POLICIES AND PROCEDURES MANUAL
FOR
GRADUATE MEDICAL EDUCATION
RESIDENCY AND FELLOWSHIP PROGRAMS

Reviewed and Approved by DIO & GMEC: December, 2016
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SECTION I.

GRADUATE MEDICAL EDUCATION (GME)
ACADEMIC AFFAIRS / MEDICAL EDUCATION OFFICE
CONTACT INFORMATION

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www.harthosp.org/ResidenciesFellowships

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OTHER CONTACTS

Assistance Program: Mental Health – Stressed Resident/Fellow Program (EAP): 860-545-2530 24-hour, 7 day/week basis.

Benefits/Payroll/Human Resources: HHCandMe@hhhealth.org (860) 696-3500
Toll free: 1-844-780-9950

Liability Insurance: CHS (860) 972-6265

Controlled Substance Registration: http://www.state.ct.us/dcp/ (860) 713-6100
State of Connecticut
Department of Consumer Protection
Drug Control Division
165 Capitol Avenue, Hartford, CT 06106

ECFMG (Educational Commission on Foreign Medical Graduates) (215) 386-5900
http://www.ecfmg.org/
3624 Market St.
Philadelphia, PA 19104
Sponsorship Department (215) 823-2121

Hartford County Medical Association (HCMA) (203) 699-2400
http://www.hcma.org/
1520 Highland Avenue
Cheshire, CT 06410

Impaired Physician: Haven Health: www.havenhealth.org

ITS HELP Desk (860) 545-HELP

Compliance HOT LINE: HCC.OCAPComplianceline.com 1-855-HHC-OCAP or (860) 972-4069
(Concerns a resident/fellow, faculty and staff may have about a program)

Licensure for CT: http://www.ct.gov/dph/site/default.asp (860) 224-5011

PhotoID Center: HHPHotoIDandParking@hhchealth.org (860) 972-0129

Risk Management: Alison Reynolds, Director; 85 Jefferson Street (860) 972-9766

Security Dept (860) 545-2147

Social Security Office 1-877-619-2851
https://www.ssa.gov
960 Main Street, 2nd Floor
Hartford, CT

United States Citizenship and Immigration Services 1-800-375-5283
https://www.uscis.gov
Hartford Field Office: 450 Main Street, 1st Floor, Hartford, CT 06103-3060
LINKS

**National**
AGCME - Accreditation Council for Graduate Medical Education [http://www.acgme.org/](http://www.acgme.org/)

AACOM - American Association of Colleges of Osteopathic Medicine [http://www.aacom.org/Pages/default.aspx](http://www.aacom.org/Pages/default.aspx)

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


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

FSMB Federation of State Medical Boards [http://www.fsmb.org/](http://www.fsmb.org/)


LOAN CONSOLIDATION Information [https://www.aamc.org/services/first/first_for_residents/78784/primerstart.html](https://www.aamc.org/services/first/first_for_residents/78784/primerstart.html)

NAFSA NAFSA: Association of International Educators [http://www.nafsa.org/](http://www.nafsa.org/)


NPI (National provider Identification): **Apply online at:** [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)


USCIS United States Citizenship and Immigration Services - [http://www.uscis.gov/portal/site/uscis](http://www.uscis.gov/portal/site/uscis)

USDOS - United States Department of State [http://www.state.gov/](http://www.state.gov/)


**Connecticut**
Connecticut Medical Assistance Program (CMAP): [www.ctdssmap.com](http://www.ctdssmap.com)


Welcome to Graduate Medical Education (GME) at Hartford Hospital. The purpose of GME is to provide residents/fellows with an organized educational program in a selected discipline. The emphasis of each program will be to facilitate the resident’s/fellow’s personal and professional development in six general competencies, ensure safe and appropriate patient care, and provide guidance and supervision of the resident/fellow. Hartford Hospital is committed to excellence in education and medical care. An ethical and professional environment will be provided in which all educational requirements will be met.

The GME/Medical Education Office staff along with the GME Committee (GMEC) will oversee all residency/fellowship programs sponsored by Hartford Hospital. Dr. Peruvamba Venkatesh, Chief Academic Officer and Institutional Official (DIO), has the authority and responsibility for the oversight and administration of the GME Programs.

The GME/Medical Education Office staff is available to any resident/fellow should there be concerns about educational experience that have not been resolved at the program level. All staff in the GME/Medical Education office has an open door policy and welcome suggestions regarding improvement in educational experience at Hartford Hospital.

The Policies and Procedures Manual for Graduate Medical Education Residency and Fellowship programs has been developed as a guide and a resource for residents/fellows. The purpose of the written policies in this book is to establish guidelines for what all residents/fellows can expect at Hartford Hospital, as well as what is expect of the residents/fellows. Residents/fellows should use this book as a resource to answer questions regarding policies and procedures.

Graduate Medical Education Administrative Organization

The GME/Medical Education Office of Hartford Hospital is affiliated with the University of Connecticut School of Medicine and is responsible for administering the activities that are common to all of the residency/fellow programs. When applicants are selected to join residency/fellows programs, the Program Director provides required information to the Medical Education Office staff. When all submitted information is found to be satisfactory, a contract will be approved with final signature by the Designated Institutional Official.

The GME/Medical Education Office is responsible for coordinating activities regarding employment issues with Hartford Hospital Human Resources. Additional activities include assisting international graduates in obtaining appropriate visa/employment status, keeping permanent records on residents and fellows, providing the appropriate State agencies with a list of all residents/fellows employed and supporting the individual departments in carrying out their responsibilities of conducting GME programs.

The GME/Medical Education Office has oversight responsibilities for approximately 19 residency and fellowship programs. In addition, GME/Medical Education has oversight of the University of CT residents, fellows and medical students who rotate at Hartford Hospital which includes approximately 30 programs. Hartford Hospital must be in good standing with our accrediting organization, Accreditation for Graduate Medical Education (ACGME), in order to be successful as a sponsoring institution.
INTSTITUTIONAL RESOURCES
Hartford Hospital ensures that the DIO has sufficient financial support and protected time to effectively carry out his or her educational, administrative, and leadership responsibilities; the DIO engages in.

Program Administration: Hartford Hospital in collaboration with each ACGME and non-ACGME accredited program, must ensure that the program director(s) has sufficient financial support and protected time to effectively carry out his/her educational, administrative, and leadership responsibilities, as described in the Institutional, Common, and specialty-specific Program Requirements. The program(s) receive adequate support for core faculty members to ensure both effective supervision and quality resident/fellow education; the program director(s) and core faculty members engage in professional development applicable to their responsibilities as educational leaders; the program coordinator(s) has sufficient support and time to effectively carry out his/her responsibilities and, resources, including space, technology, and supplies, are available to provide effective support for each of its ACGME-accredited programs.

Hartford Hospital’s Commitment to Graduate Medical Education
Hartford Hospital sponsors graduate medical education in Residency Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) to prepare physicians for certification by a specialty board recognized by the American Board of Medical Specialties. As a sponsor it commits the necessary financial support for administrative, educational and clinical resources, including personnel required to support the excellence of its educational programs. Hartford Hospital assumes supervisory, administrative and educational responsibility for its programs via the Vice President for Academic Affairs and the Graduate Medical Education Committee (GMEC). As a Major Participating Institution, Hartford Hospital assumes responsibility for resident supervision and accepts a shared role with the University of Connecticut for educational administration of Integrated Residency programs.

__________________________________________________________
Douglas Elliot
Chairman, Board of Directors
Date

__________________________________________________________
Stuart Markowitz, M.D.
President and Chief Executive Officer
Date

__________________________________________________________
Peruvamba Venkatesh, M.D.
Chief Academic Officer/Designated Institutional Official
Chairman, Graduate Medical Education Committee
Date
ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) COMPETENCIES

Hartford Hospital is committed to providing residents/fellows with an educational environment which allows residents/fellows to successfully demonstrate with satisfaction and understand the following attributes and objectives set forth by the Accreditation Council for Graduate Medical Education (ACGME).

Each residency/fellowship program enables its residents/fellows to develop competence in six areas. Towards this goal, programs define specific knowledge, skills, and attitudes required and provide the clinical and educational experiences needed in order for residents/fellows to demonstrate this competence. As specified in the ACGME Common Program Requirements, all Hartford Hospital sponsored Graduate Medical Education programs have integrated the general competencies into written curriculum and evaluations related to education and clinical care. Programs use resident/fellow performance data as the basis for program improvement. Programs are expected to use external measures to verify resident/fellow and program performance levels.

The six core competencies as defined by the ACGME are as follows:

**Patient Care**
Residents/fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

**Medical Knowledge**
Residents/fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

**Practice-based Learning and Improvement**
Residents/fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents/fellows are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one's knowledge and expertise;
- set learning and improvement goals;
- identify and perform appropriate learning activities;
- systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- incorporate formative evaluation feedback into daily practice;
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- use information technology to optimize learning; and,
- participate in the education of patients, families, students, residents/fellows and other health professionals.
**Interpersonal and Communication Skills**
Residents/fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents/fellows are expected to:

- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicate effectively with physicians, other health professionals, and health related agencies;
- work effectively as a member or leader of a health care team or other professional group;
- act in a consultative role to other physicians and health professionals; and,
- maintain comprehensive, timely, and legible medical records, if applicable.

**Professionalism**
Residents/fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents/fellows are expected to demonstrate:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society and the profession; and,
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

**Systems-Based Practice**
Residents/fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents/fellows are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinate patient care within the health care system relevant to their clinical specialty;
- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in inter-professional teams to enhance patient safety and improve patient care quality; and,
- participate in identifying system errors and implementing potential systems solutions.
GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC) COMPOSITION, MEMBERSHIP AND RESPONSIBILITIES

The Hartford Hospital Graduate Medical Education Committee (GMEC) has oversight, final authority and responsibility for all aspects of residency education. The DIO and GMEC are responsible for assuring compliance with ACGME requirements. All members on the Committee are voting members which include the DIO, residents/fellows nominated by their peers (minimum two) from ACGME and non-ACGME programs, program directors (two minimum), a quality patient safety officer and administrators. Committee may also include other members of the faculty or other members as determined. Additional GMEC members may include others as determined by the GMEC which may include subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow. The sub-committees actions that address required GMEC responsibilities are reviewed and approved by the GMEC.

The GMEC meets on a monthly basis. Each meeting of the GMEC includes attendance by at least one resident member and maintains meeting minutes that document execution of all required GMEC functions and responsibilities.

The Executive Committee of the GMEC is comprised of the DIO, Program Directors, faculty and Medical Education Manager. The Executive Committee meets on a quarterly basis, as needed, when resident/fellow issues arise.

Responsibilities

Oversight of:
1. The ACCME accreditation status of the Sponsoring Institution and each of its ACGME accredited and non-ACGME programs

2. The quality of the GME learning and working environment within the sponsoring institution within the Sponsoring Institution, each of its ACGME-accredited and non-ACGME programs, and its participating sites.

3. The quality of educational experiences in each ACGME-accredited and non-ACGME program that leads to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements

4. The ACGME-accredited programs’ annual evaluation and improvement activities;

5. All processes related to reductions and closures of individual ACGME-accredited and non-accredited programs major participating sites, and the Sponsoring Institution.

Review and approval of:
1. Institutional GME policies and procedures

2. Annual recommendations to the Sponsoring Institution’s Administration regarding resident/fellow stipends and benefits

3. Applications for ACGME accreditation and non-ACGME new programs

4. Requests for permanent changes in resident/fellow complement
5. Major changes in each of its ACGME-accredited and non-ACGME programs’ structure or duration of education

6. Additions and deletions each of its ACGME-accredited programs’ participating sites

7. Appointment of new program directors

8. Progress reports requested by a Review Committee

9. Responses to Clinical Learning Environment Review (CLER) Reports

10. Requests for exceptions to duty hour requirements

11. Voluntary withdrawal of ACGME and non-ACGME program accreditation

12. Requests for appeal of an adverse action by a Review Committee;

13. Appeal presentations to an ACGME Appeals Panel

14. The GMEC must demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review (AIR).
   a) The GMEC must identify institutional performance indicators for the AIR which include:
      (1) results of the most recent institutional self-study visit;
      (2) results of ACGME surveys of residents/fellows and core faculty members; and,
      (3) notification of each of its ACGME-accredited programs’ accreditation statuses and self-study visits
   b) The AIR must include monitoring procedures for action plans resulting from the review.
   c) The DIO must submit a written annual executive summary of the AIR to the Governing Body

15. The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process.
   a) The Special Review process must include a protocol that:
      (1) establishes criteria for identifying underperformance; and,
      (2) results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

16. Resident Duty Hours
   a) Develops and implements written policies and procedures regarding resident duty hours to ensure compliance with the institutional, common and specialty/subspecialty – specific program requirements.
   b) Consider for approval requests from program directors prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours in compliance with ACGME policies and procedures for duty hour exceptions.
Desigenees for Designated Institutional Official (DIO)
The DIO along with the support of the GMEC has established and implemented a policy that ensures that in the absence of the DIO, that the Manager of the Medical Education Programs reviews, and cosigns all program information forms and any documents or correspondence submitted to the ACGME by program directors which includes the following:
  - Program changes, prior to submission to the ACGME
  - All applications for ACGME accreditation of new programs;
  - Changes in resident complement, major changes in program structure or length of training
  - Additions and deletions of participating sites
  - Appointments of new program directors
  - Progress reports requested by any Review Committee
  - Responses to all proposed adverse actions
  - Requests for exceptions of resident duty hours
  - Voluntary withdrawal of program accreditation
  - Request for an appeal of an adverse reaction
  - Appeal presentations to a Board of Appeal or the ACGME.

Hartford Hospital Resident/Fellows Forum
The Hartford Hospital Resident and Fellow Forum include representatives from all Hartford Hospital sponsored residency programs. It has been established to provide an opportunity for communication and the exchange of information related to the working environment of residents and fellows at Hartford Hospital. Through this forum residents and fellows are able to raise and resolve issues in a confidential manner without fear of intimidation or retaliation. Residents and fellows have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present. Residents/fellows have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.

One individual resident or fellow from each program will be elected by his or her peers to serve as a representative to the forum. A program may elect the same individual to serve on the forum and represent them at the Graduate Medical Education Committee (GMEC) or they may choose another individual.

Pertinent issues can be addressed via the representative or through alternative communication. The forum will also serve as a contact between the residents, fellows and the GMEC.

This information will be included in the house staff manual.

QUARTERLY MEETINGS WITH HOUSESTAFF RESIDENTS/FELLOWS
The Designated Institutional Official (DIO) along with the Manager of Medical Education meet on a quarterly basis with each specific residency and/or fellowship program’s residents/fellows. This meeting is conducted so that individuals can discuss issues and/or concerns in regards to their educational program, process improvement ideas and information conducive to their educational experience. The meeting is held without any program administrators in attendance. Follow up, feedback and actions are forwarded to the Program Directors and monitored by the GMEC.
SECTION II.

ELIGIBILITY / SELECTION / EMPLOYMENT
RESIDENT/FELLOWS RECRUITMENT - Eligibility and Selection of Residents/Fellows Policy

Hartford Hospital has written policies and procedures for resident/fellow recruitment and appointment, and monitors each of its ACGME and non-ACGME programs for compliance.

An Applicant must meet one of the following qualifications to be eligible for appointment to a Residency or Fellowship program at Hartford Hospital:

1. Graduation from a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or,
2. Graduation from a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or,
3. Graduation from a medical school outside the United States or Canada, and meeting one of the following additional qualifications:
   - Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or,
   - Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty/subspecialty program; or, are eligible to work in the U.S. (have permanent resident status) or obtain a J1 visa, which is the only visa which Hartford Hospital sponsors.
   - Has graduated from a medical school outside the United States and has completed a Fifth Pathway** program provided by an LCME-accredited medical school.

** Has completed an academic year of supervised clinical education provided by an LCME-accredited medical school having met the following conditions:
   - completion at an accredited college or university in the U.S., undergraduate premedical education of the equality acceptable for matriculation in an accredited U.S. medical school;
   - having studied at a medical school outside the U.S. and Canada, but listed in the World Health Organization Director of Medical Schools;
   - have completion of all formal requirements of the foreign medical school except internship and/or social service;
   - having attained a score satisfactory to the sponsoring medical school on a screening examination, and
   - having passed either the foreign Medical Graduate Examination in the Medical Sciences, Part I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

STEP III Policy (USMLE 3/COMPLEX 3):
All residents must take USMLE3/COMPLEX 3 before the end of their PGY1 year. Successful completion of the USMLE 3/COMLEX 3 is a requirement to be promoted or appointed the PGY3 or above training level.

As of 7/1/2014, if a resident enters a Hartford Hospital residency program as a PGY2 and has not taken and passed USMLE 3/COMPLEX 3, the resident must take the USMLE 3/COMLEX 3 within the first six (6) months of the PGY2 year. Failure to meet the requirements outlined in this policy will result in a formal meeting with the program director and a designee from the Medical Education Office.
Additional Eligibility Requirements: Effective: July 1, 2016

Residency Programs:
All prerequisite post graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency Program or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC) -accredited residency program located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program.

A physician who has completed residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

A review committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. Review Committees will grant no other exceptions to these eligibility requirements for residency education.

Fellowship Programs:
All required clinical education for entry into ACGME-accredited and non-accredited fellowships programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada.

Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.

Fellow Eligibility Exception: A Review Committee may grant the following exception to the fellowship eligibility requirements: An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in III.A.2. AND iii.a.2.a), but who does meet all of the following additional qualifications and conditions:

- Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations in the core specialty and
- Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GEMC, and
- Satisfactory completion of the USMLE steps 1, 2 and if the applicant is eligible, 3 and;
- For an international graduate, verification ECFMG certification; and,
- Applicants accepted by this exception must complete fellowship Milestones evaluations (for the purposes of establishment of baseline performance by the CCC),conducted by the receiving fellowship program within six weeks for matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant’s Milestones evaluation conducted at the conclusion of the residency program.
An exceptionally qualified applicant has (1) completed a non-ACGME accredited residency program in the core specialty, and (2) demonstrated clinical experience, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: a) participation in additional clinical or research training in the specialty or sub-specialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after each residency training; (d) completion of an ACGME-International-accredited residency program. Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement: The review committee for ______________ program does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2

At Hartford Hospital, Programs select residents/fellows among eligible applicants on the basis of their preparedness, aptitude, academic credentials, communication skills and personal qualities. Hartford Hospital Programs do not discriminate with regard to gender, race, age, religion, color, national origin, disability, veteran status or any other applicable legally protected status. Hartford Hospital Programs participate in organized matching programs where available, such as the National Resident Matching Program (NRMP).

Recruitment and appointment are monitored for compliance by the Medical Education Office in collaboration with the Designated Institutional Official.
## Eligibility Exception Decisions by Specialty

### Common Program Requirements  Section III.A.

<table>
<thead>
<tr>
<th>Specialty/Subspecialty</th>
<th>Allow Eligibility Exceptions</th>
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<tbody>
<tr>
<td>Allergy and Immunology*</td>
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<tr>
<td>Anesthesiology Subspecialties</td>
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<tr>
<td>Neurology Subspecialties</td>
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<td>Nuclear Medicine*</td>
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<td>Obstetrics and Gynecology Subspecialties</td>
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<tr>
<td>Urology Subspecialties</td>
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</table>

* The Review Committee does allow the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission.
NRMP Policy on Professionalism: Recruitment of Residency/Fellowship Applicants
Since the majority of our residency and fellowship programs participate in the NRMP Match or other formal matching programs, we as an institution abide by the NRMP policy on Professionalism.

All programs must be familiar with the Match Participation Agreement for applicants that use the NRMP Match. The particular area that we would like to draw attention to is:

http://www.nrmp.org/res_match/policies/map_main.html#restrictions
and section 6.0 of the Match Participation Agreement (Restrictions on Persuasion)

Hartford Hospital is committed to following this policy on professionalism for all its sponsored programs.
All Hartford Hospital Graduate Medical Education programs must strictly adhere to all parts of the NRMP Match participation Agreement as it is a legally binding agreement with established and significant penalties for violations. In particular, they must comply with section 6.0 Restriction on Persuasion.

Accordingly, all Hartford Hospital program directors, and those representing them such as interviewers, should avoid the following in discussions with applicants:

(a) Soliciting applicant rank preferences
(b) Suggesting that placement on a rank order list is contingent upon submission of a verbal or written statement indicating ranking preferences.
(c) Requiring applicants to reveal the names or identities of programs to which they have or may apply.

For those situations when the topic of where the applicant is applying arises for any good reason, care must be taken to not be perceived as trying to extract information that is even indirectly related to how the applicant is planning to rank the program. Repeated requests for information after the applicant has demonstrated unwillingness to share information about where they are applying should be avoided. In addition, applicants should not be surveyed before the match lists are due if the survey requests any information about program preferences.

All program directors are required to sign the NRMP attestation form indicating their understanding of this policy and guarantee that faculty participating in recruitment have a full understanding of the guidelines and policy on professionalism, as it relates to the recruitment of candidates to the Hartford Hospital sponsored programs.

DACA (Deferred Action for Childhood Arrivals Status):
On June 15, 2012, the Secretary of Homeland Security announced that certain people who came to the United States as children and meet several guidelines may request consideration of deferred action for a period of two years, subject to renewal. They are eligible for work authorization (EAD), Connecticut medical licensure/resident/fellow permit, and a Connecticut driver's license. The VA will not accept DACA candidates. If your program has a required VA rotation, you may not accept DACA candidates. If the rotation can be completed somewhere else, then your DACA candidates are eligible to participate in your program. The AAMC added DACA status to the Electronic Residency Application Service so you can filter for these candidates if needed.
**ADA Policy**
Hartford Hospital Graduate Medical Education is committed to achieving equal educational opportunity and full participation for all residents and fellows. It is the policy that no qualified person, on the basis of discrimination, be excluded from participating in any program.

The Americans with Disabilities Act of 1990 (ADA) and accompanying regulations define a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities such as walking, seeing, hearing, or learning. Further information can be obtained from the ADA website (www.ada.gov).

The Program Director and the Medical Education office will work with a resident or fellow in the development and implementation of reasonable accommodations for a disability as defined in the Americans with Disabilities Act. It is the responsibility of a resident or fellow to communicate directly with the program director and request accommodations prior to starting the training program. Documentation and additional testing may be required to validate that the individual is covered under the Americans with Disabilities Act as a disabled individual.

Reasonable accommodations, when necessary, will be made for current and future activities, but cannot be made retroactively to remove remediation, probation or termination.

While the use of accommodations may enable the resident or fellow to better demonstrate his/her abilities, accommodations do not guarantee improved performance. Please see Hartford Hospital Human Resources Americans with Disabilities Act Policy for further information.

I have read the above and understand the position of the Hartford Hospital Graduate Medical Education, as well as my responsibility to request reasonable accommodations from my program director. I understand that the program director may be required to provide the request to the Medical Education office to approve and implement the appropriate accommodation.

_______________________________________________  __________________________
PRINT NAME                                PROGRAM
_______________________________________________  __________________________
SIGNATURE                                DATE

**ECFMG Certification**
The Educational Commission for Foreign Medical Graduates (ECFMG), through its program of certification, assesses whether international medical graduates are ready to enter residency or fellowship programs in the United States.

An international medical graduate is a physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada. To be eligible for ECFMG Certification, the physicians’ medical school and graduation year must be listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER).
Citizens of the United States who have completed their medical education in schools outside the United States and Canada are considered international medical graduates; non-U.S. citizens who
have graduated from medical schools in the United States and Canada are not considered international medical graduates.

ECFMG Certification assures that international medical graduates have met minimum standards of eligibility required to enter Graduate Medical Education programs. ECFMG Certification does not, however, guarantee acceptance into programs.

ECFMG Certification is one of the eligibility requirements for international medical graduates to take Step 3 on the three-step United States Medical Licensing Examination (USMLE). Medical license authorities in the United States require ECFMG Certification, among other requirements, to obtain an unrestricted license or practice medicine.

The ECFMG Information Booklet should be consulted for certification requirements, examination requirements, medical education credentials etc.

Fifth Pathway graduates are not required to have an ECFMG certificate.

Non United States citizens (including Canadian citizens) will need an appropriate employment authorization/visa status to participate in all Hartford Hospital residency/fellowship programs.

Transfer Requirements
Per ACGME requirements, program directors must have written verification of previous training for residents transferring from one program to another.

To determine the appropriate level of education for a resident who is transferring from another residency/fellowship program, the program director must receive, prior to acceptance into the program, written verification of the previous educational experiences, a statement regarding the performance evaluation of the transferring resident including an assessment of competence in the six areas, the dates of the prior training, and whether or not the resident has received credit for the full amount of time in the prior program. This includes but is not limited to residents who have not completed a program and are transferring to another program in order to complete training.

The program director is also required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

International Citizen Policy
All residents/fellows must be eligible for employment to participate in any Graduate Medical Education sponsored programs. Hartford Hospital supports the use of the clinical (ECFMG sponsored) J-1 Visa for all eligible residents/fellows. Residents/fellows with a valid Employment Authorization Document (EAD) issued by the United States Citizenship and Immigration Services (USCIS) are also eligible. The Hartford Hospital Graduate Medical Education Programs do not sponsor H1-B visas under any circumstances.
NPI (National Provider Number)
A National Provider Identifier (NPI) is a unique identifier used to track health care providers and health plans throughout the United States. All residents/fellows are required to apply for and receive a NPI number.

A social security number is required to get an NPI number. Residents/fellows new to United States employment must get a social security number before applying for an NPI.

*Since the information is public, the residency/fellowship program address must be registered. Residents/fellows must ask their Program Director or Program Coordinator for the address that should be used.*

The “student” taxonomy is appropriate for students, residents and fellows. If a resident/fellow already has a NPI listed in a different taxonomy, it must be changed to student or he/she must get a Connecticut Medical License. If the resident/fellow has a Connecticut Medical License he/she will have a different taxonomy reflective of their status as an independent practitioner. In this case the resident/fellow needs to register for CMAP to provide care to all patients in the state of Connecticut.

The NPI application and information can be found at [http://www.nppes.cms.hhs.gov/](http://www.nppes.cms.hhs.gov/). Additional information is also provided in the Welcome Package for incoming residents/fellows.

Residents/fellow must have an NPI before they start training at Hartford Hospital with the appropriate taxonomy and program address. Failure to comply with this requirement could result in a resident’s/fellow’s inability to prescribe medications. Hartford Hospital not be responsible for any loss of privileges or fines as the result of the resident’s/fellow’s failure to comply with the above mandate.

Connecticut Controlled Substance Number (CSR)
The State Department of Consumer Protection mandates that all residents/fellows (with or without a state Medical license) practicing in the State of Connecticut must be registered in order to prescribe any controlled substance to any patient. This is different than the Federal DEA number as this is a State regulation.

Incoming residents/fellows who are required by their program to prescribe any controlled substance must register by July 15th. After the initial registration, all residents/fellows will be notified by the State of Connecticut when renewal is required. Residents/fellows are required to renew their biennial registration.

All physicians are required to notify the State of Connecticut Department of Consumer Protection License Services Division at 165 Capitol Ave., Hartford, CT 06106 within five (5) days of a change in address or department.

Failure to comply with this requirement could result in a resident’s/fellow’s inability to prescribe controlled substance medications and may also result in a fine. Hartford Hospital will not be responsible for any loss of privileges or fines as the result of the resident’s/fellow’s failure to comply with the above mandate.
Connecticut Medical Assistance Program (CMAP)
All non-licensed and licensed residents and fellows are now required to register with the Connecticut Medicaid Assistance Program (CMAP). This is a mandatory registration and enrollment will be required before commencement into a program. Please realize the importance of registering for CMAP and that if a resident/fellow is not registered it can directly affect patients.

You will require an NPI number to apply for CMAP. If you do not yet have a social security number and are unable to apply for an NPI number, you will be given one week once your social security number is received to apply for your NPI and to register with CMAP. Once registered and an ATN is assigned, you will be required to give this number to the Medical Education Office and your program coordinator. Enrollment can be made through www.ctdssmap.com.

Connecticut Prescription Monitoring and Reporting System (CPMRS)
The purpose of the Connecticut Prescription Monitoring and Reporting System (CPMRS) is to present a complete picture of a patient’s controlled substance use, including prescriptions by other providers, so that the provider can properly manage the patient’s treatment, including the referral of a patient to services offering treatment for drug abuse or addiction when appropriate. This is managed by the Connecticut Department of Consumer Protection.

Once you receive your Connecticut Controlled Substance Number you are required to register as a user with the CPMRS at www.ctpmp.com. Information will also be provided for incoming residents/fellows. Failure to comply with this requirement could result in a resident’s/fellow’s inability to prescribe medications and may also result in a fine. Hartford Hospital will not be responsible for any loss of privileges or fines as the result of the resident’s/fellow’s failure to comply with the above mandate.

State Licensure/Permit Requirement
The State of Connecticut requires all residents/fellows to have a Connecticut State Permit. The Graduate Medical Education (GME) Office designee will obtain the permit for all residents/fellows. No application by the resident/fellow is needed. The permit is issued by the State of Connecticut Department of Public Health. The resident/fellow does not receive the permit.

A Connecticut State medical license is not required to participate in most residency/fellowship programs. Resident/Fellows should refer to their program’s licensure policy in the program’s manual. A resident/fellow that obtains a Connecticut medical license and participates in a program that does not require a medical license will do so at their own expense.

Provider Enrollment, Chain and Ownership System (Pecos)
The Provider, Enrollment, Chain and Ownership System (PECOS) is a Medicare requirement that allows practitioners to prescribe Durable Medical Equipment (DME). Examples of DME are crutches, wheelchairs, braces, splints, needles/syringes, tracheostomy supplies, and incontinence supplies. Residents/Fellows who do not prescribe DME do not need to enroll in PECOS.

A National Provider Identifier (NPI) is required before enrolling in PECOS. The application is available on-line and on paper. The paper application for PECOS is called the Medicare Enrollment Application (CMS-8550). The online application is available at https://pecos.cms.hhs.gov/pecos/login.do.
Orientation

All new residents/fellows to Hartford Hospital are required to attend a new Housestaff Resident/Fellow Graduate Medical Education (GME) Orientation. Components of the GME orientation include patient safety, quality improvement, quality assurance, NPI, CMAP, employment eligibility, impaired physician education, fatigue, duty hours information, HIM, pharmacy procedures, CLER information, HIPAA and confidentiality, Risk Management and research information along with requirements for the hospital accreditation by the Joint Commission (JC) and GME accreditation by the Accreditation Council for Graduate Medical Education (ACGME). All components must be completed before a resident/fellow can begin.

The New Housestaff Resident/Fellow GME Orientation is typically scheduled on a Monday at the end of June. Residents/fellows beginning off cycle will complete an orientation at the time of commencement of employment with the Medical Education Office. Annual stipend includes orientation period.

Institutional Curriculum (IC)
The Institutional Curriculum (IC) was designed to provide a curriculum that is universal to all programs and either reflects Residency Review Committee requirements or hospital/Joint Commission requirements. An IC guarantees residents/fellows meet credentialing aspects to train. The IC should not replace the program’s unique curriculum that a Program Director might develop, but it represents a minimum standard for these topics. Some courses are required to be completed to start, some courses will be completed annually and some courses will be done once during a residency or fellowship period. Other than the required Orientation and annual courses, the Program Director determines when and how often other course will be completed. Most of the courses are done online.

Incoming or Orientation Requirements/Courses
- Review GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES
- NEW HIRE PRIVACY AND INFORMATION SECURITY AWARENESS EDUCATION (30 day new hire)
- NEW HIRE HAZARDOUS COMMUNICATION (30 day new hire)
- NEW HIRE HUMAN RESOURCES POLICY AND PROCEDURES (30 day new hire)
- FIRE/SAFETY ON-LINE COURSE
- Fluoroscopy (Cerebral, Radiology programs)
- ADA FORM
- RESPIRATOR FIT TESTING
- SLEEP LOSS AND FATIGUE (SAFER)
- FIRE SAFETY EDUCATION
- DISTRESSED, FATIGUE AND IMPAIRMENT [New, continuing individuals (every 2 years) & faculty]

Annual Courses
- ALARM MANAGEMENT EDUCATION
- CHEST PAIN CENTER ACCREDITATION
- DEAF AND HOH EDUCATION
- SYSTEM COMPLIANCE PRIVACY AND INFORMATION
- EMERGENCY MANAGEMENT BASIC EDUCATION
- HAZARDOUS WASTE MANAGEMENT EDUCATION TRAINING COURSE
- INFECTION CONTROL EDUCATION TRAINING COURSE
- FAST STROKE RECOGNITION AND RESPONSE
- EMPLOYEE SAFETY EDUCATION
- WORKPLACE VIOLENCE AWARENESS & PREVENTION EDUCATION
- N95 MANDATORY RESPIRATOR FIT TEST PROGRAM
- INFORMED CONSENT (PA)
- PATIENT RESTRAINT AND SECLUSION IN THE ACUTE CARE SETTING (PA)
- CULTURAL COMPETENCY: BACKGROUND & BENEFITS (PA)/PROVIDING CULTURALLY COMP (PA)
- MEDICAL ETHICS
- MODERATE SEDATION/ANALGESIA (PA): (Dental, Emergency Medicine, Trauma, Psychiatry, Child Psychiatry, Psychosomatic Medicine programs)
- IOL PATIENT BOUNDARIES & PROFESSIONAL ETIQUETTE (Psychiatry & Child Psychiatry)

**One Time Session:**

- SAFETY STARTS WITH ME (High reliability)
- H3W LEADERSHIP DEVELOPMENT – One Day Session
- SAFETY STARTS WITH ME REFRESHER (High reliability) – Every two years for continuing individuals
- ALICE TRAINING (Armed Intruder Response)

**Core Program Courses:** MEDICAL RISK MANAGEMENT
CONTRACT:

HOUSE STAFF RESIDENT AND FELLOW CONTRACT

Terms and Conditions of Employment between the Hospital and the Resident or Fellow:
In accordance with the eligibility requirements for a House Staff Resident/Fellow (physician), as outlined by the Accreditation Council on Graduate Medical Education under the Section on Resident Eligibility and Selection in the Essentials of Accredited Residencies in Graduate Medical Education:

__________ is appointed as a __________ at PGY level ______
Name
Resident/Fellow (include program name)
in ____________ for the 12-month period of ____________ to ____________
Department/Program M/D/Y M/D/Y

Offer of employment is contingent upon successful completion of all pre-employment screening consisting of drug screen, physical examination, background and reference checks, medical credentialing and, if your position requires: professional licensing verification, fingerprinting, DCF background check, it is required that you complete a pre-employment physical with the Occupational Health Department.

The House Staff Resident/Fellow agrees to accept appointment with the following responsibilities:
1. To complete on commencement of appointment certification on Bloodborne Pathogens and TB skin testing.
2. To comply with the policies as outlined in the Graduate Medical Education (GME) policies, House Staff Manual as well as the Institutional and Program Orientations. GME Policies are distributed at the orientation session prior to the start of your training. Policies can be accessed thru: www.harthosp.org/ResidenciesFellowships
3. To complete medical records within required designated period to avoid delinquency classification.
4. To not receive fees from patients for services rendered in connection with my responsibilities as a House Staff resident/fellow.
5. To not make a commitment with any other hospital to serve as a House staff resident/fellow during the contracted period.
6. To obtain the approval of the Program Director for any medical activities contemplated outside my educational program.
7. To fulfill my responsibilities as a House Staff resident/fellow which involves a combination of supervised, progressively more complex and independent patient evaluation and management functions as well as formal educational activities.
8. I understand that my level of competence & qualifications for advancement and reappointment is determined by my Program Director through regular occurring performance evaluations by supervising House Staff, Attending faculty and are recorded and shared with me in confidence.
9. To provide care commensurate with my level of advancement and competence under the general supervision of Medical Staff faculty. This includes: participation in safe, effective and compassionate patient care; development of an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and of how to apply cost containment measures in the provision of patient care; participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students, participation in institutional orientation, education programs and other activities involving the clinical staff; participation in institutional committees/councils to which I am appointed or invited; and performance of the above duties in accordance with the established practices, procedures and policies of the institution and its programs, departments as well as other institutions to which I may be assigned; including, among others, state licensure requirements for physicians in training, where these exist.
10. Obtain flu vaccination within the required time frame.
11. I understand that in the event of an adverse action directed towards me in relation to
demonstration of any academic or other deficiencies which could jeopardize normal progress towards completion of my program, my due process rights are protected under Hartford Hospital’s GME Due Process and Appeals policy.

12. I understand that if the Hospital decides to reduce the size of a residency program, to close a residency program, or the Hospital intends to close, it must inform the GMEC, the DIO, and the residents in the program as soon as practicable. Further information can be accessed thru www.harthosp.org/ResidenciesFellowships.

**Hartford Hospital Agrees to Provide:**

**Annual Stipend:** $________________ (annual stipend includes orientation period)

**On-Call In-House Meal allowance, On-Call Rooms** and **Lab Coats with Laundry Service** provided.

**Vacation:** Three Weeks (5 day work week and scheduled under Program guidelines) per contracted year. Vacation time cannot be accrued. There is no compensation for days not used.

**Paid Educational/Professional Leave:** Up to one week (5 business days) is given and must be approved and arranged through the Program Director.

**Institutional Leave:** An Institutional leave may be granted by the Program Director in accordance with Hospital* policy. If the leave is for an extended period of time, the program requirements may not be fulfilled as defined by the specific Residency Review Committee and Specialty Board. Extended leave can impact the criteria for satisfactory completion of the program and upon a resident’s/fellow’s eligibility to participate in examinations by the relevant certifying board(s). Additional information can be accessed thru: www.harthosp.org/ResidenciesFellowships.

**Paid Sick Leave:** Ten days (work days) of sick leave are allowed for each academic year. Dependent upon the individual program, an additional five days may be given at the discretion of the program director. Sick leave cannot be carried over into new academic year. In the event of serious injury or prolonged illness additional sick leave may be granted. Sick time should only be taken when an individual is ill and unable to work. It may impact the criteria for satisfactory completion of the program and upon a resident’s/fellow’s eligibility to participate in examinations by the relevant certifying board(s). An extended period of sick leave may extend the duration of the individual’s residency or fellowship program and will be at the discretion of the program director.

**Maternity Leave:** Full salary when medically unable to work, requires physician’s affidavit identifying the leave as a "medical necessity".

**Family, Parental and Medical Leave:** Must have worked for Hartford Hospital for at least 12 months, and must have worked at least 1000 hours (1250 hours for federal FMLA) in the 12-month period immediately preceding the leave. Up to 16 weeks leave in a 12 month period, not to exceed a maximum of 28 weeks in a 24 month period for the following reasons: birth, adoption or foster care of a child, or the serious illness of yourself or a family member.

**Counseling and Support Services:** A Resident or Fellow who wishes to seek confidential free counseling services for themselves and/or immediate family are encouraged to call the Assessment Center at 860-545-7200 located on the South Campus. The Center Staff are available on a twenty-four hour, seven-day week basis. Residents and Fellows are encouraged to select a primary care physician for themselves and their families’ medical needs. In emergencies, the Resident or Fellow is encouraged to use either the Emergency Department or the Rapid Assessment facility adjacent to the Emergency Department. At the new housestaff Resident and Fellow orientation, the process and policy for support services are reviewed. Program directors are advised to emphasize the same at their Program’s individual orientation. Residents and Fellows may also see seek confidential counseling services for themselves and/or immediate families.
be accessing the free, Solutions Employee Assistance Program (EAP) at 800-526-2530 on a twenty-four hour, seven-day week basis. They may also call extension 5-2530 from within the hospital for a private confidential appointment. Offices are located on campus and throughout the state and in Massachusetts. The EAP counselor provides short-term counseling and guidance (up to 3 sessions). If ongoing or specialized services are needed, the counselor will refer the resident to several resources that have been screened and evaluated. The counselor will follow-up with the Resident or Fellow. Solutions EAP also provides Critical Incident Stress Management (CISM) services, consults and workshops for teams or departments.

**Medical Support Services:** Residents/fellows are encouraged to select a primary care physician for themselves and their families’ medical needs. In emergencies, the resident/fellow is encouraged to use either the Emergency Department or contact Occupational Health for non-emergencies.

**Impairment and Substance Abuse:** If a resident/fellow is identified as not fit for duty (see Fit for Duty Policy) and substance abuse or mental health impairment is identified, the resident/fellow will be referred to the HAVEN (Health Assistance InterVention Education Network) which conducts programs for impaired healthcare workers for Hartford Hospital. They will make recommendations about further treatment and will work with the EAP program, the Medical Education Office and the Program Director in identifying whether or not the resident/fellow is fit for return to duty. Additional information can be accessed thru: [www.harthosp.org/ResidenciesFellowships](http://www.harthosp.org/ResidenciesFellowships).

**Professional Liability Insurance:** Coverage applies only with respect to providing or failing to provide professional services within the scope of your assigned duties for or on behalf of Hartford Hospital. Coverage for moonlighting or other unofficial activities is not provided. The policy applies only when the claim is based on an act of omission that happened after the retroactive date, 10/1/90; and the claim is first reported to our insurance carrier, CHS Insurance Limited, while the policy is in effect. Coverage $5,000,000/$30,000,000, aggregate $80,000,000. The policy is a claims-made and does not require tail insurance upon completion of your program. CHS Insurance Limited will defend any suit brought against a House Officer even if the suit is groundless or fraudulent. They will pay all costs defending the suit, including interest on that part of any judgment that doesn't exceed the limit of coverage. CHS Insurance Limited will not defend a suit or pay a claim after the limit has been used up in paying judgments or settlements. Any claims made for your actions, which occur after you have completed your program, will not be covered by the Hospital’s insurance policy. Coverage begins on the first day and includes tail coverage. Coverage includes legal defense and protection against awards from claims reported after the completion of the program(s) if the alleged acts or omissions of the residents are within the scope of the program(s). An official document of the details of liability coverage will be provided upon request of an individual.

**Health and Dental Insurance:** Hartford Hospital provides health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired. The details of plans are provided prior to commencement of employment. Additional information in regards to coverage can be assessed at [www.harthosp.org/ResidenciesFellowships](http://www.harthosp.org/ResidenciesFellowships).

**Long Term Disability Insurance:** Hartford Hospital provides disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. If the first the first day of disability insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired. Details of plans are provided prior to commencement of employment.
Disability income is guaranteed at $2,000/month. Coverage is portable, at your expense; provides guaranteed future benefits; coverage may be increased with no medical evidence of insurability.

**Group Life Insurance**: Coverage commences on the first day of employment, if the first day of employment is the first day of the month. If the first day of employment is a day other than the first day of the month, coverage will commence the first day of the following month.

**Access to information related to eligibility for specialty Board examinations**: The residency program accreditation standards and the board certification standards for all programs are available from several resources. The ACGME has a website at [www.acgme.org](http://www.acgme.org) which contains both program accreditation standards and board certification requirements. Additionally, the individual residency offices have copies of the program accreditation standards and board certification requirements.

**Board Specialty Examinations**: Residents and fellows who wish to seek board eligibility are required to fulfill and ensure documentation for the requirements for Specialty board.

**Accommodation for Disabilities**: Hartford Hospital Graduate Medical Education is committed to achieving equal educational opportunity and full participation for all residents and fellows. It is the policy that no qualified person, on the basis of discrimination, be excluded from participating in any program. The ADA (American Disability Act) policy can be accessed thru: hru [www.harthosp.org/ResidenciesFellowships](http://www.harthosp.org/ResidenciesFellowships)

**Harassment, Sexual Harassment and Misconduct**: The Institution’s Rule of conduct policy's purpose is to assure, safe, efficient and harmonious operations and to fully inform all employed housestaff residents/fellows, staff members and managers of their rights and responsibilities in this regard. The Institution’s Rule of conduct policy, Sexual Harassment and Misconduct policies can be assessed thru: [www.harthosp.org/ResidenciesFellowships](http://www.harthosp.org/ResidenciesFellowships)

**Concern, Complaint and Grievances**: A concern, compliant or grievance is defined as any issued perceived by a resident/fellow or Program Director as needing resolution. Generally, such a matter will not significantly threaten a resident’s/fellow’s intended career development or have the potential of leading to a recommendation of dismissal or non-renewal. Resident/Fellow related concerns may be brought to the Chief Resident and/or Acting Chief, Program Director, Faculty, Department Chair, Resident/Fellow Forum or anonymous hotline. If not resolved, the concern may be brought to the Medical Education Office Staff and/or the Chief Academic Officer/DIO. The Medical Education Office staff and/or Chief Academic Officer may act as a mediator and intercede for the resident/fellows, so as to try to reconcile differences and resolve the concern in a confidential manner. The final step is with the Medical Education Office staff and/or Chief Academic Officer. Concerns, complaints or grievances can be reported to the anonymous Medical Education hotline at 860-972-4069, the Hartford HealthCare Compliance Hotline at 1-855-HHC-OCAP or on-line [http://hhc.ocapcompliance.com](http://hhc.ocapcompliance.com).

**Appeals and Due Process**: When a resident/fellow receives notice of any action by the Program Director which would prevent him/her from normal progress in completing the full term of a residency or fellowship program, he/she shall have the right to appeal such action and right to due process. As described in the Hartford Hospital Policy on House Staff Resident and Fellow Evaluation and Promotion's policy which can be accessed thru: [www.harthosp.org/ResidenciesFellowships](http://www.harthosp.org/ResidenciesFellowships).

**Moonlighting and Extra Credit Activities**: Each Program Director, in consultation with the Hartford Hospital Vice President for Academic Affairs, shall determine whether moonlighting and/or extra credit activities are an available option for residents/fellows in that Program. Each program will have a program specific moonlighting/extra credit policy. Residents/Fellows are not required to engage in moonlighting/extra credit.
The Institution, ACGME or program may prohibit moonlighting/extra credit by residents/fellows. Additional information can be accessed thru: www.harthosp.org/ResidenciesFellowships

**Duty Hour Policy:** The duty hour policy has been developed to support the physical and emotional well-being of the residents, promote an educational environment and facilitate patient care at this institution. Each residency and fellowship program must develop a duty hour policy consistent with this Institutional policy and provide duty hour assignments and faculty availability to promote both patient safety and education. There is an anonymous hotline that can be accessed to report any violations. All programs have individual program duty hour policies. Duty hours are reviewed and monitored by the Medical Education Manager, Designated Institutional Official and Graduate Medical Education Committee (GMEC). Resident/fellow duty hours are consistent with the Common and specialty/subspecialty-specific Program Requirements across all programs, addressing areas of non-compliance in a timely manner. Duty Hour policy and Duty Hour monitoring policy can be accessed thru: www.harthosp.org/ResidenciesFellowships.

**Conditions of Reappointment/Promotion to a subsequent PGY level:** Re-appointment, promotion and graduation are contingent upon satisfactory compliance with the defined goals and objectives of the House Officer’s residency/fellowship program and the Hartford Hospital Policies and Procedures for GME. The conclusions of the Program Director, in consultation with the Education Committee of that program, based on individual evaluations, semi-annual progress reports and all other available information will provide the basis for determining whether a resident/fellow is ready for advancement to the subsequent year of the program or for graduation from the program. Additional information can be accessed thru www.harthosp.org/ResidenciesFellowships.

**Contract:** House Staff residents/fellows are given a yearly contract outlining the terms and conditions of their employment and benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance and other insurance benefits for the residents and their family, meals and laundry or their equivalent are to be provided. A housestaff manual is available on the institution’s intranet site.

**Non-renewal Appointment or Non-promotion:** Programs will provide a resident or fellow with a written notice of intent when that resident or fellow’s contract will not to renewed or when a resident or fellow will not be promoted to the next level of training, or when that resident or fellow will be dismissed no later than four months prior to the end of the resident’s or fellow’s current contract. However, if the primary reason(s) for the non-renewal or non-promotion occur(s) within the four months prior to the end of the contract, residents will be given as much notice of the intent not to renew or not promote, as the circumstances will reasonably allow, prior to the end of the contract. Residents and fellows will be allowed to implement the grievance procedures when they have received a written notice of intent not to renew their contract or intent not to renew their agreement(s) but not to promote them to the next level of training.

It is understood and agreed that by signing this Contract, I acknowledge that I have read the entire contents of the Contract, and agree to all of its conditions.

____________________________   ____________________________
Program Director                Date

____________________________   ____________________________
Chief Academic Office and/or DIO Date

____________________________   ____________________________
House Staff Resident/Fellow Date
Conditions of Reappointment/Promotion to a subsequent PGY level:

Re-appointment, promotion and graduation are contingent upon satisfactory compliance with the defined goals and objectives of the Residency/Fellowship program and the Policies and Procedures for Graduate Medical Education. The conclusions of the Program Director, in consultation with the Clinical Competency Committee and/or the Program Evaluation committee of that program, based on individual evaluations, semi-annual progress reports and all other available information will provide the basis for determining whether a resident/fellow is ready for advancement to the subsequent year of the program or for graduation from the program. Additional information can be accessed thru www.harthosp.org/ResidenciesFellowships.
SECTION III.

BENEFITS
Counseling and Support Services
At Hartford Hospital, a Resident or Fellow who wishes to seek confidential free counseling services for themselves and/or immediate family are encouraged to call the Assessment Center at 860-545-7200 located on the South Campus. The Center Staff are available on a twenty-four hour, seven-day week basis. Residents and Fellows are encouraged to select a primary care physician for themselves and their families’ medical needs.

In emergencies, the Resident or Fellow is encouraged to use either the Emergency Department or the Rapid Assessment facility adjacent to the Emergency Department. At the new housestaff Resident and Fellow Orientation, the process and policy for support services are reviewed. Program directors are advised to emphasize the same at their Program’s individual orientation.

Residents and Fellows may also seek confidential counseling services for themselves and/or immediate families be accessing the free, Solutions Employee Assistance Program (EAP) at 800-526-2530 on a twenty-four hour, seven-day week basis. They may also call extension 5-2530 from within the hospital for a private confidential appointment. Offices are located on campus and throughout the state and in Massachusetts. The EAP counselor provides short-term counseling and guidance (up to 3 sessions). If ongoing or specialized services are needed, the counselor will refer the resident to several resources that have been screened and evaluated. The counselor will follow-up with the Resident or Fellow. Solutions EAP also provides Critical Incident Stress Management (CISM) services, consults and workshops for teams or departments.

Health and Dental Insurance
Hartford Hospital provides health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired.

The details of plans are provided prior to commencement of employment.

Long Term Disability Insurance
Hartford Hospital provides disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. If the first the first day of disability insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regard interim coverage so that they can purchase coverage if desired.

Details of plans are provided prior to commencement of employment.

Group Life Insurance
Coverage commences on the first day of employment, if the first day of employment is the first day of the month. If the first day of employment is a day other than the first day of the month, coverage will commence the first day of the following month.

Professional Liability Insurance
Coverage applies only with respect to providing or failing to provide professional services within the scope of your assigned duties for or on behalf of Hartford Hospital. Coverage for moonlighting or other unofficial activities is not provided.
The policy applies only when the claim is based on an act of omission that happened after the retroactive date, October 1, 1990; and the claim is first reported to our insurance carrier, CHS Insurance Limited, while the policy is in effect. Coverage is $5,000,000/$35,000,000 aggregate $80,000,000. The policy is a claims-made and does not require tail insurance upon completion of your program.

CHS Insurance Limited will defend any suit brought against a House Officer even if the suit is groundless or fraudulent. They will pay all costs defending the suit, including interest on that part of any judgment that doesn’t exceed the limit of coverage. CHS Insurance Limited will not defend a suit or pay a claim after the limit has been used up in paying judgments or settlements.

Any claims made for your actions, which occur after you have completed your program, will not be covered by the Hospital’s insurance policy. Coverage begins on the first day and includes tail coverage. Coverage includes legal defense and protection against awards from claims reported after the completion of the program(s) if the alleged acts or omissions of the residents are within the scope of the program(s). An official document of the details of liability coverage will be provided upon request of an individual.

All Hartford Hospital programs will provide residents and fellows with information in regards to Vacation, Educational and Institutional and Extended Leave Policies. However, all programs will meet the following guidelines:

**Vacation**
Three Weeks (5 day work week and scheduled under Program guidelines) per contracted year. Vacation time cannot be accrued. There is no compensation for days not used.

**Paid Educational/Professional Leave**
Up to one week (5 business days) is given and must be approved and arranged through the Program Director.

**Institutional Leave**
An Institutional leave may be granted by the Program Director in accordance with Hospital* policy. If the leave is for an extended period of time, the program requirements may not be fulfilled as defined by the specific Residency Review Committee and Specialty Board. Extended leave can impact the criteria for satisfactory completion of the program and upon a resident’s/fellow’s eligibility to participate in examinations by the relevant certifying board(s).

*See Hartford Hospital - Leave of Absence Policy: #506

**Paid Sick Leave**
Ten days (work days) of sick leave are allowed for each academic year. Dependent upon the individual program, an additional five days may be given at the discretion of the program director.

Sick leave cannot be carried over into a new academic year. In the event of serious injury or prolonged illness, additional sick leave may be granted. Sick time should only be taken when an individual is ill and unable to work. It may impact the criteria for satisfactory completion of the program and upon a resident’s/fellow’s eligibility to participate in examinations by the relevant certifying board. An extended period of sick leave may extend the duration of the individual’s residency or fellowship program and will be at the discretion of the program director.
Contract Extension Due to Leave
Continuous training is vital to residents/fellows in all disciplines. If a resident/fellow is on leave for any approved reason and requires extended time away from training such that the resident/fellow is unable to satisfy the academic and curricular requirements of the program within the time allotted, the Program Director will need to determine the extent of resident’s/fellows’ educational experience was interrupted by time on leave. Once that is determined, the Program Director will need to decide the outcome for that individual resident/fellow and impact the “leave” had on the integrity of the learning process and training program. Possible outcomes include extension of training equal to the amount of training lost; extension of training longer than the amount lost on leave including repeating a full year of training; and lastly non-renewal of contract. The Program Director must take into consideration the full impact associated with discontinuous training for the individual resident/fellow i.e., whether the resident/fellow is meeting program and specialty standards. In all situations, the Program Director must consult with the Medical Education office prior to determining the appropriate outcome.

Extension of time granted by the program director will take into consideration the spectrum of specialty board requirements, RRC requirements, program requirements, and institutional requirements. Vacation granted during an extension will vary dependent on the amount of extension to complete the requirement of training. This will be determined by the Program Director in consultation with the Medical Education Office.

Impaired Physician
If a resident/fellow is identified as not fit for duty (see Fit for Duty Policy) and substance abuse or mental health impairment is identified, the resident/fellow will be referred to the HAVEN (Health Assistance InterVention Education Network) which conducts programs for impaired healthcare workers for Hartford Hospital. They will make recommendations about further treatment and will work with our EAP program, the Medical Education Office and the Program Director in identifying whether or not the resident/fellow is fit for return to duty.

In instances when the resident/fellow is identified as impaired due to substance abuse or mental health impairment by an outside agency such as the DEA, the Program Director should be informed and with the assistance of the Designated Institutional Official or designee, the EAP or HAVEN will be contacted to evaluate the resident/fellow. Costs for evaluation and treatment are covered by the resident/fellow insurance with any balance paid by Hartford Hospital.

Re-Entry into Training Program/Monitoring: The final decision about possible re-entry into a program rests with the residency/fellowship program director in consultation with, and approval from, the Medical Education office. One factor for re-entry is that the resident/fellow will need to have medical clearance to work (HAVEN will make a recommendation). Regardless of whether or not the program decides to have the resident/fellow re-join the program or be dismissed, the Medical Education Office will help the program decide how to proceed.

Educational Program on Physician Impairment: Hartford Hospital House Staff are required to attend the New House Staff Orientation which includes a session on Physician Impairment, its avoidance and recognition, as well as the increased risk of substance abuse.
**Fit For Duty**

When a Hartford Hospital resident/fellow has been identified by attendings or other personnel working with the resident/fellow as having serious academic or behavioral deficiencies, a Program Director, in consultations with the Designated Institutional Official or designee, may require a ‘fit for duty’ evaluation of a resident/fellow. This evaluation is used to determine if a resident/fellow’s performance is being affected by impairment that includes, but is not limited to, medical, mental health, or substance abuse problems. The purpose of this evaluation is to determine the resident/fellow’s ability to perform his/her clinical duties and responsibilities safely, meaning not a danger to patients, colleagues or self.

The Program Director or designee will discuss the problem with the Designated Institutional Official or designee. If it is agreed that a fit for duty evaluation is needed, the resident/fellow will be placed on administrative leave by the Medical Education Office until the evaluation is complete without prejudice, full pay and benefits. The Designated Institutional Official (DIO) or designee or designee will contact the Employee Assistance Program (EAP) director or designee who will do an initial interview with the resident/fellow and determine if an additional evaluation is needed. The Program Director will share information with the EAP personnel and other EAP-assigned evaluators. The resident/fellow will be referred to the appropriate professional. This is not a confidential session between the resident/fellow and a counselor because this is an academic referral and not an on-going therapeutic relationship. A report indicating whether or not the resident/fellow can safely work will be sent to the Designated Institutional Official (DIO) or designee who will share it with the Program Director.

If the resident/fellow being evaluated is determined to be fit to return to work, the EAP evaluator will make an effort to contact the Medical Education Office and/or the Program Director as soon as that determination is made, which may be prior to writing the report so that scheduling plans for the resident/fellow can be made. Hartford Hospital will pay for the Fit for Duty Evaluation. A resident/fellow who refuses a Fit for Duty Evaluation will not be allowed to work as a resident/fellow and may be terminated from the training program.

*Please see Hartford Hospital Fitness Duty Policy for additional requirements*
SECTION IV.

RESIDENT / FELLOW / PROGRAM
AND INSTITUTIONAL POLICIES
Access to information related to eligibility for specialty Board examinations
The residency program accreditation standards and the board certification standards for all programs are available from several resources. The ACGME has a website at [www.acgme.org](http://www.acgme.org) which contains both program accreditation standards and board certification requirements. Additionally, the individual residency offices have copies of the program accreditation standards and board certification requirements.

Achievement of Competency Policy
Hartford Hospital ensures that each program provides effective educational experiences for residents that lead to measurable achievement of educational outcomes in the ACGME competencies as outlined in the Common and specialty/subspecialty-specific Program Requirements. Achievement of Competency is monitored by:

1) Submission of Annual Program Review and Evaluation Report from each program which is reviewed and approved by the GMEC Annual Institutional Review Committee, DIO and GMEC,
2) Final Graduation Summary Reports submitted to the Medical Education office for each graduating resident and fellow,
3) Review of ADS aggregate data and ACGME accreditation letters.

Away Electives
An away elective, be it clinical or research-based, is a rotation at an institution that is not affiliated with Hartford Hospital.

Away Electives Not Requiring Prior Approval:
- Any rotation that is required by a program’s RRC that is not offered at the Sponsoring institution or at any of its affiliated or education sites.
- The GME office does need to be notified.

Away Electives Requiring Prior Approval:
- Any rotation that has educational value and fulfills requirements of the RRC for that discipline but is not required.
- Prior approval must be received from the Program Director.
- The Away Form required to apply for an educationally elective is available in the Medical Education Office. When completing the form the below essential components must be included:
  - Educational rationale for requesting an away elective
  - Program Director’s support for this experience
  - Evaluation tool used to evaluate the resident’s experience
  - Program’s effort to identify funding support for this experience.

Once form is submitted along with any additional documentation, if any, to the Medical Education Office, the D.I.O. will determine the merits of the request for an away elective.

Clinical Responsibilities Policy
The clinical responsibilities for each resident must be based on PGY level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.]
Programs are monitored for compliance with clinical responsibilities through the Annual Institutional Review (AIR), which includes submission of the Annual Program Review and Evaluation report.

**Concerns, Complaint and Grievance Policy/Procedure**
A concern, complaint or grievance is defined as any issue perceived by a resident/fellow or Program Director as needing resolution. Generally, such a matter will not significantly threaten a resident’s/fellow’s intended career development or have the potential of leading to a recommendation of dismissal or non-renewal. Resident/Fellow related concerns may be brought to the Chief Resident and/or Acting Chief, Program Director, Faculty, Department Chair, Resident/Fellow Forum or anonymous hotline. If not resolved, the concern may be brought to the Medical Education Office Staff and/or the Chief Academic Officer/DIO. The Medical Education Office staff and/or Chief Academic Officer may act as a mediator and intercede for the resident/fellows, so as to try to reconcile differences and resolve the concern in a confidential manner. The final step is with the Medical Education Office staff and/or Chief Academic Officer.

Concerns, complaints or grievances can be reported to the anonymous Medical Education hotline at 860-696-6055, the Hartford HealthCare Compliance Hotline at 1-855-HHC-OCAP or on-line [http://hhc.ocapcomplianceline.com](http://hhc.ocapcomplianceline.com).

**Duty Hour Policy**
The duty hour policy has been developed to support the physical and emotional well-being of the residents and fellows, promote an educational environment and facilitate patient care at this institution. Each residency and fellowship program must develop a duty hour policy consistent with this Institutional policy and provide duty hour assignments and faculty availability to promote both patient safety and education. There is an anonymous hotline that can be accessed to report violations of the 80-hour work week.

All programs will have program specific duty hour policies. Resident and fellow duty hours are consistent with the Common and specialty/subspeciality-specific Program Requirements across all programs, addressing areas of non-compliance in a timely manner.

Duty hours are reviewed and monitored by the Medical Education Manager, Designated Institutional Official and Graduate Medical Education Committee (GMEC). **See Duty Hour Monitoring and Extra Credit Activities Policy.**

**I. Maximum Hours of Work per Week**
Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

A. **Duty Hour Exceptions**
A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

II. Moonlighting and Extra Credit Activities
   A. Moonlighting and extra credit activities must not interfere with the ability of the resident and fellow to achieve the goals and objectives of the educational program.
   B. Time spent by residents and fellows in Internal (extra credit) and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
   C. PGY-1 residents are not permitted to moonlight.

   *See Institutional Moonlighting and Extra Credit Activities policy.*

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

IV. Maximum Duty Period Length
   A. Duty periods of PGY-1 residents must not exceed 16 continuous hours in duration.
   B. Duty periods of PGY-2 residents and above (including fellows) may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested.

   1. It is essential for patient safety and resident and fellow education that effective transitions in care occur. Residents and fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours per duty period.
   2. Residents and fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
   3. In unusual circumstances, residents and fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

   a. Under those circumstances with supervision (see Supervision Policy), the resident and fellow must:
      1) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
      2) immediately document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director or through New Innovations.

   b. The program director must review each submission of additional service, and track both individual resident/fellow and program-wide episodes of additional duty.
V. Minimum Time Off between Scheduled Duty Periods

A. PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

B. Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

C. Residents and fellows in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

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

   a. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents and fellows in their final years of education must be monitored by the program director.

VI. Maximum Frequency of In-House Night Float

Residents and fellows must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VII. Maximum In-House On-Call Frequency

PGY-2 residents and above (including fellows) must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VIII. At-Home Call

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

   1. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident and fellow.

B. Residents and fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

Violations of duty hour requirements and other GME concerns can be reported anonymously to the Medical Education hotline at 860-972-4069, the Hartford HealthCare Compliance Hotline at 1-855-HHC-OCAP or on-line: http://hhc.ocapcomplianceline.com.
Procedure and Criteria for Endorsing Requests for Exceptions to the Duty Hour Limits
ACGME Policy: Programs may apply to an ACGME Review Committee for a maximum 10 percent increase in the 80-hour per week duty hour limit. Each Review Committee may decide that it will not consider any requests for exception. Information on whether a Review Committee grants exceptions to the 80-hour limit can be found on that Review Committee’s web page on the ACGME website, as well as in the Specialty Program Requirements.

The institutional GMEC must review and formally endorse the request for an exception. The endorsement must be indicated by the signature of the designated institutional official. If approved, an exception will be reviewed annually by the Review Committee.

Procedure:
Program Directors requesting an RRC exception to the duty hour limits must have this request reviewed and endorsed by the Graduate Medical Education Committee (GMEC). The Program Director must submit the following documentation for review at the monthly GMEC meeting.
1. Patient Safety: Information describing how the program and institution will monitor, evaluate and ensure patient safety with extended resident work hours.
2. Educational Rationale: The request must be based on sound educational rationale that should be described in relation to the program’s stated goals and objectives for the particular assignments, rotations, and levels of training for which the increase is requested. Blanket exceptions for the entire educational program should be considered the exception, not the rule.
3. Moonlighting policy: Specific information regarding the program’s moonlighting policies for the period in question.
4. Call schedule: Specific information regarding the resident call schedules during the times specified for the exception.
5. Faculty monitoring: Evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation.

The materials submitted by the Program Director will be distributed to the GMEC membership in advance of the next meeting. Decisions regarding endorsement of requests shall be based on the following criteria:
1. The program is accredited in good standing.
2. The extent to which the proposed variance from the duty hour limits is based on sound educational rationale in relation to the program’s goals and objectives.
3. The plan for monitoring, evaluating and ensuring patient safety is adequate.
4. The plan for faculty development related to effects of resident fatigue and sleep deprivation is adequate.

The endorsement may be granted by consensus or majority vote of the GMEC.

Non-Compliance of Entering Duty Hours
Hartford Hospital Residents and Fellows who have been notified at least twice and have not entered their duty hours into the New Innovations software on-line system in a timely manner, and/or have continuous duty hour violations may receive a penalty of one (1) vacation day being taken away and/or probation.
**Policy for Duty Hour Monitoring**

The Graduate Medical Education Committee (GMEC) is responsible for monitoring resident duty hour compliance with the Institutional **Duty Hour Policy** and the ACGME Institutional and Program requirements.

All residents and fellows are required to log their daily duty hours into the New Innovations software on-line system. A duty hour attestation form is signed and dated by the residents, fellows and also by the program director attesting to compliance.

Reports are generated for each rolling four-week period and reviewed for violations in adherence to the Institutional **Duty Hour Policy**. Four week period reports are forwarded to the Program Director and copies kept on file in the Medical Education Office. If a violation is noted, the following will process will occur:

1. Resident/fellow contacted by email or telephone
2. Program Director and Program Coordinator notified
   a. An explanation is required by resident and/or Program Director regarding the specific violation(s)
3. The explanation and/or response is noted on individual report and documentation is kept in the Medical Education Office

A Duty Hour Violation Report is submitted to the DIO and GMEC for review on a monthly basis. Compliance with the Institutional **Duty Hour Policy** will be determined by review of the documentation. Modifications to a program’s duty hour or call schedule may be required if program is not in compliance. The GMEC may request additional information if it determines a program’s schedules do not satisfactorily meet the needs of the patient, continuity of care or the educational needs of residents/fellows. Failure of a program to comply with the **Duty Hour Policy** could result in probation of the program. The GMEC can recommend a local probation of program to Hospital Administration and the Board. Similar consequences could result for residents/fellows who continue to violate the **Duty Hour Policy**. A summary report of duty hour violations is distributed to Program Directors and the Chairman of the GMEC on an annual basis. In addition, non-compliance with entering duty hours in a timely manner can result in one (1) vacation day being taken away and/or probation of the resident/fellow.

**Duty Hours, Fatigue Management and Mitigation-Systems of Care and Learning Environment: Sleep (Fatigue) Mitigation**

Hartford Hospital has a system of care and a learning and working environment that facilitate fatigue management and mitigation for residents/fellows. All residents/fellows and core faculty members must participate in education about fatigue management and mitigation. Specifically, new and current residents/fellows are required to complete the SAFER/fatigue education session annually. Core faculty must complete the SAFER/Fatigue education session every other year.

When a resident/fellow identifies him/herself as being too fatigued or an attending identifies the resident/fellow as being too fatigued to safely drive home there are several options:

1) A taxi service will be available and paid for by Hartford Hospital to take the resident/fellow home. The resident/fellow is then responsible for securing their own transportation back to the hospital in the morning. This service is only available after an extended shift and is not permitted to be utilized to get to the hospital for a shift.
2) Call rooms/sleep quarters are available until the resident/fellow are less fatigued.

**Moonlighting and Extra Credit Activities Policy**

Each Program Director, in consultation with the Hartford Hospital Vice President for Academic Affairs, shall determine whether moonlighting and/or extra credit activities are an available option for Residents in that Program. Each program will have a program specific moonlighting/extra credit policy. Residents/Fellows (herewith in “residents”) are not required to engage in moonlighting/extra credit. The Institution or individual ACGME or non-accredited programs may prohibit moonlighting/extra credit by residents/fellows.

**Rules for Residencies Where Moonlighting and Extra Credit is an available option:**

1. Residents/Fellows must have written permission from their program director. An individual resident may engage only with the prior written approval of the Program Director. The Program Director shall indicate in such approval whether any such moonlighting and/or extra credit activities shall be limited to Hartford Hospital, or whether it is permitted at Hartford Hospital and/or at other designated outside institutions.

2. ACGME-accredited and non-accredited programs will monitor the affect of moonlighting/extra credit activities on a resident’s/fellows performance in the program, including adverse effects which may lead to withdrawal of permission to moonlight/extra credit.

3. Moonlighting and/or extra credit activities must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

4. Time spent by residents in Internal (extra credit) and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour maximum weekly hour limit.

5. PGY-1 residents are not permitted to moonlight or participate in extra credit activities.

6. The Program Director has the authority to deny a resident’s moonlighting/extra credit experience based on the Program Requirements of the ACGME RRC. It must comply with all of the RRC’s requirements.

7. It shall be the obligation of the Program Director to monitor the performance of residents engaged in moonlighting/extra credit to assure that factors such as fatigue are not contributing to diminished learning or performance, or detracting from patient safety.

8. The Program Director shall monitor the number of hours and the nature of the workload of residents engaging in moonlighting/extra credit. Moonlighting/extra credit forms will be forwarded to Medical Education for monitoring on a monthly basis.

9. Residents may be permitted to moonlight only when licensed to practice medicine for a state in which they might practice. (ie. Connecticut)

10. The Program Director shall acknowledge in writing that he or she is aware that the resident is moonlighting/extra credit, and this information will be part of the residents’ folder and a copy forwarded to the Medical Education Office.
11. Residents on J-1 visas are restricted by law from participating in moonlighting/extra credit activities.

12. Residents/fellows are advised to investigate the limits of their malpractice liability coverage in activities such as moonlighting outside of their program. Those activities are not part of the malpractice liability coverage provided by the resident/fellowship program. Extra credit is covered by the malpractice coverage. Malpractice coverage information can be obtained by contacting the Medical Education Office at each site. Extra credit is considered internal and a license is not required.

Residents moonlighting and/or extra credit at Hartford Hospital must be granted clinical privileges to do so. Presumably these will be temporary privileges, but must conform to the requirements of the medical staff bylaws. National Practitioner Data Bank inquiries shall be required.

Evaluation Policy

The Annual Program Review Report submitted for each program and monitoring of evaluations through the Medical Education Office software data management system, New Innovations is used for compliance of evaluation review, timeliness and are accessible to review.

Resident Evaluation - Each ACGME program must appoint a Clinical Competency Committee. At a minimum, the Clinical Competency Committee must be composed of three members of the program faculty. Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team.

There must be a written description of the responsibilities of the Clinical Competency Committee. The Clinical Competency Committee should review all resident/fellow evaluations semi-annually; prepare and assure the reporting of Milestones to ACGME; and advise the Program Director regarding resident progress, including promotion, remediation, and dismissal.

Formative Evaluation - The faculty must evaluate resident/fellow performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. The program must:

1. Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; use multiple evaluators (e.g. faculty, peers, patients, self, and other professional staff)
2. Document progressive resident/fellow performance improvement appropriate to educational level and,
3. Provide each resident/fellow with documented semiannual evaluation of performance with feedback.

The evaluations of resident performance are accessible for review by the resident.

Summative Evaluation - The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. The Program Director must provide a summative evaluation for each resident upon completion of the program.
This evaluation must:
- become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Detail)
- document the resident’s performance during the final period of education; (Detail) and,
- verify that the resident has demonstrated sufficient competence to enter practice without direct supervision

**Faculty Evaluation** - At least annually, the program must evaluate faculty performance as it relates to the educational program.

These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail) This evaluation must include at least annual written confidential evaluations by the residents/fellows.

**Program Evaluation and Improvement** - The Program Director must appoint the Program Evaluation Committee

The Program Evaluation Committee:
1. Must be composed of at least two program faculty members and should include at least one resident
2. Must have a written description of its responsibilities and,
3. Should participate actively in:
   a. planning, developing, implementing, and evaluating educational activities of the program;
   b. reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
   c. addressing areas of non-compliance with ACGME standards; and,
   d. reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

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

The program must monitor and track each of the following areas:
1. Resident performance
2. Faculty development
3. Graduate performance, including performance of program graduates on the certification examination
4. Program quality
   a. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
   b. The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.
5. Progress on the previous year’s action plan(s).

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
**Denial of Academic Credit/Termination/Dismissal**

If a resident/fellow does not satisfactorily complete remedial work during the remediation period, the Program Director, with the concurrence of the Clinical Competency Committee, may decide either to have the resident/fellow repeat part or all of that academic year’s work, or to terminate the resident/fellow from the program. This decision, and the detailed basis for it, must be sent, in writing, to the resident/fellow with a copy to the Chief Academic Officer/DIO. This should include a determination whether the resident/fellow will receive academic credit for any portion of the remediation period. In instances where the remediation period had been continued **beyond** an initial three-month period, **credit will be given for the initial three-month period.**

The Program Director, with the agreement of the Clinical Competency Committee, shall decide whether or not to permit the resident/fellow to complete a contract year. If the resident/fellow does complete a full contract year, the status of the resident/fellow in the program at the time of termination shall be documented, in writing, so that clear information can be given to other programs/institutions seeking references in the future. If the resident/fellow does not complete a full contract year, the number of months of credit to be given to this resident/fellow for that academic year shall also be documented, in writing.

1. **Under exceptional circumstances,** e.g., extreme deficiency in performance, behavior, or attitude, the Program Director, with the agreement of the Clinical Competency Committee, may decide to terminate the employment of the resident/fellow immediately.
2. **In all instances,** careful written records of the decision shall be kept; written notification to the house officer and an opportunity for the house officer to be heard prior to termination should be given.

**Appeal**

If the resident/fellow disagrees with any decision that would jeopardize the normal progress toward the completion of training, that resident/fellow has the right to appeal.

**Work Environment**

1. **Duty Hours**
   
   Each program at Hartford Hospital has a formal policy that governs resident/fellow duty hours. Programs at Hartford Hospital provide appropriate backup support when patient care responsibilities are especially difficult or prolonged. Duty hours for residents/fellows at Hartford Hospital are consistent with the individual Program Requirements of the ACGME. Compliance with such policies is reviewed annually by the GMEC.

2. **Sleeping Quarters and Food Service:**
   
   When on overnight duty, Hartford Hospital provides each resident/fellow with private, secure sleeping quarters. Sleeping quarters are maintained by Building Services daily and have functional telephones. Hartford Hospital an annual on-call meal allowance for food service benefits to residents/fellows with in-house call duty on nights, weekends, and holidays.

3. **Patient Support:**
   
   Although residents/fellows need to help out occasionally in extraordinary circumstances, Hartford Hospital provides routine patient support services for intravenous lines; phlebotomy and laboratory needs; messenger and transport services. Patient care is always the highest priority, but educational objectives for residents must not be precluded by service demands.
4. **The Hartford Hospital Public Safety:**
The Hartford Hospital Public Safety department provides services to assure the safety and security of residents in all hospital locations, including call rooms, emergency department, parking facilities, institutional grounds and related clinical facilities. An escort service is available in the form of a campus shuttle that makes 6 designated stops around the HH & IOL campus. The stops are outside the Main entrance at 80 Seymour Street, outside the 85 Jefferson Medical Building, outside the 560 Hudson Street, Education and Resource building, outside the Terry building, outside the Braceland building and outside the Donnelly building. The shuttle operates a continuous loop to these stops Monday thru Friday 7a-6p. The Public Safety Department provides an escort service to and from housestaff vehicles outside of the shuttles normal operating hours. HH Public Safety can be reached at x22147 (860-972-2147).

5. **Supervision of House Staff:**
Residents, at all times, will have access to senior resident and/or attending staff members for educational, administrative and clinical support. Each department conducting resident education will develop specific mechanisms for supervision. There is an institutional supervision policy and all program policies are reviewed by the AIR and the GMEC.

**Professionalism**
Hartford Hospital provides a system for education and monitoring of residents’/fellows’ and core faculty members’ fulfillment of educational and professional responsibilities. These responsibilities include scholarly pursuits, accurate completion of required documentation, and identification of potential resident/fellow mistreatment. Residents/fellows will tell and/or identify their respective roles to patients.

Patients and colleagues expect residents/fellows to be professionally dressed. Appearance should conform to the standards/norms of the settings in which the resident/fellow is working. The ID badge and coat (if applicable) should be worn and clearly visible for all clinical encounters.

Please refer to Hartford Hospital Professional Image and Dress code Policy and Hartford Hospital Code of Conduct Policy.
## Hartford Hospital
### Acute Care Quality Performance Indicators

<table>
<thead>
<tr>
<th>Clinical Focus Area</th>
<th>Overall Composite Last 3 Months</th>
<th>Top Quartile/Top Box</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
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</tr>
<tr>
<td>Hospital mortality measures the number of patients who die while in the hospital. Risk adjustment methodology is used to account for individual factors that impact mortality. Observed is displayed as hospital mortality minus patients on Hospice benefit (Goal–Lower Score)</td>
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<tr>
<td><strong>Readmission</strong></td>
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<tr>
<td>Hospital Readmission for select diagnosis within 30 days of discharge. This measure has the greatest opportunity for continuity of care across the continuum. Focus diagnosis: Acute Myocardial Infarction, Heart Failure, Pneumonia, Chronic Obstructive Pulmonary Disease (Goal–Lower Score)</td>
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<tr>
<td><strong>Safety</strong></td>
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<tr>
<td>The Patient Safety Metrics include Iatrogenic Pneumothorax, Central Line Infection, Post-operative Pulmonary Embolism/Deep Vein Thrombosis, Post-operative Wound Dehiscence, Accidental Perforations/Lacerations, Post op Hip Fractures, Post Op Sepsis, Pressure Ulcers (Goal–Lower Score)</td>
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<tr>
<td><strong>Patient Experience</strong></td>
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<tr>
<td>The patient satisfaction metric uses results from HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), a standardized survey of patients’ perceptions of their hospital experience. The overall rating includes percentage of patient with ratings of 9 or 10 (top two boxes). (Goal-Higher Score)</td>
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<tr>
<td><strong>Harm Rate</strong></td>
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<tr>
<td>Serious Safety Event (SSE) is an incident that reaches the patient and causes moderate to severe harm or death as a result of a deviation from a generally accepted performance standard of care. The Serious Safety Event Rate A rolling 12-month average of Serious Safety Events 10,000 adjusted days is calculated monthly (Goal–lower number)</td>
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</tbody>
</table>


Logging in: Click on the Event Reporter icon on your desktop.
Sign in using your Novell ID and password.

Information needed to submit Event Reporting Checklist

- Patient’s name and medical record number
- Was this an actual or near miss event?
- What happened? Record the type of event - Medication error? Fall/Slip? Treatment related? Surgery Related?
- Was any equipment involved?
  - Type of device/product/equipment
  - Name of device
  - Model number
  - Manufacturer name
  - Serial/Lot number, inventory number
  - Was the device recalled?
  - Was the device sequestered?
- When and where did this event occur? All Nursing Units listed under “Nursing”
- Was another area at this facility involved?
- What is the patient type? (Inpatient, Outpatient, ER, etc?)
- Is the patient aware of the event?
- What is the event severity category? (e.g., Categories A to I?)
- Did you or anyone else have a role in this event? (e.g., the patient’s attending physician, anyone who assisted in the event, witnesses, and any notifications?)

Near Misses

- What degree of harm could have occurred?
- What actions were taken as a result of this event?
- Who was involved in this event?
- What factors led to this event?
- What was the specific issue and reason that led to this event?

💡 Tips on Using the Form

Information Button Use the Information icon to review definitions of Severity levels.
Mandatory Questions Look for mandatory questions marked with a red asterisk (*). You will not be able to save the form till you have completed responses to these questions.
Add Button Click Add to add Medication name for a Medication Event
# Top Safety Events

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Description/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Event</td>
<td>Drug Omitted, Dose/Unit(s) Omitted, Wrong Dose, Wrong Strength/Concentration, Wrong Drug, Wrong Dosage Form, Wrong Technique, Med Cabinet/Pyxis/ Error, Drug Interaction</td>
</tr>
<tr>
<td>Discharge Event</td>
<td>Inadequate Discharge Plan, Discharged to Wrong Family, Medically Inappropriate Discharge, Left Without Being Treated, Left Against Medical Advice, Discharge Refusal</td>
</tr>
<tr>
<td>General Clinical Treatment /Therapy Event</td>
<td>Wrong Therapy, Failure to Act on Physician Orders, Failure to Notify Physician, No Therapy Order, Respiratory Care Event, Incomplete Treatment / Therapy, Missed Treatment/Therapy, Inappropriate Equipment Disconnection</td>
</tr>
<tr>
<td>Access &amp; Admission Event</td>
<td>Admission Denial, Delay, EMTALA Issue, Left Without Being Seen, Multiple Readmissions, Unscheduled Readmission, Wrong Patient</td>
</tr>
<tr>
<td>General Invasive Procedure /Surgery Event</td>
<td>Omitted Surgical Procedure, Wrong Procedure, Wrong Site Procedure, Wrong Patient, Procedure Cancellation, Delay, Improper Technique, Incorrect Surgical Count, Retained Foreign Object, Site Marking issue, Specimen Related issue</td>
</tr>
<tr>
<td>Vascular Access &amp; Infusion Event</td>
<td>Delay, Omitted Infusion Order, Missing Product/Unit(s), Wrong Product Administration, Contaminated Product Administration, Outdated Product (Expired) Administration, Vascular access issues, Wrong technique</td>
</tr>
<tr>
<td>Device Product/Hardware and Software event</td>
<td>Alarm issues, Failure of Electronic Info System (i.e. CPOE Order entry), Device Not Autoclaved/Sterilized Properly, Device Failure, Device Not Available</td>
</tr>
<tr>
<td>Blood/Blood Products Event</td>
<td>Products Omitted, Wrong Technique, Wrong Rate, Wrong Patient, Deteriorated/Contaminated Product Administration, Post Transfusion Complications, Testing Procedure Error.</td>
</tr>
<tr>
<td>Clinical Assessment</td>
<td>Medication reconciliation, Failure to Monitor, Documentation Issues, Missed or Incomplete Assessments, Improper Patient Handling</td>
</tr>
<tr>
<td>Clinical Event</td>
<td>Unexpected Medical/Clinical Emergency, Bodily Injury, Airway and Breathing Issues, Seizures, Abnormal Clinical Physical Issues- Pneumothorax, Arrhythmia</td>
</tr>
</tbody>
</table>

**Contact** Risk Management (860 972-2625) for any Questions  
**Contact** IS Help Desk (860 545-5699) for issues with Novell Log in
Supervision, Progressive Authority and Responsibility of Residents/Fellows* (*hereafter referred to as Residents) - Hartford Hospital and UConn Sponsored Residents

Purpose: To set institutional standards for supervision of residents that assures their education and our compliance with ACGME institutional standards at Hartford Hospital sponsored residency/fellowship training programs.

[Note: These standards are not meant to comply with standards required for billing purposes. Please see the Medicare Guidelines for Teaching Physicians, Interns, and Residents]

Assuring adequate supervision of residents is the responsibility of the program director, faculty physicians, departments, and the institution. This includes other clinical staff members as specified by individual RCs.

The following are standards for Hartford Hospital and UConn sponsored resident positions, irrespective of the affiliated site where the resident is training/working. These are minimum rules. No program can fall below these standards unless the ACGME has approved a less stringent RC standard (** see below). These standards may be expanded if:

- Medical Staff rules at a given institution exceed them.
- Additional standards are required by The Joint Commission, CMS or any other regulatory body.
- An individual program has more stringent RRC requirements for supervision.
- The clinical setting where the resident physician is training/working has additional rules.

Standards: In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician or licensed independent practitioner who is ultimately responsible for that patient’s care. All patient care performed by residents during training will be under the supervision of a physician faculty member, a licensed provider or a more senior resident. A senior resident in this circumstance is a resident with one year’s additional experience or more beyond that of his/her supervisee. The specifics of this supervision must be documented in the medical record by the supervising faculty member, licensed provider or supervising resident. Residents, fellows, faculty members and licensed providers should inform their patients of their respective roles in each patient’s care.

Levels of Supervision: Appropriate supervision of residents must be available at all times. Levels of supervision may vary depending on circumstances, skill, or the experience of the resident. ** Requirements for advancement from one supervisory level to the next has, in some fields, been defined by specific residency RCs and approved by the ACGME. Each Hartford Hospital residency defines the requirements for advancement from one level to the next, mindful of such field-specific requirements. Definitions of levels of supervision are:

- **Direct Supervision:** The supervising physician*/licensed provider is physically present with both the resident and the patient.
- **Indirect Supervision with:**
Direct supervision immediately available: The supervising physician/licensed provider is physically within the confines of the site of patient care and immediately available to provide DIRECT supervision.

Direct supervision available. The supervising physician/licensed provider is not physically present within the confines of the site of patient care, but is immediately available by phone, and is available to come in and provide DIRECT supervision.

Oversight: The supervising physician/licensed provider is available to provide review of procedures/encounters with feedback provided after the care has been delivered.

(*Supervising Physician: The supervising physician can be a faculty member or a more senior resident than the resident needing supervision – see Standards.)

Each resident must know the level of supervision required for them in all circumstances. PGY-1 residents must have, at all times, either direct supervision or indirect. Senior residents or fellows may serve as a direct or indirect supervising physician for a more junior resident or fellow, based on the needs of the patient and the skills of the individual resident or fellow.

The supervising physician/licensed provider must be immediately available in person or by telephone 24 hours a day. Programs must ensure this occurs. Residents must know who the supervising physician/licensed provider is and how to reach this individual. Schedules and contact information for supervising physicians (faculty or more senior residents or fellows) and licensed providers must be readily available to all parties involved with patient care.

The supervising physician/licensed provider must clearly communicate to the residents when and under which circumstances they expect to be contacted by the resident concerning patients. At a minimum, the resident must notify the supervising attending physician/licensed provider of any significant changes in the patient’s condition, including but not limited to:

- Patient admission to the hospital
- Transfer of a patient to a higher level of care including the intensive care unit
- Need for intubation or ventilator support
- Cardiac arrest or significant changes in hemodynamic status
- Development of significant neurological changes
- Development of major wound complications
- Medication errors requiring clinical intervention
- Any clinical problem that requires an invasive procedure or surgery
- Any condition which requires the response of a consulting team
- End-of-life decisions
- Change in code status
- Death

Supervision by Service:

Note – The language used below is customary to med/surg services. Substitutions appropriate to each field should be made in the program-specific Supervision/Responsibilities Guidelines.
Inpatient supervision: Every patient admitted to the hospital has an attending physician who is a member of the hospital attending or affiliated medical staff. The attending physician will remain responsible for the medical care of the patient in every aspect throughout the hospital stay of the patient unless the responsibility is formally transferred to another service and this transfer is appropriately noted in the patient’s medical record. When the attending physician is acting in the capacity of a supervisor, he/she must obtain a comprehensive presentation for each admission from the resident. This includes a History and Physical exam. On the non-emergency admissions, charts shall contain a provisional diagnosis and plan by the attending physician written no more than 7 days prior to the admission, or within twenty-four (24) hours after admission. On all emergency patients, histories and physicals shall be recorded within 12 hours after admission. In either case, the history and physicals must be written prior to any surgery. If the history and physical is written by a resident, the attending physician shall review and authenticate the resident’s history and physical examination within twenty-four (24) hours. The authentication shall consist of the provider’s outline of the salient points of the history, physical, and management plan. The attending physician must also require the resident to present the progress of each inpatient daily, including discharge planning. While residents may write progress notes in patient’s charts, the attending physician will also write appropriate progress notes documenting the portions of care they specifically provide or supervise. Simply countersigning a resident’s note is insufficient. All required supervision must be documented in the medical record by the resident and the supervising faculty member. The interval between practitioner’s progress notes shall not exceed three days for non-critical nor daily for critical patients. Residents must communicate with the attending physician to ensure that the orders they write are consistent with the attending physician’s medical treatment plan for the patient. No countersignature by the attending physician is required for orders written by a resident.

Outpatient supervision: The supervising physician/licensed provider must require residents to present each outpatient’s history, relevant findings, assessment, and proposed diagnostic or treatment plan. All required supervision must be documented in the medical record by the resident and the supervising provider. (Exception to this is relevant for services which practice under Medicare’s Primary Care Exception Rule). For services which have been approved to practice under Medicare guidelines, residents can be supervised with Direct Supervision, Indirect Supervision, or Oversight depending on the resident level, abilities, and the supervision policy of the resident’s program.

Supervision of consultations: The supervising consulting attending/licensed provider must communicate with the resident and obtain a presentation of the history, relevant findings, and proposed recommendations for each consultation. This must be done within an appropriate time but no longer than 24 hours after notification of the consultation request. All required supervision must be documented in the medical record by the resident and the supervising attending/licensed provider consistent with the supervisory level.

Supervision of procedures: The supervising attending must be certain that procedures performed by the resident are warranted; that adequate informed consent has been obtained and documented and that the resident has had appropriate supervision during the procedure to include sedation.

- For procedures performed in the operating room, residents will always be directly supervised by an attending physician for the key portions of the procedure.
For procedures performed outside of the operating room, residents will be supervised by an appropriately credentialed supervising physician or LIP. The supervising physician can be a faculty member or a more senior resident than the resident needing supervision.

All required supervision must be documented in the medical record by the resident and the supervising physician or LIP.

**Supervision of emergencies:** During emergencies, the resident should first and foremost provide care for the patient and notify the supervising physician/licensed provider as soon as possible to present the history, findings, and necessary diagnostic or treatment information. All supervision must be documented in the medical record by the resident and/or the supervising provider.

**Progressive authority and responsibility for Residents:** Increasing responsibility for patient care is an integral part of the medical education process. Residents are expected to function independently upon graduation. Thus, built into residency training is the **expectation** that residents will function with increasing autonomy during the course of their residency. This expectation is imbedded in the ACGME’s progressive levels of supervision outlined above and in the expectation that Advanced Residents, as defined by each RC, will function with an Oversight level of supervision. Residents progress across levels of supervision in the fashion defined by the residency and it’s RC. Further, specific roles and tasks for patient care must be assigned by program directors and faculty members.

- Roles and responsibilities for residents are determined by the program director.
- Decisions regarding the level of supervision necessary for patient care provided by an individual resident must be based on evaluation of that resident using specific criteria that pertain to the discipline.
- A faculty member acting in the capacity of a supervising attending physician should delegate portions of patient care to residents based on the needs of the patient and the skills and experience of the resident.
- Each resident must know the limits of his/her scope of authority and responsibility and the circumstances under which varying levels of supervision apply.

**Transition of Care/Hand-Off (Hartford Hospital and UConn Sponsored Residents)**

Purpose: The purpose of this policy is to establish standards within the Graduate Medical Education community at Hartford Hospital and to ensure that Transitions of Care and Handovers occur in such a manner that the quality and safety of patient care is not compromised.

The term “Transitions of Care” refers to the movement of patient care or responsibilities between health care practitioners and/or settings. Examples of Transitions of Care include:

- Admission to the hospital from an outpatient setting, including but not limited to the Emergency Department, a medical office, a procedure center, or a diagnostic area such as the Radiology Department.
- Admission of a patient to the hospital from another healthcare facility, including but not limited to an outside hospital or skilled nursing facility.
- Transfer of a hospitalized patient to a different level of care within the hospital (e.g.: from the floor to the step-down unit or ICU or vice versa).
- Transfer of patient care responsibilities from one practitioner to another. This includes but is not limited to the transfer of care that occurs: at the time of shift/duty period changes for practitioners (handover or “sign out”); or at a time when a patient is transferred from one service to another.
- Discharge, including discharge to home or to another facility such as a skilled nursing facility or rehabilitation facility.

“Handover” refers to the transfer of information and of responsibility for patient care from one practitioner to another. The Handover process is a standardized, effective, and efficient transfer of information and responsibility. Departments will develop standardized processes and template tools consistent with the setting, type of patient care, and patient acuity. The process should be verbal or written in accordance with acuity of the patient and the services and settings in which the transfer occurs. There are a variety of written information sources which may be used. Those most appropriate to the field, setting, type of care and patient acuity should be selected.

The setting, type of care, and patient acuity will designate the location of this information. Examples include: written handover template, patient handover log, accessible patient data/most recent progress note, transfer of care note/form, etc. The following is an example of the content of a handover template for a hospitalized inpatient resident handover:

- Identification of patient: name, medical record number, and date of birth
- Location of patient (i.e.: hospital room number)
- Identification of responsible attending of record
- Diagnosis and current status/condition of patient
- Relevant recent events, including changes in condition or treatment, current medication status, recent lab tests
- Potential issues that may arise with anticipatory guidance where possible (Use “if/then” statements whenever possible)
- List of tasks to complete with a plan and a rationale
- Allergies
- Code Status

Standards: Individual training programs must design schedules and clinical assignments to maximize the learning experience for residents while minimizing the number of Transitions of Care/Handovers in patient care. Individual training programs must adhere to institutional policies concerning transitions of patient care. Each program must supplement or substitute into this institutional Transition of Care/Handover policy with requirements relevant to and specific for their specialty. Programs must develop scheduling and Transition of care/Handover processes to ensure that:

- Residents do not exceed the 80 hour per week duty limit averaged over 4 weeks.
- Faculty members are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
• All parties involved in a particular program and/or Transition/Handover process have access
to one another’s schedules and contact information. All call schedules are available
electronically.
• Patients are not inconvenienced or endangered in any way by frequent transitions in their
  care.
• All parties directly involved in the patient’s care before and during the transition have the
  opportunity for communication, consultation, and clarification of information.
• Safeguards exist for coverage when unexpected changes in patient care may occur due to
  circumstances such as resident illness, fatigue, and emergency.

Each program must include the Transition of Care/Handover process in its curriculum. Residents
must be directly supervised in their ability to Transition/Handover patient care until such a time
that they have demonstrated competency in the performance of this task. Programs must
develop and utilize a method of monitoring the Transition of care/Handover process and update
as necessary.

Reduction and Closure (Hartford Hospital)
If the Hospital decides to reduce the size of a residency program, to close a residency program, or
the Hospital intends to close, it must inform the GMEC, the DIO, and the residents in the program
as soon as practicable. Though final decision will be the Hospital’s, the GMEC is required to vote
and/or make recommendations regarding the Hospital’s decision to reduce the size of a
residency program or to close a residency program. In the event of such a reduction or closure,
the hospital shall either:

(i) permit residents already in the residency program to complete their residency subject to
the terms hereof or
(ii) assist the residents in their efforts to enroll in an ACGME accredited program in which
they can continue their education. The determination as to (i) or (ii) will be made by the
Hospital in each case.

In conjunction with the Hospital, the GMEC has oversight of all processes related to reductions
and/or closures of individual programs, major participating institutions and the sponsoring
institution.

Suspension Policy
If, at any time, the actions of the resident/fellow present a clear danger to patient safety, the
Program Director has the right to immediately (and verbally) suspend the clinical
responsibilities of that resident/fellow, pending full review by the Program Director and the
Program’s Education Committee. A verbal suspension will be followed immediately with a
written notification to the resident/fellow which provides a signature line indicating the
resident/fellow is aware of the action. Concurrently a copy of this letter shall be sent to the Chief
Academic Officer/DIO.
SECTION V.

ADDITIONAL POLICIES
**Annual Institutional Review (AIR)**

The Designated Institutional Official (DIO) along with the Graduate Medical Education Committee (GMEC) demonstrates effective oversight of the sponsoring Institution's accreditation through an Annual Institutional Review (AIR). The annual process requires that the GMEC review multiple institutional performance indicators and includes monitoring procedures for action plans. The AIR is scheduled during the fall of each academic year. The members of the AIR Committee will include; the DIO, GMEC members along with resident/fellow representative. The GMEC identifies institutional performance indicators for the AIR which includes:

1. Results from the most recent institutional self-study
2. Results of ACGME surveys of residents/fellows and core faculty
3. Notification of ACGME-accredited programs’ accreditation statuses and self-study visits
4. GME Exit Survey Results (if any)

In addition, the AIR includes:

1. Monitoring of action plans resulting from GMEC reviews
2. Demographic information regarding programs and/or
3. Index outcomes measures such as resident participation in patient safety and quality of care initiatives
4. Summaries of accreditation letters of notification (if applicable)
5. Clinical Learning Evaluations Reviews (CLER) report if received during the reporting period.
6. Review of the Annual Program Review and Evaluation Reports for each program
7. Review of Quarterly Resident/Fellow Meetings

If a program needs increased monitoring based on the AIR summary, the AIR committee members will suggest a Special Review.

The DIO must submit a written annual executive summary of the AIR to the Governing Board.

**Communications Policy**

**Program Directors:**

There is an established mechanism to ensure communication between the Graduate Medical Education Committee and all program directors within the Institution.

1. Program directors are members of the Graduate Medical Education Committee which meets on a monthly basis.
2. Communication of any GME issues, policies and changes is ensured by institution email, written correspondence and telephone contact.
3. Presentation of the GME annual report to the Organized Medical Staff.
4. Compliance reports are submitted by each program director and reviewed by the GMEC annually.
5. Annual exit survey results are forwarded to all program directors and responses are required of any marginal results.

The GMEC ensures that the Program Directors, if applicable, maintain an effective communication mechanism with site directors at each participating institution for their respective programs, as to maintain proper oversight at all clinical sites.
Medical Staff:
Communication with Medical Staff which includes the impact of GME on patient safety and quality of care; accreditation status of programs; ACGME citations regarding patient care and well being of residents is assured by the submission of an annual GMEC written report. This report is also presented annually to the Medical Staff by the DIO, who is also the Chairman of the GMEC. In addition, the DIO is a member of the Executive Committee of the Medical Staff of the Institution.

Critical Incident Assistance Policy
Critical incidents occur during training and may result in investigations which involve residents/fellows. When they do, investigating individuals or groups will be strongly encouraged to contact the Program Director or designee (e.g., Site Director) of the resident/fellow’s training program before contacting a resident directly. During the course of an investigation of a critical incident, residents/fellows should follow the protocol outlined below:
1. If a resident/fellow is contacted directly by an attorney, the Connecticut Department of Health, or other investigating entity in the course of an investigation of a critical incident, the resident/fellow should decline to discuss the matter and contact his/her Program Director or Site Director immediately.
2. The Program Director will inform the institution’s Assistant Dean for Education and Risk Manager of the investigation. If the site has no Assistant Dean for Education, the Medical Director for the site and relevant Department Chair will be contacted.
3. The Program Director or designee and Risk Manager will discuss with the resident/fellow the nature of the investigation and what is expected from the resident/fellow regarding the investigation.
4. The Program Director or designee and Risk Manager will assist the resident/fellow in determining whether the resident/fellow may benefit from a separate advocate throughout the investigation.
5. If the Program Director and/or the designated authorities at the involved institutional site determine on an ad hoc basis that the resident/fellow should have a separate, qualified advocate, legal services will be provided by Hartford Hospital. When not applicable, e.g. when training is in a non-affiliated private practice and with the concurrence of both the Director of Risk Management and the attorneys at Hartford Hospital, legal services will be provided by Hartford Hospital.
6. All parties, including the resident, may contact the Graduate Medical Education official/DIO at 860-972-3112 with additional concerns.

Experimentation and Innovation
The Hartford Hospital Graduate Medical Education Committee has oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific program requirements, including:
1. Approval prior to submission to the ACGME and/or respective Review Committee
2. Adherence to Procedures for “Approving Proposals for Experimentation or Innovative Projects” in ACGME Policies and Procedures; and
3. Monitoring quality of education provided to residents for the duration of a such a project.
Assurance of oversight is monitored through the submission of annual compliance reports for each ACGME program. Reports are reviewed and approved by Institutional Review Committee and GMEC.

**Program-level requests for experimentation or innovation will be required to follow the attached ACGME Proposals for Program Experimentation and Innovation.**

**Extraordinary Circumstances (including disasters, extreme emergent situations and significant interruption in patient care)**

Hartford Hospital maintains a policy consistent with ACGME Policies and Procedures that addresses administrative support for ACGME-accredited and non-accredited programs and residents/fellows in the event of a disaster or interruption in patient care. This policy includes information about assistance for continuation of salary, benefits and resident/fellow assignment.

**Definition of a Disaster:** A disaster is defined as an event or set of events causing a need for significant alteration to the residency/fellowship experience at one or more residency/fellowship programs. (Example: Hurricane Katrina)

**Definition of Extreme Emergent Situations and Significant Interruption in Patient Care:** A local event (such as a hospital declared disaster for an epidemic) that affects resident/fellow education or work environment but does not rise to the level of disaster as defined above.

**Procedure:** In the event of a natural or man-made disaster which results in the closing of one or more training sites utilized by the residents/fellows of Hartford Hospital, the GMEC (Graduate Medical Education Committee) will protect the residents’ education and compensation (salary and benefits) to the best of its ability.

In order to achieve this, the GMEC will convene within 10 days of declaration of a disaster to contact the ACGME to determine which of the following applies:

1. If residents/fellows affected by the closing of a site can be immediately reassigned to other affiliated training sites, this will be done and there will be no break in training or compensation.
2. If no other short-term training site is available and it is determined that the closed site will re-open within 90 days or less, compensation will continue in full and the residency training period will be extended as necessary.
3. If no other short-term training site is available and the closed site will not be available for training for more than 90 days, the Program Director, with the assistance of the GMEC and the ACGME, will immediately make efforts to find suitable training at another site. Compensation will be provided for up to 90 days. If an appropriate alternative training site is not identified within 90 days, the resident/fellow will be directed to file for unemployment compensation.

**Communication:** All efforts will be made by the DIO to contact the GMEC, Program Directors and residents/fellows directly. Additionally, the following communications will occur to ensure that all programs and trainees have as much information as possible.

1. The DIO will be responsible for calling or emailing the ACGME and the Institutional Review Committee to provide information and gather information.
2. Program Directors will be responsible for calling or emailing their RRC Executive Director with information or requests for information.
3. Residents will be responsible for calling or emailing their RRC Executive Director with information or requests for information.
4. The ACGME will provide information for changing resident information on its website.

Special Review Process
The Designated Institutional Official (DIO) along with the Graduate Medical Education Committee (GMEC) demonstrates effective oversight of underperforming programs through a special review process that includes established criteria for identifying underperformance. If the Annual Program Review and Evaluation Report and/or the Annual Institutional Review identifies a program as needing increased monitoring for any reason, a special review will be suggested. Special Reviews may be a focused or a comprehensive review, depending upon the standard or standards that are not being met.

Once a program is identified, the GMEC will create a Review Committee that will be responsible for conducting either a focused or comprehensive the Special Review. The Special Review Committee will include GMEC members and will identify a team leader.

Documentation of the Special Review in the form of a report is required. At the completion of the Special Review, the team leader will write a report with potential areas of concern. The report will describe the quality improvement goals, the corrective actions and the process for GMEC monitoring of outcomes. All concerns will be addressed by the Program Director in the form of action plans with expectations that action plans be completed in a timely fashion (3-6 months).

Focused Special Reviews may be required for the following examples. This list is not meant to be inclusive:
- Poor residency or GME Exit survey
- Poor faculty survey (only ACGME programs)
- Case log/patient log concerns
- Curriculum/Evaluation tools
- Accreditation Data System (ADS) not accurate (only ACGME programs)

Comprehensive Special Reviews may be required for the following examples. This list is not meant to be all inclusive:
- Annual Program Review and Evaluation Report not in compliance or submitted
- Programs with multiple RRC citations (only ACGME programs)

Policy for Industry Support (VENDOR POLICY)
This policy addresses interactions between vendor representatives/corporations and residents/fellows and ACGME-accredited and non-accredited programs. This policy also applies to educational conferences organized through Hartford Hospital’s Graduate Medical Education (GME) Program. For additional information please see the Hartford Hospital Code of Conduct and Gifts, Gratuities and Business Policies.

GME Conferences must have as their primary purpose the dissemination of objective scientific information or educational activities. Acceptance of educational support must never be made, conditioned on, or related in any way to pre-existing or future business relationships with industry.
Restricted subsidies to underwrite the cost of Hartford Hospital continuing education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Education subsidies should be directed to the program director or designee and must be deposited into the Restricted Education Fund. The Restricted Education Fund may be expended for speaker’s fees, handout materials, refreshments, etc. at trainee educational sessions. The contributing Industry(ies) may be credited for contributing to the restricted educational grant fund.

In all instances of industry supported education (above), the following criteria must be met:

a. The primary purpose of the education must be the dissemination of objective scientific information or educational activity.
b. Acceptance of educational support must never be made conditioned on or related in any way to pre-existing or future business relationships with industry.
c. Faculty must be present to supervise any educational discussion.

No monogrammed or branded gifts (pens, coffee mugs, note pads) are permitted at GME conferences.

Except for support described in this policy, meals, gifts, gratuities and food provided to Hartford Hospital departments by outside vendors may not be accepted, in compliance with Hartford Hospital’s Code of Conduct and the Gifts, Gratuities and Business Courtesies Policy.

Please contact the Chief Academic Officer/Designated Institutional Official for specific questions.

**Information Management**

Data from Radiology, Laboratory, and Health Information Management for patient care and educational purposes are readily accessible through information retrieval systems maintained by Hartford Hospital. This information is available to support education, quality assurance activities and to provide a resource for scholarly activity.

**Inclement Weather Policy**

Residents/fellows are essential to the daily operation of each hospital and are expected to report to work when scheduled. In the event of a severe weather condition such as a snow storm residents/fellows must contact their supervisor to determine staffing needs. In some cases outpatient activities may be cancelled or delayed and residents/fellows may be temporarily reassigned to help the inpatient demands. Prior to their assigned shift each resident/fellow should contact their supervisor to determine where and if they are needed. Residents/fellows should plan for extra travel time when proceeding to and from their assigned locations. In some events residents/fellows may be needed to stay past the end of an assigned shift to ensure patient safety until appropriate staffing can be assured. Every effort will be made to establish designated rest areas for residents/fellows required to stay beyond their assigned shift.

Residents/fellows unable to arrive for a shift on time, should contact their program director immediately and make every reasonable attempt to safely proceed to their assigned location.
Internet Policy (Appropriate use of the internet and social networking sites)
Social and business networking Web sites (e.g. My Space, LinkedIn, Facebook, Twitter, Flicker) are increasingly being used for communication by individuals as well as businesses and hospitals. As such, it has become necessary to outline appropriate individual and Hartford Hospital Graduate Medical Education sanctioned use.

Guiding Principles:
1. Privacy and confidentiality between physician and patient is of the utmost importance.
2. Respect among colleagues and co-workers must occur in a multidisciplinary environment.
3. The tone and content of all electronic communication should remain professional.
4. The individual is responsible for the content of his/her own blogs/posts.
5. Material published on the web should be considered **permanent**.
6. Any information posted on the Internet is **public information**.
7. All health care providers have an obligation to maintain the privacy of patient health information as outlined by the Health Insurance Portability and Accountability Act (HIPPA).
8. Residents should adhere to all principles outlined in the Housestaff Manual and the Hartford Hospital Code of Conduct when interacting on the Internet.
9. Internet use must not interfere with the timely completion of job duties.
10. Personal blogging or posting of updates should not be done during work hours or with work computers.
11. It is always inappropriate to “friend” patients on any social networking site or to check patient profiles.
12. Avoid discussing any sensitive, proprietary, confidential, private and PHI or financial information about Hartford Hospital or any affiliated hospital.
13. Refrain from posting any material that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful or embarrassing to another person or any other any other entity. This includes, but not limited to, comments regarding Hartford Hospital or any other affiliated hospitals or employees of them.
14. Be aware that you may be held responsible for any personal legal liability imposed for any published content.
15. Social networking sites can be the source of cyber bullying, harassment, stalking, threats or unwanted activity. If you are concerned, you can contact the Hartford Hospital Security Department at (860) 545-2147 or the Medical Education Department at (860) 972-2536 for assistance.

Patient Information:
Identifiable protected health information (PHI) should **NEVER** be published on the Internet. This applies even if only the patient is able to identify him/herself from the posted information. Residents must adhere to all HIPAA principles at all times.

Communication Regarding Hartford Hospital and affiliated hospitals:
Unauthorized use of Hartford Hospital information or logos is prohibited. No phone numbers, e-mail addresses, web addresses or the name of the department or Hartford Hospital may be posted without permission from an authorized departmental individual.

In all communication where you are listed as being affiliated with the Hartford Hospital, a **disclaimer** must be attached such as: “All opinions and views expressed, in my profile (on my page) are entirely personal and do not necessarily represent the opinions or views of anyone else, including other faculty, staff, residents or students in my department at Hartford Hospital.”
Neither my department nor Hartford Hospital has approved the material contained in this profile (on this page). I take sole responsibility for this content.”

**Offering Medical Advice:**
It is never appropriate to provide medical advice on a social networking site.

**Privacy Settings:**
Residents should consider setting privacy at the highest level on all social networking sites.

**Disciplinary Action:**
Resident discipline follows the Housestaff Policy on *Non-Academic Deficiencies/Misconduct/Allegations of Misconduct.* Disciplinary action will be determined by the Program Director and will vary depending on the nature of the policy violation.

**Institutional Learning and Working Environment for Residents/Fellows**

Resident Duty Hours in the Learning and Working Environment

I. Professionalism, Personal Responsibility, and Patient Safety
   A. Hartford Hospital and its sponsoring programs must educate residents/fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

   B. Programs must be committed to and responsible for promoting Patient safety and resident well-being in a supportive educational environment.

   C. All program directors in ACGME and non-ACGME sponsored programs must ensure that residents/fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

   D. The learning objectives of the program must:
      1. be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
      2. not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

   E. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
      1. assurance of the safety and welfare of patients entrusted to their care;
      2. provision of patient- and family-centered care;
      3. assurance of their fitness for duty;
      4. management of their time before, during, and after Clinical assignments;
      5. recognition of impairment, including illness and fatigue, in themselves and in their peers;
      6. attention to lifelong learning;
      7. the monitoring of their patient care performance improvement indicators; and,
      8. honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
9. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

Discipline, Due Process, Appeals Policy

1. When a resident/fellow receives notice of any action by the Program Director which would prevent him/her from normal progress in completing the full term of a residency or fellowship program, he/she shall have the right to appeal such action. As described in section 5.2 of the Hartford Hospital Policy on House Staff Evaluation and Promotion, placement of a resident/fellow on remediation cannot be appealed, although an adverse decision at the conclusion of the remediation period can be appealed.

1.1. The notice of action to the resident/fellow from the Program Director should substantially conform to the following:
   1.1.1. It should be in writing.
   1.1.2. It should be authored by the Program Director.
   1.1.3. It should state generally the reasons for the action.
   1.1.4. It should inform the resident/fellow of his/her right to appeal by contacting the Vice President for Academic Affairs and/or the Chief Academic Officer within seven (7) business days following receipt of said notice of action. Appeals Policy will be given to the resident/fellow along with the notice of action.
   1.1.5. It should be delivered to the resident/fellow in a manner which ensures a signed and dated receipt of delivery (i.e. if hand delivered obtain the resident/fellow’s signature when given; if mailed, use certified mail, return-receipt requested).
       1.1.5.1. Concurrently, a copy of the notice of action should be sent, by the Program Director, to the Vice President for Academic Affairs and/or the Chief Academic Officer.

1.2. The resident/fellow’s payroll status, within the contract agreement period, shall not be affected during the appeal process described herein.

1.3. If the action is rescinded as a result of the process, academic credit for the resident/fellow’s activities during the appeal process will be conferred, and the resident/fellow shall be given opportunity to continue his/her training.

2. To initiate the appeal process, the resident/fellow shall notify the Vice President for Academic Affairs and/or the Chief Academic Officer.

2.1. The notification to the Vice President for Academic Affairs and/or the Chief Academic Officer should substantially conform to the following:
   2.1.1. It should be in writing.
   2.1.2. It should be clearly marked “Urgent and Confidential”
   2.1.3. It should be delivered to the Vice President for Academic Affairs and/or the Chief Academic Officer within seven (7) business days of receipt by resident/fellow of notice of action.
   2.1.4. It should be delivered in a manner which ensures a signed and dated receipt of delivery.
2.2. Failure to notify the Vice President for Academic Affairs and/or the Chief Academic Officer within the prescribed time period will terminate the appeal process at this point.

3. Upon receipt of such notice, the Vice President for Academic Affairs and/or the Chief Academic Officer shall meet with the resident/fellow within ten (10) business days, on a date and at a time and place to be determined by the Vice President for Academic Affairs and/or the Chief Academic Officer, to discuss the circumstances surrounding the action and to clarify details of the review procedures available to the resident/fellow.

3.1. During this meeting, the Vice President for Academic Affairs and/or the Chief Academic Officer shall provide to the resident/fellow, a list of eligible faculty members from which the resident/fellow is to select three names. The Vice President for Academic Affairs and/or the Chief Academic Officer shall select one (1) name from the three chosen and request that individual to appoint an ad-hoc review panel in accordance with section 5 and 6.  
3.1.1. “Eligible Faculty” is defined as: an active staff physician member of a clinical department at Hartford Hospital.  
3.1.2. Eligible Faculty may not be members of the department which sponsors the resident/fellow’s program.

4. Within seven (7) business days after the meeting described in section 3, the resident/fellow must notify the Vice President for Academic Affairs and/or the Chief Academic Officer of his/her decision to formally appeal the action.

4.1 Such notification shall conform to 2.1.1, 2.1.2, 2.1.3., 2.1.4.  
Additionally:  
4.1.1. Such notification must include the reasons(s) for the requested formal appeal, i.e., the perceived errors in fact or procedure that led to the action being appealed.  
4.1.2. Such notification must include the names of the three (3) eligible faculty members chosen by the resident/fellow, described in 3.1.  
4.1.3. Such notification must include an adequate release, permitting the disclosure of information about the resident/fellow contemplated by section 7.4

5. Within seven (7) business days following receipt of notification of formal appeal, the Vice President for Academic Affairs and/or the Chief Academic Officer shall appoint one of the eligible faculty named in section 3, to designate an ad hoc Review Panel.

6. Within seven (7) business days after accepting the Vice President for Academic Affair’s appointment and/or the Chief Academic Officer the chosen faculty member shall designate an ad hoc Review Panel consisting of two (2) attending physicians on the active staff of Hartford Hospital and one resident/fellow. One of the attending physicians shall be designated as Chairperson of the Panel.

6.1. The appointed eligible faculty member described in section 3.1 shall not serve as a member of the ad hoc Review Panel. “The Panel”  
6.2. Faculty members of the Panel must be in conformance with the criteria listed in 3.1.1, 3.1.2., and 3.1.3., above.
6.3. The resident/fellow member of the Panel shall be in his/her final year of training in a residency or fellowship program sponsored by Hartford Hospital and of a department other than the appealing resident.

7. Within seven (7) business days following the ad hoc Review Panel's designation, its Chairperson, through the Office of the Vice President for Academic Affairs and/or the Chief Academic Officer, shall notify the appealing resident/fellow, the members of the Panel, the Program Director and the Vice President for Academic Affairs and/or Chief Academic Officer, of the time and place at which the Panel shall be convened to formally hear the case.

7.1. Such time and place shall be arranged with prior consultation of the above named principals.
7.2. The Review Panel shall convene no later than 21 business days following its designation.
7.3. The Vice President for Academic Affairs shall serve as an ex-official non-voting member of the Panel
7.4. In preparation for this hearing, each principal and member of the Panel shall have the right to review and consider all pertinent material, including all documentary material pertaining to the resident/fellow maintained by the Hospital, Department and Program. All material shall be directed to (and through) the office of the Vice President for Academic Affairs and/or the Chief Academic Officer who will be responsible for distribution of materials to all participants in the hearing. If materials are submitted directly to the Panel Chairperson, it is the Chairperson's responsibility to transmit this material to the Office of Academic Affairs and/or the Chief Academic Officer in a timely manner, for distribution.

8. The hearing format shall be determined by the Panel's Chairperson and not be rigidly prescribed, except by joint consent of the Panel's Chairperson, the resident/fellow, and the Program Director. The hearing shall, however, include at least the following elements:

8.1. The Chairperson shall open the hearing by briefly summarizing the case.
8.2. The Program Director shall present the basis or rationale for upholding the action, including calling supportive witnesses, if appropriate. A list of such witnesses should be supplied to the Vice President for Academic Affairs and/or the Chief Academic Officer and to the resident/fellow (or his/her designate), preferably at least 48 hours prior to the hearing.
8.3. The resident/fellow shall present the basis or rationale for rescinding the action, including calling supportive witnesses. A list of such witnesses should be supplied to the Vice President for Academic Affairs and/or the Chief Academic Officer and to the Program Director preferably at least 48 hours prior to the hearing. The failure to list a witness does not disqualify him/her, however.
8.4. Witnesses called by either side shall be subject to cross-examination and recall at the discretion of the Chairperson.
8.5. The resident/fellow and the Panel may have the advice of Legal Counsel, but such Counsel shall not be permitted to be present at the hearing or participate in the presentation of a case or take part in the cross examination of any witnesses except as determined by the Panel.
8.6. The Panel's scope of review shall be to determine: 1) whether proper procedures were followed in the process relative to the action which prevented the resident/fellow
from completing the full term of his/her residency or fellowship program; 2) whether there were reasonable grounds on which the decision was made.

8.7. The length of the hearing shall be at the discretion of the Chairperson, but shall generally not exceed four hours.

8.8. At the conclusion of closing arguments and/or statements, the Review Panel shall immediately enter into closed session to deliberate and decide either to uphold or rescind the action; no intermediate decision shall be made.

8.9. An accurate record of this hearing shall be kept, including an audio recording, if possible. Hearing transcription shall be the responsibility of the Office of the Vice President for Academic Affairs and/or the Chief Academic Officer.

9. The Panel's discussion shall be considered final.

9.1. Such decision may be communicated orally first to the resident/fellow, than to other principals at the discretion of the Panel Chairperson.

9.2. Such decisions shall be delivered, in writing, to the resident/fellow and the Program Director within seven (7) business days following the hearing and in a manner which insures a signed and dated receipt of delivery “i.e., Certified mail, return receipt requested”.

10. Preparation and reproduction of the Panel’s final written report and letter of notification shall be the responsibility of the Panel Chairperson.

10.1. Copies of all written communications between the Program Director, the resident/fellow, the Chairperson of the Panel, or their legal representative shall be sent to the Office of the Vice President for Academic Affairs and/or the Chief Academic Officer.

Non-Academic Deficiencies/Misconduct/Allegations of Misconduct

When such behavior on the part of the resident/fellow has been alleged and not refuted to the Program Director’s satisfaction, the Program Director, after discussion with either the Director of Graduate Medical Education or the DIO, may recommend the resident’s/fellow’s dismissal without an intervening remediation period.

Misconduct (See Code of Conduct) can be reported by the residents/fellows, employees of the hospital, attending physicians, patients, or any other person. These concerns must be reported to the Program Director, who, in turn, must communicate the allegation to the resident/fellow. Upon receipt of a complaint regarding the conduct of a resident/fellow, the Program Director must conduct an initial inquiry and notify the Office of Medical Education. This inquiry should occur within five business days. If the inquiry goes beyond five business days, the resident will be placed on administrative leave without prejudice and receive full pay and benefits. During the inquiry, the resident may be placed on suspension. During the inquiry, the resident will be given the opportunity to respond to the allegations of misconduct. During suspension, the resident/fellow will continue with full pay and benefits.

If a full inquiry results in a finding of misconduct on the part of a resident/fellow, the Program Director in conjunction with other appropriate individuals such as the Department Chair, the Graduate Medical Education Executive Committee, a GME representative, and/or legal counsel from Hartford Hospital, will determine what action is appropriate under the circumstances to remedy the situation. Possible actions include, but not limited to, the following:
Written warning to the resident file (can be removed if allegation is disproved)
Extension of training
Non-renewal of contract
Immediate termination
“Fit for Duty”/EAP evaluation
Leave of Absence

Any finding of misconduct that leads to the above actions, except for verbal and written warnings, are reportable and will be part of the resident’s/fellow’s permanent record.

If the resident receives a written warning, a witness must be present in the room to verify the resident received the warning. If the resident refuses to sign the written warning, this must be noted and witnessed.

Non-Competition (Restricted Covenant)
In compliance with Accreditation Council for Graduate Medical Education (ACGME), Hartford Hospital as the sponsoring institution nor any of its ACGME-accredited or non-accredited programs, will require a resident/fellow to sign a non-competition guarantee or restrictive covenant.

Requests and Submission to the ACGME
Prior to submission to the ACGME, the Graduate Medical Education Committee must approve the following:

- all applications for ACGME accreditation of new programs and subspecialties
- changes in resident complement
- Major changes in program structure or length of training
- additions and deletions of participating institutions used in a program
- appointments of new program directors
- progress reports requested by any Review Committee
- responses to all proposed adverse actions
- requests for exceptions of resident duty hours
- voluntary withdrawals of ACGME-accredited programs
- Requests for an appeal of adverse actions; and,
- Appeal presentations to a Board of Appeal or the ACGME

In addition, the DIO is required to co-sign on all of the requests and submissions to the ACGME.
Remediation/Academic Deficiencies

Academic Deficiencies:
A resident/fellow whose academic performance does not meet program standards in any of the six general competencies may be entitled to a defined period of remedial training in order to allow the resident/fellow to improve academically and remain in the program. If the Program Director determines that there is no significant improvement in the identified deficiency/deficiencies after a defined period of remediation, a “Letter of Deficiency” is the next appropriate option. A “Letter of Deficiency” is a formal notification of deficiency in one or more of the ACGME Competencies. The letter of deficiency specifies a time of any duration, up to no more than six months, during which the resident or fellow must improve their performance. After the full six months with continued unsatisfactory performance, the Program Director must impose one of the adverse actions below.

- Denial of credit for a rotation
- Delayed promotion of a resident/fellow
- Non-renewal of contract
- Termination

The primary responsibility for defining the standards of academic performance and personal and professional development rests with individual programs and their Program Directors.

Process:
If a resident/fellow is identified as having academic deficiencies in any of the six general competencies, the resident/fellow should be given a Letter of Deficiency, which initiates a formal remediation process. A Letter of Deficiency should include the following:

- Notice of the academic deficiency
- A description of the deficiency that should be in behaviorally-specific terms, with examples
- The program’s general expectations for achievement in that competency/competencies
- Defined goals, including points of assessment
- A timeline for appropriate completion
- Consequences of success or failure
- Signature of the Program Director and the resident/fellow

The timeline and the goals of a remediation usually fit the needs of the resident/fellow, the deficiency, and the program.

The successful remediation of the academic deficiency should be documented in the resident's/fellow's performance file, along with a follow-up letter stating whether the resident/fellow successfully completed the plan and subsequent monitoring.

If the resident/fellow does not adequately complete the outlined remediation, further action may follow and may include:

- Continued remediation with a second Letter of Deficiency
- Denial of credit for a rotation
- Delayed promotion of a resident/fellow
- Non-renewal of contract
- Termination
Remediation of the deficiency cannot be longer than six months throughout the entire residency without leading to another academic action, which ultimately will require future reporting.

If deficiencies in any competencies arise that may endanger patients during the remediation period, the resident/fellow may be suspended immediately by the Program Director or designee. The egregious behavior may result in a termination after consultation with the Vice President of Academic Affairs/Designated Institutional Official.

Any action beyond the initial “Letter of Deficiency” must trigger consultation with the Medical Education Office and the Vice President of Academic Affairs. All actions are appealable except for the “Letter of Deficiency”. All appealable actions are reportable and, therefore, can allow a request for due process.

1. Suspension
   1.1. If, at any time, the actions of the resident/fellow present a clear danger to patient safety, the Program Director has the right to immediately (and verbally) suspend the clinical responsibilities of that resident/fellow, pending full review by the Program Director and the Program's Education Committee. A verbal suspension will be followed immediately with a written notification to the resident/fellow which provides a signature line indicating the resident/fellow is aware of the action. Concurrently a copy of this letter shall be sent to the Vice President for Academic Affairs.

2. Denial of Academic Credit/Termination/Dismissal
   2.1. If a resident/fellow does not satisfactorily complete remedial work during the remediation period, the Program Director, with the concurrence of the Education Committee, may decide either to have the resident/fellow repeat part or all of that academic year's work, or to terminate the resident/fellow from the program. This decision, and the detailed basis for it, must be sent, in writing, to the resident/fellow with a copy to the Vice President for Academic Affairs. This should include a determination whether the resident/fellow will receive academic credit for any portion of the remediation period. In instances where the remediation period had been continued beyond an initial three-month period, credit will be given for the initial three-month period.

   2.2. The Program Director, with the agreement of the Education Committee, shall decide whether or not to permit the resident/fellow to complete a contract year. If the resident/fellow does complete a full contract year, the status of the resident/fellow in the program at the time of termination shall be documented, in writing, so that clear information can be given to other programs/institutions seeking references in the future. If the resident/fellow does not complete a full contract year, the number of months of credit to be given to this resident/fellow for that academic year shall also be documented, in writing.

   2.3. Under exceptional circumstances, e.g., extreme deficiency in performance, behavior, or attitude, the Program Director, with the agreement of the Education Committee, may decide to terminate the employment of the resident/fellow immediately.

   2.4. In all instances, careful written records of the decision shall be kept; written notification to the house officer and an opportunity for the house officer to be heard prior to termination should be given.
3. Appeal
   3.1. If the resident/fellow disagrees with any decision that would jeopardize the normal progress toward the completion of training, that resident/fellow has the right to appeal.
Title/Subject Sexual Harassment and Misconduct Policy

Section: I. Standards of Conduct
Policy #: 107

PURPOSE:
To comply with state and federal laws and regulations concerning sexual harassment and communicate the hospital’s policy on inappropriate behavior of a sexual nature.

SCOPE:
All employees, vendors, contractors, visitors, patients, physicians and students

POLICY:
Sexual Harassment
It is the policy of Hartford Hospital to assure its employees of the right to work in an atmosphere of security and dignity, free from sexual harassment. Sexual harassment is a violation of Connecticut General Statute section 46a-60(a)(8) and is defined as follows:

Sexual harassment is any unwelcome sexual advances or requests for sexual favors or any other verbal or physical conduct of a sexual nature when: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of substantially interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Although not an exhaustive list, the following are examples of the type of conduct prohibited by the policy against sexual harassment:
1) Unwelcome sexual advances from a co-worker or supervisor, such as unwanted hugs, touches, or kisses;
2) Unwelcome attention of a sexual nature, such as degrading, suggestive or lewd remarks or noises;
3) Dirty jokes, derogatory or pornographic posters, cartoons or drawings; and
4) The threat or suggestion that continued employment advancement, assignment or earnings depend on whether or not the employee will submit to or tolerate harassment.

Sexual Misconduct
While not sexual harassment as defined by the law, other inappropriate behavior of a sexual nature directed towards patients, visitors, students, and other non-employee groups is not tolerated by the hospital.
Although not an exhaustive list, the following are examples of the type of conduct prohibited by this policy:

1) Making sexual advances towards or pursuing/promoting personal relationships with patients.
2) Inappropriate non-therapeutic physical activity with patients including hugs, touches, or kisses.

**Violations**

Violations of this policy will not be permitted and may result in discipline up to and including discharge from employment.

**PROCEDURE:**

Supervisors at all levels who become aware of conduct that is inconsistent with or violates the Hospital’s policy against sexual harassment and sexual misconduct must not wait for a formal complaint to take action to stop the conduct. Further, supervisors are required to report sexual harassment and/or sexual misconduct complaints to the Vice President of Human Resources or their designee. The Inappropriate Staff Behaviors Involving a Patient Policy #114 will be implemented following any allegations of inappropriate sexual behavior directed toward a patient.

Employees who experience such behavior from supervisors, fellow employees, physicians, employees of outside vendors and contractors, visitors, or patients; or, employees who have been disciplined in relation to a sexual harassment complaint and feel the disciplinary action was inappropriate, are encouraged to and should contact either the Vice President of Human Resources or their designee.

All new supervisory employees must receive two hours of sexual harassment education and training within six months of assuming a supervisory position. This program is offered at the Hospital two times per year.

Complaint investigations will be held in the strictest confidence. Retaliatory behavior against the complainant will not be tolerated and no reference to the complaint will be placed in the complainant’s Human Resources file.

**RELATED POLICIES:**

Policy #106-Rules of Conduct Policy
Policy #114-Inappropriate Staff Behaviors Involving a Patient Policy

Issued: March 2005
Replaces: Sexual Harassment Policy
Review Date: 01/06, 01/07, 11/07, 5/12, 7/15
Revised Date: 11/07, 5/12, 7/15
Non-renewal of Appointment or Non-Promotion Policy
Programs will provide a resident with a written notice of intent not to renew a contract or when a resident will not be promoted to the next level of training no later than four months prior to the end of the resident’s current contract. However, if the primary reason(s) for the non-renewal or non-promotion occur(s) within the four months prior to the end of the contract, residents will be given as much notice of the intent not to renew or not promote, as the circumstances will reasonably allow, prior to the end of the contract. Residents will be allowed to implement the grievance procedures when they have received a written notice of intent not to renew their contract or of intent not to renew their agreement(s) but not to promote them to the next level of training.
SECTION VI.

APPENDIX
HOUSE STAFF PHYSICIAN – Position Overview

The resident/fellow position is a physician in training who provides patient care and participates in an educational program commensurate with the individual physician’s level of advancement and competence. A resident/fellow physician’s responsibilities include patient care activities within the scope of their clinical privileges commensurate with their level of training, attendance at clinical rounds and seminars, timely completion of medical records, and other responsibilities as assigned or as required of all medical staff. Under the supervision of attending physicians, general responsibilities of the resident/fellow physician may include:

- Initial and ongoing assessment of patient’s medical, physical, and psychosocial status
- Perform history and physical
- Develop assessment and treatment plan
- Perform rounds
- Record progress notes
- Order tests, examinations, medications, and therapies
- Arrange for discharge and aftercare
- Write/dictate admission notes, progress notes, procedure notes, and discharge summaries
- Provide patient education and counseling covering health status, test results, disease processes, and discharge planning
- Perform procedures
- Assist in surgery

Residents/Fellows participate in clinical medicine under the watchful eye of supervising teaching faculty and include:

- Participation in safe and effective compassionate patient care.
- Developing an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education, and how to apply cost effective measures in the provision of patient care.
- Participation in the educational activities of the program as appropriate assumption of responsibility for teaching and supervising other residents/fellows and students and participation in institutional orientation and educational programs and other activities involving the clinical staff.
- Participation in institutional committees and councils to which the resident/fellow physician is invited to attend and/or are appointed.
- Performance of these duties in accordance with the established practices, procedures, and policies of the institution and those of its programs, clinical departments, and other institutions to which the residents/fellows are assigned.

The resident/fellow physician is both a learner and a provider of medical care. The resident/fellow is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, resident/fellow physicians are expected to gain competence and require less supervision progressing from on-site and contemporaneous supervision to more indirect and periodic supervision.

Because resident/fellow physicians are given progressive responsibility for the care of a patient, it is the program’s responsibility to determine when a physician’s ability to provide care to patients without a supervisor or act in a teaching capacity. These are based on formative and
summative evaluations of the resident's/fellow's clinical care, judgment, knowledge and technical skill.

Ultimately, it is the decision of the teaching faculty with direct responsibility of the resident/fellow as to which activities the residents/fellows will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

Twice a year, the Program Director will provide the resident/fellow physician performance ratings in the form of semi-annual evaluations in all of the six competencies. Resident/fellow physicians are apprised of their strengths and weaknesses at this time. At the completion of the program requirements, the Residency/Fellowship Program Director has the responsibility to determine and to document in writing that the resident/fellow physician possesses the skills necessary to practice at the level commensurate with their training.

**Designated Areas for Staff Food & Drink Policy**
A policy sets forth the guiding principles for a specified targeted population as such principles relate to specific clinical or operational issues.

**Purpose:** To prevent occupational exposure to blood and other potentially infectious materials and to prevent subsequent transmission to patients and visitors.

**Scope:** All Hartford Hospital Employees, Medical Staff, Hospital Volunteers, Students using the facility and Contracted Service Personnel

**Definition of Work-area:** Any area where work involving exposure to blood/other potentially infectious material may occur or where the contamination of surfaces with these substances may occur. (OSHA defined)

**Policy:**
1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational/staff exposure. These activities should be conducted in designated areas, such as “team break rooms”, cafeteria, or non-clinical/non-patient care areas.

**Intranet Key Words:** Infection, eating, food, drink, patient areas, lip balm, OSHA, contact lenses, cosmetics, occupational exposure, employees, staff

Issued: June 2008
Proponent: Housewide Healthcare Team
Replaces: New Policy Approved By: PSAG task-force assigned to examine the OHSA regulation re staff food and drink in work areas.
Review Date: At least every 2 years
Revised Date:
Cross Reference: Bloodborne Pathogens Exposure Control Plan 2006, HR policies
DOCUMENTATION POLICY
Scope: All individuals authorized to document in the Medical Record.

Medical record documentation must be created for every patient evaluated and treated at Hartford Hospital. All entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided. Documentation in the patient’s record must reflect sufficient information to clearly identify the patient, support the diagnosis and condition, justify the care and treatment, document the plan, course and results of treatment, promote continuity of care and patient safety. In addition, adequate documentation is essential to justify reimbursement, conduct quality improvement and perform research.

I. Individuals Authorized to Document in the Patient’s Medical Record:
   A. Members of the medical staff, including physicians, residents, certified nurse midwives, and mid-level providers.
   B. Members of the interdisciplinary patient care team including audiologists, chaplains, dieticians, nursing licensed staff, pharmacists, recreation therapists and assistants, rehabilitation therapists, case managers, psychologists, social workers, certified nursing assistants, therapy assistants, medical assistants, patient administrative assistants and all others as approved by the HIM Regulatory Committee.
   C. Students participating in on-site health care provider/technical training programs.
   D. Individuals under contract to provide patient care may document in the medical record within the limits of their contract.

II. General Guidelines for Documentation:
   A. All entries in the Medical Record must be:
      • On Hartford Hospital approved clinical record form(s) with the patient name, medical record number and account numbers on both sides of the form(s).
      • Legible
      • Typewritten or written in black or dark blue ink;
      • Recorded with the date and time of the entry;
      • Signed with a legal signature of the individual who made the entry. Permissible authentication methods include written and electronic signatures. Only individuals authorized to make entries into the electronic medical record will be provided an electronic signature code (See Policy Authentication by Electronic Signature).
      • In chronological order, without leaving blank lines or spaces or writing in the margins on paper forms.
   B. Abbreviations Use only approved Hartford Hospital abbreviations. (See Policy Medical Abbreviations Usage)
   C. Medical Record Entries must not be altered: The manner in which an erroneous entry may be corrected or an addendum made to an existing entry in the medical record will reflect the principles of medical record documentation requirements whether the record is paper-based or electronic. (See Policy Amendments to the Paper-based and Electronic Medical Record)

III. Guidelines for Interdisciplinary Clinical Documentation -Knowledge Based Charting (KBC)
Guidelines are available to determine the appropriate care, treatment and services to meet
a patient’s initial needs as well as his/her changing needs while in the acute care setting. The documentation process is interdisciplinary and collaborative utilizing Allscripts (Eclipsys) Sunrise Clinical Manager with KBC.

IV. Countersignature Requirements:
   A. Admission History & Physicals written by PAs, APRNs and residents must be co-signed by the attending physician.
   B. Consultations written by PAs, APRNs and residents must be countersigned by a supervising physician.
   C. Discharge summaries completed by PAs, residents and IOL clinicians must be countersigned by the supervising physician.
   D. Discharge summaries completed by APRNs must be countersigned by an attending physician.
   E. Documentation by medical students must be co-signed by a resident or an attending physician.
   F. Documentation by all other students will be co-signed by their designated supervisor. See Policy Written, Verbal, Telephone Orders for orders requiring countersignatures.

V. Resident Oversight:
   To demonstrate ongoing supervision of residents:
   A. An attending physician will enter a note within 24 hours of admission, demonstrating involvement in the plan of patient care; and
   B. A progress note demonstrating evidence of attending physician participation should be entered by an attending physician at least every 72 hours throughout the hospital stay. The suggested language of the note is “I personally interviewed and examined the patient and reviewed Dr. ____’s (resident/fellow’s) note. I agree with the history, exam, assessment and plan as detailed in the resident’s/fellow note with the following additions/exceptions/observations:________.”

   It is expected that an attending physician will add a personalized observation to demonstrate participation in the management of the patient. An attending physician from that residency program will include his/her specialty in their attestation signature.

VI. Records contain patient-specific information, as appropriate, to the care, treatment and services provided. Each medical record contains, as applicable, the following information:
   A. Patient’s name, gender, race and ethnicity, date of birth, and any legally authorized representative;
   B. Legal status of patient receiving behavioral health services;
   C. The patient’s communication needs, including preferred language for discussing health care. If the patient is a minor, is incapacitated, or has a designated legally authorized representative, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.
   D. Emergency care, treatment and services provided prior to arrival;
   E. Admitting diagnosis;
   F. Physician admission note and orders with sufficient data to justify diagnosis and warrant treatment;
   G. A Medical History & Physical Examination:
      • The History and Physical Examination (H&P) may be performed by a licensed physician who may or may not be a member of the Hartford Hospital Medical
Staff, APRN, Physician’s Assistant, Resident or Certified Nurse Midwife and must be recorded within 24 hours of the patient’s admission, or performed no earlier than 30 days prior to admission. H&P completed in advance of admission by their primary care practitioner (PCP) will be accepted regardless of whether that practitioner is a member of the HH medical staff.

- The H&P documentation shall be in accordance with the applicable written Rules and Regulations of the Department and shall be consistent with the patient’s age and must support the reason(s) for admission for care, treatment, and services, and indications for surgical procedure(s) as appropriate. It must include a provisional diagnosis with relevant positive and negative findings resulting from past medical history and review of systems, and medical necessity for planned procedures/admission. It must include any conclusions or impressions drawn from the patient’s medical history and physical exam.

- When an H&P is completed within the 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition is placed in the patient’s medical record within 24 hours after admission and always prior to surgery. If upon examination, there is no change in the patient’s condition since their H&P, the healthcare provider will indicate in the medical record that the H&P was reviewed, patient examined and that no change has occurred.

- If the physician finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the existing H&P, and conduct and document in the medical record a new H&P within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia.

H. A Consultation Examination will include:

- Full name of provider requesting the consultation
- Date of service
- Appropriate clinical information may include
  - History of present illness
  - Past medical, surgical, family, social history
  - Medications
  - Allergies
  - Review of systems
  - Physical examination
  - Diagnostic data
  - Impression & plan

I. A statement identifying who provided the service

- The phrase “The patient was seen and examined by “name”
- A statement identifying who dictated the service if different than who provided the service
- The phrase “The note is dictated by “name”
- Goals of treatment and treatment plan;
- Within 24 hours, the record should contain a nursing assessment; (See Nursing Documentation Guidelines).
- Advanced Directives: Evidence of Advance Directives; (See Patient’s Right to Self-determination/Advance Directives Policy).
- Allergies to foods and medications;
- Relevant signed consent forms
- Diagnostic and therapeutic orders, procedures, tests and results relevant to the
management of the patient’s condition, and the other information necessary to monitor the patient’s condition and ensure the patient’s safety;

- Descriptions of the patient’s progress and response to treatment and medication;
- All reassessments and plan of care revisions, where indicated;
- Any diagnoses or conditions established during the patient’s course of care, treatment, and services;
- Patient’s response to care, treatment and services provided;
- Every medication ordered or prescribed. Every dose of medication administered (including the strength, frequency, dose or rate of administration, administration devices used, access site or route, indication for use, known drug allergies and any adverse drug reaction);
- Results of all consultative evaluations;

J. Documentation of complications and unanticipated outcomes, hospital acquired infections and unfavorable reactions to drugs and anesthesia with evidence of informing the patient and, when appropriate, their families; (See Policy for Disclosure of Unanticipated Outcomes).

K. Written discharge instructions that includes all medications prescribed upon discharge, approved by the physician of record and signed by the patient and/or family member or legal representative must be retained as part of the permanent record;

L. Transfer progress note should be written when the patient is transferred to a different level of care or service;

M. A written discharge note is required for non-continuous outpatient records.

N. A final diagnosis within 30 days following discharge; and

O. A discharge summary and/or supplemental form.

P. For admissions over 48 hours, a concise, dictated discharge summary which includes: reason for hospitalization, significant findings, procedures performed, the care, treatment and services provided, patient’s condition at discharge, discharge medications and information provided to patient and family.

Q. Discharge against medical advice must be noted in the discharge summary. This must be completed within 30 days of discharge.

If a patient is discharged in less than 48 hours, the discharge summary may be handwritten. A dictated discharge summary is required for observations for chest pain.

A discharge summary may be dictated up to 24 hours before discharge, with a dictated addendum if there is a change in the patient’s condition. A dictated summary is required immediately after discharge if a patient is being transferred to another facility. A copy of the discharge summary is faxed to the provider who will be following the patient after discharge either through the autofax program or faxed manually by HIM.

VII. Operative or other procedures and the use of moderate or deep sedation or anesthesia:

A. A pre-anesthesia evaluation is completed and documented in the medical record within 48 hours prior to surgery or procedure requiring anesthesia services. It should include:
- Notation of anesthesia risk,
- anesthesia drug and allergy history,
- any potential anesthesia problem identified, and
- patient’s condition prior to induction of anesthesia
A brief operative note is entered in the medical record immediately following the conclusion of the procedure. It must include the date and time of the procedure, pre and post-op diagnoses, procedures performed and description of the procedure, the name of the primary surgeon and assistants, fluids, drains, anesthesia, findings, estimated blood loss as indicated, specimens removed, patient’s condition, complications and signature.

The completed operative report is dictated and authenticated by the surgeon and made available in the medical record within 72 hours after the procedure.

A post-anesthesia evaluation is completed and documented no later than 48 hours after surgery or procedure requiring anesthesia services (general, regional or monitored anesthesia). Documentation should include:

- Respiratory function, including respiratory rate, airway potency and oxygen saturation;
- Cardiovascular function, including pulse, rate and blood pressure;
- Mental status;
- Temperature;
- Pain;
- Nausea and vomiting; and
- Post-operative hydration

Post-operative documentation must include the patient’s vital signs and level of consciousness, medications (including intravenous fluids) and blood and blood components administered, if applicable, and any unusual events or complications, including blood transfusion reactions and the management of those events.

Post-operative documentation must include the patient’s discharge from the post-sedation or post-anesthesia care area by the responsible LIP or according to discharge criteria.

The use of approved discharge criteria to determine the patient’s readiness for discharge is documented in the medical record.

Post-operative documentation must include the name of the LIP responsible for discharge.

VIII. Ambulatory Surgery Medical Record: A discharge summary is required for ambulatory surgery cases, including interventional radiology procedures. It may be a final progress note. The discharge summary must include:

A. Discharge instructions and follow up
B. Diagnoses
C. Outcome of treatment
D. Condition on discharge

IX. Ambulatory Care Medical Record: For patients receiving continuing ambulatory care services, the medical record must contain, at a minimum, the following:

A. A list of all known significant medical diagnoses and conditions, known significant operative and invasive procedures, known adverse and allergic drug reactions and known long-term medications, including current prescriptions, over-the-counter drugs and herbal preparations;
X. The Emergency Medical Record must contain the following:
   A. Time and means of arrival;
   B. Whether the patient leaves against medical advice;
   C. Conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment, and services;
   D. A copy of the medical record must be available to the provider or medical facility providing follow-up care.

Appropriate information is communicated to any organization or provider to which the patient is transferred or discharged.

The information shared includes the following, as appropriate to the care, treatment, and services provided:
   - The reason for transfer or discharge
   - The patient’s physical and psychosocial status
   - A summary of care, treatment, and services provided and progress toward goals
   - Community resources or referrals provided to the patient

XI. Hospice Medical Record When a patient is transferred from a Hartford Hospital medical/surgical bed to a Hospice bed, the physician must write “discharge to HH inpatient hospice care” on the medical/surgical chart. The Hospice chart must include:
   A. Admit order stating the following “admit to general inpatient hospice care”
   B. Admission note within 24 hours by attending physician
   C. A notation by attending indicating that the H&P has been reviewed and updated if necessary
   D. Nursing database must be updated by RN within 24 hours
   E. Final progress note must be written by attending, even though pronouncement of death may be done by other clinician.
   F. Documentation will be completed by contracted hospice care providers.

XII. Date and time of death: The date and time the patient is pronounced dead should be the date and time of death documented on the Death Notice Form (HH6806) and on the State of Connecticut Certificate of Death.

Key Words Search:
Cross Reference: Authentication by Electronic Signature, Medical Abbreviations Usage, Amendments to the Paper-based and Electronic medical Record, Policy for Written, Verbal and Telephone Orders, Nursing Documentation Guidelines, Patient’s Right to Self-Determination/Advance Directives Policy, Policy for Disclosure of Unanticipated Outcomes, Medical Staff Rules and Regulations, Clinical Documentation Guidelines for Knowledge Based Charting (KBC)
RECORDS RETENTION Policy
It is the intent of this policy to standardize records retention practices in order to adhere to minimum standard guidelines of the ACGME, Federal, State, and University regulations.

Procedure
A. Program Specific
1. Documents to keep permanently
   - Resident Demographics such as Legal and Preferred Names, Credentials, NPI, Social Security Number, Race, Gender, Date of Birth, Birth Place, Citizenship Country, Email Address
   - Application from electronic system (e.g., Electronic Residency Application Service, San Francisco Match Central application Service) or paper (e.g., program, GME)
   - Prior training verification if applicable
   - Block Schedules
   - Summary Evaluations: Biannual evaluations, Annual Evaluation, Final Residency/Fellowship Training Verification
   - Procedure logs and Case logs
   - National Board scores (both USMLE and COMLEX)
   - Disciplinary Summaries including Letter of Deficiency with Adverse Action: (termination; extension of contract due to Letter of Deficiency with Adverse Actions; or non-renewal of contract)

2. Documents to discard in 5 years
   - All monthly evaluations
   - Duty Hour Reports

3. Documents to discard in 3 years
   - Applications for all residents no accepted into the Program must be retained for 3 years regardless of whether or not the applicant was invited for interview.

4. Documents to discard 1 year after leaving the Program
   - Pre-employment documents (MSPE and all letters of recommendation)
   - On-boarding documents such as fit-for-duty, background check, and Institutional Curriculum

5. Documents to discard 1 year after request
   - Request for verification of training including release forms

Graduate Medical Education/Medical Education Administration Office
1. Documents to keep permanently
   - Resident Agreements/Contracts/Appointment Letters
   - Application from electronic system (e.g., Electronic Residency Application Service, San Francisco Match Central Application Service) or paper (e.g., program, GME)
   - Medical School Diploma
   - ECFMG certificate
   - CV
   - Prior training verification if applicable
   - Leave of absence documentation/Short term disability (not vacation leave)
• Final Residency/Fellowship Training Summary Verification
• Copy of graduating diploma
• Disciplinary Summaries including all legal documents and Letters of Deficiency with Adverse Action: (termination; extension of contract due to Letter of Deficiency with Adverse Actions; or non-renewal of contract)
• Disciplinary Summaries including all legal documents and Letters of Misconduct if it has been determined the Letter of Misconduct will remain a part of the permanent file and be reflected on the Final Residency/Fellowship Training Summary Verification
• House Staff Index Card/Personal Information Summary (New Innovations)

2. Documents to discard in 5 years
   • Annual Summary of Duty Hour Reports

3. Documents to discard 3 years after Graduation
   • Monthly GMEC Duty Hour Reports

4. Documents to discard 1 year after Graduation
   • Pre-employment documents (MSPE and all letters of recommendation)
   • On-boarding documents (check-in packet, fire/safety, fluoro, DH attest, fatigue training, etc.)

5. Documents to discard 1 year after request
   • Request for verification of training including release forms

B. Hartford HealthCare Human Resources
1. Documents to be kept permanently
   • Database of all employment records
   • W2’s