



PROGRAM DIRECTORS' MANUAL

Icahn School of Medicine at Mount Sinai
Office for Graduate Medical Education

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I. INTRODUCTION

The Program Director is accountable to a number of individuals and organizations, including the Department Chairperson; Hospital Administration; Icahn School of Medicine at Mount Sinai (ISMMS/the School), its Designated Institutional Official (DIO), and its GME Office; the Mount Sinai Consortium for Graduate Medical Education and its GME Committee; the Joint Commission on Accreditation of Health Care Organizations (JCAHO); and the appropriate Review Committee (RC) of the Accreditation Council for Graduate Medical Education (ACGME) or other accrediting body.

A Program Director's effective time management becomes increasingly important, as does his or her ability to understand and comply with institutional, organizational, and governmental requirements and standards for postgraduate education. The requirements, responsibilities and challenges of the position are summarized in Tables 1-3 below.

The objective of this manual is to provide Program Directors with the information they need for the effective accomplishment of the educational goals. Since many issues discussed here also appear in the House Staff Manual, this manual cross-references information when addressing a concern that also pertains to House Staff. The manual also refers to the ACGME Institutional and Program Requirements, which may be found on [the ACGME website](#).

As with any attempt at a comprehensive manual, there will undoubtedly be subjects that have not been addressed or issues that could be discussed more fully. Please feel free to share your comments and concerns so that the next edition may be of even greater assistance.

Table 1	
ADMINISTRATIVE RESPONSIBILITIES OF PROGRAM DIRECTORS	
	• Annual, documented (in New Innovations) review of the educational program with faculty and resident representatives
	• Appointment of Chief Resident(s)
	• Compliance with ACGME (or other accrediting organization) and specialty board requirements
	• Compliance with National Resident Matching Program policies/procedures
	• Development of curriculum and competency-based goals and objectives that are delineated by rotation and year of training
	• Duty hour and moonlighting monitoring and reporting
	• Monitoring resident stress and well-being
	• Confirmation of resident eligibility, including certification, visas, and licensure
	• Counseling and disciplinary action
	• Managing resident time off and leave in compliance with all applicable requirements
	• Fellowship placement assistance
	• House staff scheduling and assignments
	• Implementation of New Innovations Residency Management software
	• Maintenance of resident files, including documentation of resident evaluations, privileges, procedures
	• Office management
	• Orientation manual preparation
	• Preparation for accreditation site visits/self-studies
	• Preparation of recruitment brochures
	• Writing letters of recommendation for residents

Table 2
SUPERVISORY RESPONSIBILITIES OF PROGRAM DIRECTORS
• Advisement and Discipline
• Career Counseling
• Conflict Resolution
• Credentialing
• Evaluation and Feedback
• Faculty Qualifications and Professional Development
• Mentorship
• Personnel Activities
• Research and Scholarly Activity
• Residency Program Administration
• Stress Identification and Management
• Visiting Residents
• Work Hours
• Oversight of education at participating sites

Table 3
MAJOR CHALLENGES INHERENT IN DIRECTING A RESIDENCY PROGRAM
• Need to report to many individuals and organizations within and outside of the hospital
• Need to balance service to hospital with maintaining optimal educational environment for residents
• Increasing complexity of accreditation process
• Compliance with both Section 405 of New York State Health Code and ACGME requirements concerning
• Need to maintain balance among educational, administrative, research and clinical activities

II. ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI CONSORTIUM FOR GRADUATE MEDICAL EDUCATION

A. BYLAWS

1. *Mission Statement*

The Consortium for Graduate Medical Education is dedicated to the centralization, enhancement, and oversight of the quality of education provided to House Staff at all participating institutions (Table 4), and to maintain and to improve its graduate medical education programs. ISSMS serves as the Sponsoring Institution for programs at seven of the eleven participating hospitals. There are more than XXX residents in training in Consortium participating hospitals; more than XXX residents train in the XXX sponsored residency programs.

2. *Membership*

The Consortium for Graduate Medical Education, hereafter referred to as “the Consortium,” will consist of ISSMS (“the School”), The Mount Health System Hospitals, and all affiliated institutions that have established an academic affiliation with the School for sponsorship of residencies and/or participation in joint graduate medical education (“GME”) programs.

3. *Responsibilities*

All members of the Consortium agree: a) to abide by agreed-upon rules of governance; b) to adhere to both academic and educational standards; c) to adhere to the “Mission Statement” of the Consortium; and d) to provide appropriate educational and financial support for Consortium activities and for the human resources necessary to maintain high-quality residency programs.

Residency programs will be subject to member institutions’ policies and procedures, and must also meet the departmental standards established by the respective Chairs at the School and the institutional standards set by the School. In addition, all participating hospitals and residency programs must comply with ACGME Institutional and Program Requirements and applicable special requirements. Affiliation agreements between the School and each participating institution will remain in place and will be reviewed regularly.

Table 4
MOUNT SINAI CONSORTIUM FOR GRADUATE MEDICAL EDUCATION
<p><u>New York (Mount Sinai Health System members in italics)</u></p> <p>Bronx-Lebanon Hospital Center* Brooklyn Hospital Center* Elmhurst Hospital Center Good Samaritan Hospital (West Islip)* James J. Peters (Bronx) Veterans Affairs Medical Center <i>Mount Sinai Hospital</i> <i>Mount Sinai Beth Israel</i> <i>Mount Sinai St. Luke's/Mount Sinai West (formerly Roosevelt)</i> <i>New York Eye and Ear Infirmary at Mount Sinai</i> Queens Hospital Center Richmond University Medical Center*</p>
<p><u>New Jersey</u></p> <p>Englewood Hospital and Medical Center (Leaving Consortium as of July 1, 2016)</p> <p>*Residency programs not sponsored by Mount Sinai</p>

4. Objectives

- a. Enhance the quality of education, regardless of specialty, for all residents at all participating institutions.
 - i. Monitor Consortium educational resources to allow residents at participating institutions to benefit from resources available at other participating institutions.
 - ii. Combine separate educational programs when it will enhance educational quality.
- b. Monitor and evaluate the quality of education within each sponsored residency program in the Consortium through:
 - i. GME Office review of ACGME Annual Updates in WebADS
 - ii. GME Office review of the Annual Program Evaluations in New Innovations
 - iii. Preparation of the twice-yearly Dashboard, consisting of eight quality metrics (Accreditation Status, Board Pass Rate, Resident and Faculty Scholarship, Match success, ACGME Resident and Faculty Survey results, and adherence to Case Log standards (where applicable))
 - iv. Graduate Medical Education Subcommittee Special Reviews of underperforming programs
 - v. Graduate Medical Education Committee (GMEC) review of the above at its monthly meetings.

- c. Develop a general educational curriculum across all departments and institutions, which will include discussions of:
 - i. Cultural diversity;
 - ii. Alcoholism and substance abuse/physician impairment;
 - iii. Medical ethics;
 - iv. Physician-patient relationships;
 - v. Preventive medicine;
 - vi. Sleep deprivation in residency training;
 - vii. Leadership;
 - viii. Practice in a managed care environment;
 - ix. Competency-based medical education; and
 - x. Scholarly activity.
- d. Develop methods of assessing clinical competence.
- e. Expand the academic educational network by implementing a database for resident tracking and evaluation through web-based software provided by New Innovations. This system will facilitate:
 - i. The collection of demographic data;
 - ii. The credentialing of house staff;
 - iii. The completion of evaluations;
 - iv. The measurement of compliance with New York State and ACGME duty hours standards; and
 - v. The transfer of data to IRIS for Medicare reimbursement.
- f. Meet the needs of communities served by Consortium members.
 - i. Enhance residency program recruitment of minorities underrepresented in medicine.
 - ii. Encourage house staff to practice in underserved communities upon completion of training through development of loan forgiveness programs.
 - iii. Develop evaluation techniques to measure outcomes with respect to ultimate practice location, specialty, and ability to pass certifying examinations.
- g. Establish uniform administrative policies.
 - i. Establish compliant policies for residents in such areas as benefits, evaluation and advancement, and due process.
 - ii. Act as forum for discussion between administration, house staff, and faculty on all matters pertaining to GME.
 - iii. Establish quality assurance programs to diminish adverse incidents by residents and house staff.
 - iv. Assure appropriate house staff credentialing.
 - v. Insure that a forum exists at each institution and within each residency program to allow house staff to express their educational concerns.

5. *Commitment to Diversity*

ISMMS is committed to promoting diversity in all working and learning environments and to providing appropriate resources to all of our students, residents, faculty, and staff as well as the communities we serve.

6. *Structure*

The GMEC is charged with assuring that all Consortium objectives are met and is chaired by the Senior Associate Dean for Graduate Medical Education who also holds the position of ACGME Designated Institutional Official (DIO).

The GMEC will be composed of the Senior Associate Dean and Associate Dean(s) for GME, at least four program directors from the School, one or two representatives responsible for GME administration at each affiliate institution, and at least four, but not more than twelve, peer-selected residents in ACGME-accredited positions. All members will have voting rights. New appointments to the GMEC must be reviewed and approved by GMEC members.

The GMEC will meet at least 11 times per year and will appoint ad hoc committees as needed. There will be five standing subcommittees that will meet as deemed appropriate:

- i. Hospital-based Specialty Programs
- ii. Medical Specialty Programs
- iii. Surgical Specialty Programs
- iv. Professionalism
- v. Research

The GMEC is accountable and will report to the Dean of the School and the Chief Executive Officer of The Mount Sinai Health System. Each representative of each participating institution will report to the Chief Executive Officer of his or her respective institution. All recommendations will be forwarded to the Dean and Chief Executive Officer of each member institution. If a recommendation is not unanimous, a dissenting opinion may also be forwarded.

III. ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

Mission and Scope of the ACGME:

The Accreditation Council for Graduate Medical Education (ACGME) is a separately incorporated, non-governmental organization responsible for the accreditation of graduate medical education (GME) programs. Its mission is to improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation. Its scope of accreditation extends to those institutions and programs in GME within the jurisdiction of the United States of America, its territories and possessions. The ACGME has seven member organizations:

- American Board of Medical Specialties (ABMS)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)
- American Osteopathic Association (AOA)
- American Association of Colleges of Osteopathic Medicine (AACOM)

Each member organization nominates four individuals to the ACGME's Board of Directors, except that, as of January 1, 2015, AOA and AACOM nominate two individuals each to the Board, with a subsequent phase in period for additional nominated directors, up to four directors each. Each member organization nominates two individuals per directorship, and the ACGME Board elects the directors. In addition, the ACGME Board includes three public directors, up to three at-large directors, two resident directors, and the chair of the ACGME Council of Review Committee Chairs. Two representatives of the federal government may, without vote, attend meetings of the Board.

The Accreditation Council for Graduate Medical Education (ACGME) is a private, nonprofit council that evaluates and accredits residency programs in the United States. There is a Review Committee (RC) for each approved specialty. Accreditation of a residency program indicates that it has been formally evaluated and determined to be in substantial compliance with ACGME and RC requirements, including the Institutional Requirements and Program Requirements.

Program Directors may respond to the adverse actions described below for both general and subspecialty programs when they are proposed. It should be emphasized that if an adverse action is confirmed, all residents in the program must be notified. **Any and all communications with the ACGME must be reviewed, approved and countersigned by the Designated Institutional Official.**

It should also be noted that in addition to the adverse actions below, accreditation with warning may be issued by the RC to advise a Program Director of serious concerns about the quality of the program. Because this is not considered to be an adverse action, it is not subject to appeal.

Policies and procedures for the ACGME may be found using the following link: https://www.acgme.org/acgmeweb/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf

A. ACCREDITATION STATUS FOR CORE PROGRAMS

Subsequent to a site visit from the RC, the ACGME confers an accreditation status on the program and identifies areas of noncompliance with Institutional and/or Program Requirements. Types of accreditation actions are listed below.

1. Withheld Accreditation

Accreditation is withheld when an RC determines that the application for a new program does not demonstrate substantial compliance with the requirements.

2. Initial Accreditation

Accreditation is conferred initially when an RC determines that a proposal for a new program substantially complies with the requirements.

3. Continued Accreditation

Accreditation is continued when an RC determines that a program has demonstrated substantial compliance with the requirements. Typically, the maximum length of the cycle awarded by the RC is five years. Cycle length is based upon the accreditation status, issues identified by the RC, and areas of noncompliance.

4. Continued Accreditation With Warning

Continued Accreditation with Warning is conferred when the RC determines that a program or sponsoring institution has areas of non-compliance that may jeopardize its accreditation status. Programs with the status of Continued Accreditation with Warning may not request a permanent increase in resident complement

5. Probationary Accreditation

Probationary accreditation is conferred when an RC determines that a program has failed to demonstrate substantial compliance with the requirements. The length of the review cycle for this status may not exceed two years.

An RC may withdraw accreditation of a program under probationary accreditation when it determines, following a site visit and review that a program has failed to demonstrate substantial compliance with the requirements.

Regardless of a program's accreditation status, an RC may withdraw the accreditation of a program in an expedited process based on clear evidence of noncompliance with accreditation standards due to a catastrophic loss of resources, including faculty, facilities, or funding, or egregious noncompliance with accreditation requirements.

B. ACGME REQUIREMENTS FOR ALL RESIDENCY PROGRAMS

The ACGME maintains requirements for institutional sponsorship of programs and for specific training programs in general and subspecialty areas. These Institutional and Program Requirements may be found on the [ACGME website](#). These requirements supplement the policies and procedures of the Consortium and of the institution at which the program is based. Program Directors should also refer to the House Staff Manual for additional policies. The following information is intended to assist Directors in meeting ACGME requirements efficiently and comprehensively.

1. Web Accreditation Data System (ADS) and Other GME Data Collection Systems

The [Web Accreditation Data System \(WebADS\)](#) is a secure Internet-based data collection system on the ACGME's website that collects and maintains information on residents, program structure and leadership, RC activity for the program, and sponsoring institutions. Similar information is to be posted to the AAMC's [GME Track Census](#), which feeds into the AMA's [FREIDA](#) online system.

The GME Database Administrator may assist programs in uploading basic resident data from New Innovations to WebADS. However, each program must log in to both New Innovations and WebADS to update general program information and to accept/approve the uploaded records. User names and passwords are provided directly to Program Directors by the ACGME and the AAMC.

2. Continued Accreditation Process

In the new accreditation process, the relevant Review Committee will review all programs annually. The Review Committee will confer an accreditation decision of Continued Accreditation based on satisfactory ongoing performance of the program. When a program's performance is deemed unsatisfactory, or when performance parameters are unclear, the Review Committee may change the program's accreditation status or request a site visit and/or additional information prior to rendering a decision.

The Review Committee may use the following information to assess programs:

- a. Continuous Data Collection/Review ADS annual update
 - i. Resident Survey
 - ii. Faculty Survey
 - iii. Milestone data
 - iv. Certification examination performance
 - v. Case Log data
 - vi. Hospital accreditation data
 - vii. Faculty and resident scholarly activity and productivity

- viii. Other information

- b. Episodic Information:
 - i. ACGME Complaints
 - ii. Verified public information
 - iii. Historical accreditation decisions/citations
 - iv. Institutional quality and safety metrics

Upon review of annual data, the Review Committee has the following options:

- a. The Committee may confer the existing accreditation status based on information described
- b. The Committee may request additional information prior to making an accreditation decision. The following options are available to the Review Committee:
 - i. Request clarifying information
 - ii. Initiate a focused site visit (“announced” or “unannounced”)
 - iii. Initiate a full site visit

After review of any additional information, the Review Committee will confer an accreditation status (see below).

The Committee may change the existing accreditation status based on the information described and may confer one of the following accreditation statuses/options:

- a. Continued Accreditation
- b. Continued Accreditation with Warning
- c. Probationary Accreditation– (A program or sponsoring institution with the accreditation status of Continued Accreditation must undergo a site visit before a Review Committee may confer Probationary Accreditation upon it.)
- d. Withdrawal of Accreditation– (A program or sponsoring institution must undergo a site visit before a Review Committee may confer Withdrawal of Accreditation upon it.)
- e. Recommend Administrative Withdrawal
- f. Changes in Resident Complement
- g. Recommend invoking the Alleged Egregious Violation Policy

At the time it issues an accreditation decision, the Review Committee may:

- a. Recognize and commend exemplary performance or innovations in GME;
- b. Identify areas for program improvement;
- c. Identify concerning trends;
- d. Issue new citations;
- e. Continue previous citations;
- f. Acknowledge program’s correction of previous citation(s),
- g. Increase or reduce resident complement, or

- h. Request a progress report.

After achievement of a status of Continued Accreditation, a program or sponsoring institution will submit a self-study, undergo a site visit, and receive an accreditation decision from the relevant Review Committee every 10 years. The first program self-study date will be set by the ACGME administration in consultation with the Review Committee.

The information available to the Review Committee includes the self-study document and all data and the site visitor report.

For the self-study, the Review Committee has the following accreditation status options:

- a. Continued Accreditation
- b. Continued Accreditation with Warning
- c. Probationary Accreditation
- d. Withdrawal of Accreditation
- e. Recommend Administrative Withdrawal
- f. Changes in Resident Complement
- g. Recommend Invoking the Alleged Egregious Violation Policy

The Review Committee Executive Director prepares the Letter of Notification for each program or sponsoring institution. The Program/Institutional Letter of Notification shall state the action(s) taken by the Review Committee and the current accreditation status.

3. *Correspondence with RCs*

As Designated Institutional Official, the Senior Associate Dean for Graduate Medical Education at ISMMS must review and cosign all correspondence to a RC. GMEC review and approval is required prior to DIO signature. Program directors are required to communicate with the RC when information is requested or before major changes are made to a program. Types of submissions to the RC include:

- a. Accreditation applications for new programs
- b. Changes in resident complement
- c. Major changes in program structure or length of training
- d. Additions and deletions of participating sites
- e. Appointments of new program directors
- f. Progress reports requested by any RC
- g. Responses to all proposed adverse actions
- h. Requests for exceptions of resident duty hours
- i. Voluntary withdrawal of accreditation
- j. Requests for an appeal of an adverse action
- k. Appeal presentations to a Board of Appeal or the ACGME

It should be noted that complement change requests and new program director appointments must be submitted through WebADS. The Office for Graduate Medical Education is available to provide assistance in composing correspondence to an RC.

4. *Core Competencies*

The ACGME mandates that a residency program must require its residents to attain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families

- Gather essential and accurate information about their patients

- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment

- Develop and carry out patient management plans

- Counsel and educate patients and their families

- Use information technology to support patient care decisions and patient education

- Perform competently all medical and invasive procedures considered essential for the area of practice

- Provide health care services aimed at preventing health problems or maintaining health

- Work with health care professionals, including those from other disciplines, to provide patient-focused care

Medical Knowledge about established and evolving biomedical, clinical and cognate (i.e. epidemiological and social/behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- Demonstrate an investigatory and analytic thinking approach to clinical situations

- Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Residents are expected to:

Analyze practice experience and perform practice-based improvement activities using a systematic methodology

Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

Obtain and use information about their own population of patients and the larger population from which their patients are drawn

Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

Use information technology to manage information, access on-line medical information; and support their own education

Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills that result in effective information exchange and collaboration with patients, their families, and other health professionals. Residents are expected to:

Create and sustain a therapeutic and ethically sound relationship with patients

Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills

Work effectively with others as a member or leader of a health care team or other professional group

Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development

Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

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

Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice

Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources

Practice cost-effective health care and resource allocation that does not compromise quality of care

Advocate for quality patient care and assist patients in dealing with system complexities

Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Table 5				
EVALUATION TOOLS				
Patient Care	OSCE	Mini CEX	Patient Surveys	Procedure Logs
Medical Knowledge	Chart-Stimulated Recall	Oral Exam	Written Multiple-Choice Exam	
Interpersonal and Communication Skills	360-Degree	Patient Surveys	Standardized Patients	
Professionalism	360-Degree	Checklist		
Practice-Based Learning	Resident Portfolios	Chart/EMR Review		
Systems-Based Practice	Resident Portfolios	360-Degree	Resident specific outcomes measures	
Other Tools Designed by the Program				

Goals and Objectives must be developed by year of training and for each rotation. There are a number of ways to teach and assess the Competencies (Table 5 above). Program Directors are encouraged to utilize the materials that best suit the program's needs.

During Special Reviews by the Office for Graduate Medical Education, the Special Review Subcommittee reviews the program's compliance with the Core Competencies, including corrective plans for residents who have demonstrated deficiencies in any of the Competencies.

Program directors should also read Section VI.I-J in this Manual for information about assessment methods for attainment of the Competencies.

5. *Curriculum*

Each residency program must establish and distribute to residents a curriculum containing goals and objectives for the residency. Goals and objectives must be delineated by rotation and by year of training. Before the beginning of each rotation, program faculty must review the rotation's goals and objectives with each resident. Programs are required to use the Curriculum Module in New Innovations to distribute the goals and objectives prior to the beginning of each rotation. Program faculty and resident representatives must have annual, documented meetings to review the curriculum as described below.

6. *Program Letter of Agreement*

The ACGME requires that a Program Letter of Agreement (PLA) be developed for each institution to which residents rotate for required education and assignments. This Agreement is with ISMMS and an affiliated institution. **It is the policy of ISMMS that a PLA be developed for all assignments, whether required or elective.**

The PLA must contain the following information:

- a) The names of all faculty who will assume both educational and supervisory responsibilities for residents;
- b) Faculty responsibilities for teaching, supervision, and formal evaluation of residents;
- c) The duration and content of the educational experience;
- d) The policies and procedures that will govern resident education during the assignment;
- e) Competency-based, program- level specific goals and objectives for the experience.

The required form for PLAs for rotations within the Consortium is Appendix 2 to this Manual. The form for rotations to non-Consortium hospitals is Appendix 3. The form for rotations to non-hospital sites— including ambulatory care sites and private physicians' offices—is Appendix 4. Drafts of all PLA's should be sent to the GME Office for review before signature. Once approved, all other signatures should be obtained before forwarding to the DIO for signature

7. ACGME Milestones

When the ACGME made the move to continuous accreditation, specialty groups worked together to develop outcomes-based **Milestones** as a framework for determining resident and fellow performance within the six ACGME Core Competencies.

What are Milestones?

Simply defined, a milestone is a significant point in development. The Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident or fellow physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

Who developed the Milestones?

Each specialty's Milestones Working Group was co-convened by the ACGME and relevant American Board of Medical Specialties (ABMS) specialty board(s), and was composed of ABMS specialty board representatives, program director association members, specialty college members, ACGME Review Committee members, residents, fellows, and others.

Why Milestones?

First and foremost, the Milestones are designed to help all residencies and fellowships produce highly competent physicians to meet the health and health care needs of the public. To this end:

The Milestones serve important purposes in program accreditation by:

Allowing for continuous monitoring of programs and lengthening of site visit cycles
Providing Public Accountability – report at a national level on aggregate competency outcomes by specialty

Establishing a community of practice for evaluation and research, with focus on continuous improvement of graduate medical education (GME)

For educational (residency/fellowship) programs, the Milestones:

Provide a rich, descriptive, developmental framework for Clinical Competency Committees (CCCs)

Guide curriculum development

Support better assessment practices

Enhance opportunities for early identification of struggling residents and fellows

For residents and fellows, the Milestones:

Provide more explicit and transparent expectations of performance
Support better self-directed assessment and learning
Facilitate better feedback for professional development

How are the Milestones used by the ACGME?

Resident/fellow performance on the Milestones provides a source of specialty-specific data for each specialty Review Committee to use in assessing the quality of residency and fellowship programs nationally, and for programs to use in facilitating improvements to curricula and resident performance if and when needed. The Milestones are also used by the ACGME to demonstrate accountability of the effectiveness of GME within ACGME-accredited programs in meeting the needs of the public.

The ACGME requires that resident Milestones be entered in ADS twice yearly. Deadlines are firm and the reporting windows are typically from early November – early January, and before the end of each academic year.

C. Special Reviews

I. Overview

The subcommittees of the Graduate Medical Education Committee (GMEC) are responsible for conducting reviews of residency programs sponsored by Icahn School of Medicine at Mount Sinai (the “School”) to assess their compliance with Institutional and Program Requirements of the Accreditation Council for Graduate Medical Education (ACGME). These may be comprehensive reviews of the entire program or more focused reviews, depending of the issues identified.

The GMEC subcommittees designate the School’s Office for Graduate Medical Education (“GME Office”) to maintain and update information regarding the quality of sponsored residency programs, to provide this information, as needed to the GMEC subcommittees, and to coordinate, participate in, and document Special Reviews as warranted.

Special Reviews are conducted by members of the GMEC subcommittees, staff of the GME Office and resident representatives, and follows the procedures outlined below. The GMEC reviews findings and recommendations from all Special Reviews.

II. Criteria

GMEC subcommittees identify potentially underperforming programs for Special Review. Criteria for underperformance include, but are not limited to:

- A. Significant ACGME noncompliance as reported in ACGME letters of notification;
- B. Significant noncompliance with applicable law, e.g., as reported in IPRO

- survey results;
- C. Significant ACGME Resident Survey noncompliance;
- D. Significant ACGME Faculty Survey noncompliance;
- E. Concerns communicated to the GME Office or GMEC subcommittee members by residents, faculty, or staff;
- F. Failure to submit required information in a timely and/or complete fashion;
- G. Concerns regarding resident educational outcomes, including low board pass rates;
- H. Deficient or uneven resident procedural experience as evidenced by ACGME Case Logs;
- I. Significant resident or faculty attrition;
- J. Significant duty hour noncompliance identified in internal monitoring processes;
- K. Insufficient resident participation in patient safety and quality activities;
- L. Insufficient scholarly activity by residents and/or faculty; and/or
- M. Program-specific issues identified by the GMEC or its subcommittees.

III. Composition

A Special Review is conducted by no fewer than 3 and no more than 8 representatives, including:

- A. *Administration*: At least 1 representative from the GME Office;
- B. *Faculty*: At least 1 faculty member from departments other than the program being reviewed; and
- C. *Residents*: At least 1 resident from a sponsored residency program.

IV. Program Information

Prior to the Special Review, each participant is provided with the following materials:

- A. The pertinent ACGME Institutional and Program Requirements;
- B. Previous ACGME accreditation letters and any subsequent correspondence to or from the ACGME;
- C. Previous, relevant Internal Review or Special Review reports and any subsequent progress reports;
- D. The results of ACGME Resident and Faculty Surveys;
- E. The results of the most recent Annual Program Review;
- F. The most recent ACGME Annual Update;
- F. The written corrective plan for ACGME citations (if applicable); and
- G. Duty hours monitoring results.

V. Review of Documents

The program under review is responsible for compiling written information requested by the Special Review representatives prior to the Special Review. Such information may include:

- A. A questionnaire provided by the GME Office.
- B. Goals and objectives for each year of training and for each rotation. (The program's full curriculum must be available for review in the Curriculum module of New Innovations.)
- C. Departmental policies regarding the supervision of residents.
- D. Departmental policies regarding resident duty hours (including moonlighting).
- E. Curriculum vitae for key program faculty. (In core programs, a list of relevant qualifications and representative publications will suffice.)
- F. Samples of all evaluation forms used in residency education, including evaluations of residents, faculty, rotations, and the program.
- G. A summary of evaluation tools.

The program may be asked to provide supplemental information (e.g., resident portfolios) at the time of the Internal Review.

VI. Meeting with Program Director

The Special Review representatives meet with the Program Director to assess compliance with ACGME Common and Institutional Requirements as well as specialty/subspecialty requirements. The meeting may focus on components of the educational program, including:

- A. Areas related to ACGME Common, specialty-specific, and Institutional Requirements, including professionalism, personal responsibility, and patient safety; transitions of care; alertness management/fatigue mitigation; supervision of residents; clinical responsibilities; teamwork; and resident duty hours.
- B. Educational goals and objectives of the program.
- C. Instructional plans formulated to achieve these objectives that encompass the six Core Competencies: Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practiced-Based Learning and Improvement, and Systems-Based Practice:
 - 1. Assessment as to whether each program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate attainment of the Core Competencies.
 - 2. Provision of evidence of the program's use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas.
 - 3. Appraisal of the development and use of dependable outcome measures by the program for each of the general competencies.
 - 4. Appraisal of the effectiveness of each program in implementing a process that links educational outcomes with resident competency.
- D. Adequacy of available resources to meet these objectives.
- E. Implementation of the Next Accreditation System, including milestones assessments and Clinical Competency Committee activities.
- F. Effectiveness of the program in:
 - 1. Utilizing resources provided.
 - 2. Supervising residents.

3. Addressing recommendations of previous Internal Reviews.
 4. Addressing recommendations of previous ACGME surveys.
 5. Developing a program to evaluate ACGME Core Competencies.
 6. Implementing a process that links educational outcomes with program improvements.
- G. Adequate scholarly activity by residents and faculty.
 - H. Professional development of faculty and residents.
 - I. Process and documentation of evaluations of the residents, faculty, and the program.
 - J. Results of the Annual Program Review, including resident performance, faculty development, performance of graduates on certifying board examinations, and program quality.

VII. Meeting with Key Faculty

The Special Review representatives meet with key faculty members to assess ACGME compliance and to discuss their experiences in the educational program. The Program Director is responsible for ensuring the availability of key faculty. The number of key faculty should be determined as follows:

In programs training no more than 5 residents, at least 2 core faculty members should attend.

In programs training 6 to 12 residents, at least 3 core faculty should attend.

In programs training 13 to 19 residents, at least 4 core faculty should attend.

In programs training 20 to 39 residents, at least 5 core faculty should attend.

In programs training more than 40 residents, at least 6 core faculty should attend.

In programs with 12 or fewer residents, the meeting with faculty may be combined with the program director meeting. If there are required rotations outside of the hospital where the program is based, there should be faculty representation for each major participating site.

VIII. Meeting with Residents

The Special Review representatives meet with at least one resident representative from each year of the program without the program director and faculty present. The purpose of this meeting is to review residents' perceptions of the strengths and weaknesses of the program, including the residents' perception of the program's performance in the areas listed in Sections II and IV above. If there are no residents in the program, a second Special Review will be conducted once a resident has begun training.

The Special Review representatives may obtain information concerning:

- A. The systems used to improve the work environment and educational program.
- B. The processes used to address resident concerns in a confidential and protected manner.
- C. The means of redress for complaints and grievances that could result in dismissal

- from the program.
- D. Supervision of residents during all clinical activities.
 - E. Residents' access to their files (including evaluations).
 - F. Residents' confidential evaluations of the faculty, rotations, and the educational program.
 - G. Instruction and support to provide compassionate, appropriate, and effective patient care and to meet the training objectives inherent in the ACGME Core Competencies.
 - H. Provision of all conditions of appointment to all prospective residents at the time of interview.
 - I. Resident participation in departmental committees.
 - J. Verification of the information supplied by the program.

IX. Final Report

Within one month of the Special Review meetings, the chair(s) of the review and the Co-Chairs of the relevant GME subcommittee will receive a draft of the written Special Review report, prepared by the GME Office staff member who attended the review. After any feedback is incorporated, and within two months of the Special Review meetings, the GME Office staff person sends the final Special Review report to the Program Director, with copies to the Dean of the School, the Chair and/or Division Chief of the department under review, and the Hospital President.

For comprehensive reviews, the report contains:

- A. A description of the issue(s) that prompted the review.
- B. Assessment of compliance with ACGME Common, specialty-specific, and Institutional Requirements, including any recommended quality improvement goals or required corrective actions.
- B. Information including the name of the program; the participants in the Special Review; a description and documentation of the Special Review process; an assessment of correction of any previous citations or concerns; and discussion of the progress in addressing internal or ACGME citations and concerns.
- C. Verification of the existence of a curriculum with goals and objectives delineated by rotation and year of training.
- D. Assessment of the program's methods for evaluating the residents, faculty, and curriculum.
- E. A summary of the tools being developed and implemented by the program for instruction and assessment concerning the ACGME Core Competencies and the Next Accreditation System.
- F. Confirmation of appropriate supervision of residents in the program.
- G. Evaluation of scholarly activity as defined by the ACGME.
- H. Evaluation of residents' participation in educational and professional activities, including professional development, quality and patient safety activities, and membership on departmental committees.
- I. Comments on the results of the Resident or Faculty Survey (if applicable).
- J. The process for GMEC and subcommittee monitoring for corrective actions.

For focused reviews, the report contains:

- A. A description of the issue(s) that prompted the review.
- B. Information including the name of the program; the participants in the Special Review; a description and documentation of the Special Review process, a summary of the findings, and recommended corrective actions, if any.
- C. The process for GMEC and subcommittee monitoring for corrective actions.

X. GMEC Oversight and Progress Reports

The GMEC considers the recommendations and takes appropriate action to ensure that the Program Director and the institution follow the recommendations. In most cases, GMEC subcommittees are responsible for setting timelines for correction and reporting by the reviewed programs.

If the Special Review report recommends improvements, the Program Director must submit to the co-chairs of the relevant GMEC subcommittee, and to the Designated Institutional Official, or DIO, a progress report detailing the program's progress in correcting areas of noncompliance with ACGME standards and concerns raised by residents during the Internal Review. The progress report is due by the deadline specified by the GMEC subcommittee. The DIO presents the progress report to the GMEC for review. The GMEC or subcommittee may accept the progress report or request additional action, which may include a subsequent Special Review.

D. ANNUAL UPDATE

The ACGME requires each program to submit an annual update, which is used by your RRC to determine the program's status in its new, continuous accreditation model. This is typically due in September of the academic year; the GME Office MUST review the information in your Annual Update before it is submitted as final to the ACGME.

The following information is collected:

Program Information

1. Primary teaching site.
2. Duty Hour/Learning Environment section.
3. Program address information.
4. Responses for all current citations.
5. Update of major changes in the program
6. Overall Evaluation Methods
7. Update program Director email.
8. Program Director certification information.
9. Clinical training sites and information for each institution.
10. Current block diagram (instructions for the proper development of the Block Diagram may be found using the following link:
<https://apps.acgme.org/ads/Content/Downloads/BlockDiagramInstructions.pdf>
- an example is presented below.

Resident Information

1. Confirm all residents.
2. Update scholarly activity for each resident.

Faculty Information

1. Enter profile information for all physician and non-physician faculty.
2. Enter all required CV information for your physician faculty and ALL non-physician faculty (required by your specialty).
3. Update scholarly activity for each physician faculty member.

Sample Block Diagrams

Block Diagram 1⁽¹⁾ In this example, the year's rotations are divided into 12 (presumably one-month) clinical rotations. Rotations may include structured outpatient or research time and electives.

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2	Site 3	Site 3	
Rotation Name	Wards	Wards	ER	CCU	ICU	Wards	ER	ICU	Clinic	Wards	Clinic	Elec/Vac
% Outpatient	20	20	100	0	0	40	100	0	100	20	100	
% Research	0	0	0	0	0	0	0	0	0	0	0	

Block Diagram 2⁽¹⁾ In this example, the year's rotations are divided into 13 equal (presumably four-week) clinical rotations. Rotations may include structured outpatient or research time, and electives.

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2	Site 3	Site 3	Site 3	
Rotation Name	Wards	Wards	ER	CCU	ICU	Wards	Wards	ICU	Clinic	Wards	Wards	Clinic	Elec/Vac
% Outpatient	30	30	100	0	0	20	20	0	100	0	0	100	
% Research	0	0	0	0	0	0	0	0	0	0	0	0	

Block Diagram 3⁽¹⁾ In this example, the year's rotations are divided into six blocks of equal duration. One of the blocks is used for an elective, which can be chosen from a list of elective rotations and a vacation month.

Block	1	2	3	4	5	6
Site	Site 1	Site 1	Site 2	Site 2	Site 3	
Rotation Name	CCU	Med. Outpt.	Wards	ER	Wards	Elective/Vacation
% Outpatient	0	100	0	100	0	
% Research	0	0	0	0	0	

Possible electives:

Cardiology Inpatient Site 1	Pulmonary Disease Outpatient Site 3
Cardiology Outpatient Site 2	Gastroenterology Inpatient Site 3
Pulmonary Disease Inpatient Site 2	Gastroenterology Outpatient Site 1

Block Diagram 4⁽¹⁾ In this example for a subspecialty program, the year's rotations are divided into four equal blocks. Structured research time comprises 40% of the resident's time on the specialty outpatient month. There is one three-month block devoted entirely to research.

Block	1	2	3	4
Site	Site 1	Site 2	Site 2	
Rotation Name	Specialty Outpatient	Specialty Outpatient	Wards	Research
% Outpatient	100	100	0	
% Research	0	40	0	100

(1) In any block diagram, there must be a formal allocation for vacation time. If not shown in the block diagram, a "Notes" section must indicate how vacation time is taken.

E. ANNUAL PROGRAM REVIEW (APR)

The ACGME also requires all programs to perform an annual self-assessment. This Annual Program Review (APR) is performed by your Program Evaluation Committee (PEC) and is documented in the Annual Program Evaluation (APE) form New Innovations. The PEC should include faculty representatives from all participating sites and resident representatives from each year of the program. The form is divided into sections that correspond to those on the ACGME Resident Survey. As part of the APE programs are required to submit a number of supplemental documents and to create Action Plans that address areas of concern identified by the ACGME or by the PEC.

To ensure a uniform level of academic rigor across all of our programs, ALL programs, whether they are accredited by the ACGME, a Board, a specialty society or are unaccredited, must complete an APR and fill out an APE.

The GME Office reviews all APEs. All suggested revisions must be incorporated into the final document.

F. RESIDENT/FELLOW SURVEY

The ACGME's Resident/Fellow Survey is an additional method to monitor graduate medical education and to provide early warning of potential noncompliance with ACGME accreditation standards. All core specialty programs (regardless of size) and subspecialty programs (with four or more fellows) are surveyed every year between January and June. Aggregate reports will be made available to programs with four or more residents if a 70% response rate is reached.

This Survey is administered yearly and the information gathered will be used at the time of the program's yearly accreditation review. The ACGME will notify programs directly when their participation is required. This notification will include detailed information on accessing the Survey and a deadline for completion. Residents/fellows will have six weeks to complete the survey.

Upon notification, Program Directors should meet with the house staff as soon as is feasible to review the login process and to provide background information about the Survey. Residents should be reminded to read the questions carefully, Program Directors may also remind residents of institutional and program resources such as the lecture on resident fatigue and alertness management at Orientation; various functionalities of the New Innovations Residency Management Software; and the GME Office, the Ombuds Office and the House Staff Council.

The GME Office reviews the aggregated Survey results for all programs with four or more trainees. In accordance with GMEC policy, the Senior Associate Dean for GME will request the Program Director's systematic review when the Survey reports any duty hour noncompliance or noncompliance of 20% or greater in any other areas. Program Directors must create written corrective action plans for

noncompliant areas; the plans are reviewed by the GMEC. Programs with significant noncompliance must administer a follow-up survey of the residents using a questionnaire in New Innovations, and must create additional corrective action plans as warranted. As noted above in the section on Special Reviews, significant ACGME Resident Survey noncompliance is one of the criteria areas that may trigger the Special Review of a program.

The content areas for the Resident Survey include:

Duty Hours

- 80 hours
- 1 day free in 7
- In-house call no more frequently than every 3rd night
- Night float no more than 6 nights in a row
- 8 hours between duty periods (differs by level of training)
- Continuous hours scheduled (differs by level of training)

Reasons for exceeding duty hours (if noted):

Patient needs

- Paper work
- Additional educational experiences Cover someone else's work
- Night float
- Schedule conflict

Faculty

- Sufficient supervision
- Appropriate supervision
- Sufficient instruction
- Faculty and staff interested
- Faculty and staff create environment of inquiry

Evaluation

- Have access to evaluations
- Evaluate faculty
- Evaluations of faculty confidential
- Evaluate program
- Evaluations of program confidential
- Program uses evaluations to improve
- Satisfied with feedback after assignments

Educational content

- Provided goals and objectives for assignments
- Instructed to manage fatigue
- Satisfied with scholarly activities
- Appropriate balance for education
- Education (not) compromised by service

- Supervisors delegate appropriately
- Provided data to show effectiveness
- Variety of Patients

Resources

- Access to reference materials
- Electronic medical record in hospital
- Electronic medical record in ambulatory
- Electronic medical records integrated
- Electronic medical record effective
- Way to transition care when fatigued
- Process for problems and concerns
- Education (not) compromised by other trainees
- Residents can raise concerns without fear

Patient Safety

- Tell patients of respective role of residents
- Culture reinforces patient safety responsibility
- Participated in quality improvement
- Information (not) lost during shift changes

Teamwork

- Work in interprofessional teams
- Effectively work in interprofessional teams

Overall evaluation of program

G. FACULTY SURVEY

The ACGME's Faculty Survey is another method to monitor graduate medical education and to provide early warning of potential noncompliance with ACGME accreditation standards. All core specialty programs (regardless of size) and subspecialty programs (with four or more fellows) are surveyed every year between January and June. Aggregate reports will be made available to programs with four or more residents if a 60% response rate is reached.

This Survey is administered yearly and the information gathered will be used at the time of the program's yearly accreditation review. The ACGME will notify programs directly when their participation is required. This notification will include detailed information on accessing the Survey and a deadline for completion. Faculty will have six weeks to complete the survey.

Faculty will be asked questions in the following areas, and will be asked to base their responses on experiences in the current academic year:

Faculty Supervision and Teaching

Hours spent teaching and supervising residents

- Sufficient time to supervise residents
- Residents seek supervisory guidance
- Faculty and PD as effective educators

Educational Content

- Worked on scholarly project with residents
- Residents see patients across a variety of settings
- Residents receive education to manage fatigue
- Effectiveness of beginning residents in performing clinical duties
- Effectiveness of intermediate residents in performing clinical duties
- Effectiveness of advanced residents in performing clinical duties

Resources

- Program provides a way for residents to transition care when fatigued
- Resident workload exceeds capacity to do the work
- Satisfied with faculty development to supervise and educate residents
- Satisfied with process to deal with residents' problems and concerns
- Prevent excessive reliance on residents to provide clinical service

Patient Safety

- Information not lost during shift changes or patient transfers
- Tell patients of respective roles of faculty and residents
- Culture reinforces patient safety responsibility

Teamwork

- Program effective in teaching teamwork skills
- Residents communicate effectively when transferring clinical care
- Residents effectively work in interprofessional teams

Overall evaluation of program

H. CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)

As a component of its next accreditation system, the ACGME has established the Clinical Learning Environment Review (CLER) program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites.

The information below provides specifics about the institution’s approach to CLER’s six focus areas:

Area including subtopics	Mount Sinai initiatives
<p>Patient Safety – including opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.</p>	<ul style="list-style-type: none"> • MERS - accessible from all work stations • Multidisciplinary rounds • Resident participation in Morbidity and Mortality Conferences, Adverse Events investigations (huddles, debriefs, RCAs)
<p>Quality Improvement – including how sponsoring institutions engage residents in the use of data to improve systems of care reduce health care disparities and improve patient outcomes.</p>	<ul style="list-style-type: none"> • Resident Quality Council • Resident participation in QI meetings • Several departments with collaborations with Department of Health Evidence and Policy to reduce disparities; ACO can include race, ethnicity in reports • Residents provided with individual data to assess clinical effectiveness
<p>Transitions in Care – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.</p>	<ul style="list-style-type: none"> • Adopted SBAR format as institution standard – lecture at Orientation and department specific training • GME Committee approved new institutional policy • Department specific handoff forms in Epic • Pilot project in Medicine and Surgery to standardize transmit and document acuity status – full rollout for 2014-15 academic year
<p>Supervision – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.</p>	<ul style="list-style-type: none"> • Institution-wide and additional department-specific polices – lecture at Orientation and department specific training • GME Office reviews policies each year and monitors compliance through ACGME Resident Survey • New Innovations used to track attainment of procedural competency; nursing staff have access for verification*
<p>Duty Hours Oversight, Fatigue Management and Mitigation – including how sponsoring institutions: (i) demonstrate effective and meaningful oversight of duty hours across all residency programs institution-wide; (ii) design systems and provide settings that facilitate fatigue management and mitigation; and (iii) provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.</p>	<ul style="list-style-type: none"> • Institution-wide and additional department-specific polices – lecture at Orientation and department specific training • GME Office reviews policies each year • Logging done in New Innovations – at minimum 4-weeks/quarter with daily logging in many programs • GME Office and GME Committee monitors compliance through ACGME Resident Survey and review of quarterly compliance reports submitted to GME

	Office and GME Committee
<p>Professionalism—with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of residents and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.</p>	<ul style="list-style-type: none"> • Professionalism among many topics presented at Orientation • GME office acts as liaison between programs and Legal/HR • GME Office reviews all submissions to ACGME • GME Office reviews program policies each year and monitors compliance through ACGME Resident Survey

*Nursing staff able to check privileges in real time:

www.new-innov.com

Institution = MSSM (case sensitive)

Login ID = nurse1

Password = 123@nurs

Logger>Privilege Report

Enter name – privileges listed by level of supervision required – those classified as Independent can be done by the resident without direct supervision

IV. NEW YORK STATE REQUIREMENTS

A. NEW YORK STATE EDUCATION LAW

1. *Licensure*

House officers in programs accredited by any official body do not have to be licensed; those in un-accredited programs must obtain licenses. Graduates of American, Puerto Rican, and Canadian medical schools who have passed all parts of the United States Medical Licensing Examination (USMLE) can apply for licensure in the State of New York after satisfactorily completing one year of residency training in an ACGME-accredited program. Graduates of foreign medical schools who have passed all parts of the USMLE and who have received ECFMG certification may also apply for licensure after three years of training in an ACGME-accredited residency program. Physicians in ACGME-accredited residency programs who practice medicine under supervision are not specifically required by New York State to have a license or a limited permit.

2. *Limited Permits*

A limited permit allows an individual to practice medicine only under the supervision of a licensed physician and only in a public, voluntary, or proprietary hospital. The limited permit is valid for only two years but may be renewed biannually at the discretion of the department.

In accordance with Article 131, Section 6525 of New York State Education Law, the following individuals are considered eligible for a limited permit:

- a. A person who fulfills all requirements for a license as a physician except those relating to the examination and citizenship or permanent residence in the United States;
- b. A foreign physician who holds a standard certificate from the Educational Commission for Foreign Medical Graduates or who has passed an examination satisfactory to the State Board for Medicine and in accordance with the commission's regulations; or
- c. A foreign physician or a foreign intern who is in the country on a non-immigration visa for the continuation of medical study, pursuant to the exchange student program of the United States Department of State.

The fee for each limited permit and for each renewal is \$105.

3. *Practice of Medicine within the State without Either a License or Limited Permit*

It is possible to be exempt from having either a license or a limited permit in accordance with New York State Education Law, Article 131, Section 6526. Under the following limitations, a person may practice medicine within the State without a license:

- a. Any physician who is employed as a resident in a public hospital provided such practice is limited to such hospital and is under the supervision of a licensed physician;
- b. Any physician who is licensed in a bordering state and who resides near a

border of this state, provided such practice is limited in this state to the vicinity of such border and provided such physician does not maintain an office or place to meet patients or receive calls within this state;

- c. Any physician who is licensed in another state or country and who is meeting a physician licensed in this state for purposes of consultation, provided such practice is limited to such consultation;
- d. Any physician who is licensed in another state or country, who is visiting a medical school or teaching hospital in this state to receive medical instruction for a period not to exceed six months, or to conduct medical instruction, provided such practice is limited to such instruction and is under the supervision of a licensed physician;
- e. Any physician who is authorized by a foreign government to practice in relation to its diplomatic, consular, or maritime staffs, provided such practice is limited to such staffs;
- f. Any commissioned medical officer who is serving in the United States Armed Forces or public health service, or any physician who is employed in the United States Veterans Administration, provided such practice is limited to such service or employment;
- g. Any intern who is employed by a hospital and who is a graduate of a medical school in the United States or Canada, provided such practice is limited to such hospital and is under the supervision of a licensed physician;
- h. Any medical student who is performing a clinical clerkship or similar function in a hospital and who is matriculated in a medical school that meets standards satisfactory to the department, provided such practice is limited to such clerkship or similar function in such hospital;
- i. Any dentist or dental school graduate eligible for licensure in the state who administers anesthesia as part of a hospital residency program established for the purpose of training dentists in anesthesiology;

However, consistent with Section 405.4 of the New York State Health Code, residents who are unlicensed, even those with limited permits, must be appropriately monitored. As such, the Program Director must:

- j. Review the licensure, education, training, physical and mental capacity, and experience of individuals practicing under the provisions of this subdivision;
- k. Based on written criteria, recommend privileges that are specific to treatments and procedures for each individual prior to delivery of patient care services;
- l. Continuously monitor patient care services provided by such individuals to assure provision of quality patient care services within the scope of privileges granted; and
- m. Take disciplinary action or other corrective measures against the individual providing service and/or the attending/supervising physician when services provided exceed the scope of privileges granted.

Additional information regarding licensure is available on the [New York State Department of Education website](#).

B. PROFESSIONAL MISCONDUCT

1. Types of Misconduct

New York State law defines the parameters of misconduct. The following is a summary of the most significant types of professional misconduct that must be reported. The complete text of this act can be found in Article 131-A (Definitions of Professional Misconduct Applicable to Physicians, Physician Assistants, and Specialist Assistants) of New York State Law.

- a. Obtaining the license fraudulently
- b. Practicing the profession fraudulently or beyond its authorized scope
- c. Practicing the profession with negligence on more than one occasion
- d. Practicing the profession with gross negligence on a particular occasion
- e. Practicing the profession with incompetence on more than one occasion
- f. Practicing the profession with gross incompetence
- g. Practicing the profession while impaired by alcohol, drugs, physical disability or mental disability
- h. Being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, except for a licensee who is maintained on an approved therapeutic regimen which does not impair the ability to practice, or having a psychiatric condition which impairs the licensee's ability to practice
- i. Being convicted of committing an act constituting a crime
- j. Being found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was made would, if committed in New York State, constitute professional misconduct under New York State law
- k. Accepting and performing professional responsibilities that the practitioner knows s/he is not competent to perform
- l. Delegating professional responsibilities to a person when the practitioner knows or has reason to know such person is not qualified to perform them
- m. Performing professional services that have not been duly authorized by the patient or his or her representative
- n. Altering or falsifying medical records in such a way that needed information for patient care is omitted or falsified
- o. Fee splitting

2. Additional Reporting Requirements

In addition to the requirement that a physician be reported for conduct described above,

any licensed health care professional and any physician in training must be reported if the following should occur:

- a. The suspension, restriction, termination, or curtailment of the training, employment, association, or professional privileges of a licensed health care practitioner, or medical resident, related in any way to:
 - i. Alleged mental or physical impairment;
 - ii. Incompetence;
 - iii. Malpractice;
 - iv. Misconduct; or
 - v. Impairment of patient welfare.
- b. The denial of certification or completion of training of any individual for reasons related in any way to I.A-E above.
- c. The voluntary or involuntary resignation or withdrawal of association, or of privileges, to avoid the imposition of disciplinary measures.
- d. The receipt of information that indicates that any licensed health care professional or medical resident has been convicted of a crime.
- e. The denial of staff privileges to a physician if the reasons for such denial are related to I.A-E above.

C. NEW YORK STATE HOSPITAL CODE 405.4

In the late 1980s, in response to the untoward death of a young woman in New York Hospital, the Bell Commission was formed to make recommendations concerning work hours and supervision of residents. In 1989, the New York State Hospital Code Section 405.4 was established, setting requirements for resident work hours and supervision. Although all hospitals in the State were expected to comply, compliance was variable; surgical programs were the least compliant.

Compliance was not pursued by the State until 1997, when, at the request of the New York City Public Advocate's Office, inquiries into compliance began, and, in 1998, the State Health Department announced its intention to ascertain compliance of Section 405 through routine audits.

It is absolutely essential that all Program Directors make certain that their residents are in compliance with Section 405 of the New York State Hospital Code as well as all ACGME requirements. Principal parts of Section 405 are described in Section V.D-G.

V. INSTITUTIONAL REQUIREMENTS

Some requirements will vary with each institution within the Consortium. In many instances requirements will be identical to the material presented in the section on the ACGME. Many requirements are also printed in the House Staff Manual, which should be consulted when questions arise with respect to residents enrolled in training programs. The material provided below complements the information provided in Section III of this manual and in the corresponding sections of the House Staff Manual.

A. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed primarily to improve the efficiency and effectiveness of the health care system, while including the principles of fraud and abuse prevention. It also required Congress to enact comprehensive rules regarding privacy, security, and universal identifiers.

The Privacy Rule, which applies to all protected health information (PHI) regardless of format, went into effect on April 14, 2003.

The Security Rule, which applies to PHI in electronic format only (or ePHI), went into effect on April 23, 2005.

The National Provider Identifier (NPI) Rule, which requires that every provider who bills or plans to bill electronically apply for and use a single, lifetime NPI, went into effect in May 2007.

All members of the MSHS workforce must receive an annual HIPAA refresher training. The training is currently provided to house staff during Orientation and is available on the Intranet. Additional targeted training is provided as appropriate. Breaches of either the Privacy or Security Regulations must be reported to the Chief HIPAA Officer and will be investigated. Sanctions will be applied, if appropriate, in accordance with institutional policy. (See HIPAA Sanctions Policy, H-17, on the HIPAA website.)

NPI applications and queries to the NPI database may be made by accessing the CMS website.

To ensure protection of both PHI and ePHI, HIPAA also requires that covered entities such as member hospitals of MSHS enter into a Business Associate Agreement (BAA) with its Business Associates (BAs). A Business Associate is any entity that handles PHI on the institution's behalf. It is the Program Director's responsibility to ensure that a HIPAA compliant agreement is signed with any such BA. An example of a BA is any residency oversight entity that requires PHI in order to certify a residency program. The BA agreement format, institutional HIPAA policies and HIPAA compliant forms are available on the Mount Sinai Intranet under Core Services/HIPAA.

B. DRUG-FREE WORKPLACE

In keeping with the mandates of the New York State Department of Health, the Joint Commission on Accreditation of Health Care Organizations, and the Drug-Free Workplace Act, all new employees, including house staff, are required to complete a health screening process before beginning work.

The adverse impact of substance abuse on workplace safety, efficiency, and productivity has been well documented and continues to be a primary concern to employers, employees, and the public. Toward that end, all incoming house staff have had urine toxicology testing included as part of their health screens.

The test screens for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates, and phencyclidine. All initial positive specimens are confirmed by gas chromatography and then reviewed by a certified Medical Review Officer. The results of any information relating to the drug screening are confidential, and a strict chain of custody is followed. Positive results may preclude the house staff from being successfully credentialed.

In general, there has been support of all groups within the institution, including house staff, for this position. It is anticipated that this policy will assist us in continuing to provide the best possible medical care.

C. RESIDENT WORK HOURS

The New York State Hospital Code Section 405.4 (The Bell Commission Report) establishes guidelines for working hours of House Staff Officers.

In addition, effective July 1, 2003, the Accreditation Council for Graduate Medical Education (ACGME) approved similar standards relative to supervision, on-call activities, and moonlighting. Effective July 1, 2011, the ACGME revised its Common Program Requirements to include additional standards related to work hours and supervision.

Postgraduate trainees may not have work schedules that exceed 80 hours per week, averaged over a four-week period, inclusive of all work activities. PGY-1 residents may not work more than 16 consecutive hours and all other postgraduate trainees may not work more than 24 consecutive hours. All postgraduate trainees must have at least one day free of duty each week, and may not be assigned at-home call on those days. All postgraduate trainees should have at least 10 hours off (and must have at least 8 hours off) between all daily duty periods. Postgraduate trainees must not be scheduled for more than six consecutive nights of night float. Postgraduate trainees in PGY-2 and above must not be assigned in-house call more frequently than every third night, averaged over a four-week period. Extended duty periods that include in-house call must be followed by at least 16 hours off duty. Work in the Emergency Room is limited to no more than 12 consecutive hours per assignment. Residents are expected to follow these and other provisions of the 2015 ACGME Common Program Requirements and New York State Hospital Code 405.

ACGME as of July 2011	New York State Health Code Section 405	What NYS programs must adhere to
Hours worked \leq 80 hours/week averaged over 4 weeks	Same	Same
PGY-1 residents cannot work more than >16 consecutive hours	Not in rules	ACGME standard
PGY-2 and above: cannot work > 28 consecutive hours after 24 hours of patient care	Cannot work > 27 consecutive hours – after 24 hours of patient care	NYS
<ul style="list-style-type: none"> ❖ Time off between duty shifts: <ul style="list-style-type: none"> ❖ PGY -1 and intermediate level: must have 8 and should have 10 hours off between duty assignments ❖ Senior residents: may have fewer than 8 hours off 	Minimum 8 hours off between duty assignments	ACGME for PGY-1 and intermediate; NYS for senior
One 24-hour period off per week averaged over 4 weeks	One 24-hour period off per week NOT averaged	NYS

All residency-training programs sponsored by the Icahn School of Medicine at Mount Sinai are required to maintain compliance with applicable work hour requirements. Compliance with working hour restrictions is monitored routinely and corrective action is developed and implemented when violations are identified.

All House Staff are asked to document the hours of work completed for no less than four weeks per quarter. Duty hour reporting periods are determined by the GME Office. Where appropriate, residents are asked to log their duty hours on a more frequent basis.

Residents enter their hours worked in the Duty Hours module of the New Innovations (NI) Residency Management Software. At the end of each reporting period (or more frequently if required), the Program Coordinator and Director report any violations of the New York State and ACGME duty hour requirements. Violations are identified in duty hour exception reports from NI. When violations are identified, the Program Coordinator and

Directors are required to submit an action plan for resolving each issue identified.

The GME Office collects duty hour data and action plans from the residency training programs, verifies and analyzes the information submitted by the programs, and provides information to the GMEC, and the Program Directors.

The Office for Graduate Medical Education and the GMEC may make recommendations for improvement based upon the information provided.

Residents may report concerns or violations related to duty hours standards to the internal, confidential Duty Hours Helpline at (866) MD- HOURS or (866) 634-6877; to their institutional Ombudspersons - and/or to the Senior Associate Dean or Associate Deans for Graduate Medical Education.

D. MOONLIGHTING

House Staff Officers are never required to engage in moonlighting activities. Should House Staff Officers wish to engage in such activities, they must notify their respective Program Directors of their intent to work additional hours as physicians providing professional patient care services, and they must have a New York State license. Regulations on maximum work hours have been set forth in Section 405.4 of the New York State Health Code and the ACGME Duty Hours Standards. The time spent on moonlighting activities must be counted toward the work hour limits imposed by these standards.

The House Staff Officers are responsible for guaranteeing that they are in compliance with these hours. For more information regarding Section 405.4 of the New York State Health Code, see the above section, "Resident Work Hours."

House Staff may not moonlight in the specialty in which they are training. PGY-1 House Staff may not moonlight under any circumstances. Eligible House Staff may moonlight if i) they complete Mount Sinai's Institutional moonlighting attestation ii) they are appropriately credentialed via the medical staff office; and iii) their program director completes the approval form (Appendix 5).

House staff may also moonlight at another institution if i) they complete the MSHS moonlighting attestation; ii) their program director completes the approval form; iii) they are appropriately credentialed at the other institution; and iv) they have their own malpractice insurance coverage that covers them at the institution where they will moonlight.

House Staff Officers who are not U.S. citizens or permanent residents must discuss and verify eligibility with, and obtain additional written permission from, the International Personnel Office. **House Staff Officers on J1 and H1 visas are not permitted to moonlight.**

It is the obligation of the House Staff Officer seeking dual employment to gain written permission from his or her Program Director. A copy of the approval form, completed by the Program Director, must be placed in the House Staff Officer's file. It is at the discretion of the Program Director to place further constraints on moonlighting for House Staff Officers, as s/he deems appropriate. In addition, the House Staff Officer's performance in the residency will be monitored to determine the effects of these extra hours. Any adverse effects on performance of duties as a House Staff Officer may result in a withdrawal of permission to moonlight.

E. ALERTNESS AND FATIGUE MANAGEMENT

Residents and faculty are educated regarding resident work hour regulations and are responsible for monitoring and identifying resident fatigue and sleep deprivation. ISMMS provides the following training resources:

1. All new residents are required to complete the online Core Curriculum including a session on sleep deprivation and fatigue mitigation presented by a physician who is certified in Sleep Medicine by the American Board of Internal Medicine. This presentation is posted to New Innovations for review by all faculty and residents.
2. The offsite retreat for rising Chief Residents includes training in the recognition of impairment including the identification and management of fatigue and sleep deprivation.
3. Programs have access to a curriculum in Sleep Alertness and Fatigue Education in Residency (SAFER) developed by the American Academy of Sleep Medicine.
4. Additional education is provided at program-level orientation sessions and departmental faculty meetings.

Any resident who feels too fatigued to safely care for patients or to actively engage in learning, or any peer or faculty member who recognizes such impairment in a resident, must report their observations to the Program Director immediately. The Program Director is responsible for ensuring appropriate clinical coverage arrangements must be made until the trainee is sufficiently rested to return to duty, as determined by the Program Director or designee. The Program Director may also relieve the resident for the remainder of his or her shift. It is the responsibility of the Program Director to investigate instances of excessive resident fatigue to determine the cause and to develop an action plan if warranted.

The Program Director and/or supervisor must ensure that the fatigued resident is able to return home safely.

F. PRIVILEGING

A “privilege” is the permission to perform a procedure without the supervision of an attending physician. Privileges are earned by accumulating the required number of repetitions of a procedure (which vary from procedure to procedure) under the supervision of an attending physician who will then evaluate competence.

Privileges that have been granted may be viewed in the Procedure Logger module of New Innovations. Access to privileging information is available to the clinical staff in The Mount Sinai Health System and all hospitals in the GME Consortium. House Staff are encouraged to review their posted list of privileges from time to time with their Residency Coordinator.

The New York State Hospital Code Section 405.4 contains several provisions that apply to postgraduate trainees in New York State. This includes a credentialing requirement for postgraduate trainees, stipulating that trainees may not perform treatments or procedures without direct visual supervision by an authorized physician until they have been granted authorization (i.e., “privileged”) to perform these procedures under general supervision.

Each department has its own House Staff privileging process with a list of treatments and procedures that are specific to each PGY level. All House Staff Officers should know what procedures they are privileged to perform under general supervision and which procedures require direct visual supervision.

G. SUPERVISION

The Senior Associate Dean for Graduate Medical Education (Designated Institutional Official, or DIO) is responsible for ensuring that the institution fulfills all responsibilities identified within this section. Along with the DIO, each Program Director is responsible for monitoring resident supervision, identifying problems, and devising plans of action for their remedy. At a minimum, the monitoring process will include:

- a. A review of supervision plans and policies as part of each ACGME-accredited program's Annual Program Review and during the Internal Review at the accreditation midpoint;
- b. A review of incidents and risk events with complications to ensure that the appropriate level of supervision occurred;
- c. A review of accrediting and certifying bodies' concerns and follow-up actions;
- d. A review of resident evaluations of their faculty and rotations;
- e. An analysis of events where violations of graduated levels of responsibility may have occurred; and
- f. Reviews pertaining to monitoring of resident supervision will be communicated, at a minimum, on a yearly basis, to the institutions' Medical Boards and the Boards of Trustees.

Principles:

Attending physicians must actively supervise residents and appropriately document this supervision in the medical record.

Within the scope of the residency-training program, all residents will function under the supervision of appropriately credentialed attending physicians. Each patient must have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care, and the name of the responsible physician should be available to residents, faculty and patients. Residents and faculty members should inform patients of their respective roles in each patient's care.

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

Every residency program must ensure that adequate supervision at an appropriate level is provided for residents at all times. A responsible attending must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, if needed. Each program will publish and make available in a prominent location, call schedules indicating the responsible attendings(s) to be contacted.

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 from one year of training to the next based on ACGME requirements and guidelines, milestones progression, national standards-based criteria (where available), and the program curriculum.

Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents should be given increasing responsibilities to conduct clinical activities with limited supervision and should serve as teaching assistants for junior residents.

Resident responsibilities in each year of training are defined in each program's curriculum, which is available in the Curriculum module of the New Innovations (NI) Residency Management Software. These should also be distributed to residents annually.

Each program is required to maintain its own program-specific plans and policies related to supervision. At a minimum, the plans and policies must account for residents' attainment of graded authority and responsibility as assigned by the Program Director and faculty; distinguish between direct and indirect supervision and oversight within the program; describe faculty supervision assignments; and contain guidelines for circumstances and events in which residents must communicate with supervising faculty members. Residents must know the limits of their scope of authority, and the circumstances under which they are permitted to act with conditional independence.

PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available.

Privileging checklists are available in the Procedure Logger module of NI. Training programs are required to update resident privileges at least semiannually. These privileges reflect the patient care services that may be performed by the resident and the level of supervision required.

Our programs adhere to current accreditation requirements as set forth by the ACGME, American Dental Association, Joint Commission on Accreditation of Healthcare Organizations or other applicable organizations for all matters pertaining to the training programs, including the level of supervision provided. It is also expected that the requirements of the various certifying bodies, such as the pertinent member board of the American Board of Medical Specialties and American Dental Association, will be incorporated into training programs and fulfilled to ensure that each program graduate will be eligible to sit for a certifying examination.

Throughout all clinic hours, there will be an attending physician present and immediately available to the resident.

a. Roles and Responsibilities

The Graduate Medical Education Committee (GMEC) is responsible for establishing and monitoring policies and procedures with respect to the institution's residency training programs.

Each Program Director is responsible for the quality of overall residency education and for ensuring that the program is in compliance with the policies of the respective accrediting and certifying bodies. The Program Director maintains plans and policies related to supervision in compliance with applicable regulatory standards and institutional policies and procedures. The Program Director maintains timely, complete, and accurate resident privileging information. The Program Director defines the levels of responsibility for each year of training by preparing a description of types of clinical activities residents may perform and those for which residents may act in a teaching capacity. The Program Director monitors resident progress and ensures that problems, issues and opportunities to improve education are addressed.

The Attending Physician is responsible for, and is personally involved in, the care provided to individual patients. When a resident is involved, the attending physician continues to maintain personal involvement in the care of the patient. The attending physician will direct care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.

Documentation of involvement includes at a minimum:

- b. Attending physician progress notes written at least daily;
- c. Attending physician countersignature on operative reports; and
- d. Attending physician note for all ambulatory and emergency room encounters.

Residents must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities and/or disciplinary action up to and including termination.

b. Graded Levels of Responsibility

As part of their training program, a resident will be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor being physically present or act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill.

Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient. Based on documented evidence (including evaluations by attending physicians and Program Directors, procedure logs, and other clinical practice information reflecting a resident's knowledge, skill, experience, and judgment) residents may be assigned graduated levels of responsibility requiring direct supervision, indirect supervision, or oversight by the attending physician. The assignment of resident privileges will be made available to other staff that have a need to know through the Procedure Logger module of NI.

H. MEDICARE BILLING AND RESIDENTS' RESPONSIBILITIES

1. The 1998 Audit determined that one cannot bill Medicare and other federal health care programs for services performed by House Staff. However, until recently the method of documenting, to the satisfaction of Medicare, that an attending physician had actually performed these services remained unclear. Several years ago the Office of Inspector General (OIG) instituted the Physicians at Teaching Hospitals (PATH) Audit Program to determine compliance with standards for billing by teaching physicians.

During this audit, medical records are reviewed to determine whether a teaching physician was physically present; how the teaching physician documented his/her involvement with the care of the patient; and whether documentation supports the level of evaluation and management service (E&M services) billed. The OIG found numerous instances of noncompliance, resulting in settlements by the inspected institutions to return funds of as much as \$30 million. The PATH audit conducted at Mount Sinai in April 1998 resulted in a negotiated financial settlement of \$2.263 million, as well as an agreement by Mount Sinai Hospital effective through October 31, 2004, to execute compliance programs geared toward training all faculty, residents, billing staff, and billing agents and a new employee orientation program (New Beginnings) within 45 days of hire. The Faculty Practice Office of Compliance and Regulatory Policy Services provide the details of these programs to departments.

The PATH audit reinforced the following observations:

- a. Countersignatures on charts, as well as “seen and agree” statements, are not acceptable to establish the physical presence of a teaching physician.
- b. Collateral documentation concerning the presence of a physician at the time the service is provided is not acceptable in the absence of physician documentation in the chart.
- c. In order to bill for ancillary services, documentation must support medical necessity, and the report must be present in the medical record.

2. Billing Requirements (see Appendix 6)

Although there are numerous rules and regulations that must be followed to document billing for appropriate services, specific issues to remember with respect to residents are as follows:

- a. If a resident participates in a service in a teaching setting, the clinical documentation must support the presence of the teaching physician during the key portion of any service or procedure for which payment is sought.
- b. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.
- c. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.
- d. A complete manual concerning the documentation program can be obtained from the Faculty Practice Office of Compliance and Regulatory Policy Services.

I. GME PAYMENTS - The following table explains how GME is funded in the United States

Indirect Medical Education (IME) Payments

- What does IME cover?
 - Unmeasured complexity of Medicare patients not captured by the program's inpatient payment system
 - Other operating costs associated with being a teaching hospital (standby capacity, specialized services, etc.)
- How is IME paid?
 - Payment add-on percent per inpatient discharge



Direct Graduate Medical Education (DGME) Payments

- What does DGME cover?
 - Resident stipends and fringe benefits
 - Salaries and fringe benefits of supervising faculty
 - Other direct costs (e.g., accreditation fees)
 - Allocated overhead costs
- How is DGME paid?
 - Payment made per resident (up to a cap)

STEPS USED TO CALCULATE DGME PAYMENT

1. Calculate hospital's per resident amount (PRA) based on 1984 costs*/or costs from a later year for new teaching hospitals.
2. Update PRA every year for inflation for primary care residents. Update PRA for every year except 1994 and 1995 for non-primary-care residents.
3. Multiply PRA by number of residents in current year (subject to cap).
4. Multiply by hospital's "Medicare share" (i.e., Medicare inpatient days ÷ total days).
5. Divide by 2 for residents the hospital trains past the period required for board certification (e.g., fellows, residents repeating a year).

EXAMPLE

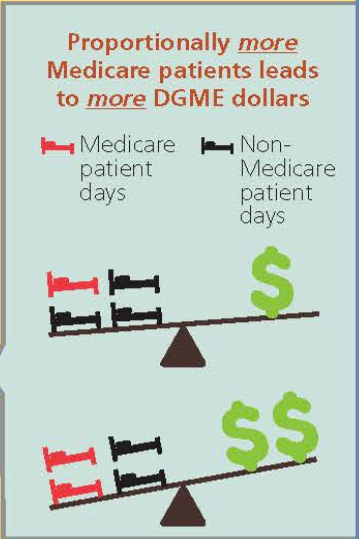
Hospital spent \$75,000 per resident in 1984. PRA set at \$75,000

Primary care: \$75,000 updated to \$100,000
 Non-primary care: \$75,000 updated to \$90,000

1 primary care resident full-time equivalent (FTE) = \$100,000
 1 non-primary-care resident FTE = \$90,000

Assume 40% Medicare share.
 Primary care: \$100,000 × 40% = \$40,000
 Non-primary care: \$90,000 × 40% = \$36,000

Primary care: \$40,000 ÷ 2 = \$20,000
 Non-primary care: \$36,000 ÷ 2 = \$18,000



* Amounts will vary based on individual hospital circumstances.

STEPS USED TO CALCULATE IME PAYMENT PER INPATIENT STAY

1. Determine the hospital's intern and resident-to-bed (IRB) ratio based on the hospital's number of resident FTEs and beds.
2. Plug IRB ratio into **statistical formula in the law** to calculate IME%.
 Formula: $1.35 \times ((1 + \text{IRB ratio})^{0.405} - 1) \times 100 =$
3. Calculate the IME% add-on payment for each inpatient stay.

EXAMPLE

Hospital trains 85 resident FTEs. Hospital has 333 beds.

IRB ratio = $85 \div 333 = 0.255$

$1.35 \times ((1 + 0.255)^{0.405} - 1) \times 100 = 13.00\%$

Patient admitted for a cardiac defibrillator implant

IME Payment for Inpatient Case = (Payment for Medicare Severity Diagnosis-Related Group [MS-DRG] × IME%) = (\$29,748 × 13.00%) = \$3,867.24

Changing the ratio of residents to beds changes teaching intensity and affects IME payments



Sources:

- Direct Graduate Medical Education Payments: Social Security Act § 1886(h); 42 C.F.R. § 413.75-413.79. Indirect Medical Education Payments: Social Security Act § 1886(d)(5)(b); 42 C.F.R. § 412.105.
- GAO-13-709R Health Care Workforce Training Programs.

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GME indicates graduate medical education.

J. INTERACTIONS WITH OUTSIDE VENDORS

Relationships between commercial entities and academic medical centers have become increasingly intertwined and complex. The substantial financial assets of corporations and the broad intellectual resources of academic centers create natural opportunities for joint pursuit of common objectives. Yet occasionally the commitments and fiduciary duties of industry may conflict with our core scientific and education missions. Furthermore, while offers of “free” goods, gifts, donations or grants for teaching programs may serve a beneficial purpose, they may violate the federal Anti-Kickback Statute and similar New York State laws. These laws prohibit the knowing solicitation or receipt, offer or payment of anything of value in return for patient, product or service referrals and punish any violator with significant fines, jail terms and exclusion from federal and state health care programs. In light of these potentially conflicting missions and regulatory prohibitions, it is critical that all members of the Mount Sinai community remain acutely sensitive to avoiding any actual or perceived conflict of interest. Mount Sinai does business with corporations associated with a wide range of activities, including but not limited to: the sale of products and services to the institution; referral and receipt of patients for health care services; and sponsorship of scientific research. Vendors include: pharmaceutical, biotechnology, office supply, and medical device/s supply companies; research supply and equipment companies; building contractors; consultants; medical service providers; billing and collection companies; and other service companies. For purposes of this policy, the term “vendor” encompasses all commercial entities that do business with Mount Sinai and its faculty, staff and trainees.

All decisions relating to purchasing or other business processes must promote the best interests of Mount Sinai without favor or preference based on personal considerations. All actions must reflect Mount Sinai’s commitment to the highest ethical standards of conduct as described in the Compliance Manual and the Code of Ethics and Business Conduct and must be consistent with all institutional policies, including but not limited to the Purchasing Policy, the Policy on Conflicts of Interest, and policies in the Faculty Handbook (e.g., Financial Arrangements with Extramural Entities and Use of Mount Sinai Name. Guidelines promulgated by the federal Office of the Inspector General (OIG) and the PhRMA Code must also be observed.

Maintaining rigorous practices will ensure our commitment to the well-being of our patients, the integrity of our research and the soundness of our educational programs. The following excerpted guidelines apply to all faculty, staff, and trainees of ISMMS, The Mount Sinai Health System, and are designed to assist in avoiding potential conflicts of interest between Mount Sinai and industry. The full Vendor Interaction Policy may be viewed on the Mount Sinai Intranet.

1. Gifts

A gift is defined as anything of value that is given by a business or individual that does or seeks to do business with Mount Sinai to either the recipient or his /her close family members, and for which the recipient neither paid nor provided services. Gifts from vendors are strictly prohibited regardless of value, including, but not limited to:

- a. Cash in any amount
- b. Any product or service, or discounts on products or services

- c. Prizes
- d. Gift certificates
- e. Tickets
- f. Loans
- g. Meals
- h. Transportation
- i. Hotel accommodations
- j. Use of a company's vehicles or vacation facilities
- k. Stocks or other securities, or participation in stock offerings
- l. De minimis gifts e.g. trade show trinkets distributed to large numbers of people by vendor representatives.
- m. Group gifts from vendors meant to be shared by all members of the staff, e.g. flowers, chocolates, etc.
- n. Vendor invitations to be their guests at charitable events sponsored by Mount Sinai, e.g., the Crystal Ball, to which the vendor has purchased tickets.

If unsolicited gifts arrive via the post office or private carrier, the department head or administrator will advise on the best method for returning the gift.

2. Vendor Support for Medical Center Educational Events

Vendor support for Mount Sinai-sponsored educational events, whether held on campus or off-campus, will only be accepted in accordance with the following provisions:

- a. Deposit to General Fund: With the exception of CME events (see Section C below); any vendor contribution must be in the form of a general educational grant paid directly to a School or Hospital fund. No direct payments may be made to any Mount Sinai faculty member, trainee, or employee. Mount Sinai shall retain exclusive responsibility for all aspects of educational events. Corporate sponsors may not make commercial exhibits, distribution of promotional materials, or the inclusion of company representatives a requirement for support. A letter of an agreement outlining expectations and restrictions will be signed by both the Department Chair and the vendor.
- b. Food and Beverages: Direct provision by vendors of food and beverages, or subsidies for food and beverages, is prohibited.
- c. Continuing Medical Education: Vendor support for accredited continuing Medical education (CME) programs must be submitted in accordance with the policies and procedures of Mount Sinai's Page and William Black Post Graduate School for Continuing Medical Education. Vendor support for CME programs will be managed in accordance with the Standards for Commercial Support of the Accreditation Council for Continuing Medical Education (ACCME), including:
 - i. Independence from commercial interests in course goals, content and methods
 - ii. Resolution of personal conflicts of interest
 - iii. Bias-free content and format
 - iv. Disclosures relevant to potential commercial bias
 - v. Management of commercial promotion
- d. Program Content: Programs must have true educational value and can never be designed to influence purchasing decisions. The Standards for Commercial Support of the Accreditation Council for Continuing Medical Education

(ACCME) are applicable to all educational events, whether or not they fall under the auspices of the Postgraduate School; guidelines include:

- i. Curriculum content, faculty selection and program quality will be the sole responsibility of Mount Sinai department management and/or faculty involved in the event.
 - ii. Speaker selection and educational content will be at the discretion of the department.
 - iii. Guest speakers must sign a standard disclosure statement indicating compliance with institutional conflict of interest policies.
 - iv. All presentations must be free of commercial bias for or against any vendor's products or services. Generic rather than trade names of drugs must be used at conferences.
 - v. Vendor representatives may not address the audience unless specifically invited by the Mount Sinai event organizers.
 - vi. Promotional materials from commercial sponsors may not be displayed in the room before, during or after the activity.
 - vii. Vendors may apply for exhibit space outside the room(s) in which the educational event is held. The granting of such requests is at the discretion of the conference organizers and fees may be levied. In the event that exhibit space is approved, exhibitors will be subject to gift restrictions as described in the full Vendor Interaction Policy, as well as to the PhRMA Code.
 - viii. Refreshments, study materials, and other materials should be appropriate to the event.
- e. Acknowledgment of Vendor Support: Commercial support may be acknowledged in printed materials, but specific products may not be mentioned.
 - f. Vendor Support for Trainees: Vendor support can never be made directly to or earmarked specifically for an identified individual. Vendor support for trainee education, including salary support, must be in the form of educational grants to Mount Sinai.
 - g. Education and Training on Vendor's Own Products: Vendor representatives from pharmaceutical, biotechnology and other industries may visit healthcare providers or researchers to talk about and demonstrate their new products. While generally acceptable as straightforward sales visits, an appointment is always required; representatives are not permitted on campus on a drop-in basis. Visits to health care providers must comply with Mount Sinai's policy on Medical Sales Representatives. Sales representatives are not permitted in patient care areas and may not access any patient-specific information. Refreshments and gifts from vendors, however modest, are prohibited during visits by representatives.

Scheduled appointments are required for vendor visits to train physicians, researchers or others in device use or new technologies.

3. Vendor Support for Off-Campus Educational Events

Faculty and staff with special expertise may be invited to give lectures or otherwise participate in conferences and seminars in a variety of venues outside Mount Sinai, including other academic institutions, professional conferences, international symposia, expert training in device use or new technologies, and presentations to lay audiences. The Department Chair will have overall responsibility for monitoring the frequency and nature of faculty and staff participation in these off-campus activities. In all cases, speakers must be aware of and abide by institutional policies

on the Use of Mount Sinai Name. If off-campus events are sponsored by industry, employees and trainees are encouraged to participate only when Continuing Medical Education (CME) credit is offered. For events that fall outside the realm of CME, following are guidelines for participation:

- a. Educational Value of Event: Discretion must be employed in determining whether to attend, based on whether the event has a legitimate educational value. For example, industry sponsors often organize their own conferences and invite faculty or trainees to attend. It is incumbent upon the invitee and his/her Chair to determine whether it is truly a learning event or is designed primarily to influence participants to favor the vendor's products. The setting for and cost of the event should be appropriate to its purpose.
- b. Speaking Engagements: Lectures are often arranged through a corporate Speakers Bureau, and may involve compensation. Participation can be of value to the invited speakers as well as to conference attendees, and can enhance Mount Sinai's reputation. At times, however, events sponsored by vendors are designed to influence participants in their relationship with the vendor. Further, participants in Speaker's Bureaus may be asked to use materials prepared by the vendor. It is therefore essential that faculty and staff participate in such events only when there is a legitimate educational purpose and the individual's role is meaningful and substantive and reflects his or her own work.
- c. Paid Engagements: Faculty who receive compensation for participating in off-campus events outside the scope of CME will be subject to the Policy on Financial Arrangements With Extramural Entities, and must submit written agreements for approval by the Department Chair prior to participation. Faculty must also adhere to CME guidelines concerning disclosure. For engagements involving expert training, the individual must also abide by the guidelines of the relevant professional organizations.
- d. Vendor Support to Participate in Events: Mount Sinai faculty, staff and trainees may not accept scholarships or other special funding directly from a vendor. Vendors may make donations a general departmental education fund; the department will use its own criteria to select trainees to receive support for participation in educational events. Under no circumstances can a trainee be paid by a commercial sponsor to attend an educational event.

4. Pharmaceutical Samples

Physicians and staff may not accept pharmaceutical samples for their own personal use or for distribution to patients or family members. Distributing sample drugs would place physicians in a drug-dispensing role, subject to applicable laws and regulations. There will be only two circumstances that warrant an exception to this prohibition:

- a. If there is a compelling medical necessity to treat an urgent condition, where immediate treatment prior to leaving the physician's office will alter the clinical outcome
- b. If there is a need to demonstrate appropriate use of a product. In these exceptional cases, the minimum possible sample should be given. Appropriate documentation of the medication dispensed or the device utilized must be entered in the patient's medical record.

K. COMPLIANCE PROGRAM

In addition to the compliance program that addresses billing, Mount Sinai also established an enterprise-wide Compliance Program that includes:

1. A Mission Statement to ensure the Institution upholds its commitment to legal and ethical conduct by all faculty and staff.
2. Maintenance and update of the Medical Center's Code of Conduct and Business Ethics. The code maintains ten basic tenets of conduct ranging from compliance with legal requirements, respect for other employees, adherence to proper business practices, maintenance of accurate records through protection of occupational safety, and maintenance of a drug-and alcohol-free workplace. This is supplemented by a more detailed Compliance Manual.
3. A Helpline has been established for meeting these standards of conduct. Violation or questions about compliance with institutional policy can be answered by calling the confidential Compliance Helpline at 1-800-853-9212. Callers may remain anonymous and may follow the resolution of reported violations.
4. Employees of Mount Sinai are expected to bring immediately to the attention of their supervisor, The Chief Compliance Officer, the Office of Corporate Compliance or the Legal Department information regarding suspected improper conduct. Employees are also expected to cooperate fully in any investigation.
5. The Medical Center also maintains strict adherence to a policy of non-reprisal for bringing violations to the attention of Institutional management.
6. Mount Sinai also will take disciplinary action, including dismissal where appropriate, against any employee who violates any legal requirements or Institutional policies. This includes anyone who fails to report violations or retaliates against someone reporting in good faith a possible violation.
7. There are policies also in furtherance of the Deficit Reduction Act as the Institution is committed to preventing and detecting fraud waste or abuse. Mount Sinai strives to educate staff to submit accurate claims and reports to the Federal Government. Although Mount Sinai requires employees bring their concerns to the Institution, it does not preclude individuals from bringing the same to the Federal or State Governments.

L. DISASTERS AFFECTING ONE OR MORE RESIDENCY PROGRAMS

A disaster is an event or set of events causing significant alteration to the residency experience at one or more residency programs. If, because of a disaster, at least an adequate educational experience cannot be provided for each resident and/or fellow the institutional sponsor of the residency program(s) will:

1. Arrange temporary transfers to other programs and/or institutions until such time as the residency and/or fellowship program can provide an adequate educational experience for each of its residents and/or fellows;
2. Cooperate in and facilitate permanent transfers to other programs or institutions. Programs or institutions will make the keep or transfer decision expeditiously so as to maximize the likelihood that each resident will timely complete the resident year; and
3. Inform each transferred resident of the minimum duration of his or her temporary transfer, and continue to keep each resident informed of the minimum duration. If and when a program decides that a temporary transfer will continue to and/or through the end

of a residency year, it must so inform each such transferred resident. The Designated Institutional Official (DIO) will call or email the Institutional Review Committee Executive Director with information and/or requests for information. Similarly, the Program Directors will contact the appropriate Review Committee Executive Director with information and/or requests for information.

Residents should call or email the appropriate Review Committee Executive Director with information and/or requests for information. Within ten days after the declaration of a disaster, the DIO will contact ACGME to discuss due dates that ACGME will establish for the programs (a) to submit program reconfigurations to ACGME, and (b) to inform each program's residents of resident transfer decisions. The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.

In the event of a disaster at non-Consortium programs or institutions, consideration will be given to accepting temporary or permanent transfers. If interested, programs must complete a form that may be found on the ACGME website.

M. VISITING RESIDENTS FROM NON-CONSORTIUM HOSPITALS

It is recognized that our hospitals are educational resources for residents in training at other residency programs who are in need of specific rotations to fulfill their residency requirements, or who wish to enhance their training through elective rotations at Mount Sinai. In the past, residents could be accepted without difficulty. However, with the passage of the Balanced Budget Act of 1997, Mount Sinai is no longer able to accept all residents on an open-ended basis, as these residents are included in the total FTE count. Requests to have residents from non-affiliated institutions come to one of our hospitals must be made to the GME Office and must contain the following information: a) specific reasons that demonstrate the importance of accepting the resident; and b) any advantage that might accrue to Mount Sinai based on this acceptance.

In accordance with institutional guidelines, prior to acceptance of a resident from a non-affiliated institution both our and the resident's institution must either:

- Sign a Visiting Trainee (Resident/Fellow) Agreement (VTA) for a one-time only rotator (Appendix 7).

-OR-

- Complete and sign a Program Letter of Agreement (PLA). Before this process is initiated it should be sent to the GME office for review BEFORE signatures are obtained. Once all signatures have been obtained, the DIO of the GME Office will be the final signature and PLA will be on file at that office.

In addition, appropriate credentialing paperwork must be forwarded to the GME/House Staff Office at least 6 weeks before the resident's arrival as follows:

- i. A completed Rotator Checklist (**Appendix 8**)

- ii. VISA HOLDERS – If rotator has a VISA MUST go thru MSH International Personnel Clearance FIRST (not applicable for Elmhurst & Queens) – Please email joshua.fieser@mountsinai.org in the International Personnel Office for the latest form and instruction. Once cleared, attach their clearance email for our reference.
- iii. Health Commerce System User ID if based at a New York State Hospital: To confirm rotator’s status we require the final “OK” email from Koreena Nazir in the GME Office. Please send an email to koreena.nazir@mssm.edu along with a scanned copy of the completed checklist and USER ID entered on it. Please enter the following: NEW.....USER ID #: _____ *If in process, send to Koreena as soon as it is submitted by Sending Institution
- iv. Visiting Trainee Agreement- (VTA) – Required - MUST be sent to amanda.mercado@mssm.edu in GME to be reviewed FIRST and confirmed that it can be signed by all parties BEFORE the packet is sent to House Staff (Applicable to institutions NOT in the Consortium)
- v. Program Letter of Agreement (PLA) – One must be on file in the GME office. If there is not one on file, one must be created and sent to amanda.mercado@mssm.edu in the GME to be reviewed FIRST and confirmed that it can be signed by all parties BEFORE the packet is sent to House Staff. Please note a Master Affiliation Agreement (MAA) may need to also be submitted. Please contact amanda.mercado@mssm.edu in GME office to confirm there is a current one MAA on file.
- vi. A copy of the House Staff Application (**Appendix 9**)
- vii. A copy of the House Staff Recommendation Form (**Appendix 10**)
- viii. A copy of the medical school diploma, with English translation where applicable.
- ix. A copy of the final transcript. The transcript must list the graduation date.
- x. A copy of the current curriculum vitae (CV) and CV addendum form (**Appendix 11**).
- xi. International medical graduates must include a copy of their ECFMG certificates. The ECFMG number and the date of issue should be clearly visible on the document.
- xii. A clearance Health Clearance form filled out by Employee Health Service. (In keeping with the institution’s policy of a drug-free campus, residents coming to us for the first time must complete a Health Clearance form and have it signed by their Employee Health Service Department. Also, the rotator should have had a urine toxicology screening performed by his/her home institution, with confirmation of a negative result included in the material forwarded to the GME/House Staff Office (**Appendix 12**).
- xiii. A copy of the House Staff Officer’s most recent delineation of privileges/procedures at the home institution, signed by the House Staff Officer and Chairperson. It should detail what procedures the rotator is able to perform

supervised or independently.

- xiv. A copy of the current New York State license or limited permit (if applicable a verification of license <http://www.op.nysed.gov/opsearches.htm#licno> and disciplinary action <http://w3.health.state.ny.us/opmc/factions.nsf> should be done and the results should be included for submission along with license registration).
- xv. Rotation definitions for New Innovations block schedules (**Appendix 13**).

The above information should be forwarded to the receiving clinical department.

- b. The clinical department receives the above paperwork and reviews it for accuracy and completeness.
- c. The clinical department then reviews forwards the information to the GME Office
- d. The GME/House Staff Office reviews all of the documents and confirms a complete packet has been submitted. Once the packet is confirmed the rotator will be approved to begin on their start date. Only then will a hospital DEA and DIC code will be assigned to the rotator for EPIC access and an email be sent to the security department to allow for an rotator ID card to be created.
- e. The information will be saved on New Innovations (NI) under the rotator's profile, where the information is retained for reference and government reimbursement.

N. ROTATION OF RESIDENTS WITHIN THE MOUNT SINAI HEALTH SYSTEM

A delegated credentialing process has been created for rotations within the Mount Sinai Health System. The process must be started at least 6 weeks in advance to the rotation start date.

The following documents must be submitted to the GME office 6 weeks before the start of a rotation:

1. Fully executed PLA -for long standing rotation OR Goals & Objectives - for one-time elective rotation (facilitated by *sending* program)
2. In-System Rotation Form (facilitated by *sending* program)
3. Delegated Authorization Form (facilitated by trainee's local GME)
4. Credentialing Summary Form (facilitated by trainee's local GME)

The sending institution coordinator should:

1. Confirm PLA (for long standing rotation) is approved and on file with your local GME office.
 - a. If PLA is *not* complete or on file, please contact your local GME office for a template. NOTE: It is the responsibility of the *sending* institution to initiate the PLA.
 - b. A PLA with Goals and Objectives is required for all elective rotations, both recurring and one-time.
2. Complete an "In-System Rotation Form" a. *Sending* institution program coordinator will need to contact the *receiving* institution program coordinator to obtain the "Receiving Rotation Assignment/Name in New Innovations."
3. Update trainee's New Innovations block schedule to reflect the *receiving* rotation

- assignment/name listed on the “In-System Rotation Form.” (Appendix 13)
4. Submit “In-System Rotation Form” to the *sending* institution’s GME office for signature.
 5. Submit “In-System Rotation Form” to the *receiving* institution’s program coordinator. If a *receiving* program coordinator does not exist, please email form to the *receiving* GME office.
 - a. GME Contacts:
 - i. MSBI: Merdena Harrell (mharrell@chpnet.org)
 - ii. MHS: Heather Joseph (heather.joseph@mssm.edu), Angie Cotto (angie.cotto@mssm.edu) or Shou-Su Yu (shou-su.yu@mssm.edu)
 - iii. MSSLR: Judy Irons (jirons@chpnet.org)
 - iv. NYEE: Amanda Mercado (amanda.mercado@mssm.edu)
 6. *Receiving* program coordinator ought to verify information provided on the “In-System Rotator Form” and then submit to their local GME office for processing.
 7. The local GME representative will then:
 - a. Confirm fully executed PLA or Goals & Objectives are on file
 - b. Confirm Delegated Authorization Form is signed and posted in the “Notes & Files” section of New Innovations.
 - c. Confirm Credentialing Summary Form is signed and posted in the “Notes & Files” section of New Innovations.
 - d. Confirm trainee’s New Innovation block schedule accurately reflects New Innovations rotation assignment as well as definition.
 - e. Sign and upload the “In-System Rotation Form” to trainee’s “Files & Notes” section.
 8. Finally, a confirmation email will be sent to both *receiving* and *sending* program coordinators (or site director if no assigned coordinator) indicating the trainee is approved to rotate.

This process is required for every in-system rotation.

Example #1:

Dr. Resident Ironman, MSBI trainee, is scheduled to rotate to:

Block 3 (September 1-30) on MSSLR Hematology/Oncology Consult Service
and Block 7 (January 1-31) on MSSLR Hematology/Oncology Transplant Service

***Two (2) “In-System Rotation Forms” are required for each rotation above because the rotation names and definitions are different.*

Example #2:

Dr. Resident Superman, MSSLR trainee, is scheduled to rotate to:

Block 2 (August 1-31) on MSBI Pathology Consults

Block 11 (May 1-31) on MSBI Pathology Consults

***One (1) “In-System Rotation Form” is required for the rotation to MSBI Pathology Consults and BOTH dates should be included. Note the rotation definition name will still be the same, but there will be additional dates. This is due to schedule changes, which often occur throughout the year.*

EPIC/PRISM Access: Once the *receiving* coordinator has received the GME confirmation email, she/he may move forward with submitting an IT request for EPIC/PRISM or any other clinical system(s) necessary for the rotation.

O. ROTATION OF RESIDENTS FROM OUTSIDE THE SYSTEM BUT WITHIN CONSORTIUM (i.e. Elmhurst to Mount Sinai, Queens Hospital to Mount Sinai, etc.)

- f. The clinical department at the Consortium institution organizes the following information:
- i. A completed Rotator Checklist
 - ii. A copy of the House Staff Recommendation Form
 - iii. A copy of the House Staff Application
 - iv. A copy of the medical school diploma, with English translation where applicable.
 - v. A copy of the final transcript. The transcript must list the graduation date.
 - vi. A copy of the current curriculum vitae (CV) and CV addendum form
 - vii. International medical graduates must include a copy of their ECFMG certificates. The ECFMG number and the date of issue should be clearly visible on the document.
 - viii. A clearance Health Clearance form filled out by Employee Health Service
 - ix. A copy of the House Staff Officer's most recent delineation of privileges/procedures at the home institution, signed by the House Staff Officer and Chairperson. It should detail what procedures the rotator is able to perform supervised or independently.
 - x. A copy of the current New York State license or limited permit (if applicable a verification of license <http://www.op.nysed.gov/opsearches.htm#licno> and disciplinary action <http://w3.health.state.ny.us/opmc/factions.nsf> should be done and the results should be included for submission along with license registration).
 - xi. Rotation definitions for New Innovations block schedules.

The above information should be forwarded to the receiving clinical department.

- g. The clinical department receives the above paperwork and reviews it for accuracy and completeness.
- h. The clinical department then reviews forwards the information to the GME Office
- i. The GME/House Staff Office reviews all of the documents and confirms a complete packet has been submitted. Once the packet is confirmed the rotator will be approved to begin on their start date. Only then will a hospital DEA and DIC code will be assigned to the rotator for EPIC access and an email be sent to the security department to allow for an rotator ID card to be created.
- j. The information will be saved on New Innovations (NI) under the rotator's profile, where the information is retained for reference and government reimbursement.

Questions regarding this process may be directed to Ms. Heather Joseph, House Staff Manager at (212) 241-3332.

VI. RESIDENCY PROGRAM MANAGEMENT

A. RECRUITMENT OF HOUSE STAFF

1. *Resident Selection*

The Consortium for Graduate Medical Education of the Icahn School of Medicine at Mount Sinai is dedicated to attracting the highest quality House Staff as well as to maintaining cultural diversity among the resident body. The Consortium welcomes applications from all eligible physicians. Selection is based solely on the applicant's demonstrable ability and qualifications for the job. In compliance with federal, state, and municipal laws and in observance of well-established tradition of fairness, equal opportunity is given to all applicants without regard to race, creed, color, religion, national origin, age, gender, disability, marital status, sexual orientation, veteran status, or citizenship status.

Residents in all programs sponsored by the Icahn School of Medicine at Mount Sinai should be selected based on their qualifications and ability to benefit from the educational program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate should be considered in the selection.

All Icahn School of Medicine at Mount Sinai residency programs, both sponsored and affiliated, must register with the Electronic Residency Application Service (ERAS), which is sponsored by the AAMC. Programs should require prospective House Staff to apply via ERAS. Use of this service allows for efficient management of data, including information on incoming House Staff that must be uploaded to New Innovations.

All residency programs sponsored by Icahn School of Medicine at Mount Sinai should participate in the National Resident Matching Program (NRMP) for the selection of residents for first-year positions. The GME Committee will review residency recruitment on a yearly basis, including residency positions filled outside of the NRMP.

2. *Eligibility*

The ACGME's Common Program Requirements are changing as of July 2016.

Eligibility Requirement – Residency Programs

- a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)- accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program.
- b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only

to entry into residency in those specialties for which an initial clinical year is not required for entry.

- c) A Review Committee may grant the exception to the eligibility requirements specified in Section b) for residency programs that require completion of a prerequisite residency program prior to admission.
- d) Review Committees will grant no other exceptions to these eligibility requirements for residency education.

Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada.

- a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.
- b) Fellow Eligibility Exception A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, defined as one who has (1) completed a non ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME International-accredited residency program.

Such exceptions will be made for an applicant who does not satisfy the eligibility requirements listed in above), but who does meet all of the following additional qualifications and conditions:

1. Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and
2. Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and
3. Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and
4. For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and
5. Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.

If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.

Additional information is available on the ACGME website at:

<https://www.acgme.org/acgmeweb/Portals/0/PDFs/Eligibility-Exception-Decisions-bySpecialty.pdf>

B. RESIDENCY DATA MANAGEMENT

Each institution and program in the Consortium must report data including demographics and privileging information on every House Staff Officer within the Consortium. The status of current and graduating House Staff must be provided in a timely manner. Information on incoming House Staff, as well as updates on the status of all House Staff, must be submitted each academic year. Program directors and coordinators must update this data as follows:

1. **New residents:** The process of gathering information on new residents starts immediately after the Match conducted by the National Resident Matching Program (NRMP). Programs download House Staff data from the Electronic Resident Application System (ERAS) website, add to that file the names of any new House Staff accepted outside of the Match, and forward a copy of the downloaded information as an e-mail attachment to Gaber Badran, GME Senior Software Specialist (gaber.badran@mssm.edu).
2. **Reappointments:** Demographic records for reappointed House Staff must be reviewed in New Innovations to ensure proper promotion of program level and postgraduate year (total training years).
3. **Terminations:** Demographic records for House Staff who are terminated must be reviewed in New Innovations to ensure accuracy of data in the resident's/fellow's record at the time of departure.

New Innovations Residency Management Software

The Consortium utilizes the New Innovations residency management software. This web-based application service provider assists Program Directors in managing information that must be reported to various institutions, organizations, and government agencies. The software also houses general information about Consortium residents. New Innovations is accessible via any computer with Internet access. A username and password must be provided to access to the website, and the content that is visible varies with the defined role of the user, whether GME Administrator, Program Director, Residency Coordinator, House Staff Officer, or faculty member.

New Innovations provides a platform to report House Staff demographic information to the Consortium GME Office. Use of the following modules by all Consortium programs is mandatory:

1. *Personnel Data* for House Staff including basic demographics, education, visa information, and certifications.
2. *Block Schedules* for all resident assignments.

3. *Procedure Logger* for all privileges granted to House Staff after completion of satisfactory repetitions of procedures.
4. *Duty Hours* for logging all work hours (floor, clinic, call, moonlighting, etc.) as well as time off-duty or on leave. House Staff rotating through programs within the GME Health System are required to log duty hours for the duration of the rotation.

Through New Innovations, the Consortium GME Office has provided each program with templates for evaluations of House Staff by faculty, other personnel, and patients, as well as for evaluations of faculty, rotations, and the program by House Staff. Use of New Innovations to schedule and complete evaluations is strongly encouraged for all Consortium programs.

The use of New Innovations software is key to providing optimal service to Consortium members and to generating required statistics and reports throughout the academic year. As such, receipt of information that is both complete and timely is emphasized and encouraged. The Consortium GME Office appreciates program directors' cooperation in the collection and exchange of data within the Consortium.

C. ALTERATION IN SIZE OR TYPE OF RESIDENCY TRAINING PROGRAM

1. ACGME-Approved Programs

The Balanced Budget Act of 1997 placed a cap on the total number of residents in ACGME-approved programs to the baseline that existed within each institution as of 1996. This number, however, does not refer to the actual number of residents in the program, but rather to the number of full-time equivalents (FTEs) at each institution participating in ACGME-approved training programs at that institution. This includes FTEs of residents from other training programs rotating to each hospital. If an institution exceeds the 1996 cap, then reimbursement cannot be obtained from the Centers for Medicare and Medicaid Services (CMS) for the excess number. It is therefore necessary to keep careful track of the number of FTEs at the Medical Center over time.

a. Increasing the Number of Residents in ACGME-Approved Programs

Each ACGME Residency Review Committee (RRC) determines the maximum number of residents per year who may train in an accredited residency program. However, this number may not be approved by the hospital funding the residency programs. If a Program Director wishes to increase the resident complement of his/her ACGME-approved residency-training program, a request must be made to the GME Office. This request should be accompanied by the following information: 1) whether the number of residents in the program will exceed the maximum number of residents permitted by the ACGME; 2) whether the increase in residents, if approved, would result in an increase in full-time equivalents or, due to the inclusion of another hospital in the rotation, the number of full-time equivalents would be maintained while increasing the total number of residents in the program; 3) justification for requesting such an increase, which must be based on educational value, not service needs; and 4) a statement of approval by the appropriate Department Chairperson.

The GME Office will respond to requests within two weeks to confirm any addition

information needed and to verify when the complement requests will be reviewed by the GMEC for approval.

Establishing a New ACGME-Approved Program

Should a Chairperson wish to establish a new ACGME-approved program, following information should be submitted to the GME Office: 1) justification of the need for this program; 2) total number of residents requested per year; 3) total number of full-time equivalents 4) complete description of the residency program, including other participating institutions; and 5) approval of the Department Chairperson and Program Director of the core Residency Program if applicable.

The GME Office will respond to requests within two weeks to confirm any additional information needed and to verify when the request for the new program be reviewed by the GMEC for approval.

2. *Non-ACGME-Approved Programs*

Requests to establish a new non-ACGME-approved program should be made to the GME Office using Appendix 8. The form requests the following information: 1) a justification for establishing such a program; 2) the number of residents requested; 3) a statement how the program will be funded as no institutional funds can be used for non-ACGME-approved programs; and 4) Competency-based goals and objectives and 5) approval of the appropriate Department Chairperson.

The GME Office will also wish to know if/how the new program will impact on existing programs.

The GME Office will respond to requests within two weeks to confirm any additional information needed and to verify when the request for the new program be reviewed by the GMEC for approval.

3. Request to Fill a Non-ACGME Position with Non-Hospital/ Non-School Funds

A request to fill a non-ACGME-approved residency/fellowship position with non-Hospital/non-School funds requires completion of the request form (Appendix 9), including designation of the fund covering the resident's/ fellow's salary and benefits.

The Funding Commitment by the Department includes full salary and benefits for the resident/fellow for the duration of training. Please consult with your local GME Office as fringe benefits vary across the institutions.

The following documents must be submitted to the GME Office for review prior to final approval:

- *Approved Request to Fill a Non-ACGME-Approved Position with Non-Hospital/Non-School Funds.*
- Completed *P-111*, indicating position, applicant name, and funding source.
- Completed *House Staff Application* and supporting documents.

D. CONTRACTS

Prior to employment each House Staff Officer receives a written contract that sets forth our institution's commitment to the resident and his/her responsibilities to the Hospital. Examples of Consortium member hospital contracts are posted on the [GME Web site](#) for review by applicants.

E. REAPPOINTMENT

The House Staff Officer will be reappointed to the next level of training at the Program Director's sole, reasonable discretion. The Program Director will base the reappointment and promotion determinations on the House Staff Officer's successful completion of his/her current training and the absence of pending Disciplinary Action against the House Staff Officer. House Staff Officers will be notified in writing at least four months before the expiration of their appointment (no later than March 1 for appointments commencing July 1) if their contracts are not to be renewed for the next year of a given residency program or if they will not be promoted to the next postgraduate year of training. Notifications of nonrenewal or non-promotion will include the reason for the action and are subject to the hearing rights found in the House Staff Manual. If a training program is discontinued his/her Program Director will assist the House Staff Officer in obtaining placement in another approved program.

F. LEAVES OF ABSENCE

Program Directors are responsible for the administrative management of leaves of absence. Each Consortium institution maintains its own policies for health and disability insurance, leaves of absence, vacation, parental leave, sick leave, and the effects of leaves on satisfying criteria for program completion.

Most specialties require that a resident complete a minimum number of months actively caring for patients to receive credit for the residency. If a period of disability or leave combined with vacation time results in a failure to meet this time requirement, the resident will be allowed to remain on the House Staff until the time requirement is met, assuming he/she is in good standing. It is essential for the Program Director to make certain that the resident has been placed on disability or leave as soon as the leave period has begun. This will allow funds to be made available to compensate the resident for the leave period. Periods of disability or leaves of absence must be logged in New Innovations.

G. EVALUATIONS

The Consortium GME Office has provided resident, faculty, and program evaluation templates to all programs through the New Innovations residency management software. These evaluations are compliant with ACGME requirements and may be customized to suit the needs of each program.

1. Evaluation of the House Staff Officer

The performance of each House Staff Officer must be evaluated during each educational assignment (i.e. Each rotation). A comprehensive performance evaluation must be completed for each House Staff Officer at least semiannually and residents must be given access to this evaluation. (Even when House Staff are given access to their evaluations online, this does not replace these semiannual reviews.) Program Directors must also complete an exit evaluation for each graduating House Staff Officer that attests to whether the House Staff Officer is competent to practice without direct supervision.

Evaluations must be structured to measure residents' attainment of all six Core Competencies. Multi-source evaluations are also available in New Innovations. Each program must establish a policy according to which residents may have access to the evaluations in their resident portfolio.

Many physicians are hesitant to be frank in their assessment of a resident for fear of subsequent legal problems. However, frank reviews are an essential component of the training process and, if necessary, the disciplinary process. Legal problems can be avoided, and House Staff and the institution will benefit most, when: a) adequate documentation exists; b) inconsistent positive or negative evaluations are reconciled to the extent possible prior to review with the resident; and c) the resident is counseled should any adverse evaluations be submitted. Program Directors who issue academic advisements and disciplinary action based on adverse evaluations must be sure to follow the procedures outlined below.

2. Evaluation of Faculty

At least annually, the program must evaluate faculty performance as it relates to the educational program. These evaluations must include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities, as well as written, confidential evaluations by the residents.

Residents must complete confidential, written evaluations for supervising faculty involved in their training at the end of each rotation (at least quarterly for rotations of more than three months).

When evaluations indicate that faculty performance could be improved, it is the responsibility of the Program Director to review evaluations with the faculty member and to develop a plan to resolve any concerns that have been identified.

3. Evaluation of the Program

The process for program evaluation is described on page 25.

H. MONITORING EDUCATIONAL OUTCOMES

Educational outcomes should be monitored by program directors as follows:

1. Where applicable, programs should track residents' performance and pass rates on In-Service examinations and Board-certifying and recertifying examinations.
2. Programs should generate reports from New Innovations to:

- a. Track each resident's performance over time.
- b. Compare each resident's individual performance to that of his or her peers.

Residents should be evaluated while on wards, on electives, and in continuity clinic, and should be evaluated by faculty, junior residents, and students. Peer and self-evaluations are desirable.

3. Programs should foster resident self-assessment, utilizing standardized forms as well as outside resources (e.g., the Pedialink program of the American Academy of Pediatrics).
4. Programs should use charts or electronic medical record reviews to track patient outcomes. Examples include:
 - a. Management of diabetes, hypertension or asthma.
 - b. Use of screening tests/tools for breast cancer, domestic or child abuse, depression.
 - c. Immunization rates.
5. Direct observation of resident performance, along the lines of the Internal Medicine CEx, should be considered.
6. Programs should keep records of their graduates' publications.
7. Programs should use the National Practitioner Data Bank to monitor adverse outcomes.

I. ISSUANCE OF DISCIPLINE OR ACADEMIC ADVISEMENTS TO HOUSE STAFF

The information provided below supplements School policy for "Disciplinary Action." In issuing Discipline or Academic Advisement, one must act in accordance with the "Disciplinary Action" policy in various House Staff Manuals. Any questions concerning this issue or the imposition of Discipline or Academic Advisement should be directed to the Senior Associate Dean for Graduate Medical Education ((212) 241-6694) and the Director of Graduate Medical Education (at affiliate institutions).

1. Types of Intervention

The proper level of intervention should be selected:

- a. An Academic Advisement (or "academic alert") is issued when a House Staff Officer's academic performance does not meet departmental standards but is not sufficiently below standard to warrant disciplinary action.
- b. Disciplinary Action may include, but is not limited to, a written warning, probation, summary suspension, suspension pending investigation, or termination. The type of discipline will depend upon the circumstances of each case.

2. Job Retention

A House Staff Officer may be disciplined, or terminated from his or her residency program, for failure to abide by the By-laws, Rules, and Regulations, or policies of the Medical Center or of the medical staff; for falsification of any Medical Center document; for any activity that may threaten the safety or welfare of a patient, employee, or other physician; or for any action that may be detrimental to Medical Center operations.

3. Administrative Suspension

Operative reports are to be dictated as soon as possible after surgery. Discharge summaries are to be completed immediately following discharge. If a resident has not completed his/her medical records at the time of the patient's discharge, he/she should obtain the record for completion in the chart completion area of the Medical Records Department. House Staff will be notified by mail of chart deficiencies. Charts not completed within 30 days (including signatures) are deemed delinquent. The Medical Board has approved suspension of admitting and operating privileges of physicians with delinquent medical records. Department Chairpersons will be notified of any delinquent records.

When a resident is on rotation at an affiliate hospital, it is his/her responsibility to complete dictation of all his/her medical charts before rotating to another affiliate or returning to their home institution. Department Chairpersons should notify affiliate hospitals of any delinquent records.

4. Investigation and Documentation

Whenever possible, Academic Advisement or Discipline should be issued after a full investigation, which may or may not include an interview with the House Staff Officer.

The Program Director should maintain documentation of any incidents or issues that may ultimately lead to Academic Advisement or Discipline in order to provide evidence of the House Staff Officer's conduct and any measures taken by the program. Documentation is often critical to due process if the House Staff Officer challenges the action taken. Because Disciplinary Action should be considered if the House Staff Officer does not meet the requirements of an Academic Advisement, Academic Advisement should also be fully documented.

To this end, performance evaluations should be complete, candid, timely, and precise. Contemporaneous memoranda and other correspondence are also helpful. Note, however, that in some instances when it is not possible to document all issues, Disciplinary Action may still be appropriate.

5. Communication to the House Staff Officer

Communication is an important part of Academic Advisement or Disciplinary Action. Where possible, it is recommended that the type of intervention, the reasons for it, and any expected corrective action, be first communicated to the House Staff Officer in person. At that time, or immediately thereafter, written notice of Academic Advisement or Disciplinary Action should be provided. To ensure receipt and compliance with the policies set forth in the House Staff Manual, it is recommended that notice be hand-delivered or sent by Certified Mail with return receipt requested. If the notice is hand-delivered, it may be helpful to make the delivery in the presence of a witness and to have the House Staff Officer sign a document indicating receipt. If the House Staff Officer refuses to sign, the witness should document the refusal. Appropriate language is available from the Labor Relations Division of Human Resources. Written notice of an Academic Advisement must specify the nature of the problem as well as the steps the House Staff Officer must take to remedy the problem. Written notice of Disciplinary Action must specify the action taken or the type of discipline; the terms of any monitoring, probation, or other restrictions; and the reasons for imposing discipline. Any relevant documentation (as described in the House Staff Manual) may be useful in preparing the notice.

The House Staff Manual specifies who may issue disciplinary action and how the discipline should be communicated. The Department Chairperson and/or Program Director should sign notices of Academic Advisement. The Department Chairperson, Hospital Director, or other appropriate person should generally sign notices of Disciplinary Action. In some instances, a Chief of Service may sign the notice. (Affiliated institutions may have differing or additional requirements.)

Where Disciplinary Action short of termination is imposed, it is appropriate to advise the House Staff Officer of the possible consequences of his or her failure to comply with the corrective action (for example, that similar future conduct may result in termination). The notice should inform the House Staff Officer of his or her right to a hearing, and should include a description of due process, as provided in the House Staff Manual. One may also wish to include a copy of the House Staff Manual's provisions concerning Disciplinary Action. Note that the resident has a right to a hearing when Disciplinary Action includes the nonrenewal of his or her contract.

6. Reporting Disciplinary Action

While policies may vary at affiliated hospitals, it is not necessary to report Academic Advisement to institutional administration at The System Hospitals. However, Disciplinary Action must be reported to the GME Office, the Director of Graduate Medical Education, and the Labor Relations division of the Human Resources Department. Copies of the notice of Disciplinary Action should be placed in the House Staff Officer's departmental and personnel files.

As stated in Section IV of this manual, New York State Law requires that institutions report: a) the suspension, restriction, termination, or curtailment of training, employment, association, or professional privileges, or the denial of the certification of completion of training for reasons related to alleged mental or physical impairment, incompetence, malpractice, misconduct, or impairment of patient safety or welfare; b) the voluntary or involuntary resignation or withdrawal of association or of privileges with the Hospital to avoid the imposition of disciplinary measures; c) the receipt of information indicating that a physician has been convicted of a crime; or d) denial of staff privileges for the reasons specified in a) above. Certain types of professional misconduct must also be reported. Separate regulations govern reporting to the National Practitioner Data Bank.

While Disciplinary Action is often reportable to the State, an Academic Advisement that does not include the actions described above is not reportable.

Disciplinary Action should also be reported immediately to the offices of the Hospital Director and General Counsel, as reportable actions must be communicated to the State promptly. The GME Offices will help you ensure that the appropriate individuals at each site are correctly involved in the process.

7. Institutional Support

One should consult with the Senior Associate Dean for Graduate Medical Education when evaluating what discipline to impose, how to impose it, or during any other steps of the process. The offices of the Hospital Director and General Counsel should be advised of any requests for a hearing following notification of Disciplinary Action.

Policies and procedures for disciplinary action are available in each institution's House Staff Manual.

J. PROGRAM CLOSURE OR REDUCTION AND ADVERSE ACCREDITATION ACTIONS

Program Directors must notify each affected House Staff Officer immediately:

1. Of a decision to discontinue any training program for any reason; and/or
2. Upon receipt from the Accreditation Council for Graduate Medical Education, Council on Podiatric Medical Education or the Commission on Dental Accreditation of any confirmation of an adverse accreditation action.

If a decision is made to significantly reduce the size of a residency program or to close a program, Program Directors must inform the affected House Staff Officers of this decision as soon as possible. In such cases, the Program Director must allow House Staff Officers already in the program to complete their education if possible, or must assist the House Staff Officers in enrolling in accredited programs within the Consortium or at other institutions.

K. PHYSICIAN IMPAIRMENT

The Physician Wellness Committee investigates physicians who are suspected of impairment. Impairments can be of many etiologies, including drug abuse, psychiatric impairment, personality disorders, and physical limitations affecting patient care and/or collegial behavior. If impairment is suspected, the Program Director (or other faculty or staff) must report this physician, regardless of status, to the Impaired Physician Committee for evaluation. (The source of the report is kept confidential.) Timely reporting is necessary to avoid medical errors and harm to patients and/or staff. The Hospital has a legal and moral obligation to ensure the safety and quality of the medical care it provides, and to assist the impaired physician in seeking treatment and rehabilitation, by evaluating physicians suspected of impairment.

The stresses inherent in residency training may often cause some House Staff to experience increased anxiety and difficulty in functioning. In addition, either before or during residency training, a resident may have resorted or will resort to the use of mood-altering drugs to sustain his/her functioning. It is the responsibility of the Program Director to make residents aware of the signs and symptoms of impairment, and to be knowledgeable of the proper steps to take when impairment is detected.

Information is provided to the House Staff in the House Staff Manual concerning physician impairment. However, from the perspective of the Program Director, it is essential that a House Staff Officer's difficulty in functioning is identified as quickly as possible and addressed expeditiously. This provides the most help to the resident and helps to prevent any adverse events with respect to patient care. If a resident seems depressed or overly anxious or if his or her function seems otherwise impaired, an administrative psychiatric evaluation may be requested. In such cases, the report concerning the resident's ability to participate in program activities will be filed with the Program Director. If it is felt that an administrative evaluation is not necessary, a recommendation should be made to seek psychotherapy.

A Program Director may suspect a physician of using mood-altering drugs based on certain behaviors associated with drug use. However, a urine toxicology screen must be obtained to confirm drug use. Consistent with institutional guidelines, an employee's refusal to give a spot urine sample for analysis (for cause) is grounds for immediate suspension and possible termination. Instances of physician impairment due to drug use should be reported to the Physician Wellness Committee at your institution. The Physician Wellness staff can meet with the resident and subsequently make recommendations to treat impairment.

The GME Offices at each institution should be contacted if impairment is suspected to ensure that the resident receives appropriate support and to ensure compliance with hospital policies and legal requirements.

L. THE INTERNATIONAL MEDICAL GRADUATE

1. The Educational Commission for Foreign Medical Graduates (ECFMG)

All candidates for residency training who are foreign trained International Medical Graduates must receive certification by the ECFMG regardless of their visa eligibility (with a few

exceptions). The United States Department of State has designated the ECFMG as the only organization authorized to sponsor foreign national physicians to engage in graduate medical education or training.

The ECFMG will only provide certification to qualified individuals who are entering ACGME-approved residency programs. Foreign-born IMGs who wish to enter non-ACGME-approved programs will not routinely be able to receive ECFMG approval. However, ECFMG approval can, on an exception basis, be given to foreign national physicians who wish to enter the United States for advanced training in programs involving observation, consultation, teaching, or research, with or without patient contact, without necessarily having received the ECFMG certificate. These visitors cannot be engaged in residency training or be involved in the treatment of patients.

Health Code (see below), which allows physicians licensed in their own country to enter the United States without ECFMG certification to engage in clinical training under appropriate supervision for a period not to exceed six months. Unfortunately, although this is permitted by the State of New York, the ECFMG will not routinely give certification to allow residents to do this unless they have already received the ECFMG Certificate, and the United States Citizenship and Immigration Service (USCIS) will not issue J-1 or H-1B visas without ECFMG certification.

2. *Visas*

Available visa types for residency or fellowships are:

- a. Exchange visitor (J-1)
- b. Temporary worker (H-1B)
- c. Temporary worker (E-3)
- d. Valid employment authorization card “EAD”(includes J-2, L-2, OPT etc.), or
- e. O-1, Alien of Extraordinary Ability

All visas are employer and site specific. Special permission must be obtained from International Personnel if a resident/fellow wishes to work at another site. International Personnel must be notified immediately of any terminations, disciplinary action, or change in training related to a resident/fellow on a visa. Residents/Fellows on visas are not permitted to moonlight.

a. ECFMG Clinical J-1 Visa

ECFMG sponsorship is routinely given to individuals who have ECFMG certification and are accepted into ACGME approved programs or programs recognized by the American Board of Medical Specialties.

In general, the J-1 visa is granted up to 7 years in this category, which allows sufficient time to complete the educational requirements for certification as recognized by the ACGME. Certain exceptions are considered to extend beyond 7 years if the American Board of Medical Specialties requires an extra year of research beyond the accredited length recognized by the ACGME. In addition, visa extensions can be obtained if the resident is appointed Chief Resident, providing such an appointment is competitive, responsibilities are clearly defined, and the position is eligible for Health

Care Financing Administration (HCFA) reimbursement.

Upon termination of the J-1 visa, as per immigration regulations, the physician is required to return to his/her home country for a period of two years. If the physician wishes to remain in the United States upon completion of the time allotted by ECFMG, he/she may apply for a J-1 Waiver of the two-year home residency requirement. Successful completion of USMLE 1 & 2 is required.

b. Temporary Worker H-1B Visa

The H-1B visa is a nonimmigrant visa issued to workers coming to the United States to perform work within one of the designated “specialty occupations.” The H-1B category allows specialty workers to enter the United States to work for a period of up to six years, which is issued in three-year increments. A “specialty occupation is defined as an occupation requiring the alien to possess theoretical and practical application of a body of highly specialized knowledge. In order to meet this requirement, immigration regulations require the applicant to have a bachelor’s degree or its equivalent in an enumerated specialty for entry into the United States in that occupation.

Foreign medical doctors applying to a clinical employer or residency training program for H-1B classification must additionally show:

- a. A state medical license;
- b. Successful completion of USMLE 1, 2 & 3;
- c. English language proficiency as documented by ECFMG certification or a medical school diploma from a U.S. accredited school; and
- d. A M.D. or equivalent foreign degree or unrestricted foreign Clinical Medical License. If a FMG has obtained a J-1 waiver of the two-year home residency requirement, J-1 doctors may change their status to that of an H-1B.

If the H-1B employee is terminated, the employer is responsible for reasonable return transportation costs. Upon termination, the employer will notify the immigration service that they wish to withdraw the H-1B petition since the employee is no longer in their employ.

c. Temporary Worker E-3 Visa

The E-3 is a visa category available only for Australian citizens coming to the U.S. to work temporarily in a specialty occupation. “Specialty occupation” is one that requires a theoretical and practical application of a body of specialized knowledge and the attainment of a bachelor’s or higher degree in the specific specialty (or its equivalent) as a minimum for entry into the occupation in the United States.

An E-3 applicant must meet academic and occupational requirements, including licensure where appropriate, for admission into the United States in a specialty occupation. If the job requires licensure or other official permission to perform the specialty occupation, the applicant must submit proof of the requisite license or permission before the E-3 visa may be granted. In certain cases where such a license or other official permission is not immediately required to perform the duties described in the visa application, the alien must show that he or she will obtain such licensure within a reasonable period of time following admission to the United States.

E-3 applicants are admitted for a two-year period renewable indefinitely in one year increments, provided the applicant is able to demonstrate that he/she does not intend to remain or work permanently in the U.S.

Applicants are not required to have USMLE's or ECFMG certification to be eligible for E-3 status. It is important to note that the E-3 visa is employer-specific. If the E3 employee is terminated, the employer is responsible for reasonable return transportation costs. Upon termination, the employer will notify the immigration service that they wish to withdraw the E-3 petition since the employee is no longer working for the employer.

d. Persons of Extraordinary Ability - O-1 Visa

This classification is reserved for persons of extraordinary ability demonstrated by sustained national or international acclaim. The O-1 is rarely offered to residents/fellows and should not be offered to applicants until International Personnel has reviewed for eligibility. Unlike the J-1 and H-1B visas, no special examination requirements apply.

e. Lawful Permanent Resident (Immigrant)

This status is given to individuals who hold green cards. These individuals are permitted to remain in the United States permanently and to accept any employment for which they qualify (including appointment to a residency program).

3. International Personnel Office

International Personnel oversees all employment based immigration matters for the health system. Program Directors should confer with International Personnel prior to extending offers to foreign medical graduates to ensure visa eligibility. On several recent occasions departments have asked International Personnel to accept foreign nationals without the appropriate visas into a program, Program Directors should be aware, that International Personnel cannot accommodate such requests without placing the institution in violation of federal regulations and in danger of receiving substantial fines and penalties.

This section offers a reminder of some of the ground rules governing our responsibility to our immigration program. International Personnel is responsible for ensuring continued compliance with all applicable Homeland Security, U.S. Department of Labor, and U.S. Department of State regulations as they relate to our foreign national employees. In a continuing effort to ensure compliance, the following procedural guidelines must be followed:

- a. Under no circumstance is any foreign national allowed to work, study, observe, or volunteer without an appropriate visa. The process should begin at least 45 days prior to the anticipated arrival of the foreign national by filing the appropriate application with the International Personnel.
- b. Departments may not request a change in an employee's immigration status in an effort to reflect a more positive tax analysis.
- c. Employees are not permitted to use outside counsel for employment-based immigration petitions unless exigent circumstances exist. Additionally, employees must obtain permission to work with outside counsel from the

Director of International Personnel. Medical residents are not eligible for employer-based sponsorship.

Please note that immigration regulations change from time to time. Updates to immigration changes are available from [Human Resources](#).

Any questions or requests for more information should be directed to the Director of International Personnel at (212) 241-8300.

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VII. GME RESOURCES

A. THE HOUSE STAFF MANUAL

Each participating institution has its own House Staff Manual, which sets forth the rights, benefits, responsibilities, policies and procedures that apply to training. It should be emphasized to all House Staff that it is important for them to be familiar with their Manual's content and to refer to it when any questions arise concerning policies and benefits. The House Staff Manuals may be accessed on the [GME website in the Resources section](#).

B. HOUSE STAFF REPRESENTATION

Feedback from residents provides a vital means of improving their training, and there are a number of forums where residents may share their ideas.

The ACGME requires House Staff representation on all appropriate institutional and departmental committees. In the GME Consortium, House Staff representation exists on the GME Committee and its subcommittees. Residents serve on a variety of institutional committees at each of the participating hospitals.

Each participating institution has House Staff Council, a forum for residents to communicate and exchange information regarding their educational and work environment, their programs, and other resident issues. The Council serves as a forum for communication among trainees; represents the interests of trainees in its activities and in the School community; provides recommendations to the Associate Dean for Graduate Medical Education on issues pertaining to Graduate Medical Education; reports regularly on its activities to the Graduate Medical Education Committee; and informs other trainees of the Council's activities.

Program Directors play a critical role in ensuring that residents are familiar with and utilize our established internal mechanisms to present and discuss issues, and to serve on appropriate departmental committees. The administration relies upon Program Directors to address and resolve issues the residents raise and to bring appropriate issues to the administration's attention. It is also essential that Program Directors explain to residents and fellows why it may not always be possible to implement their requests. Program Directors' use of resident input is assessed in the Internal Review of the residency program. Effective two-way communication by the Program Directors with their residents is essential in assuring that we provide an environment conducive to high-quality residency training.

C. THE OMBUDS OFFICE

The Ombudspersons may assist your trainees with:

- Academic or career concerns
- Harassment, discrimination, or other unfair treatment
- An interpersonal dispute in need of a neutral third party

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- Uncertainty about or unfair application of a policy
- Knowledge of misconduct
- Personal issues
- Issues involving intellectual property

Each institution has its own Ombuds staff; please contact your GME Office for further details

D. INSTITUTE FOR MEDICAL EDUCATION

In 2001, The Institute for Medical Education (IME) was created to establish an administrative entity devoted entirely to the advancement of teaching skills and the support of educators who fuel our teaching community. Nationally, there are approximately 20 Academies/Institutes of Educational Excellence. The IME was one of the first in the United States and its medical education leaders have become a national presence in the world of Medical Education.

1. Mission Statement

The IME serves the vital need of educating, mentoring, and retaining the best educators for students, residents and faculty. Fostering the success of educators includes recognizing and rewarding those who display dedication and excellence in their work, providing programs that develop and reinforce their teaching skills and their success in the promotions process, and creating a community of dedicated educators who contribute their knowledge and experience back to this community by serving as teachers and mentors.

The IME is a distinct entity within the Department of Medical Education that provides an interdisciplinary, interdepartmental, and inter-institutional context where teachers across departments and at affiliated hospitals can interact, learn from, and support each other's efforts to provide outstanding education, to collaborate on research, and to develop an academic career track. The IME is an inclusive organization that fosters a sense of academic community and support for faculty who see teaching as the major focus of their academic career. Membership is available to all educators and a more advanced level of membership (Fellowship) is being developed to identify the best among teaching faculty and to use this smaller cadre of IME Fellows to support and sustain the IME's goals.

2. Goals and Benefits of Membership

a. Recognition/Reward for Excellence in Education:

- i. Monetary Awards*
- ii. Teaching Awards*
- iii. Fellowship level of membership for selected students, resident and faculty*
- iv. Faculty development (teaching skills, leadership skills)*

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 - v. Opportunities to present scholarly work
- b. Support for Promotion on Educator Track:
 - i. Access to mentors
 - ii. Faculty Development (CV and portfolio writing workshops)
 - iii. Appointments & Promotions letters of support for fellows
 - iv. Support development of scholarship
- c. Support and development in teaching/education:
 - i. Stimulate innovation
 - ii. Access to mentors
 - iii. Share curricula, ideas, time, resources
 - iv. Communication and networking opportunities
 - v. Access to national professional development programs
 - vi. Identify excellence benchmarks
 - vii. Master Clinician teaching programs
- d. Support and development of scholarship:
 - i. Help with development and implementation of educational research projects
 - ii. Communication and networking opportunities
 - iii. Access to national professional development programs
 - iv. Opportunities to present scholarly work (local, regional, national)

3. *Current Programs*

The Institute has developed a number of programs that promote outstanding teaching and educational scholarship for our medical educators.

- a. Teaching Skills Development
 - i. The Resident Teaching Development Program, the first major program developed by the IME in 2001, was for residents, given that they are the primary educators of our students. This 7-hour teaching course is now part of every core clinical specialty residency curriculum.
 - ii. The Teach the Teacher course is the faculty development program held once a year to train faculty to teach and implement the resident teaching curriculum in their own departments.
 - iii. The Teaching Skills Faculty Development Series is open to all ISMMS faculty. Topics include small group teaching skills, bedside teaching, teaching on rounds, giving effective lectures, creating exam questions, writing goals and objectives, developing scholarship, leadership skills, and other topics by request.
 - iv. Becoming a Medical Teacher is a fourth-year medical student elective. We believe that doctors are lifelong teachers of patients and that formal teaching skills

- A instruction should begin in medical school.
- b. Professional Development
- i. The Educational Leadership Conference is an annual faculty development retreat for all course directors, clerkship directors, deans, and other educational leaders. Medical Education Grand Rounds is a bimonthly conference that serves as a forum for educators to exchange ideas about curricular innovations, new teaching theories, research in education, use of technology, or mentorship of teachers.
 - ii. The Harvard Macy Program for Physician Educators is a 2-week program designed to enhance the educational scholarship of physician educators. Thus far, the IME has sponsored approximately 23 faculty with key roles in education to attend this internationally recognized program. They have returned to make substantial educational contributions for students, residents, and faculty.
- c. Reward and Recognition
- i. Teacher Appreciation Day: Excellence in Teaching awards are presented to those faculty nominated by students and colleagues as their best teachers and mentors.
 - ii. Education Research Day provides a forum for faculty to present their innovative educational projects and research. The Blue Ribbon recipients are sponsored to present their work at the AAMC (Association of American Medical Colleges) Annual Meeting.

More detailed descriptions of programs can found on the [IME website](#).

E. RESIDENTS TRAVEL FUND

The Travel Fund reimburses residents for travel to professional meetings where they are presenting their scholarly work. Such involvement boosts the reputation of both the specific program and the School of Medicine. Awards are limited to \$700 per individual per academic year. The completed funding request form (Appendix 10) should be sent via email to julia.fiore@mssm.edu.

F. VISITING ELECTIVES PROGRAM FOR STUDENTS UNDERREPRESENTED IN MEDICINE

A competitive electives program has been designed to increase the diversity of House Staff, and consequently that of faculty, at ISMMS by making subsidized electives available to third- and fourth-year underrepresented minority students.

These four-week electives are offered on a space-available basis to selected third- and fourth-year medical students in good standing at accredited medical schools. The electives are offered to third-year students between March and June, and to fourth-year students between July and February.

Interested students should consult our Electives Manual for specific application instructions.

Reimbursement is provided for travel, and attempts are made to provide housing at the

A host institution for successful applicants. For the duration of the elective, students have access to seminars and other facilities at the School of Medicine and the affiliated hospital. Faculty advisors meet with the students on a regular basis.

Applicants may find information and application materials online. The student should rank his/her first three choices of electives and institutions on the application form. Virtually all institutions offer General Medicine and Pediatrics senior electives. In addition to the application, the following must be included:

- a. Curriculum Vitae
- b. Official medical school transcript
- c. United States Medical Licensing Examination (USMLE) Step 1 score (Score Card)
- d. Letter of recommendation from the Dean
- e. Letter of recommendation from a faculty member at the student's school in the department to which the student is applying

The above material must be mailed with the completed application to the Center for Multicultural and Community Affairs at vepsum@mssm.edu.

G. THE GME WEBSITE

The GME website briefly describes the Consortium and provides links to all participating institutions. All Program Directors should access this website to make certain that both their institutions and their programs are described accurately. Web updates should be submitted via your departmental IT liaison.

H. JOBSITE

The Jobsite has been developed to assist residents who are completing their training in their search for career opportunities. It can be accessed at <http://careers.mountsinaihealth.org/physician/>

I. BIOETHICS PROGRAM

The Bioethics Program, directed by Rosamond Rhodes, Ph.D., offers a number of education programs to Consortium members, including: resident and faculty participation in conferences and seminars, graduate programs, Ethics Committee training sessions, and conference and departmental Grand Rounds presentations by Bioethics Program staff. The Bioethics Program may be contacted at (212) 241-6602.

VIII. APPENDICES - the forms below are presented for informational purposes only. Your coordinator either has the official PDF versions or can request them from the GME Office.

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Appendix 1: List of Useful Web Addresses

[Association of American Medical Colleges: http://www.aamc.org/](http://www.aamc.org/)

[American Board of Medical Specialties: http://www.abms.org/](http://www.abms.org/)

[Accreditation Council for Graduate Medical Education \(ACGME\): http://www.acgme.org/](http://www.acgme.org/)

[Educational Commission on Foreign Medical Graduates: http://www.ecfm.org/](http://www.ecfm.org/)

[Electronic Residency Application Service \(ERAS\): http://www.aamc.org/students/eras/](http://www.aamc.org/students/eras/)

[Fellowship and Residency Electronic Interactive Database \(FREIDA\): http://www.ama-assn.org/ama/pub/category/2997.html](http://www.ama-assn.org/ama/pub/category/2997.html)

[GME Track: https://services.aamc.org/gme/admin/login/index.cfm/](https://services.aamc.org/gme/admin/login/index.cfm/)

[Greater New York Hospital Association \(GNYHA\): http://www.gnyha.org/](http://www.gnyha.org/)

[GME Consortium: http://icahn.mssm.edu/education/residencies-fellowships](http://icahn.mssm.edu/education/residencies-fellowships)

[Institute for Medical Education: http://icahn.mssm.edu/research/institutes/institute-for-medical-education](http://icahn.mssm.edu/research/institutes/institute-for-medical-education)

[Health System Jobsite: http://careers.mountsinaihealth.org/physician/](http://careers.mountsinaihealth.org/physician/)

[New Innovations: http://www.new-innov.com/](http://www.new-innov.com/)

[New York State Department of Education: http://www.nysed.gov/](http://www.nysed.gov/)

[New York State Department of Health: http://www.health.state.ny.us/](http://www.health.state.ny.us/)

[National Resident Matching Program: http://www.nrmp.org/](http://www.nrmp.org/)

Appendix 2: Program Letter of Agreement (Affiliates)



Icahn School of Medicine at Mount Sinai
Graduate Medical Education
Program Letter of Agreement (PLA)

[INSTITUTION] [SPECIALTY RESIDENCY / FELLOWSHIP] Training Program

and

[AFFILIATED SITE NAME]

*This document serves as an Agreement between **[INSTITUTION SPECIALTY RESIDENCY / FELLOWSHIP] Training Program** and **[AFFILIATED SITE NAME]** involved in resident/fellowship education.*

This Letter of Agreement is effective from **[DATE]**, and will remain in effect for five years, or until updated, changed or terminated by the **[INSTITUTION SPECIALTY RESIDENCY / FELLOWSHIP] Training Program** and **[AFFILIATED SITE NAME]**.

1. Persons Responsible for Education and Supervision:

At Sponsoring Institution: **[PROGRAM DIRECTOR]**

At Participating Site: **[LOCAL DIRECTOR]**

List other faculty by name or general group:

[LIST FACULTY HERE]

The above-mentioned people are responsible for the education and supervision of the residents/fellows while rotating at **[AFFILIATED SITE NAME]**.

2. The faculty at **[AFFILIATED SITE NAME]** must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. The specific evaluation process will be approved by the Program Director.

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If a problem is identified with a resident, immediate feedback will be given to the resident involved and transmitted to the Program Director. Residents' activities will be governed by those policies and procedures at the residents' home institution.

3. The content of the educational experiences has been developed according to ACGME Residency/Fellowship Program Requirements, and includes the following competency-based goals and objectives:

[INSERT GOALS AND OBJECTIVES HERE]

OR (CHOOSE ONE OR THE OTHER)

In cooperation with Program Director, Site Director and the faculty at Participating Site are responsible for the day-to-day activities of the Residents/Fellows to ensure that the outlined goals and objectives are met during the course of the educational experiences at Participating Site.

[INSERT GOALS AND OBJECTIVES HERE]

4. The duration(s) of the assignment(s) to the participating site is (are):

[LIST DURATION OF ASSIGNMENT; WHICH PGY-LEVELS ROTATE]

5. During assignments to **[AFFILIATED SITE NAME]**, resident/fellows will be under the general direction of the Icahn School of Medicine at Mount Sinai's Graduate Medical Education Committee's and Program's Policy and Procedure Manual and Participating Site's policies for AY2015-2016.

6. This document is a supplement to and incorporates by reference the terms of the Institutional Affiliation Agreement signed between **[INSTITUTION]** and **[AFFILIATED SITE NAME]**. As such, it will only address issues pertaining to the **[SPECIALTY]** Residency Training Program at **[INSTITUTION]**.

7. Salary, benefits, and liability coverage for residents while on rotation to **[AFFILIATED SITE NAME]** will be covered by **[INSTITUTION]**. **[AFFILIATED SITE NAME]** agrees to reimburse **[INSTITUTION]** for salary and fringe for the time the residents spend at **[AFFILIATED SITE NAME]**. The reimbursement amount for **[number of]** FTEs for the rotation period (start date – end date) is estimated at **[dollar amount]**.

Agreed by:

Program Director at Home Institution
Site)

Signed: _____

Site Director (Clinical Supervisor at Affiliated

Signed: _____

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Print Name: _____

Date: _____

Designated Institutional Official
Icahn School of Medicine at Mount Sinai

Signed: _____

Print Name: I. Michael Leitman, M.D., F.A.C.S

Date: _____

Print Name: _____

Date: _____

Designated Institutional Official
Receiving Institution

Signed: _____

Print Name: _____

Date: _____



**Icahn School of Medicine at Mount Sinai
Graduate Medical Education
Program Letter of Agreement (PLA)**

***[Sponsoring Institution's Residency/Fellowship Program
and Non-Affiliated Site]***

This document serves as an Agreement between [Sponsoring Institution's Residency/Fellowship Program and Participating] Site involved in resident/fellowship education.

This Letter of Agreement is effective from ___/___/____, and will remain in effect for five years, or until updated, changed or terminated by the Residency/Fellowship Program and Participating Site.

1. Persons Responsible for Education and Supervision

At Sponsoring Institution: Program Director

At Participating Site: [Local Director]

List other faculty by name or general group:

The above-mentioned people are responsible for the education and supervision of the residents/fellows while rotating at Participating Site.

2. Responsibilities

The faculty at Participating Site must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.

3. [NON-AFFILIATED SITE NAME] shall obtain and maintain in full force and effect at its sole cost and expense, throughout the term hereof (i) commercial general liability insurance (including, but not limited to, contractual liability) in the amount of no less than \$1,000,000 per occurrence/\$3,000,000 in the aggregate for personal and bodily injury

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and broad form property damage and (ii) professional liability insurance in the amount of no less than \$1,300,000 per occurrence/\$3,900,000 in the aggregate covering **[NON-AFFILIATED SITE NAME]**, its trustees, officers and employees for negligent acts or omission or commission arising out of this Agreement. **[NON-AFFILIATED SITE NAME]** shall give **[THE CONSORTIUM INSTITUTION]** thirty (30) days prior written notice of any change in, or cancellation of such insurance. Prior to the commencement of this Agreement, **[NON-AFFILIATED SITE NAME]** shall deliver to **[THE CONSORTIUM INSTITUTION]** certificate(s) of insurance evidencing such insurance. Nothing stated herein shall in any respect limit the indemnities contained in this Agreement.

4. **[THE CONSORTIUM INSTITUTION]** shall obtain and maintain in full force and effect at its sole cost and expense, throughout the term hereof: (i) commercial general liability insurance (including, but not limited to, contractual liability) in the amount of no less than \$1,000,000 per occurrence/\$3,000,000 in the aggregate for personal and bodily injury and broad form property damage and (ii) professional liability insurance in the amount of no less than \$1,300,000 per occurrence/\$3,900,000 in the aggregate covering **[THE CONSORTIUM INSTITUTION]**, its trustees, officers and employees for their negligent acts or omission or commission arising out of this Agreement. Such insurance will be with a carrier acceptable to **[NON-AFFILIATED SITE NAME]**. **[THE CONSORTIUM INSTITUTION]** shall give thirty (30) days prior written notice of any change in, or cancellation of such insurance. Prior to the commencement of this Agreement, **[CONSORTIUM INSTITUTION]** shall deliver to **[NON-AFFILIATED SITE NAME]** certificate(s) of insurance evidencing such insurance. Nothing stated herein shall in any respect limit the indemnification contained in this Agreement.

5. Salary, benefits, and liability coverage for residents while on rotation to **[NON-AFFILIATED SITE NAME]** will be covered by **[THE CONSORTIUM INSTITUTION]**.

6. **[NON-AFFILIATED SITE NAME]** shall indemnify, defend and hold harmless **[THE CONSORTIUM INSTITUTION]**, its trustees, employees, officers, and representatives from and against any and all damage, expense, causes of action, suits, claims, judgments or liabilities by reason of the negligent acts or omissions of **[NON-AFFILIATED SITE NAME]**, its officers and employees (including employed instructors or faculty members) arising out of this Agreement. This provision shall survive the term and termination of this Agreement.

7. **[THE CONSORTIUM INSTITUTION]** shall indemnify, defend and hold harmless **[NON-AFFILIATED SITE NAME]**, its trustees, officers, employees, and representatives from and against any and all damage, expense, causes of action, suits, claims, judgments or liabilities by reason of the negligent acts or omissions of **[THE**

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CONSORTIUM INSTITUTION], its officers and employees (including its employed instructors or faculty members) arising out of this Agreement. This provision shall survive the term and termination of this Agreement.

8. Educational Goals and Objectives:

[INSERT GOALS AND OBJECTIVES HERE]

Period of Assignment of Residents:

[LIST DURATION OF ASSIGNMENT; WHICH PGY-LEVELS ROTATE]

9. Educational Responsibilities: It is agreed that the faculty at **[NON-AFFILIATED SITE NAME]** will provide the appropriate educational and clinical supervision of house staff. Evaluations of house staff performance will be forwarded to the Program Director upon completion of the rotation. The specific evaluation process will be approved by the Program Director. If a problem is identified with a resident, immediate feedback will be given to the resident involved and transmitted to the Program Director. Residents' activities will be governed by those policies and procedures of the residents' home institution.

Agreed by:

Program Director at Home Institution

Signed: _____

Print Name: _____

Date: _____

Site Director (Clinical Supervisor)

Signed: _____

Print Name: _____

Date: _____

Designated Institutional Official at the Icahn School of
Medicine at Mount Sinai

Signed: _____

Print Name: I. Michael Leitman, M.D., F.A.C.S

Date: _____

Medical Director or Equivalent at
Rotation Site

Signed: _____

Print Name: _____

Date: _____

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Appendix 4: Program Letter of Agreement (Other Non-Affiliated Sites)
RESIDENCY ROTATION AGREEMENT
For Non-Hospital Sites

This Residency Rotation Agreement (“Agreement”) is made and entered into effective _____, by and among **CONSORTUIM INSTITUTION** and **[NON-HOSPITAL SITE NAME]** (“Non-Hospital Site”).

RECITALS

WHEREAS, _____ participates in an approved medical residency program (“Program”) intended to provide education, training, and clinical experience to residents participating in the Program (“Residents”);

WHEREAS, Non-Hospital Site operates a **[TYPE OF CLINICAL SETTING]** and provides patient care services in the area of **[SPECIALTY]** specifically focusing on **[TYPE OF PROCEDURES/EXPERIENCES]** (“The Site”);

WHEREAS, Physicians employed or contracting with Non-Hospital Site diagnose and treat patients and Residents furnish patient care services with the physicians as part of their training at The Site;

WHEREAS, MSH makes claims to the Medicare program for payment of graduate medical education (“GME”) costs and desires to include time spent by Residents at The Site as part of the calculation used to make claims to the Medicare program for payment of GME costs;

WHEREAS, MSH is required to pay all or substantially all of the costs of the training Program, as defined by Medicare requirements, at The Site in order to make claims to the Medicare program for GME costs; and

WHEREAS, The Site is not a hospital or part of a hospital as defined by Medicare.

NOW THEREFORE, in consideration of the mutual recitals and promises contained herein, the parties agree as follows:

1. **Payment of Resident Costs.** MSH incurs and shall bear all the costs of employing Residents (including salaries and fringe benefits, liability coverage, and where applicable, travel and lodging) (“Resident Costs”) when Residents rotate to The Site. MSH estimates that **[NUMBER]** Resident FTEs will rotate **[NUMBER]** weeks to The Site over the first term of this Agreement. MSH thus estimates that total Resident Costs for rotations to The Site are \$ **[RESIDENT SALARY AND FRINGE BENEFITS divided by 52 multiplied by NUMBER OF WEEKS OF ROTATION multiplied by NUMBER OF RESIDENTS ROTATING PER YEAR]** for the first term of the Agreement.

2. **Insurance and Indemnification.** Non-Hospital Site shall obtain and maintain in full force and effect at its sole cost and expense, throughout the term hereof (i) commercial general

A liability insurance (including, but not limited to, contractual liability) in the amount of no less than \$1,000,000 per occurrence/\$3,000,000 in the aggregate for personal and bodily injury and broad form property damage and (ii) professional liability insurance in the amount of no less than \$1,300,000 per occurrence/\$3,900,000 in the aggregate covering Non-Hospital Site, its trustees, officers and employees for negligent acts or omission or commission arising out of this Agreement. Non-Hospital Site shall give MSH thirty (30) days prior written notice of any change in, or cancellation of such insurance. Prior to the commencement of this Agreement, Non-Hospital Site shall deliver to _____ certificate(s) of insurance evidencing such insurance. Nothing stated herein shall in any respect limit the indemnities contained in this Agreement.

_____ shall obtain and maintain in full force and effect at its sole cost and expense, throughout the term hereof: (i) commercial general liability insurance (including, but not limited to, contractual liability) in the amount of no less than \$1,000,000 per occurrence/\$3,000,000 in the aggregate for personal and bodily injury and broad form property damage and (ii) professional liability insurance in the amount of no less than \$1,300,000 per occurrence/\$3,900,000 in the aggregate covering MSH, its trustees, officers and employees for their negligent acts or omission or commission arising out of this Agreement. Such insurance will be with a carrier acceptable to Non-Hospital Site. MSH shall give thirty (30) days prior written notice of any change in, or cancellation of such insurance. Prior to the commencement of this Agreement, MSH shall deliver to Non-Hospital Site certificate(s) of insurance evidencing such insurance. Nothing stated herein shall in any respect limit the indemnification contained in this Agreement.

Non-Hospital Site shall indemnify, defend and hold harmless MSH, its trustees, employees, officers, and representatives from and against any and all damage, expense, causes of action, suits, claims, judgments or liabilities by reason of the negligent acts or omissions of Non-Hospital Site, its officers and employees (including employed instructors or faculty members) arising out of this Agreement. This provision shall survive the term and termination of this Agreement.

_____ shall indemnify, defend and hold harmless Non-Hospital Site, its trustees, officers, employees, and representatives from and against any and all damage, expense, causes of action, suits, claims, judgments or liabilities by reason of the negligent acts or omissions of MSH, its officers and employees (including its employed instructors or faculty members) arising out of this Agreement. This provision shall survive the term and termination of this Agreement.

3. **Supervision.** _____ shall designate physicians to be responsible for implementing the **[SPECIALTY]** Residency Training Program and shall serve as contacts to the Program Director and Department Chairperson. The physician(s) shall be **[LIST PHYSICIAN(S) HERE]**.

It is agreed that the physicians at Non-Hospital Site will provide the appropriate supervision of house staff. Evaluations of house staff performance will be forwarded to the MSH Residency Program Director upon completion of the rotation. The specific evaluation process will be approved by the _____ Residency Program Director. If a problem is identified with a resident, immediate feedback will be given to the resident involved and transmitted to the MSH Residency Program Director. Residents' activities will be governed by the policies and procedures of MSH and **[NON-HOSPITAL SITE NAME]**.

4. **Goals and Objectives.** _____ shall maintain goals and objectives for the rotation in compliance with ACGME requirements. **Goals and objectives structured according to the ACGME Core Competencies are attached as Appendix A to this Agreement.**

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5. **Term and Renewal.** The term of this Agreement is one (1) year commencing [START DATE] and continuing through [END DATE]. This Agreement shall renew automatically for successive terms of one year unless either party gives notice of termination one hundred eighty (180) or more days prior to the end of the initial or any renewal term.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement, effective as of the date and year first written above.

Hospital:

Residency Program Director

By: _____

Name: _____

Title: _____

Date: _____

Designated Institutional Official

By: _____

Name: I. Michael Leitman, M.D., F.A.C.S.

Title: Senior Associate Dean for GME

Date: _____

Non-Hospital Site:

[NON-HOSPITAL SITE NAME]

Clinical Supervisor

By: _____

Name: _____

Title: _____

Date: _____

Medical Director or Equivalent

By: _____

Name: _____

Title: _____

Date: _____

Appendix A

Core Competency-Based Goals and Objectives

[LIST HERE]

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Appendix 5: Moonlighting Approval and Attestation

**Icahn School of Medicine at Mount Sinai
Consortium for Graduate Medical Education
Moonlighting Request Form**

I am requesting permission to moonlight, and understand that permission to moonlight is subject to the following conditions:

1. My moonlighting activities must not interfere with responsibilities related to my residency or fellowship program.
2. I must accurately report my moonlighting hours in all work hour surveys.
3. My total work hours must be in accordance with the New York State Hospital Code Section 405 (not applicable in New Jersey programs) and ACGME standards:
 - a. I must not work more than 80 hours per week, averaged over a four-week period.
 - b. I must not work more than 24 consecutive hours (plus up to 3 hours of time to allow transfer of care in New York-based programs and 6 hours for New Jersey-based programs).
 - c. I must have at least one 24-hour period free from clinical duties per week
4. I must inform my training director of all moonlighting shifts and schedules.
5. I understand that professional liability insurance (“malpractice insurance”) has been provided for duties within the scope of my residency or fellowship training. This insurance DOES NOT cover moonlighting activities at other facilities. I understand that I will be required to submit proof of separate and appropriate professional liability coverage that covers the requested moonlighting activity.
6. I must possess and maintain a current, unrestricted medical license.
7. I will not report any cases seen during moonlighting activities in procedure logs maintained by my residency or fellowship program.
8. I understand that approval to moonlight is granted through the end of the academic year in which it is approved, and must be renewed each subsequent academic year.
9. My performance in the residency/fellowship program will be monitored for the effects of moonlighting, and permission may be withdrawn if adverse effects are observed.
10. Permission to moonlight may be withdrawn if academic advisement or disciplinary action is issued to me by the residency/fellowship program.
11. Failure to comply with any of the above items may result in withdrawal of permission to moonlight and/or disciplinary action.

Resident/Fellow Name: _____

Date: _____

Resident/Fellow Signature: _____

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**Icahn School of Medicine at Mount Sinai
Consortium for Graduate Medical Education
Moonlighting Request Form**

Date of Request: _____

Resident/Fellow Name: _____

Residency/Fellowship Program: _____

Moonlighting Employer: _____

Name of Supervisor at Moonlighting Location: _____

Contact Phone # of Supervisor at Moonlighting Location: _____

Description of Moonlighting Duties: _____

Requested Dates of Moonlighting Activity: Start: _____ End: _____

Range of Moonlighting Hours Per Week: From: _____ To _____

Resident/Fellow Will Bill for Professional Services (Yes/No): _____

Professional Liability Carrier: _____

Professional Liability Policy Number: _____

Unlimited Medical License Number (specify state): _____

Resident/Fellow Signature: _____

.....

I have reviewed the above request for moonlighting activity and determined that the resident/fellow has demonstrated eligibility to moonlight. The resident/fellow is not required to engage in moonlighting. The resident/fellow's performance in the residency/fellowship program will be monitored for the effect of moonlighting. Permission to moonlight may be withdrawn if adverse effects are observed. This statement of permission will be retained in the resident/fellow's educational file.

Residency/Fellowship Program Director Signature

Date

Program Director Name (print)