions a program might consider include assigning a mentor with expertise in a given area of deficiency, additional required readings, sessions in a skills lab, and/or added rotations in a given area. If, after remediation, a resident still fails to advance sufficiently on one or more milestones, a CCC might consider extending education, or counseling the resident to consider another specialty or profession.
- Aggregate, de-identified information for the all residents in the program will be reported to the ACGME

REFERENCES: www.ACGME.org ; Clinical Competency Committee – Roles and Responsibilities (document)

P. Institutional and Program Quality

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Medical Education	
PAGE: 73 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE: 9/23/2014	DISTRIBUTION: department wide
APPROVED BY: GMEC, CMO and VP of Academic Affairs	
POLICY DESCRIPTION: Institutional and Program Quality: Program Evaluation Committee (PEC), Annual Program Evaluation (APE), and Annual Institutional Review (AIR)	

<p>SCOPE:</p> <p>The MCH Medical Education department, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE: The purpose of this policy is to outline the process for Institutional and Program Quality Improvement for all ACGME-accredited training programs at Miami Children's Hospital.</p>
<p>DEFINITIONS: [any words or phrases within the policy and procedure that have a meaning that is not widely known, or a meaning specific to its use within the policy and procedure]</p>
<p>POLICY:</p> <p>The Graduate Medical Education Committee (GMEC) of Miami Children's Hospital provides oversight for the quality of the GME learning and working environment, the quality of educational experiences in each ACGME-accredited program; and the ACGME-accredited programs' annual evaluation and improvement activities. The GMEC requires that the educational effectiveness of a program must be evaluated at least annually in a systematic manner. Each ACGME-accredited program must have a Program Evaluation Committee (PEC).</p> <p>The Program Evaluation Committee (PEC)</p> <p>The program director must appoint the PEC. The PEC must be composed of at least two program faculty members and should include at least one resident. The only time the PEC meeting is allowed not to have a resident representative is if the program has a year with no resident enrolled but the PEC must still meet at least annually. Refer to the attached document to this policy that delineates the Roles and Responsibilities of the PEC. The PEC reviews program goals and objectives, and the effectiveness with which they are achieved.</p> <p>In the evaluation process, the group must review the following documents where applicable:</p> <ol style="list-style-type: none"> 1. Program goals and objectives, teaching activities, evaluation tools 2. Action plan from the last APE report 3. Residents annual confidential program evaluation 4. Faculty annual confidential program evaluation 5. The most recent report of the last internal review by the institution 6. RRC citations from the last program ACGME accreditation survey 7. Competency grid 8. ACGME ADS national residents survey data 9. ACGME ADS national faculty survey data 10. List of scholarly activities of the faculty and residents 11. Data from the confidential faculty evaluations by residents

12. List of faculty development activities.
13. In-service examination scores
14. Procedure logs
15. Conference attendance reports
16. Online modules usage report (IPM modules)
17. Duty hour compliance report
18. Data from the general competency evaluations of residents by faculty
19. Board pass rate by graduates
20. Post-graduation placement etc.
21. List of Scholarly activities of ex-graduates where applicable

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 four areas:

1. Program Quality
2. Faculty development
3. Resident Performance
4. Graduate performance

The Annual Program Evaluation (APE) Report (See attached Template)

The APE should address the following issues where applicable:

- 1- Program Quality
 - b. Accreditation/ Citations
 - i. Number and description of Citations
 - ii. Number and description of concerns
 - iii. Compliance with ACGME requirements:
 1. Semi annual evaluations
 2. Annual written program evaluation by the residents
 3. Confidentiality of faculty evaluation by the residents.
 4. Program specific requirements
 5. SOC for fellowship programs where applicable
 6. Core curriculum
 - c. Program goals and objectives and their effectiveness.
 - d. Competency plans: teaching and evaluation methods of 6 core ACGME competencies (review your competency grid and modify where needed)
 - e. Resources:
 - i. Minimum and maximum patient loads where applicable
 - ii. Adequacy of Supervision
 - iii. Library and laboratory support
 - iv. Support for scholastic activities
 - f. Early departures and transfers
- 2- Faculty Development
 - a. Faculty evaluations of teaching by residents/fellows.
 - b. Faculty development activities and attendance
 - c. National leadership
 - d. Faculty Scholarly activities
- 3- Resident Performance
 - a. In-service examination scores and remedial measures
 - b. Procedure performance (do they meet the minimum numbers required by the specific RRC).
 - c. Conference attendance, professionalism, and continuous development
 - d. Scholarly activities of residents and fellows
 - e. Duty hour compliance and resident/fellow well-being
 - f. Procedures and case logs

- 4- Graduate Performance
 - a. Board pass rate
 - b. Post-graduation placement etc.
 - c. Scholarly activities of ex-graduates where applicable

The GMEC requires that each program conducts its annual review by the PEC, and prepares an APE report using the format approved by the GMEC in order to evaluate the effectiveness of the program and use data from metrics and evaluations to make changes and improvements to the program. The APEs of all accredited programs will be used in the Annual Institutional Review (AIR) which will result in a report that is submitted by the DIO to the Governing Body (Medical Staff Executive Committee and MCH Board of Trustees) annually in the fall of each year.

The Annual Institutional Review (AIR)

The GMEC must identify institutional performance indicators for the AIR which include:

1. Results of the most recent institutional self-study visit
2. Results of ACGME surveys of residents/fellows and core faculty
3. Notification of ACGME-accredited programs' accreditation statuses and self-study visits.

The AIR must include monitoring procedures for action plans resulting from the review.

The AIR utilizes the programs' APEs to conduct the AIR. The DIO submits a written annual executive summary of the AIR to the institution's Governing Body.

PROCEDURE:

If deficiencies are found, the PEC should prepare explicit **Action Plans**, which should be approved by the faculty and documented in the minutes of the meeting (maintained by the program). Each Action plan must have a timeline, a responsible party, and measurable outcome.

Special Review Process

The GMEC must demonstrate effective oversight of underperforming programs through a Special Review process. The Special Review process could be a subcommittee of the GMEC which is tasked with conducting the Special Review of underperforming programs and reporting back to the GMEC with an action plan. The Special Review Process must include a protocol that:

- Establishes criteria for identifying underperformance
- Results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.


The Special Review Process subcommittee must prepare a report (minutes of the meeting) and submit to the DME/DIO and document it in the minutes of GMEC. Names of individuals involved in the review should be included in the report.

REFERENCES:

Attachments to this policy:

- Roles and Responsibilities of the PEC
- APE Report Template

Q. The Use of Social Media

MIAMI CHILDREN'S HOSPITAL POLICY AND PROCEDURE	
	
ISSUED BY: Department of Medical Education	
PAGE: 76 of 53	REPLACES POLICY DATED:
EFFECTIVE DATE: 9/22/2014	DISTRIBUTION: department wide
APPROVED BY: GMEC, Deise Granado-Villar, MD; CMO, Senior VP of Faculty and Academic Affairs	
POLICY DESCRIPTION: The Use of Social Media	

<p>SCOPE:</p> <p>The MCH Department of Medical Education, including all employees and contractors or any and all personnel providing services.</p>
<p>PURPOSE:</p> <p>The purpose of this policy is to address the use of social media by residents, and fellows as MCH employees and members of the Department of Medical Education. This includes but not limited to, communications over the internet, on personal websites or web pages, and in online communities. This GME policy supplements the hospital policy on Employee Communication.</p>
<p>DEFINITIONS:</p> <p>Social media is a type of online media that expedites conversation as opposed to traditional media, which delivers content but doesn't allow readers/viewers/listeners to participate in the creation of the content. The term social media defines various activities that integrate technology, social interaction and the construction of words and pictures. It encompasses a wide variety of internet-based resources to share content among users. Examples of social media include collaborative projects (e.g. Wikipedia), blogs and microblogs (e.g. Twitter), video sharing content communities (YouTube), social networking sites (e.g. Facebook), picture-sharing sites (e.g. Instagram), virtual game worlds (e.g. World of Warcraft), and virtual social worlds (e.g. Second Life). Technologies include but are not limited to, Wikis, blogs, forums, picture-sharing and video-sharing wall postings, email, instant messaging, and music-sharing. Because social media and other forms of electronic communications are rapidly evolving and changing, the examples contained in this policy are meant to be illustrative, but by no means represent the entire field of social media. As technology changes and newer forms of communication develop, this policy shall apply to the various forms of electronic communication that are available.</p>
<p>POLICY:</p> <p>MCH recognizes that appropriate use of social media can have beneficial effects both within MCH and among the general public. Accordingly, the Department of Medical Education employees, with the guidance and assistance of MCH's Marketing Department, are encouraged to use the various forms of MCH-sponsored Social Media as tools to communicate internally within MCH and externally with other providers, patients, and the general public. Such use of MCH-sponsored social media should be preapproved by the appropriate individual or department.</p> <ol style="list-style-type: none"> 1. Patient experiences and information are prohibited from being digitally recorded or posted on the internet. Use of the internet includes posting on blogs, instant messaging [IM], social networking sites (e.g., Facebook, MySpace, Twitter), email, posting to public media sites,

mailing lists and video-sites. Communications must never contain any information that directly or indirectly identifies a patient. This includes information that does not directly identify a patient, but would permit someone to identify a patient, either through the identification of a disease or health condition; an event precipitating the patient's health condition, such as an accident or other trauma; the patient's or provider's location within MCH; the names and or specialties of the patient's health care team; the patient's language or country of origin; or any other detail that alone or in combination with other facts in the public or private domain might allow a third party to identify the patient. In addition, patient information should never be saved on personal USB memory devices or recording devices. Patient information may only be emailed within a hospital's secured network. Patient information must not be emailed outside of this system.

- Such actions are a direct violation of the patient's privacy and confidentiality per the Health Insurance Portability and Accountability Act (HIPAA).
 - The HIPAA Privacy Rule protects all "individually identifiable health information" and requires that individuals involved in health care maintain the security of patient records in any form (i.e., electronic, paper, or oral).
 - The Miami Children's Hospital Information Technology (IT) policy specifically states that MCH Employees are expected to comply with all HIPAA policies as set forth, and particular care should be taken to avoid copying sensitive patient information onto removable devices such as flash drives, etc.
 - All MCH network connections should be for purposes of education, research, and public service.
2. MCH policies prohibit accessing websites that are not directly related to education or patient care.
 3. Information (written or digital) about colleagues and co-workers should not be posted anywhere without their consent and if posted should be truthful and accurate.
 4. When posting information on the internet, consider the following:
 - The impact of the information you disseminate via social networking sites prior to posting material. Respect for one's colleagues, co-workers, and institution is essential to maintaining a professional work environment.
 - The permanency of published material on the internet – once posted on the internet, things live forever.
 - The fact that patients regularly Google their physicians and that posts reflect on MCH as an institution.
 5. The patient-physician relationship relies on mutual respect and professionalism. Social networking with patients, including communicating with patients or giving medical advice via social networking sites should not be done.
 6. Postgraduate trainees must not represent or imply that they are expressing the opinion of the organization by using hospital or institution proprietary information such as logos or mastheads. Trainees must comply with the current hospital or institutional policies with respect to such information.
 7. If residents and fellows create blogs, clear disclaimers that the views expressed by the author in the blog are the authors' alone and do not represent the views of the hospital must be posted.
 - Be clear and write in the first person
 - Make it clear that the writing is coming from an individual and not on behalf of MCH or its training program(s)
 8. MCH Representatives' communications using MCH Social Media must not include information that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful, disparaging, or humiliating to fellow employees, business partners, competitors, patients, students, volunteers, or other representatives of MCH. Such communications may violate other MCH policies even when posted or communicated on personal sites.

PROCEDURE:

1. Inappropriate use of the internet and social networking sites may result in:
 - o Documentation in professionalism score/report card
 - o Professionalism academic remediation
 - o Discipline for breach of hospital or institutional policy
 - i. Loss of computer privileges at hospital
 - ii. Potential suspension
 - iii. Potential termination
 - o Other assignments and/or remediation plans based upon the infraction

2. Any violation of HIPAA can result in potential dismissal from program as well as possible litigation due to patient privacy infringement

What You Should Do:

- Be smart. Be respectful.
- Be authentic. When you post or comment in social media always state your name.
- Be transparent. State that it is your opinion. Unless authorized to speak on behalf of MCH you must state that the views expressed are your own.
- Be careful. Protect what personal information you share online.
- Be responsible and act ethically. When you are at work, your primary responsibility is the work of MCH.

What You Should Never Disclose:

- Confidential MCH Information: If you find yourself wondering whether you can talk about something you learned at work – don't.
- Patient Information: Do not talk about patients or release patient information or any information that reasonably could identify a patient.
- Personnel Information: Do not refer to your co-workers in an abusive or harassing manner.
- Legal Information: Do not disclose anything to do with a legal issues.
- Materials that belong to someone else: Stick to posting your own creations. Do not share copyrighted publications, photos, logos or other images that are trademarked. If you do use someone else's material, give them credit. In some cases you may also need their permission.

REFERENCES: [list of supporting and source documentation used to validate the policy and procedure]



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