UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Holy Cross
Hospital

Internal Medicine Residency Program Manual

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INTRODUCTION

Dear Housestaff:

Welcome to the start of your Internal Medicine training at the University of Miami at Holy Cross Hospital! I am very excited to work with all of you in the coming year. At UM at Holy Cross Hospital we take pride in the quality of patient care, the resources of educational activities available to you and the culture of caring created by all of our residents, faculty, staff, associates and leadership. This year will bring tremendous growth in your knowledge, skills and your identity as a physician. As part of this program, I am confident that each of you will excel and be capable of caring for a vast array of patients and disease processes as well as lead our healthcare system to continued improvements. While the road may be long, I am sure you each will take great satisfaction in the experiences here at the University of Miami at Holy Cross Hospital.

Lisa C. Martinez, MD
Program Director, Internal Medicine Residency
University of Miami at Holy Cross Hospital

HOLY CROSS HOSPITAL MISSION STATEMENT

Holy Cross Hospital, in partnership with Trinity Health, strives to serve as a compassionate and transforming healing presence within our communities. The vision of this institution is to become the national leader in improving the health of communities and each person served, being the most trusted health partner for life. As a faith-based healthcare ministry, it is vitally important to meet both challenges and opportunities in the context of and in accordance with the institutions "Core Values", including reverence, justice, commitment to those who are poor, stewardship, and integrity. Holy Cross Hospital strives to provide progressive services and programs to meet the evolving healthcare needs of individuals and families.

UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE MISSION STATEMENT

The vision of the University of Miami Miller School of Medicine has a vision to develop the highest quality medical care, research and education in meaningful, sustainable ways while being culturally sensitive to the surrounding community's needs. This is achieved through:

- Delivering high-caliber, compassionate health care
- Leading life-changing discoveries and advancing patient care through innovative research
- Educating the next generation of medical leaders
- Promoting the health of our community

UNIVERSITY OF MIAMI AT HOLY CROSS HOSPITAL INTERNAL MEDICINE

The University of Miami Miller School of Medicine Regional Campus Internal Medicine Training Program is designed to provide residents with a strong background in internal medicine and preparing them for a variety of career paths, while also being able to navigate the future changes that face medicine. Our program has supportive teaching faculty whose goal is to teach and mentor each of our residents. The curriculum offers exposure to many different aspects of medicine, including clinical, research and administrative experiences. Our clinical experiences are vast and cover both inpatient and ambulatory practices, focusing on the knowledge and skills necessary to become a competent, caring General Internist. Our residents will graduate with the clinical reasoning and ability to tackle the variety of challenging clinical scenarios that face practicing internists. Furthermore, with support from the University of Miami and its research curriculum, will prepare our residents to dissect the literature and create new knowledge for the field. Lastly, by working in an Accountable care organization and a patient centered medical home, and having direct experiences in leadership and the administration of healthcare, our residents will be well prepared to face the future changes in medicine.

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RESIDENT RESPONSIBILITIES AND SUPERVISION

CLINICAL RESPONSIBILITIES

Inpatient medicine: Residents working in the hospital during their General Medicine, Intensive Care Unit or Cardiology rotations will be considered the primary care providers for their patients. However they will not be eligible for Medical Staff Privileges, and will assume responsibilities for patient care as delegated by an attending physician of the Medical Staff. The attending physician is ultimately responsible for the care of all patients. First year residents will have direct supervision (at the bedside) or indirect supervision with immediate direct supervision available provided by either an attending physician or appropriate PGY-2 or 3 resident (see resident supervision). PGY-1 residents are expected to obtain a full history and physical on new patients, appropriately focused history and physical on follow up patients daily as well as additional encounters based on patient need and document these encounters. Their interaction with patients should be respectful and professional, and fit within the expectations of all physicians at Holy Cross Hospital and the University of Miami. With the appropriate supervision of the attending physician, residents will develop assessments and management plans appropriate for the patient. They will implement the management plan including entering pharmacy, radiology and laboratory orders in the EMR, and communicating with consultants, primary care physicians, and other healthcare professionals involved in patient care. Attending physicians should be notified of any admissions within 24 hours of admission. Attendings are to be notified of any change in clinical status, new procedures not previously discussed, patient complaint, and additional situations at the discretion of the attending and resident.

Patient care limits in Inpatient medicine:

PGY-1: The PGY1 level resident can have no more than 3 admissions/day and cannot carry more than 10 patients. On weekends, the intern will be directly supervised by the attending.

At night the PGY1 resident can admit up to 4 patients.

PGY-2/3: The PGY2/3 resident supervises an intern. The resident's responsibility is to oversee the care provided by the intern and lead the team to excellence in patient care. PGY-3's should be available to PGY—2's to help them on their progression to leader of a team. Both PGY-2 and 3 should know all patients on the team, regardless of what intern they work with. Upper level residents can see an additional 2 General medicine consults. On the weekends, the resident will cover the other interns patients and be supervised directly by the attending. The intern working that weekend day will also be supervised by the attending.

At night, residents will supervise interns admitting up to 4 patients, and can admit an additional 2 patients.

Patient care limits in ICU:

PGY-1: The PGY-1 level resident can have no more than 3 admissions/day and cannot carry more than 7 patients.

PGY-2/3: The PGY-2/3 resident supervises the intern, and are responsible for overseeing the care provided, leading the team to excellence in patient care. When the resident's intern is off, they are responsible for rounding

on the patients, writing all notes and caring for patient throughout the day. At night, the PGY-3 will admit up to 3 patients, and cross cover all teaching patients. The resident will also be responsible for going to all codes on the floors and assessing possible new admissions to the ICU.

Electives: During outpatient elective rotations, residents will have an opportunity to see a specialty/subspecialty practiced in ambulatory offices and consultations. Residents should refer to the syllabus, and contact the subspecialty education coordinator/rotation director to confirm start location and time. When in the office, residents will see patients and begin to formulate an assessment and management plan. After discussing with supervising physician, and having supervising physician evaluate patient as well, residents will be able to finalize he note, if they have access to the EMR.

If a consult is to be seen, second and third year residents can see patients in the hospital and then review the patient's assessment and plan with attending over the phone until they are able to come in to see patients. First year residents can also see patients independently, however the supervising physician must be available in the hospital for direct supervision if needed.

Continuity clinic: In their continuity clinic, residents will act as the primary care provider for their patients. Each trainee will see patients independently and begin to formulate an appropriate plan. The resident must then present the patient to the supervising physician prior to completing the visit. It is the supervising physician's responsibility to guide each trainee and provide the appropriate amount of oversight. Supervising physicians should be involved in the care of the patient, including evaluating the patient in person.

In the ambulatory setting, residents are responsible for following up on ordered labs, tests and consults on patients. All residents should check their continuity clinic "inbox" daily when on ambulatory rotations to assure all results are followed up in a timely manner. There will be a "firm system," where a resident will have a "clinic buddy" that will cover their inbox when they are on inpatient rotations.

Patient load in continuity clinic:

PGY-1: No more than 6 patients in a half day session at 6 months (progressively increasing over the year)

PGY-2: No more than 6 patients in a half day session

PGY-3: No more than 8 patients in a half day session.

DOCUMENTATION RESPONSIBILITIES

Inpatient: An H&P or progress note should be completed in the Electronic Medical Record by the trainee within 12 hours of the patient encounter and sent to the supervising attending for co-signature and attestation. H&P and progress notes will generally be completed by the PGY-1 resident, although depending on patient load and rotation, PGY-2/3 may complete a note. One note should be completed on a patient each day, including weekends. All Trainees shall write original notes (although can use templates); the use of copy and pasting is discouraged. And not permitted for assessments and plans. After 24 hours of delinquency, residents will receive an electronic reminder to complete the note, and after 3 days of delinquency, Program Director will be notified of delinquency. If the note remains incomplete/delinquent for **more than one week**, disciplinary action may be taken. Trainees will also be responsible for creating and communicating appropriate hand offs of care and

discharge summaries, please see below. The presence of a student note in the chart does not replace the resident note. Writing an addendum to a student note in not an acceptable resident note.

Continuity Clinic: A note must be completed prior to close of day for each patient seen. A note that is not in the chart within 24 hours is considered delinquent, and the supervising physician will be notified. Notes that are delinquent for more than 48 hours will trigger a notification to the Program Director.

Order Entry: All orders on teaching service patients are to be placed in the EMR by residents. In the rare instance an attending must enter an order, this must be communicated with the resident team. For times when a resident's patient is being covered by an attending physician (such as protected conferences or nights), there must be an appropriate transfer of care with rationale for any change in plan to facilitate the resident's learning. Residents will be responsible for following up on results, however the attending physician is ultimately responsible for the care of each patient.

HAND OFFS

INPATIENT: Trainees will be required to give appropriate hand offs and transitions of care for patients prior to leaving the hospital. On General Internal medicine rotations, this will occur between 4-5 pm for short days and at 7 pm on long days. The night team will provide hand offs from overnight at 7am. For the ICU, residents will sign out to the night team and intensivist at 7pm.

At Holy Cross Hospital we use a secure word document on the protected server for written hand offs.

A good hand off requires a shared mental model, meaning both providers must have the same understanding of the patient's condition, plan and contingency. By utilizing the I-PASS mnemonic, a concise but relevant hand off can occur.

- Illness severity
- Patient summary – include identifying information, what led to admission, hospital course, and ongoing assessment/plan
- Action List
- Situation awareness and contingency plan
- Synthesis by receiver

The secure document server is used to compose a written hand off as below. The verbal sign off is still the same.

Identifying information	Patient Summary	Events leading up to admission	Hospital Course	Assessment/plan	To do	Contingency plan
Name MRN Room	Pertinent PMH Allergies Meds					

Code status						

CONTINUITY CLINIC:

There will be a "firm system" where each resident will have a "clinic partner" to cover their tasks and patients. Use of this optimizes communication between providers and exemplifies professional behavior. A quick verbal sign off at the end of the ambulatory week with the clinic partner who will be starting the next week will assure your patients get the best care needed. A printed version can be left in the clinic in a designated secure location for reference for the next two residents in ambulatory while you are on inpatient. Below is a template you can use:

- Any known scheduled follow ups for your patients in the next four weeks;
- Any anticipated issues in your patients over the next four weeks;
- Any labs that need to be followed up and how you would respond to anticipated result;
- Best way to contact you for questions.

DISCHARGE SUMMARIES: Discharge summaries are a form of communication between the physician caring for the patient in the hospital and the physician taking over care at the next level of care (ambulatory, SNF, hospice, etc). Discharge summaries should be completed within 24 hours of discharge and forwarded to the physician assuming care for the patient. Discharge summaries should be concise description of the patient's hospital course, pertinent labs.

If a discharge summary has not been completed within 48 hours of discharge, the trainee will receive a reminder to complete it. After 7 days of delinquency another reminder will be sent to both the trainee and Program Director as notification. After 20 days, if the discharge summary has not been completed disciplinary action may be taken. The attending of record is ultimately responsible for completion of the discharge summary.

RESIDENT SUPERVISION:

Our program recognizes the importance of graded and progressive responsibility in clinical activities in order to facilitate the development of the knowledge and skills needed to enter into unsupervised practice. This progression of responsibilities will be based on the trainee's level of education, ability and experience. The following information is intended to outline requirements for the supervision of residents.

Definitions:

- Direct Supervision: The supervising physician is physically present with the resident and the patient.
- Indirect Supervision with Direct supervision immediately available: The supervising physician is physically in the hospital or other site of patient care and is immediately available to provide direct supervision.

- Indirect supervision with direct supervision available: The supervising physician is not physical in the site of patient care, but is immediately available by electronic or telephonic means, and is available to provide direct supervision.
- Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

For first year residents, direct supervision *or* indirect supervision with direct supervision immediately available will be provided at **all** times. Faculty with appropriate medical staff privileges or senior residents (PGY-2 or higher with appropriate experience) will either be at the bedside with the PGY-1 trainee or *in* the hospital available for immediate supervision and support at the bedside. On weekends, interns are supervised by the attending of service, not the upper level resident.

Second and third year residents will be able to provide supervision to interns and students at the discretion of the attending physician, however they will also be appropriately supervised for their level of training. This includes indirect supervision with either direct supervision available or immediately available. There are certain instances where oversight is provided based on senior residents demonstrated abilities and knowledge. In some situations, such as continuity clinic a third year resident can see a patient oversight by the supervising physician if that patient meets the criteria set out by Medicare for the primary care exception with a CPT code of 99213 or lower. In all of these cases, the supervising physician must review patient course and are ultimately responsible for all care rendered by trainees. Supervising physicians are to review and sign all notes, procedure notes and discharge summaries.

Regardless of trainee post graduate year, supervising faculty must be contacted for the following situations:

- An invasive procedure is required that had not already been discussed previously;
- A patient is being transferred to a higher level of care (for instance a floor patient going to the ICU);
- A patient has expired;
- A patient and/or their family has made a change to code status and/or end of life decisions;
- A patient is leaving against medical advice;
- A patient and/or family member is being disruptive, abusive or is reporting a grievance;
- A medical error has occurred.

REPORTING ERRORS:

Residents should report *any* adverse events or near misses using the MIDAS system. These reports allow us, as an institution, to provide high quality care to our patients and prevent future errors, and are not punitive. The system can be located on the HCAP portal. If you have any questions about how to use the system, please contact Patricia Schuldenfrei, patricia.schuldenfrei@holy-cross.com

SUPERVISION OF INVASIVE PROCEDURES:

Trainees should have adequate experience with observed procedures (central line placement, thoracentesis, paracentesis, arthrocentsis/joint injection, lumbar puncture, arterial line placement, ACLS, pap smears) prior to performing procedures independently. These experiences can include simulation activities or directly supervised by faculty on patients. Competence will be based on performance, but a minimum of at least 3 competently observed procedures on live patients should be performed prior to independently performing the procedure. The logs of these procedures will be available on New Innovations. If the resident has not yet competently completed the minimum of three competently and completely performed procedures, a supervising physician must be present for the entire procedure. The supervising physician may be an attending physician with appropriate medical staff credentials or a third year resident who has received competence in said procedure under indirect supervision of an attending physician with appropriate medical staff credentials. All invasive procedures must be discussed with the attending of record prior to performing the procedure.

RESIDENTS AS SUPERVISORS FOR STUDENTS

Medical students will rotate through our program to enhance their clinical learning. It is the resident's responsibility to provide supervision, education and support to the medical students in a professional manner such that they can continue to grow into their role as physician in training.

Third year medical students: Students in their third year clerkship may be on an inpatient or outpatient experience. Interns and residents should conduct themselves in a professional manner at all times, role modeling appropriate physician behavior. Residents shall provide direct supervision of students (in the patient room) or indirect supervision with direct supervision immediately available for all clinical activities students participate in. Students should be encouraged to begin interpreting the data they gather and forming assessments and management plans with appropriate guidance from residents and attendings. Interns and residents should help the students develop skills to be a competent physician. This can be accomplished by short talks on diagnoses, physical diagnosis rounds or review of literature. Interns and residents should review medical student notes, and provide feedback. If there is ever a concern for patient safety, the resident should report concern to the attending physician and clerkship director.

Fourth year medical students (Sub-Interns): Students in their sub internship may be placed on an inpatient team. They will work directly with a senior resident (PGY-2 or beyond), and take on many of the roles of an intern with appropriate supervision (direct supervision or indirect with direct immediately available). They should be allowed the opportunity to be the primary care provider for their patients. With supervision, they should place and call consults, write H&P's, and progress notes and participate in transfers of care with appropriate supervision. Of note, a resident must still document their own note on the patient, and use of the students note via either copy and pasting or signing as resident's own is prohibited.

NON CLINICAL AND ADMINISTRATIVE RESPONSIBILITIES

In addition to many of the clinical duties, trainees are also expected to complete other non-clinical and administrative responsibilities. These include logging duty hours on a regular basis. Duty hours should be logged daily, however if more than a week has passed without logging duty hours in New Innovations, the resident will receive a warning, followed by a delinquency if not completed in 2 weeks. Just as attending physicians are

expected to complete evaluations in a timely manner, trainees are also expected to complete evaluations on their supervisors within two weeks of the end of the rotation. After one month, the resident will receive a warning, to complete, followed by notification of the PD following 6 weeks since end of rotation. See below on duty hours and evaluations.

CONFERENCE ATTENDANCE

Our program revels in the clinical experience trainees receive, but also recognizes the importance and role of conferences in education. Academic half days allow trainees ample time to attend, free of clinical duties. Residents are expected to arrive on time and leave once the conference has ended. Given that residents' roles are to care for patients, it is also appreciated that emergencies with patients come up and require some absences from conferences. Below are expectations for attendance at different conferences:

- Internal medicine conference (Wednesday afternoons): 90% (excused on night medicine, vacation and rotations in Miami)
- Ambulatory academic half day: 95% (for those on ambulatory blocks)
- Grand Rounds: 90% (excused on night medicine, vacation and rotations in Miami)
- Noon Conference/Morning report: 75% (expected of all residents on inpatient (GIM, MICU, inpatient cardiology) except those on night medicine)

RESIDENT INVOLVEMENT IN INSTITUTIONAL COMMITTEES

Trainees are encouraged to participate in many of the committees in the training program and hospital. One trainee from each year will be selected by their peers to participate in the Program Evaluation Committee. This committee reviews the program to assure it is meeting the training needs of the residents.

One resident from each year will also be selected by their peers to represent their class and program on the Graduate Medical Education Committee. This committee discusses all graduate medical programs at the hospital and assures that it is in compliance with ACGME requirements as well as meeting the needs of the institution and program.

There will also be a representative from the program serving on several hospital committees including Quality and patient safety committee.

PROGRAM CURRICULUM:

OVERVIEW OF ACGME COMPETENCIES

The ACGME has 6 Core competencies and corresponding milestones that have been integrated into our curriculum and experiences:

Medical Knowledge	1. Clinical knowledge 2. Knowledge of diagnostic tests and procedures
Patient Care	1. Gathers & synthesizes essential & accurate information to define each patients clinical problem(s) 2. Develops and achieves comprehensive management plan for each patient 3. Manages patients with progressive responsibility and independence 4. Skill in performing procedures 5. Requests and provides consultative care
System Based Practice	1. Works effectively within an interprofessional team 2. Recognizes system error and advocates for system improvement 3. Identifies forces that impact the cost of healthcare and advocates for and practices cost-effective care 4. Transitions patients effectively within and across health delivery systems
Problem Based Learning and Improvement	1. Monitors practice with a goal for improvement 2. Learns and improves via performance audit 3. Learns and improves via feedback 4. Learns and improves at the point of care
Professionalism	1. Has professional and respectful interactions with patients, caregivers and members of the interprofessional team 2. Accepts responsibility and follows through on tasks 3. Responds to each patients unique characteristics and needs 4. Exhibits integrity and ethical behavior in professional conduct
Interpersonal and communication skills	1. Communicates effectively with patients and caregivers 2. Communicates effectively in interprofessional teams 3. Appropriate utilization and completion of health records

PGY Specific goals:

Goal (milestone)	PGY-level at which should be attained	Evaluation Method
Collect a thorough history and physical, as well as access additional information as appropriate on each patient (PC1).	1	Attending evaluation Direct Observation Peer evaluation
Document appropriate clinical care, thought processes and plan in the electronic medical record(ICS3)	1	Attending evaluation 360
Develop a prioritized differential diagnosis (PC1)	1	Attending evaluation Peer evaluation
Apply current concepts in basic and clinical science to clinical problems	1	Peer evaluation Attending evaluation
Communicate with patients in a way that is free of medical jargon and empathetic to patients condition (ICS 1, Prof 1)	1	Direct observation Patient evaluation 360
Utilize a patient centered approach to care (Prof 3,4)	1	Patient evaluation 360 Attending evaluation
Display professionalism and reliability in patient care (Prof 2, Prof 4, PC3)	1	Peer evaluation 360 Attending evaluation Patient evaluation
Effectively communicate with other healthcare professionals (ICS-2, SBP-1)	1	360 Direct observation
Understand how system errors affect patient care and identify areas of improvement in that system (SBP-2)	1	Direct observation Quality Rotation evaluation
Identify Gaps in own knowledge and use evidence to adjust way care is delivered (PBLI-1-4)	2	Attending evaluation

		Performance Review Peer Evaluation
Cite indications, contraindications and technique for the following procedures, and be able to perform them with appropriate supervision(MK -2, PC-4): i. Central Line placement ii. Paracentesis iii. Thoracentesis iv. Lumbar Puncture v. Arthrocentesis	2 3 (independently)	Direct observation/ simulation
Use a value based and patient centered approach to developing appropriate diagnostic and therapeutic plans (PC2, SBP 3, MK 2)	2	Attending evaluation Peer evaluation
Use appropriate scientific data to support a hypothesis or plan (PBLI-1, MK 1, MK 2)	2	Attending evaluation
Can communicate relevant information in a patients care in both written and verbal forms to optimize the transition of care for a patient (ICS-3, ICS-2, SBP-4)	2	Direct observation Simulated Chart Recall
Work collaboratively with other physicians in consultation, developing plans are value conscious and limit redundancy (PC5, SBP-3)	3	Attending evaluation Direct observation
Lead difficult conversations and end of life discussions with patients and their families, taking patient unique situations into account. (ICS-1, Prof 3,4)	3	Direct observation
Teach others about different topics in medicine, communicating at the appropriate level of understanding (ICS 1, 2, PBLI-1)	3	Attending evaluation Peer evaluation Patient evaluation
Display efforts to remain abreast of current and new medical knowledge and use study design to defend the validity/applicability of evidence(PBLI-1, MK-1,2)	3	Self-evaluation, Journal Club participation

BLOCK SCHEDULE

By using the innovative 4+2 block scheduling, our program allows for adequate time for concentration on inpatient duties separate from outpatient duties. Residents will be assigned four week rotations which will include required inpatient rotations, elective, vacation, research and other rotations. After each four week block, residents will rotate onto a 2 week block of ambulatory, where they will focus on their continuity clinic and other ambulatory activities.

block	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
Weeks	2	4		2	4		2	4		2	4		2	4		2	4		2	4		2	4		2	2
rotation	*Ambulatory*	GIM	GIM	*Ambulatory*	Quality & Patient safety	elective	*Ambulatory*	GIM	GIM	*Ambulatory*	ICU	ICU	*Ambulatory*	ED	ED	*Ambulatory*	vacation	RSAP	*Ambulatory*	ICU	night	*Ambulatory*	GIM	GIM	*Ambulatory*	elective

The following are the rotations each resident has during their three years:

Rotation	**PGY-1** (weeks)	**PGY-2** (weeks)	**PGY-3** (weeks)	**Prelim** (weeks)
GIM	12	10-12	8-10	12-14
Night Medicine	2	4	4	4
MICU	6	4	4-6	8
Inpatient Cardiology	4	4-6	4	0
ED	4	0	0	4
Ambulatory with specialty and continuity clinic	18	18	18	4

Ambulatory Geriatrics	2*	0	2	0
Neurology	0	2	0	0
Elective	4	6	6-8	12
Resident Scholarly Activity Program	Throughout second half of year in ambulatory	0	Dedicated time in ambulatory	0
Quality Rotation	Throughout first half of year in ambulatory	0	Dedicated time in ambulatory	0
Vacation	4	4	4	4

CLINICAL ROTATIONS

INPATIENT:

GENERAL INTERNAL MEDICINE

This rotation prepares residents for care of the acutely ill patient necessitating inpatient treatment.

Residents will take admissions every day from 7 am until 4 pm, unless they are the “Late resident” every other day, where they will admit until 6 pm and stay until 7 pm to sign out to night team. All interns can take up to 3 admissions/day. One hold over from the night team counts as a transfer for each intern, where each additional hold over will count as one of the three admissions.

Residents and interns will arrive no later than 7 AM to take sign out from the night team and begin seeing their patients. Teaching rounds with the attending begin at 9AM. Interns and Residents are expected to present their patients at Interdisciplinary rounds which begin at 10 am, 10:30am and 11 am depending on the floor. Following rounds, residents should complete patient care duties. All residents are expected at conference at 12:30 (either afternoon report or grand rounds). On Wednesday afternoons, the residents should sign out to the attending to attend didactics, and return upon completion to finish patient care and sign out to the late shift resident. On

weekends interns and residents will each have a day off. It is crucial to have at least one intern and one resident at all times. When an intern is off, the resident from the other team will see and manage their patients.

The Night team will arrive at 7 PM and receive sign out from the late resident.

Specific roles for residents and interns:

- ✓ *PGY-1 Role*: Arrive by 7 am, receive sign out from night team, pre-round on patients. Place orders, follow up on night issues/consults. Touch base with resident prior to rounds. Present on attending rounds, including assessment and plan you have discussed with resident prior to rounds. Following rounds intern should place discharge orders, call consultants, complete all notes by noon and place additional orders. Discuss plans with nurses, consultants as appropriate. See new admissions and make independent assessment/plan prior to discussing with resident. Contact PCPs or other outpatient providers. Place all orders and complete H&P for new admissions. Update Sign out. Complete discharge summaries within 24 hours of d/c.
- ✓ *PGY-2/3 Role*: Arrive by 7am; receive sign out from night team. Review patient data from day prior and night admissions. Prioritize unstable and potential discharge patients. Review assessment and plan with intern prior to rounds. Allow intern to present cases, give additional feedback as appropriate. Bring one evidence based topic to rounds on at least one patient admitted the day prior for teaching purposes. If orders are discussed on rounds, help with placing orders. Following rounds provide support as needed. See all new admissions – if unstable place emergent orders, otherwise allow intern to place orders. Review sign outs completed by intern. Complete discharge summaries within 24 hours of d/c. Provide education and support throughout the day, being available to intern as a resource. PGY-2/3 will also be responsible for the supervision and education of the MS-3 and 4 students on rotation. PGY-3's, as the more senior resident on the team, will also function as a resource for the PGY-2 in their progression to leader of a team. Each residents should know all patients on the service regardless of which intern they work with.
    - *Discuss patient care with attending throughout the day*

MICU

This rotation will provide residents with the skills and knowledge to care for critically ill patients.

Each member of team should arrive to receive sign out no later than 6 am. Intern/Resident team will take admissions every day from 6am until 3pm. Intern and Resident teams alternate staying late until 6 pm to sign out to night team. Interns admit up to 3 new patients/day for a total intern cap of 7 patients. At 6pm the late intern and resident will sign out to the night resident in the ICU. There will always be at least one intern and one resident at any time. When a resident or intern is off, their paired intern/resident will be responsible for rounding and writing notes on their partners patients.. Residents will be responsible for responding to all code blues on the floors.

Residents will respond to codes during rounds, while interns remain on rounds for continuity of care. Both Residents and Interns are free from clinical duty from 12:30-4:30 on Wednesdays. Resident on late call should stay in ICU for afternoon conference, the early resident/intern may attend conference

Specific roles for residents and interns:

- ✓ *PGY-1 role*: Arrive by 6 am and pre-round on patients. Discuss patient care with each nurse for your patients. Place orders, follow up on night issues/consults. Touch base with resident prior to rounds regarding assessment and plan. Present on attending rounds, including assessment and plan you have discussed with resident. Following rounds, call consultants, complete all notes by noon and place additional orders. Discuss plans with nurses, consultants as appropriate. See new admissions and make independent assessment/plan prior to discussing with resident. Place all orders and complete H&P for new admissions. Update Sign out.
- ✓ *PGY-2/3 role*: Arrive at 6am. Review patient data from day prior. Prioritize unstable patients. See all patients Review assessment and plan with intern prior to rounds. Allow intern to present cases, give additional feedback as appropriate. If orders are discussed on rounds, help with placing orders. Provide specific teaching points during rounds to create an environment of inquiry and education. Following rounds provide support as needed to intern. See all new admissions – if unstable place emergent orders, otherwise allow intern to place orders and make plans. Supervise interns on procedures, and assure that each intern is getting appropriate procedures. In charge of responding to all codes. If there are any discharges, complete discharge summaries. PGY-3's, as the more senior resident on the team, will also function as a resource for the PGY-2 in their progression to leader of a team. Each residents should know all patients on the service regardless of which intern they work with.
    - *Discuss patient care with attending throughout day*

NIGHT MEDICINE

Night Medicine prepares residents and interns for caring for acutely ill patients at night, obtaining a skill set in cross coverage as well as how to navigate the hospital when resources are reduced.

Night medicine resident and intern will arrive at 7pm to receive sign out from the day team. They will spend the evening admitting patients and cross covering on patient on the blue and green teaching teams. Each intern can admit up to 4 patients on the night service, and the resident can admit an additional 2 patients independent of the intern. The night team will hand off the admissions and the events on established patients at 7am with the day team. Ambulatory residents will cover the Saturday night coverage.

In the ICU there will only be one PGY-3 resident. This resident will arrive at 6 pm, and will cross cover all teaching patients in the ICU, respond to all code blues and code sepsis, perform needed procedures on the floors and ICU's and admit up to 3 new patients. They will sign out to the day team at 6 am. As with the floor coverage, Saturdays will be covered by a resident on ambulatory.

INPATIENT CARDIOLOGY

This rotation will allow residents to learn how to care for patient with acute cardiovascular issues, as well as how to effectively serve as a consultant. Interns will take 3 admissions/day, not to carry more than 10 at a time.

One Resident will supervise an intern while also being able to admit/consult an additional 2 patients. Interns and residents arrive at 7 am and take admissions until 6 pm. One of the interns will also be an Emergency Medicine intern.

Specific resident roles:

- ✓ *PGY-1 Role*: Come in by 7 am to get sign out on patients. Pre round on patients, enter orders, start notes. Review assessment and plans with resident prior to rounds. Present on rounds. Have notes on admitted patients completed by noon. Complete discussed orders, call consults, etc. See new patients, discuss with resident, place orders, write H&P. For consults – gather all information on patients, examine patient, make an assessment & plan that is discussed with attending, and provide your recommendations to the referring team. Write consult notes. Sign out team to the night team at 7pm when on late shift.
- ✓ *Pgy-2 Role*: Assist and supervise intern with inpatients and as needed for consults. See all patients on intern's team, check in with intern prior to rounds. See own patients consulting on, write those daily notes, as well as new consult H&Ps. Present only own patients/consults on rounds. Provide a teaching point (Evidence, etc) on at least one admission or new consult from the day prior
- ✓ *PGY-3 Role*: Assist PGY-2/intern as needed, help with overall education of the team, including education talks in the afternoon several times/week. Assist and supervise intern with inpatients and as needed for consults. See all patients on intern's team, check in with intern prior to rounds. See new consults, present to attending, communicate recommendations to the referring team. PGY-3 will also be directly responsible for the supervision and education of the third year medical student on rotation, when there is a PGY-3.

EMERGENCY MEDICINE

Residents on this rotation will learn how to evaluate, manage, and triage patients in an acute setting. Residents will work eighteen 8 hour shifts, which will include night shifts as well as day shifts. Residents are responsible for the primary assessment of patients, inputting orders, documenting and calling consults under the supervision of an ED physician. Residents may also be asked to supervise and teach MS-4 students. Shift schedules will be available through Tangier.

OUTPATIENT AND NON CLINICAL

CONTINUITY CLINIC

Categorical interns and residents will be seeing patients at Broward Community and Family Health Centers or Wilton Manors. Morning clinics begin at 8:30 and end at noon. Afternoon sessions begin at 1:30 and end at 5, except Tuesdays at BCFHC that begins at 2 pm and ends at 7pm. You are responsible for checking your tasks on a daily basis while on ambulatory. You will be paired with two "firm partners" for whom you will also help monitor tasks for. See "sign off" for more information.

Each resident will have a secondary continuity site either at a Holy Cross Medical Group, Light of the World or Broward Community and Family Health Centers.

RESIDENT SCHOLARLY ACTIVITY PROJECT

First year categorical residents will have a longitudinal experience with the Resident Scholarly activity program in Miami. This will entail didactic seminars with Drs. Tamariz and Palacios from the University of Miami. You will meet regularly with Dr. Tamariz and your content mentor regarding your project and progress. A scholarly project must be completed by the end of the three years. A scholarly project includes a peer reviewed publication, actively involved in performing research, or a poster presentation. While presentations at Journal Club are scholarly, they do not fulfill this requirement. Each resident must also submit at least one write up to the regional ACP meetings during their three years.

QUALITY AND PATIENT SAFETY ROTATION

First year residents will complete a longitudinal rotation that focuses on gaining the skills to practice high quality medicine while being able to address any system issues that arise. This rotation will include independent learning to complete IHI modules, experiences with a variety of hospital committees committed to improving patient safety and quality, small group exercises with faculty members and time to research a possible project. Like the RSAP project, this is an experience that will continue during your 3 years. You will be responsible for completing a quality or patient safety project by the end of your first year. This project can and should be done as an interdisciplinary team, including other residents.

NEUROLOGY

Second year residents will spend 2 weeks with our neurologists learning key components of neurology that are important in the care of general medicine patients. It is very important that you complete the checklist prior to starting this rotation and that you have read the assigned texts to optimize the amount of learning you get out of this experience.

ELECTIVE ROTATIONS

There are a variety of medicine and non-medicine rotations. You will work with the specialists in that field. The hours are variable depending on the subspecialty, please refer to the specific rotations curriculum and goals/objectives. Below are the elective contacts:

Elective	**Contact**	**Email**
Rheumatology	Jihan Saba, MD	Jihan.saba@holy-cross.com
Infectious Diseases	Ricardo Reyes, MD	Reye5240@bellsouth.net
Gastroenterology	Daniel Kosches, MD	Dan.kosches@gmail.com
Ophthalmology	Jim Lang, MD	jlangmd@bellsouth.net
Dermatology	Barry Galitzer, MD	Barry@galitzer.com
Sports Medicine	Fernando Manalac, MD	Fernando.manalac@holy-cross.com

Cardiology	Josh Larned, MD	Joshua.larned@holy-cros.com
Nephrology	Gabriel Valle, MD	drkidney@comcast.net
Pulmonology	Edward Coopersmith, MD	Dr4chest@aol.com
Sleep medicine	Alexandre Abreu, MD	AAbreu@med.miami.edu
Palliative Care	Michelle Thompson, MD	Michelle.thompson@holy-cross.com
Allergy and Immunology	Linda Cox, MD	Lidacox1955@gmail.com
Physical medicine and Rehabilitation	Phyllis Bulkan, MD	Phyllis.failla@holy-cross.com
Hematology and Oncology	Ena Segota, MD	Zdenka.segota@holy-cross.com
Light of the World	Lisa Martinez, MD	Lisa.martinez@holy-cross.com
Endocrinology	Novelette Thompson, MD	Novelnt@aol.com
Anesthesiology	Ali Rashid, MD	alimrashid@gmail.com
Radiology (procedural and diagnostic)	Michael Rush, MD	mikerushmd@yahoo.com
Pain Management	Porter McRoberts, MD	portermcroberts@gmail.com

AWAY ELECTIVES

Residents are permitted one month in their three years to complete electives at the University of Miami Main Medical Campus. This includes rotations at University of Miami Hospital, Sylvester Cancer Center and/or Jackson Memorial Hospital. Requests should be made to the chief resident. This elective is contingent on the selected facility accepting the dates and rotation. Room and Board or travel expenses will not be covered by the program.

DIDACTICS

CORE MEDICINE ACADEMIC HALF DAY

Every Wednesday, residents have protected time from clinical duty to attend core conferences. Beginning at 12:30 most (except when broadcasting UM grand rounds which begin at noon). The Academic half day begins with a one hour grand rounds followed by one hour of Journal Club, Morbidity and Mortality, teaching seminar, business and leadership in medicine seminar, or patient transition conference. These conferences are followed by 2 hours of interactive discussions in medicine. The day ends with a wrap up to discuss any changes, issues or accolades regarding the residency program.

The Academic half day will occur in the SICC room A except for Grand Rounds

GRAND ROUNDS

Every week, except holidays and other occasions, a speaker will discuss medical topics that are based in evidence or educational or administrative topics that are relevant to the practice of medicine in a teaching hospital. These occur once/month at 12:30.

MORBIDITY AND MORTALITY

Quality and patient safety are paramount to physicians being effective in their delivery of healthcare. Every month M&M will occur following grand rounds. These conferences are intended to discuss near misses, or medical errors/adverse events in an objective and non-judgmental way , aimed at affectively identifyingthe specific systems based problem that contributed to the error. These are not intended to point blame but rather to promote new initiatives that improve patient safety and create a culture of improvement.

One resident will present a case and a faculty member will facilitate the discussion. Following identification of different systems based issues, the group will be split into smaller groups to discuss strategies to overcome these system issues and share with the entire group following the discussion.

JOURNAL CLUB

Integrating our own experiences in medicine with good quality evidence in our decisions regarding patients will result in better quality care. Reviewing high impact journal articles, and occasionally less well designed articles, Journal Club is designed to provide the tools necessary to dissect the literature. Every month two residents will be assigned a journal article to examine using the JAMA users guide to the medical literature. With the assistance of the faculty advisor, the resident will discuss the journal article with the entire program, encouraging discussion amongst the group. All residents are expected to read the articles.

TEACHING SEMINAR

As physicians we have a large role in the education of patients, communities, students, residents and other health care providers. Every 8 weeks residents will attend a workshop on how to become effective educators. Some of the discussions are geared towards all PGY levels, others will have residents split into smaller groups. The goal is to develop a tool box of ways to disseminate information to others effectively and lead teams.

PATIENT TRANSITION CONFERENCE

Similar to M&M, Patient Transition Conference focuses on areas where systems can be improved. In this case, in transitioning patients between providers (both physicians and other care providers) or care settings. Every 8 weeks one hour will be dedicated to discussion of transitions that were successful and those that could be improved, and how we can more consistently be successful.

ACUTE MANAGEMENT SERIES

Every Wednesday afternoon for the first 8 months, two hours will be spent covering topics that focus on disease states and the management of them. They will encompass general internal medicine, subspecialties of internal medicine and some areas outside of internal medicine that are pertinent to the general care of our patients. It is important that residents come prepared to these discussions, as they are intended to be interactive and case based. For many of the discussions, faculty will recommend readings prior to the lecture time.

BOARD REVIEW

Following Acute Management Series, board review will begin and continue until the end of the year. This is an opportunity to review relevant issues in medicine that will be seen in practice and on the ABIM boards. PGY-2 residents will have MKSAP books to help prepare them for the Boards. The topics that will be discussed will be available in advance so that each resident can read that section in MKSAP.

AMBULATORY HALF DAY

Every Tuesday morning on ambulatory, residents will participate in an ambulatory half day that begins at 8:30 AM in the SICC B. Beginning at 8:30, an ambulatory morning report case will be discussed, presented by residents and discussion facilitated by faculty. From 9:15-11 an interactive discussion of topics pertinent to the practice of ambulatory medicine will be presented in an interactive format. This time may be replaced by a procedures clinic where ambulatory procedures are practiced.

RESEARCH REQUIREMENTS

Each first year resident will participate in the RSAP program. This will expose residents to the core knowledge needed to participate in research. At this time they will also begin to select a mentor to work with over their three years. Residents should complete a project by the end of their three years, and present it at Resident Quality and Scholarly Activity Fair.

Residents are also required to submit an abstract to the ACP Florida Chapter meeting prior to completion of their three years.

QUALITY IMPROVEMENT PROJECT

Each resident will go through a longitudinal quality experience that will include completion of 15 IHI modules (9 of which must be completed at the end of their first 6 months). During this time, residents will decide on projects to work on, and pair with other residents to work on them during their ambulatory time. Their project will be presented at the end of the year Resident Quality and Scholarly Activity Fair.

EVALUATION POLICY AND EVALUATION FORMS

EVALUATIONS OF RESIDENTS

Residents will be evaluated on a regular basis by a variety of methods as detailed below.

ATTENDING EVALUATIONS

All Residents will be evaluated at the end of their rotation by their attendings in New Innovations. Attendings will discuss the pertinent feedback with the residents during the rotation as well. The evaluations will be mapped to milestones in order to get a better picture of each resident's performance in each Competency

In addition to end of the rotation evaluations, attendings will also perform MiniCEX's/Direct Observations with residents. These will be completed at the bedside and taken into account into overall performance.

For continuity experiences both at Broward Community and Family Health Centers, and during the longitudinal subspecialty experience in second year, residents will have evaluations completed semi-annually by their supervising attendings.

PEER EVALUATIONS

Peers will evaluate residents/interns they have worked with quarterly in an anonymous fashion. These evaluation will supplement the resident's complete clinical, academic and professional performance. These will be reviewed at the semi-annual meeting.

SELF EVALUATIONS

Semi-annually residents will complete self evaluations on themselves. These will be discussed during the semi-annual meetings with the program director. These will be used for developing individualized learning plans for further growth.

IN-TRAINING EXAMS

Every year all categorical residents will complete an In-Training exam. This is an exam put together by the American College of Physicians (ACP) and Alliance for Academic Internal Medicine (AAIM) that is intended to help residents monitor their own strengths and weaknesses, as well as allow the program to identify strengths and weaknesses within the delivered curriculum. This will be used solely for guiding your studies, and NOT used for evaluating your performance in the core competencies.

360 MULTISOURCE EVALUATIONS

As a program that focuses on interdisciplinary care of our patients, the feedback from our associates is very important. Allied health professionals in different environments will evaluate resident performance on a semi-annual basis. The associates on the general medicine floors and ICU's will evaluate each resident's inpatient

performance. The nurses and staff at the two supplemental continuity sites will evaluate resident performance in the ambulatory setting.

EVALUATIONS OF FACULTY AND ROTATIONS

Online evaluation of Faculty will be evaluated via an anonymous online tool in New Innovations. Just as faculty are held responsible for completing evaluations on residents in a timely manner, residents should complete evaluations of the faculty they work with within 2 weeks of the end of a rotation. The feedback helps faculty identify areas of strength and weakness and tailor their teaching appropriately.

Within these evaluations, there will also be questions related to the rotation that will help the program improve, and are not reflective of the faculty performance. For instance you may have thought working with a particular attending was very useful, but the rotation was poorly structured. This would not affect the attending physicians evaluation, but will help us improve the rotation. The subspecialty education coordinators and Program Evaluation Committee (PEC) will use this information to further tailor the curriculum.

INFORMAL FEEDBACK

During rotations, attendings will provide residents with informal feedback to reinforce behaviors and encourage improvement. These are only used as feedback, and will not be used in the overall assessment, unless it is reported in the end of the rotation feedback.

PROGRAM PROCEDURES:

ATTENDANCE POLICY

Residents are to display professional behavior in all activities, including being present for clinical and other learning activities. 100% attendance is expected for all clinical encounters, and the conference expectations are listed above. If a resident necessitates time off, they should attempt to arrange their vacation to accommodate those days. If a resident needs to miss a clinical encounter, the request should be made at least 8 weeks in advance to the Program Director and rotation director, at which point the decision will be made if the absence is warranted and what additional clinical experiences would need to be planned. After an unexcused absence, a resident will receive a warning. If a resident has more than one unexcused absence, they will be brought to the program director's office and may receive a written warning or disciplinary action.

If an emergency arises the resident should contact the GME office as well as their supervising attending to inform them of the absence. The supervising attending, rotation director and program director will decide if any additional experiences will be needed to make up the absence.

Residents are also expected to attend conferences. Time has been protected such that all residents should be able to attend Wednesday afternoon academic half days with the exception of those on vacation, those on night medicine and those on away rotations. It is also expected that all residents on ambulatory blocks will attend ambulatory academic half days on Tuesday morning, as there are no conflicting duties. Afternoon report and Morning report are educational experiences that are critical in developing a resident's ability to think critically about patient scenarios. While it is recognized that unexpected changes in patient conditions could pull a resident away, it is expected that residents will attend at least 75% of the conferences as described above.

Leave Policy

Vacation:

Each resident will have 4 weeks of vacation spanning two blocks, which are 2 weeks each. If a resident requests a vacation at the beginning or the end of the year, it should be noted that these blocks are often truncated by a few days, and may lessen the vacation by 2-3 days. Residents can request certain times to have vacation; however this is not a guarantee of time off. The Chief resident will work with the residents to accommodate the request to the best of their ability within the schedule, however may not be able to grant the exact time off. It is important to log your vacation time in New Innovations, so as not to trigger a Duty Hour Violation.

Unplanned personal days:

Time off is given up to the maximum of four weeks/year, or twelve weeks over three years, allowed by the ABIM. This is inclusive of vacation, personal leave, sick leave, interview leave, etc. Residents who require additional time will not be able to complete program in accordance with ABIM guidelines, and may become "off-cycle." For days off for personal illness, illness of child, etc., the resident should contact the Chief Resident immediately to arrange for appropriate coverage. The Program Director shall be notified of the unplanned absence, and shall decide on final approval.

- Interviews: It is recognized that time off will be needed for interviews for those going on to fellowship or future employment interviews. These interviews should be scheduled during administrative time. If the interview cannot occur during that time, resident should contact the chief resident to discuss coverage within 4 weeks of planned interview. Resident cannot arrange for coverage of more than one day/rotation.

Bereavement/Funeral:

Residents can have up to 3 consecutive working days following the death of an immediate family member, defined as spouse, same sex domestic partner, child, and parent/step-parent, parent in law, grandchild, grandparent, legal guardian or foster child. The Chief Resident should be notified as soon as possible, to assist in arranging for clinical coverage.

Medical Leave:

If Medical leave is requested, the resident must furnish documentation by physician of need for leave. The Chief resident should be notified as soon as possible of the need for leave, as well as for how long, to arrange for appropriate clinical coverage. The Resident should also contact the office manager of the continuity clinic (if applicable) to inform them of the anticipated leave. Program Director will also be notified of anticipated leave. It is important to note, that rotations may need to be repeated depending on length of leave.

Maternity Leave:

Our program recognizes the importance of family for all of our residents. Maternity leave includes the birth of a biological child as well as adoption of a child. If a resident is to require maternity leave, the chief resident and program director should be notified as soon as possible for estimated dates of coverage. Per the ABIM guidelines, residents wishing to complete their training on time cannot take more than 12 weeks of leave, inclusive of vacation, over their three years. Request for combining vacations can be made to extend time at home without extending training, however more than 4 weeks cannot be given in each year without extending training per ABIM protocol..

If a resident wishes to extend their maternity leave, and thereby also extend their training, she should discuss plans with program director.

Paternity Leave:

Our program recognizes the importance of family for all of our residents. Paternity leave includes the birth of a biological child as well as adoption of a child. If a resident is to require paternity leave, the chief resident and program director should be notified as soon as possible for estimated dates of coverage. Residents will be granted 3 days following the birth of a child. If additional time is requested, it can be provided, although will count towards the 12 weeks of maximum leave time allowed by ABIM. Request for combining vacations can be made to extend time at home without extending training, however more than 4 weeks cannot be given in each year without extending training per ABIM protocol..

If a resident wishes to extend their paternity leave as well as their training, he should discuss plans with the program director.

CONTINGENCY COVERAGE

On rotations which do not involve direct responsibility for inpatient care, members of the housestaff are placed on a pull list to provide coverage for other housestaff who are unable to complete their duties secondary to emergencies. The pull list is NOT utilized to provide coverage for interviews or conferences. The purpose of the pull list is for housestaff to help each other when they need support. The pull list is a representation of the collegiality and respect housestaff have for one another; therefore, housestaff are expected to treat their colleagues as they would wish to be treated.

Housestaff may be assigned to pull list during the following rotations:

Electives, Geriatrics, Neurology

A resident will be on pull list for the following times:

- PGY1- weekends while on elective
- PGY2/3- one week of your 2-week elective block

The pull list time will be assigned in advance, and will be visible in new innovations as “Back up”.

Requests for time on/off the pull list must be made 6 weeks in advance. Once approved, New Innovations will reflect the change.

Housestaff will be on pull from Saturday 12:00 am – Sunday 11:59 pm (48 hours) for PGY-1s and Monday 12:00 am - Sunday 11:59pm during the pull list week for residents. However, housestaff may be called about a planned pull at anytime on that preceding Sunday.

Housestaff will be called (on either home or cell phone) by the Chief Medical Resident (CMR) when they are being pulled. Housestaff also may be notified via email about planned pulls that will take place in more than 24 hours. Housestaff must inform the CMR of any changes to their contact information as soon as they occur.

Housestaff are expected to be reachable at all times while they are on the pull list. If housestaff are in an area without cellular service, the CMR must be provided an alternate number at which you can be reached.

Housestaff are expected to return a call from the CMR within 15 minutes and are expected to be at the hospital no later than 1 hour after the first call from the CMR.

Housestaff are responsible for checking their schedules and having their cell phones activated the SUNDAY morning (9 am) BEFORE their pull list week begins.

Cell phones must be on and carried by the housestaff for 24 hours a day while they are on the pull list.

It is unacceptable to consume alcohol or other sensorium-altering drugs while on pull list.

Housestaff must be capable of working during the entire time they are on the pull list.

There is no limit to the number of pulls during a pull list period.

The pull list is a nontransferable individual responsibility that the housestaff have with the program and each other. Any changes to the pull list must be communicated in writing and approved through the CMR

Violations of these guidelines represent a breach of professionalism and will result in disciplinary action.

DUTY HOURS POLICY

Our program is compliant with the ACGME requirements of graduate medical education programs for duty hours.

Duty hours encompass all clinical and academic activities related to the residency program, i.e., patient care, administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. Duty hours must be limited to a maximum of 80 hours per week, averaged over a four-week period, inclusive of moonlighting (see below).

- A first year resident **must** not exceed 16 hours in duration, and it is expected that they will be no more than 14. First year residents should have 10 hours off between shifts, but **must** have 8 hours off. When on night float, they must not work more than 6 consecutive nights, while also meeting the requirements stated above.
- Second year residents cannot work more than 24 hours by ACGME rules, however our current scheduling does not require any overnight call for upper level residents. As such, second year residents will follow the same rules for duty hours as first year residents mentioned above.

It is recognized that there are times that patient care may require residents to stay past the duty hour limits, and expect these to be infrequent. If there is a situation that a residents needs to stay later that their duty hours permit, a statement must be submitted explaining why the violation occurred in New Innovations. These will be reviewed by the program director. If the reason is not acceptable, the program director will contact the resident for clarification or more information.

All moonlighting is included in duty hours reporting.

DUTY HOUR REPORTING

As mentioned above, all activities that encompass clinical and academic activities should be reported. This includes direct patient care, conferences,

Residents are to log and /or confirm their hours on a weekly basis in New Innovations. This can be done via the online module or the app (New-Innovations GME). Residents who do not complete their duty hours reporting weekly will be notified of delinquency, and if duty hours are not reported in 2 weeks will receive a violation. If the duty hours are still not reported after 3 weeks, Program Director will be notified and disciplinary action may be taken.

NEW INNOVATIONS

New Innovations is a Residency Management Suite of applications designed for managing post graduate medical training, including tools for scheduling, evaluations, tracking duty time, case logs, conferences, and many other important aspects of program maintenance. Access is provided to all housestaff, faculty, and staff through website, www.new-innovations.com using institution code UMRMC.

Access

Each resident is designated a username and password by the program administrator. Residents are to keep this information confidential; never sharing access with other software users.

Residents may access the program through two modalities – online at www.new-innovation.com or by downloading the smart phone application New Innovations – GME. Residents are strongly encouraged to refrain from saving their username within the application and website portal for reasons of privacy protection.

Program Usage

Residents are to utilize New Innovations regularly; logging in to complete various tasks, check for programmatic updates, and confirm schedules. The following tasks are required of the resident:

- Completing assigned checklists on or before the due date;
- Review academic and clinical schedules weekly;
- Log and/or confirm duty hours weekly;
- Read and acknowledge via digital signature the reception of goals/objectives within 2-days of rotation start date;
- Log procedures as completed;
- Log scholarly activity as completed;
- Complete evaluations within 14-days of assignment.

Issues / Maintenance Reporting

Residents are to report issues and maintenance requests to the Program Administrator by e-mail. Whenever possible, include a screen shot of the affected page. In the event the program administrator is not available, further assistance can be reached at support@new-innov.com .

DISASTER POLICY

This policy is to provide guidance for residents and the program subsequent to an event or series of events that cause significant interruption in the provision of patient care as mandated by ACGME's Policy and Procedures. Events that are included in this policy are unexpected disruptions to the continued safety and/or function of the participating site's hospital's physical plant resulting from natural disaster, local emergency or man-made disaster. When such an occurrence restricts the ability of the participating site to provide for the safe and effective training of actively enrolled residents, the DIO and Program Director will work with ACGME and RRC for Internal Medicine to determine next steps. The Program Director will confirm the location of all residents, determine the means for ongoing communication with each, and notify emergency contacts of any resident who is injured or cannot be located. The Resident, once contacted, may need to contact the RRC Executive Director to exchange information as needed. If the Disaster negatively impacts the ability of the residency program to maintain compliance with

basic requirements for training for more than 30 days, residents will need to transfer from the program to continue their education.

For more information on disaster policy, please refer to the Graduate Medical Education Manual for the University of Miami Regional Campus.

HURRICANE POLICY

In the event of a hurricane or other natural disaster, residents will be notified of clinic closures by program administration, and a plan for coverage of inpatients will be disseminated. There will be a team of residents that will provide care immediately before and during the disaster, and another team that will relieve this team once it is safe to travel to the hospital. Residents should be prepared to potentially stay for more than a typical shift depending on safety of travel. If need be, there will be space available if residents are unable to return home after a shift to rest.

MOONLIGHTING POLICY

Moonlighting is permitted in our program to second or third year residents (first year residents are NOT permitted to moonlight), but is not required. It is defined as any medical services rendered outside the formal program assignments. The Program Director must be notified of the request for moonlighting, and can only occur with advanced written permission from the program director. All hours worked while moonlighting will count towards the duty hours rules discussed above, and resident cannot work more than 80 hours in one week inclusive of activities in residency program AND moonlighting. Hours are to be logged in New Innovations under "moonlighting." Furthermore, residents will be monitored for signs of fatigue, and effects on their performance. If adverse effects are noted as a result of moonlighting, Program Director and/or Graduate Medical Education Committee (GMEC) reserves the ability to withdraw moonlighting privileges. Revocation of moonlighting privileges may be due to fatigue/impairment in performance during resident duty, duty hour violations, falsification of moonlighting activities, or disciplinary action.

Residents on inpatient months can moonlight for a maximum of 24 hours/month as long as remaining under 80 hours total and not affecting performance. Those on ambulatory rotations may moonlight for a maximum of 48 hours/month, remaining under 80 hours/week when added to program assignments. If a resident chooses to moonlight during vacation, they must not exceed the 80 hours/week.

All residents that wish to moonlight must obtain a full Florida License to practice medicine (not their training license). Liability protection is provided for residents only within resident related activities, and will NOT cover resident during moonlighting activities. Residents must obtain their own liability insurance or have the moonlighting employer provide it.

GRIEVANCE POLICY

A grievance is any cause of distress in the working environment felt to afford reason for complaint or resistance. This policy does not apply to actions arising out of the Resident Performance, Discipline and Dismissal Policy.

Grievances must be dealt with in a confidential manner, and without fear of retaliation. This program welcomes any concerns, complaints or grievances. The Program Director, Associate Program Director and Chief Resident shall make themselves available to any resident who wishes to discuss a grievance. Incidents are typically first reported directly to the Chief Resident at the time of the incident, however if resident feels the grievance would be better addressed by the PD or APD, they can arrange for a time to discuss with them.

For grievances that occur on specific rotations, the resident should first contact the attending physician, followed by the subspecialty education coordinator. If this fails to resolve the issue, the resident should contact the Chief Resident. If the Chief Resident is unable to adjudicate the situation, the Program Director should be contacted.

If satisfactory resolution is still not apparent after the Program Director has become involved then the resident should provided a written grievance report directly to the Senior Manager of Graduate Medical Education outlining the issue. The written grievance should describe the involvement of the Chief Resident and the Program Director. A committee will be formed consisting of, at least, the following individuals:

1. Grievant' s Program Director
2. Senior Manager of GME (or designee)
3. Designated Institutional Official (or designee)
4. A resident not involved in the situation
5. Any other department representative deemed necessary by management to perform a reasonable investigation and decision making process.

Upon hearing the grievance, the committee will investigate all issues associated with the complaint and will provide a final written decision to the resident.

All proceedings and decisions of the grievance committee shall be reported to the Graduate Medical Education Committee and the applicable program director in a confidential manner.

If a resident would like to report confidential complaint, they may use the online Housestaff Feedback form, which submits anonymous e-mail directly to the Office of Graduate Medical Education for DIO review. The website is on line at www.gme.med.miami.edu

TRAVEL POLICY

The following Policy and Procedures apply to resident travel and reimbursement for presentations submitted to the Institutional Travel Award. This will provide institutional guidelines regarding travel for educational activities. The Institutional Travel Award Policy shall apply to all graduate medical education training programs at the University of Miami.

The involvement of residents in travel related to scholarly activity is necessary and encouraged by UMMSOM/Holy Cross Hospital. All travelers are expected to be good stewards of Departmental resources and assist by using cost saving measures.

Specific Guidelines and Limits:

- The intent of the Institutional Travel Award is to help residents defer the costs associated with presenting scholarly works at a conference.

- Reimbursement from the Institutional Travel Award is limited to oral and poster presentations or other educational activities pre-approved by the Program Director. In terms of poster presentations, only the first author or designee will qualify for reimbursement.
- All abstract submissions must be pre-approved by the Resident's Program Administration.
- Routinely, one conference per resident per year will be considered. It will be up to the discretion of the program director to allow a resident to submit reimbursement for additional meetings. For this purpose, the year begins July 1 and ends June 30, and refers to the date of the conference --NOT the date of submission of receipts for reimbursement.
- The Institutional Travel Award is limited per academic year, therefore, it is recommended that the Residents identify opportunities as early as possible and work with their Program Administration to pre-approve allocation of funds.
- In order to allocate funds for as many residents as possible, all reimbursement is capped at a maximum of $250 for state chapter conferences, $500 for in-state national conferences or $1,000 for out-of-state national conferences.
- The resident may use his/her educational allowance to assist with the balance from the trip.
- The conference agenda must be submitted with the itemized receipts.
- Original, itemized receipts are required to be submitted no later than two weeks after the resident returns from the conference. Non-itemized receipts will not be reimbursed. All receipts *must* be recorded in the name of the resident. Receipts and hotel folios payable to/by family members cannot be submitted for reimbursement
- Airfare must be coach and travelers are encouraged to plan ahead to take advantage of the lowest possible fares.

- Excess baggage charges will be reimbursed when reasonable and necessary, i.e. traveling with heavy/bulky materials or equipment necessary for conducting business.
- Every available attempt should be made to utilize the conference lodging. Should the conference lodging be full, reimbursement over the special rate will not be reimbursed.
- Lodging is only reimbursed during the dates of the presentation. If a resident stays past the presentation date, any additional charges incurred during that time are the resident's responsibility. Lodging reimbursement will not exceed the official conference lodging rate.
- When more than one resident is traveling to attend the same meeting, if feasible, they should share accommodations.
- Meal reimbursement is limited to the $50 per diem rate. Based upon the following conditions: if the traveler's departure time is after 3PM, their allowance is $25. On the day of the traveler's return, if their arrival time is before 3PM their allowance is $25. Any costs incurred over these limits will be the resident's responsibility.
- Alcoholic beverages are not reimbursed.
- All reimbursement forms are to be turned in to the GME Office for final approval from the DIO for submission and reimbursement.

POLICY ON DISCRIMINATION

Each of our residents has a right to practice and learn in an environment that is free from discrimination. The University of Miami Miller School of Medicine, as well as Holy Cross Hospital, are committed to providing an environment that fosters excellence. Discrimination in any of its practices on the basis of race, color, sex, national origin, marital status, religion or sexual orientation is prohibited and will not be tolerated. This prohibition on discrimination applies to all aspects of employment, including, but not limited to, hiring, firing, promotion, assignment, compensation, discipline and other terms and conditions of employment.

If the University of Miami Miller School of Medicine Regional Campus is notified that an employee has been subjected to discrimination, including sexual harassment, by another employee or a non-employee of the work place, UMMSM Regional Campus will investigate and take immediate and appropriate corrective action. All residents should feel free to file a complaint if they feel discriminated against or harassed. All complaints and investigations shall remain confidential so long as confidentiality can be preserved. If an investigation shows that sexual harassment or other discrimination has occurred, corrective action will be taken immediately. Corrective action may include suspension, probation, termination or reassignment.

Below are the behaviors that can be considered sexual harassment:

- Unwelcome Sexual advances: An employee who is repeatedly propositioned by a supervisor or a co-worker trying to establish an intimate relationship
- Coercion: Asking an employee for a date or sexual favor with a stated or unstated understanding that a favor will be bestowed or a reprisal made regarding accepting or rejecting such offer.
- Favoritism: Allowing intimate relationships between management and employees that may result in creating a sexual, hostile environment due to favors given or denied as a result of the relationship.
- Physical Conduct: Unsolicited physical contact, such as touching or pinching, or unsolicited obscene or rude gestures
- Visual Harassment: Graffiti, pornographic pictures, or pervasive displays of nudity
- Verbal: Sexually suggestive statements, comments, jokes or lewd language

Any resident who believes that he/she has been a victim of sexual harassment is encouraged to voice that concern directly by reporting any alleged discrimination to his/her Program Director and the DIO.

If the offender is associated with or employed by a participating health care institution then the UM Regional Campus will take such necessary steps to ensure that appropriate corrective action is taken. If the offender is an employee, agent of member of the medical staff of a participating health care institution, the University of Miami Regional Campus will notify the CEO of the affected institution and will cooperate with the investigation and corrective action, if any is deemed necessary. It is not the intent of the University of Miami Regional Campus to discriminate or retaliate against any employee because he or she presents a complaint or concern. This complaint procedure does not in any way waive or otherwise affect an employee's rights under federal or state laws governing discrimination.

EMPLOYEE ASSISTANCE PROGRAM:

The University of Miami Miller School of Medicine offers a faculty and staff assistance program (FSAP) for residents in our program. This is a confidential service provided by licensed mental health professionals. This can cover workplace concerns (such as conflict with a coworker) to personal concerns (such as financial concerns or grief). If a resident would like to use the FSAP, they can call 305-286-6604.

In addition, if there is a concern with regards to the program, you can contact the Ombudsperson for the residency, Gauri Agarwal, MD at 561-886-1202 or gagarwala@med.miami.edu.

PATIENT PRIVACY

Accessing patient information for a patient for whom you are not formally involved in their care is prohibited and may result in disciplinary action, including termination. All electronic medical record systems keep a log of those who have accessed a patients record. It is important to log off every time you leave your computer to assure a breach of this policy doesn't occur due to use by somebody else.

Patient privacy is also protected from disclosure. As mentioned in the Social Medial section, disseminating any information that can be used to identify a patient is strictly prohibited and could result in disciplinary action, including termination. Patient information must also be protected around others in public places such as elevators, hallways, etc. Patient information should not be discussed in these areas, as it could lead to disclosure of patient information. Doing so could lead to disciplinary action and termination. All residents should review HIPAA policies.

NEEDLESTICK

It is imperative that all residents use universal precautions when examining patients. When using sharp objects such as scalpels or needles, residents must keep a count and location of all sharps to prevent a needlestick. Do not bend or recap a needle.

If a resident has a blood born pathogen exposure or other exposure concerning for transmission of disease, the site should be cleaned with soap and water. If the exposure occurred on a mucous membrane, the site should be flushed with water. The resident should report the incident to their attending and immediately report to the associate health office on the second floor of the hospital. The Associate Health Office will go on to identify risk of transmission, including screening the source patient for blood borne pathogens, and may recommend prophylaxis. If between the hours of 4pm and 7am, resident should report to the Emergency Department, and not the associate health office, where a screening for blood born pathogens will be initiated and decision to initiate post exposure prohpylaxis made. The source patient will be notified the following day by associate health for need for testing. It is important to note that your Medical Insurance may be charged, and you may be charged a copay for the visit. Following the incident, a MIDAS Event form should be completed to identify any systems issues that may have contributed to the incident that are correctable. The University of Miami Employee Health Clinic (305-243-3400) and GME office (Halcyon Quinn: 305-243-3233) should also be notified of the incident in order to assure appropriate follow up.

SOCIAL NETWORKING

While it is understood that Social media and networking are used to share ones ideas and opinions about a variety of situations, we also recognize that comments can reflect on others as well as the person posting. Sites such as Twitter, Facebook, LinkedIn, Doximitry and others are examples of social media sites, however are not all inclusive.

While information, comments and opinions posted on social media may be intended for one group to see, it cannot be guaranteed it will not be seen by others. Below are guidelines on use of social media while at the University of Miami at Holy Cross Training Program.

HIPAA (Health Insurance Portability and Accountability Act) is a federal regulation that provides patients protection of their health information. Any disclosure of patients protected health information (PHI) is a violation of this regulation. However, protected health information is not only name, date of birth or medical record number. It can include statements that could be traced back to a patient and identify them. Any posting, discussions or blogs that are posted that contain any PHI are **always** unacceptable and will result in disciplinary action.

In addition to **never** posting any PHI on any social media site, it is also expected that residents will conduct themselves appropriately on social media. A resident's postings not only reflects on the individual posting, but could reflect on the program, the hospital or the University. Patients can also search individuals on Facebook or other sites, and have been known to refuse care from a resident who's Facebook page is unbecoming of a physician.

It is expected that while on social media residents will be respectful to patients and colleagues in the program and in the hospital. Do not post anything that could be viewed as malicious, obscene, threatening or intimidating that may disparage others or may be construed as harassment or bullying. This includes not posting anything that could lead to a hostile work environment on the basis of race, sex, disability, religion or any other status protected by law.

When information is posted, it should be true and accurate. If posting medical viewpoints, it is important that you acknowledge that your opinion is your own and may not represent views of the University of Miami or Holy Cross Hospital.

Use of Social Networking sites while working is prohibited unless work related (for example, posting an article to the Holy Cross Hospital or University of Miami sites to share with colleagues).

GME POLICIES

PROGRAM COMMITTEES

PROGRAM EVALUATION COMMITTEE

The program evaluation committee is composed of faculty actively involved in curriculum adjustments as well as a resident representative from each class, including preliminary class. The goal of the PEC is to review the program goals and objectives, and how the curriculum reaches those goals. It recommends curricular adjustments depending on findings of each committee meeting. The committee meets every 4 months to discuss rotation evaluations, resident progress in achieving goals and performance on objective exams such as simulation or ITE. The PEC will compile an end of year evaluation of the program.

CLINICAL COMPETENCY COMMITTEE

The Clinical competency committee (CCC) is composed of Core faculty as voting members and a Chair. There are also non voting members, including chief resident, nursing and program administrator. The CCC meets quarterly to discuss each individual resident progress on milestones and competencies. The voting members of the committee are each assigned a resident for whom they are "advisors" for and will help guide each resident on areas of excellence and deficiency to continue to succeed. The Committee will recommend to the Program Director how residents are performing on milestones, and every 6 months the Program Director will take those recommendations when submitting to the ACGME.

As described below the CCC will also make recommendations on whether a resident is progressing and should be continued on same trajectory or need for remediation.

ELIGIBILITY AND SELECTION CRITERIA:

Eligible applicants to the University of Miami Regional Campus Internal Medicine Program at Holy Cross must be graduates of a medical school accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA) or of an international medical school listed by the World Health Organization published World Directory of Medical Schools.

- The Minimum Criteria for medical graduates to be considered are:
- Academic and clinical qualifications to be appointed as a resident physician in the University of Miami Regional Campus sponsored program
- Eligible for employment by the University of Miami Regional Campus
- A student in good standing or a graduate of a medical school accredited by either the LCME, AOA or an international medical school listed by the World Health Organization published World Directory of Medical Schools
- Anticipated eligibility for licensure by Florida Department of Health and for registration by the US Drug Enforcement Agency

- International Medical Graduates (IMG's) must have current or anticipated certification by the Educational Commission for Foreign Medical Graduates (ECFMG); or have completed a Fifth Pathway program provided by an LCME accredited medical school
- For non-citizens, permanent residency status in the United States, Work Authorization or a J-1 Visa. No other visas are accepted.
- Passed both USMLE Step 1 and Step 2 CK by the time of rank order list submission

Applicants will be screened via the Electronic Residency Application Service and invited to interview based on the recommendations of the intern selection committee. Applicants will be invited to interview, and only those residents that can attend a face to face interview will be eligible for ranking to our program via the National Residency Matching Program (NRMP). We participate in the "all in policy" from the NRMP. Our program does not discriminate with regard to gender, race, age, religion, national origin, sexual preference, disability or veteran status or any factor prohibited by law. Rank order will be decided based off of a number of factors including academic performance, extracurricular activities, research participation, interpersonal and communication skills and overall fit for our programs mission.

Each applicant will be interviewed by two faculty members. Interpersonal skills and professionalism will be assessed as well as any difficulties noted during medical school will be discussed. At the completion of interviews all applicants who participated in a face to face interview will be discussed by the intern selection committee. Using information from the original ERAS application as well as information obtained during the interview, a rank order list will be created. This will be submitted to the NRMP. No first year positions will be filled outside of the NRMP match.

Applicants applying for a PGY-2 or 3 position must have an appropriate waiver from the NRMP as well as from their current program director. Applicants must submit a Curriculum Vitae, a personal statement, three letters of recommendation (one must be from current program director) as well as their medical school transcript, copy of diploma, ECFMG certificate as appropriate and USMLE step 1, 2 and 3 transcripts. These documents will be reviewed by the Program Director and Program Administrator. If acceptable, an offer to interview will be extended. The applicant will be interviewed by two members of the intern selection committee. Following the face to face interview the intern selection committee will have an opportunity to discuss offering a position to the applicant. As above, our program does not discriminate with regard to gender, race, age, religion, national origin, sexual preference, disability or veteran status.

APPOINTMENT AND PROMOTION POLICY:

Once an individual has been "matched", the program director will notify sponsoring institution so that a Letter of Appointment and Resident Contract Agreement can be prepared for signatures.

If the individual has previous residency training, a letter or certificate from their previous program director(s) documenting residency credit and dates of training will be needed.

Appointments are for one year. Promotion to each successive level will be determined by the Clinical Competency Committee, who meets quarterly. Each resident will be evaluated by their supervisors at the end of each rotation (see Evaluation Policy and Evaluation Forms). In addition, residents will be assessed by their peers, patients and other health professionals with whom they work. Residents will meet with either the Program Director, or

Associate Program Director every 6 months to provide performance feedback and assure that residents are meeting requirements for promotion. Each resident should achieve proficiency in the milestones as appropriate for their level of training and six general competencies required by the Accreditation Council of Graduate Medical Education (ACGME). In addition, in order to be promoted from the PGY-2 to the PGY-3 level, the trainee should have passed the USMLE Step 3.

If a trainee is not meeting adequate performance in any of the ACGME areas of general competency, a letter of deficiency, signed by both the program director and the Designated Institutional Officer will be provided to the resident. This letter will include a statement identifying the deficiencies or problem behaviors, a plan for remediation and the criteria to base successful remediation, the duration of the remediation and the consequences of failure to meet the conditions of the remediation.

If based upon evaluations or other factors deemed appropriate by the Program Director, a decision regarding non-renewal of agreement is made; it should be done at least 4 months prior to the expiration of a resident agreement. A trainee who is not being promoted to the next level will have full access to the University of Miami Regional Campus Grievance Process. A trainee may not remain at the same level of training for more than 24 months, exclusive of leave. For further information, please refer to the University of Miami Regional Campus Graduate Medical Education Manual

PROMOTION TO PGY-2

Requirements for PGY-1 residents to be promoted to PGY-2:

- Satisfactorily completed 12 months of rotations, with evaluations rating resident satisfactorily in all 6 Core ACGME competencies.
    - If a rotation is needed to be remediated, this may result in resident being “off-track”
- Be recommended and approved by the clinical competency committee for promotion
- Complete the 16 IHI modules assigned during the quality rotation.
- Have completed a quality project progress sheet and met with mentor
- Completed the RSAP progress form on research and scholarly activity (may be intertwined with the quality project).
- Complete pending evaluations on rotations
- Attended conferences as described in conference attendance

PROMOTION TO PGY-3

Requirements for PGY-2 residents to be promoted to PGY-3:

- Satisfactorily completed 12 months of rotations, with evaluations rating residents satisfactory in all 6 Core ACGME competencies
    - If a rotation is needed to be remediated, this may result in resident being “off track”
- Be recommended and approved by the clinical competency committee for promotion

- Complete and sign off on central line placement and pap smears (3 successfully completed under supervision)
    - Resident should also have logged 5 IV lines, 5 Venous blood draws, 5 arterial blood samples
- Taken and Passed USMLE Step 3 (it is encouraged to complete this by the end of first year)
- Actively Participated in RSAP program, as shown by RSAP involvement and mentor form filled out
- Submitted an abstract to a local, regional or national conference
- Renewed ACLS/BLS

RESIDENT PERFORMANCE, DISCIPLINE AND DISMISSAL POLICY

The following Policy and Procedures for Resident Performance and Due Process (hereinafter "Performance Policy") shall apply to all graduate medical trainees at the University of Miami. The Performance Policy provides assurance that residents proceed along a continuum of competence as required by their specialty, complete the requirements for certification by their specialty board, and are afforded due process when adverse actions are anticipated.

Definitions:

Graduate Medical Trainee: Any resident or fellow participating in a postgraduate medical program.

Graduate Medical Education: The office that oversees trainees in GME, directed by the DIO and a Director of Graduate Medical Education Programs (or GME Manager).

DIO: The designated institutional official is the individual qualified to oversee the GME programs and reports to the leadership of the sponsoring institution. The DIO also chairs the Graduate Medical Education Committee (GMEC).

Academic Deficiency: Inadequate acquisition of or performance in any of the ACGME's areas of general competencies, including patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, or systems based practice, as expected for the graduate medical trainee's level of experience and education. If a deficiency is not corrected by providing regular feedback to the trainee, a *period of remediation* may be imposed. Deficiencies are not reportable events.

Misconduct: A lapse in ethical or moral behavior, irrespective of the graduate medical trainee's level of experience and education. Acts of misconduct are addressed with *disciplinary action* and may be reportable events.

Adverse Action: Suspension, non-renewal, non-promotion, or dismissal of a graduate medical trainee from his or her program. Adverse actions are generally reportable events.

Reportable Events: Those actions the program or institution must disclose to others upon request, including, without limitation, future employers, privileging hospitals, and licensing and specialty boards.

PROCEDURE

1. TRAINING PROGRAM ASSESSMENT STRUCTURE AND PLAN

   The program primary responsibility for monitoring the competence of the program's graduate medical trainees, for recommending promotion and board eligibility, and, when necessary, imposing any remedial,

adverse or disciplinary actions. Graduate medical trainees shall be evaluated on both the clinical and non-clinical requirements of the ACGME and/or the certifying specialty Board. All graduate medical trainees are expected to be in compliance with University and hospital policies, which include, but are not limited to, the Compliance Code of Conduct and other policies on federal health care program compliance, duty hour restrictions, sexual harassment, moonlighting, infection control, and completion of medical records. A faculty clinical competency committee appointed by the program director should assist the program director in these functions and meet regularly. Where circumstances warrant, the membership of a clinical competence committee may be altered to avoid a potential conflict of interest, or to protect the privacy of the graduate medical trainee. The Chair of a department or DIO may or may not exercise the option to become a member of the competence committee.

2. PERFORMANCE REVIEWS

Our program will provide written summary performance reviews to trainees semi-annually. A review of the graduate medical trainee's experience and competence in performing required clinical procedures should be included in these summaries. Summary performance reviews may be written by program directors, designated faculty members, or members of a program's clinical competence committee consistent with the assessment plan of the program and in compliance with the ACGME.

3. PROMOTION

Those graduate medical trainees judged by a program to have completed satisfactorily the requirements for a specific level of training will be promoted to the next level of responsibility unless the graduate medical trainee specifically is enrolled in a training track of limited duration that is not designed to achieve full certification (e.g., a one-year preliminary position). No graduate medical trainee may remain at the same level of training for more than 24 months, exclusive of leave. A graduate medical trainee whose performance is judged to be satisfactory will advance until the completion of the program/certification requirements. For specific requirements for promotion, see below for each year's requirements.

4. ACADEMIC DEFICIENCY

A. Definition of Deficiency: Inadequate acquisition of or performance in any of the ACGME's areas of general competencies, including patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, or systems based practice, as expected for the graduate medical trainee's level of experience and education

B. Letter of Deficiency: If, after documenting routine feedback, it is determined that a graduate medical trainee is not performing at an adequate level of competence in any of the general competencies, or otherwise fails to fulfill the responsibilities of the program in which he or she is enrolled, the graduate medical trainee will be issued a Letter of Deficiency by the program director or program's education committee. The letter must be signed by both the Program Director and the Designated Institutional Official. The graduate medical trainee must be informed in person of this decision and must be provided with a hard copy that includes the following:

1. A statement identifying the deficiencies or problem behaviors.

2. A plan for remedial action and criteria by which successful remediation will be judged.

3. The duration of the remedial period in which deficits are expected to be corrected; ordinarily, this period will be at least three months.

4. Written notice that failure to meet the conditions of remedial action could result in additional remediation or training time and/or suspension or dismissal from the program during any point, or at the conclusion of, the remedial action period.

5. Written acknowledgement of receipt by the graduate medical trainee of the Letter of Deficiency.

C. The Designated Institutional Official (hereinafter "DIO") must receive a copy of this documentation.

D. If remedial action is extended beyond the initial period, the competency of the graduate medical trainee should be evaluated monthly, but no less than every three months. If, at the end of the remedial action period the graduate medical trainee has not met the requirements of the remediation period, remains unsatisfactory, the graduate medical trainee may be suspended or other adverse action may be initiated (*see Sections 6C and 6D).*

E. If the graduate medical trainee successfully completes the remedial action, written documentation must be included in the graduate medical trainee's file describing the satisfactory completion of all remedial action plans. These episodes of deficiency are not reportable adverse actions and *thus are not subject to GME due process requirements.*

5. MISCONDUCT

A. Definition of Misconduct: A lapse in ethical or moral behavior, irrespective of the graduate medical trainee's level of experience and education. Acts of misconduct are addressed with disciplinary action and may be reportable events.

B. When a graduate medical trainee engages in behavior that is clearly unethical, immoral, or criminal in nature, such as harassment, theft, fighting, dishonesty, breach of contract, the program director may choose to impose disciplinary action rather than a period of remedial action. If misconduct is alleged or suspected, the program director should:

a. Meet with the person complaining of misconduct.
b. Meet with the trainee to advise the trainee of the existence of the complaint, to give the trainee an opportunity to respond to the allegations, and to identify any potential witnesses to the alleged misconduct.
c. Consult with the DIO to determine whether the hospital leadership, legal affairs and/or human resources should be contacted as appropriate based on the issues and the people involved. Of note, all allegations of sexual harassment will be reported immediately to human resources in accordance with the University's and/or hospital's policy against harassment.
d. Upon consensus of the Program Director and GME, the accused trainee can be suspended from clinical or program activities (see below) with or without pay, pending the outcome of a full inquiry.
e. Upon request of the trainee, or if the Program Director, GME, hospital leadership, or human resources decide the incident warrants more investigation, then a "Full Inquiry" must be done.

Full Inquiry**:** A full inquiry is an internal investigation of the allegation/incident by appropriate individuals, which may include GME, the Program Director, the hospital leadership, human resources, legal, or others. The inquiry process is administered by the Director of GME Programs. Factual results of the inquiry will be prepared by the GME Director and/or other responsible individuals and reported back to the program director and the trainee officer for appropriate action.

1) If the full inquiry results in a finding that no misconduct occurred, no action will be taken against the trainee. If trainee was suspended pending the inquiry, the trainee will be reinstated with full benefits and pay. A letter documenting the findings of the full inquiry will be placed in the trainee's file and the matter will be closed.

2) If the full inquiry results in a finding that a graduate medical trainee participated in misconduct, the Program Director shall determine, in conjunction with the hospital leadership, GME, human resources, legal, or other appropriate individuals, what action is appropriate under the circumstances, to remedy the situation. The Program Director may take actions including the following**:** a verbal or written warning; election to not promote to the next PGY level with or without contract non-renewal; suspension or dismissal from the program.

3) If after completion of the full inquiry new information about the specific incident becomes available, the Program Director or the trainee may request another inquiry.

6. SUSPENSION AND DISMISSAL

The DIO must be notified prior to enactment of any or all of the following:

A. Suspension of Clinical Activities

A graduate medical trainee may be suspended from clinical activities by his or her program director, department chair, the faculty director of the clinical area to which the graduate medical trainee is assigned, the Chief Medical office or Staff, the CEO of the Medical Center or the Dean of the School of Medicine. This action may be taken in any situation in which continuation of clinical activities by the graduate medical trainee is deemed potentially detrimental or threatening to health care operations, including but not limited to patient safety or quality of patient care, suspension or loss of licensure, or debarment from participation as a provider of services to Medicare and other federal programs' patients. Unless otherwise directed, a graduate medical trainee suspended from *clinical activities* may participate in non-clinical program activities. A decision involving suspension of a graduate medical trainee's clinical activities must be reviewed within three (3) working days by the program director or full-time department chair to determine whether the graduate medical trainee may return to clinical activities and/or whether further action is warranted (including, but not limited to, counseling, remedial action, fitness for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of institution officials.

B. Program Suspension

A graduate medical trainee may be suspended from all program activities and duties by his or her program director, department chair, or any other person listed in Section 5A. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional; incompetent; erratic; potentially criminal; noncompliant with the Compliance Code of Conduct, federal health care program requirements, Corporate Compliance Agreement, or University policies and procedures ("noncompliance"); or is threatening to the well-being of patients, other graduate medical trainees, faculty, or staff. A decision involving program suspension of a graduate medical trainee must be reviewed within three (3) working days by the department chair or program director to determine whether the graduate medical trainee may return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to, career or academic advising, remedial action, fitness for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of institution officials.

C. Dismissal During or at the Conclusion of Remedial Action

A Letter of Deficiency in a training program constitutes notification to the graduate medical trainee that dismissal from the program can occur at any time during or at the conclusion of remedial action. Dismissal prior to the conclusion of a remedial action period may occur if the conduct that gave rise to the Letter of Deficiency is repeated or if grounds for program suspension or summary dismissal exist. Dismissal at the end of a remedial action period may occur if the graduate medical trainee's performance remains unsatisfactory or for any of the foregoing reasons.

D. Summary Dismissal

For serious acts of incompetence, impairment, unprofessional behavior, falsifying information, noncompliance, or lying, or if a graduate medical trainee is listed as excluded on the Department of Health and Human Services' Office of Inspector General's "List of Excluded Individuals/Entities" or on the General Services Administration's "List of Parties Excluded from Federal Procurement and Non-Procurement Programs" or is discovered to have been convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a) (an "excludable crime," i.e., criminal offenses related to governmentally financed health care programs, including health care fraud; criminal abuse or neglect of patients; and or felony controlled substance convictions related to the provision of health care), a program director or department chair, or any person listed in Section 5A, may immediately suspend a graduate medical trainee from all program activities and duties for a minimum of three (3) days and, concurrently, issue a notice of dismissal effective at the end of the suspension period. The graduate medical trainee does not need to have been issued a Letter of Deficiency, nor be at the end of a remedial action period, for this action to be taken.

E. Notification of Suspension and Dismissal

The graduate medical trainee must be notified in writing of the reason for and terms of suspension and dismissal, have an opportunity to respond to the action before the dismissal is effective, and receive a copy of the GME Appeals Process.

7. GME APPEALS PROCESS FOR ADVERSE (REPORTABLE) ACTIONS

In the event that a graduate medical trainee (i) is not promoted, (ii) is suspended, (iii) is dismissed from a program, (iv) does not have his/her appointment/contract renewed, or (v) is the subject of any adverse action that is reported to the State Boards of Medicine, Dentistry, or Pharmacy or a relevant specialty board, the graduate medical trainee may appeal such non-promotion, suspension, dismissal, non-renewal of appointment/contract, or adverse action as follows:

A. Committee Appeal

A graduate medical trainee may initiate an appeal by submitting a written notice of appeal to the DIO, with a copy to the program director and Graduate Medical Education, within 14 working days of the date of the appeal able action (hereinafter "adverse action"). A faculty committee, consisting of at least two experienced program directors will hear the appeal within fourteen calendar days following receipt of the notice of appeal and appointment of the review committee. *A member of the GME Office must be present during this hearing and record the findings of the committee.* The graduate medical trainee may have a faculty advocate appear and participate on the graduate medical trainee's behalf at the hearing. It is the responsibility of the graduate medical trainee to secure the voluntary participation of a faculty advocate. Prior to the hearing, the graduate medical trainee must notify the DIO if the graduate medical trainee will be accompanied by a faculty advocate.

At the appeals hearing, the trainee will present evidence in support of the appeal. The program director (or designee) will present a statement in support of the adverse action. At a minimum, the committee must review any relevant records, or other evidence supporting the adverse action. A record of the hearing will be kept by the member of the GME Office present for the hearing. After presentation of evidence, the appeals committee will meet in closed session to consider the adverse action. The committee may uphold or reject the adverse action, or may impose alternative actions, which may be more or less severe than the initial action. The committee's decision must be submitted to the DIO within 14 working days of the request for appeal and copied to the GME Office.

B. DIO Review

The DIO will review the committee's efforts and recommendations and make the following determinations:

1. Whether the trainee was provided due process according to this policy
2. Whether applicable University, department, and/or Health System policies were fairly and appropriately applied, and
3. Whether there is sufficient evidence to support the adverse action or other action recommended by the departmental appeals committee.

The DIO may uphold or reject the adverse action, may uphold or reject other actions recommended by the appeals committee, or may recommend alternative actions. The decision of the DIO will be submitted to the graduate medical trainee and the program director within

thirty (30) calendar days of the notice of appeal. This decision will be considered final and not appealable.

8. OTHER CONSIDERATIONS

External rules, regulations, or law governs mandatory reporting of problematic behavior or performance to licensing agencies or professional boards. The fact that such a report is made is not a matter which may give rise to the appeal process; only the adverse action as specified by this section is appeal able. Where mandatory reporting of problematic behavior or performance occurs, external agencies will be notified of the status of any internal appeal regarding the matter reported and its outcome. Graduate medical trainees should be aware that participation in the GME appeals process does not preclude investigation or action on the part of external entities.

NON-RENEWAL OF APPOINTMENT

All residency appointments shall be for a period not to exceed one year and may be renewed by the DIO in writing, upon recommendation by the Program Director. In the event a decision is made not to reappoint a resident the resident shall be advised of such in writing by the Program Director at least four months prior to the end of the appointment. However, if the primary reason(s) for the non-reappointment (renewal) occurs within the four months prior to the end of the contract, the program director will provide the resident with as much written notice of the intent not to reappoint as the circumstances will reasonably allow prior to the end of the current appointment (contract). This notice shall include a brief description of the grounds for the determination not to renew the resident's appointment.

The resident may appeal this determination by submitting a written request for an appeal to the program director within fourteen (14) calendar days after the receipt of written notification of non-advancement or non-renewal to the Program Director.

REQUIREMENT FOR COMPLETION OF TRAINING:

Once the resident has completed 3 years of training, shown proficiency in the milestones, and maintained full compliance with the terms of the resident agreement, the resident will receive a certificate of completion from the University of Miami Regional Campus. The American Board of Internal Medicine has specific requirement to allow a trainee to sit for the board certifying exam. Trainee must have completed Graduate Medical Education training by August 31 of the year of the examination year to sit for the examination. The trainee must have completed 36 months of full-time training, with 30 being in internal medicine, its subspecialties or Emergency Medicine. Training may include up to three months of other electives approved by the internal medicine program director. The trainee is allowed up to one month per year for leave of absence, or a total of 12 weeks over the three years, inclusive of vacation time. Any additional time will need to be made up prior to satisfactorily completing the training program. At least 24 months of the 36 months of residency education must occur in setting where the resident personally provides or supervises less experienced residents in the inpatient or ambulatory settings. At least six months of direct patient responsibility on internal medicine rotations must occur during the PGY-1 year.

Trainees must also be deemed competent in the below mentioned procedures (those in red are not requirements for ABIM, but are for our program).

	Know, Understand and Explain				Perform Safely and Competently
	Indications; Contraindications; Recognition & Management of Complications; Pain Management; Sterile Techniques	Specimen Handling	Interpretation of Results	Requirements & Knowledge to Obtain Informed Consent	
Abdominal paracentesis	X	X	X	X	x
Advanced cardiac life support	X	N/A	N/A	N/A	X
Arterial line placement	X	N/A	X	X	
Arthrocentesis	X	X	X	X	x
Central venous line placement	X	X	N/A	X	x
Drawing venous blood	X	X	X	N/A	X
Drawing arterial blood	X	X	X	X	X
Electrocardiogram	X	N/A	X	N/A	
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	
Nasogastric intubation	X	X	X	X	
Pap smear and endocervical culture	X	X	X	X	X
Placing a peripheral venous line	X	N/A	N/A	N/A	X
Pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	

Clinical Competences will be reported each year for internal medicine residents. The overall clinical competence in the 6 ACGME competencies will be reported as follows:

- Satisfactory or Superior: Granted full credit for year
- Conditional on improvement: Full credit for PGY-1, PGY-2, but no credit for final year of training until achieves satisfactory rating
- Unsatisfactory: No credit, must repeat year