GEORGETOWN UNIVERSITY | MedStar Health

PODIATRIC MEDICINE AND SURGERY RESIDENCY

Approved by the Council on Podiatric Medical Education
With the added credential in Reconstructive Rearfoot/Ankle Surgery

Residency Manual

110 Irving Street NW Washington, DC 20010

Program Director: John Steinberg, DPM, FACFAS

Assistant Program Director: Caitlin Zarick, DPM FACFAS

AVP GME: Jennifer Remington, MHSA

Program Manager: Obi Faluro, MSPH

NOTICE

This Resident Manual provides detailed information and an outline of the program structure. It is meant to serve as a reference tool. Please clarify any questions or concerns directly with the Program Director.

The MedStar House Staff Manual is the system wide tool and reference for institution and program policy. If there is a conflict between this Resident Manual and the MedStar House Staff Manual, then the MedStar House Staff Manual shall supersede the Resident Manual.

The MedStar House Staff Manual is appended to the end of this Resident Manual for your reference.

2025 - 2026 PODIATRIC SURGERY RESIDENTS

PGY 3
Patrick Kagel, DPM (Chief Resident)
Tarina Ayazi, DPM
Alex Dang, DPM
Mitchell Goldman, DPM
Alyson Boudreau, DPM
Carley Smelkinson, DPM

PGY 2
Harsh Bhavsar, DPM (Academics Chair)
Robert Chubb, DPM (Research Chair)
Azeen Farahani, DPM
Landon Hadley, DPM
Anitha Machupalli, DPM (Student Chair)
Jenna Whited, DPM

PGY 1
Abigail Anderson, DPM
Courteney Asase, DPM
Sibella Campbell, DPM, MA
Faty Dieye, DPM
Christian Elder, DPM
Timothy Hoffmeister, DPM

RESIDENCY EDUCATION COMMITTEE

- John Steinberg, DPM
- Caitlin Zarick, DPM
- Ali Rahnama, DPM
- Jonathan Furmanek, DPM
- Tiffany Hoh, DPM
- Jayson Atves, DPM
- Kurtis Bertram, DPM

The Residency Education Committee for the Medstar Health Georgetown University Podiatric Surgery Residency Program is composed of the above attending physicians. The committee meets twice yearly to discuss and refine the residency education program. This committee also conducts the required performance reviews of the individual residents at the same interval in which resident performance and evaluations are reviewed by the committee and the program director and assistant program director.

PMSR COMPREHENSIVE GOALS

Our program follows all CPME 320 guidelines and competencies, which all residents and faculty must adhere to. Please refer to, “Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies, Council on Podiatric Medical Education”, appended to this document.

Our program has been approved by the CPME for residency training. Please refer to the CPME 330 “PROCEDURES FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES”, appended to this document.

CPME COMPETENCIES

- Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
- Assess and manage the patient’s general medical and surgical status.
- Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
- Communicate effectively and function in a multi-disciplinary setting.
- Manage individuals and populations in a variety of socioeconomic and health-care settings.
- Understand podiatric practice management in a multitude of health-care delivery settings.
- Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

How MedStar Podiatric Residency Meets CPME Rotation Requirements:

Required Rotations:

Anesthesiology	MWHC Third Floor OR	2 weeks	PGY 2
Behavioral Sciences	MWHC Inpatient Psychiatry	2 weeks	PGY 1
Emergency Medicine	MWHC Ortho Trauma Service	1 month	PGY 2
Infectious Disease	MWHC ID Inpatient	2 weeks	PGY 2
Internal Medicine	MWHC Medicine Wards	1 month	PGY 1
Medical Imaging	MWHC Radiology	2 weeks	PGY 2
General Surgery	MWHC Trauma Surgery	1 month	PGY 1
Podiatric Medicine	MWHC Core, Perez, Feldman	10.5 months	PGY 1, 2, 3
Podiatric Surgery	MWHC Pod, Kaiser VA, Kaiser MD, Balt	8 months	PGY 1, 2, 3
Surgical Intensive Care Unit	MWHC SICU	2 weeks	PGY 1

Medical Subspecialty Rotations:

Intensive Care	MWHC SICU	2 weeks	PGY 1
Wound Care	MGUH Center for Wound Healing and Limb Salvage Team	4 months	PGY 1, 2
Pediatrics	CNMC Ortho	2 months	PGY 2

Surgical Subspecialty Rotations:

Orthopedic Surgery	CNMC Ortho	2 months	PGY 2
Vascular Surgery	MGUH Vascular Surgery	2 weeks	PGY 2
Plastic Surgery	MGUH Plastic Surg	2 months	PGY 3

GOALS OF THE PROGRAM

- Provide an intensive 3 year experience in multidisciplinary graduate training for the podiatric surgeon.
- Provide instruction in all phases of podiatric medicine and surgery that comply with the graduate educational training program requirements for board eligibility in the American Board of Foot and Ankle Surgery and the American Board of Podiatric Medicine to comply with the Council on Education Requirements.
- Emphasize the importance of basic sciences to clinical practice and provide further knowledge in those subjects fundamental to the resident's specialty.
- Provide in depth education in the most recent preventative, diagnostic, and treatment considerations available to the specialty of podiatric medicine and surgery.
- Develop the resident's ability to provide comprehensive surgical care of the foot and ankle to include pre and post operative decision making.
- Educate the resident on assessing a patient's physical ability to undergo anesthesia for surgical procedures.
- Provide orientation in research methodology and evaluation and permit development for personal research potential.
- Develop the Resident's fundamental teaching skills in Biomechanics and Foot and Ankle Surgery.
- Provide the resident the ability to learn the proper procedures for grant application and funding.
- Develop an understanding of value and indications for hospitalization for patients requiring podiatric services.
- Provide experience in using pharmacological agents for the treatment of podiatric conditions.
- Develop an understanding of application of advanced surgical wound care techniques.

ORIENTATION

Just before beginning the residency year in July, a period of approximately 2 weeks in June will be dedicated to orientation and instruction of new residents on their duties and responsibilities within the hospital's podiatric service. This is in addition to a system wide MedStar orientation given to all new residents of all specialties outlining the hospital's procedures and policies.

RESIDENT RESPONSIBILITIES

- Members of the resident staff are expected to abide by the policies of Medstar Washington Hospital Center at all times.
- The resident must be familiar with and abide by the rules/regulations of the hospital staff, departments, and committees of all affiliated institutions.
- **At all times, your patients are to be your first consideration.** Visit each of your patients at least once daily, give them professional care as the attending physician directs and make progress notes of all significant events in the development of the case.
- Provide complete privacy for each patient during examination and also in protection of their medical records and personal information.
- Do not sit on the patient's bed unless it is necessary for examination.
- Guard against unnecessary conversation within the hearing range of other patients in clinic rooms, patient rooms, etc.
- Never disparage any physician or the hospital to a patient.

ADDITIONAL INFORMATION

- The resident will be assured of appropriate health and malpractice coverage policies; the amount to be determined at the beginning of the training year.
- The resident is directly responsible to the Director of Podiatric Surgery Residency.
- As the resident rotates through various departments, the resident will be ultimately responsible to the Chairman of that particular department.
- On each rotation, the Podiatric Surgical Resident will not assume any responsibility for patient care or management except at the discretion of the attending physician or surgeon on that particular service.
- The resident's daily/weekly schedule for each particular rotation will be determined by that particular department team/chair.
- The resident will have the choice and available resources for research publication during his/her years at the hospital.
- The resident will be given a formal contract from Medstar Washington Hospital Center, to be renewed annually. Refer to the House Staff Manual for details and explanation of salaries and benefits.

GME EDUCATION FUNDS

Each resident will have an Education/Book Fund in the amount of $833/year from the Graduate Medical Education Department that can be used for personal educational expenses including a max of $750 for computer/iPad/phone purchases.

RESIDENT ATTENDANCE AT CONFERENCES

- Residents will be registered by our Program Manager for three major conferences/courses according to class:
    - PGY1: ACFAS Fixation Fundamentals Course
    - PGY2: ACFAS Arthroscopy
    - PGY3: Baltimore Limb Deformity Course
- All residents are encouraged to attend major local conferences such as APMA Annual, DLS, etc.
- It is encouraged to attend the ACFAS Scientific Annual conference by submitting an abstract or poster for acceptance.
- If you have a special interest in attending a meeting that is not outlined above, you can apply for permission to use your educational funds from the hospital to accomplish this.

ABSTRACT SUBMISSION TO CONFERENCE

- Residents can always apply for consideration to attend additional meetings (ACFAS, ADA, AOA) if you present a poster or a manuscript and are accepted by the Scientific Committee.
- Topics and conference requests must be submitted to the Program Director once you BEGIN working on it.
- Poster must be submitted to Dr. Steinberg **one month** before the submission deadline.
- Dr. Steinberg will decide if the topic and conference are appropriate and will assign a mentor (attending or MGUH Fellow) to help refine the poster/manuscript.

MENTORSHIP PROGRAM

Mentorship is available and encouraged at all levels. Each of the core program faculty are available to all residents for mentorship, coaching, and advice. We also encourage senior resident mentorship for new residents and peer to peer support is vital to everyone's success.

Structured Faculty Mentor Program:

This program assigns a core faculty member to each PGY class for the year. The faculty mentor will serve as the go to mentor for the entire class and meet with them regularly as a group. There is budgeted program money set aside for in person gatherings of $250 per quarter for each group. The goal of this program is for the residents of each PGY to meet regularly with their assigned class mentor and also for there to be group team building and wellness activities.

PGY1 Class Mentor: Kurtis Bertram, DPM

PGY2 Class Mentor: Jayson Atves, DPM

PGY3 Class Mentor: Ali Rahnama, DPM

GENERAL CONDUCT/KEY RULES AND REGULATIONS

- Residents will conduct themselves in a professional and courteous manner at all times.
- Patients will be treated with compassion and confidentiality. Medical staff and other employees will be treated with respect. Discussions regarding podiatric attending staff are not to be held in front of or with patients, students or other staff members.
- Unless otherwise directed, discussions that are held between you and your attending(s) and/or supervisors are to be considered confidential and must not be repeated to other residents/attendings/staff without prior approval
- You must wear your official hospital photo identification badge above your waist at all times.
- You will be provided with a schedule of your required residency rotations.
- Your attendance is REQUIRED in order to complete these rotations. Each rotation begins on the first of each month and ends on the last day of that month. Only the Residency Director or the assigned Site Director/Coordinator may excuse your absence. ½ month rotations are 1-15 and 16-month's end.
- Residents are not to accept fees or gratuities from patients, their relatives or friends.
- You will not practice your profession or assist any physician outside the affiliated institutions.
- No alcoholic beverages are permitted in the hospitals. No person who has been drinking may attend to a patient.
- Smoking in the hospitals is prohibited.
- Fraternization with patients is prohibited.

COMMUNICATION

- All residents are issued a pager. All residents must keep their pager with them and in operation at all times, unless on leave (vacation/sick/authorized) or unless otherwise excused by the Director of Podiatric Medical Education. If pages are forwarded to a cell phone, then you may use this instead of a pager.
- All residents are to maintain a working cellular phone and be accessible 24/7.
- Official communications from the residency program will generally occur via email.
- Each resident is responsible for checking e-mail DAILY, unless on leave. Each resident is responsible for keeping the Director informed of a current email address for his or herself. **You must check your MedStar email daily**.

PHOTOGRAPHING AND RECORDING OF PATIENTS POLICY

Refer to Section 2.57 of the House Staff Manual.

CORPORATE POLICIES/ CONFLICT OF INTERESTS POLICIES

Refer to Section 6.8 of the House Staff Manual.

PODIATRIC SERVICE SPECIFIC RESPONSIBILITIES

- Residents on the podiatric service are responsible for all inhouse patients. First and second year residents are responsible for updating the third year residents and the attendings on the patients' status on a daily basis. Morning rounds are to be completed in a timely manner (usually before 7:30 AM) and all attendings updated by 9-10 AM.
- Initial consults will be seen by the on-call resident and any other available member of the team, who will then update the attending on call within a timely manner.
- Third year residents will be ultimately responsible for inhouse patients and surgery. He or she will be available at all times to answer questions from junior residents regarding patient care and management.
- Senior residents will be ultimately responsible for contacting surgery centers and updating the surgery schedule in advance. Senior residents will be in charge of assigning cases to junior residents. All cases will be covered, if possible. The Program Director and or the Chief Resident must be advised of any potentially non-covered cases.
- Residents are responsible for ensuring NPO status, consent for surgery, and medical clearance for pre-op patients.
- The resident claiming first assist in the surgery is responsible for post-op notes, orders, and dictations. All cases performed at MWHC must be dictated in a timely manner. All cases performed at surgery centers must be dictated before leaving the surgery center.
- The senior resident for the in-house team should be aware of all consults that come in overnight. In addition, the senior resident will be responsible for assigning a period of rest to the on-call resident if needed in attempt to avoid resident exhaustion and burnout. We encourage all junior residents to openly express if he/she needs to rest as a result of feeling ill or sleep deprivation from overnight call.

DRESS CODE

- Professional attire or surgical scrubs need to be worn at all times while on duty and at academic events. Clean white coat should be worn for all instances involving patient contact, unless otherwise prohibited. Surgical scrubs will be worn for surgical procedures as provided by each facility. Correct surgical scrubs are required for each facility. You must change scrubs each day.
- Refer to section 2.8 in the House Staff Manual for further details.

TASK ACTIVITIES FOR PODIATRIC SURGERY

- Please see “In-House Responsibilities” handout for specific roles and responsibilities.
- Resident is to perform preoperative medical and podiatric H & P’s
- Resident is to fill out all pertinent information on consent form for all outpatient surgeries at bedside prior to induction of anesthesia
- Resident is to evaluate pre- and post-operative x-rays
- Resident is to evaluate results of laboratory tests
- Resident is to participate in pre- and post-operative care of all podiatric inpatients
- Resident is to participate as the first assistant in podiatric surgery
- Residents are to document participation in the patient’s chart and complete a brief post- operative note
- Resident is to be exposed to the late follow-up of surgical patients in the offices of podiatric attendings and hospital clinics
- Resident is to attend all scheduled lectures
- Resident is to inform the Program Director or Chief resident if he/she is unable to attend academics. Approval must be granted by the program director or chief resident if he/she is to miss academics/lecture for extenuating circumstances (i.e. surgical case)

ROUNDS

- Rounds with attendings are mandatory. Residents are to attend rounds and present any update in the status of the patient with current vital signs, labs, orders, or any other pertinent information. Being prepared beforehand is key. Residents are to obtain vital signs, labs, or any room changes before rounds.
- PRE-OP ROUNDS
    - Complete Pre Op Note
    - Clearance
    - Orders
    - Consents
    - X-rays
- POST-OP ROUNDS
    - All patients to be seen daily with written progress notes
    - Daily status report to be given to attending
    - Residents must call any attending with a patient in-house with a status report of the patient after morning rounds on a daily basis.

ON CALL SCHEDULE

- Residents will alternate days and have at least one full weekend of call while on the podiatric service.
    - Weekday call from 6am – 6am
    - Weekend call from Friday 6am to Monday 6am
- There will be an assigned resident on “second-call” daily, to be available 24 hours a day to answer questions from the “on-call” resident.
- Residents are responsible to be present for any emergencies that require immediate surgery or in hospital care.
- Residents answer to podiatric medicine and surgery attending physicians, while their patients are in the hospital, admission through discharge.
- Patients are to be seen and evaluated daily by the on-call resident and followed up by the senior resident.
- Rounds (am) are conducted each day before surgeries begin. Daily reports to attendings are mandatory. The on-call resident is to communicate with attending regarding times for daily rounds.
- Call may be taken at home unless there is an emergency needing immediate and constant attention.

CLINIC

- Attendance is mandatory for assigned residents on the Medstar Washington Hospital Center podiatry rotation. Other residents are welcome to assist in the clinic if they have down time as long as it does not interfere with their responsibilities of the specific rotation they are in for the month.
- Purpose: To afford the residents clinical and educational exposure and provide the following:
- An opportunity to observe and participate in the working operation and business management of a clinical practice. This will include billing and accounting mechanisms, ordering process and maintenance of clinical supplies and materials, utilization of office personnel and equipment and practice management procedures.
- To provide an opportunity for supervised participation in the diagnosis and treatment of clinic patients in, but not limited to, the following areas:
    - Podiatric Medicine
    - Podiatric Surgery
    - Orthopaedics
    - Biomechanics
    - Dermatology
    - Diagnostic Radiology
    - Pharmacology
- To observe and participate in the follow-up care of clinic patients.
- To observe and participate under supervision in the general management of a clinical practice:
    - Scheduling patients
    - Coordinating Hospital and Clinic affairs
- To provide an opportunity to inter-relate with a supervisor on a one-to-one basis for individual patient work-ups, diagnosis, and treatment plans.

DUTY HOURS

Refer to Section 2.14 of the House Staff Manual.

DIDACTICS/ACADEMIC CONFERENCES

- Educational Meetings are designed to augment the clinical content of the program. These meetings are held weekly on Wednesday afternoons. Attendance is mandatory. Attendance conflicts must be brought to the attention of the Program Director and the Chief resident prior to the meeting. Unauthorized absences will lead to loss of vacation/annual leave days.
- Residents are to use online and library resources for weekly lectures and academic reviews.
- The chief resident will coordinate weekly team review and discussion on these topics and will maintain a schedule.
- Rotating students at MWHC are to be included in these academic reviews.
- Journal Club will be held at least monthly during Wednesday afternoon academics. Generally, the chief resident or delegate will assign these articles via email, to be read and prepared to discuss. Typically, residents on the podiatric service will be charged with leading the group discussion. Attendance is mandatory.
- Podiatry Grand Rounds / Case Conference / M&M are held at 6pm on the first Wednesday of each month. Attendance is *mandatory.*
- Cadaver Surgery Workshops will be held at least every other month.
- Online Resources via Medstar SITEL and Starport
- SITEL Simulation Lab- held semiannually
- Please make use of the APMA free online education series: http://www.redrc.org/index.cfm

RESEARCH

- Residents may participate in research activities of the podiatric service and will be assigned duties/activities by the director of the research, residency director and/or research fellows.
- Each resident may initiate a research proposal/project during their residency program.
- Although research is not mandatory, it is highly encouraged and recommended that a resident be involved in at least one publication in a peer reviewed journal during their residency training.
- Peer reviewed journals require substantive contribution to be a co-author which is determined by the Principal Author/Investigator.
- Residents will be exposed to the research process including: conception, execution, data collection, analysis and writing.

ACADEMIC IMPROVEMENT POLICY/ RESIDENT REMEDIATION POLICY
Refer to Section 4.1 in the House Staff Manual

UNPLANNED ABSENCES/SICK DAYS POLICY

- If there is an outstanding circumstance (i.e. illness, extreme snow/inclement weather, etc.) that requires you to be absent for any days during the rotation, the resident must inform the Residency Director as well as the Chief Resident and head of the rotation prior to your absence. They should also be informed or/approve any scheduled appointments (i.e. doctor's visit, board exams, etc.) in advance.
- Please provide the Residency Program Manager with any change of address, phone number and/or emergency contact information.
- Sick days will be taken from your allotted vacation time.

VACATION POLICY

- Residents are allowed 3 weeks of vacation per year, one week at a time.
- All vacation requests must be submitted to the chief resident at the beginning of the academic year.
- No more than 1 week of vacation at a time.
- Vacations are 7 days long, DO NOT EXPECT TO GET BOTH THE WEEKEND BEFORE AND AFTER OFF
- Vacations should be scheduled during rotations that are one month in duration or greater.
- No two residents on the same service may take the same vacation week.

MOONLIGHTING AND OUTSIDE PROFESSIONAL EMPLOYMENT

Refer to Section 2.31 of the House Staff Manual.

LOGGING POLICY

- All logs are kept accurately utilizing the Podiatry Residency Resource Online Case Log System (PRR). You will be assigned a login code, and will receive this via email directly from PRR.
- Each resident should keep a daily log including all surgical procedures and clinical- patient interactions.
- These logs are submitted to the Residency Director for review, evaluation, verification,and electronic signature.
- Please refer to the CPME website for proper logging instructions.

EVALUATIONS AND REMEDIATION

- Evaluations will be completed on-line through New Innovations. Each rotation director and other assigned faculty will evaluate residents based on the objectives established for each rotation. Rotation evaluations will also be shown to each resident, as they are made available to the Residency Director. Residents will sign off on the evaluation, and may add comments disputing the evaluation. The Residency Director will review the evaluation and comments, and take necessary action.
- Face to face and written Semi-annual evaluations with the Program Director utilizing input from the Residency Education Committee will also be held twice a year for each resident.
- Program and faculty evaluations will be completed anonymously by all residents
- Residents are responsible for assuring that evaluations are completed for all NON PODIATRY rotations. Evaluations should be completed by an attending.
- Exit interviews: Each resident will complete final written evaluations and have a verbal exit interview with the Program Director in June just prior to graduating from the program. This interview will include the resident's overall evaluation of the program, the programs administration and provide them an opportunity to identify problem areas and suggest improvements in the program.

EXTERNS/STUDENT CLERKSHIPS

- Students are with us primarily as learners, and are not to be treated as free labor. They should be treated at all times with respect, and common courtesy should be extended to them.
- An effort should be made to teach students/externs. "Down-time" is perfect for this.
- Challenging questioning is allowed and even expected, but not acceptable if it is "extreme" or malicious. The same policy applies to attendings.
- Despite how friendly you might become with students, remember that they are prospective residents of the program. Never disparage any physician, the hospital or the residency program to visiting externs or students. Private matters concerning attendings, residents, residency policy issues and other such matters should not be discussed in front of the students.
- The student coordinator PGY2 will assist with Externship / Student Clerkship logistics and communication

MEDSTAR HEALTH GEORGETOWN UNIVERSITY
PODIATRIC SURGERY RESIDENCY PROGRAM

ROTATION GUIDELINES & COMPETENCY MANUAL 2024

BEHAVIORAL MEDICINE (PSYCHIATRY)

ROTATION GOALS

- Become familiar with common psychiatric conditions often seen in the hospital including but not limited to:
    - Mood disorders including
        - Major depression, dysthymic Disorder, Bipolar disorder, Cyclothymic disorder
        - Anxiety or comorbid anxiety such as panic, OCD, PTSD, GAD
    - Suicidal/Homicidal thinking or actions
    - Substance abuse or comorbid substance abuse/dependence
    - Cognitive disorders (delirium or dementia)
- Become familiar with common medications used in and dosing regimens for the treatment of psychiatric conditions.
- Become knowledgeable of the value of the Psychiatrist/Psychologist in the care of the Podiatric patient and when to make the appropriate referral.
    - Formulate multi-axial differential diagnosis on selected cases.
    - Evaluate the psychiatric manifestations of brain disease, of known etiology, or pathophysiology.
    - Explain the concepts of personality & personality disorders as they relate to physical and mental illness.
    - Evaluate, and explain the management of patients with:
        - psychoses associated with schizophrenia, affective, general medical, or other psychotic disorders.
        - uncomplicated mood disorders & uncomplicated anxiety disorders.
        - acute reactions to stress, adjustment disorders, somatoform, eating, and/or psychosexual disorders.
    - Present to faculty a diagnostic formulation and undertake a differential diagnosis.
    - Differentiate organic/medical problems from other psychiatric disorders.
    - Learn and apply the ethical, legal, and professional aspects of psychiatric practice that are of particular relevance to the elective experience.

CPME 320 COMPETENCIES FOR BEHAVIORAL MEDICINE ROTATION

- Section 6.1.A
    - Understanding of psychosocial aspects of health care delivery.
    - Knowledge of and experience in effective patient-physician communication skills.
    - Understanding cultural, ethnic and socioeconomic diversity of patients.
    - Knowledge of the implications of prevention and wellness.

ATTENDING PHYSICIANS

- Dr. Sara Jones
- Dr. Chan Dang-Vu
- Dr. Jean D'Souza
- Dr. Andrew Radu
- Dr. Stephen Peterson
- Dr. Risa Fishman
- Dr. Benjamin Raatjes
- Dr. Elspeth C. Ritchie, MD (Chair)
- MGUH Psych Resident (changes every 2 months)

CHECK-IN / POINT OF CONTACT

- Before the beginning of the rotation, the resident should contact Nadine Mathis (nadine.a.mathis@medstar.net)
- On the first day, please report to East Building room 3105

WEEKLY SCHEDULE

Monday 8:30 AM
Tuesday 8:30 AM
Wednesday 8:30 AM
Thursday 8:30 AM
Friday 8:30AM

RESIDENT RESPONSIBILITIES

- Shadow fellow and/or resident
- Be involved in patient care
- Focus on suicide, mood disorders, & capacity

ASSESSMENT TOOLS

Montreal Cognitive Assessment (MoCA) Version 7.1 (Click to download)
Mini-Mental State Examination (MMSE) (Click to download)
STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE) (Click to download)
VAMC Saint Louis University Mental Status Examination (Click to download)
ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) (Click to download)

HELPFUL RESOURCES

Medical Clearance of Psychiatric Patients 2011 (Click to download)
Decisional Capacity (Click to download)
English law for the surgeon I Consent, capacity and Competence 2011 (Click to download)
A guide to assessing decision making capacity 2004 (Click to download)

The Depressed Patient And Suicidal Patient In The Emergency Department: Evidence-Based Management and Treatment Strategies 2011 (Click to download)
Guideline for Assessing and Managing the Suicidal Patient (Click to download)
Mood Disorders and Suicide - Textbook chapter (Click to download) (Click to download)
Diagnosis of mental disorders (very basic overview) (Click)
Common Psychiatric Disorders Chapter 25 (Click)
A Short Course in Psychiatry, (James Morrison, M. D., Oregon Health & Science University, January 2009) (Click)
The Psychiatric Review of Symptoms: A Screening Tool for Family Physicians, AFP 1998 (click)
Psychiatric Illness and Diabetes: An Overview –Psychiatric Aspects of Diabetes Mellitus (Trigwell, Peveler) APT 1998 (click)
The cost of mood disorders in patients with chronic wounds 2012 (click)

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to function with appropriate level of confidence and self-reliance in Behavioral Medicine clinical setting.
- Resident demonstrates reliability and professional responsibility in the completion and fulfillment of tasks and duties.
- Resident exhibits understanding of the psychosocial aspects of health care delivery.
- Resident functions as an integral team member and communicates effectively with other members of the Behavioral Medicine team.

VASCULAR SURGERY

ROTATION GOALS

- Demonstrate the use and interpretation of Non Invasive Vascular Laboratory testing modalities.
- Demonstrate knowledge of the pathophysiology, diagnosis, and treatment of arteriosclerosis, aneurysms, fistulas, venous insufficiency, phlebitis, peripheral edema, vascular trauma, thrombophlebitis
- Demonstrate the proper tests in order to diagnose and assess deep and superficial venous incompetency.
- Demonstrate the techniques, indications, and use of compression stockings.
- Demonstrate the ability to clinically assess of the patient with peripheral vascular disease, acute arterial insufficiency, intermittent claudication, chronic arterial occlusive disease, and critical limb ischemia.
- Demonstrate an ability to utilize the laboratory, radiographic and diagnostic techniques of acute arterial occlusion.
- Demonstrate the ability to diagnose and evaluate the clinical manifestations of peripheral arterial aneurysms.
- Demonstrate knowledge of medical and surgical protocols and techniques for arterial revascularization.
- Demonstrate knowledge of the medical and surgical protocols and techniques for salvage and reconstructive surgery.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - B6: Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to:
        - Understanding management of preoperative and postoperative surgical patients with emphasis on complications. Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision. Understanding surgical procedures and principles applicable to nonpodiatric surgical specialties

ATTENDING PHYSICIAN(S)

- Cameron Akbari, MD

CHECK-IN / POINT OF CONTACT

- One week before the beginning of the rotation, the resident should contact the Chief Resident of Vascular Surgery. The easiest way to contact the chief is by paging Vascular surgery on call

WEEKLY SCHEDULE

Monday- Friday 5:30am-6pm

RESIDENT RESPONSIBILITIES

- Pre Rounds in the AM
- Perform all surgical cases assigned with special attention to Lower Extremity Angiograms and Bypasses

DRESS CODE

- Hospital Scrubs/White Coat

PEARLS

- Spending as much time w/ Dr. Akbari will allow the resident to gain as much knowledge, hands on surgical skills and competency in the vascular surgical field.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to become experienced in the use of noninvasive techniques to evaluate vascular disease.
- Resident is able to assist in and take an active role in vascular surgical cases.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident has become familiar with primarily diagnostic arteriography and can appropriately interpret results

ANESTHESIOLOGY

ROTATION GOALS

1. To demonstrate an understanding of the anesthetic considerations for a variety of medical conditions and perform the appropriate/necessary preoperative assessment/preparation of the patient.
2. To acquire the knowledge necessary to conduct appropriate fluid and blood component therapy
3. To recognize and describe the main drug classes frequently used in the perioperative period
4. To review and describe the principles of acute pain management.
5. To acquire basic skills in airway management

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1B
    - 7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to: Local anesthesia. General, spinal, epidural, regional, and conscious sedation anesthesia.

ATTENDING PHYSICIAN

- Dr. Phillipe Phung

CHECK-IN / POINT OF CONTACT

- Before the beginning of the rotation, the resident should contact Latasha Cook 2 days prior to the start of your rotation at 202-877-7504. On the first day, please report to Latasha Cook (her office is near the Main OR) to obtain your schedule for your rotation.

WEEKLY SCHEDULE

This will be distributed on the first day of your rotation

.

RESIDENT RESPONSIBILITIES

- Participate in all surgical cases you are assigned to. If not assigned to cases that day ask if any help is needed in Main OR or 3rd floor OR that day.
- Be on time every day as tardiness is unacceptable.

DRESS CODE

- Hospital Scrubs

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat anesthetic concerns in the inpatient and outpatient setting
- Resident able to successfully intubate, manage anesthetic gases intra-op, and successfully extubate patient.
- Resident is familiar with anesthesia decision making for case selection, patient medical clearance for surgery, and ASA classification of risk.

Orthopaedic Trauma Service - MWHC

ROTATION GOALS

- Gain knowledge in management of Emergency Medicine patients with orthopedic trauma pathologies.
- Learn the medical and surgical management of the trauma service patient.
- Participate in Trauma and Emergency Room Care for patients with acute trauma and polytrauma.
- Gain comfort in managing the acute emergency medicine patient and perform triage for medical and surgical care.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
    - 1. Perform and interpret the findings of a thorough complete history and physical exam, including problem-focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis.
    - 2. Formulate an appropriate diagnosis and/or differential diagnosis.
    - 3. Order and interpret appropriate diagnostic studies, including:
        - Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT.
    - B. Assess and manage the patient's general medical and surgical status.
        - Perform and interpret the findings of comprehensive medical history and physical examinations (including preoperative history and physical examination).
        - Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals.
        - Understanding management of preoperative and postoperative surgical patients with emphasis on complications.
        - Enhancing surgical skills, such as suturing and retracting.
    - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
        - Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.
        - Practice and abide by the principles of informed consent.
        - Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.
        - Demonstrate professional humanistic qualities.
    - D. Communicate effectively and function in a multi-disciplinary setting.
        - Communicate in oral and written form with patients, colleagues, payers, and the public.
        - Maintain appropriate medical records.
    - E. Manage individuals and populations in a variety of socioeconomic and

health-care settings.

- Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.
- Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.

- G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
  - Read, interpret, and critically examine and present medical and scientific literature.
  - Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.
  - Demonstrate information technology skills in learning, teaching, and clinical practice.
  - Participate in continuing education activities.

- 6.1B #8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.

ATTENDING PHYSICIAN(S)

- Robert Golden, MD
- Evan Argintar, MD
- James Tozzi, MD
- David Hampton, MD

CHECK-IN / POINT OF CONTACT

- Page the on-call orthopedic resident 1 week before your rotation to inform them you will be arriving

CHECK-IN / POINT OF CONTACT

- Before the beginning of the rotation, resident should contact Dr. Robert Golden
- On the first day, please report to MWHC Orthopaedic Clinic 5th floor POB North.
- Forms to be completed before starting rotation (if applicable): none

WEEKLY SCHEDULE

Monday – Conference at 6:30 am in Siegel
Tuesday – RTL at 7:00am in Ortho Conference Room (5th floor POB)
Wednesday – RTL at 7:00am in Ortho Conference Room (5th floor POB)
Thursday – Oncology conference at 6:30 am
Friday – RTL at 7:00am in Ortho Conference Room (5th floor POB)

DRESS CODE

- Scrubs in OR

- Clinical Attire + white coat in clinic

COMPUTERS / DOCUMENTATION GUIDELINES

- Per MWHC standard.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed.

- Resident is able to adequately diagnose and treat patients in the emergency setting.
- Resident is able to function with appropriate level of confidence and self-reliance in the emergency/trauma setting.
- Resident is able to manage pre and post operative medical concerns in the emergency / trauma patient.
- Resident is able to interact with emergency room / trauma bay team and facilitate proper patient triage.

INTERNAL MEDICINE

ROTATION GOALS

- Ability to take a good medical history and perform a careful and accurate physical examination.
- Ability to write concise, accurate and informative histories, physical examinations and progress notes.
- Develop strategies to efficiently evaluate and manage common inpatient medical problems.
- Ability to formulate comprehensive and accurate problem lists, differential diagnoses and plans of management.
- Ability to make basic interpretation of chest and abdominal x-rays.
- Ability to make basic interpretation of electrocardiograms.
- Understanding the basic pathophysiology, clinical manifestations, diagnosis and management of medical illnesses commonly seen by a general internist in the ambulatory setting.
- Communicate effectively with physician colleagues and members of other health care professions to assure comprehensive patient care.
- Interact professionally towards patients, families, colleagues, and all members of the health care team.
- Identify and acknowledge gaps in personal knowledge and skills in the care of ambulatory patients.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1B. Assess and manage the patient's general medical and surgical status.
- 5: Participate actively in medicine and medical subspecialities rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.
- B. Assess and manage the patient's general medical and surgical status.
- 1. Perform and interpret the findings of comprehensive medical history and physical examinations (including preoperative history and physical examination), including (see Appendix A): Comprehensive medical history. Comprehensive physical examination. - vital signs. - physical examination including head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination. 2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s). 3. Recognize the need for (and/or order) additional diagnostic studies, when indicated, including (see also section A.3 for diagnostic studies not repeated in this section). EKG. Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound. Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis. Other diagnostic studies. 4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education. 5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.

ATTENDING PHYSICIAN

- Attending physician changes on a month to month basis

COORDINATOR

- Gaitri Tiwari (202-877-8271)

CHECK-IN / POINT OF CONTACT:

On the first day of the rotation, the incoming Podiatry resident should meet with the Chief Resident at Floor 2A, room 50 at 7:00 am to obtain your schedule and team assignment.

CHIEF RESIDENT CONTACT:

- 202-877-3111

WEEKLY SCHEDULE

Your schedule will be contingent upon which team and attending you are assigned
Below is an example of the common weekly schedule.

	Monday	Tuesday	Wednesday	Thursday	Friday
7:00 - 7:30AM	Preround	Preround	Preround	Preround	Preround
7:30AM-8:30AM	Morning Report	Morning Report	Morning Report (10:30-11:45 AM)	Morning Report	Chairman's Conference (9:00- 10:00 AM)
8:30-10:00AM	Work Rounds	Work Rounds	Work Rounds	Work Rounds	Work Rounds (7:30-9:00 am)

10:00-11:00AM	**Teaching Rounds**	**Teaching Rounds**	**Teaching Rounds**	**Teaching Rounds**	**Teaching Rounds(10:30 am-11:30am)**
12:00PM	**Noon Conference**	**Noon Conf**	**12:30PM Grand Rounds Main Auditorium**	**Noon Conf**	**Noon Conf**

		2-3PM Case Based Student Seminar with Teaching Resident 2A-50		**2-3PM Evidence Based Student Seminar 2A-50**	

RESIDENT RESPONSIBILITIES

- Your team will consist of two interns, a resident, yourself and a third-year student.
- You will be working directly with your team's resident who will assist you with the
- management of patients assigned under your care.
- You will be expected to carry between 1-2 patients for the majority of the rotation.
- The number of admissions will be determined by your resident depending on your current patient load and complexity.
- You are expected to write the admitting history, physical exam, initial laboratory evaluation, and plans for additional evaluation, treatment, and patient education under the supervision of your resident. You will write admitting orders on your patients to be countersigned by the resident.
- You should get your orders co signed before placing them in the chart.
- You should prepare the physician's problem list and keep it up to date.
- You are expected to write daily progress notes (SOAP notes) on all of your patients and these will be co- signed by your resident daily. You should prepare a flow sheet when appropriate.
- After discussing the patient with your resident you are responsible for contacting the patient's attending to review the patient's status and plans for further evaluation and treatment.
- You are also responsible for signing your patient out to the cross-covering intern before leaving each day. Your resident will help you prepare your sign-out sheet and

go over pertinent information to be shared with the covering intern.

DRESS CODE

- Business professional + white coat

COMPUTERS / DOCUMENTATION GUIDELINES

- On the day of your rotation, please provide your chief resident with your contact email address.

PEARLS

- Pick up the sign out list, daily from the night float team at 7 AM in room 2A50 on weekdays and house staff lounge (6^{th} floor) on weekends.
- You are also expected to round with your team on one of the weekend days to be determined by the team resident, this insures a total of 4 days off during your rotation.
- Given the call schedule, your day off may be scheduled on a weekday. Check with your resident about holidays.
- Your daily progress notes should be reviewed and co-signed by your resident EACH DAY
- You are encouraged to communicate with the attending and patients' families only after discussion with the resident.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to take an adequate medical history and perform a careful and accurate physical examination
- Resident is able to make recommendations about preventive, diagnostic and therapeutic options and interventions based on clinical judgment, scientific evidence, and patient preference
- Can the resident develop strategies to efficiently evaluate and manage common inpatient medical problems?
- Has the resident developed a familiarity with indications for and interpretation of chest and abdominal X-ray and electrocardiograms?

SICU

ROTATION GOALS

- Develop triage and management skills of the acute trauma patient in the inpatient setting
- Develop skills for stabilizing critically ill patient to include cardiovascular and respiratory emergencies
- Learn team approach for rapid assessment of critical patients
- Perform comprehensive H&P with total body assessment
- Gain skills in the perioperative management of the surgical patient including management of common postoperative problems such as fever, wound infection, hypoxia, hypotension, low urine output, mental status changes, nausea, vomiting and inadequate pain control.
- Gain skills in the interpretation of imaging studies including CXR, abdominal films, MRI and CT scans.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - B. Assess and manage the patient's general medical and surgical status.
        - 1,2,3,5
        -
    - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
        - 1,2,3,4,5
    - D. Communicate effectively and function in a multi-disciplinary setting.
        - 1,2
    - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
        - 1,2,3,4,5
    - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
        - 1,2,3,4,5

ATTENDING PHYSICIAN(S)

- Dr. Chadi Tanios Abouassaly, MD
- Dr. Alena Lira

CHECK-IN / POINT OF CONTACT

- Report to SICU on the start day of your rotation 2H ICU
- Contact Alena Lira, MD (alena.lira@medstar.net)

WEEKLY SCHEDULE

Monday- 6:30am-6:30pm
Tuesday- 6:30am-6:30pm; Weekly conference at 7am- 11am Wednesday- 6:30am-6:30pm
Thursday- 6:30am-6:30pm; Grands rounds at 7am-9am Friday- 6:30am-6:30pm
Saturday and/or Sunday- 6:30am-6:30pm
Allow up to one additional hour for evening signout (begins at 6:30pm)

- ICU didactic series Mo-Fri 12:30-1:30pm

RESIDENT RESPONSIBILITIES

- The residents are to assume responsibility and perform technical procedures commensurate with their experience, competence, respect and mutual trust. In general, this increases yearly with added experience, judgment and ability.
- Triage and assist in management of SICU patients

DRESS CODE

- Scrubs

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed:

- Resident is able to adequately assist in formulating working diagnoses/plan with SICU patients
- Resident is able to assist in and take active role in Trauma Service SICU patient triage and management
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident is able to function with professionalism in SICU Trauma Service setting.

Medical Imaging- Radiology

ROTATION GOALS

- To become familiar with the radiological tests available
- To understand the indications and contraindications of radiological tests
- To improve accuracy of interpretation of selected radiological studies
- To interpret radiologic studies taken in the inpatient, outpatient, and emergency room setting.
- Evaluate findings and special procedures
  - Understand and assist in special procedures (arteriography, biopsies, joint injections)
  - CT scans, MRI, radio nuclear studies, ultrasound

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1

  A 3: Perform (and/or order) and interpret appropriate diagnostic studies, including: Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, vascular imaging.

  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
  - 1,2,3,4

ATTENDING PHYSICIAN(S)

Dr. Jelinek

CHECK-IN / POINT OF CONTACT

- On the first day, please report to Kimberly Miller (Kimberly.M.Miller@medstar.net or 202-877-6429) on the ground floor in the Radiology Department.
- Upon arrival you will receive your schedule for the 1 week period.

WEEKLY SCHEDULE

	Time	Location
Monday	**8-4**	**WHC**
Tuesday	**8-4**	**WHC**
Wednesday	**8-4**	**WHC**
Thursday	**8-4**	**WHC**
Friday	**8- 4**	**WHC**

RESIDENT RESPONSIBILITIES

Be on time and show appropriate skills as a team player

DRESS CODE

- Business professional

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to successfully interpret various imaging including to include X-ray, MRI, and CT studies.
- Resident is able to distinguish between non-pathological and pathological findings in various imaging modalities.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident is able to understand the differing indications for various radiographic examination.

Infectious Disease

ROTATION GOALS

- To obtain a basic knowledge of diagnosis and medical management of infectious diseases
- Actively participate in patient care in the inpatient and outpatient clinical setting.
    - See patients for evaluation and treatment, complete notes, participate in active care
- Gain independence and efficiency in patient care in the clinical setting.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - B. Assess and manage the patient's general medical and status.
        - 9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences: Recognizing and diagnosing common infective organisms. Using appropriate antimicrobial therapy. Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring. Exposure to local and systemic infected wound care.
    - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
        - 1,2,3,4,5
    - D. Communicate effectively and function in a multi-disciplinary setting.
        - 1,2
    - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
        - 2,3
    - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
        - 1,2,3,4

ATTENDING PHYSICIAN(S) / FELLOW(S) (Vary month to month)

- Dr. Glenn Wortmann (Section Director)
- Dr. Saumil Doshi (ID Fellowship Director)
- Dr. Maria Ruiz (Attending physician)
- Dr. Leon Lai (Attending physician)
- Dr. Chris Woods (Attending physician)
- Dr. Sheena Ramdeen (Attending physician)
- Dr. Anjali Majumdar (Attending physician)

CHECK-IN / POINT OF CONTACT

- Check in with Ms. Dorothy Sackey, who will be outside Dr. Wortmann's office (2A56): Take the A elevators to 2nd floor, turn left & go through 'Department of Medicine' door. Make a right at the end of the hallway. 2A56 will

be on your left. She will page the fellow on the B consult service (9859), who will be working with you.

- WEEKLY SCHEDULE (every day in-patient rounds are performed)

RESIDENT RESPONSIBILITIES

- Direct participation of the resident in the evaluation and management of patients in a clinic/hospital setting.
- Perform and interpret the findings of comprehensive medical history and physical examinations (including preoperative history and physical examination), including:
  - Comprehensive medical history.
  - Comprehensive physical examination
- Formulate an appropriate differential diagnosis of the patient's general medical problem(s).
- Recognize the need for (and/or order) additional diagnostic studies, when indicated
- Possible presentation of journal article

DRESS CODE

- Business professional + white coat

PARKING

- As per WHC

COMPUTERS / DOCUMENTATION GUIDELINES

- Amalga, Medconnect

PEARLS

- Warren Joseph ID text

ROTATION SPECIFIC ASSESSMENT QUESTIONS

All questions are answered by "Excellent, Average, Below Average, or Not Assessed"

- Resident is able to assist in and take an active role on the ID Service.
- Resident is able to recognize and diagnose common infective organisms.
- Resident has understanding of appropriate antimicrobial therapy.
- Resident is able to interpret laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.

Kaiser Maryland Foot & Ankle (Podiatric Surgery)

Contact Person: Medical Education Coordinator 301-816-5672 or (Please contact one month before you start this rotation to make sure you are all set for your rotation at all of the Kaiser locations)

ROTATION GOALS

- Cover all surgical cases any day of the week generated by the podiatry group.
    - If there is conflict, discuss with rotation director
- Actively participate in patient care in the outpatient clinical setting.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - A. Pevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
        - 1,2,3,4,5
    - B. Assess and manage the patient's general medical and surgical status.
        - 1,2,3,4
    - C. Practice with professionalism, compassion, and concern in a legal, ethical,
      and moral fashion.
        - 1,2,3,4,5
    - D. Communicate effectively and function in a multi-disciplinary setting.
        - 1,2
    - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
        - 1,2,3
    - F. Understand podiatric practice management in a multitude of health-care delivery settings.
        - 1,2,3,4,5
    - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
        - 1,2,3,4

ATTENDING PHYSICIANS

- Tim Swartz, DPM – Division of Podiatry Chairman
- Kristy Golden, DPM (Rotation Director)
- Jordan Tacktill, DPM
- Amit Luhadiya, DPM
- Jamie Chaffo, DPM
- Max Levene, DPM
- Steve Chatlin, DPM
- Dean Jones, DPM
- Khaled Madi, DPM
- Akbar Abyaneh, DPM

OTHER ATTENDING LOCATIONS FOR SURGERIE

- Gaithersburg
    - 655 Watkins Mill Rd, Gaithersburg, MD 20879

- OR #: 240-632-4293
- Park in the back lot (free)

WEEKLY SCHEDULE

- Schedule will vary as surgeries can be added on any day of the week.
- Check weekly OR schedule on EPIC (need attending assistance as residents do not have access to surgery schedule).
- Call after 3pm daily to see if any surgeries have been added on for the following day (see “KP Center Locations” section for direct OR phone #s).

RESIDENT RESPONSIBILITIES

- Prepare for and cover all surgical cases for the week.
  - Review notes, films, read texts, etc
- Be on time for surgery.
  - If you are running late you should inform attending directly
  - If you are late for surgery, do not interrupt a procedure that has already started
- Contact appropriate attending at least 1 day prior to surgery to inquire about any case specifics.
- If applicable, have MRI/radiographs either printed out or pulled up on the OR computer for each case.
  - Preferably reviewed on computer

DRESS CODE

- OR – Kaiser blue scrubs must be obtained at each surgical center.
  - Gaithersburg – ask Donna or front desk for assistance

PARKING

- Please see section on “KP Center Locations” above for details. All parking is free.
- Capitol Hill is connected underground to Union Station for those opting to travel via metro.

COMPUTERS & COMPUTER TRAINING

- Contact Kaiser Medical Education

MEALS

- Each location has a refrigerator and microwave readily accessible.
- Food establishments are either within short driving OR walking distance.
  - Capitol Hill is connected underground to Union Station, which has a large food court.

PEARLS

- Behave in a professional manner at all times. Patients receive an evaluation after each visit.
  - Dr. Swartz will explain this with you

- Accessing email @ KP requires going through several steps of security; as such, many attendings prefer communication via text message or telephone. Inquire with any questions/concerns.
- Be on time to all clinics and surgical cases. If you are going to be late or absent, please contact the appropriate attending via his or her communication method of choice.
- Kaiser Resident Badges are not available. Gaithersburg is the only center that will issue you a daily contractor's badge to access the OR, clinics, etc (ask security desk). Everywhere else you will have to ask someone to let you into areas requiring badge swipe entrance.

ROTATION SPECIFIC ASSESSMENT QUESTIONS

All questions are answered by "Excellent, Average, Below Average, or Not Assessed"

- Resident is able to adequately diagnose and treat podiatric concerns in the outpatient clinical setting.
- Resident is able to assist in and take active role in lower extremity surgical cases with good sense of leadership and autonomy.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident has technical surgical skills appropriate for his / her level of training.

Kaiser Virginia Foot & Ankle (Podiatric Surgery)

Contact Person: Medical Education Coordinator 301-816-5672 or (Please contact one month before you start this rotation to make sure you are all set for your rotation at all of the Kaiser locations)

ROTATION GOALS

- Cover all surgical cases any day of the week generated by the podiatry group.
    - If there is conflict, discuss with rotation director
- Actively participate in patient care in the outpatient clinical setting.
    - See patients for evaluation and treatment, complete notes, participate in active
      care
- Actively participate in diagnostic and therapeutic procedures.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
        - 1,2,3,4,5
    - B. Assess and manage the patient's general medical and surgical status.
        - 1,2,3,4
    - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
        - 1,2,3,4,5
    - D. Communicate effectively and function in a multi-disciplinary setting.
        - 1,2
    - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
        - 1,2,3
    - F. Understand podiatric practice management in a multitude of health-care delivery settings.
        - 1,2,3,4,5
    - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
        - 1,2,3,4

ATTENDING PHYSICIANS - DPM

- Robert Grandinetti, DPM– Division of Podiatry Chairman
- Ryan Ahalt, DPM
- Eleanor Wilson, DPM
- Matthew Testani, DPM
- Annie MccLenahan, DPM
- Daniel Short, DPM
- Christopher Bourke, DPM
- Virginia Parks, DPM

ORTHOPEDIC SURGEONS

- Roberta Kasman, MD
- Marc Kouyoumdjian, MD
- Jessica Hirschhorn, MD
- Donald Saroff, MD
- Anil Taneja, MD
- Brian Stephens, MD
- Sidney Chetta, MD
- Caroline Moazzam, MD

PLASTIC SURGEONS

- Chun Rhim, MD
- William Epps, MD

KP CENTER LOCATION

8008 Westpark Dr
McLean, VA 22102
(703) 287-6400

Contact Person for Cases:
Varsala: 703-287-6462

RESIDENT RESPONSIBILITIES

- Prepare for and cover all surgical cases for the week.
  - Review notes, films, read texts, etc
- Be on time for surgery.
  - If you are running late you should inform attending directly
  - If you are late for surgery, do not interrupt a procedure that has already started
- Contact appropriate attending at least 1 day prior to surgery to inquire about any case specifics.
- If applicable, have MRI/radiographs either printed out or pulled up on the OR computer for each case. Preferably reviewed on computer
- Personal matters, lectures, presentations should be completed on your own time, not during clinic time
- Cover all lower extremity cases with orthopedic surgeons willing to work with us.
- It is the Residents responsibility to stay in touch with Varsala about lower extremity cases as they get added on frequently.

DRESS CODE

- OR – Kaiser blue scrubs must be obtained at the surgery center

PARKING

- Please see section on “KP Center Locations” above for details. All parking is free.

MEALS

- The surgery center provides sandwiches in the Anesthesia Physician Lounge daily.
- There is a Harris Teeter up the street if all sandwiches are gone.

- There is a refrigerator in the Anesthesia Physician Lounge if you bring your lunch.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat podiatric concerns in the outpatient clinical setting.
- Resident is able to assist in and take active role in lower extremity surgical cases with good sense of leadership and autonomy.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident has technical surgical skills appropriate for his / her level of training.

Georgetown Limb Service (Plastic Surgery PGY3)

ROTATION GOALS

- Resident will gain knowledge in surgically evaluating and treating lower extremity wounds with plastic surgical principles and techniques
- Resident will become familiar with different biologic dressings and appropriate wound selection for their use.
- Resident will learn plastic surgery techniques used to treat different pathologies of the lower extremity including local and free tissue transfer
- Resident will gain experience in performing surgical procedures on the lower extremity.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
  - B. Assess and manage the patient's general medical and surgical status.
    - 6. Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to: 24 Understanding management of preoperative and postoperative surgical patients with emphasis on complications. Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision. Understanding surgical procedures and principles applicable to nonpodiatric surgical specialties.
  - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
    - 1,2,3,4,5
  - D. Communicate effectively and function in a multi-disciplinary setting.
    - 1,2
  - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
    - 1,2,3
  - F. Understand podiatric practice management in a multitude of health-care delivery settings.
    - 1,2,3,4,5
  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
    - 1,2,3,4

ATTENDING PHYSICIANS

- Dr. Christopher Attinger
- Dr. Karen Evans

CHECK-IN / POINT OF CONTACT

- Before/at the beginning of the rotation, resident should contact Kaitlin Wesley at 202- 444-1233. On the first day, please report to GME office.
- Forms to be completed before starting rotation : Rotation registration form and CV to be faxed to GUH GME; Kaitlin Wesley. Registration form will be emailed to you prior to your rotation.

WEEKLY SCHEDULE

Monday : Dr. Steinberg OR / Dr. Evans OR
Tuesday : Dr. Attinger OR
Wednesday : Dr. Atves/ Dr. Evans OR
Thursday : Dr. Atves/ Dr. Evans OR
Friday : Dr Attinger OR

RESIDENT RESPONSIBILITIES

- **PGY3**
  - **Help the plastics PGY3 with chief responsibilities to run the limb service.**
  - **Round on patients assigned to you prior to running the list with the rest of the team.**
  - **Complete appropriate preoperative and postoperative paperwork for patients going to surgery; including prescriptions and discharge instruction paperwork for same day surgery patients.**
  - **Cover clinic when you are not covering cases.**
  - **The resident will take call one weeknight per week and two weekends per month.**

DRESS CODE

- Scrubs. Scrub access can be granted by contacting linen/laundry services.

PARKING

- Your ID badge will allow access to the employee parking garage, which is at entrance 3 or 4, at no cost to the resident.

COMPUTERS / DOCUMENTATION GUIDELINES

- The same username and passwords for WHC will be used at GUH.

MEALS

- Refrigerator and microwave available in wound center conference room.
- Walking distance to Epicurean, Cosi, Starbucks, Subway, Chick Fil A
- Resident lounge in CCC building, floor 3 often times will have sandwiches in the refrigerator.
- A meal card will be provided to all residents with $10.00 applied to everyday the resident is taking a night shift.

PEARLS

Shadow the current WHC podiatry resident for 1-2 days prior to starting your rotation for instruction on how to prepare paperwork and facility tour.

- Allow plenty of time in the mornings to see all of your assigned patients prior to running the list.
- Be sure to review patient labs, antibiotics, allergies and X-rays prior to surgery.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat surgical wound patients with plastic surgical principles.
- Resident is able to appropriately assess and formulate treatment plans for plastic surgical repair including wound closure and tissue grafts.
- Resident is able to manage post operative complications from plastic surgery procedures of the lower extremity
- Resident is able to interpret laboratory values and correlate with clinical findings in preparation of surgical closure.

Georgetown Limb Service (Wound Care PGY1 and PGY2)

ROTATION GOALS

- Resident will become familiar with different biologic dressings and appropriate wound selection for their use.
- Resident will learn how to medically manage inpatients with wounds.
- Resident will gain knowledge in antibiotic therapy management for inpatients and outpatients with wounds
- Resident will learn perioperative management of wound patients.
- Resident will learn negative pressure wound care, topical wound care, wound assessment, wound triage, evaluate for wound infection, emergency room evaluation of wound patients..

- **CPME 320 COMPETENCIES FOR THIS ROTATION**
- Section 6.1
  - A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
    - 1,2,3,4,5
  - B. Assess and manage the patient's general medical and surgical status.
    - 1,2,3,4
  - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
    - 1,2,3,4,5
  - D. Communicate effectively and function in a multi-disciplinary setting.
    - 1,2
  - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
    - 1,2,3
  - F. Understand podiatric practice management in a multitude of health-care delivery settings.
    - 1,2,3,4,5
  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
    - 1,2,3,4

ATTENDING PHYSICIANS

- Dr. John Steinberg
- Dr. Christopher Attinger
- Dr. Karen Evans
- Dr. Jayson Atves
- Dr. Caitlin Zarick
- Dr. Richard Youn

CHECK-IN / POINT OF CONTACT

- Before/at the beginning of the rotation, resident should contact Kaitlin Wesley at 202- 444-1233. On the first day, please report to GME office.
- Forms to be completed before starting rotation : Rotation registration form and CV to be faxed to GUH GME; Kaitlin Wesley. Registration form will be emailed

to you prior to your rotation.

WEEKLY SCHEDULE

Intern and on call duties per team with rotation with other interns on service.

RESIDENT RESPONSIBILITIES

- Intern Resident is expected to take call pager every weekday.
  - Examine and formulate treatment plans for all patients the Limb Team is consulted on.
  - Resident will round two weekends per month.
  - Manage all inpatients and coordinate tasks with the wound care nurses.
  - Properly prepare in-patients for surgery which includes obtaining consent for
    surgery and blood, preop orders, assessing the need for blood transfusions,
    holding anticoagulants, contacting other services for risk evaluation, etc.
  - The resident will admit any patients from clinic that the attending feels is necessary.
  - The resident will work with attendings and NP team to provide wound care to inpatients, ER Consults, and clinic patients.

DRESS CODE

- Scrubs. Scrub access can be granted by contacting linen/laundry services.

PARKING

- Your ID badge will allow access to the employee parking garage, which is at entrance 3 or 4, at no cost to the resident.

COMPUTERS / DOCUMENTATION GUIDELINES

- The same username and passwords for WHC will be used at GUH.

MEALS

- Refrigerator and microwave available in wound center conference room.
- Walking distance to Epicurean, Cosi, Starbucks, Subway, Chick Fil A
- Resident lounge in CCC building, floor 3 often times will have sandwiches in the refrigerator.
- A meal card will be provided to all residents with $10.00 applied to everyday the resident is taking a night shift.

PEARLS

Shadow the current WHC podiatry resident for 1-2 days prior to starting your rotation for instruction on how to prepare paperwork and facility tour.

- Allow plenty of time in the mornings to see all of your assigned patients prior to running the list.
- Be sure to review patient labs, antibiotics, allergies and X-rays prior to surgery.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat common wound types including ischemic, diabetic, and pressure ulcers
- Resident is able to appropriately assess and formulate treatment plans for diabetic and venous stasis ulcers.
- Resident is able to identify clinical signs of infection and manage with antibiotic therapy or topical therapy
- Resident is able to interpret laboratory values and correlate with clinical findings as they relate to non healing wound patients and limb salvage.

General Surgery / Trauma Surgery

ROTATION GOALS

- Develop basic surgical skills including exposure, suturing, tying, flap elevation wound closure and vascular access.
- Gain skills in the perioperative management of the surgical patient including management of common postoperative problems such as fever, wound infection, hypoxia, hypotension, low urine output, mental status changes, nausea, vomiting and inadequate pain control.
- Gain skills in the interpretation of imaging studies including CXR, abdominal films, MRI and CT scans.
- Assist in the operating room: be able to provide exposure, suture, tie, use electrocautery properly, dissect tissue appropriately and close wounds effectively using interrupted and/or subcuticular sutures

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
  - B. Assess and manage the patient's general medical and surgical status.
    - 1,2,3,5
  - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
    - 1,2,3,4,5
  - D. Communicate effectively and function in a multi-disciplinary setting.
    - 1,2
  - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
    - 1,2,3,4,5
  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

- 1,2,3,4,5

ATTENDING PHYSICIAN(S)

- Anthony Shiflet, DO
- James Street, MD
- Christine Trankiem, MD
- Jack Sava, MD

CHECK-IN / POINT OF CONTACT

- Report to Medstar trauma bay on the start day of your rotation.

WEEKLY SCHEDULE

Monday- 6am-6pm

Tuesday- 6am-6pm; Weekly conference at 7am- 11am Wednesday- 6am-6pm

Thursday- 6am-6pm; Grands rounds at 7am-9am Friday- 6am-6pm

Saturday and/or Sunday- 6am-6pm

RESIDENT RESPONSIBILITIES

- The residents are to assume responsibility and perform technical procedures commensurate with their experience, competence, respect and mutual trust. In general, this increases yearly with added experience, judgment and ability.
- Report to trauma bay for all code yellows to assist in the primary survey.

DRESS CODE

- Scrubs

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed:

- Resident is able to adequately assist in formulating working diagnoses/plan with general surgical concerns in the outpatient clinical setting.
- Resident is able to assist in and take active role in general surgical cases.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident is able to function with professionalism in general surgical settings.

CNMC Orthopedic Surgery

ROTATION GOALS

- Develop skills in history taking skills and musculoskeletal exam skills
- Gain an understanding of the diagnosis and treatment of orthopedic and bone health

  conditions in children and adolescents.
- Actively participate in clinic, inpatient care and surgical care of patients

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
  - A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.
    - 1, 2, 3, 4, 5
  - B. Assess and manage the patient's general medical and surgical status.
    - 1, 2, 3
  - C. Practice with professionalism, compassion, and concern in a legal, ethical,

    and moral fashion.
    - 1, 2, 3, 4
  - D. Communicate effectively and function in a multi-disciplinary setting.
    - 1, 2
  - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
    - 1, 2, 3
  - F. Understand podiatric practice management in a multitude of health-care delivery settings.
    - 1, 2, 3, 4, 5
  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
    - 1

ATTENDING PHYSICIAN(S)

- Laura Tosi, MD
- Shannon Kelly, MD
- Kaleb Friend, MD
- Jeffrey Hanway, MD
- Emily Hattwick, MD
- Robert Henshaw, MD
- John Lovejoy, MD
- Benjamin Martin, MD
- Matthew Oetgen, MD
- Suzanne Walters, MD
- Bob Wilson, MD
- Megan Young, MD

CHECK-IN / POINT OF CONTACT

- Before/at the beginning of the rotation, resident should contact Kameaka Graves at kgraves@cnmc.org or 202-476-4064. On the first day, please report

to 5th Floor Unit Conference Room at 6:45 AM.
- Forms to be completed before starting rotation will be emailed by Kameaka Graves before start of rotation

WEEKLY SCHEDULE

Subject to change depending on chief on service and resident availability. Morning rounds at Unit 5E at 7:00 AM Everyday; Indication conference at Nelson Media Room 2 Thursday at 6:45 AM unless otherwise told (could be earlier).

Monday - Dr. Tosi wound/follow up clinic 8 AM – 6 PM

Tuesday - Dr. Tosi bone health clinic 8 AM – 12 PM; Dr. Tosi Spina Bifida clinic 1 PM – 5 PM

Wednesday - Dr. Tosi surgery, time TBD

Thursday – Clinic 8 AM – 5 PM and/or surgery 8AM – 5PM, time TBD

Friday - Dr. Tosi surgery, time TBD

RESIDENT RESPONSIBILITIES

- Round on post op patient(s) everyday
- Write progress notes on post op inpatient(s) everyday while in house
- Evaluate clinic patients and present patients to attendings assigned to
- Dictate clinic notes according to attending preferences

DRESS CODE

- Clinic – Professional attire and white coat
- Surgery – Blue CNMC Scrubs

COMPUTERS / DOCUMENTATION GUIDELINES

- Documentation regarding computer logins will be given during orientation on first day
- Contact Lamisha Smith (LLsmith@childrensnational.org) 1 month prior to start date to fill out appropriate paperwork.

MEALS

- No meals provided by CNMC, Cafeteria located on 2nd floor
- Resident can come to Washington Hospital Center for meals

PEARLS

- Behave in a professional manner at all times.
- Be on time to all clinics and surgical cases. If you are going to be late or absent, please contact Siobhan and On Call resident at 202 476 8203

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat pediatric lower extremity orthopedic concerns in the outpatient clinical setting.
- Resident is able to assist in and take active role in pediatric lower extremity orthopedic surgical cases.

- Resident has developed skills in history taking and musculoskeletal exam
- Resident is able to diagnosis and treat orthopedic and bone health conditions in children and adolescents.

Podiatric Medicine (MWHC Core, Perez, Feldman Rotations)

ROTATION GOALS

- Resident will become familiar with evaluation and management of foot and ankle pathology in the office, clinic, and hospital settings.
- Resident will learn and be able to utilize proper biomechanical examination techniques for the assessment and management of lower extremity pathology
- Resident will learn all aspects of conservative care for common lower extremity pathology.
- Resident will learn clinic and office management and practice workflow
- Resident will learn how to incorporate conservative podiatric medical care with podiatric surgical care.

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
  - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
    - 1,2,3,4,5
  - D. Communicate effectively and function in a multi-disciplinary setting.
    - 1,2
  - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
    - 1,2,3
  - F. Understand podiatric practice management in a multitude of health-care delivery settings.
    - 1,2,3,4,5
  - G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
    - 1,2,3,4

Perez: Daily clinic and surgical cases with Daniel Perez, DPM in Laurel, MD and Silver Spring, MD
Feldman: Weekly clinic and surgical cases with Gary Feldman, DPM in Bethesda, MD
MWHC CORE: Rotating outpatient assignments in the CVC, and POB clinics on campus at MWHC.
Bertram: Cases at MMMC in Olney, MD

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat common lower extremity podiatric medical pathology
- Resident is able to appropriately assess and formulate treatment plans for podiatric medical care in the hospital and clinic setting
- Resident is able to identify clinical signs of biomechanical pathology in the lower

extremity

- Resident is able to interpret laboratory values and correlate with clinical findings as they relate to podiatric medical pathology

MedStar Baltimore – Podiatric Surgery

ROTATION GOALS

- Cover all surgical cases any day of the week generated by the podiatric and orthopaedic attendings. You may also cover vascular and plastic surgeons.
    - If there is conflict, discuss with PGY2 on service, then PGY2 can discuss with Chief and if issues Chief can discuss with Program Director
- Actively participate in patient care in the outpatient clinical setting.
    - See patients for evaluation and treatment, complete notes, participate in active care at office and surgical sites.
- Gain independence and efficiency in patient care in the clinical setting.
- Actively participate in diagnostic and therapeutic procedures

CHECK-IN / POINT OF CONTACT

Please check in with Dr. Jonathan Furmanek prior to the start of your rotation.
You should have already received a badge/parking/access for Franklin Square and Union Memorial during your residency orientation before starting residency.

RESIDENT RESPONSIBILITIES

PGY2:

- Take Call / pager Monday night each week.
- Stay at the apartment with the PGY1 Mon-Fri and serve as a mentor and teammate for inpatient and on call and surgical cases/ ER.
- Mon-Wed is covering Dr. Furmanek and will only help 1st year on an as needed basis (particularly in the evenings), but from 6 am - 6pm he/she is with Dr. Furmanek.
- Creating the daily surgical schedule
- PGY2 is the “chief” of the rotation. All conflicts should run through PGY2 before going to Program Chief
    - PGY2 will be responsible for checking the surgical schedule each evening and creating a daily surgical schedule
    - Daily surgical schedule should include the following information for the upcoming day: assignments for the PGY2 and PGY1 for case / clinic coverage, who is rounding and what time, which resident is on call, any other miscellaneous information regarding the upcoming day (academics etc)
- PGY2 is responsible for the call stated below.

PGY1

- Will be primarily call most of the rotation (specific call defined below) at MedStar Franklin Square
- Can help to cover outpatient cases in the Baltimore area when there are no cases scheduled at MSFS
- If there are cases on Thurs/Fri that are uncovered, the 2nd year will come up to help. The first year will cover Dr. Carroll’s cases on Friday and the 2nd year will cover outpatient cases unless a big recon is occurring and most help is needed (but we should be given the 2nd year at least 48 hours notice about this).

CALL RESPONSIBILITIES

Week = Monday AM - Fri AM Weekend = Friday AM - Monday AM

You can find which attending is on call through Amion.

PGY1

- Responsible for 7 weeks and 5 weekends (defined above)

PGY2

- Responsible for 2 weeks and 2 weekends
- The call schedule is defined above. The PGY2 and PGY1 should discuss dividing call as explained above at least 2 weeks prior to starting the rotation
- This will allow time to divide appropriate call given vacations / conferences / outstanding conflicts
- During the 2 weeks the PGY2 is on week call, the PGY1 will hold the pager until the PGY2 finishes with Wynes on Mon-Wed

ROTATION GUIDELINES

- The residents are responsible for holding and answering the "MFSMC Podiatric Surgery On- call pager" (resident) 410-932-1218. This pager is in use 24/7.
- Dividing cases should be allocated to best diversify the residents educational experience.
- The first responsibility will be to cover MFSMC podiatric surgery attendings, followed by podiatric surgery attendings at outside surgery centers, followed by other specialities (ortho, vascular, plastics).
- Communication is key. If there is a case that a resident would like to cover to better their education / diversify their experience and it is outside of the noted priority list, reach out the pod attendings to clarify case coverage.
- Please notify attendings ONE DAY in advance if the on-call resident will be off campus for cases the upcoming day.
- **It is the on-call resident's RESPONSIBILITY to forward all pages to the appropriate attending IMMEDIATELY when they are received if off campus.** If the resident is scrubbed into a case please assign an individual not scrubbed in to monitor the pager.
- ALWAYS contact any attending the night prior if you are covering a case. It will be the PGY2 responsibility to alert any attendings if they will NOT have coverage.
- Pre Op: Patients will be PPC'd by resident on call, however if plans change prior to surgery and consent has been completed, it should be up to the attending to edit the consent in pre op bay
- Podiatry Associates: if they ask for assistance with a consult and the resident is not off site covering a case, it is expected they will assist with the consult
- For rounding with podiatry associates, currently not being done. If they do request assistance with rounding it must provide an education benefit or will not be done.

ROUNDING

- Rounding: We should try to mimic MWHC in that the 1st and 2nd year resident will run the list together nightly and decide who should be rounded on the following morning. (post ops, pre ops, etc.)
- We will send the list of who the resident will see in the morning in the evening bible. Those patients will be rounded on in the morning, and then an attending needs to be available during the day to round/rtl with whichever resident is available.
- We will change and update plans accordingly based on that RTL. Also, if a patient that an attending wants seen was not rounded on in the morning, it is up to that attending to see the patient when they RTL/round later with the resident.
- If there are no cases on a given day, the resident should be allowed to round slightly later in the morning, as long as they still RTL/round with an attending later. This will give residents more responsibility.
- Whichever attending is at Franklin Square that day, should make themselves available at some point to IN PERSON round/rtl with the resident. It gives an opportunity for teaching and keeps communication open.

MFSMC WEEKLY SCHEDULE

Monday: PGY1 FSH Rounds & Cases/ PGY2 Outpatient Cases
Tuesday: PGY1 FSH Rounds & Cases/ PGY2 Outpatient Cases
Wednesday: PGY1 FSH Rounds & Cases/ PGY2 Outpatient Cases
Thursday: PGY1 FSH Rounds & Cases/ PGY2 Outpatient Cases
Friday: PGY1 FSH Rounds & Cases/ PGY2 Outpatient Cases
Saturday/Sunday: On-call coverage resident/attending

HOUSING

Overlook at Franklin Square
8501 Franklin Square Dr, Rosedale, MD 21237
410-682-9681

SITE CONTACT AND LOCATION DETAILS:

MedStar Franklin Square Medical Center (MFSMC)
9000 Franklin Square Dr, Baltimore, MD 21237 443–777–7000
Jody Gilbert, GME Director,
Jody.Gilbert@medstar.net,
410-554-6755
Site Director: Dr. Vincent Martorana

MedStar Harbor Hospital (MHH)
3001 S Hanover St, Baltimore, MD 21225
Jody Gilbert, GME Administrator,
Jody.Gilbert@medstar.net
410-554-6755
Site Director: Dr. Jonathan Furmanek

Timonium Surgery Center
1954 Greenspring Drive, Ste LI18,
Lutherville, MD 21093
410–560–3301
Misty Smith, Administrator
Site Director: Dr. John Senatore

Kaiser Baltimore
1701 Twin Springs Rd. Halethorpe, MD 21227
703-359-7878
John Holland, Administrator

Site Director: Dr. David Wood

Baltimore Washington Medical Center
301 Hospital Dr
Glen Burnie, MD 21061
Site Director: Mark Linzer, DPM

Glen Burnie Surgery Center
308 Hospital Dr #102
Glen Burnie, MD 21061
Site Director: Mark Linzer, DPM

Ellicott City Surgery Center
2850 N Ridge Rd Ellicott City MD 21043
Site Director: Roberto Brandao, DPM

Westminster Surgery Center
826 Washington Rd #131, Westminster, MD 21157
Site Director: Justin Lewis, DPM, 954-540-9337

ATTENDING PHYSICIAN(S)

Paul Carroll DPM,
paul.j.carroll@medstar.net,
203-641-6565
Jonathan Furmanek, DPM,
jonathan.furmanek@medstar.net

Tiffany Hoh, DPM,
tiffany.k.hoh@medstar.net,
702-538-3573
Mark Linzer, DPM; 919-395-6414
Justin Lewis, DPM, 954-540-9337

CPME 320 COMPETENCIES FOR THIS ROTATION

- Section 6.1
    - A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremities.
        - 1, 2, 3, 4, 5
    - B. Assess and manage the patient's general medical and surgical status.
        - 1, 2, 3, 4
    - C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
        - 1, 2, 3, 4, 5
    - D. Communicate effectively and function in a multidisciplinary setting.
        - 1, 2
    - E. Manage individuals and populations in a variety of socioeconomic and health-care settings.
        - 1, 2, 3
    - F. Understand podiatric practice management in a multitude of health-care delivery settings.
        - 1, 2, 3, 4, 5
    - G. Be professionally inquisitive, life-long learners, and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.
        - 1, 2, 3, 4

DRESS CODE

- Professional attire or surgical scrubs need to be worn at all times while on duty and at academic events. Clean white coat should be worn for all instances involving patient contact, unless otherwise prohibited. Surgical scrubs will be worn for surgical procedures as provided by each facility. Correct surgical scrubs are required for each facility. You must change scrubs each day.

- Refer to section 2.8 in the House Staff Manual for further details.

ROTATION SPECIFIC ASSESSMENT QUESTIONS:

All questions are answered by “Excellent, Average, Below Average, or Not Assessed”

- Resident is able to adequately diagnose and treat podiatric concerns in the outpatient clinical setting.
- Resident is able to assist in and take active role in lower extremity surgical cases with good sense of leadership and autonomy.
- Resident is able to function with appropriate level of confidence and self-reliance in clinical setting.
- Resident has technical surgical skills appropriate for his / her level of training.

Medstar Health Podiatric Surgery Residency Program Reimbursement Policy

Types of travel to expect during your residency:

- Invited Research/Conferences (* Must be listed as 1st Author for Invited Travel Fund reimbursement)
- Continuing Education Courses/Workshops
- Required Rotation Travel

Invited Research Travel:

Prior to applying for or accepting any invited research offers, you must obtain written approval from your program director. The written approval must be forwarded to the Office of Graduate Medical Education. All reimbursement requests must be submitted to GME within thirty (30) days of the invited research travel or reimbursement will be forfeited.

- For house staff in training programs two to three (2-3) years in length: $10,000 total for the duration of your training

Continuing Education Courses/ Workshops

You are expected to attend different courses during your training. This includes ACFAS Arthroscopy Course, the AAFAO Advanced Course, and the Baltimore Limb Deformity Course, one for each year of your program. Once registered for a course, you should book your travel immediately using MedStar Travel and coordinate expense reimbursement with the program manager.

The following <u>invited travel expenses</u> will be reimbursed:

- Registration fee
- Roundtrip coach airfare (not first class, business class, or upgraded air travel accommodations)
- Hotel accommodations: are not to exceed $250 per night including taxes. Daily hotel expense more than $250 per night is **YOUR** responsibility. Sharing room expenses is highly recommended (please request separate receipts)
- Meal allowance of $75 per day maximum with the submission of an itemized receipt, **excluding alcohol**. **Itemized receipt required.**
- Reasonable roundtrip transportation to and from the airport
- Airport parking fees (for personal car)
- **Rental cars will *not* be reimbursed.**
- Incidental expenses such as checked baggage fees, tolls, poster printing expenses and abstract submission fees <u>ARE</u> eligible for reimbursement.
- Shared ride to and from airport & to and from conference venue site and hotel/Air BnB location only (*Receipts showing destination address(es) & fees paid required)

Mileage Reimbursement (Based on current year IRS Mileage Rate)

MedStar WILL reimburse for mileage above and beyond your daily commute. MedStar WILL NOT reimburse mileage expenses for your daily commute to and from work. Your daily commute is defined as the distance to/from your home and MWHC. Mileage reimbursement requests must fall within the below guidelines:

1. All mileage reimbursements are based on the distance in excess of your normal commute to/from MWHC.
    - This same commute distance applies even when you are living at the Baltimore / WVU housing.
    - The travel to/from WVU housing will be covered by above but only for required travel. Required travel wound include retreats or mandatory educational events. If you decide to return to the MWHC area for personal reasons (weekend with friends), this commute would NOT be reimbursed.
    - This also applies when returning to DC for mandatory conference/lab from Baltimore housing.

2. Necessary Tolls will be reimbursed but we will not reimburse for optional Express Lane use.
3. Mileage reimbursement requests must be submitted within 30 calendar days from the end of the last rotation block. (If your rotation ends February 28th, you have until March 29th to submit your reimbursement request).
4. Your request must include a printout of the directions between the eligible travel sites. This print-out must include the point of origin, destination, and miles traveled in between.

All travel must be booked at least one month in advance of the trip. Flights must be booked via MedStar Travel and approved by your department.

***PLEASE NOTE:** **YOU MUST INCLUDE ALL ITEMIZED RECEIPTS THAT SHOW PAYMENT WAS MADE AND A TRAVEL EXPENSE FORM ALONG WITH THE GME REIMBURSEMENT REQUEST SIGNED BY YOUR DEPARTMENT.**

(4.19.2024 JSS)

CPME 320

STANDARDS AND REQUIREMENTS FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

COUNCIL ON PODIATRIC MEDICAL EDUCATION

Adopted October 2022
Implementation Date: July 1, 2023

TABLE OF CONTENTS

INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency programs conducted under sponsorship of health-care institutions and colleges of podiatric medicine. Residencies afford these individuals structured learning experiences in patient management along with training in the diagnosis and care of podiatric pathology. The individuals involved in these training programs are referred to as "residents" and are recognized as such by the institutions sponsoring the programs.

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council's approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of graduate education, postgraduate education, certification, and continuing education. By confirming these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council has been authorized by APMA to approve institutions that sponsor residency programs that demonstrate and maintain compliance with the standards and requirements in this publication. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council.

Standards and requirements in this publication are divided into institutional standards and requirements and program standards and requirements. Standard 6.0 and the associated requirements were developed as a collaborative effort of the Council on Podiatric Medical Education, the American Board of Foot and Ankle Surgery (ABFAS), and the American Board of Podiatric Medicine (ABPM).

Under no circumstances may the standards and requirements for approval by the Council supersede federal or state law.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council's community of interest may be affected.

The Council formulates and adopts its own approval procedures. These procedures are stated in CPME 330, *Procedures for Approval of Podiatric Residencies*. This document, as well as CPME 320, may be obtained on the Council's website at www.cpme.org or by contacting the Council office.

ABOUT THIS DOCUMENT

This publication describes the standards and requirements for approval of podiatric residency programs. The standards and requirements, along with the procedures for approval, serve as the basis for evaluating the quality of the educational program offered by a sponsoring institution and holding the institution and program accountable to the educational community, podiatric medical profession, and the public.

The **standards** for approval of residency programs serve to evaluate the quality of education. These standards are broad statements that embrace areas of expected performance on the part of the sponsoring institution and the residency program. Compliance with the standards ensures proper educational practice in the field of podiatric medicine and thus enables the Council to grant or extend approval.

Related to each standard is a series of specific **requirements**. Compliance with the requirements provides an indication of whether the broader educational standard has been satisfied. During an on-site evaluation of a residency program, the evaluation team gathers detailed information about whether these requirements have been satisfied. Based upon the extent to which the requirements have been satisfied, the Council determines the compliance of the sponsoring institution and the residency program with each standard.

- The verb "shall" is used to indicate conditions that are imperative to demonstrate compliance.

The **guidelines** are explanatory materials for the requirements. Guidelines are used to indicate how the requirements either must be interpreted or may be interpreted to allow for flexibility, yet remain within a consistent framework. The following terms are used within the guidelines:

- The verbs "must" and "is" indicate how a requirement is to be interpreted, without fail. The approval status of a residency program is at risk if noncompliance with a "must" or an "is" is identified.

- The verb "should" indicates a recommended, but not mandatory, condition.

- The verb "may" is used to express freedom or liberty to follow an alternative.

Throughout this publication, the use of the terms "institution" and "program" is premised on the idea that the program exists within and is sponsored by an institution.

The terms "college" and "school" are used interchangeably throughout this document.

STANDARDS FOR APPROVAL OF PODIATRIC RESIDENCY PROGRAMS

The following standards pertain to all residency programs for which initial or continuing approval is sought. The standards encompass essential elements including sponsorship, administration, program development, clinical expectations, and assessment.

INSTITUTIONAL STANDARDS:

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

PROGRAM STANDARDS:

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

INSTITUTIONAL STANDARDS AND REQUIREMENTS

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

1.1 The sponsor shall be a hospital, academic health center, health-care system, or CPME-accredited college of podiatric medicine. Hospital facilities shall be provided under the auspices of the sponsoring institution or through an affiliation with an accredited institution(s) where the affiliation is specific to residency training.

A surgery center may co-sponsor a residency with a hospital, academic health center, health-care system, and/or college of podiatric medicine but cannot be the sole sponsor of the program.

Institutions that co-sponsor a residency program must define their relationship to each other to delineate the extent to which financial, administrative, and teaching resources are to be shared. The document defining the relationship between the co-sponsoring institutions must describe arrangements established for the residency program and the resident in the event of dissolution of the co-sponsorship.

1.2 The sponsoring institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission, the American Osteopathic Association, or a health-care agency approved by the Centers for Medicare and Medicaid Services. The sponsoring college of podiatric medicine shall be accredited by the Council on Podiatric Medical Education.

1.3 The sponsoring institution may contract with other health-care facilities to provide resident training. The sponsoring institution shall formalize arrangements with each training site, including private practice offices, by means of a written agreement that clearly defines the roles and responsibilities of each institution and/or facility involved.

When training is provided at an affiliated training site, the participating institutions must:

- indicate their respective training commitments through a written agreement reaffirmed at least once every 10 years.

This document must:

- acknowledge the affiliation and delineate financial arrangements, liability coverage, and educational contributions of each training site;

- be signed by the chief administrative officer, designated institutional official (DIO), or designee of each participating institution or facility;

- include an effective date; and

- be forwarded to the program director.

If the program director does not participate actively at the affiliated training site, or if a significant portion of the program is conducted at the affiliated training site, a site coordinator must be designated formally to ensure appropriate conduct of the program at this training site. The site coordinator must hold a staff appointment at the affiliated site and be a faculty member involved actively in the program at the affiliated institution or facility. Written confirmation of this appointment, either within the affiliation agreement or in a separate document, must include the signatures of the program director and the site coordinator.

Residents must not participate in training at affiliated sites until the agreements are fully executed.

The expected daily commute to each sponsoring and affiliated training site must not have a detrimental effect upon the educational experience of the resident. Training provided outside of the US (and its territories) may not be counted toward the requirements of any training resource.

Intent and Background: *Agreements are meant to ensure that residents are protected with professional and general liability insurance. Institutions owned by the same corporate entity as the sponsoring institution may need affiliation agreements if they function independently.*

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

2.1 The sponsoring institution shall ensure that the physical facilities, equipment, and resources of the primary and affiliated training site(s) are sufficient to permit achievement of the stated competencies of the residency program.

The physical plant must be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources, and a health information management system must be available for resident training.

The sponsoring institution must have been in operation for at least 12 months before

submitting an application for approval to assure that sufficient resources are available for the residency program.

2.2 The sponsoring institution shall afford the resident ready access to adequate educational resources, including a diverse collection of current podiatric and non-podiatric medical texts and other pertinent reference resources (i.e., journals and digital materials/instructional media).

Educational resources must include the electronic retrieval of information from medical databases that are readily available at no cost to the resident.

2.3 The sponsoring institution shall afford the resident dedicated office and/or study spaces at the institution(s) in which residency training is primarily conducted, including access to electronic resources.

2.4 The sponsoring institution shall provide a designated administrative staff member, frequently referred to as a program coordinator, to ensure efficient administration of the residency program.

The program coordinator must dedicate sufficient time to the administration of the program and must devote the equivalent of 0.5 FTE to the program.

The institution must ensure that neither the program director nor the resident assumes the responsibility of ancillary medical staff.

Intent and Background: *Each program requires a lead administrative staff member, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty, and other staff members. The individual is expected to develop unique knowledge of the program requirements, policies, and procedures. Program coordinators assist the program director in compliance efforts, educational programming, and support of residents. FTE is equivalent to a full-time employee at the sponsoring institution.*

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

3.1 The sponsoring institution shall utilize a residency selection committee to interview and select prospective resident(s). The committee shall include the program director and individuals who are active in the residency program.

3.2 The sponsoring institution shall conduct its process of interviewing and selecting residents equitably and in an ethical manner.

The sponsoring institution must make available to the prospective resident information describing the selection process and conditions of appointment established for the program. Interviews must not occur prior to, or be in conflict with, interview dates established by the national resident application matching service with which the residency program participates. The sponsoring institution must make the residency curriculum available to the prospective resident.

3.3 The sponsoring institution shall participate in a national resident application matching service and shall abide by the rules and regulations set forth by the matching service.

The sponsoring institution, including the program director, faculty, and residents, must not obtain a commitment, either oral or written, from the prospective resident prior to the date established by the national resident matching service in which the institution participates

Intent and Background: *The requirement exists to ensure programs and applicants are not subjected to undue influence or coercion during the match process.*

3.4 Application fees, if required, shall be paid to the sponsoring institution and shall be used only to recover costs associated with processing the application and conducting the interview process.

The sponsoring institution must publish its policies regarding application fees (i.e., amount, due date, uses, and refunds).

3.5 The sponsoring institution shall accept only graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed all components of Parts I and II examinations of the National Board of Podiatric Medical Examiners.

3.6 The sponsoring institution shall ensure that the resident is compensated equitably with and is afforded the same benefits, rights, and privileges as other residents at the institution.

If the sponsoring institution does not sponsor other residency programs, then the resident must be compensated equitably with other residents in the geographic area.

The institution shall provide the following benefits:

a. Health insurance

The sponsoring institution must provide health insurance for the resident for the duration of the training program. The resident's health insurance must be at

least equivalent to that afforded other professional employees at the sponsoring institution.

b. Professional, family, and sick leave

The resident's leave benefits must be at least equivalent to those afforded other professional employees at the sponsoring institution.

c. Leave of absence

The sponsoring institution must establish a policy pertaining to leave of absence or other interruption of the resident's designated training period. In accordance with applicable laws, the policy must address continuation of pay and benefits and the effect of the leave of absence on meeting the requirements for completion of the residency program.

d. Professional liability insurance coverage

The sponsoring institution must provide professional liability insurance for the resident that is effective when training commences and continues for the duration of the training program. This insurance must cover all rotations at all training sites and must provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution must provide the resident with proof of coverage upon request.

e. Other benefits if provided (e.g., meals, uniforms, vacation policy, housing provisions, payment of dues for membership in national, state, and local professional organizations, and disability insurance benefits)

The sponsoring institution should disclose annually to the program director the current amounts of direct and indirect graduate medical education reimbursement received by the sponsoring institution.

3.7 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall be signed and dated by the chief administrative officer of the institution or DIO and the resident.

The contract or letter must state the following:

a. Type of certificate the resident will be awarded:
    - Podiatric Medicine and Surgery Residency (PMSR) or
    - Podiatric Medicine and Surgery Residency with the added credential in Reconstructive Rearfoot/Ankle Surgery (PMSR/RRA) or
    - Podiatric Medicine and Surgery Residency with Reconstructive

Rearfoot/Ankle Surgery (PMSR/RRA)

b. the amount of the resident stipend;
c. duration of the agreement;
d. benefits provided; and
e. the length of the program, if it is approved by the Council to exceed 36 months.

When a letter of appointment is utilized, a written confirmation of acceptance must be executed by the prospective resident and forwarded to the chief administrative officer or DIO.

The contract or letter of appointment must be forwarded to the program director.

The stipend offered by the institution is determined as an annual salary. The amount of resident compensation must not be contingent on the productivity of the individual resident.

In the case of a co-sponsored program, the contract or letter of appointment must be signed and dated by the chief administrative officer or DIO of each co-sponsoring institution and the resident and be forwarded to the program director.

For programs in which residents sign contracts with multiple institutions, a letter of understanding between those institutions must be in place, identifying the program director as the final authority to oversee resident training at all sites.

3.8 The sponsoring institution shall ensure that the resident is not required to sign a non-competition guarantee or restrictive covenant with the institution or any of its affiliated training sites upon graduation.

3.9 The sponsoring institution shall develop the following components compiled into a residency manual (in either written or electronic format) that is distributed to and acknowledged in writing by the resident at the beginning of the program and following any revisions. The manual shall include, but not be limited to, the following:

a. The mechanism of appeal

The sponsoring institution must establish a written mechanism of appeal that ensures due process for the resident and the sponsoring institution should there be a dispute between the parties. Any individual possessing a conflict of interest related to the dispute, including the program director, must be excluded from all levels of the appeal process.

b. Performance improvement methods established to address instances of unsatisfactory resident performance

The sponsoring institution must establish and delineate performance improvement methods to address instances of unsatisfactory resident performance (academic and/or attitudinal) and identify the time frame allowed for improvement. Performance improvement methods may include, but not be limited to, requiring that the resident repeat particular training experiences, spend additional hours in a clinic, or complete additional assigned reading to facilitate achievement of the stated competencies of the curriculum. Performance improvement methods should be completed no later than three months beyond the normal length of the residency program.

c. Resident clinical and educational work hours

d. Rules and regulations for the conduct of the resident

e. Transition of care

Programs, in partnership with their sponsoring institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

f. Curriculum, including competencies and assessment documents specific to each rotation (refer to requirements 6.1 and 6.4)

Intent and Background: *Assessment documents and competencies must correlate. They may be included in a single document.*

g. Training schedule (refer to requirement 6.3)

h. Schedule of didactic activities and critical analysis of scientific literature (refer to requirements 6.7 and 6.8)

i. Policies and programs that encourage optimal resident well-being (refer to requirement 3.13)

j. CPME 320 and CPME 330

These documents may be provided within the manual or the manual may include links to the residency section of CPME's website.

3.10 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements.

The certificate must include the following:

- The statement "Approved by the Council on Podiatric Medical Education"

- At a minimum, the certificate must be signed by the program director and the chief administrative officer or DIO. In the case of a co-sponsored program, the certificate must be signed by the chief administrative officer or DIO of each co-sponsoring institution and the program director.
- Date of completion
- Identification of the residency as a "Podiatric Medicine and Surgery Residency"
- If applicable, the certificate must identify the added credential as "with the added credential in Reconstructive Rearfoot/Ankle Surgery" or "with Reconstructive Rearfoot/Ankle Surgery"

3.11 The sponsoring institution shall ensure that the residency program is established and conducted in an ethical manner.

The conduct of the residency must focus upon the educational development of the resident rather than on service responsibility to individual faculty members.

Programs, in partnership with their sponsoring institution and affiliates, must provide a professional, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of trainees, faculty, and staff.

3.12 The sponsoring institution shall ensure that the resident does not assume the responsibility of ancillary medical staff.

3.13 The sponsoring institution shall ensure that policies and programs are in place to encourage optimal resident well-being.

The institution must provide residents the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during working hours.

The institution must provide education and resources that support sponsoring institution-employed faculty members and residents in identifying in themselves or others the risk factors of developing or demonstrating symptoms of fatigue, burnout, depression, and substance abuse, or displaying signs of self-harm, suicidal ideation, or potential for violence.

The institution must provide access to confidential and affordable mental health care, necessary for either acute or ongoing mental health issues.

The institution must provide an environment in which the physical and mental well-being of the resident is supported, without the resident fearing retaliation of any kind.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

4.1 The sponsoring institution shall report annually to the Council office on institutional data, residents completing training, residents selected for training, changes in the curriculum, and other information requested by the Council and/or the RRC.

4.2 The sponsoring institution shall inform the Council office in writing within 30 calendar days of substantive changes in the program.

The sponsoring institution must inform the Council of changes in areas including, but not limited to the following:

- Change in sponsorship
- Change in the chief administrative officer, DIO, or designee
- Resignation or termination of the program director, and/or appointment of a new program director
- Resident resignation, termination, or transfer
- Delay in resident starting date
- Resident extended leave of absence
- Resident extension of training

Intent and Background: *The Council must be informed of these changes to ensure continuity of communication with the institution and program director. Information related to the resident is needed for future verification of training.*

4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, and current and incoming residents informing them of adverse actions or voluntary termination of the program. Program applicants shall be notified prior to their interview.

The institution must submit either the program applicants' and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicants' and the current and incoming residents' receipt of the institution's letter. These materials must be submitted as part of the progress report that is due to CPME at a date identified by the RRC.

Adverse actions include probation, withholding of provisional approval, and withdrawal of approval.

PROGRAM STANDARDS AND REQUIREMENTS

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

5.1 The sponsoring institution shall designate one podiatric physician as program director to serve as administrator of the residency program. The program director shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.

The sponsoring institution must provide compensation to the program director. This compensation must be commensurate with that provided other residency directors at the institution. If the sponsoring institution does not offer other residency programs, then the program director must be compensated equitably with other program directors in the geographic area.

The program director must be a member of the medical staff and/or employed by the sponsoring institution, or in the case of a co-sponsorship, at one of the sponsoring institutions. The program director must be a member of the graduate medical education committee or equivalent within the institution. The program director should be a member of national, state, and/or local professional organization(s).

Because of the potential of creating confusion in the leadership and direction of the program, co-directorship is specifically prohibited; however, the program director may appoint an assistant/associate director to assist in administration of the residency program. A residency training committee also may be established to assist the program director in the administration of the residency program.

Co-sponsoring institutions must designate one program director responsible for the entire co-sponsored residency. This individual must be provided the authority and have the ability to oversee resident training at all sites.

5.2 The program director shall possess appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and achieving the stated competencies of the residency.

The program director (appointed after July 1, 2023, the implementation date of this document) must be certified by at least one board recognized by the Specialty Board Recognition Committee (SBRC) and must have a minimum of three years of post-residency clinical experience.

In certain circumstances, the sponsoring institution may, with approval by the RRC or its chair, appoint an interim residency director who does not meet the

qualifications identified in this requirement and guideline. Institutions must specify the anticipated length of time the interim director will serve, and this appointment may be subject to continued approval by the RRC.

Intent and Background: *Leading a program requires knowledge and skills that are established during residency and further developed subsequently. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming established professionally. The three-year period is intended for the individual's professional maturation.*

5.3 The program director shall be responsible for the administration of the residency in all participating institutions. The program director shall be able to devote sufficient time to fulfill the responsibilities required of the position. The program director shall ensure that each resident receives equitable training experiences.

The director is responsible for maintenance of records related to the educational program, communication with the RRC and Council, scheduling of rotations, instruction, supervision, review and verification of logs, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. In a co-sponsored program, the director is responsible for ensuring that the Council is provided requested information for **all residents at all training sites**, not just at one of the co-sponsoring sites (e.g., the institution at which the director is based).

The director must not delegate to the resident maintenance of records related to the educational program, communication with the RRC and Council, scheduling of rotations, instruction, supervision, verification of logs, evaluation of the resident, periodic review and revision of curriculum content, or program self-assessment.

The director must ensure resident participation in training resources and didactic experiences (e.g., lectures, journal review sessions, conferences, and seminars).

5.4 The program director shall participate at least annually in faculty development activities (i.e., administrative, organizational, teaching, and/or research skills for residency programs).

The faculty development activities and programs should be delivered by continuing education providers approved by the Council or another appropriate agency. Formal faculty development programs provided by teaching hospitals and colleges will be acceptable with appropriate documentation.

5.5 The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident.

The complement of faculty relates to the number of residents, institutional type and size, organization, and capabilities of the services through which the resident rotates, and training experiences offered outside the sponsoring institution.

Faculty members must take an active role in the didactic activities (e.g. presentation of lectures, conferences, journal review sessions). Faculty members must supervise and evaluate the resident in clinical sessions and assume responsibility for the quality of care provided by the resident during the clinical sessions that they supervise. Faculty members must discuss patient evaluation, treatment planning, patient management, complications, and outcomes with the resident and review records of patients assigned to the resident to ensure the accuracy and completeness of these records.

The program director has the authority to approve and remove program faculty members from participation in the residency program at all sites.

5.6 Podiatric and non-podiatric medical faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible.

The active podiatric faculty must include sufficient representation by individuals qualified or certified by each board recognized by the SBRC, or by individuals possessing other specialized qualifications acceptable to the RRC. Faculty members must be able to competently instruct and supervise residents.

Podiatric faculty should participate in faculty development activities to improve teaching, research, and evaluation skills.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

The resident must be afforded training in the breadth of podiatric health care. Completion of a podiatric residency currently leads to the following certification pathways: the American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM).

Completion of a podiatric residency with the added credential in reconstructive rearfoot/ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of ABFAS.

Additional educational experiences may be added to the curriculum to extend the length of the program up to 48 months. The program director must obtain the approval of the sponsoring institution and RRC prior to implementation and at each subsequent approval review of the program. Programs that extend the residency beyond 36 months must present a clear educational rationale.

The Council and RRC view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

- Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, biomechanical, and surgical means.

- Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident's competencies in the perioperative care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.

- Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

  Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.

At the beginning of the training year, all site coordinators or rotations directors must be provided the training schedule, competencies, and assessment documents for their respective rotation(s).

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the lower extremity.

1. Perform and interpret the findings of a thorough history and physical exam,

including neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis as indicated.

2. Formulate an appropriate diagnosis and/or differential diagnosis.

3. Understand the indication(s) for and interpret appropriate diagnostic studies, including:

    - Medical imaging (e.g., plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging).
    - Laboratory tests (e.g., hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis).
    - Pathology (e.g., anatomic and cellular pathology).
    - Other diagnostic studies (e.g., electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies).

4. Participate directly in the evaluation and management of patients in inpatient and outpatient settings, including the following:

    - Perform biomechanical examination and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
    - Dermatologic conditions.
    - Neurological conditions.
    - Orthopedic conditions.
    - Arterial and venous conditions.
    - Wound care.
    - Congenital deformities (e.g., manipulation, casting, bracing of foot/ankle).
    - Trauma.
    - Office-based procedures (e.g., injections and aspirations, nail avulsion, biopsies).
    - Pharmacologic management.
    - Lower extremity health promotion and education.

5. Participate directly in the evaluation and management of the surgical patient when indicated, including the following:

    - Evaluating, diagnosing, selecting appropriate treatment, and recognizing and managing complications.
    - Progressive development of knowledge, attitudes, and skills in

perioperative assessment and management in foot and ankle surgery (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).

6. Assess the treatment plan and revise it as necessary.

B. Assess and manage the patient's general medical and surgical status.

1. Perform and interpret the findings of comprehensive medical history and physical examinations through diverse podiatric and non-podiatric experiences, including (see Appendix A):

   - Comprehensive medical history.
   - Comprehensive physical examination.
     - Vital signs.
     - Physical examination (e.g., head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic examination).

2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).

3. Understand the indication(s) for and interpret the results of diagnostic studies including (see also section A.3 for diagnostic studies not repeated in this section).

   - EKG.
   - Medical imaging (e.g., plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound).
   - Laboratory studies (e.g., hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, and urinalysis).
   - Other diagnostic studies.

4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.

5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, gender, psychosocial status, and socioeconomic status.

6. Participate actively in non-podiatric surgical rotations that include surgical

evaluation and management of patients including, but not limited, to:

- Understanding management of preoperative and postoperative surgical patients.
- Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
- Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.

7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:

   - Local anesthesia.
   - General, spinal, epidural, regional, and conscious sedation anesthesia.

8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.

9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:

   - Recognizing and diagnosing common infective organisms.
   - Using appropriate antimicrobial therapy.
   - Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
   - Managing patients with local and systemic infections.

10. Participate actively in a medical imaging rotation that should include musculoskeletal and non-musculoskeletal pathology and incorporates evaluating and interpreting various medical imaging modalities (e.g., plain radiography, nuclear medicine imaging, MRI, CT, and diagnostic ultrasound).

11. Participate actively in a behavioral medicine rotation that incorporates evaluation and management of patients with behavioral, mental, and/or psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).

12. Participate actively in a vascular/endovascular surgery rotation that incorporates the evaluation and management of patients with peripheral arterial disease including, but not limited to, the following training experiences:

- Evaluating and interpreting various vascular studies.
- Understanding the indications for various vascular/endovascular revascularization procedures.

C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

2. Practice and abide by the principles of informed consent.

3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

4. Demonstrate professional humanistic qualities.

5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of health-care costs.

D. Communicate effectively and function in a multi-disciplinary setting.

1. Demonstrate effective physician-patient communication skills.

2. Demonstrate effective physician-provider communication skills.

3. Demonstrate appropriate medical record documentation.

4. Demonstrate appropriate consultation and/or referrals.

E. Manage individuals and populations in a variety of socioeconomic and health-care settings.

1. Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.

2. Demonstrate cultural humility and responsiveness to values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender identity, and/or sexual orientation is/are different from one's own.

3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

F. Understand podiatric practice management in a multitude of health-care delivery settings.

1. Demonstrate familiarity with utilization management and quality improvement.

2. Understand health-care coding and reimbursement.

3. Explain contemporary health-care delivery systems.

4. Understand insurance issues including professional and general liability, disability, and Workers' Compensation.

5. Understand medical-legal considerations involving health-care delivery.

6. Demonstrate understanding of common business practices.

G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and evidence-based practice.

1. Read, interpret, and critically analyze and present medical and scientific literature.

2. Demonstrate information technology skills in learning, teaching, and clinical practice.

3. Participate in education activities.

6.2 The sponsoring institution shall require that the resident maintain web-based logs documenting clinical and didactic experiences related to the residency.

The format must be approved by and accessible for review by the RRC.

The format must categorize and summarize medical/surgical diversity and experiences (refer to Appendices A and B).

6.3 The program shall establish a formal schedule for clinical training.

The program shall provide an anticipated rotation schedule for residents throughout the entirety of their training, including rotation lengths, rotation formats (block or sequential only), and rotation locations. Specific dates need only be included for the current academic year.

The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

The residency must be continuous and uninterrupted unless extenuating circumstances are present.

The length of residency education to be conducted in a supervised podiatric private practice office-based setting must not exceed seven months or 20 percent of a 36-month training program.

6.4 The residency program shall provide rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include podiatric medicine and surgery as well as non-podiatric rotations. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.

The program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources. In developing the curriculum, the program director must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

In addition to podiatric medicine and surgery, the following rotations and minimum lengths of training are required. Each of the rotations must be a minimum of two weeks of training, in block or sequential format, unless otherwise noted:

a. Anesthesiology.

b. Behavioral medicine.

c. Emergency medicine (minimum of four weeks of training).

d. Medical imaging.

e. Medical specialties. There is a minimum requirement of **12 cumulative weeks** of training in medical specialties.

   Training must include rotations in:
   - Internal medicine/Family medicine (minimum 4 weeks).
   - Infectious disease.

   Training must also include at least **two** of the following rotations:

- Burn unit, dermatology, endocrinology, geriatrics, intensive/critical care unit, neurology, pain management, pediatrics, physical medicine and rehabilitation, rheumatology, wound care, and vascular medicine.

f. Surgical specialties: There is a minimum requirement of **8 cumulative weeks** of training in surgical specialties. Training must include at least **two** of the following rotations, with a minimum of two weeks in endovascular/vascular surgery:

   - Endovascular/vascular surgery (at least two weeks).
   - Cardiothoracic surgery, general surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, plastic surgery, or surgical intensive care unit (SICU), trauma team/surgery.

While a typical training week involves five working days, CPME recognizes that holidays may shorten a work week.

***Intent and Background*:** *The program should be structured so that each rotation is a minimum of the required length of time, allowing for the resident to successfully achieve the competencies of the rotation. Individual resident schedules may vary due to faculty schedules, holidays, or other unforeseen circumstances; however, the intent is that the program affords residents the necessary time required in each rotation.*

6.5 The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of training.

ACLS certification must be obtained as early as possible during the training year but no later than six months after the resident's starting date.

6.6 The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.

The program director must assure that patient records document accurately the resident's participation in patient care activities.

The resident should participate in quality improvement and utilization review activities.

6.7 Didactic activities that complement and supplement the curriculum shall be available.

Residents must be afforded protected time for weekly didactic activities. Didactic activities must be provided in a variety of formats. These formats may include

lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

Training in the following must be provided to the resident at least once per year of training:

- Falls prevention.
- Resident well-being (e.g., substance abuse, fatigue mitigation, suicide prevention, self-harm, and physician burnout).
- Pain management (i.e., multi-modal approach to chronic and acute pain) and opioid addiction.
- Cultural humility (e.g., training in implicit bias, diversity, inclusion, and culturally effective components particularly regarding access to care and health outcomes).
- Workplace harassment and discrimination awareness and prevention.
- Foundation of and importance of coding and medical documentation.

Training in research methodology must be provided at least once during residency training (e.g., web-based training, formal lectures, or a dedicated research rotation).

The majority of didactic activities must include participation by at least one faculty member.

The program director may appoint a faculty member to coordinate didactic activities.

Intent and Background: *Didactic experiences provide an opportunity to expand the resident's knowledge in the breadth of podiatric medicine, including biomechanical assessment and surgical evaluation and management. The annual instruction may be provided during resident orientation, focused activities, and through web-based programs. CPME recognizes that holidays may interrupt regularly scheduled weekly didactic activities.*

6.8 The curriculum shall afford the resident instruction in the critical analysis of scientific literature.

A journal review session, with participation of faculty and residents, must be scheduled at least monthly. The resident should present current articles and analyze the content and validity of the research.

6.9 The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.

The program must define levels of resident supervision appropriate for the level of

training.

6.10 The residency program shall ensure the resident is afforded appropriate clinical and educational work hours.

Work Hours: Clinical and education work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home.

Work Periods: (A) Except as provided in (B) below, clinical and educational work periods for residents must not exceed 24 hours of continuous in-house activity and must be followed by at least eight hours free of clinical work and education. (B) The 24-hour work period may be extended up to four hours of additional time for necessary patient safety, effective transitions of care, and/or resident education.

In-house Call: Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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

Outside Activities: The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident's ability to function in the training program.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

7.1 The program director shall review, evaluate, and verify resident logs on a monthly basis.

The program director must review the logs for accuracy to ensure that there is no duplication, miscategorization, and/or fragmentation of procedures into their component parts. Procedure notes must support the selected experience.

The program director must monitor resident logs to ensure resident attainment of the Minimum Activity Volume (MAV) and diversity requirements prior to completion of training.

7.2 The faculty and program director shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.

a. Faculty Assessment of the Resident

Assessment forms must be completed for all rotations identified in the curriculum. The document must specify the dates covered, the name of the resident, and the name of the faculty member. The assessment must be signed and/or electronically acknowledged and dated by the faculty member, the resident, and the program director. The document must assess competencies specific to each rotation including communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency must allow sufficient opportunity for performance improvement.

Assessment must be documented at least once for every three months of uninterrupted training in podiatric medicine and/or podiatric surgery service and must include assessment of resident outpatient podiatric experiences (clinic and/or private practice offices).

Intent and Background: *Podiatric medicine and surgery assessment forms may be combined or separate documents.*

Electronic or written acknowledgement of receipt and review of the assessment by the resident and program director is acceptable.

b. Program Director Semi-annual Assessment of the Resident

The program director must conduct and document a semi-annual meeting with each resident on an individual basis. The semi-annual assessment must be signed and dated by the program director and the resident. This review must include the following:

- Review of completed rotation assessments (see requirement 7.2a).
- In-training examinations.
- Projected attainment of MAVs.

c. Program Director Final Assessment of the Resident

The program director must conduct a final meeting with each resident upon completion of the program. A final assessment must be provided in a written format and include the date and signatures of the program director and the resident. The final assessment 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; and
- verify that the resident has achieved the competencies of the residency program and ensure attainment of MAVs in all categories.

Intent and Background: *The final assessment of the resident is to be conducted*

in lieu of the semi-annual assessment. This assessment must be conducted within the resident's final two months of training.

7.3 The program shall require that all residents take at least one in-training examination during each academic year, as offered by SBRC-recognized specialty boards.

The sponsoring institution must pay any fees associated with the examinations. The program must require that residents take one exam from each SBRC-recognized specialty board at least once during their time in residency training.

Examination results are used as a guide for resident performance improvement and as part of the annual self-assessment of the program.

7.4 The program director, faculty, and resident(s) shall conduct a formal, written annual self-assessment of the program's resources and curriculum. Information resulting from this review shall be used in improving the program.

The review must include the following:

a. Identification of individuals involved (e.g., program director, faculty, and residents).

b. Performance data utilized (e.g., evaluation of the program's compliance with the standards and requirements of the Council, the resident's formal evaluation of the program, the director's formal evaluation of the faculty, and the extent to which the didactic activities complement and supplement the curriculum).

c. Measures of program outcomes utilized (e.g., in-training examination results, success of previous residents in private practice and teaching environments, board certification pass rates, hospital appointments, and publications).

d. Results of the review (i.e., whether the curriculum is relevant to the competencies, the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether the resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved).

APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

A. Patient Care Activity Requirements (Abbreviations are defined in section B.)	**MAV**
Case Activities	
Foot and ankle surgical cases (PMSR/RRA)	300
Foot and ankle surgical cases (PMSR only)	250
Trauma cases	50
Podopediatric cases	25
Other podiatric procedures	100
Lower extremity wound care	50
Biomechanical examinations	50
Comprehensive history and physical examinations	50
Procedure Activities	
First and second assistant procedures (total)	400
First assistant procedures, including:	
Digital	80
First Ray	60
Other Soft Tissue Foot Surgery	45
Other Osseous Foot Surgery	40
Reconstructive Rearfoot/Ankle (added credential only)	50

B. Definitions

1. Levels of Resident Activity for Each Logged Procedure

First assistant: The resident participates actively in the procedure under direct supervision of the attending.

Second assistant: The resident participates in the procedure in a limited capacity under direct supervision of the attending.

2. Minimum Activity Volume (MAV)

MAVs are patient care activity requirements that assure that the resident has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. It is incumbent upon the program director and the faculty to assure that the resident has achieved competency, regardless of the number of repetitions.

3. Required Case Activities

A case is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

a. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.

b. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients in the acute phase of a traumatic episode. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Comprehensive history and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

   Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.

   Intent and Background: *The acute phase of trauma is defined as occurring within six weeks of the initial injury.*

c. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of foot and ankle pathology in patients who are less than 18 years of age.

d. Biomechanical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by biomechanical means. These experiences include, but are not limited to, performing lower extremity biomechanical examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders.

   Intent and Background: *Biomechanical cases should be performed in a variety of settings (surgical and non-surgical) and should include diverse pathology and treatment methods. Biomechanical exams should be a representation of the learning*

experiences of the residents.

e. Comprehensive history and physical examinations. Admission, preoperative, and outpatient H&Ps may be used as acceptable forms of a comprehensive H&P, 25 of which must be performed during non-podiatric rotations. A problem-focused history and physical examination does not fulfill this requirement.

The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to use information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

f. Lower Extremity Wound Care. Management of lower extremity wounds, including debridement of ulcers or wounds (e.g., neuropathic, arterial, traumatic, venous, thermal), advanced wound modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot), and/or hyperbaric oxygen therapy. Does not include 6.6, repair of simple laceration or simple delayed wound closure in Appendix B. Non-podiatric wound care should be logged as category 10.20.

4. Required Procedure Activities

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable (e.g., a bunionectomy that has been fragmented into an osseous procedure and an adjunctive soft tissue procedure, creating two separate procedures, is unacceptable).

Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies.

C. Assuring Diversity of Experience

The construct of the procedure categories assures some degree of diversity in the resident's training experience. The two paragraphs below relate to **first assistant procedures only.**

To assure proper diversity within each procedure category and subcategory, at least 33 percent of the procedure codes within each category and subcategory must be represented. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedure codes must have at least one activity.

To avoid overrepresentation of one procedure within a category and subcategory, one procedure code must not represent more than 33 percent of the minimum number of procedures required in each procedure category and subcategory.

Intent and Background: *This statement applies more to a resident just meeting the minimum procedure requirement in a procedure category than to a resident significantly exceeding the procedure requirement in a procedure category. For example, the number of partial ostectomies must not exceed 26 when the minimum of 80 required Digital procedures are logged.*

D. Multiple Residents / Fellows

1. Only one resident / fellow may take credit for first assistant participation on any one procedure.

2. More than one resident may take credit for second assistant participation.

3. The activity of a fellow shall not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

4. When multiple procedures are performed on a single patient, more than one resident/ fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

5. Individual procedures may not be fragmented to allow for multiple residents/fellow(s) to claim first assistant participation.

APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

The following categories, procedures, and codes must be used for logging surgical procedure activity:

1 Digital Surgery (lesser toe or hallux)

1.1 partial ostectomy/exostectomy
1.2 phalangectomy
1.3 arthroplasty (interphalangeal joint [IPJ])
1.4 implant (IPJ) (silastic implant or spacer)
1.5 diaphysectomy
1.6 phalangeal osteotomy
1.7 fusion (IPJ)
1.8 amputation
1.9 management of osseous tumor/neoplasm
1.10 management of bone/joint infection
1.11 open management of digital fracture/dislocation
1.12 revision/repair of surgical outcome
1.13 other osseous digital procedure not listed above

2 First Ray Surgery

Hallux Valgus Surgery
2.1.1 bunionectomy (partial ostectomy/Silver procedure), with or without capsulotendon balancing procedure
2.1.2 (procedure code number no longer used)
2.1.3 bunionectomy with phalangeal osteotomy
2.1.4 bunionectomy with distal first metatarsal osteotomy
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
2.1.6 bunionectomy with first metatarsocuneiform fusion
2.1.7 metatarsophalangeal joint (MPJ) fusion
2.1.8 MPJ implant
2.1.9 MPJ arthroplasty
2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis

Hallux Limitus Surgery

2.2.1 cheilectomy
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
2.2.3 joint salvage with distal metatarsal osteotomy
2.2.4 joint salvage with first metatarsal shaft or base osteotomy
2.2.5 joint salvage with first metatarsocuneiform fusion
2.2.6 MPJ fusion
2.2.7 MPJ implant
2.2.8 MPJ arthroplasty

Other First Ray Surgery

2.3.1 tendon transfer/lengthening/procedure
2.3.2 osteotomy (e.g., dorsiflexory)
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
2.3.4 amputation
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
2.3.6 management of bone/joint infection (with or without bone graft)
2.3.7 open management of fracture or MPJ dislocation
2.3.8 corticotomy/callus distraction
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
2.3.10 other first ray procedure not listed above

3 Other Soft Tissue Foot Surgery

3.1 excision of ossicle/sesamoid
3.2 excision of neuroma
3.3 removal of deep foreign body (excluding hardware removal)
3.4 plantar fasciotomy
3.5 lesser MPJ capsulotendon balancing
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
3.7 open management of dislocation (MPJ/tarsometatarsal)
3.8 incision and drainage/wide debridement of soft tissue infection (includes foot, ankle or leg)
3.9 plantar fasciectomy/ plantar fibroma resection
3.10 excision of soft tissue tumor/mass (without reconstructive surgery; includes foot, ankle or leg)
3.11 (procedure code number no longer used)
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
3.13 microscopic nerve/vascular repair (forefoot only)
3.14 other soft tissue procedures not listed above (limited to the foot)
3.15 (procedure code number no longer used)
3.16 external neurolysis/decompression (including tarsal tunnel)

3.17 decompression of compartment syndrome (includes foot or leg)

4 Other Osseous Foot Surgery

4.1 partial ostectomy (including the talus and calcaneus) (includes foot, ankle, or leg)
4.2 lesser MPJ arthroplasty
4.3 bunionectomy of the fifth metatarsal without osteotomy
4.4 metatarsal head resection (single or multiple)
4.5 lesser MPJ implant
4.6 central metatarsal osteotomy
4.7 bunionectomy of the fifth metatarsal with osteotomy
4.8 open management of lesser metatarsal fracture(s)
4.9 harvesting of bone graft (includes foot, ankle, or leg)
4.10 amputation (lesser ray, transmetatarsal amputation)
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
4.13 open management of tarsometatarsal fracture/dislocation
4.14 multiple osteotomy management of metatarsus adductus
4.15 tarsometatarsal fusion
4.16 corticotomy/callus distraction of lesser metatarsal
4.17 revision/repair of surgical outcome in the forefoot
4.18 other osseous procedures not listed above (distal to the tarsometatarsal joint)
4.19 detachment/reattachment of Achilles tendon with partial ostectomy

5 Reconstructive Rearfoot/Ankle Surgery

Elective - Soft Tissue
5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
5.1.5 delayed primary or secondary repair of ligamentous structures
5.1.6 tendon augmentation/supplementation/restoration
5.1.7 open synovectomy of the rearfoot/ankle
5.1.8 (procedure code number no longer used)
5.1.9 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

Elective - Osseous

5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.2 (procedure code number no longer used)
5.2.3 subtalar arthroeresis
5.2.4 midfoot, rearfoot, or ankle fusion
5.2.5 midfoot, rearfoot, or tibial osteotomy
5.2.6 coalition resection
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy/arthroscopy with removal of loose body or other osteochondral debridement
5.2.9 ankle implant
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
5.2.11 other elective rearfoot reconstructive/ankle osseous surgery not listed above

Non-Elective - Soft Tissue

5.3.1 repair of acute tendon injury
5.3.2 repair of acute ligament injury
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
5.3.4 excision of soft tissue tumor/mass of the foot, ankle, or leg (with reconstructive surgery)
5.3.5 (procedure code number no longer used)
5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above
5.3.8 (procedure code number no longer used)

Non-Elective - Osseous

5.4.1 open repair of adult midfoot fracture
5.4.2 open repair of adult rearfoot fracture
5.4.3 open repair of adult ankle fracture
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
5.4.5 management of bone tumor/neoplasm (with or without bone graft)
5.4.6 management of bone/joint infection (with or without bone graft)
5.4.7 amputation proximal to the tarsometatarsal joints
5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above
5.4.9 (procedure code number no longer used)

6 Other Podiatric Procedures

6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
6.3 nail avulsion (partial or complete)
6.4 matrixectomy (partial or complete, by any means)
6.5 removal of hardware (internal or external fixation)
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement); includes simple delayed wound closure
6.8 extracorporeal shock wave therapy
6.9 taping/padding/splinting/casting (limited to the foot and ankle)
6.10 orthotics/prosthetics (limited to the foot and ankle casting/scanning/impressions for foot and/or ankle orthosis)
6.14 percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma, digital tenotomy)
6.15 foot care (nail debridement, callus paring)
6.16 therapeutic/diagnostic injections (without sedation)
6.17 incision and drainage (performed outside of the operating room)
6.18 closed reduction of fracture or dislocation
6.19 removal of foreign body (not in the operating room)
6.20 application of external fixation

7 Biomechanics

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment

8 History and Physical Examination

8.1 comprehensive history and physical examination
8.2 problem-focused history and physical examination

9 Surgery Specialties

9.1 general surgery
9.2 orthopedic surgery
9.3 plastic surgery
9.4 vascular surgery
9.5 cardiothoracic surgery
9.6 hand surgery
9.7 neurosurgery
9.8 orthopedic/surgical oncology
9.9 pediatric orthopedic surgery
9.10 surgical intensive care unit (SICU)
9.11 trauma team/surgery
9.12 other

10 Medicine and Medical Subspecialty Experiences

10.1 anesthesiology
10.2 cardiology
10.3 dermatology
10.4 emergency medicine
10.5 endocrinology
10.6 family practice
10.7 gastroenterology
10.8 hematology/oncology
10.9 imaging
10.10 infectious disease
10.11 internal medicine
10.12 neurology
10.13 pain management
10.14 pathology
10.15 pediatrics
10.16 physical medicine and rehabilitation
10.17 psychiatry/behavioral medicine
10.18 rheumatology
10.19 sports medicine
10.20 wound care (non-podiatric)
10.21 burn unit
10.22 intensive/critical care (ICU/CCU)
10.23 geriatrics
10.24 vascular medicine
10.25 other

11 Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal)
11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot)
11.3 hyperbaric oxygen therapy

13 Other Clinical Experiences

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

GLOSSARY

The Council strongly encourages sponsoring institutions and program directors to become familiar with the following definitions to ensure complete understanding of this publication.

Academic Health Center

An academic health center is the entire health enterprise at a university including health professions, education, patient care, and research. An academic health center consists of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association, one or more health profession schools or programs (such as podiatric medicine, dentistry, allied health, nursing, pharmacy, public health, graduate studies, or veterinary medicine), and one or more owned and affiliated teaching hospitals or health systems.

Accreditation

Accreditation is the recognition of institutional or program compliance with standards established by the Council on Podiatric Medical Education, based on evaluation of the institution's own stated objectives. Accreditation is a voluntary process of peer review. The Council is responsible for accrediting colleges of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

Affiliated Training Site

An affiliated training site is an institution or facility that provides a rotation(s) for residents. Examples of sites include: a college of podiatric medicine, a teaching hospital including its ambulatory clinics and related facilities, a private medical practice or group practice, a skilled nursing facility, a federally qualified health center, a public health agency, an organized health care delivery system, an outpatient surgery center, or a health maintenance organization (clinical facility).

American Board of Foot and Ankle Surgery (ABFAS)

ABFAS is the specialty board currently recognized by the Council on Podiatric Medical Education's Specialty Board Recognition Committee to certify in the specialty area of podiatric surgery. ABFAS maintains two certification pathways: foot surgery and reconstructive rearfoot/ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot/ankle status.

American Board of Podiatric Medicine (ABPM)

ABPM is the specialty board currently recognized by the Council on Podiatric Medical Education's Specialty Board Recognition Committee to certify in the specialty area of podiatric medicine and orthopedics. ABPM maintains one certification pathway leading to certification in podiatric orthopedics and primary podiatric medicine.

Approval

Approval is the recognition of a podiatric residency program, podiatric fellowship program, or sponsor of continuing education that has attained compliance with standards established by the Council on Podiatric Medical Education. Approval is a program-specific form of accreditation.

Behavioral Medicine

Behavioral medicine incorporates management of patients with behavioral, mental, and psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).

Centralized Application Service for Podiatric Residencies (CASPR)

CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to podiatric residency programs approved by the Council. CASPR conducts a national matching process, based on a mathematical algorithm, for the purpose of placing applicants into residency positions. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the residency application and matching process.

Certification

Certification is a process to provide assurance to the public that a podiatric physician has successfully completed an approved residency and an evaluation, including an examination process designed to assess the knowledge, experience, and skills requisite to the provision of high-quality care in a particular specialty.

Clinical Competency Committee

A committee appointed by the program director that completes the milestones for each resident on a semi-annual basis. Members of the committee must have extensive experience working with the residents and must comment on the progression of each resident throughout the program and identify gaps in their individual training. At least one member of the committee must be from the podiatric residency faculty.

Collaborative Residency Evaluator Committee (CREC)

CREC is an effort of ABFAS, ABPM, and the Council to improve the methods by which residency evaluators and team chairs are selected, trained, assessed, remediated, and dismissed. The composition of the Committee includes three individuals from each organization, one of whom must be the executive director or that individual's designee, who must be an employee of the organization represented.

Competencies

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. ABFAS and ABPM have identified competencies related to certification pathways.

Council of Teaching Hospitals (COTH)

COTH is a membership organization comprised of institutions sponsoring Council-approved podiatric residency programs (including programs holding provisional and probationary approval). The goals of COTH include fostering excellence in residency training, promoting a code of ethics, developing policy, and serving as a forum for the exchange of ideas on residency education. COTH is a component of the American Association of Colleges of Podiatric Medicine. The Council on Podiatric Medical Education and RRC encourage sponsoring institutions to participate in COTH.

Curriculum

The curriculum is the residency program's unique organization and utilization of its clinical and didactic training resources to assure that the resident achieves the competencies identified by the Council and is prepared to enter clinical practice upon completion of the residency.

Designated Institutional Official (DIO)

The individual with the authority or responsibility for oversight and administration of the graduate medical education program at the institution.

Due Process

Due process is a defined procedure established by the sponsoring institution that is utilized whenever any adverse action is proposed or taken against a resident. All parties in a residency program are protected when there is a written and disseminated due process policy in place.

Duplication

Duplication occurs when a resident enters the same case and procedure on the same day of surgery more than once in clinical/patient logs.

External Assessments

External assessments are standardized evaluations of residents that are monitored and/or delivered by organizations external to the residency program for the purpose of validating the resident's experiences and development. An example is an annual in-training examination conducted by a specialty board.

Faculty

Faculty refers to the entire teaching force responsible for educating residents. The term faculty does not imply or require an academic appointment or salary support.

Fragmentation

Fragmentation occurs when a specific surgical procedure in clinical/patient logs is unbundled or fragmented inappropriately into its individual component parts.

Health-care System

A health-care system is a group of hospitals or facilities that work together to deliver services to their communities.

Hospital

A hospital is an institution that provides diagnosis and treatment of a variety of medical conditions in inpatient and outpatient settings. The institution may provide training in the many special professional, technical, and economic fields essential to the discharge of its proper functions.

Internal Assessments

Internal assessments are those evaluations of residents that are conducted within the residency program by faculty, staff, peers, and patients for the purpose of validating the serial acquisition of necessary knowledge, attitudes, and skills by the residents. Knowledge, attitudes, and skills should be evaluated separately. Knowledge may be assessed with internal modular testlets. Attitudes may be assessed with an attitudinal assessment form. Skills may be assessed by utilizing a standardized technical skills assessment form and observing a particular skill set.

In-training Examination

Administered by the specialty board(s), the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification by the specialty board(s).

Milestones

Milestones are a semi-annual assessment tool, completed by a clinical competency committee, that provide a consistent framework for formative assessment of the resident. Milestones demonstrate the resident's progress toward competency throughout residency training.

Miscategorization

Miscategorization occurs when a surgical procedure or clinical encounter in patient/clinical logs is misclassified into an incorrect procedure code.

Podiatric Medicine and Surgery

Podiatric medicine and surgery is the profession and medical specialty that includes the study, prevention, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.

Residency

A residency is a postgraduate educational program conducted under the sponsorship of a hospital, college of podiatric medicine, or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges of podiatric medicine through clinical and didactic experiences.

A residency program is based on the resource-based, competency-driven, assessment-validated model of training:

- Resource-based implies that the program director constructs the residency program based upon the resources available. While the Council recognizes that available resources may differ among institutions, the program director is responsible for determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.

- Competency-driven implies the program director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the

sponsoring institution as having successfully completed the residency program.

- Assessment-validated implies the serial acquisition and final achievement of the competencies are validated by assessments of the resident's knowledge, attitudes, and skills. To provide the most effective validation, assessment is conducted both internally (within the program) and externally (by outside organizations).

Residency Review Committee (RRC)

The RRC is responsible for determining eligibility of applicant institutions for initial and subsequent on-site evaluation, authorizing increases in and reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

The composition of the RRC shall include two representatives from each specialty area in which specialty residency training occurs to be recommended by the boards, two representatives from the AACPM Council of Teaching Hospitals (hereinafter referred to as "COTH") to be recommended by AACPM, two representatives from residency programs at large to be selected by the Council, and at least two Council members. The specialty organizations and COTH each shall be requested to provide a list of names from which the Council chair shall select an appointee for the Committee. If the chair does not identify a suitable appointee, then the Council may request a second list of names. The members of the Committee are appointed by the Council chair and confirmed by the Council.

Although the RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the RRC.

Specialty Board Recognition Committee (SBRC)

The SBRC is a committee established by the Council on Podiatric Medical Education on behalf of the podiatric medical profession to recognize specialty boards. The recognition of a specialty board by the SBRC serves to provide important information to the podiatric medical profession, health-care institutions, and the public about the sound operations and fair conduct of the board's certification process. The Council and the SBRC are committed to a process that assures the public that those podiatric physicians who are certified have successfully completed the requirements for certification in an area of specialization. The Council's authority for the recognition of specialty boards through the SBRC is derived solely from the House of Delegates of the American Podiatric Medical Association. The SBRC recognizes the American Board of Foot and Ankle Surgery and the American Board of Podiatric Medicine.

Training Resources

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medical and surgical subspecialties.

Verification

Verification is the process by which the program director reviews resident clinical/patient logs to ensure resident attainment of the Minimum Activity Volume (MAV) requirements and for accuracy to ensure there is no duplication, miscategorization, and/or fragmentation of procedures or clinical encounters.

CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies*

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CPME 330

PROCEDURES FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

COUNCIL ON PODIATRIC MEDICAL EDUCATION

Adopted October 2022
Implementation Date: July 1, 2023

TABLE OF CONTENTS

INTRODUCTION

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council's approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of graduate education, postgraduate education, certification, and continuing education. By confirming these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council was established by the APMA House of Delegates in 1918 and charged with formulating educational standards. The Council began accrediting colleges of podiatric medicine in 1922. The Council conducted its first residency evaluation in 1964.

The Council has been authorized by APMA to approve institutions that sponsor residency programs demonstrating and maintaining compliance with the standards and requirements published in CPME 320, *Standards and Requirements for Approval of Residencies in Podiatric Medicine and Surgery*. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council. The American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM) collaborate with the RRC and the Council in evaluating residencies.

"Approval" is the recognition accorded residencies that are determined to be in substantial compliance with established standards and requirements. The approval process related to a residency is essentially a six-step process, involving: (1) development of application and/or pre-evaluation materials documenting the ability of the program to comply with the Council's standards and requirements; (2) on-site evaluation conducted at the institution, at which time the application and/or pre-evaluation materials are validated by an evaluator or evaluation team appointed by the Council; (3) subsequent review by the RRC of findings identified in the report of the on-site evaluation and any information that the program provides following the visit; (4) an approval recommendation from the RRC to the Council; (5) determination of approval status by the Council; and (6) periodic follow-up of progress in improving the quality of the program. Procedural reconsideration, reconsideration, and appeal of a proposed adverse approval action are available as described in this document.

Recommendations and decisions relative to the approval process for residencies are the sole responsibilities of the RRC and/or the Council, as indicated in this publication. Neither Council staff, on-site evaluators, individual members of the RRC or the Council, nor any other agent of the RRC or the Council is empowered to make or modify approval recommendations or decisions.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council's community of interest may be affected.

The following evaluation/approval procedures have been developed to assist residencies in

preparing for initial or continuing approval and to guide the RRC and the Council in their deliberations concerning the approval of residencies.

Throughout this publication, the use of the terms “institution” and “program” is premised on the idea that the program exists within and is sponsored by an institution.

COMMUNICATION BETWEEN RRC/COUNCIL AND THE SPONSORING INSTITUTION

Both the sponsoring institution and the program director are responsible for administering the residency program. Standards 1–4 in CPME publication 320 are institutional standards, and compliance with these standards is the responsibility of the sponsoring institution. Standards 5–7 are program-specific standards, and compliance with these standards is the responsibility of the program director.

The RRC and the Council have adopted the following general policies related to communication with an institution sponsoring a residency. Information related to specific correspondence (e.g., notification of approval actions) appears in the pertinent sections of this document.

The RRC and the Council require that the program’s director is the individual responsible for submitting all materials to Council staff related to all application, on-site evaluation, and approval processes. All materials submitted by the sponsoring institution must be submitted on media as determined by the Council or its committees accompanied by a cover letter signed by the program director. Signatures may be electronic or handwritten. The RRC, the Council, and evaluators will not consider unsigned or unverified correspondence, resident logs, and/or resident evaluation forms. Such materials do not document review and validation by the director. Unsigned or unverified correspondence or residency materials will be returned to the program director; submission of such materials may adversely affect the approval status of the residency.

All correspondence and inquiries must be directed to the Council office. Use of other channels of communication may delay the processing of information submitted by the sponsoring institution and result in inconvenience to the institution.

The RRC and the Council email correspondence to the program director at the director’s preferred email address indicated on the institution’s application and/or most recent annual or pre-evaluation report. The institution’s chief administrative officer (CAO) or designated institutional official (DIO) is copied on all correspondence. For a co-sponsored program, the Council sends copies of correspondence to the email address of the institution at which the program director is based (although administrators of all co-sponsoring institutions will receive copies of correspondence from the Council).

The sponsoring institution is responsible for informing the Council office in writing within 30 calendar days of substantive changes in the program. The program director or administrative staff must inform the Council of changes in areas including, but not limited to, sponsorship, appointment of a new program director, or appointment of a new chief administrative officer.

The Council’s residency documents and forms are available on the Council’s website (www.cpme.org), including proposed changes to Council documents (standards, requirements, and procedures) with a request for comments by a specific deadline. When the RRC or the

Council develops a policy (e.g., interpretation of a particular requirement in a Council or RRC document), the policy is published on CPME's website.

Administration of the residency program falls directly under the purview of the program director and the institution's chief administrative officer or designated institutional official. As such, formal communication with CPME will always include these individuals. Communication with the administrative staff/program coordinator is not part of the formal communication process. The program director is ultimately responsible for administration of the program.

RESIDENCY REVIEW COMMITTEE

The RRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in or reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

Composition of the RRC includes two representatives each from ABFAS and ABPM (selected by these organizations and confirmed by the Council), two representatives from the Council of Teaching Hospitals (COTH) of the American Association of Colleges of Podiatric Medicine (selected by AACPM and confirmed by the Council), two representatives from residency programs at large (selected by the Council), and at least two Council members.

Although the RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of the RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the RRC.

APPLICATION FOR PROVISIONAL APPROVAL OF A NEW RESIDENCY PROGRAM

Submission of the Application

The Council encourages the applicant institution to contact Council staff early in the developmental stages of the program should questions arise related to the Council's standards, requirements, and procedures.

The Council recognizes that programs seeking approval do so voluntarily. Therefore, the burden of proof regarding compliance with Council standards and requirements is the responsibility of the sponsor. Submission of a new application may be required when an approved sponsoring institution or residency has undergone a change so substantial that it is essentially a new institution or program.

The applicant institution must be in operation for at least 12 months before applying for approval to assure that sufficient resources are available for the program. The institution must have an active podiatric and/or foot and ankle service prior to applying for approval.

An institution seeking approval of a new podiatric residency is required to submit an application

fee and CPME form 309, *Application for Provisional Approval*, and required supplementary documentation (see Fee Policies). **The application must be submitted prior to activation of the residency.** The process for submission of the application through determination of an approval action by the Council may require 9–12 months or more**.**

Council staff reviews the application for completeness. If the application is considered to be incomplete, Council staff corresponds with the program director and specifies the information required to complete the application. If the application, supplementary documentation, and fee are in order, Council staff forwards the institution's application to the RRC for determination of eligibility for on-site evaluation.

If the sponsoring institution ascertains that it has the capability to train more residents than the number indicated on the application, the institution must amend its application. This amendment must occur **before** eligibility for on-site evaluation has been determined. The program director must inform the Council office of the institution's intention and provide appropriate documentation substantiating the ability of the program to increase its proposed number of positions. Council staff will include this information in the materials to be presented to the RRC once the application is complete. (Alternatively, the sponsoring institution may request an increase in or reclassification of positions following the granting of provisional approval; see Authorization of Increases in Residency Positions.)

Determination of Eligibility for On-site Evaluation

The RRC considers the application for provisional approval by e-ballot, virtual meeting/ conference call, or at one of its meetings.

The RRC reviews the application to determine whether the new residency is eligible for on-site evaluation. In determining eligibility, the RRC will not consider a number of resident positions other than that for which the institution has applied. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent virtual meeting/conference call or upcoming meeting.

When the RRC determines a new residency is eligible for on-site evaluation, this status indicates the institution appears to be developing a residency that has the potential for meeting the Council's standards and requirements for approval.

Neither eligibility for on-site evaluation nor the conduct of an initial on-site evaluation ensures eventual approval.

Correspondence regarding the RRC action is addressed to the program director. A copy of the letter is forwarded to the chief administrative officer or designated institutional official of the sponsoring institution. If eligibility for on-site evaluation is confirmed, the letter includes a copy of CPME 312, *Agenda Guide for Provisional Approval*, to assist the program director in planning for the initial on-site evaluation.

If the RRC proposes denial of eligibility for on-site evaluation, justification for the action is delineated in the letter and provisions for requesting procedural reconsideration, reconsideration, and appeal are identified (see Procedural Reconsideration, Reconsideration, and Appeal).

An institution may not interview prospective residents or schedule interviews prior to receiving provisional approval from CPME.

Withdrawal or Termination of the Application

A sponsoring institution that has submitted an application for provisional approval or for which eligibility for on-site evaluation has been determined may withdraw its application at any time before the Council takes an action on the approval status of the program.

Council staff may terminate the application for either of the following reasons:

- The sponsoring institution fails to formally respond within six months to written requests from Council staff and/or the RRC for information to complete the application

- The sponsoring institution fails to schedule the on-site visit within six months of the date the institution was determined eligible for the evaluation

Council staff will correspond with the program director and the institution's chief administrative officer or designated institutional official to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

RE-EVALUATION AND CONTINUING APPROVAL OF AN EXISTING RESIDENCY PROGRAM

Council staff regularly reviews the list of approved programs and contacts the appropriate program directors when re-evaluation is due (see Categories of Approval and Approval Period).

The Council may elect to deviate from the established on-site evaluation cycle by conducting either a comprehensive or focused visit to follow up on identified concerns. Circumstances that may warrant scheduling a follow-up visit include: when a program has been transferred to another institution; when a residency has undergone a substantial change; when major deterioration in the residency has occurred; and/or when a formal complaint against an approved residency requires on-site evaluation of the issues related to the complaint. The Council reserves the right to conduct an evaluation of the residency whenever circumstances require such review. Continuation of approval by the Council is contingent upon the findings of the on-site evaluation team and approval recommendation by the RRC. Therefore, the re-evaluation may have an impact on the previously-granted approval status.

Pre-evaluation Materials

Institutions seeking continuing approval of residencies must submit CPME form 310, *Pre-evaluation Report*, along with all required supplementary documentation. If Council staff review determines that the pre-evaluation report is incomplete, the program director will be notified and requested to submit the required information. An on-site evaluation will not be conducted if this requested material is not received, which may jeopardize the approval status of the program. In the event the on-site evaluation is cancelled due to non-receipt of requested information in a timely manner, the visit may be re-scheduled, but all costs related to the visit will be the

responsibility of the sponsoring institution.

ON-SITE EVALUATION (NEW AND EXISTING RESIDENCY PROGRAMS)

The on-site evaluation is conducted to assess the general quality of the residency, the institution's ability to establish a curriculum that assures each resident achieves the competencies identified by the Council, and the institution's plans for continued improvement. The evaluation team appointed to conduct the visit gathers information related to validation of the institution's application for provisional approval or pre-evaluation report. The evaluation team develops a report of its findings that includes a narrative summary identifying program strengths and weaknesses and areas of potential noncompliance.

Evaluation team members do not act as consultants to the residency or the sponsoring institution. The team members' primary roles as fact-finders and observers are to provide the RRC an assessment of the sponsor's potential compliance with the Council's standards and requirements. With a view toward assisting the institution to understand more completely its role as related to the residency, the evaluation team report may include non-binding recommendations for improvement of the program.

Evaluation Team

The Council chair appoints the evaluation team based upon a recommendation from the RRC chair and Council staff. The initial on-site evaluation is conducted by at least two evaluators. On-site re-evaluation of an approved residency is generally conducted by a team comprised of at least three evaluators. Under certain circumstances, two individuals may evaluate an approved residency.

The institution has the prerogative of rejecting any member of the proposed evaluation team when an appropriate cause related to conflict of interest can be clearly identified. In such a case, a formal statement from the sponsoring institution is to be submitted to the Council office no later than15 calendar days after receipt of the on-site confirmation letter, affording the Council sufficient opportunity to appoint a replacement evaluator. The Council does not appoint members to the evaluation team who have any known conflict of interest in the evaluation of the institution, including graduates and current and former faculty members or administrators of the institution.

The evaluation team represents the Council and the RRC. At least one of the members of the evaluation team is an ABFAS diplomate, and at least one of the members of the evaluation team is an ABPM diplomate.

Other individuals (e.g., current members of the Council and the Council's committees and members of the Council's professional staff) may accompany an evaluation team to observe the on-site evaluation.

Evaluation team members will have participated in a training session for residency evaluators. Evaluation team chairs will have participated previously in on-site evaluations of residencies.

The Collaborative Residency Evaluation Committee (CREC), consisting of representatives of

ABFAS, ABPM, and the Council, identifies and is responsible for training new and current on-site evaluators.

Preparation for On-site Evaluation

The evaluation team chair determines the date of the on-site evaluation in conjunction with the program director and the other member(s) of the evaluation team. Once eligibility for on-site evaluation is determined for a new program, the evaluation is conducted in sufficient time to allow for consideration of the report of the on-site evaluation at meetings of the RRC and the Council. Ordinarily, an institution sponsoring an existing program is given approximately 45 calendar days' notice prior to the on-site evaluation. The timeline for evaluating an existing program may be abbreviated when the on-site evaluation is conducted in response to the RRC and/or Council concerns about major deterioration or substantial change in the residency or when a formal complaint against an approved residency requires on-site evaluation of the issues related to the complaint.

Once the evaluation team and the sponsoring institution have agreed on the date and time of the evaluation, Council staff corresponds with the program director to confirm the members of the evaluation team and the time and date of the evaluation. A copy of CPME 310, *Agenda Guide*, is forwarded to the program director. Using the *Agenda Guide*, the program director is required to work with the team chair to prepare a schedule identifying personnel to be interviewed by the evaluation team. The agenda must be forwarded to the Council office at least four weeks prior to the on-site visit to allow for adjustments if necessary.

The team members are provided access to clinical logs and review the logs to establish a list of charts that they wish to review during the on-site evaluation. The team provides this list to the program director in advance of the on-site evaluation. The evaluation team retains the prerogative of requesting additional charts on the day of the visit if warranted.

When a focused visit is scheduled, the letter informing the program director of the date of the evaluation includes specific information related to interviews to be conducted and information to be available for review by the evaluator(s).

Conduct of the On-site Evaluation

Depending on the number of individuals and facilities involved, a minimum of one day is required to evaluate a podiatric residency. In order for the evaluation team to assess the curriculum content and the extent of resident supervision, the agenda for the on-site evaluation requires that key participants in the program be interviewed, as indicated in CPME 310.

As part of the on-site evaluation, the team conducts interviews with the program director, chief administrative officer or designated institutional official, members of the podiatric and non-podiatric faculty, and, for provisionally approved and existing programs only, the podiatric resident(s). The evaluation includes a tour of the physical facilities, a working session to allow for review of charts and additional information provided, an executive session of the evaluation team to discuss findings and recommendations, and a concluding session with the program director and the chief administrative officer to discuss the findings. During the exit interview with institutional representatives, the evaluation team chair explains the Council's procedures for initial and/or continuing approval of residencies (specifically, the sequence of events that will

follow the visit).

Failure of key participants in the residency to be available will be cause for cancellation of the on-site visit, which may jeopardize the approval status of the program.

Interviews must be conducted with active faculty directly involved in the residents' training and for all rotations provided by the program. Video interviews may be acceptable for rotation faculty only if a rationale is provided. Video interviews must be approved by the team chair in conjunction with CPME staff on a CPME-approved platform determined ahead of time and provided by the institution.

In special circumstances, if a team member is unable to physically attend the on-site evaluation due to emergency circumstances, a team member may participate virtually in the site visit.

Virtual Site Visits

CPME staff, in consultation with the Council chair, may determine that a virtual site visit must be conducted in lieu of an on-site visit due to natural disasters, pandemics, or other circumstances of that magnitude. The program director is responsible for ensuring that the evaluation team has adequate opportunity to engage in all of the meetings listed above. The program director should prepare, ahead of time, all technological necessities to ensure that the evaluation team meets with the individuals listed above and that the evaluation team is able to conduct all documentation reviews. Additionally, the program director is expected to prepare contingency plans in case of unforeseeable technological difficulties including power loss or other acts of nature. CPME provides the virtual platform and shares the access codes for the meetings.

If for any reason the evaluation team is not provided with the opportunity to hold these meetings, or if the individuals requested are not in attendance sufficient to adequately assess the program, then the Council may determine that the report of the on-site evaluation is insufficient to consider approval of the program and may schedule another site visit at cost to the program. Inability to communicate with the individuals due to technological barriers will be viewed negatively by the evaluation team and ultimately by the Council.

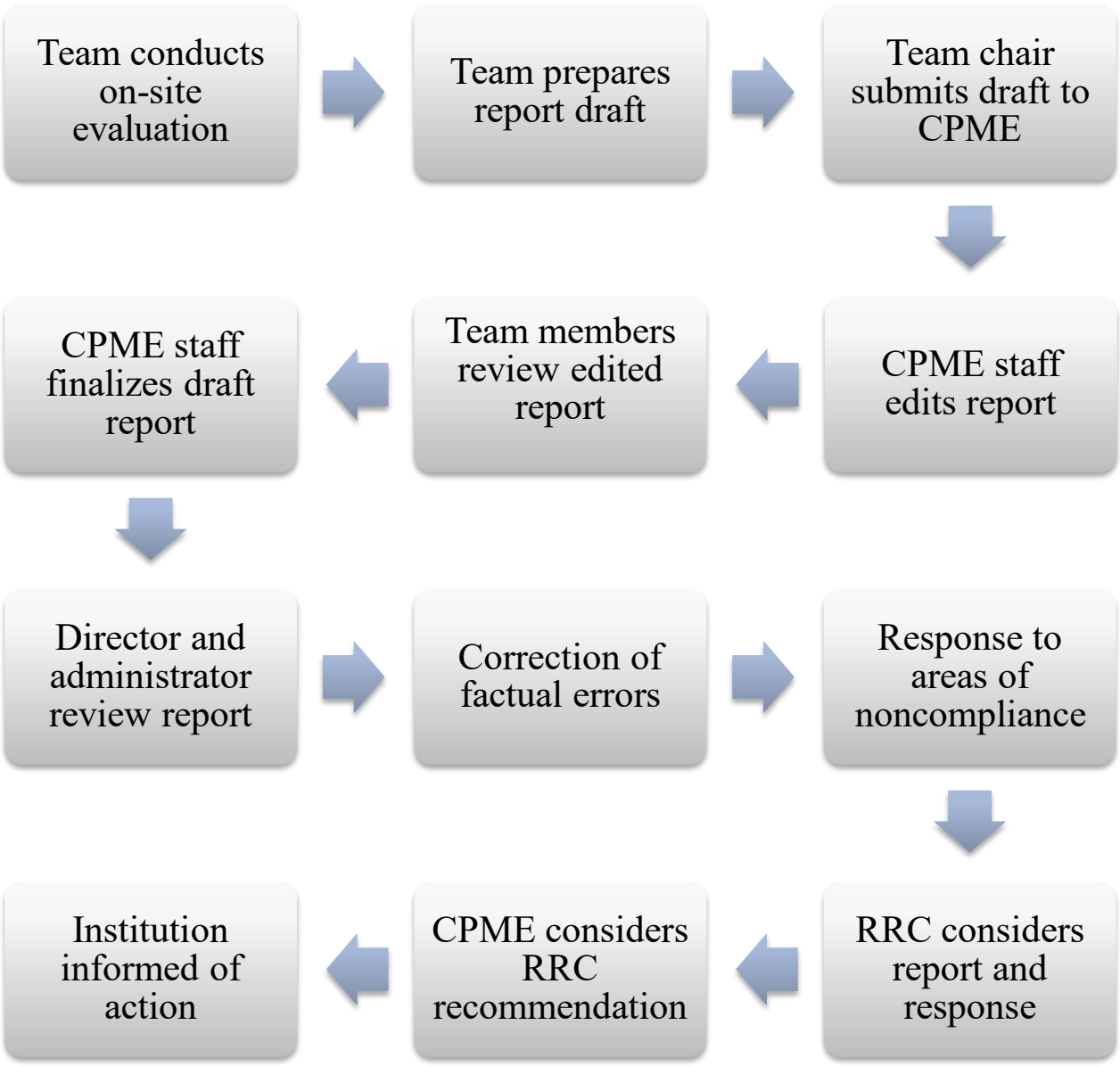
Preparation of the Report

The evaluation team prepares a draft report based on findings from the on-site evaluation. The team forwards this draft report to the Council office for editing. The edited draft of the report is then returned to each team member for review and comments.

A draft copy of the report, consisting of a summary of findings, a list of interviewees, areas of potential noncompliance, commendations, and recommendations, is forwarded to the program director and the chief administrative officer of the sponsoring institution.

The sponsoring institution must provide a substantive response to areas of potential noncompliance identified by the evaluation team, including supporting documentation, prior to consideration of the report by the RRC. The cover letter to the institution specifies the deadline for receipt of this documentation.

The following steps are included in the approval process:



CONSIDERATION BY THE RRC AND THE COUNCIL

RRC Review

The RRC reviews evaluation team reports, institutional responses to evaluation team reports, interim progress reports from provisionally approved programs, progress reports from provisionally approved and approved programs, applications for provisional approval, requests for increases in or reclassification of residency positions, requests for reconsideration, and other requests.

During discussions about the approval status of individual residencies, any RRC members who are affiliated with the institution under consideration in a governance, administrative, staff, or faculty capacity must recuse themselves from the deliberations. Members of the RRC who served on the most recent residency evaluation team are required to recuse themselves from voting until the Council has determined a final approval action.

Review of Evaluation Team Reports

Based upon review of the draft team report and any response submitted by the sponsoring institution, the RRC makes a confidential recommendation to the Council regarding the approval status of the program (see Categories of Approval and Approval Period).

The confidential recommendation includes the approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas of noncompliance with Council standards and requirements, and a schedule for requesting progress reports, including the interim progress report required of a provisionally approved program. In reviewing an on-site evaluation report, the RRC has the prerogative of recommending that the Council accept a revised report, which may include adding, modifying, or deleting areas of potential noncompliance.

Review of Interim Progress Reports and Progress Reports

The RRC considers interim progress reports submitted by provisionally approved programs related to development of the proposed clinical and didactic curriculum once a resident(s) is active in the program (see Categories of Approval and Approval Period).

The RRC also considers progress reports submitted by existing provisionally approved and approved programs related to correction of specific areas of noncompliance with CPME standards and requirements and/or concerns identified by the RRC and/or the Council.

Based upon review of the progress report and/or the interim progress report, the RRC determines the extent to which the submitted information addresses previously identified areas of noncompliance and/or concerns and/or makes a confidential recommendation to the Council regarding the approval status of the program (see Categories of Approval and Approval Period).

The confidential recommendation includes the approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas that are in noncompliance with Council standards and requirements, identification of areas of noncompliance that have been addressed in the progress report, and a

schedule for requesting progress reports. The institution may be requested to submit further documentation of progress made in addressing areas of noncompliance and/or concerns expressed by the RRC.

In reviewing an interim progress report and/or a progress report, the RRC has the prerogative to add, modify, or delete areas of noncompliance or make a confidential recommendation to the Council regarding a change in the approval status of the program (see Categories of Approval and Approval Period).

Council Action

At a meeting of the Council, the RRC chair presents for each residency program the confidential recommendation of the RRC regarding approval status, date by which the next on-site evaluation must be conducted and/or approval period, authorized number of residents, identification of areas that are in noncompliance with Council standards and requirements, identification of areas of noncompliance that have been addressed in the institution's response to the evaluation team report or in the institution's progress report, and a schedule for requesting progress reports. Areas of noncompliance determined by the Council may include, but are not limited to, those indicated by the evaluation team and the RRC. The institution may be requested to submit documentation of progress made in addressing areas of noncompliance and/or concerns expressed by the RRC or the Council.

Approval actions are taken by the Council at official meetings of the Council. Under special circumstances, e-ballots or virtual meetings/conference calls may be used for residency approval decisions.

During discussions about the approval status of individual residencies, members of the Council who are affiliated with the institution under consideration in a governance, administrative, staff, or faculty capacity must recuse themselves from the deliberations. Members of the Council who served on the most recent residency evaluation team are required to recuse themselves from discussion and voting until the final approval action has been determined.

CATEGORIES OF APPROVAL AND APPROVAL PERIOD

The Council bases the approval action on the category and number of resident positions that each institution has requested. The Council has established the following categories of approval, which are published on the Council's website:

Provisional Approval

Provisional approval indicates recognition of a new residency that, in general, is expected to be in substantial compliance with the Council's standards and requirements for approval upon activation of the program. Provisional approval is determined on the basis of on-site evaluation prior to activation of the residency. When the Council grants provisional approval, this status is effective on the date the action is taken by the Council (see Activation of a Provisionally Approved Residency). Provisional approval will not be considered for any training year or portion of a training year prior to the effective date of granting of provisional approval.

As a condition of continued provisional approval, the institution must provide an **interim progress report** by a date identified in the approval letter. The interim progress report allows the RRC to monitor the continued development of the program in accordance with the program's proposed clinical and didactic curriculum once the resident is active in the program. The interim progress report includes, but is not limited to, resident logs documenting participation in all relevant podiatric medical and surgical activities, documentation of the program's assessment of the resident's progress in achieving the competencies identified by the Council, the formal schedule for clinical training, and the signed resident contract or letter of appointment.

As a further condition of continued provisional approval, the institution also may be requested to provide one or more **progress reports** at specified intervals, as indicated in the approval letter. The progress report(s) is to demonstrate correction of specific areas of noncompliance in meeting one or more requirements and/or to address concerns identified by the RRC and/or the Council.

Provisional approval extends no longer than 24 months beyond the designated length of the program.

The approval letter includes the date by which the next scheduled on-site evaluation will occur. Ordinarily, on-site re-evaluation of a provisionally approved podiatric residency is conducted during the program's fourth year of operation. The RRC and/or the Council may schedule an earlier on-site re-evaluation should significant concerns become evident from review of the program's progress report(s).

Approval

Approval indicates recognition of an existing residency that is in full compliance with the Council's standards and requirements for approval. In granting approval, the Council expresses its confidence in the abilities of the institution to continue providing adequate support and implementing ongoing improvements in the residency.

The approval letter includes the date by which the next scheduled on-site evaluation will occur. Re-evaluation of an existing program is scheduled approximately six years from the date of its previous evaluation. The RRC and/or the Council may schedule an earlier on-site re-evaluation should significant concerns become evident from review of the program's annual report or progress report(s).

Approval with Report

Approval indicates recognition of an existing residency that is in substantial compliance with the Council's standards and requirements for approval. In granting approval, the Council expresses its confidence in the abilities of the institution to continue providing adequate support and implementing ongoing improvements in the residency.

As a condition of continued approval, the institution may be requested to provide one or more progress reports at specified intervals, as indicated in the approval letter. The progress report(s) is to demonstrate correction of specific areas of noncompliance in meeting one or more requirements or to address concerns identified by the RRC and/or the Council. Failure to meet the requirements as stated by the Council may result in probation.

The approval letter includes the date by which the next scheduled on-site evaluation will occur. Re-evaluation of an existing program is scheduled approximately six years from the date of its previous evaluation. The RRC and/or the Council may schedule an earlier on-site re-evaluation should significant concerns become evident from review of the program's annual report or progress report(s).

The RRC may request that the institution submit additional progress reports to allow for further monitoring of issues of concern and/or to answer questions arising from review of the progress report.

Probation

Probation indicates that a residency is in noncompliance with the Council's standards and requirements for approval to the extent that the quality and effectiveness of the residency are in jeopardy. This category serves as a strong warning to the institution that serious problems exist that could cause the residency to fail. When probation is extended, the residency is considered to be a candidate for withdrawal of approval. The RRC and/or the Council have the prerogative of adding to the probationary action the requirement that no new residents or transfers enter the residency until areas of noncompliance have been addressed to the satisfaction of the RRC and the Council.

The program must provide evidence of significant progress in correction of areas of noncompliance within a specified period. This period of probation is to be determined by the Council, but is usually limited to a maximum of two years. Failure to meet the requirements as stated by the Council during the two-year period, including any extension for good cause, will result in withdrawal of approval.

A decision to extend probation is not subject to the Council's procedures for procedural reconsideration, reconsideration, or appeal.

The institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

Withholding of Provisional Approval

Withholding of provisional approval is determined in the event that a new program seeking provisional approval evidences substantial noncompliance with the Council's standards and requirements for approval. When the Council proposes withholding provisional approval of a residency, factors that have a significant impact on the effectiveness of the program are identified as the basis for the action. A decision to withhold provisional approval will not become final or be published until the processes of procedural reconsideration, reconsideration, and appeal are exhausted (see Procedural Reconsideration, Reconsideration, and Appeal).

Withdrawal of Approval

Withdrawal of approval is determined under any one of the following conditions:

- A program on probation has failed to correct one or more areas of noncompliance, or a new area(s) of noncompliance has emerged, and therefore the program evidences substantial noncompliance with the Council's standards and requirements for approval

- An institution withdraws voluntarily from resident training. Actions to withdraw approval voluntarily are not subject to the Council's procedures for procedural reconsideration, reconsideration, and appeal

- Two or more programs merge into a single new program, resulting in the loss of identity of a previously approved program

Reclassification of a program requires withdrawal of the program's previously approved category.

When the Council considers an action to withdraw approval, factors that have a significant impact on the effectiveness of the residency are identified as the basis for the action. The RRC and/or the Council have the prerogative of adding to the action to withdraw approval the requirement that no new residents or transfers enter the residency until areas of noncompliance have been addressed to the satisfaction of the RRC and the Council. A decision to withdraw approval will not become final or be published until the processes of procedural reconsideration, reconsideration, and appeal are exhausted. Reconsideration and appeal are available only to programs on probation that have failed to correct areas of noncompliance (see Procedural Reconsideration, Reconsideration, and Appeal).

When the Council proposes to withdraw approval of a program, the institution is required to verify to the Council, in writing, that all current and incoming residents, and program applicants selected for interview have been notified of this approval status (applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

NOTIFICATION OF ACTION

Within a reasonable period following the Council's meetings, an approval letter indicating the Council action is forwarded to each institution currently under consideration. Confidential correspondence regarding Council actions is addressed to the program director. A copy of the letter is forwarded to the chief administrative officer of the sponsoring institution.

When the Council action is to place the program on probation, to continue probation, to withhold provisional approval, or to withdraw approval, the letter to the director is sent by email and certified mail, with a return receipt requested. Letters to withhold provisional approval or to withdraw approval are forwarded to the director within 30 calendar days of the Council action.

Each letter indicates the approval status of the program and the number of authorized positions. When the Council takes an action that requests submission of an interim progress report and/or a progress report, the letter identifies the reason(s) for taking the action. The letter outlines the necessary information that must be submitted for the RRC and the Council to review the approval status of the program at future meetings, as well as the date on which this information is due in the Council office.

When the Council considers withholding provisional approval or withdrawing approval, the

letter advising the institution of the proposed action contains: (1) the specific reason(s) for taking the proposed action; (2) the date the action becomes effective unless a request for procedural reconsideration or reconsideration is received from the institution; (3) the right of the institution to request procedural reconsideration, reconsideration, and appeal and the date by which such a request must be received by the Council; and (4) the institution's obligation to inform current residents, incoming residents, and program applicants selected for interview regarding the approval status of the program.

When the approval action is based on the report of an on-site evaluation, a final copy of the report is enclosed with the approval letter. The report reflects the residency program as it existed at the time of the on-site evaluation along with program modifications made subsequent to the on-site evaluation. The final report will indicate whether identified areas of noncompliance have subsequently been corrected, partially corrected, or not corrected. The institution may distribute the final report as it wishes and is encouraged to provide as wide a distribution as possible to the faculty members who participate in the program.

The Council awards a certificate to institutions sponsoring programs recognized in the categories of provisional approval, approval, and approval with report.

RESIDENT NOTIFICATION OF ACTION

When the Council places a program on probation or withdraws program approval, the sponsoring institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been notified (applicants must be notified in writing prior to the interview).

The institution must submit a copy of the notification sent to the applicant/incoming resident/current resident. The institution also must submit either the applicant's/incoming resident's/current resident's written acknowledgment of the status of the program or verifiable documentation of this individual's receipt of the institution's letter (e.g., signed copies of return receipts for certified mail or copies of emails). These materials must be submitted as part of the progress report requested by the Council at the time it informed the institution of the action.

ACTIVATION OF A PROVISIONALLY APPROVED RESIDENCY

Provisional approval is effective on the date granted by the Council. Provisional approval will not be considered for any training year or portion of a training year prior to the effective date of granting of provisional approval.

The Council recognizes that a residency may have an effective date of provisional approval that is later than July 1. The Council permits up to six months of resident training overlap on a one-time basis for programs that begin after July 1.

The Council will withdraw provisional approval if the residency is not activated within two calendar years of the effective date of provisional approval. This action is not subject to the Council's procedures for reconsideration, reconsideration, and appeal.

PROCEDURAL RECONSIDERATION, RECONSIDERATION, AND APPEAL

The following reconsideration and appeal procedures are available for each of the following proposed adverse actions.

If the RRC proposes **denial of eligibility for on-site evaluation**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, followed by appeal, **or**
- Reconsideration, followed by appeal.

If the RRC proposes **denial of either an increase in positions or reclassification of positions**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, **or**
- Reconsideration.

If the Council proposes **withholding provisional approval or withdrawing approval**, the institution may request one of the following:

- Procedural reconsideration, followed by reconsideration, followed by appeal, **or**
- Reconsideration, followed by appeal.

A request to initiate the processes of procedural reconsideration, reconsideration, and appeal will be accepted for cause and will not be accepted solely on the basis of dissatisfaction with the proposed adverse action, nor will it be accepted on the basis of modifications made subsequent to the determination of the adverse action. A residency that conforms to Council standards, requirements, and/or procedures subsequent to determination of an adverse action (resulting in withholding of provisional approval or withdrawal of approval) will be viewed as a new residency and will be required to follow the application procedures described earlier in this publication.

The institution receives formal written notification of the adverse action following the action of the Council. The basis for the adverse action and the institution's right to request procedural reconsideration, reconsideration, and appeal are stated clearly in the notification letter.

When the Council considers an adverse action (resulting in withholding of provisional approval or withdrawal of approval), the action does not become final, nor is it published, until the institution has been afforded opportunity to complete the processes related to procedural reconsideration, reconsideration, and/or appeal. If the institution does not initiate the procedural reconsideration, reconsideration, and appeal processes, the institution's rights to due process through the Council are viewed to be exhausted.

During this due process period, the approval status of the residency reverts to the status prior to the adverse action, and the program is prohibited from accepting new or transfer residents. If the

Council sustains an action to withdraw approval, the final action becomes effective at the conclusion of the academic year in which the action is sustained.

Procedural Reconsideration

Procedural reconsideration is the process that allows the institution the opportunity to request that the Council review the proposed adverse action for the purpose of determining whether the Council, the RRC, or the evaluation team failed to follow Council procedures described in this publication. Because procedural reconsideration is designed for the review of errors in the application of Council procedures, matters of disagreement related to issues of substance will not be reviewed within the procedural reconsideration process. Such matters, however, may be identified as the basis for a request for reconsideration and/or appeal.

A request for procedural reconsideration must be submitted within 30 calendar days following receipt of the notification letter. If such a request is not submitted and postmarked or date-stamped within this 30-day period, the Council considers the institution to have waived all rights to procedural reconsideration. The sponsoring institution is encouraged to submit its written request to the Council office by email and certified mail, with a return receipt requested.

The request for procedural reconsideration must identify the procedure(s) in question and describe in detail the institution's claim that the procedure(s) was not followed, including any documentary evidence to support the claim. Following review by Council staff, the request for procedural reconsideration is considered by the Council's Executive Committee by virtual meeting/conference call or meeting. The Council acknowledges in writing the receipt of all procedural reconsideration materials.

Based on a recommendation of the Executive Committee, a decision may be made by the Council, either by virtual meeting/conference call or meeting to: (1) sustain the previous action; (2) rescind the previous action and refer the matter for additional review by the RRC; or (3) defer action and conduct a new on-site evaluation. If a new evaluation is conducted, the cost of the evaluation is shared equally by the institution and the Council. The program director and the institution's chief administrative officer are notified of the action taken with respect to the procedural reconsideration no later than 30 calendar days following the next scheduled meeting of the Council following the original determination of the action that led to the request for procedural reconsideration.

Reconsideration

Reconsideration is the process that allows the institution the opportunity to request that the RRC and/or the Council review the proposed adverse action for the purpose of determining whether any error or omission occurred in making the decision.

A written request for reconsideration must be received in the Council office within 30 calendar days following receipt of the notification letter. If a request for reconsideration is not received within this 30-day period, the Council considers the institution to have waived all rights to reconsideration and subsequent appeal. The sponsoring institution is encouraged to submit its written request to the Council office by email and certified mail, with a return receipt requested.

The request must include specific facts and reasons for which the institution contends the adverse

action should not be taken. Council staff acknowledges in writing the receipt of all reconsideration materials.

Following review by Council staff, the materials are considered by the RRC by virtual meeting/conference call or at its next meeting. Reconsideration related to denial of eligibility for on-site evaluation or an increase in positions may be considered by the RRC by virtual meeting/conference call or at its next meeting. Reconsideration related to withholding of provisional approval or withdrawal of approval must be considered by the RRC at its next meeting.

Related to proposed actions to deny eligibility for on-site evaluation or to deny an increase in positions, the RRC has the options of rescinding or sustaining the proposed action.

Reconsideration of the adverse action is completed no later than the next scheduled meeting of the RRC following the original determination. The program director and the institution's chief administrative officer are notified of the RRC action.

Based on a recommendation of the RRC, a decision to sustain or rescind a proposed action to withhold provisional approval or withdraw approval is considered by the Council at its next scheduled meeting. A recommendation may be made by the RRC and/or the Council to assess the request for reconsideration by conducting an on-site evaluation of the residency. The on-site evaluation is designed to evaluate the particular issues or concerns related to the adverse action.

When an on-site evaluation is conducted, action is deferred to the second scheduled meeting following the original determination of the adverse action. The program director and the institution's chief administrative officer are notified of the Council's action.

During the reconsideration process, a representative(s) of the institution under reconsideration may request in writing the opportunity to provide a statement to the RRC regarding the proposed adverse action. Any additional information that is to be brought to the attention of the RRC must be submitted to the Council office prior to the meeting.

Appeal

Following completion of the procedural reconsideration and/or reconsideration processes, the institution may appeal the decision to a hearing committee. The appeal process followed by the Council is articulated in CPME 935b, *Guidelines for the Conduct of Appeals and Arbitration by Residencies, Fellowships, Providers of Continuing Education, and Specialty Boards*. The institution is free to pursue a substantive and/or procedural claim.

REAPPLICATION FOLLOWING WITHHOLDING OR WITHDRAWAL OF APPROVAL

An institution seeking approval of a residency program that has had provisional approval withheld or approval withdrawn is expected to follow the procedures outlined for new residencies (see Application for Provisional Approval of a New Residency Program and Fee Policies). With respect to re-evaluation of a program that has had provisional approval withheld or approval withdrawn, the RRC will focus principal attention on those areas that were of greatest concern in the original decision to withhold provisional approval or withdraw approval.

AUTHORIZATION OF INCREASES IN RESIDENCY POSITIONS

Increases in residency positions are considered and authorized by the RRC. Applications for increases are considered by e-ballot, virtual meeting/conference call, or at a meeting of the RRC. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent e-ballot, virtual meeting/conference call, or meeting.

Institutions seeking authorization of increases in positions in provisionally approved and/or approved residencies are required to submit CPME form 345, *Application for Increase in or Reclassification of Residency Positions*, required supplemental materials, and an application fee (see Fee Policies). The application must be submitted prior to activation of the residency position(s), preferably at least six months before the anticipated starting date. A six-month lead time is necessary should additional information be required.

The effective date of granting an authorization of increased residency positions by the RRC will be no earlier than the date on which the program has both authorization of the increase and the additional resident(s) in place.

In order to determine whether the institution has the appropriate resources for an increase in residency positions, the RRC will review information including, but not limited to:

- The last on-site evaluation report, pertinent progress report materials, and most recent approval letter,
- A completed CPME form 345, *Application for Increase in or Reclassification of Residency Positions*. The application provides information regarding the rationale for the proposed increase with supporting documentation to justify the increased number of positions.
- Resident logs (to be reviewed online).

The RRC will not consider an application for an increase submitted by a program on probation. If a program on probation increases positions without authorization, the Council will withdraw approval of the program at its next scheduled meeting.

If the sponsoring institution fails to respond in writing within six months to written requests from Council staff and/or the RRC for information to complete the application, the application will be terminated by staff. Council staff will correspond with the program director and the institution's chief administrative officer to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

ONE-TIME INCREASE IN POSITIONS

If a program will exceed its number of approved residency positions (per training year or overall complement) for more than three months of training, the program director must apply for a one-time increase in positions by submitting CPME form 345, *Application for Increase in or*

Reclassification of Residency Positions, and an application fee (see Fee Policies).

INCREASE IN POSITIONS TO ACCEPT RESIDENTS DUE TO PROGRAM CLOSURE

When an institution accepts multiple residents from a program that is closing, leading to an increase in positions, CPME requires the institution to submit CPME form 345, *Application for Increase in Positions*, and the corresponding fee. Programs will need to follow the procedure for resident transfer for all residents entering the program; however, the transfer fee will only be assessed for a single resident.

RECLASSIFICATION OF APPROVED POSITIONS

Applications for reclassifying approved positions are considered by e-ballot, virtual meeting/conference call, or at a meeting of the RRC. The RRC has the prerogative of taking no action on the application in order to request further information from the sponsoring institution and/or to discuss the application during a subsequent e-ballot, virtual meeting/conference call, or meeting.

A program may request one of the following by submitting CPME form 345, *Application for Increase in or Reclassification of Residency Positions*, required supplemental materials, and an application fee (see Fee Policies):

- Reclassification of one or more PMSR to PMSR/RRA positions in provisionally approved and/or approved residencies
- Reclassification of one or more PMSR/RRA positions to PMSR positions in provisionally approved and/or approved residencies

The application must be submitted prior to reclassification of the residency position(s), preferably at least six months before the anticipated change. A six-month lead time is necessary should additional information be required.

In order for the RRC to determine whether the institution has the appropriate resources for the reclassification of residency positions, the institution must submit the following information for review:

- A cover letter signed by the program director indicating why the institution is reclassifying the residency program, identifying the number of positions to be reclassified and the effective date of the reclassification.
- Letters of attestation from current and incoming residents affected by the change.
- If the institution is reclassifying a portion of the approved positions, an explanation as to how the institution will determine which of the current residents will be offered the reclassified position(s).
- Sample contracts for residents affected by the change.

- A sample PMSR and or PMSR/RRA certificate.

- A completed CPME form 345. The application provides information regarding the rationale for the proposed reclassification with supporting documentation.

The RRC will also review the last on-site evaluation report, pertinent progress report materials, the most recent approval letter, and resident logs.

The RRC will not consider an application for a reclassification from PMSR to PMSR/RRA submitted by a program on probation. If a program on probation reclassifies positions without authorization, the Council will withdraw approval of the program at its next scheduled meeting.

If the sponsoring institution fails to respond in writing within six months to written requests from Council staff and/or the RRC for information to complete the application, the application will be terminated by staff. Council staff will correspond with the program director and the institution's chief administrative officer to inform them that the application has been terminated. The sponsoring institution may submit a new application, supplemental materials, and application fee after the application has been terminated.

ONE–TIME CERTIFICATE REQUESTS

Sponsoring institutions may submit the following one-time certificate requests for a resident in either a PMSR or a PMSR/RRA:

- A PMSR certificate for a resident in a PMSR/RRA who cannot complete the RRA requirement

- A 36-month PMSR/RRA certificate for a resident in a PMSR/RRA that requires 48 months to complete but who completes only 36 months of training.

An institution that sponsors a PMSR residency may not request a one-time PMSR/RRA certificate even if the resident has met the requirements of a PMSR/RRA. However, the program may apply to reclassify all or a portion of the residency positions to PMSR/RRA. The application to reclassify the residency must be submitted at least six months prior to the resident's completion of training.

Inactive Status for Provisionally Approved Programs

A provisionally approved residency or a position(s) in a provisionally approved residency that is temporarily inactive will be considered eligible for continued approval for a period not to exceed two years immediately following the granting of provisional approval by the Council. A residency that is not activated within two years must follow the application procedures for new programs if and when training is initiated. If a residency position(s) is not activated within two years, the sponsoring institution must submit CPME form 345, *Application for Increase in Positions*, and the application fee if and when the position(s) is to be activated or reactivated. (An inactive program or position is one in which funding, staffing, or available training resources have been interrupted or in which a suitable or interested candidate for the residency has been unavailable.)

Institutions with inactive approved programs are required to submit annual report forms and annual assessment fees throughout the recognized period of inactivation.

The RRC will not consider extensions of approval for inactive programs that have reached the end of their approval period.

RESIGNATION, TERMINATION, OR SUSPENSION OF THE RESIDENT

If a resident resigns from or is terminated or suspended from a residency for any reason, written notice must be sent to the Council office within 30 calendar days of the termination date. It is the responsibility of the program director to notify the Council of any resignation, suspension, or termination of a resident, regardless of the approval status of the program.

If the resident's appointment is suspended or terminated, the notice must indicate the general cause for the termination but need not contain a statement of specific facts. The notice also must contain a description of the process by which the suspension or termination decision was reached to assure that institutional due process procedures were followed.

EXTENSION OF TRAINING

The program must notify the Council regarding extension of training. When the extension goes beyond three full months, the notice must include:

- a revised contract;
- training schedule for the extended period of training;
- the projected completion date;
- the reason for extension of training; and
- the impact extension of training will have on the other residents in the program.

Additional information may be required by the RRC, including submission of CPME form 345 and applicable fees.

Leave of absence: If a resident's leave of absence results in extension of training, the program must submit written notice to Council staff within 30 days of the resident's return from a leave of absence.

Performance improvement: The program must submit written notice to the Council for performance improvement plans that result in extension of resident training beyond 36 months.

PROGRAM TERMINATION

If an institution with an approved residency closes or if for any other reason the program is discontinued, the Council will withdraw approval of the program based on voluntary termination by the sponsoring institution, effective on the date of closure or termination of the residency.

It is the responsibility of the program director and the chief administrative officer to notify the Council in writing of termination of the residency. Additionally, the institution is required to verify to the Council, in writing, that all current residents, incoming residents, and program applicants selected for interview have been informed of the voluntary termination of the program

(when possible, applicants must be notified in writing prior to the interview) (see Resident Notification of Action).

Within 30 days of the closure of the program, the sponsoring institution must complete the annual report or provide a formal letter to the Council identifying the names of the residents who have completed the program and copies of certificates (if applicable).

When an institution voluntarily discontinues a residency prior to completion of the training cycle, arrangements may be made to transfer the resident(s) to another approved residency (see Resident Transfer).

RESIDENT TRANSFER

Resident transfers must be submitted to CPME for review by the RRC chair within 30 days of the resident's official acceptance.

Residents Re-entering Training Programs

A residents who possesses a certificate in any category and wishes to re-enter residency training must begin as a first-year resident and complete three full years of training.

Residents Repeating First Year of Training

A resident who has completed one or more years of training and wishes to restart training in a different residency program as a first-year resident is not considered a resident transfer. As such, logs and completed rotations will not transfer into meeting the requirements of the new program.

Residents Repeating Second Year of Training

A resident who has completed two years of training and wishes to repeat the second year of training as a transfer resident must also complete the third year of training, regardless of the overall length of training completed. The program may not request early graduation of the resident, even if the resident meets all the training requirements.

Resident Transfer in the Third Year of Training

Residents must spend at least 11 months of training in the program that awards the certificate. This policy will not impact residents who must transfer due to program closure.

Documentation Required for Transfer

The director of the program accepting the resident must submit the transfer fee (see Fee Policies) and the following information to the Council office within 30 days of the resident's official acceptance:

- The name of the releasing institution, the category of the residency program, and the dates the resident participated in the program

- Confirmation that the resident is transferring into an open position and the year into which the resident is accepted

- A list of completed rotations, along with a signed statement that the program director has reviewed the completed assessment forms and residents have successfully completed these rotations

- A statement that the program director has received copies of completed milestones, if applicable, for the transferring resident

- Comprehensive training schedule for the remainder of the resident's training that allows for achievement of all prescribed competencies specific to the residency category

Program directors are required to provide copies of completed assessment forms and all completed milestones, if applicable, to the director of the program accepting a resident transfer, regardless of the reason the resident left the previous residency program.

Once Council staff has determined that the transfer request is complete, it is forwarded to the RRC chair for consideration. If the RRC chair approves the transfer, the institution to which the resident has transferred may grant a certificate upon the resident's successful completion of the residency. The institution is authorized to grant only a certificate of completion for the residency category in which it is approved by the Council.

If the Council's procedures for resident transfers are not followed, the resident involved may not be granted a certificate of completion by any residency, and the Council may extend probationary approval.

INTERNAL RESIDENT TRANSFER

A program that sponsors both PMSR and PMSR/RRA programs may initiate an internal resident transfer into an open position from one category to the other with prior approval of the RRC chair. The resident transfer must include all required documentation (outlined above) and the resident transfer fee, as well as attestations signed by the resident(s) acknowledging acceptance of the new residency category.

MULTIPLE RESIDENT TRANSFERS DUE TO PROGRAM CLOSURE

When an institution accepts multiple residents from a program that is closing, CPME requires the institution to submit CPME form 345, *Application for Increase in Positions*, and the corresponding fee. The institution accepting the residents will need to follow the procedure for resident transfer for all residents entering the program; however, the transfer fee will only be assessed for a single resident.

PROGRAM TRANSFER/CHANGE IN SPONSORSHIP

Institutional sponsorship of a training program may be transferred from one institution to another under certain circumstances. The program director must contact the Council office in writing within 30 days of sponsorship changes. In the event the program sponsorship change involves

addition or removal of a co-sponsor, the institution must notify the Council in writing within 30 days of this change.

The following documentation is required in all cases:

- Letter of intent from the chief administrative officer of the new sponsoring institution or co-sponsoring institution (if applicable)
- Letter from the chief administrative officer of the original sponsoring institution acknowledging the transfer or addition of a co-sponsoring institution
- List of any new administrative staff (CAO/DIO) and podiatric and non-podiatric medical faculty (with board qualification/certification status and professional qualifications)
- Contact information for the program director and CAO/DIO, including phone number, email, and mailing address
- Copies of signed resident contracts
- Curriculum vitae of the program director (if the director is new)
- Copies of affiliation agreements (if applicable)
- Residency manual that includes all required components (refer to CPME 320, requirement 3.9)

A full or focused on-site evaluation may be required. The institution to which the program is transferred must grant a certificate to each resident who successfully completes the program. The certificate must be appropriate for the resident's entire training sequence and the program category approved by the Council.

ANNUAL REPORT

Completion of an annual report form, CPME 340, is required of each institution sponsoring an approved residency beginning with the program's first year of provisional approval. The annual report provides the Council current information for CPME's database and the list of approved residencies maintained on the Council's website. As part of the annual report, the Council requests the names of residents completing the program and the new and returning residents in the program.

Co-sponsoring institutions must submit a single copy of the annual report that provides information about the program as a whole, rather than each individual co-sponsor submitting its own annual report. The annual report for the co-sponsored program is to include the signatures of the program director and chief administrative officers, or their designees, of each co-sponsoring institution. (If an institution is involved in a co-sponsorship and also sponsors a separate residency program, the institution is required to participate in preparation of the annual report for the co-sponsored program and to submit a separate annual report for the residency for which it is the sole sponsor.)

If extenuating circumstances exist relative to resident completion of a training year, the program director must notify the Council within 30 days of the decision and provide this information in the annual report. Examples of extenuating circumstances include, but are not limited to, an extension of a resident's training period to address instances of unsatisfactory performance or to complete a portion of the training year the resident was unable to fulfill due to illness and/or disability.

Council staff reviews annual reports and brings concerns to the attention of the RRC at its next meeting. Council staff may correspond with the program director to request that the sponsoring institution provide specific information for consideration at the RRC meeting.

Failure to submit the annual report and/or annual fee is cause for the Council to place the sponsor on probation and subsequently to consider withdrawal of approval. The RRC and/or the Council reserve the right to request additional materials to clarify information in the annual report.

CONFIDENTIALITY AND DISCLOSURE POLICIES

All reports and communications regarding residencies are confidential within the Council, RRC, appeal committees, evaluation teams, and Council staff. On-site evaluators, RRC members, and Council members sign a confidentiality statement on a periodic basis, confirming that privileged information will not be disclosed in any manner.

Because of the tripartite relationship of accreditation, certification, and licensure, the Council has the prerogative of providing confidential information regarding the approval status of residencies to the appropriate Council-recognized specialty boards and to state boards for examination and licensure, upon the specific written requests of these organizations.

All proceedings of the RRC and the Council with respect to determining residency recommendations and actions are held in executive session.

The Council office, RRC, and the Council will not release or confirm the following information in any form:

- The name or status of a sponsoring institution that has initiated contact with the Council office concerning an application for provisional approval, increase in positions, or reclassification of approved positions

- The name or status of a sponsoring institution that has applied for provisional approval or an increase in positions but has not yet been informed of a decision

- The name or status of a sponsoring institution that has applied for and been denied eligibility for on-site evaluation or authorization of an increase in or reclassification of approved positions (prior to exhaustion of the procedural reconsideration, reconsideration, and appeal processes, as applicable)

- The name or status of a sponsoring institution that has had provisional approval withheld or approval withdrawn (prior to exhaustion of the procedural reconsideration, reconsideration, and appeal processes)

The list of approved residencies on the Council's website identifies residencies that are eligible for on-site evaluation, residencies holding provisional approval, residencies that are approved, and residencies approved on a probationary status. Areas of noncompliance, as reflected by standard and requirement numbers, are included in the probationary information.

Withdrawal of program approval is published following exhaustion of the entire process of

procedural reconsideration, reconsideration, and appeal or following the institution's indication that it does not wish to pursue these processes.

THIRD-PARTY COMMENT

The Council provides opportunity for individuals or organizations to submit written comments concerning an institution's qualifications for provisional or continued approval. The Council publishes notices on its website regarding its plans to conduct either a focused evaluation or a comprehensive evaluation of an institution that seeks provisional approval or continuation of approval. The notice indicates the deadline for receipt of third-party comments.

Third-party comments must be signed, address substantive matters relating to the quality of the program and the CPME standards and requirements, and be received no later than 15 days prior to the program's scheduled visit date. Comments will be forwarded to the evaluation team, and to the program director for response if appropriate, during the evaluation visit process.

REVIEW OF FORMAL COMPLAINTS

A mechanism exists for reviewing formal complaints against approved residencies. The Council reviews only those complaints related to the alleged noncompliance of a program with the Council's standards and requirements. The mechanism for reviewing formal complaints is specified in CPME publication 925, *Complaint Procedures*.

STATEMENTS OF APPROVAL STATUS

An institution sponsoring a **provisionally approved** residency must use the following statement in reference to its approval status:

> The (category of program) sponsored by (name of institution) has been granted provisional approval by the Council on Podiatric Medical Education. Provisional approval is the recognition accorded a new residency that is determined to be in substantial compliance with established standards and requirements. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

An institution sponsoring an **approved** residency must use the following statement in reference to its approval status:

> The (category of program) sponsored by (name of institution) is approved by the Council on Podiatric Medical Education. Approval is the recognition accorded a residency that is determined to be in substantial compliance with established standards and requirements. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

An institution sponsoring a residency that is approved on a **probationary** status must use the following statement in reference to its approval status:

> The (category of program) sponsored by (name of institution) is approved on a probationary basis by the Council on Podiatric Medical Education. Probation indicates that

a residency is in noncompliance with the Council's standards and requirements for approval to the extent that the quality and effectiveness of the residency are in jeopardy. The Council is an independent, specialized accrediting agency that provides accreditation and approval services for the American Podiatric Medical Association.

No other statements regarding approval by the Council may be used without the permission of the Council.

ASSESSMENT OF EVALUATOR EFFECTIVENESS

The effectiveness of the on-site evaluation process is assessed formally by the institution and the evaluation team. The Collaborative Residency Evaluator Committee (CREC) monitors the effectiveness of on-site evaluators by reviewing evaluation questionnaires completed by institutions regarding the performance of on-site evaluators, as well as those completed by the team leaders and other team members. CREC forwards a report of its review, identifying areas requiring follow-up and evaluators who might require remediation or dismissal to the Council's Executive Committee for its review. CREC is the collaborative effort of ABFAS, ABPM, and the Council to develop, implement, and review procedures to select, train, and assess podiatric residency evaluators and team chairs.

In reviewing evaluation team reports, the RRC may forward comments about individual evaluators to the Council's Executive Committee. To assure objectivity in its approval recommendations, the RRC is never provided the post-evaluation questionnaires completed by the sponsoring institution and evaluation team members.

The Council commends effective evaluators and provides remediation for ineffective evaluators. The RRC, CREC, and/or the Executive Committee may suggest to the Council that evaluators who demonstrate repeated ineffectiveness be removed from the list of residency evaluators.

NONDISCRIMINATION POLICY

The Council prohibits discrimination related to all of its activities on the basis of sex, creed, race, national origin, age, color, sexual orientation, gender identification, political belief, disability, or any other factor protected by law.

FEE POLICIES

The Council has developed fee schedules for various aspects of its evaluation and recognition activities as outlined in CPME's Residency Fees document.

The costs related to on-site evaluations of new programs are borne by the sponsoring institution. The Council requires pre-payment of a specified on-site evaluation fee.

Institutions that have had provisional approval withheld or approval withdrawn and subsequently reapply must submit a reapplication fee.

The Council has established an annual fee assessed each institution sponsoring an approved residency or residencies. A late fee is assessed related to submission of the annual assessment fee.

Institutions requesting appeals of adverse actions are assessed a portion of the anticipated actual costs prior to the appeal. Institutions are billed the remainder of any additional actual costs after the appeal.

All fees are nonrefundable. The Council reserves the right to add or revise established fees.

CPME 330

House Staff Manual

MedStar Health

Academic Year 2024-2025

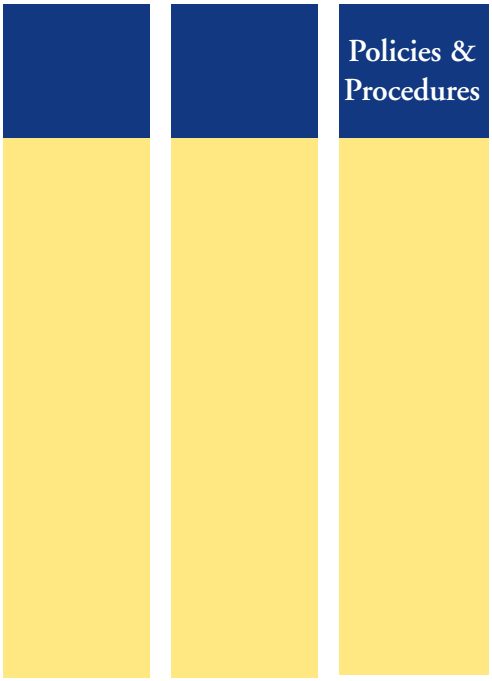


Table of Contents

Section 1. Introduction

Section 2. Policies

Section 3. Compensation/Benefits Programs

The MedStar Health house staff manual applies to all residents and fellows in all MedStar Health training programs and at all MedStar Health sites, locations, and hospitals.

Welcome from Stephen R.T. Evans, MD

It is my pleasure to welcome you to the leading academic health system in Maryland and the Washington, D.C., region. I hope you share our excitement and enthusiasm to be part of MedStar Health, and it is the start of a long and successful career at our organization. MedStar is committed to supporting you as you journey through the remarkable process of becoming a doctor.

At MedStar, we are committed to our vision to be the trusted leader in caring for people and advancing health. It drives our passion and purpose every day. We provide a culture of learning that cultivates knowledge through research, innovation and education, with an ever-present focus on our high reliability organization (HRO) journey that provides the highest levels of quality and safety to our patients. Our mission is to serve our patients, those who care for them and our communities, and we will rely on each of you to help deliver on this commitment. You have an important job as students, and we are honored to guide you in becoming the best and brightest physicians of the future.

We also look forward to witnessing your transformation from student to physician. Our system, leaders and associates support your evolution into world-class clinicians, educators, scientists, and leaders. Thank you in advance for your curiosity, innovative ideas and commitment to advancing health. I assure you it is a worthwhile and unforgettable experience, and I am confident your contributions will help advance your growth as a physician and the strength of our MedStar Health system.

Stephen R.T. Evans, MD
Executive Vice President, Medical Affairs and Chief Medical Officer
MedStar Health

Policies

Academic Improvement Policy

MedStar Health
Graduate Medical Education Policy

I. Purpose

To establish a policy and process for all graduate medical education (GME) programs at MedStar Health to use in the normal process of evaluating and assessing competence and progress of House Staff. Specifically, this policy will address the process to be utilized when a resident/fellow is not meeting the academic expectations of a program, and therefore, fails to progress.

II. Scope

This policy will apply to all House Staff officers who participate in a GME training program within MedStar Health.

III. Definitions

House Staff or House Officer – refers to all interns, residents and fellows enrolled in a GME program.

Objective Feedback – Assessments and evaluations that are typically structured and scored or rated based on predetermined criteria that are uniformly applied. Examples include but are not limited to tests, shelf exams, USMLE scores, OSCEs, etc,

Subjective Feedback – Assessments and evaluations that are made by faculty and other evaluators, structured or unstructured, based on their professional judgments and opinions. Examples include but are not limited to rotational evaluations, verbal feedback, 360 evaluations, etc.

IV. Process

A. **Performance Feedback**: All residents and fellows should be provided routine feedback regarding their performance that is consistent with the educational program. Some examples of feedback include verbal feedback, rotational evaluations, semi-annual evaluations, unsolicited feedback, and mentoring (See Evaluation Policy).

B. **Clinical Competency Committee**: Each residency training program must have a Clinical Competency Committee ("CCC")[1] that is responsible for routinely assessing house officer performance and making recommendations to the Program Director (see Clinical Competency Committee Policy).

C. **"Letter of Deficiency"**: When a house officer does not show improvement following normal feedback (verbal, written, structured or unstructured), a "Letter of Deficiency" should be prepared and delivered to the house officer. The "Letter of Deficiency" must be signed by the program director and should be co-signed by the Assistant Vice President, GME or his/her designee. The purpose of the "Letter of Deficiency" is to amplify the message and clearly articulate the house officer's deficiencies. They should be competency based. The "Letter of Deficiency" should provide the house officer with clear notice of the identified deficiency(s) and an opportunity to improve. Letters of deficiency generally require the house officer to develop an independent learning plan that will be discussed and endorsed by the program director or advisor. A letter of deficiency is simply feedback, and not considered to be a reportable action. Letters of deficiency should be prepared by the program director or their designee. A final summative assessment (FSA) will be prepared by the program director and/or department for all trainees upon leaving the program. The FSA should be a fair and balanced reflection of academic and pro-

[1] The Clinical Competency Committee may be referred to as the "Progress and Promotions Committee" or other terminology. This is a departmental committee that consists of the faculty and others as deemed appropriate by the department. This committee should meet regularly to assess resident/fellow performance and make recommendations to the program director regarding further action.

fessional performance throughout the training course, including both strengths as well as areas identified for improvement. A copy of the finalized FSA should be shared with the resident/fellow. The content of the FSA is not open to discussion or negotiation by the resident/fellow, and as such is not subject for due process or similar review.

D. **Failure to Cure the Deficiency:** If the Program Director determines that a house officer is not meeting academic standards, or has failed to satisfactorily cure deficiencies. The program director may consider the following in determining whether or not to take further action: Review of the entire academic record, subjective and objective assessments and evaluations, feedback from the faculty, and feedback from the Clinical Competency Committee.

The Program Director may elect to take further action, which may include one or more of the following steps:

i. Additional Letter of Deficiency, OR

ii. Reportable Actions:

1) Election not to promote to the next PGY level

2) Extension of contract, which may include extension of the defined training period. Note that extension of training for non-academic reasons, such as approved medical leave, is not subject for due process review.

3) Dismissal from the residency or fellowship program

Reportable Actions: The decision not to promote a house officer to the next PGY Level, to extend a house officer's contract, to extend a house officer's defined period of training, to deny a house officer credit for a previously completed rotation, and/or to terminate the house officer's participation in a residency or fellowship program are each considered "reportable actions." Reportable Actions are those actions that the Program must disclose to others upon request, including without limitation, future employers, privileging hospitals, credentialing boards, and licensing and specialty boards. House Officers who are subject to a Reportable Action may request a review of the decision as provided in this Policy.

E. **Request for Review**: A review of the decision to take a Reportable Action may be requested by the house officer. A Request for Review should be submitted to the Assistant Vice President, GME or their designee within fourteen (14) days of learning of the Reportable Action. Upon receipt of a Request for Review, the Assistant Vice President, GME will first determine whether the matter is reviewable under this Policy, and if so, the Assistant Vice President, GME shall appoint a neutral physician reviewer. Unless there is a conflict of interest, the initial physician reviewer will be the Associate Designated Institutional Official (DIO) of the entity, who will:

i. Review the complaint

ii. Meet with the house officer

iii. Review the house officer's entire academic record

iv. Discuss with the program director

v. Consider any extenuating circumstances

vi. Consult with others, as appropriate, to assist in the decision making process; and

vii. Determine whether this Policy was followed. Specifically that the house officer received notice and an opportunity to cure, and the decision to take the Reportable Action was reasonably made.

The Assistant Vice President, GME will:

i. Appoint the physician reviewer (the Associate DIO will serve as the first level reviewer unless there is a conflict of interest)

ii. Assist the physician reviewer to identify other potential participants, if warranted and requested by the physician reviewer

iii. Attend all meetings held by the physician reviewer

iv. Coordinate communications between the physician reviewer and the house officer

v. Monitor timely completion of the review process

vi. Notify the Physician Chair of the System GMEC and Corporate Vice President, Academic Affairs (VPAA) of the request for review

F. **Opportunity for a Final Review:** If either the house officer or the program director disagree with the decision of the physician reviewer, either can request a final review of the decision to take a Reportable Action. This final review is conducted by the Physician Chair of the System GMEC, together with the Corporate Vice President for Academic Affairs or their designee. A request for final review shall be submitted to the Corporate Vice President for Academic Affairs within fourteen (14) days of learning of the Physician Reviewer's decision. The roles of these individuals and the process are generally the same as described in the "Request for Review" above; however, the report of the first level review will be utilized in this decision making process. The final reviewer will seek to determine additional information, extenuating circumstances, or matters that were not covered in the initial review process. The decision of the Physician Chair of the System GMEC constitutes a final and binding decision. Upon conclusion of the review, a report of the final review will be provided to both the house officer and the program director.

Policy Approved by: System GMEC
Policy Maintained by: MedStar Academic Affairs

Accommodations for Individuals with Special Needs Policy

Policy Statement

MedStar Health is an equal opportunity employer. It is committed to treating individuals with disabilities in a fair, lawful and equitable manner; thereby providing them with the same employment opportunities, terms and conditions, benefits and privileges as individuals without disabilities, as required by applicable federal, state or local laws. This commitment extends to individuals who are current employees or job applicants.

MedStar Health will, among other things, provide individuals with disabilities with reasonable accommodations to apply for employment, participate in the interview process, perform essential functions of the relevant position, and enjoy equal benefits and privileges of employment as are enjoyed by similarly situated employees who do not have disabilities.

MedStar Health prohibits the unlawful use of an individual's physical or mental disability, need for a reasonable accommodation, or relationship with an individual with a disability as determining factors in employment decisions. Rather, our focus is on objective criteria, such as an applicant's or employee's skills, abilities and other job or business- related factors.

Philosophy Statement

MedStar Health is committed to being an employer of choice by attracting, developing and retaining skilled and engaged associates through the use of best practice employment procedures.

Procedure

In order to further MedStar Health's success in carrying out these important commitments, this policy provides guidance on accommodating job applicants and associates in the workplace. It also outlines how job applicants or associates may request reasonable accommodations. This reasonable accommodation procedure may be initiated either by an employee/new hire/ applicant or by a MedStar leader, Human Resources and/or Occupational Health. Because of the individualized nature of an individual's disability limitations, job duties, and workplace needs and business concerns, the applicant/employee and leaders, Human Resources and/or Occupational Health should engage in an interactive process.

I. Accommodating Disabled Job Applicants and Candidates

A. Reasonable Accommodations

Some job applicants who are disabled may be in need of reasonable accommodations in order to apply and/or interview for available job positions. For example, a job applicant with a visual disability may need assistance completing a written application or an applicant with a hearing disability may need assistance in participating in an oral interview (i.e., providing a sign language interpreter).

Job applicants may request accommodations to participate in the interview process when submitting their applications for employment. In addition, if an applicant informs the department leader, supervisor or associate involved in the application/interview process that he/she needs an accommodation to participate in the interview process, the leader, supervisor or associate should notify Human Resources for advice and assistance on providing a reasonable accommodation to the applicant. Occupational Health and/or the Legal Department should also be contacted if necessary.

B. Guidelines for Conducting Interviews

Department leaders, supervisors and associates who are involved in interviewing and/or hiring job candidates should ask questions and make decisions on job- related criteria and focus on the candidate's qualifications to perform the job, either with or without a reasonable accommodation. In other words, neither the existence of a candidate's disability nor the need for a reasonable accommodation should be factors in considering his/her request for an accommodation to engage in the interview process, or in considering him/her for hire. If it has been determined that providing an accommodation presents an undue hardship to MedStar Health, then an accommodation may not be provided. Human Resources and the Legal Department, however, should be consulted in making this assessment.

II. Hiring Decisions

Hiring decisions should be based on job-related criteria. As explained above, the existence of an individual's physical or mental disability and/or need for a reasonable job accommodation should not be factors in hiring decisions.

Similarly, an individual's relationship with someone who is disabled (i.e., a disabled parent or child) should not be a factor in making hiring decisions. If there is a concern that an undue hardship is presented to MedStar Health in providing a new hire with a job accommodation, Human Resources and/or the Legal Department should be consulted.

III. Accommodating Associates with Disabilities

A. Responding to Associates' Job Accommodation Requests

Associates with disabilities may submit a request for job accommodations to their Department leaders, Human Resources or Occupational Health, who will coordinate, review, and respond to the request.

Department leaders who receive requests for disability-related accommodations should seek the assistance of Occupational Health, Human Resources, or the Legal Department in reviewing job accommodation requests made by associates with disabilities. In some cases, it may be necessary to involve other internal or external resources to explore the availability and feasibility of certain accommodations. Further, it is helpful that the associate and the treating physician be involved in accommodation communications, as they can provide useful information regarding what accommodations may be effective.

Information regarding an associate's medical condition(s) and any need for a reasonable job accommodation is considered confidential and should not be disclosed to anyone who does not have a legitimate, business-related need to know such information.

B. Examples of Reasonable Accommodations

It is important to remember that reasonable accommodations are those that enable the associate to perform the essential functions of his/her job or to enjoy equal benefits and privileges of employment as are enjoyed by

similarly situated employees who do not have disabilities; they are not intended to eliminate essential job functions. An associate who is provided reasonable job accommodations should be held to the same job performance standards as other associates without disabilities.

Reasonable job accommodations can take many forms. Some examples include, but are not limited to, the following:

- Providing special equipment (i.e., Braille keyboard; specialized computer equipment)
- Modifying the workplace (i.e., moving furniture to allow access for wheelchair users)
- Modifying marginal job functions or the manner in which essential/core job functions are performed (i.e., altering the time/manner in which reports must be completed)
- Providing a modified work schedule (i.e., flex time so that the associate can attend medical treatment sessions)
- Providing an unpaid leave or accrued paid leave of absence (i.e., personal, medical or other leave so that the associate can obtain treatment or for recuperation)

  NOTE: In certain situations, a reasonable job accommodation may also include extensions of leave if such an extension is reasonably expected to give the associate time to become able to perform the essential functions of his or her job. To determine if a leave extension is appropriate, management should consult with Human Resources and Occupational Health; the Legal Department may also be consulted.
- Making arrangements to allow for the disabled associate's participation in social and business activities equal to that of individuals without disabilities (i.e., selection of a site for a holiday party/business meeting that is wheelchair accessible)
- Reassignment to another available position (i.e., temporary or permanent transfer to an available position that does not require the creation of a new position).

  IMPORTANT: Not every accommodation is reasonable for every given situation. Each case must be reviewed individually to ensure that the accommodation is effective and does not cause an undue hardship to MedStar Health. When no accommodation is available for the associate's current position, the associate should be provided a reasonable amount of time and assistance from Human Resources to be considered for other available, or soon to be available, job positions within MedStar Health that he/she is qualified to perform, with or without a reasonable accommodation.

  REMEMBER: Reasonable accommodations must be considered and, in the appropriate cases, provided to associates with disabilities regardless of whether the associate's disability was caused by an on-the-job illness or injury, or whether it is also covered by the Family & Medical Leave Act.

IV. Non-Harassment and Non-Retaliation

In keeping with its commitment to provide a fair, just and welcoming workplace for applicants and associates with disabilities, MedStar Health does not condone discrimination, harassment or retaliation in any form against such individuals; this includes, but is not limited to, harassing or retaliating against anyone who requests a job accommodation during the hiring or employment stage with MedStar Health. This prohibition also applies to 1) good faith complaints made by applicants or associates that are related to their disability status and requests for job accommodations; and 2) an applicant's or associate's participation in an internal or investigation of such complaints or alleged violations of federal, state or local laws addressing disability discrimination.

Please contact Human Resources with any questions regarding this policy.

Provisions of this policy apply to all associates to the extent they do not conflict with relevant terms of an applicable contract.

Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS)

MedStar house staff, with the exception of pediatric residents and neonatal fellows, are expected to maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certification at all times during training. For pediatric residents, current Pediatric Advanced Life Support (PALS) certification must be maintained. Neonatal fellows must maintain current Neonatal Resuscitation Program (NRP).

Clinical Experience and Education (Duty Hours)

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy for all graduate medical education training programs at MedStar Health hospitals to monitor and schedule appropriate work/duty hours of the house officers ensuring that the educational goals of the program and learning objectives are not compromised by reliance on the House Staff to fulfill institutional service obligations.

II. Scope
This policy will apply to all graduate medical education (GME) training programs within MedStar Health.

III. Definitions
House Staff or House Officer – refers to all interns, residents and fellows enrolled in a training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

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

IV. Responsibilities/Requirements
A. Programs and sponsoring institutions must educate house staff 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. The program must be committed to and responsible for promoting patient safety and House Staff well-being in a supportive educational environment.

C. The program director must ensure that house staff 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 house staff 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. House staff and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

1. safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
2. provision of patient and family-centered care;

3. assurance of their fitness for work;
4. management of their time before, during and after clinical assignments;
5. recognition of impairment, including illness, fatigue, and substance use in themselves, their peers, and other members of the healthcare team;
6. commitment to lifelong learning;
7. the monitoring of their patient care performance improvement indicators; and,
8. honest and accurate reporting of clinical and educational work hours, patient outcomes and clinical experience data.

F. All house staff and faculty must demonstrate responsiveness to patient needs that supersedes self-interest. This includes recognition 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.

G. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

H. The program must:

1. educate faculty and house staff to recognize the signs of fatigue and sleep deprivation;
2. educate all faculty members and house staff in alertness management and fatigue mitigation processes; and,
3. encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

I. Each program must have a process to ensure continuity of patient care, consistent with the program's policies and procedures, in the event that a house officer may be unable to perform his/her patient care responsibilities due to excessive fatigue.

J. The program, in sponsorship with the, sponsoring institution must ensure adequate sleep facilities and/or safe transportation options for house staff that may be too fatigued to safely return home.

K. House Staff Duty Hours:

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting.

   a) 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.

      (i) 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*.

      (ii) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

2. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by house staff in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour maximum weekly hour limit.

3. PGY-1 house staff are not permitted to moonlight. (See the MedStar GME Policy on Moonlighting for further institutional guidelines.)

4. House staff must be scheduled for a minimum of one day free of clinical and educational work every week (when averaged over four weeks). At home call cannot be assigned on these free days.

5. Residents should have eight hours off between scheduled clinical work and education periods. There may be

circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80- hour and the one-day-off-in-seven requirements.

6. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

a) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

b) In rare circumstances, house staff, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit. Under those circumstances, the House Staff officer must:

(i) Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

(ii) Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

c) The program director must review each submission of additional service, and track both individual House Staff and program-wide episodes of additional duty.

7. Residents must have 14 hours free of clinical work and education after 24 hours of in-house call.

8. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (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.)

9. Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

10. Time spent on patient care activities by house staff 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 clinical work and education, when averaged over four weeks.

a) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each House Staff officer.

(i) House Staff are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour weekly maximum.will not initiate a new “off-duty period.”

L. All house staff must log their duty hours in the residency management database, New Innovations.

M. Program Directors will be required to monitor their duty hour schedules and processes regularly. Duty hour compliance will be reviewed by the GMEC.

N. Any house officer working in excess of the hours mentioned above should report the situation to their Chief Resident, Program Director, Department Chair, GME, or the Vice President, Medical Affairs.

Policy Approved by: System GMEC

Policy maintained by: MedStar Academic Affairs

Conflict of Interest and Interactions with Industry

I. Purpose

The purpose of this policy is to clarify and establish appropriate guidelines for interactions between MedStar Health representatives and Industry. This policy documents the framework for all interactions with Industry and is aimed at assuring such relationships are ethical, do not impair professional judgment, and do not create conflicts of interest (or conflicts of commitment, as applicable) that could endanger patient safety, impair objectivity or data integrity, or damage the reputation of MedStar Health its affiliated entities or its representatives.

II. Policy

It is the policy of MedStar Health and its affiliated entities (collectively "MedStar") that interactions with Industry (as defined below) should be conducted in a fashion that avoids or minimizes actual or perceived conflicts of interest (and/or conflicts of commitment, as defined below). In order to maximize the benefits of biomedical research, medical education, and to assure continued advancements in the prevention, diagnosis and treatment of disease, MedStar must assure that any relationships with Industry are consistent with MedStar's vision of being the *Trusted Leader in Caring for People and Advancing Health*. While many interactions with Industry are positive and can expand knowledge, drive innovation, improve quality of care and are important for promoting the educational, clinical, and research missions of MedStar; actual or perceived conflicts may compromise the ability of MedStar to provide patient care, conduct research, transact business, make purchasing decisions, and may otherwise pose a risk to the operations or reputation of MedStar and its associates. As a result, it is vital that we continue to make patient welfare our first priority and that all relationships with Industry meet the highest standards of professional ethics and that MedStar is appropriately transparent about any actual or perceived conflicts.

This policy is aimed at fostering and promoting appropriate and ethical relationships important to MedStar's mission, vision, and values while eliminating relationships that are potentially harmful to MedStar or its patient's interests. This policy affirms that the culture of MedStar requires the exercise of independent professional judgment in the activities of each of its representatives. To maintain the trust of its patients and the public, potential conflicts must be identified and avoided or when actual or perceived conflicts do arise, they must be addressed appropriately as described herein.

This conflict of interest policy is intended to supplement and be complementary to MedStar's Code of Conduct, Business Ethics and Confidentiality Policy, and other policies involving conflicts of interest including MedStar Health Research Institute Policy on Conflicts of Interest (available at http://apps01.medstar.net/MRI/MRI-Policies.nsf/). However, it does not replace those policies or materials. To the extent this policy conflicts with or is more stringent than the Code of Conduct or other MedStar policies, this policy shall supersede such other policies and materials. All applicable state and federal laws continue to apply in accordance with their terms.

III. Scope

Unless any specific exceptions are specifically noted, this policy applies to MedStar Health, Inc, all its affiliated entities and subsidiaries, including their:[1]

Officers and Directors: All their officers and members of their boards of directors acting in-their capacity on behalf of MedStar;

Full-time and Part-time Associates/Employees: All full-time and part-time associates/employees of a MedStar entity;

Employed Physicians and Independent Contractors: All employed physicians, and independent contractors who perform activities or services at a MedStar facility and could be perceived as representing MedStar;

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[1] Note, please see Requirements and Guidelines for Implementing this Policy for individuals subject to reporting of potential financial conflicts of interest.

Faculty and Teaching staff: All faculty and teaching staff (whether employed or not) including independent contractors or voluntary faculty who have academic responsibilities for or perform teaching activities for MedStar;

Residents, Fellows and Students: All residents, fellows, and students, who receive training at a MedStar facility and could be perceived as representing MedStar;

Individuals with material decision-making responsibilities: Any other individuals who have material decision making responsibilities (including ordering or recommending the ordering of goods or services) on behalf of MedStar.

This policy specifically does not apply to private physicians with clinical privileges at MedStar facilities who are acting or performing services in their private practices or in their capacity as private physicians.

IV. Definitions

A. Conflict of Commitment (COC) – means any situation in which an employee undertakes external or private commitments which burden or interfere with the individual's obligations to MedStar.

B. Conflict of Interest (COI) – means any situation when an individual or their Immediate Family Member has Financial Interests or other personal interests that may compromise:

1. their professional judgment;
2. their performance of fiduciary or job responsibilities; or
3. the delivery of patient care or other services.

C. Financial Interest – means:

1. any compensation arrangement with any Industry Company (including any subsidiary or affiliated entity);
2. stock or ownership interests in an Industry Company (including any subsidiary or affiliated entity) amounting to greater than a 3% ownership interest;
3. company issued stock-options in an Industry Company (including any subsidiary or affiliated entity) regardless of amount or present value; or
4. any other compensation, reimbursement, or remuneration that improperly influences, or gives the appearance of improperly influencing business judgment, objectivity, relationships, or business outcomes.

D. Immediate Family Member – means the spouse or domestic partner, household members, and dependents of an individual with an actual or potential conflict of interest and includes step-children and children by adoption.

E. Industry Company – means any company that manufactures a pharmaceutical product, biological product, medical device, medical equipment, or medical supply whose use, provision or prescription is eligible for coverage by government reimbursement (i.e. Medicare, Medicaid). This includes any company who manufactures such a covered product, regardless of whether or not the manufacture of medically-related products is their principal business or simply a minor portion of their business activities.

F. Industry Representative – means any representative of any Industry Company (whether employed by or otherwise affiliated with) such entity.

G. Industry – The term "Industry" shall mean, independently or collectively, any combination of, Industry Company and Industry Representatives.

V. Responsibilities

Certain relationships and conduct with an Industry Company or Industry Representative are expressly prohibited by this policy while other relationships may provide benefits to MedStar's patients and may be appropriately managed, but require specific written approval. Finally certain conduct or relationships are permissible and require no advance approvals. ALL PERSONS SUBJECT TO THE REPORTING OBLIGATIONS OF THIS POLICY AS DESCRIBED BELOW IN SECTION 12 MUST REPORT ALL REPORTABLE POTENTIAL CONFLICTS OF INTEREST AS REQUIRED BY THIS POLICY. Any individual subject to this policy or the

Immediate Family Members of an individual subject to this policy must carefully consider whether their relationship with Industry requires any advance reporting and when in doubt, they should report the relationship or contact their Compliance Director for further guidance.

1. *Personal Gifts*. All cash, cash equivalent (i.e. gift cards), and non-cash gifts from Industry including but not limited to, perishable and non-perishable food items, floral arrangements, artwork, music, sporting event tickets, other entertainment, as well as any branded materials including pens, notepads, coffee mugs, clothing, or any other item with company logo or product information prominently displayed, is prohibited. However, unsolicited, non-branded, and general use gifts which have an educational value and are for the benefit of patient care or medical education, including books, anatomic models, illustrations, clinical diagrams, etc. are permitted provided they are of nominal value and they are not solely for a specific individual recipient's benefit. For example, a stethoscope would be considered a personal gift, while a book for a department library generally would not.

2. *Meals, Invitations, and Entertainment*. Industry sponsored meals, invitations, and entertainment (including, for example, both in-house and external/off-site meals, events, and entertainment) are considered personal gifts and are prohibited, unless otherwise specifically permitted by this policy. This includes industry-donated lunches and other meals for grand rounds and noon-time conferences.[2] However, Industry may donate funds centrally to the GME/CME Office to support a general fund for meals and/or educational activities, provided:

i. The donation is unrestricted and the Industry Representatives may not determine the content or presenter for any specific programs; and

ii. The Industry Company making a donation to a general meal fund may only be listed or identified among all commercial sponsors of on-site educational programs and may not be specifically identified as supporting any particular educational activity.

3. *Attendance at Industry-Sponsored (and Third-Party Industry Sponsored) Conferences, Education Sales, or Promotional Events*.[3] Honoraria, compensation, reimbursement or other remuneration paid directly or indirectly by Industry for listening to a sales presentation or for time, effort, or attendance of an individual at Industry-Sponsored or Third-Party Sponsored conference, training, education, or promotional sessions is not permitted.[4] However, reimbursement for, or payment of, the reasonable and necessary expenses associated with modest travel, meals, and lodging for bona-fide purchasing, training, education are permitted if they are primarily for:

i. Learning how to properly and safely use medical devices, equipment and other technologies, or compliance with legal, regulatory or accreditation requirements; and

ii. The payment is pursuant to the terms of a written agreement with the Industry Company, or is related to the review of capital equipment MedStar is considering purchasing or acquiring which cannot be transported to the MedStar facility.

4. *Industry-Sponsored Scholarships and Other Education Support for Trainees*. Industry may offer (and MedStar may solicit and accept), scholarships, grants, financial assistance or other donations for educational purposes including to support the position or training of medical students, residents, fellows and other healthcare professionals in training provided:

i. The MedStar entity (not Industry or donor) must select the beneficiaries of any such support consistent

[2] Note: Industry-supplied or supported food and meals may be accepted in connection with programs accredited by the Accreditation Council on Continuing Medical Education (ACCME) and in compliance with ACCME guidelines; in the context of professional society meetings if provided to all attendees.

[3] Honoraria received from educational institutions (universities, teaching hospitals, non-profit institutions, and professional societies) is permitted.

[4] Except that support may be provided by Industry to conference sponsors to reduce overall conference or educations event expenses.

with any regulatory [i.e.,"Match"] rules and entity selection policies and support cannot be designated to hire named physicians, or specific individuals into funded slots, nor can they be used to fund "named" fellowships, except as approved by the VPMA (or as applicable, the entity President or their designee) in line with principles of named chairs/endowments;

ii. All donations and support must be unrestricted and no limitations or quid pro quo requirements can be placed on the incumbents' future employment, practice, referrals, or location of practice. However donations CAN be designated for a specific clinical specialty, defined fund, department, or program;[5] and

iii. All such unrestricted gifts, donations, or professional support must be collected and managed through either the VPMA/Academic Affairs/GME/CME office's (as applicable) or the local entity Foundation, such funds must be used for GME/CME or medical student training purposes, and it is the entities responsibility to implement this requirement.

5. *Speaking, Consulting Arrangements, and Advisory' Services with Industry*. Individuals subject to the reporting obligations of this policy may speak for Industry at Industry-Sponsored events or provide consulting or advisory services (including expert witness testimony) provided:

i. The engagement is reported and approved by the entity VPMA (or as applicable, the entity President or their designee) in advance;

ii. The engagement does not otherwise pose an unacceptable conflict of commitment for MedStar employees (as determined by the VPMA or as applicable, the entity President or their designee);

iii. The arrangement is governed by a written agreement that specifically describes all services to be provided as well as the legitimate need and purpose for services/engagement which is not tied to the value or volume of any referral, purchase, order or recommendation for such referral, purchase, or order; the individual has sufficient expertise and experience to justify the consulting or speaking relationship, and the compensation or remuneration for the engagement is not in excess of fair market value (FMV);

iv. Industry pays for only modest travel, lodging and meals in connection with the engagement;

v. If the engagement is for speaking, the individual creates all slides (or other presentation materials), not an Industry Representative (unless specific attribution is made consistent with Section 10 below), and retains full control and approval authority over the content of the speech (other than approval over use of trade secret and proprietary information), the individual does not act as an Industry Company representative or suggest that MedStar endorses the Industry product or services, and the individual prominently discloses their Financial Interest to participants on materials presented.[6]

6. *Fiduciary, Management, or Other Financial Interests with Industry*. Individuals subject to reporting under this policy who have any Financial Interest in any Industry company including an ownership interest, fiduciary role, management role, or a compensation arrangement (including for speaking or consulting), or any stock options (even if they have a present value of zero dollars) must disclose the relationship consistent with reporting requirements of this policy, but not less than annually, and the financial relationships may be subject to further management up to and including dissolution of the relationship.[7] Individuals subject to reporting under this policy may not have Financial Interests, fiduciary roles, or management responsibilities with any Industry Company, including but not limited to services on board of directors, as an officer, manager, medical director of and Industry Company if the individual has any ordering, recommending, or patient-care responsibilities in which that Industry Company's product or services may be used by a patient, unless:

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[5] Such limitations do not apply to other non-Industry commercial sponsors (i.e. American Heart Association, American Cancer Society, etc.)

[6] Industry created slides, images, and materials illustrating biological or chemical structures may be utilized if they do not prominently display company names or logos. Industry created slides or materials may display copyright ownership and the name of the Industry company copyright owner.

[7] Industry relationships will be evaluated individually and collectively with any other outside commitments when determining whether such activities can be approved and appropriately managed.

i. The role is disclosed, reviewed, and approved in advance by the entity VPMA (or as applicable, the entity President or their designee);

ii. An appropriate management oversight plan is implemented to assure professional objectivity in decision making, and in ordering or recommending goods or services; and

iii. The relationship must be fully disclosed in writing to the patient if the individual has any patient-care responsibilities.

7. *Detailing, Tying, Switching, or Ordering*. Any Financial Interest, compensation, gifts or remuneration received in exchange for attending any meetings for the purpose of listening to sales information, or reviewing product training or education (so-called "detailing"), or in exchange for ordering or prescribing (so-called "tying"), or for changing an order or prescription (so-called "switching") of a product is prohibited.

8. *Conflicts of Commitment*. Financial Interests, speaking or consulting arrangements, fiduciary and other roles with Industry may pose an inappropriate conflict of commitment for MedStar employees/associates. Unless reviewed and specifically approved in advance by the VPMA (or if applicable the entity President or their designee), any individual or collective external or private commitments with Industry that are undertaken ***by employees*** which may burden or interfere with the individual's obligations to MedStar are prohibited.[8] Any outside activities must not distract employees from fulfilling their professional obligations to MedStar including their obligations of professional loyalty, time and energy necessary for their patient care, teaching or research responsibilities.

9. *Site or Facility Access*. Site or facility access by Industry Representatives such as Industry sales and marketing representatives for the purpose of soliciting MedStar facilities and representatives is governed by MedStar's Vendor Access Policy (available here: http://starport4medstar.net/Corp/administration/Pages/MedStarPolicies.aspx).

10. *Publications/Ghost-Writing/Ghost-Authoring*. Publishing articles or materials under an individual's own name that are written by, or in material part by, Industry Representatives is prohibited. Specifically, individuals subject to this policy shall not accept writing assistance, editorial assistance, manuscript preparation, revision, production, or submission services, slide preparation or revision; or other services from Industry (either directly or indirectly) unless such materials provided by Industry are specifically attributed to the author (i.e. each slide of a presentation must be appropriately attributed). "Guest" authorship or "ghostwriting" is not allowed. All persons who make a substantial contribution to a manuscript, presentation, or other writing meeting the ICMJE standards/criteria or other accepted scientific standards for authors ship should be listed as authors and their affiliations listed (academic, Industry, other).

11. *Free Drug/Product Samples*. Free drug and product samples may be accepted from Industry provided the drug samples are for patient use in accordance with the Prescription Drug Marketing Act, are limited and reasonable quantities for evaluation and demonstration purposes, any free drug sample may not billed to any payor, and the sample may not be accepted in exchange for tying or switching any products or as an inducement for any other purchasing, ordering, or prescribing. All personal and family use by the recipient is prohibited except in emergency situations and only for short courses of therapy. All samples must be recorded and reported to a central facility database (typically the facility pharmacy).

V. Exceptions

Exceptions to this policy may be granted on an individual basis upon review and approval by the applicable compliance director, President (or their designee) and the General Counsel (or their designee).

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[8] MedStar employees must report any actual or potential conflicts of commitment to their entity VPMA or President (or their designee). Services to foundations, professional societies, non-profit organizations, or academic institutions which do not do business with or compete against MedStar do not need to be reported under this policy.

VI. What Constitutes Non-Compliance
Actions or conduct in violation of this Policy.

VII. Consequences of Non-Compliance
Violations of this Policy may require the responsible individual to undergo additional training and/or may subject the individual to disciplinary actions, including, but not limited to, suspension or termination of Hospital privileges, expulsion from educational programs, and/or suspension or termination of employment, as applicable.

VIII. Explanation and Details/Examples
N/A

IX. Requirements and Guidelines for Implementing the Policy
1. Duty to Disclose Financial Relationships with Industry. The obligation to disclose any relationships with Industry that constitute an actual or potential conflict of interest applies to the following individuals:
   a. Officers and Directors: All officers and members of boards of directors acting in their capacity on behalf of MedStar;
   b. Full-time and Part-time Associates/Employees: Only management level associates/employees.
   c. Employed Physicians and Independent Contractors: All employed physicians and independent contractors who perform activities or services at a MedStar facility and could be perceived as representing MedStar[9];
   d. Faculty and Teaching staff: All faculty and teaching staff (whether employed or not) including independent contractors or voluntary faculty who have academic responsibilities for or perform teaching activities for MedStar;
   e. Residents, Fellows and Students: Only residents, fellows, who receive training at a MedStar facility and are subject to MedStar's Graduate Medical Education (GME) program requirements.
2. Procedures for Disclosure of Conflicts.
   a. Individuals subject to this policy may also be subject to the terms of their employment agreements or other MedStar policies (including the MRI Research Conflict of Interest policy) which may separately require disclosure of any potential conflicts of interest, conflicts of commitment, or other outside activities and they are required to comply with those requirements separately.
   b. All individuals required to disclose conflicts under this policy must electronically submit a conflict of interest disclosure statement available consistent with Attachment A to this policy via the Internet at https://medstar.coi-smart.com/.
   c. At the time their disclosures are submitted, all individuals required to disclose conflicts must certify that they:
      i. Have received a copy of this conflict of interest policy,
      ii. Have read and understand this policy,
      iii. Are in compliance with and agree to continue to comply with this policy,
      iv. Agree to disclose all applicable potential or actual conflicts,
      v. Agree to take such actions as determined to be appropriate by MedStar in order to manage or eliminate any potential conflicts of interest.
3. Review and Management of Conflicts.
   a. MedStar Entity Associates/Employees/Employed Physicians/Independent Contractors
      i. Disclosures submitted by a a MedStar entity associate/employee, employed physician, or independent contractor of a MedStar entity will be reviewed, evaluated, managed, documented and monitored by that

[9] Employees of MedStar who are leased to other institutions and do not perform services at a MedStar facility, nor hold themselves out as MedStar representatives would not be subject to the annal reporting obligation, but may still be subject to contractual reporting obligations as well as the requirements of this policy generally.

entity's Compliance Director in consultation with the entity's President (or their designee) in order to appropriately manage any potential or actual conflicts.

ii. The Office of Corporate Business Integrity (OCBI) or MedStar Legal Department will be consulted as necessary on the identification or management of any conflicts,

iii. All potential or actual conflicts involving physicians or independent contractors will be reviewed, evaluated, and monitored by the entity VPMA (or if applicable, the President or their designee).

b. Faculty/Teaching Staff/Residents/Fellows/Students

i. Disclosures submitted by faculty/teaching staff/residents, fellows, or students will be reviewed, evaluated, managed, documented and monitored by the entity GME Director (or as applicable, the President or their designee) in consultation with the corporate GME office.

ii. The Office of Corporate Business Integrity (OCBI) or MedStar Legal Department will be consulted as necessary on the identification or management of any conflicts,

iii. All potential or actual conflicts involving faculty, teaching staff, residents, fellows, or students will be reviewed and monitored by the entity VPMA (or as applicable, the President or their designee), and the corporate GME office.

c. Corporate Associates/Employees and all Senior Managers

i. Disclosures submitted by corporate associates/employees, MedStar Senior Managers, or any MedStar entity that does not have a Compliance Director will be reviewed, evaluated, managed, documented and monitored by OCBI in consultation with the MedStar Legal Department,

ii. Any disclosures involving members of the MedStar Legal Department will be reviewed, evaluated, managed, documented and monitored by the OCBI in consultation with the CEO. Any disclosures involving members of the OCBI will be reviewed, evaluated, managed, documented and monitored by the General Counsel in consultation with the CEO.

d. Board Members

i. Disclosures submitted by Members of a MedStar entity Board of Directors will be reviewed, evaluated, managed, documented and monitored by the General Counsel (or their designee) in order to identify any potential or actual conflicts of interest.

ii. The General Counsel will determine the appropriate steps to be taken to manage any potential or actual conflicts of interest identified.

iii. Actual conflicts will be reported to the chair of the Governance Committee of the MedStar Board.

e. COI Management Process. The MedStar entity Compliance Director, in consultation with the Office of Corporate Business Integrity (and MedStar Legal Department when necessary), will work with the VPMA (or as applicable entity President or their designee) to determine what if any action is required to manage an individual's potential or actual conflict of interest in a manner which eliminates the potential for harm to patients, impairment of professional judgment, impairment of objectivity or damage to MedStar reputation.

f. Documentation of COI Management. All such management actions will be appropriately documented and regularly monitored by the relevant Compliance Director (or Legal Department as applicable) in conjunction with the individual's superiors and entity VPMA (or as applicable entity President or their designee).

g. Compliance with Policy. Failure of an individual to adhere to any such management actions constitutes a violation of this policy and may result in disciplinary actions up to and including termination of employment, termination of agreement, or referral for any other actions that may be appropriate as determined by the General Counsel.

4. Frequency of Reporting. Disclosures under this policy must be made consistent with the requirements of this policy, but not less than annually, as well as upon any material change in the individual's conditions or relationships with Industry.

5. Publication of Conflicts.
   a. Identified conflicts will be posted in an appropriate manner on MedStar's Internet page in sufficient detail to enable consumers, employees and other interested parties to adequately understand the nature of the conflict.
   b. Financial Interests resulting in a conflict will only be reported publicly in a manner that indicates the individual has a reportable Financial Interest in an Industry Company, but the details of the Financial Interests will not be reported, unless otherwise required by law.

X. Related Policies

MedStar Health Business Ethics and Confidentiality Policy
MedStar Health Vendor Access Policy
MedStar Health Code of Conduct
MedStar Research Institute Conflicts of Interest and Conflicts of Commitment Policy

XI. Procedures Related To Policy: N/A

XII. Legal Reporting Requirements: N/A

XIII. Reference to Laws or Regulations of Outside Bodies

AMA Code of Medical Ethics, Opinion 8.061 - "Gifts to Physicians from Industry"
HHS OIG Compliance Program Guidance for Pharmaceutical Manufacturers
Pharmaceutical Research and Manufacturers Association (PhRMA) Code of Interactions with Healthcare Professionals
Health Industry Group Purchasing Association (HIGPA) GPO Ethics Guidance
AdvaMed (Device Manufacturers Code of Ethics)
Institute of Medicine (IOM) Report, Conflict of Interest in Medical Research, Education, and Practice (2009).

XIV. Right To Change or Terminate Policy

Any material changes to this Policy require review and approval by the EVP for Medical Affairs and the MedStar Legal Department. The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team. The CEO has the final sign-off authority on all corporate policies.

Attachment A: Questions for Conflict of Interest with Industry Disclosures

Questions for all individuals required to file a disclosure:

Financial Interest of You and Your Family Members

1. To your knowledge, have you or an immediate family member had any financial interests, fiduciary roles or management responsibilities in a biomedical, pharmaceutical, medical device or medical equipment company in the last 12 months, including?

- stock or ownership interests greater than 3%
- compensation or other payment arrangements of any amount
- any company-issued stock-options regardless of amount or present value
- any role as an officer or director

_____ Yes _____ No

If yes, describe each interest, including who has/had the interest (you or the name of your immediate family member), the name the company, the description of the interest or responsibility (including value if known). *(text box)*

Detailing, Tying, Switching or Ordering

2. To your knowledge, have you or an immediate family member received any compensation, gifts or other payment of any amount from a biomedical, pharmaceutical, medical device or medical equipment company in exchange for Detailing, Tying, Switching, or Ordering any products, goods or services over the last 12 months?

_____ Yes _____ No

If yes, please describe each incident in detail, including who received the compensation or anything of value (you or the name of your immediate family member), the name of the company, the compensation or payment received, and the nature of the activity. *(text box)*

Speaking and Consulting Services

3. To your knowledge, have you or an immediate family member received OR requested approval of any financial interest, compensation, gifts or other payment of any amount from a biomedical, pharmaceutical, medical device or medical equipment company in exchange for consulting services, or speaking engagements on behalf of such a company over the last 12 months?

_____ Yes _____ No

If yes, please describe each incident in detail, including who received the compensation, gifts or payment (you or the name your **immediate family member),** the name of the company, the compensation, gifts or payment received, and the nature of the activity. *(text box)*

Meetings, Conferences and Other Events

4. To your knowledge, have you or an **immediate family member** received any financial interest, compensation, gifts or other payment of any amount from a biomedical, pharmaceutical, medical device or medical equipment company in exchange for attending any **educational** or **professional meetings, conferences** or **events** which were sponsored (or partially sponsored) by such a company over the last 12 months?

_____ Yes _____ No

If yes, describe each incident in detail including who attended the event(s) (you or the name of your **immediate family member),** the nature of the event(s), the name of the company or companies that sponsored it and the compensation or gifts received. *(text box)*

Other Potential Conflicts

5. Do you or an **immediate family member** have any other relationships with, or have you received anything else of value from, a biomedical, pharmaceutical, medical device or medical equipment company over the last 12 months that could reasonably appear to influence your medical or professional objectivity?

_____ Yes _____ No

If yes, describe in detail. *(text box)*

Certification for All Disclosures

By entering my username and password below, I certify that:

- To the best of my knowledge the information I have provided above is complete and accurate.
- Should my situation change at any point such that the information provided above no longer constitutes complete and accurate answers to all questions I will promptly update this disclosure.
- Neither I, nor any Immediate Family Member, has disclosed or used, or will disclose or use any confidential, special or inside information obtained through my association with any MedStar Health entity for the personal profit or advantage of myself or any Immediate Family Member.
- Neither I, nor any Immediate Family Member, has accepted gifts, gratuities, or entertainment that are in excess of limits stated in the MedStar Code of Conduct or the MedStar Health, Inc. Business Ethics and Confidentiality Policy or this policy that might influence my judgment or actions concerning the business of any MedStar Health entity, except as listed on a separate disclosure sheet. (This does not include the acceptance of items of nominal or minor value that are clearly tokens of respect or friendship, are not related to any particular transaction or activity, and are permitted under the MedStar Code of Conduct.)
- I understand that I have an obligation to take remedial action to correct, or cause others to correct, any violation of the MedStar Code of Conduct, the Business Ethics and Confidentiality Policy, or this policy of which I become aware, and to report any material violation of the Code or Policy to the Office of Corporate Business Integrity (directly or by calling the Ethics Hotline at 1-877-811-3411), or to the MedStar Legal Department.
- I have read and understand MedStar's Conflict of Interest Policy, Code of Conduct and the Business Ethics and Confidentiality Policy and agree to comply with them.

Responsibilities in Local Extreme Emergent Situations (Disaster Policy)

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy for all graduate medical education (GME) training programs within MedStar Health in the event of disaster or any interruption in patient care.

II. Scope
This policy will apply to all GME training programs within MedStar Health.

III. Definitions
House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health graduate medical education training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program for purposes of clinical education.

Sponsoring Institution – the MedStar hospital that sponsors the GME training program.

Extreme emergent situation – a local event (such as a hospital-declared disaster for an epidemic) that affects House Staff education or the work environment but does not rise to the level of an ACGME-declared disaster as defined in the ACGME Policies and Procedures.

IV. Responsibilities/Requirements
MedStar Health is committed to its GME programs and house staff. In order to protect and assist house staff in the event of disaster or any interruption in training, the following policy is provided and supported by the institution.

1. The system-wide MedStar Disaster Oversight Committee will coordinate the provision of House Staff deployment as needed for patient care in the event of a regional disaster.
2. The Sponsoring Institution will continue patient care and GME training activities during a disaster, if at all possible.
3. The House Staff are first and foremost physicians, but may only perform duties based upon their degree of competence, their specialty training and the context of the specific situation. Many House Staff officers at an advanced level of training may even be fully licensed in their state, and therefore, they may be able to provide patient care independent of supervision.
4. In the event of a disaster, house staff must not be expected to perform beyond the limits of their competence as judged by program directors and other supervisors or outside the scope of their individual licensure.
5. The local GME Committee will be responsible for monitoring duty hours for affected house staff.
6. If a break in service does occur due to any natural disaster or interruption in patient care, the DIO and VPMA will review the situation to decide the best course of action.
7. In the event of an extreme emergent situation, the DIO will contact the Executive Director of the Institutional Review Committee (ED-IRC) regarding the status of the educational environment for its ACGME-accredited programs.
8. Once the DIO has received confirmation from the ED-IRC, program directors may contact their respective Executive Directors if necessary to discuss specialty-specific concerns regarding interruptions to House Staff education or effect on educational environment.
9. Program directors are expected to communicate and update the DIO and VPMA on the status and results of conversations with their Executive Directors.

10. In the event of an interruption in training, written notice will be given to all house staff.
11. If it is determined that training must be discontinued for a period of time, the Sponsoring Institution will support a House Staff officer transfer to another ACGME-accredited program to continue, and if necessary, complete training.
12. Salary and benefits will be continued for the house staff for the duration of their contract.
13. The Sponsoring Institution will provide letters of support for their house staff who require transfer to another institution. If available, evaluations and other employment documentation will be supplied upon request of the House Staff officer and/or receiving institution.
14. The Sponsoring Institution will work with the receiving institution to transfer associated cap positions, if applicable.
15. The DIO will notify the ER-IRC when the extreme emergent situation has been resolved.
16. In the event of an on-going disaster, the System GMEC will monitor the situation.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Dismissal from a Residency Program and Termination of Employment

MedStar Health
Graduate Medical Education Policy

I. Purpose

To establish a policy for all post-graduate training programs within the MedStar Health System for use in dismissal of house staff from a residency program, and the corresponding the termination of house staff employment prior to the date of contract expiration.

II. Scope

This policy will apply to all house staff in the MedStar Health System. All information contained in this policy shall be read in conjunction with the house staff agreement.

III. Definitions

House Staff or House Officer –refers to all interns, residents and fellows enrolled in a MedStar Health post-graduate training program.

Dismissal – refers to the termination of participation in a residency or fellowship training program at the election of the program prior to the completion of the academic course of study.

Termination – the act of severing employment prior to the date of expiration of the house officer's contract or the non-renewal of a house officer's contract prior to the completion of an academic course of study at the election of either party to the contract.

IV. Responsibilities/Requirements

A. Withdrawal or dismissal from a house officer's academic program prior to the completion of an academic course of study may be done at either the discretion of the house officer or the hospital, or at the mutual agreement of the house officer and the hospital.

B. **Resignation**

1. If the house officer desires to withdraw from his or her program, the house office must submit a letter of resignation to the Program Director, at least 30 days in advance, stating the reason for the action. The 30 days' notice may be waived, in whole or in part, at the discretion of the Program Director.

2. An exit interview may be requested by the Program Director and/or the Director of Medical Education/VPMA (or designee).

C. **Dismissal**

1. The Hospital may elect to dismiss a house officer from enrollment in a program prior to the established completion date due to:

a) Academic Failure to Progress

b) Misconduct

c) Abandonment of position/employment

d) Any other reason set forth in the house staff agreement.

2. The decision to dismiss should be made consistent with other applicable GME policies, such as the "Academic Improvement Policy" or the "House Officer Misconduct" Policy.

3. When a house officer is informed of dismissal, he/she has the right to request due process as delineated in the "Due Process" policy.

D. **Non Renewal of Contract:**

1. A program director may elect not to renew a house officer's contract (i.e., deny promotion to the next level of education) consistent with the Academic Improvement Policy or House Staff Misconduct Policy.

2. Non-renewal of contract is an action that allows the resident to request due process (See policy for "Academic Improvement" and "House Staff Misconduct").

3. The Office of Graduate Medical Education should be notified immediately upon the Program Director's decision to not renew an employment contract.

4. Consistent with the Promotion Policy, house officers should be notified each academic year whether the house officer is on-track to be promoted to the next educational level of training. If the program cannot confirm that a house officer is on track for promotion to the next academic level, then the house officer should be notified, to the extent possible, that the decision is being held until a specific future date, and the reason for holding on the decision (i.e., academic concerns, pending evaluations, scores, etc…).

5. Even if a house officer is notified of the program's intent to promote, if circumstances warrant, the program may reverse its decision and elect not to promote or to dismiss a house officer in accordance with other provisions of this policy.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Dress Code and Personal Appearance

I. Policy Statement

MedStar Health believes in providing high quality and safe care, treatment and services to patients. Therefore, MedStar Health associates are required to dress in a manner that is safe and is based on MedStar Health dress code and personal appearance guidelines while on duty; while on property owned or leased by MedStar Health; or when representing MedStar Health in public.

II. Philosophy Statement

MedStar Health expects all associates to contribute to a professional and collegial environment by exemplifying the SPIRIT (Service, Patient First, Integrity, Respect, Innovation, and Teamwork) values with our patients, visitors, customers and colleagues.

III. Procedure

A. Dress Code

1. Religious Dress

MedStar Health is committed to promoting diversity and equality of religious preference or requirements of customary dress. Leaders will consider associates' religious or cultural dress requirements and the needs of the patients that we serve. A review of our infection prevention and safety standards will be conducted as appropriate.

2. Identification Badges

ID badges must be worn by associates at all times while on premises and should be displayed according to entity standards. No pins or other stick-on items may be attached to the badge. Associates who damage or lose their ID badges are responsible to pay for replacement badges.

3. General Requirements (Applicable to Patient Care and Non-Patient Care Areas)

It is essential that each associate present a neat, professional, well-groomed appearance while on duty, on the entity premises, and while representing the entity off premises. Associates should adhere to the following dress and personal appearance requirements:

- Associate's appearance should be clean, neat and professional. Clothing should be unexaggerated in style, clean, properly fitting and not wrinkled. Clothing should not appear too tight, too baggy, too short in length, revealing, faded, or in need of repair. Certain items are not appropriate, including, but are not limited to, denim materials, T-shirts, and shorts.
- Lab coats and scrubs may only be worn by authorized clinical personnel, unless required by regulatory agencies or department policy.
- Associates who are required to wear uniforms are expected to follow their department-specific dress code standards.
- Hats and other head coverings are not permitted, unless required for religious purposes or part of the uniform.
- Shoes need to be appropriate in style, depending on the nature of the position. Flip flops and non-business style open toe shoes are not appropriate.
- Extreme or eccentric hairstyles (i.e. spiked, shaved message, striped, etc.) or extreme hair color (i.e., blue, purple, green, etc.) are not permitted.
- Fingernails should be kept clean and be in compliance with the applicable MedStar Health practice. Neon nail polish and nail jewels are not acceptable. In some areas (such as food services), nail polish may be prohibited.
- Due to close contact with patients, visitors and coworkers, the use of strong, heavy scents and fragrances is not permitted.
- Generally, visible tattoos and facial piercings are prohibited.
- Moderate jewelry is permitted and must be appropriate to the nature of the associate's job. In some areas, jewelry may not be permitted or may be limited in size/amount for safety and/or infection control reasons.
- Associates are expected to follow any additional guidelines related to their job.

4. Additional Requirements Applicable to Patient Care Areas

- Fragrances may not be worn.
- Long hair should be worn up, secured in back, or appropriately covered in accordance with established departmental standards/protocols.
- Nails must be trimmed no longer than ¼ inch in patient care areas (unless more stringent standards have been established based on nature of duties.) In accordance with CDC guidelines, no artificial fingernails or extenders may be worn by associates providing patient care.
- If patient care duties, or an unexpected event, (such as severe infectious disease outbreak), requires an associate to wear an N95 respirator, then the associate must be completely free of makeup (and any other facial product) that visibly stains or soils the N95 respirator and be clean shaven within the sealing area of the N95 respirator to maintain appropriate fit and protection.

IV. Definitions

Patient Care Areas: Any area where associates have direct patient contact or patient interactions.

Non-Patient Care Areas: Any area where associates do not have any direct patient contact or interactions and/or areas where direct patient contact or interactions are minimal, such as, limited to contact in the halls, cafeteria, etc.

V. Responsibility

A. Associates

Every associate is expected to follow this policy as established by MedStar Health and the departments in which they work. Failure to follow the Dress Code and Personal Appearance policy can result in corrective action up to and including termination.

B. Leaders

1. Ensure that dress code and personal appearance policies are contained in department manuals or are accessible to associates, and that each new associate is informed of such policies during departmental orientation.
2. Ensure associates' compliance with this policy in addition to the applicable dress code and personal appearance policy and address violations of this policy through coaching and/or corrective action.
3. Interpret and enforce this policy in a consistent manner.
4. Ensure that the associate's appearance is consistent with the mission and environment of the department and meets the following objectives:
   - Demonstrates a public image commensurate with the quality of patient care and services.
   - Protects the health and safety of patients, visitors and associates.
   - Meets infection prevention standards for a safe environment.

VI. Exceptions

Exceptions may be granted to portions of this policy (either on a case-by-case basis or through a department dress code and personal appearance policy) for departments/locations with no patient, visitor, or vendor face-to-face contact and/or based on the operational function of the department. All exceptions require the approval of the relevant senior Human Resources leader.

Examples of an exception: Associates working in a non- air conditioned warehouse, may be permitted to wear shorts during the summer months or associates working in a satellite call center or business office with no face-to-face contact with patients, visitors, or vendors are permitted to wear business casual attire or participate in a sponsored jeans day.

Please contact your leader or Human Resources with any questions regarding this policy.

Provisions of this policy apply to all associates to the extent they do not conflict with relevant terms of an applicable contract.

Due Process Policy

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy for all graduate medical education (GME) training programs within MedStar Health to use in reviewing all actions resulting in dismissal or otherwise altering the intended career path of the house officer.

II. Scope
This policy will apply to all house officers who participate in a GME training program within MedStar Health. Due Process, as described within, applies to actions that are taken as a result of academic deficiencies or misconduct (see related Academic Improvement Policy and House Officer Misconduct policy).

III. Definitions
House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Training Program – refers to a residency or fellowship educational program.

Dismissal – The act of terminating a House Staff officer's participation in a training program prior to the successful completion of the course of training, whether by early termination of a contract or by non-renewal of a contract.

IV. Academic Matters
The Hospital's Academic Improvement Policy affords due process to house officers who are dismissed from a residency program or whose intended career development is altered by an academic decision of a program. See Academic Improvement Policy for delineation of the specific processes available to a house officer to challenge an academic decision made by his/her Department.

V. Misconduct Matters
The Hospital's House Officer Misconduct Policy affords due process to house officers who are disciplined or dismissed from a residency program in a manner that alters their intended career development. See House Officer Misconduct Policy for delineation of the specific processes available to a house officer to challenge discharge or discipline decisions based on alleged misconduct by a house officer.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Evaluation Policy

MedStar Health
Graduate Medical Education Policy

Purpose:
To establish a policy for all graduate medical education training programs within MedStar Health to use in the assessment of house officer and faculty performance, and house officer and faculty evaluation of the hospital and the program. This evaluation process is utilized to improve the educational processes and programs.

Scope:
This policy will apply to all graduate medical education training programs in the MedStar Health System. All

information contained in this policy shall be used as minimum criteria for evaluation. More detailed evaluation criteria shall be delineated by the clinical departments in their respective departmental evaluation policy.

Definitions:

House Staff or House Officer: refers to all interns, residents and fellows participating in a MedStar Hospital graduate medical education training program.

Graduate Medical Education Program: refers to a residency or fellowship educational program.

Objective Feedback: Assessments and evaluations that are typically structured and scored or rated based on predetermined criteria that are uniformly applied. Examples include but are not limited to tests, shelf exams, USMLE scores, OSCEs, etc.

Subjective Feedback: Assessments and evaluations that are made by faculty and other evaluators, structured or unstructured, based on their professional judgments and opinions. Examples include but are not limited to rotational evaluations, verbal feedback, 360 evaluations, and "Just in Time" feedback at the point of clinical care.

Final Summative Assessment: A document that is prepared by the Program Director or Chairman for every house officer, upon departure of the program. The final summative assessment is a fair and balanced review of the house officer's overall performance in the residency program, including strengths and weaknesses, and is based on the 6 core competencies and specialty specific requirements.

Recommendation Letter: A letter prepared for the purpose of promoting a house officer for a position in which they are seeking to gain.

Milestones: Competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.

IV. Responsibilities/Requirements:

A. Faculty have the responsibility to provide ongoing assessment and feedback to house officers. This feedback may be verbal or written.

B. All documentation of house officer performance by the faculty, both formal and informal, should be maintained as permanent documentation by the department.

C. Rotational evaluations will be one of the tools utilized in determining promotion.

D. The Program Director will be responsible for communicating the departmental policy for evaluation to house staff and faculty.

E. Formative Evaluation:

1. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.
2. The program director should:

   a) Provide objective and subjective assessments of performance based on the 6 core competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice based on the specialty-specific Milestones;

   b) Use multiple evaluation methods and techniques, such as

      (i) Verbal feedback

      (ii) Rotational evaluations

      (iii) 360 evaluations

      (iv) Objective assessments

(v) Reflective exercises and/or portfolios

(vi) Simulation

(vii) Unsolicited feedback

(viii) Discussion and recommendations of the Clinical Competency Committee

c). Methods of evaluation should be reviewed in their entirety. One evaluation does not have more weight than another; for example, rotational evaluations are equally as important as other methods of evaluation including verbal feedback;

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

e) Document progressive resident performance improvement appropriate to educational level; and,

f) Provide each resident with documented semi-annual evaluation of performance with feedback.

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

F. **Final Summative Assessment:**

1. The specialty-specific Milestones must be used as one of the tools to ensure house officers are able to practice core professional activities without supervision upon completion of the program.

2. The program director must prepare, sign and provide a Final Summative Assessment for each house officer upon departure from the program.

3. The final summative evaluation should:

a) Become part of the house officer's permanent record that is maintained by the sponsoring institution and must be accessible for review by the house officer;

b) Be an honest, fair and balanced assessment of the house officer's overall performance in the program including both strengths and weaknesses;

c) Be based on the six core competencies;

d) Include documentation of procedures if appropriate;

e) Verify that the house officer has demonstrated sufficient competence to enter practice without direct supervision.

4. The final summative assessment is not negotiable and is not subject for review or contest.

G. **Letters of Recommendation**

1. House officers may request a letter of recommendation to assist them with obtaining another position, job, employment, scholarship, or other purpose.

2. A Letter of Recommendation is separate from the Final Summative Assessment, and is not intended to be a fair and balanced assessment of overall performance in the program; a recommendation letter reflect the personal opinions of the person writing the letter.

3. Each program director should have a policy on whether or not they will prepare letters of recommendation in addition to the final summative assessment.

4. Faculty may choose to prepare letters of recommendation for house staff, upon request, so long as the following criteria are adhered to:

a) The faculty member must properly identify themselves, their role in the program, and the extent of their interaction with the house officer.

b) The faculty member must not purport to represent the program or the overall assessment of the trainee by the program.

c) The faculty member must only comment on the house officer's performance for which they have personal knowledge of.

d) Letters should be written on personal letterhead, not that of the program or institution or misleading as representing official documentation from the program leadership.

e) Faculty must refrain from writing letters if directed as such by the Chairman in cases of academic failure to progress.

H. **Faculty Evaluation:**

1. The program must evaluate faculty performance as it relates to the education program at least annually.

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

3, The faculty evaluation must include at least annual written confidential evaluations by the residents.

I. **Program Evaluation and Improvement:**

1. The program must document formal, systematic evaluation of the curriculum at least annually to track each of the following areas:

a) Resident performance;

b) Faculty development;

c) Graduate performance, including performance of program graduates on the certification examination; and,

d) Program quality, specifically that residents and faculty must have the opportunity to confidentially evaluate the program in writing at least annually and that the program must use the results of house staff evaluations of the program together with other program evaluation results for program improvement.

2. If deficiencies are found, the program should prepare a written action plan to document initiatives to improve performance in the areas as cited. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Examination Policy

MedStar Health
Graduate Medical Education Policy

I. Purpose

To establish a policy for all Graduate Medical Education (GME) training programs within MedStar Health to use in the appointment and promotion of House Staff.

II. Scope

This policy will apply to all eligible House Staff who participate in GME training programs within the MedStar Health system. All information contained in this policy shall be used as minimum criteria.

III. Definitions

House Staff or House Officer – refers to all eligible interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

USMLE – refers to the United States Medical Licensing Examination.

COMLEX – refers to the Comprehensive Osteopathic Medical Licensing Exam. APMLE – refers to the American Podiatric Medical Licensing Examination NBDE – refers to the National Board Dental Exam

iNBDE – refers to the Integrated National Board Dental Exam

IV. Responsibilities/Requirements:

1. All applicants for positions in a graduate medical education training program within MedStar Health are expected to have taken and passed prior to their first day of employment in the training program all components of the applicable examinations listed below:
   - USMLE Steps 1 and 2CK
   - COMLEX Levels 1 and 2CE
   - APMLE Parts 1 and 2
   - iNBDE or NBDE Parts 1 and 2
2. Failure of an applicant to take the applicable examinations listed above by their contracted start date will make null and void any letters of offer and/or employment contracts issued by MedStar Health.
3. In the event that a letter of offer or employment contract is withdrawn for a matched applicant, programs must adhere to NRMP policies and procedures.
4. Applicants who have not passed the applicable examinations will not be accepted in transfer from other graduate medical education programs.
5. By six months into their PGY-2 year, all House Officers enrolled in a residency training program within MedStar Health should take and pass the applicable examinations: USMLE Step 3; COMLEX Level 3: APMLE Part 3.

   By the end of their PGY-2 year, all House Officers must take and pass the applicable examination: USMLE Step 3; COMLEX Level 3: APMLE Part 3

   Evidence of successful completion must be submitted to both the program and GME offices.
6. If the House Officer has not passed USMLE Step 3; COMLEX Level 3; or AMPLE Part 3 by the six-month point of the PGY-2 year, a Letter of Deficiency may be issued at the discretion of the Program Director pursuant to the Academic Improvement Policy.
7. If USMLE Step 3; COMLEX Level 3; or AMPLE Part 3 has not been passed by the end of the House Officer's PGY-2 year of training, the House Officer will not be promoted to the PGY-3 level. If a passing score on USMLE Step 3; COMLEX Level 3; or AMPLE Part 3 has not been achieved before the first day of the PGY-3 year, House Officers may be dismissed from the residency program or, at the discretion of the program director, may alternatively be placed on a paid leave of absence until a passing score is received and submitted, up to 90 days.
8. Applicants to a fellowship program must take and pass USMLE Step 3; COMLEX Level 3; or AMPLE Part 3 prior to their first day of employment in the training program or the contract will be null and void.

Policy Approved by:

Policy Maintained by: MedStar Academic Affairs

Fatigue Mitigation Transportation Reimbursement for Trainees

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy for all graduate medical education (GME) training programs within MedStar Health to use for reimbursement requests from fatigued trainees using transportation to get home safely.

II. Scope
This policy will apply to all House Staff who participate in GME training programs within the MedStar Health system.

III. Definitions
House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

Transportation Service – service such as Uber, Lyft, taxi. It must be basic service (Uber Plus, Lyft Black, etc do not qualify).

IV. Responsibilities/Requirements
A. Trainees may use a transportation service to get home if they feel they are too fatigued to get home safely.

B. The house staff member must contact the program director, or his/her approved designee, within 24 hours of use to request and receive approval for the use of alternative transportation.

C. Written approval for the use of alternative transportation home must be forwarded to GME along with the receipt for reimbursement within thirty (30) days from the date of usage (ex. Email from program director or designee).

D. The end location of the service must be the house officer's a verifiable home address.

E. The house officer is permitted to use the alternative transportation back to the hospital/training site the next day if his/her car is left there.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Grievance Resolution

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy for all graduate medical education (GME) training programs within MedStar Health to use in the formal resolution of House Staff officers' complaints and grievances.

II. Scope
This policy will apply to all House Staff who participate in GME training programs within the MedStar Health system. This policy does not apply to actions arising out of the Academic Improvement Policy or the House Officer Misconduct Policy.

III. Definitions

House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

Grievance – a cause of distress (such as an unsatisfactory working condition) felt to afford reason for complaint or resistance.

IV. Responsibilities/Requirements

A. Grievances must be dealt with in a confidential manner, and without fear of retaliation. Incidents should be reported directly to the House Staff officer in charge at the time of the incident.

B. If the House Staff officer in charge is unable to rectify the situation, the attending on the team should be consulted.

C. For any incident that is not resolved as stated above or that is not associated with a particular incident on a patient unit, House Staff should proceed directly to their Chief House Staff officer.

D. If the House Staff officer does not feel as though the Chief House Staff officer has effectively resolved the issue, he/she should take the problem to the Program Director for resolution.

E. If satisfactory resolution is still not apparent after the Program Director has become involved, then the House Staff officer should provide a written grievance report directly to the Director of Medical Education outlining the issue. This report should describe the involvement of the Chief House Staff officer and the Program Director.

F. The Director of Medical Education will review the written grievance report to ensure that all of the appropriate steps, as indicated above, were followed. A grievance committee will then be formed consisting of, at least, the following individuals:

1. The Program Director for the grievant
2. Director of Medical Education (or designee)
3. A House Staff officer not involved with the situation
4. The Associate DIO of the entity
5, Any other department representative deemed necessary by management to perform a reasonable investigation

G. Upon hearing the grievance, the committee will investigate any and all issues associated with the complaint and will provide a final written decision to the House Staff officer.

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

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Health and Disability Insurance

I. Purpose

To establish a policy outlining health and disability insurance coverage for all graduate medical education (GME) training programs within MedStar Health.

II. Scope

This policy will apply to all house officers who participate in a GME training program within MedStar Health.

III. Definitions

House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

IV. Health and Disability Insurance Coverage

A. MedStar Health provides health insurance benefits for House Staff and their eligible dependents as of the first day of employment. House Staff may chose from the following high-quality health insurance plans:

1. CareFirst PPO
2. MedStar Select
3. Kaiser Permanente HMO Plan

B. MedStar Health provides the following disability insurance benefits for House Staff as of the first day of employment:

1. Short-Term Disability (STD): STD coverage is designed to ensure continuing income for those house staff who are unable to work due to a non-work related injury or illness. Eligible employees may participate in the STD plan subject to all terms and conditions of the agreement between MedStar Health and the insurance carrier. STD is available for full-time house staff. Coverage begins on the first day for an accident and after a 7 day waiting period for an illness and can continue for up to 25 weeks or until clearance to return to work is granted, whichever occurs first. The STD program replaces 60% of salary. Disabilities arising from pregnancy or pregnancy-related illness are treated the same as any other illness that prevents and employee from work.

2. Long-Term Disability (LTD): MedStar Health provides a LTD benefit plan to help house staff cope with an illness or injury that results in a long-term absence from employment. LTD benefits are designed to ensure a continuous income for employees who are disabled and unable to work. LTD benefits begin after a 180 day elimination period of disability is satisfied. LTD plans provide a bridge between short-term disability benefits and retirement income. Benefits will cease at the end of the maximum benefit period (age 65), the date your disability ends, or the date that medical documentation expires. House Staff receive 70% of income up to a maximum $3,000 monthly benefit. MedStar Health also offers an expanded LTD plan for minimal cost during the training period. This insurance coverage is portable; that is, house staff may continue the coverage in effect by assuming payment of the premium upon completion of the training program (additional information available upon request).

Policy Approved by: System GMEC

Policy maintained by: MedStar Academic Affairs

Policy on House Staff as Primary Investigator

Graduate Medical Education

I. Purpose

To establish a policy for all graduate medical education (GME) training programs within MedStar Health related to the role of house officers as primary investigator on a research study or protocol.

II. Scope

This policy applies to all House Staff who participate in GME training programs within the MedStar Health system. The policy applies to all research involving human subjects conducted at MedStar Health facilities. It also applies to research involving human subjects conducted outside of MedStar Health facilities in which MedStar Health is engaged in research. This policy applies regardless of the Institutional Review Board (IRB) reviewing the study.

III. Definitions

House Staff or House Staff Officer – refers to all interns, residents and fellows enrolled in a MedStar Health graduate medical education training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

Research Study or Protocol – any research study or protocol, regardless of IRB status, taking place within MedStar Health entities, or by trainees currently enrolled in a MedStar Health training program.

IV. Responsibilities/Requirements

A. The Primary Investigator (PI) is responsible for all aspects of the study – including design, IRB submission, following protocol, and delegating work. The ultimate responsibility of the PI is to oversee the body of work, and he or she is responsible if any patient or regulatory concerns arise.

B. Individuals who serve as a Principal Investigator of research involving human subjects must be qualified by education, training and experience to assume responsibility of the conduct of the research. Considering the longitudinal responsibilities for research studies, trainees may not serve in the role as primary investigator on MedStar Health research studies. This designation must be reserved for faculty mentors/supervisors.

V. Right to Change or Retire Policy

Modifications or retirement of this policy may be made at the direction of the Institutional Official for research at MedStar Health or the Vice President, Academic Affairs, as necessary, to remain in compliance with MedStar Health policies.

VI. Responsibilities

It is the responsibility of all trainees participating in research within MedStar to be familiar with this policy. It is the responsibility of the MedStar GME program to inform trainees of this policy.

VII. Exceptions

Exceptions to this policy may be granted on a case by case basis jointly by the Institutional Official for research at MedStar Health and the Vice President of Academic Affairs or their designees.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs/MedStar Health Research Institute

Leave of Absence Policy

I. Purpose

To establish a policy that outlines medical, parental and caregiver leave for house sta and provides accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a house officer's eligibility to participate in examinations by the relevant certifying board(s).

II. Scope

This policy applies to all house staff enrolled in GME training programs within MedStar Health.

III. Definitions

House Staff or House Officer: Refers to all interns, residents and fellows enrolled in a MedStar Health GME training program.

Graduate Medical Education (GME) Training Program: Refers to a residency or fellowship program.

IV. Responsibilities/Requirements

It is the policy of MedStar Health to provide a minimum of six (6) weeks of fully paid leave for eligible house staff who are on an authorized Leave of Absence. Paid leave may be extended beyond six (6) weeks for certain

qualifying events under MedStar's policies on Short Term Disability and Family/Medical Leave. In addition, paid leave may be taken in increments shorter than six (6) weeks.

House Staff may qualify for paid leave for the following events:

- Medical Leave for a house officer's own illness, injury, or medical condition or to obtain preventive medical care. This includes medical leave for childbirth. Length of medical leave is determined based on medical documentation.
- Parental Leave: due to the birth, adoption or foster care placement of a child.
- Caregiver Leave: to take care of a family member with a serious health condition.

House staff are also entitled to one (1) additional week of fully paid leave, reserved for use outside of medical, parental or caregiver leave. This additional paid leave should be used within the same appointment year of the original leave.

During any approved medical, parental, or caregiver leave of absence, the house officer is ensured the continuation of health and disability insurance benefits for themselves and their eligible dependents.

Leave benefits are available on the first day of enrollment in the GME training program.

V. Process

1. The house officer should notify the program director at least three (3) months prior to the expected leave date if known.
2. After coordination with the program director, the house officer must contact the Office of Graduate Medical Education to begin the leave process. With the understanding that each house officer's leave request is unique and nuanced, it is important to work closely with both the program director and the Office of Graduate Medical Education.
3. The Office of Graduate Medical Education will initiate a leave of absence application checklist and coordinate the leave of absence with the Office of Leave Management. The Office of Leave Management provides oversight of all leave types for MedStar associates and physicians and serves as a liaison with MedStar's leave management administrator.
4. House staff out on medical leave must be cleared to return to work through Occupational Health prior to rejoining the GME training program.

VI. Training Program Extensions

1. In the event of a leave of absence, the GME training program may need to be extended in order to fulfill program and/or certifying board requirements.
2. Each program director should have their own programmatic policy which defines the amount of leave permissible for satisfactory completion of the program and specialty board eligibility. Program directors are responsible for ensuring that their house staff are provided with accurate information regarding the impact of an extended leave of absence on satisfactory completion of the program and eligibility to participate in examinations by the relevant certifying board(s).
3. Program directors must notify the Office of Graduate Medical Education of any training program extensions as soon as possible so that the graduation date and institutional record of the house o cer can be modified as necessary.

Policy Approved by: MedStar Health GMEC
Policy Maintained by: MedStar Academic Affairs

Misconduct Policy

MedStar Health
Graduate Medical Education Policy

I. Purpose
To establish a policy and process for all graduate medical education (GME) programs at MedStar Health to use when allegations of misconduct are made against a house staff officer.

II. Scope
This policy applies to all Graduate Medical Education (GME) training programs at MedStar Health.

III. Definitions
House Staff or House Officer – refers to all interns, residents and fellows participating in a program of post-graduate medical education.

Misconduct – Improper behavior; intentional wrongdoing; violation of a law, standard of practice, or policy of the program, department, or hospital. Misconduct may also constitute unprofessional behavior, which may also trigger action under the Academic Improvement Policy. These actions may proceed simultaneously.

IV. Process
A. **Allegations of Misconduct:** A house officer, employee of the Hospital, attending physician, patient, or any other person who believes that a house officer has engaged in misconduct or improper behavior of any kind should immediately report his/her concerns to his/her supervisor, or any other supervisor in the Hospital, who in turn should communicate the allegations to the house officer's Program Director.

B. Upon receipt of a complaint regarding the conduct of a house officer, the Program Director should conduct an inquiry, as follows:

1. Meet with the person complaining of the misconduct to understand the nature of the complaint and any related information.
2. Meet with the house officer to advise the house officer of the existence of the complaint, to give the house officer an opportunity to respond to the allegations, and to identify any potential witnesses to the alleged misconduct.
3. Based on the information received from the complaint and the information received from the house officer, the Program Director must determine if a continued inquiry needs to take place in order to reach a conclusion in the matter. In order to do this, the Program Director should talk with the Assistant Vice President, GME or their designee to review the situation and determine proper direction. If a continued inquiry is not warranted, then with the consent of the Assistant Vice President, GME, one does not need to be conducted.
4. If an inquiry is warranted, the Program Director should consult with the Assistant Vice President, GME to determine whether others should be contacted or included in the inquiry process as appropriate based on the issues at hand and the people involved. For example, Human Resources, Compliance, Security, or other departments may need to be included. The Associate DIO of the institution should serve in a hands-on role during the inquiry process.
5. All allegations of sexual harassment will be reported immediately to Human Resources in accordance with the Hospital's policy against harassment.

6. A continued inquiry process is administered by the Assistant Vice President, GME. Information learned during the inquiry will be prepared into a report and provided to the program director for final review and decision making.
7. Upon consensus of the Program Director and Assistant Vice President, GME, the accused house staff officer can be removed from duty (with or without pay) pending the outcome of the inquiry process. If no findings of misconduct are found, the house officer's pay will be reinstated in full.

C. Upon receipt of the inquiry report, the program director will review the findings with the Assistant Vice President, GME and together they will determine an appropriate course of action. This determination may be made upon consultation with others including Human Resources, Legal, or others.

D. The Program may take actions including, without limitation, the following:

1. A verbal or written warning*

2. Reportable Actions:

a) Election to not promote to the next PGY level

b) Non-renewal of contract

c) Suspension

d) Dismissal from the residency or fellowship program

* If the program director determines that misconduct occurred, but the level of misconduct does not rise to a required dismissal from the program, and that the house officer has the ability learn from the experience, then the issue can be converted to an academic matter. In this situation, the house officer should receive a Letter of Misconduct outlining the issue, future expectations, and academic improvement required under the competence of professionalism.

Reportable Actions: The decision not to promote a house officer to the next PGY Level, not to renew a house officer's contract, to suspend a house officer, and/or to terminate the house officer's participation in a residency or fellowship program are each considered "reportable actions." Reportable Actions are those actions that the Program must disclose to others upon request, including without limitation, future employers, privileging hospitals, and licensing and specialty boards. House Officers who are subject to a Reportable Action may request a review of the decision as provided in this Policy.

E. **Request for Review:** A review of the decision to take a Reportable Action may be requested by the house officer. A Request for Review should be submitted to the Assistant Vice President, GME within fourteen (14) days of learning of the Reportable Action. Upon receipt of a Request for Review, the Assistant Vice President, GME will first determine whether the matter is reviewable under this Policy, and if so, the Assistant Vice President, GME shall advise the Physician Chair of the System GMEC and the Corporate for Vice President Academic Affairs (or their designee) who will:

1. Review the complaint
2. Meet with the house officer
3. Review the house officer's file and the inquiry report
4. Meet with the program director
5. Consider any extenuating circumstances
6. Consult with others, as appropriate, to assist in the decision making process; and
7. Determine whether this Policy was followed. That is, that the house officer received notice and an opportunity to be heard, and the decision to take the Reportable Action was reasonably made.

The Assistant Vice President, GME will:

1. Advise the Physician Chair of the System GMEC and the Corporate VP, Academic Affairs of the request for review
2. Assist the Physician Chair of the System GMEC (or designee) to identify other potential participants, if warranted
3. Monitor timely completion of the review process

The decision resulting from this review is a final and binding decision. A written report will be provided to the resident and the program director, and others as appropriate.

V. No Retaliation:

Initial and full inquiries will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an initial inquiry or a full inquiry conducted under this policy. A house staff officer who believes he/she may have been retaliated against in violation of this policy should immediately report it to their supervisor, the Assistant Vice President, GME, or any other supervisor.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Moonlighting and Outside Professional Employment

MedStar Health
Graduate Medical Education Policy

I. Purpose

To establish guidelines for employment outside of the MedStar Health System academic curriculum for residency and fellowship training.

II. Scope

This policy will apply to all house officers participating in post-graduate training programs at MedStar Health hospitals.

III. Definitions

House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health hospital's post-graduate training program.

Post-Graduate Training Program – refers to a structured residency or fellowship educational program accredited by the ACGMC, CPMB, ADA or other recognized accrediting body, or a non-accredited program which is recognized by the American Board of Medical Specialties (ABMS), for purposes of clinical education (collectively "approved programs"). For purposes of this policy, graduate medical education programs also include structured educational programs that are unapproved and unaccredited (collectively "unapproved programs").

Moonlighting – refers to any and all clinical activities outside of the scope of the defined post-graduate training program.

External Moonlighting – refers to moonlighting on behalf of an employer other than the sponsoring institution and any of its academically affiliated sites.

Internal Moonlighting – refers to moonlighting on behalf of the sponsoring institution or any of its academically affiliated sites.

Outside Professional Employment – refers to any non-clinical employment a house officer engages in outside of the defined post-graduate training program.

IV. Conditions/Requirements

A. General Restrictions

1. No house officer may moonlight without having first obtained, at their own cost, an unrestricted license to practice medicine in the jurisdiction in which the moonlighting activity will take place.

2. No house officer may moonlight without first having been appropriately credentialed by the medical staff office of the facility where the moonlighting is to occur.

3. Any house officer holding an H-1B or J-1 visa, by virtue of USCIS regulations and/or ECFMG sponsorship, is not allowed to accept work or receive income in any capacity other than that of a resident physician in the specific residency identified on the DS2019 issued by the ECFMG or the visa petition approved by the USCIS.

4. Moonlighting, whether internal or external, is prohibited if it is inconsistent with providing residents and fellows sufficient time for educational activities. Moonlighting will only be approved if, in the judgment of the Program Director, the proposed moonlighting activity will not interfere with the house officer's ability to meet his/her educational obligations in a satisfactory manner. The Program Director must prospectively approve, in writing, all moonlighting of house officers within their scope of supervision. This written approval will be noted in the house officer's institutional personnel (GME) file. The Program Director may withdraw permission for moonlighting activities if he/she determines the moonlighting activities are having an adverse effect upon participation in educational activities.

B. **House Staff in Approved (Accredited) Programs.**

1. A house officer in an approved program is never required to moonlight, but moonlighting may be permissible under certain circumstances.

2. External Moonlighting

a) A house officer may moonlight externally if: (i) the house officer is fully licensed and credentialed by the facility where the moonlighting is to occur; and (ii) the house officer has the prior written permission of the Program Director.

b) A house officer who moonlights outside of the MedStar Health System is not provided coverage of professional liability insurance by MedStar Health or its affiliates. It is the responsibility of the moonlighting house officer to obtain appropriate professional liability insurance for any moonlighting activity outside of the MedStar Health System.

3. Internal Moonlighting

a) Any moonlighting occurring within the sponsoring institution (or its academically affiliated sites) must be counted toward duty hour limits (80 hour rule, 30 hour rule, and 10-hour rest period). It is the responsibility of the program director and the institution to monitor and comply with all duty hour regulations.

b) A house officer may only moonlight within the sponsoring institution (including any of its academically affiliated sites) if: (i) the house officer is fully licensed and credentialed by the medical staff office of the facility where the moonlighting is to occur; (ii) the services to be performed can be distinguished from those services that are part of the house officer's training program; (iii) the services will be performed in an outpatient department or emergency department of the sponsoring institution;[1] and (iv) the house officer has the prior written permission of the program director.

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[1] If these criteria are not met, there can be no reimbursement for the house officer's moonlighting activities under Medicare Parts A or B. The house officer cannot bill Medicare Part B, and in order for the attending physician to bill Medicare Part B the attending physician must have: (1) participated in the service; and (2) the attending physician's provision of services must be properly documented in accordance with applicable reimbursement guidelines. In addition, all costs associated with the house officer's moonlighting activities must be separated out and not included on the cost report line relating to residency training on the Hospital's Medicare cost report.

(i) House staff in graduate medical education programs may not moonlight within the sponsoring institution or any academically affiliated site, unless the services to be provided during moonlighting are clearly distinguishable from the services furnished by the house officer in his/her approved or recognized medical training program. Any proposed services that fall within the scope of the house officer's training program or within the house officer's department is presumptively forbidden. Factors to be considered in determining whether proposed services are distinguishable from the services furnished by the house officer in an approved or recognized medical training program include, but are not limited to:

(1) Whether the house officer is working on the same unit during moonlighting activities and during the activities of the training program;

(2) Whether the house officer is seeing the same patients during moonlighting activities and during the activities of the training program;

(3) Whether the house officer is performing work for which he/she would require supervision if the work were performed during the regularly scheduled hours of the residency training program;

(4) Whether the house officer will be evaluated for the moonlighting activities through the residency/fellowship program evaluation process; and

(5) Whether the house officer is using any of the patients seen during the moonlighting activities as case studies for residency/fellowship program papers.

4. The VPMA of the hospital must review the aforementioned five criteria to determine if services are separate and distinguishable. If that determination is made, then the decision should be memorialized by way of a memo to the file and made available for future review.
5. House staff in approved programs who meet all of the above criteria and who wish to moonlight must have a separate contract that specifies the services they are permitted to provide independently. The contract must specify that these services are not part of their residency/fellowship program. The contract also must indicate a separate salary that will be paid at fair market value for these services. The contract must be terminable at the discretion of the training Program Director, if at any time he or she concludes that the moonlighting services are interfering with the house officer's educational responsibilities. Such contracts must meet all requirements of the Hospital's Contract Administration Policy, including review by the Legal Department, as necessary.
6. A house officer who engages in internal moonlighting activities at an academically affiliated site that is not part of the MedStar Health System is not provided coverage of professional liability insurance by MedStar Health. It is the responsibility of the moonlighting house officer to obtain appropriate professional liability insurance for any moonlighting activity outside of the MedStar Health System.

C. **House Staff in Unapproved (non-Accredited) Programs.**

1. External Moonlighting

a) A fellow who is enrolled in an unapproved program may moonlight externally if: (i) the fellow is fully licensed and credentialed by the facility where the moonlighting is to occur; and (ii) the fellow has the prior written permission of the Program Director.

b) A fellow who is enrolled in an unapproved program who moonlights outside of the MedStar Health System is not provided coverage of professional liability insurance by MedStar Health or its affiliates. It is the responsibility of the moonlighting fellow to obtain appropriate professional liability insurance for any moonlighting activity outside of the MedStar Health System.

2. Internal Moonlighting

A fellow who is enrolled in an unapproved program may moonlight within the sponsoring institution (or its academically affiliated sites) under the following circumstances:

a) A fellow who is enrolled in an unapproved program may moonlight in any position within the institution for which he or she is qualified, if (a) the house officer is fully licensed and credentialed; and (b) the house officer's position is not included in the sponsoring institution's GME Cost Report.

b) In the judgment of the Program Director, the proposed moonlighting activity does not interfere with the fellow's ability to meet his/her educational obligations in a satisfactory manner.

c) Any moonlighting occurring within the sponsoring institution (or its academically affiliated sites) must be counted towards the 80-hour weekly limit on duty hours.

3. Fellows enrolled in an unapproved program who meet all of the above criteria and who wish to moonlight internally must have a separate contract that specifies the services they are permitted to provide independently. The contract must specify that these services are not part of their fellowship program. The contract also must indicate a separate salary that will be paid at fair market value for these services. The contract must be terminable at the discretion of the training Program Director, if at any time he or she concludes that the moonlighting services are interfering with the house officer's educational responsibilities. Such contracts must meet all requirements of the Hospital's Contract Administration Policy, including review by the Legal Department, as necessary.
4. Fellows enrolled in an unapproved program who meet all of the above criteria and engage in moonlighting may bill for any services within the scope of his or her license and employment contract.

Policy Approved by the VPMA Council August 5, 2010

Non-competition Guarantees and Restrictive Covenants

I. Purpose
To establish a policy outlining non-competition guarantees and restrictive covenants for house staff.

II. Scope
This policy will apply to all house officers who participate in a GME training program within MedStar Health.

III. Definitions
House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

IV. Non-Competition Guarantee and Restrictive Covenants
A. Under no circumstance will a MedStar Health house officer be required to sign a non-competition guarantee or a restrictive covenant as a condition of employment or enrollment in a GME program.

Policy Approved by: System GMEC

Policy maintained by: MedStar Academic Affairs

If an extension of training is necessary, the house officer should make up the missed time before being promoted

Paid Time Off and Leaves of Absence

I. Purpose
To establish a policy outlining paid time off (PTO) benefits and leaves of absence for all graduate medical education (GME) training programs within MedStar Health.

II. Scope
This policy will apply to all house officers who participate in a GME training program within MedStar Health.

III. Definitions

House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

IV. PTO Benefits

A. All house staff are eligible for two weeks of PTO, which includes vacation, personal and sick time. PTO requests must be made in advance to the program director or the appropriate departmental designee. Requests will be granted based upon a number of factors, including operational need and staffing requirements. An additional two weeks of PTO may be granted with the approval of the program director, and in accordance with program specific PTO policies. Holiday scheduling for house staff is determined by each program individually, and is dependent upon 24-hour operational and staffing needs.

B. House staff do not accrue PTO. Any unused PTO will be forfeited upon conclusion of the residency/fellowship training period.

V. Leaves of Absence

A. In the event of a leave of absence, the educational training period may be extended in order to fulfill the department, specialty board, or state licensing board's requirements. Each program director should have their own programmatic policy which defines the amount of leave permissible for satisfactory completion of the program and specialty board eligibility. Program directors are responsible for ensuring that their house staff are provided with accurate information regarding the impact of an extended leave of absence on satisfactory completion of the program and eligibility to participate in examinations by the relevant certifying board(s).

B. House staff and program directors must adhere to each specialty board's policy specifying the maximum amount of time a house staff officer may be absent during each year of training. If a house staff officer's educational training period must be extended to satisfy board and/or department requirements, he/she must make up the excess time before being promoted to the next PGY level.

C. House staff must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. It is up to each educational program to determine the process by which a house officer should request the time off.

Policy Approved by: System GMEC

Policy maintained by: MedStar Academic Affairs

Personal Use of Drugs and Alcohol in the Workplace

Effective Date: October 01, 2019
Last Reviewed: January 1, 2024

Purpose

To ensure that an associate's personal use of drugs or alcohol does not affect the safety of our patients or other associates. This policy applies to all employed associates, physicians (private and employed) and physician residents, as well as non- employed individuals who work or learn at MedStar Health sites, including without limitation: students, rotating residents, volunteers, contingent staff and contractors.

References made to "associates" are intended to apply to all of the above.

MedStar Health does not permit the illicit use of drugs or other controlled substances or misuse of alcohol by associates while working or engaged in MedStar Health business. Associates who misuse, possess, sell, divert or transfer drugs or other controlled substances, or who offer to divert, buy or sell such substances, are subject to corrective action up to and including dismissal. Likewise, associates who misuse drugs or other controlled sub-

stances or alcohol during work hours or whose use of drugs or other controlled substances or alcohol off-duty affects their job performance or reflects poorly on MedStar Health's reputation are subject to corrective action or dismissal. "Illicit use" means, without limitation, the misuse of prescription drugs, misuse of Cannabis, or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription drugs is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. As a High Reliability Organization (HRO), MedStar Health employs a Care for the Caregiver approach in all instances in violation of this policy.

Philosophy Statement

MedStar Health expects all associates to contribute to a professional and collegial environment by exemplifying the SPIRIT (Service, Patient First, Integrity, Respect, Innovation, and Teamwork) Values with our patients, visitors, customers and colleagues.

Procedure

A. Establishment of Reasonable Suspicion

All associates who believe they may be impaired by drugs or alcohol, suspect that a co- worker may be impaired or who have reason to suspect diversion or noncompliance with this policy are expected to report their concerns to their supervisor. MedStar Health will remove a potentially impaired associate from the workplace where there is reasonable suspicion that the associate may be under the influence of drugs or other controlled substances or alcohol at work, or when there is reasonable suspicion that an associate has been involved in diversion of drugs in the workplace.

Reasonable suspicion may be based on reports or direct observation of impairment including behavior, or conduct that includes, but is not limited to: slurred speech; glassy eyes; inability to perform tasks; sleeping or inability to stay awake; accident involving hospital property or on hospital premises; agitated or violent behavior; disorientation; loss of coordination unexplained changes in performance; or odor of alcohol on breath.

Reasonable suspicion may also be based on recommendations from investigators at the local site after investigation of evidence that includes, but is not limited to: indicators from diversion analytics software; reports from automated dispensing machines or electronic safes; discovery of physical evidence; possession of alcohol or illegal drugs; unauthorized or inappropriate possession of controlled substances; discrepancies regarding narcotic counts or administration; or information from another credible source.

B. Fair and Transparent Management of Cases

1. Associates who self-report potential impairment are placed on leave and treated with as much privacy as possible.

   MedStar Health offers a job-protected leave of absence, short-term disability benefits (pay), and continued health insurance coverage to all eligible associates in order to allow the associate to seek and receive appropriate treatment.
2. Associates who are suspected of being under the influence of drugs or other controlled substances or alcohol in the workplace, are placed on suspension with pay pending completion of an investigation, which includes a urine drug test, and may include additional investigatory steps.
   a. This leave may be converted to a leave of absence with short-term disability benefits if the associate immediately seeks treatment (which is encouraged).
3. Associates who are suspected of diverting drugs for sale or distribution to others will be placed on suspension with pay pending completion of an investigation.
4. Non-employed individuals are not eligible for employment-based benefits, such as leaves of absence, short-term disability benefits or health insurance coverage. However, MedStar Health remains committed to en-

couraging all impaired individuals to receive effective treatment, and to considering each case on an individualized basis.

5. Where required by law, and in accordance with all applicable laws, rules, and regulations, MedStar Health will complete reporting to appropriate agencies, i.e., professional licensing boards, other State/Local agencies, etc. All reporting will be conducted in collaboration with MedStar Health's Office of the General Counsel.
6. If the associate seeks to return to work, a final decision on whether and under what conditions an associate returns will be made based on the totality of the facts and circumstances then known to MedStar Health.
    a. Factors that may be considered include, without limitation, whether the associate voluntarily self-reported the issue, whether the associate cooperated fully in MedStar Health's investigation, whether the associate's behavior placed patients or associates at risk, whether the associate violated legal, ethical, or behavior standards, whether the associate has successfully completed treatment and is committed to continuing in recovery, whether the associate's treating provider recommends return to the healthcare work environment, whether there is a suitable position available, and whether the associate's license (if any) remains intact. If MedStar Health concludes that an associate or non-employed individual diverted drugs for sale or distribution, the associate or non-employed individual will be terminated and will not be eligible to return to work.
    b. Before returning to work, the associate must be cleared through Occupational Health as fit for duty, at which time consideration will be given to any required accommodations or on-going monitoring and treatment recommended by the associate's caregiver. Associates will be required to enter into, and comply with, a monitoring agreement as a condition of continued employment. Violation of the monitoring agreement may result in corrective action, up to and including dismissal.
7. MedStar Health will conduct an individualized assessment of each case using a small group of leaders with experience in managing diversion/impairment issues for similar associates.
8. To ensure future safety of patients and associates, MedStar Health will use dedicated peer review committees to monitor and oversee associate's or non- employed individual's compliance with monitoring agreements. These committees include a Physicians Health Committee (including residents, fellows and credentialed providers), a Nurses and Licensed Health Professionals Health Committee, and an Associates Health Committee.

Please contact your supervisor or Human Resources with any questions regarding this policy.

Provisions of this policy apply to all associates to the extent they do not conflict with relevant terms of an applicable contract.

Professional Liability Insurance

I. Purpose

To establish a policy outlining professional liability insurance coverage for all assignments within the scope of the training program in Graduate Medical Education (GME) within MedStar Health.

II. Scope

This policy will apply to all house officers who participate in a GME training program within MedStar Health.

III. Definitions

House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

IV. Professional Liability Coverage

A. As agents of the hospital, and in accordance with the rules and regulations of the hospital and the Accreditation Council for Graduate Medical Education (ACGME), house staff are covered for professional liability by the MedStar Health, Inc. Risk Management Financing Plan for all work performed within the scope of the training program. House staff are covered under this plan for any incident that occurs while employed by MedStar Health, even if the claim arises after employment terminates. Coverage through the Plan provides limits of $1,000,000/$3,000,000 and is occurrence based. In addition, excess coverage is purchased on a claims made basis. All subpoenas and information relating to professional liability actions against the hospital or its staff should be referred to Risk Management or Legal Affairs.

Policy Approved by: System GMEC

Policy maintained by: MedStar Academic Affairs

Program Closures and Reductions in Force

I. Purpose

To establish a policy for all graduate medical education (GME) programs at MedStar Health to state the intentions of the Hospitals regarding the potential for program closure or reductions in force.

II. Scope

This policy will apply to all GME training programs within the MedStar Health system.

III. Definitions

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a GME training program.

IV. Responsibilities/Requirements

A. The Sponsoring Institution will make every effort to notify the DIO and Graduate Medical Education Committee in writing as soon as possible of any major change in a training program, i.e. reduction in the size of a program or program closure.

B. House staff will be notified in writing as soon as possible of any major change in the training program.

C. All current contracts will be honored.

D. If possible, house staff currently enrolled in impacted GME training programs will be allowed to complete their education. Otherwise, every effort will be made to help each house officer find alternative training in an accredited program.

E. The ACGME or accrediting body will be notified as soon as possible of the Sponsoring Institution's intention to permanently reduce the approved complement of a program or to close a program.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Promotion of House Officers

I. Purpose

To establish a policy for all graduate medical education (GME) training programs within MedStar Health to use in the promotion and appointment of house officers to the next level of training.

II. Scope

This policy will apply to all GME training programs in the MedStar Health system. All information contained in this policy shall be used as minimum criteria for promotion. More detailed promotion criteria shall be delineated by each clinical department in its respective Departmental Promotion Policy.

III. Definitions

House Staff or House Staff officer – refers to all interns, residents and fellows participating in a MedStar Health training program.

Graduate Medical Education Training Program – refers to a residency or fellowship educational program.

Letter of Deficiency – refers to the process of formally providing "notice and opportunity to cure" as described in the "Academic Improvement" Policy.

IV. Responsibilities/Requirements

A. The decision as to whether or not to re-appoint and promote a House Staff officer to the next level of training shall be made annually by the Program Director upon review of the House Staff officer's performance.

B. The Program Director shall consider all feedback and evaluations of the House Staff officer's performance (refer to the Policy for Evaluation of House Officers) and any other criteria deemed appropriate by the Program Director.

C. Pursuant to the Academic Improvement policy, House Staff officers must be provided with a written notice when that House Staff officer's contract will not be renewed, when that House Staff officer will not be promoted to the next level of training, or when that House Staff officer will be dismissed.

D. Graduate Medical Education should be notified immediately upon the Department's decision to not renew a house staff contract.

E. The Program Director may elect to extend the House Staff officer's contract pending satisfactory completion of academic requirements. In this event, the decision to promote will be deferred until satisfactory completion of the educational program is confirmed.

F. A decision not to extend or promote a House Staff officer's contract should be preceded by a Letter of Deficiency pursuant to the Academic Improvement Policy.

G. If a program director elects not to promote a House Staff officer, or extend a House Staff officer's contract, the House Staff officer has a right to due process in accordance with the Academic Improvement Policy or the House Officer Misconduct Policy.

V. Non-Renewal of Contract

See Policy for "Dismissal and Termination"

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Selection and Credentialing of House Officers

MedStar Health
Graduate Medical Education Policy

I. Purpose

To establish a policy for all graduate medical education (GME) training programs within the MedStar Health system to use in the selection of House Staff officers. To further establish a procedure for the credentialing of House Staff officers.

II. Scope

This policy will apply to all GME training programs in the MedStar Health system. All information contained in this policy shall be used as minimum criteria for selection. More detailed selection criteria shall be delineated by each clinical department in its respective Departmental Selection Policy.

III. Definitions

House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a training program regardless of accreditation status.

Match – refers to the formal process of matching House Staff officers to accredited training programs, administered by an official program including, but not limited to, the National Residency Matching Program (NRMP).

Responsibilities/Requirements

A. All applicants for a House Staff position must be graduates or pending graduates of:
   1. An LCME (Liaison Committee on Medical Education) accredited medical school in the United States or Canada; or
   2. An AOA (American Osteopathic Association) accredited medical school in the United States; or
   3. An accredited college for specialty training in Podiatric Medicine or an American Dental Association (ADA) accredited dental school;
   4. Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional criteria:
      a) Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or
      b) Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty/subspecialty program; or,
      c) Has graduated from a medical school outside of the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical school.

B. All applications for House Staff positions must be submitted by one of the following methods:
   1. The Electronic Residency Application Service (ERAS); or
   2. The Universal Application for Residency Training; or
   3. Approved MedStar GME application for residency training.

C. The Program Director, or designee, will evaluate and select the candidates he/she believes to be the most qualified for the positions available within the training program.

D. **PROCEDURE**. Once an applicant is selected for an interview, the following procedure must be employed by all programs:
   1. The following credentials must be collected for each candidate:
      a) Application and Personal Statement

b) Original Dean's letter

c) Original (certified) Medical School Transcript

d) Verification of graduation from the Medical School. (Appointments to PGY- 1 positions may be made prior to graduation; however, graduation must be verified before the PGY-1 resident begins the program).

e) Three (3) letters of reference from attending physicians familiar with the individual's performance. If the candidate has previously been in a GME training program, one letter must be from the candidate's former Program Director.

f) Documentation of successful completion of Steps 1 and 2CK of the United States Medical Licensure Examination (USMLE) or Level 1 and 2CE of the COMLEX Examination OR successful completion of APMLE Parts 1 and 2/ iNBDE or NBDE Parts 1 and 2 as applicable. If an applicant has not received the passing results at the time of interview, successful completion will become a "Condition of Employment."

g) Candidates for fellowship positions must have successful completion of USMLE Step 3,COMLEX Level 3, or AMPLE Part 3. If an applicant has not received the results of Step 3/Level 3/ Part 3 at the time of interview, successful completion will become a "Condition of Employment."

2. Candidates of medical schools that are not accredited by the LCME, the AOA or other accredited college for specialty training must have the following additional documentation:

a) Official certified translations of all documents listed above in English; and

b) Certification by the Educational Commission of Foreign Medical Graduates (ECFMG).

3. Candidates for non-accredited training programs who are not graduates of LCME or AOA accredited schools and who have not completed residency training in the United States must be reviewed and approved per the Sixth Pathway criteria and process noted under Section 4.b(1-5) of this Selection Policy.

4. TRANSFERS AND "OUT OF MATCH" CANDIDATES:

a) In addition, before accepting a House Staff officer who is transferring from another program or is taken outside of a formal match, written verification of previous GME training and a competency-based summative performance evaluation of the candidate must be obtained.

b) The complete application and verification of previous GME training must be reviewed and approved by the Assistant Vice President, GME prior to any offers of employment.

1. If the AVP-GME does not deem the candidate to meet acceptable standards for employment, s/he will notify the Program Director and the Department Chair of the decision.

2. The Program Director, together with the respective Department Chair, may request a second review of the candidate which will be done by either the VP-Academic Affairs/DIO and/or the Physician Chair of the GMEC.

3. If the second review also results in determination of unacceptable candidacy, then the applicant will not be permitted to proceed with enrollment in a MedStar Health program.

4. If either the AVP-GME or the VP-Academic Affairs and/or the Physician Chair of the GMEC endorse the candidate as meeting criteria, the application must then be reviewed and approved by the Institution's GMEC.

5. For **non-accredited training programs** wishing to enroll a candidate who has no prior training in the United States (6th Pathway), the GMEC provide "substantial oversight" of the candidate's acceptability for training based on the following criteria (as developed/maintained by ECFMG and ACGME):
   a. Determine the candidate meets criteria as "exceptionally qualified" international graduate based on all three of the following criteria:
      1. Completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and
      2. Demonstrates clinical excellence, in comparison to peers, throughout training; and
      3. Additional evidence of exceptional qualifications which may be met by one or more of the following criteria:
         a. Participation in additional clinical or research training in the specialty or subspecialty;
         b. Demonstrated scholarship in the specialty or subspecialty; and/or
         c. Demonstrated leadership during or after residency.
   b. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

5. All candidates should interview with the Program Director (or designee) and one or more members of the faculty. Telephone or virtual interviews are granted in lieu of a personal interview in the event of business necessity, such as the COVID pandemic and/or recommendation of COPA.
6. All accredited training programs are expected to participate in a formal match, such as but not limited to, the National Residency Matching Program (NRMP) and to follow all rules and requirements as set forth by the official matching program.
7. All candidates should be evaluated based on the following minimum criteria:
   a) Preparedness
   b) Ability
   c) Aptitude
   d) Academic credentials
   e) Communication skills
   f) Personal qualities, such as motivation and integrity
8. All candidates invited for interviews must be informed in written or electronic format, of the terms, conditions and benefits of appointment either in effect at the time of the interview or that will be in effect at the time of eventual appointment to include:
   a) Financial support;
   b) Vacations; parental, sick and other leaves of absence;
   c) Professional liability, hospitalization, health, disability and other insurance accessible to the House Staff and their eligible dependents.

9. Upon selection (or after the Match), contracts shall be prepared by Graduate Medical Education, and signed by the Vice President, Academic Affairs. All contracts for categorical House Staff throughout the system will follow the academic/fiscal year dates beginning July 1 and ending on June 30 of each year, except during the first year of residency/fellowship when contract start dates will coincide with the first day of MedStar House Staff Orientation. Preliminary House Staff contract start dates will also coincide with the first day of MedStar House Staff Orientation and may end earlier than June 30. Occasionally, House Staff contracts may be "off-cycle" due to leaves of absence or other performance-related reasons.
10. If any of the required credentials documentation, as identified above, is missing on the effective date of the contract, the contract may be void.
11. If a prospective House Staff officer fails to graduate from medical school prior to the start date of the residency program, the contract will be made null and void.
12. MedStar Health is an equal opportunity employer. GME training programs will not discriminate with regard to sex, race, age, religion, color, sexual orientation, national origin, disability, or veteran status. MedStar Health is committed to recruiting and retaining a GME house staff that is diverse, inclusive and equitable.
13. CONDITIONS OF EMPLOYMENT: Offers of employment and/or acceptance into the educational program are contingent upon certain conditions, including but not limited to:
    a) Pre-employment health examination and drug screen
    b) Criminal background check
    c) Primary source verification of medical school completion and any previous GME experience
    d) Successful completion (pass) of USMLE Steps 1 and 2CK, or COMLEX Level 1 and 2 CE, if not completed at the time of interview; OR successful completion of APMLE Parts 1 and 2/ iNBDE or NBDE Parts 1 and 2 as applicableFor a fellowship position, this includes successful completion of USMLE Step 3/COMLEX Level 3/AMPLE Part 3.
    e) Approved enrollment in the respective state licensing program for trainees and/or approval of a full license for practice.

E. Medical Staff Credentialing

1. GME House officers, enrolled in any program (accredited or non-accredited) shall not apply for or be granted medical staff credentials or privileges at any MedStar Health entity unless an approval exception is made by the AVP-GME. This includes all enrolled chief residents, regardless of their board-eligibility status.
2. Approval Exceptions may include:
    a) MedStar Health GME approved moonlighting where the house officer will serve as the attending physician of record for such moonlighting activities (refer to the MedStar Health GME Moonlighting Policy for process and requirements and approvals); or
    b) Approved non-accredited fellowships that are structured and approved to include a portion of the trainee's time in clinical practice at specific sites within the health system
3. Any other requests for exceptions must be reviewed and approved by the VP- Academic Affairs and/or the Physician Chair of the GMEC.

Policy Approved by: System GMEC (DATE)

Policy Maintained by: MedStar Academic Affairs

Checklist for House Staff Transferring from Outside Programs:

- ☐ Letter from Outside Program Director(s) from any previous training program(s)
- ☐ Dean's Letter
- ☐ Written Verification of Previous Educational Experience
- ☐ Final Summative Evaluation(s)
- ☐ Milestones Evaluation(s)
- ☐ Review and approval by DIO/GME

Based on the documentation provided above, an offer of employment is:

- ☐ Approved
- ☐ Not Approved

DIO Signature Date GME Signature Date

Social Media Policy

I. Purpose:
To establish the guidelines of acceptable use of social media by MedStar Health associates and affiliated staff, including creation of official sites and participation in public sites.

II. Policy
MedStar Health supports the use of social media by its associates, understanding that participation in online communities can promote better communication with colleagues, the general public, and other community stakeholders.

MedStar Health trusts and expects that associates exercise personal responsibility when participating in social media activity. MedStar Health expects that associates and affiliated staff who engage in social media will be mindful that their postings impact MedStar Health's reputation and legitimate business interests. Social media activity may include, but is not limited to, online forums, blogs, microblogs, wikis, videologs, and social networks. Current examples of social networks include Facebook, Twitter, YouTube, LinkedIn, Pinterest, Instagram, SnapChat, TikTok, and Doximity. Communications within these platforms need to be consistent with MedStar Health policies, guidelines, and standards.

III. Overview
MedStar Health trusts and expects that associates understand that their social media use can affect MedStar Health cyber-security. Like any other interaction on the internet, social media use provides an opportunity for cyber-criminals to access information. Associates may also reveal proprietary or confidential information unintentionally through their social media activities that could violate the Health Information Portability and Accountability Act (HIPAA) or the privacy and security of protected health information (PHI). For example, associates may not realize that part of a patient file is visible in a picture, violating HIPAA rules and MedStar Health policy. In addition, opening or viewing a suspicious link on social media may infect a MedStar Health computer or device affecting the overall security of our information systems.

IV. Scope

This policy applies to all associates, volunteers, students, physicians, residents, contractors and vendors of MedStar Health, (collectively "associates and affiliated staff") and its affiliated entities (collectively "MedStar Health" or "MedStar Health").

Independent physicians on our medical staff and physicians with privileges at a MedStar Health facility are also covered under this policy since HIPAA requires confidentiality of patient information regardless of the media platform.

V. Definitions

Communications—Communications on a social network includes content shared via written text, image, audio, animation or video (including streaming video). Content includes user generated content and shared posts.

Digital Marketing—Corporate department, within the Corporate Marketing and Strategy department, responsible for governing and administering the strategy and policy for social media at MedStar Health. To contact Digital Marketing regarding social media, email web@MedStar Health.net.

Health Insurance Portability and Accountability Act (HIPAA)—Federal regulation that sets forth privacy and security standards to protect personal health information.

MedStar Health Resource—Computers, cell phones, wired and wireless devices, networks, online resources and bandwidth paid for by MedStar Health and made available to associates and affiliated staff to perform business and clinical functions and other job responsibilities on behalf of MedStar Health.

Personal Social Media Activities—Accessing or posting information to a social media site not related to an individual's job responsibilities for MedStar Health, participation in MedStar Health sanctioned activities or associated professional activities.

Private Message—A private form of messaging between different members on a given platform. It is only seen and accessible by the users participating in the message.

Protected Health Information—Protected Health Information or PHI means individually identifiable health information that is created or received by a covered entity (e.g. MedStar Health)

Social Media Platforms—Websites and applications that enable users to create and share content or to participate in social networking. These include online forums, blogs, microblogs, wikis, videologs, and social network sites. Examples of social network sites include, but are not limited to, Facebook, Twitter, YouTube, LinkedIn, Instagram and SnapChat.

VI. Procedures

A. General Guidelines

1. MedStar Health respects the right of individuals to use social media for personal reasons, using their own resources, and on their own time.
2. Individuals must not use social media to make claims on behalf of MedStar Health (e.g. claiming that MedStar Health is part of a lawsuit)
3. By adding MedStar Health as their employer on social media accounts, or representing themselves as an associate of MedStar Health, associates acknowledge that they are representing MedStar Health's SPIRIT Values, and their social media activities must reflect our organization's values.
4. Each individual associate, physician and volunteer of MedStar Health or its affiliates is responsible for all content (either posted by you or someone else) posted on social media (written, audio, video, or otherwise) on that individual associate's account.

5. Associates must use a personal email address (not a MedStar Health address) as primary means of identification for personal social media activities, with the exception of LinkedIn.
6. Associates must understand and follow the terms of use and community standards for each social network they use.
7. Communications sent via social media should be consistent with the MedStar Health Code of Conduct, and with MedStar Health's mission, vision, values, policies, and with all applicable laws.
8. Communications in online communities should never contain information that identifies a patient or his/her health condition in any way, even if a patient's name is not used, unless they have consented via the Photo, Interview and Media Consent Form.
9. Social media must not be used to respond to a patient's question about his/her care in a public response. Any such dialogue should be communicated via a secure private message (e.g. myMedStar Health patient portal).
10. Associates should never use discriminatory language or demonstrate discrimination on social media.
11. Associates should never use defamatory or libelous commentary on social media.
12. MedStar Health resources, including email and Internet access, are provided to support MedStar Health business purposes only. Managers have the right and responsibility to counsel their staff, revoke access privileges for abuse of the system, or take other corrective action, if necessary.
13. Photographs and recordings (audio and video) of patients and facilities are strictly prohibited from personal social media entries except as otherwise described herein.
    a. The Marketing and Strategy Department is permitted to post photographs and recordings (audio and video) of MedStar Health patients and facilities with prior written consent via the Photo, Interview and Media Consent Form from the identified parties.
    b. Associates are permitted to repost/share posts containing patient information on his/her personal social media account only after it's posted via an official MedStar Health page. Any other exceptions must be pre-approved by the Marketing and Strategy Department.
14. Photographs and recordings (audio and video) of MedStar Health associates are permitted for MedStar Health's marketing and communication purposes without written consent, unless otherwise required through an entity specific policy. Any associate may decline being photographed or recorded.
15. Any associate may refuse to be photographed or recorded by a patient or visitor. An associate may seek assistance from Security, if needed.
16. Photographs and recordings (audio and video) taken during public events, either on MedStar Health property or not, do not require written consent from the attendees. This includes photographs taken by any attendee.
17. Associates and affiliated staff must not respond to media or press contacts. If contacted for comment by the media, information should be forwarded to the appropriate Media Relations department.
18. Associates and affiliated staff not managing an official MedStar Health social media account must not respond to online complaints, criticisms, or negative commentary about MedStar Health. If negative commentary is observed, the information should be forwarded to Reputation Management or submitted via our website feedback form.
19. Associates with access to post on behalf of MedStar Health through its social media accounts are prohibited from creating and launching paid social advertising on MedStar Health social media platforms (refer to Content Owner Responsibilities in section 4.1). All advertising on social media networks is managed by Digital Marketing or Digital Agency of Record. Content owners who wish to advertise on MedStar Health

social media platforms must submit an official request form. For more information, please email web@MedStar Health.net.

20. Confidential business or proprietary information must not be disclosed via social media.
21. MedStar Health patients must not be referenced in social media entries without prior written consent through the Photo, Interview and Media Consent Form, obtained through the Marketing and Strategy Department. This is true even if associates believe they have anonymized the information, by, for example, not using the patient's name. The Photo, Interview and Media Consent Form authorizes MedStar Health, not an individual associate, to share patient information.
22. Content posted on social media that implies a partnership or endorsement by MedStar Health must be approved in advance by Marketing and Strategy. Posts regarding partnerships with sports teams/franchises should be brought to the attention of the Director of Sponsorship Marketing.
23. Individuals who have concerns regarding associate conduct or inappropriate behavior demonstrated on social media are encouraged to contact their immediate supervisor, Human Resources, or the MedStar Health Integrity Hotline at 877-811-3411.
24. Administrators and editors of MedStar Health's official social media accounts possessing a mobile device that can gain access to an official MedStar Health social media profile through a third-party app or mobile browser (whether or not it is used to post content) are responsible for implementing all appropriate security measures governing access, use and transmission of information, including, but not limited to, assuring devices are properly password protected (see 4.4).
25. Physicians who wish to have their professional social media account added to their Find a Doctor profile on the MedStar HealthHealth.org website, must first consult with Marketing and Strategy.

B. Creation of MedStar Health Business Social Media Account

It's against policy to create a social media account representing MedStar Health's business without prior approval from Marketing and Strategy.

C. Responsibilities

1. Human Resources
    a. Ensures that all associates and others affiliated with MedStar Health are provided with information relating to this policy.
    b. Assists management and associates in ensuring compliance with this policy.
    c. Serves as a resource for management and associates in need of information.
    d. Intervenes in any situation where this policy is being violated.
    e. Contacts Information Services on behalf of managers to provide a detailed internet usage report when non-business activity is suspected.
2. Information Services (IS)
    a. At the request of Human Resources, shuts down or restricts access to social media sites from MedStar Health network resources if the resources are being used in violation of this policy.
    b. Provides internet activity logs and assists in interpreting those logs, when requested.
3. Management
    a. Managers who have a business need to create an official MedStar Health social media profile/site must request permission from the vice president over their department, their entity's Marketing and Strategy department and Digital Marketing

b. Vice presidents must review and approve requests for official social media profiles/sites based on a business need for the site.

c. Managers will contact Human Resources when non-business online activity is suspected.

4. Editors of Official MedStar Health Social Media Accounts

a. Editors, as named by their department's leadership, are responsible for posting content, responding to inquiries and maintaining compliance with HIPAA, MedStar Health policies (including Privacy, Security and Human Resources) and other applicable laws, rules and regulations.

b. Authorize Digital Marketing as the administrators of the account.

c. Complete mandatory social media training prior to receiving initial access to a MedStar Health social media account.

d. Follow MedStar Health brand standards and social media best practices.

e. Notify Digital Marketing if they possess a mobile device that can gain access to an official MedStar Health social media profile through a third-party app or mobile browser (whether or not it is used to post content). If mobile access is available, content owners must:

f. Implement all appropriate security measures governing access, use and transmission of information, including, but not limited to, ensuring mobile devices are properly password protected and encrypted.

g. Have general security awareness, including awareness of potential malicious software issues, knowledge of security and privacy policies and procedures, and awareness of the sensitivity levels of information processed on the personal mobile device (e.g. Protected Health Information (PHI)).

h. Notify the ISD Help Desk should their mobile device be lost, stolen or compromised by any malicious software.

i. Take appropriate precautions to appropriately safeguard their mobile device.

5. Entity Marketing and Strategy Department

a. Approves, as appropriate, all requests for creation of official MedStar Health entity-level social media profiles/sites.

b. Authorizes individuals to provide official content and responses on social media sites.

c. Notifies Digital Marketing if/when an associate with access to a MedStar Health social media account leaves MedStar Health or is otherwise no longer in need of access.

6. Digital Marketing

a. Approves, as appropriate, all requests for creation of official MedStar Health corporate and diversified business social media profiles/sites.

b. Provides support and guidance on the management of MedStar Health social media profiles/sites, including overall strategy, brand guidelines, and best practices.

c. Serves as primary owner of all official MedStar Health social media profiles/sites to aid in the smooth transfer of ownership and maintain continuity of control.

d. Provides consult to MedStar Health associates on the social media policy.

e. Maintain a comprehensive list of all MedStar Health social media accounts, passwords and associates who have access.

7. Brand Strategy
    a. Provides social media monitoring and response guidance.
8. Associates
    a. Be knowledgeable and follow MedStar Health's Code of Conduct and other policies relating to branding standards, intellectual property, privacy (including HIPAA), and confidentiality of business and patient information.
    b. Contact their manager, entity compliance officer, the Human Resources department, or the Integrity Hotline if they see any MedStar Health-related private information shared online.

D. What Constitutes Non-Compliance?

Some examples of non-compliance include, without limitation:

1. Use of MedStar Health resources for personal social media activity.
2. Disparaging MedStar Health, its associates, patients, physicians or agents, or any other healthcare organization on a social media platform, while acting as an official representative of MedStar Health.
3. Discussing confidential work-related activities on a social media platform
4. Posting any patient-related information on a social media platform without signed written patient consent and appropriate authorization. (see Section B)

E. Consequences of Non-Compliance

1. Non-compliance with this policy may result in corrective action, up to and including termination of employment or dismissal of contract staff. Managers should consult Human Resources when considering taking corrective actions.
2. If any of the following is found and brought to MedStar Health's attention in an online commentary posted by a MedStar Health associate, physician, volunteer, or contractor, it may be grounds for corrective action, even if it occurs as part of an individual's personal use of social media:
    a. Posts that disclose confidential patient information or other confidential/proprietary information (see Section B)
    b. Posts that are defamatory or libelous
    c. Posts that are threatening, harassing, abusive or humiliating to another person or entity (even when a proper name isn't used)
    d. Social networking activities that interfere with an associate's productivity or job duties.
    e. Posts that attempt to conduct official MedStar Health business or clinical operations (e.g. responding to media or press contacts, acting as an official spokesperson for MedStar Health or providing clinical care to a MedStar Health patient)
3. If the approval process for a social media account representing MedStar Health's business has not been followed, an unauthorized social media profile/site may be shut down. MedStar Health reserves the right to require any associate to close an unapproved social media profile/site that refers to MedStar Health.

F. Related Policies

- Associate Conduct
- Acceptable Use Policy
- Human Resources Records
- Code of Conduct

- IS Security Policy
- Email Use Policy
- Branding policies
- HIPAA policies
- Intellectual Property policies
- Confidentiality policies
- Solicitation and Distribution Activities Policy
- Media Relations
- Harassment Prevention Policy
- GME policies
- Non-Discrimination Policy

G. Procedures which are related to the policy

Not Applicable.

H. Legal reporting requirements

Associates must contact the Legal Department or their manager in the event a threat to pursue legal action against MedStar Health is shared on social media. Associates must report any sign of violation of a patient's privacy to their manager, a compliance officer, or the Integrity Hotline at 877-811-3411 as soon as they are aware of it.

I. Reference to laws or regulations of outside bodies

Not Applicable.

J. Right to change or terminate policy

This policy should be modified with the advice of the Social Media Steering Committee, Human Resources, Legal, Compliance, Marketing and Strategy, and pursuant to the review and approval of the Legal department.

Version History

Version 7 Effective 12.8.19
Version 6 Effective 10.8.18
Version 5 Effective 2.27.17
Version 4 Effective 2.28.14
Version 3 Effective 8.2.13
Version 2 Effective 7.12.13
Version 1 Effective 12.1.11

Supervision of House Officers and Transitions of Care

I. Purpose

To establish a policy for all graduate medical education (GME) programs at MedStar Health to ensure appropriate levels of supervision, progression of responsibility and procedural competency of House Staff.

II. Scope

This policy will apply to all House Staff officers who participate in a GME training program within MedStar Health. All information contained in this policy shall be used as minimum criteria for supervision. More detailed supervision criteria shall be delineated by each GME program in its respective Supervision Policy.

III. Definitions

Licensed Independent Practitioner – a physician with an unrestricted license to practice medicine in the appropriate state.

House Staff or House Staff officer – refers to all interns, residents and fellows enrolled in a training program.

PGY – refers to "Post Graduate Year," or the year of training in which the house officer is currently enrolled in past completion of medical school.

IV. Responsibilities/Requirements

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

1. This information should be available to house staff, faculty members, and patients.
2. House staff officers should inform patients of their respective roles in each patient's care.

B. The program must demonstrate that the appropriate level of supervision is in place for all house staff who care for patients.

C. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced house staff office. Other portions of care provided by the house staff can be adequately supervised by the immediate availability of the supervising faculty member or house staff officer, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of house staff-delivered care with feedback as to the appropriateness of that care.

D. To ensure oversight of house staff supervision and graded authority and responsibility, the program must use the following classification of supervision:

1. Direct supervision: the supervising physician is physically present with the house staff officer and patient.
2. Indirect supervision:

   a) With direct supervision immediately available – the supervising physician is physical within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

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

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

E. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each house staff officer must be assigned by the program director and faculty members.

1. The program director must evaluate each house staff officer's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
2. Faculty members functioning as supervising physicians should delegate portions of care to house staff, based on the needs of the patient and the skills of the house staff officer.
3. Senior house staff should serve in a supervisory role of junior house staff in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual. The program director must evaluate each house staff officer's abilities based on each house staff officer.

F. Programs must set guidelines for circumstances and events in which house staff must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

1. Each house staff officer must know the limits of his/her scope of authority, and the circumstances under which he/she are permitted to act with conditional independence.

    a) In particular, PGY-1 house staff should be supervised either directly or indirectly with direct supervision immediately available. (Each Review Committee will describe the achieved competencies under which PGY-1 house staff progress to be supervised indirectly, with direct supervision available.)

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

H. The clinical responsibilities for each house staff officer must be based on PGY-level, patient safety, house staff officer education, severity and complexity of patient illness/condition and available support services. (Optimal clinical workload will be further specified by each Review Committee.)

I. House Staff must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. (Each Review Committee will define the elements that must be present in the specialty.)

J. Transitions of Care:

1. Programs must design clinical assignments to minimize the number of transitions in patient care.

2. Sponsoring institutions and programs must ensure and monitor effective, structured handover processes to facilitate both continuity of care and patient safety.

3. Programs must ensure that house staff officers are competent in communicating with team members in the hand-over process.

4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and house staff officers currently responsible for each patient's care.

K. It is the responsibility of each Program Director to establish written policies for supervision in their respective program detailing specific expectations. All program policies must be reviewed and approved by the Graduate Medical Education Committee.

V. Supervision of Procedural Competency:

A. House Staff officers must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent to independently perform that procedure or who has been credentialed by MedStar Health to perform that procedure.

B. The Department Chair or Program Director is responsible for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.

C. The Program Director for each GME program will be responsible for maintaining an updated list of house staff who have been certified as competent to perform procedures independent of direct supervision. This list will be maintained in New Innovations and available to nursing.

D. The Program Director must also develop a method for surveillance of continued competency after it is initially granted.

E. Once the house staff officer has been evaluated as competent to perform a specific procedure or set of procedures by an LIP, s/he may perform that procedure independently ***after consultation with the patient's treating physician***. A house staff officer who is determined to be competent in a specific procedure (the senior house staff) may also teach the procedure to another house staff officer (the junior house staff) and provide direct supervision. This direct supervision by the senior house staff does not replace the required, but not necessarily direct, supervision by an LIP.

F. The ability to obtain and document informed consent is an essential component of procedural competency. The supervising LIP must also supervise and attest to the trainee's competence in obtaining and documenting informed consent. Until a trainee is judged competent in obtaining informed consent, s/he may only obtain informed consent while supervised by an individual with credentials in that procedure. It is recommended that a minimum of five observed IC discussions be the criteria for each different procedure.

G. Eligible House Staff may be licensed by the appropriate licensing board. This requirement will be directed at the institutional level.

Policy Approved by: System GMEC

Policy Maintained by: MedStar Academic Affairs

Work Hour Extension Policy

I. Purpose

To establish a policy for all graduate medical education training programs within MedStar Health to request institutional endorsement for duty hour extension applications to the Residency Review Committees (RRC).

II. Scope

This policy will apply to all ACGME-accredited training programs within MedStar Health.

III. Definitions

House Staff or House Officer – refers to all interns, residents and fellows enrolled in a MedStar Health postgraduate training program.

Graduate Medical Education Training Program – refers to a structured residency or fellowship educational program, accredited by the ACGME, CPME, ADA or other recognized accrediting body, or a non-accredited program which is recognized by its specialty board, for purposes of clinical education.

Work Hours – Defined as work time scheduled for all clinical and academic activities related to the residency program, including, but not limited to patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, scheduled academic activities such as conferences and moonlighting. Work hours do not include time for a program of self study, e.g., reading and preparation time spent away from the duty site.

WorkHour Extension – refers to the ACGME's exception to the Work Hour Requirement whereby individual residency programs may request up to a 10 % addition to the 80-hour limit, or a maximum of 88 clinical and educational work hours, based on a sound educational rationale. Prior permission of the MedStar GMEC is required.

IV. Responsibilities/Requirements

A. All requests for duty hour extensions must first be reviewed and approved by the local and System Graduate Medical Education Committee (GMEC). In order to be placed on the agenda for the GMEC meeting, the following information must be submitted to the Graduate Medical Education Office (GME Office) at least 2 weeks' prior to the next meeting.

1. Documentation that the program is accredited and in good standing (continued full accreditation or full accreditation) without a warning or a proposed or confirmed adverse action.
2. Information that describes how the program and institution will monitor, evaluate, and ensure patient safety with extended resident work hours.
3. The educational rationale in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of training for which the increase is requested.

4. Specific information regarding the program's moonlighting policies for the periods in question.
5. Specific information regarding the resident call schedules during the times specified for the exception.
6. Evidence of faculty development activities regarding the effects of fatigue and sleep deprivation.

The GMEC will review all of the documentation for educational justification of a duty hour extension. The GMEC will not endorse any extension that is not completely warranted for educational reasons.

B. Procedure: If approved by the GMEC, all of the above information should be sent to the GME Office in addition to:

1. A written statement of institutional endorsement of the requested duty hour extension signed by the Designated Institutional Official (DIO).
2. A copy of this policy.
3. The current accreditation status of the program and of the sponsoring institution.

The Director of Medical Education will forward the request to the respective RRC.

Policy Approved by: System GMEC
Policy Maintained by: MedStar Academic Affairs

Workplace Harassment Prevention

I. Policy Statement

MedStar Health is committed to providing a work environment for all of its associates that is free of harassment, including harassment based on race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligations, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local laws and regulations.

II. Philosophy Statement

MedStar Health expects all associates to contribute to a professional and collegial environment by exemplifying the SPIRIT values with our patients, visitors, customers and colleagues.

III. Scope of Policy

This policy applies to all associates, medical staff members, residents, vendors, agency staff, contractors, temporary associates, students and any other persons working in MedStar Health's healthcare environment.

IV. Prohibited Behavior

Harassment is defined as unwelcome or unsolicited comments or conduct that targets a person based on his/her race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligations, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local laws and regulations, and that is so severe or so pervasive that it interferes with an associate's job performance or creates an intimidating, hostile or offensive working environment.

All such conduct is unacceptable in the workplace, in any work-related settings - such as business trips and business-related social functions - and when representing MedStar Health, regardless of whether the conduct is engaged in by a leader, co-worker, physician, client, patient, vendor, or other third party.

Some examples of what may be considered harassment, depending on the facts and circumstances, are the following:

a. *Verbal Harassment:* Derogatory or vulgar comments (including slurs, jokes, insults, epithets, or teasing) regarding any protected characteristic. Verbal harassment also includes threats of physical harm.

b. *Visual Harassment:* Offensive gestures, posters, symbols, cartoons, drawings, computer displays, e-mails, etc. that denigrates or shows hostility or aversion based on any legally protected basis. Distribution of written or graphic material which relates to these protected characteristics and which could be viewed as offensive, vulgar or derogatory.

c. *Physical Harassment:* Hitting, pushing or other aggressive physical gestures and contact, inappropriate touching, threats to touch and encroachment of personal space in a confrontational manner may constitute physical harassment.

d. *Behaviors That Undermine A Culture of Safety and Quality:* Verbal or non-verbal conduct on the basis of any protected characteristic that harms or intimidates others to the extent that entity operations, quality of care or patient safety could be compromised. Demeaning, offensive or degrading conduct on the basis of any protected characteristic. Examples of these behaviors include but are not limited to abusive, loud or intimidating behavior, throwing instruments, charts or other objects, threats of violence or retribution, belittling or berating statements, name calling, use of profanity or disrespectful language, inappropriate comments written in the medical record, failure to respond to patient care needs or staff requests, and degrading or demeaning comments regarding patients, their families; entity personnel and/or the entity.

e. *Sexual Harassment:* Sexual harassment can include all of the above actions, as well as other unwelcome conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities and other physical, verbal, or visual conduct based on sex when 1) submission to such conduct is an explicit or implicit term or condition of employment; 2) submission to or rejection of the conduct is used as the basis for an employment decision; or 3) the conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment. This can include threats that are not carried out.

Sexual harassment may also include, but is not limited to, explicit sexual propositions, sexual innuendo, suggestive comments, gender-based slurs, sexually oriented or gender-based "kidding" or "teasing," "practical jokes," jokes about gender-specific traits, and improper physical contact, such as patting, pinching or brushing against another's body. Sexual harassment may include verbal or physical conduct of a sexual or gender-based nature engaged in by a person of the same sex as well as of the opposite sex.

V. Procedure

A. Reporting Harassment in the Workplace

All MedStar Health associates are responsible for helping to ensure that workplace harassment is prevented. The most effective way in which this can be accomplished is for an associate who believes that he/she has witnessed harassment, knows of harassment or is being subjected to harassment to promptly notify a leader, Human Resources and/or the Compliance Department. If the associate makes a complaint under this policy and has not received an acknowledgement within five (5) business days, he or she should contact the HR Leader immediately.

B. Compliance Department Hot Lines

Associates who wish to contact the Compliance Department to discuss and/or raise complaints of possible violations of this policy should call the Integrity Hotline at 1-877-811-3411.

C. Internal Investigations

In keeping with its commitment under this policy, MedStar Health will promptly and effectively investigate complaints under this policy upon receipt.

To the extent possible, investigations under this policy will be treated as confidential; however confidentiality cannot be guaranteed. Therefore, the investigator(s) and those participating in the investigation should take reasonable steps to maintain the confidentiality of the complaining party, the alleged transgressor, witnesses and other individuals who may assist or otherwise be involved in the investigation.

1. Exceptions

   It is important to note that complete confidentiality cannot be guaranteed in such investigations. For example, it may be necessary to reveal the identity of the complaining party and/or witnesses in order for the alleged transgressor to be apprised of the allegations against him/her and to be afforded a fair opportunity to provide a response to the allegations. In such instances, the alleged transgressor, the complaining party and any affected witnesses should be reminded of the company's non-retaliation policy described below.

2. Harassment Complaints

   MedStar will investigate all complaints of harassment. Intentionally making false claims or reports of harassment are serious in nature, and will be handled appropriately.

   Every leader who learns of any associate's concern about conduct in violation of this policy, whether in a formal complaint or informally, must immediately report the issues raised to their immediate leader and HR Leader.

   Upon completion of the investigation, MedStar Health will take corrective measures against any person who has engaged in conduct in violation of this policy, if MedStar Health determines such measures are necessary. These measures may include, but are not limited to, counseling, written warning, suspension, or immediate termination. Anyone, regardless of position or title, whom MedStar Health determines has engaged in conduct that violates this policy will be subject to corrective action, up to and including termination.

D. Non-Retaliation

Associates have a legal right to report and/or assist in investigations of possible violations of this and/or the Equal Employment Opportunity policy. MedStar Health acknowledges, and will take appropriate steps to protect, this legal right. Specifically, it is MedStar Health's policy that an associate who reports and/or assists in the investigation of a possible violation of this policy will not be subjected to retaliation, of any form, on or off workplace premises, by supervisory or non-supervisory personnel.

Retaliation that is prohibited by this policy includes, but is not limited to, the following conduct that occurs as a direct result of an associate's report of and/or assistance in the investigation of a harassment policy violation: explicit or implied threats, verbal or physical, inappropriate comments, acts of intimidation, presence in the associate's work area without business reasons, negative change in working conditions, unwarranted corrective action or unwarranted exclusion from meetings, conferences or other work-related events.

If an associate believes that he/she is being subjected to retaliation as described above, he/she should immediately notify a leader, Human Resources and/or the Compliance Department.

Anyone, regardless of position or title, whom MedStar Health determines has engaged in conduct that violates this policy against retaliation will be subject to corrective action, up to and including termination.

VI. Responsibilities

A. Leaders

1. Adhere to the letter and the spirit of MedStar Health's Workplace Harassment Prevention Policy, and related laws and regulations.
2. Promote compliance with the terms of this policy and be alert to possible policy violations.
3. Foster an environment that reflects MedStar's SPIRIT values and is free from harassment or retaliation.
4. Immediately report to Human Resources any known, perceived, or rumored violations of this policy.
5. Cooperate with any internal investigations that may arise from any known or perceived violations of this policy.

6. Periodically review MedStar Health's Workplace Harassment Prevention Policy with associates and document that such reviews have taken place and reinforce the importance of acting upon any conduct which could be perceived as harassing in nature.

B. Associates, and All Persons Providing Services to MedStar Health

1. Adhere to the letter and the spirit of MedStar Health's Workplace Harassment Prevention policy, and related laws and regulations.
2. Foster an environment that reflects MedStar's SPIRIT values and is free from harassment or retaliation.
3. Inform management and/or Human Resources of situations where actual or potential violations of this policy exist.
4. Cooperate with management and/or Human Resources to ensure compliance with this policy.
5. Cooperate with any internal investigations that may arise from known or perceived violations of this policy.
6. Review and ensure understanding of this policy and present any questions regarding the policy to management and/or Human Resources.

C. Human Resources

1. Assist in ensuring that leaders and associates comply with and understand this policy.
2. Ensure that federal and state government nondiscrimination posters, as well as MedStar Health's Workplace Harassment Prevention and Equal Employment Opportunity (EEO) Policies, are displayed permanently in conspicuous locations in all MedStar Health facilities.
3. Ensure MedStar Health's EEO, Harassment Prevention, and Accommodations for Individuals with Special Needs policies are covered in new associate orientation programs.
4. Assist in educating leaders and associates regarding this policy, its requirements and their responsibilities under this policy.
5. Where appropriate, report complaints of known or perceived violations of this policy to the Legal Department.

6 Where appropriate, conduct internal investigations of complaints regarding known or perceived violations of this policy.

7. Serve as MedStar Health's representative to federal and state employment discrimination agencies regarding charges filed by associates, former associates and/or job applicants and, with the assistance of the Legal Department, provide requested information, position statements and the like to appropriate entities to foster resolution of complaints and charges.

Please contact Human Resources with any questions regarding this policy.

Provisions of this policy apply to all associates to the extent they do not conflict with relevant terms of an applicable contract.

Compensation/Benefits Programs

Care.com

Caring for your family while you are at work can often be a challenge. Whether it's after-school care, caring for a child who is home ill or the responsibility for aging parents, sometimes you need additional support, even at a moment's notice. MedStar knows that life can be unpredictable, so to help alleviate life's unexpected challenges, we have added a new benefit to support a productive work-life balance for our residents and fellows. To activate your benefit, go to medstar.care.com and select "Enroll Now" or call 855.781.1303 or email careteam@care.com for assistance. You must enter your MedStar email address to validate your employment.

If you decide to use the backup care benefit, you will be charged a subsidized rate of $8.00/hour for in-home care and $15 per child per day at a child care center with a total of 10 days provided to each employee. For assistance with everyday care, the Care.com website / smartphone platform is a wonderful resource that is available to all employees.

Emergency House Staff Loans:

The emergency loan program is available to all house staff for ***emergent*** personal loans. Loans shall not exceed $2,500, and will be repaid through automatic payroll deduction (minimum of $100 per pay period), prior to completion of residency. Any outstanding balance that has not been repaid will be deducted automatically from the last pay check. If the balance due exceeds the monies available in the last pay check, the house officer will be required to pay the balance upon check out. Each house officer will have a maximum of one (1) outstanding loan at any given time.

Employee Assistance Program:

The MedStar Employee Assistance Program (EAP) offers a wide array of free counseling assistance to employees, including the house staff. Services include, but are not limited to, professional counseling, child and elder care referrals, financial and legal advice. All information is kept completely confidential. The EAP has several locations throughout the Baltimore and DC metropolitan areas and accommodates evening appointments. They may be reached at 1-866-765-3277.

FMLA

Family and Medical Leave Act of 1993 (FMLA) – refers to a United States labor law which provides ***eligible*** employees with up to twelve (12) work weeks of family and/or medical leave in the applicable twelve (12) month period.

A. FMLA allows a leave of absence to house staff who wish to take time off from work due to one or more of the following:

1. For the birth of and/or to care for a house officer's newborn son or daughter
2. To care for a child who was recently adopted by or recently placed with, via a foster care arrangement, the house officer
3. To care for a family member (child, parent, or spouse) who has a serious health condition
4. For a personal serious health condition or disability (A serious health condition means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility; or continuing treatment by a health care provider.)

5. For "qualifying exigencies" (as defined by applicable law and regulations) that arise out of the employee's spouse, son, daughter or parent being notified of or on active duty in support of a contingency operation

B. Under FMLA, MedStar provides eligible house staff with up to twelve workweeks of family and/or medical leave in a twelve month period. During FMLA, house staff may utilize paid time off or short-term disability leave to continue to be paid while on a leave of absence. No more than one form of paid leave can run simultaneously with FMLA leave at a given time. Once paid leave is exhausted, the employee will be on unpaid FMLA leave, to the extent that it has not already been exhausted. Health care benefits will continue during FMLA leave (paid or unpaid), provided that house staff continue to pay their required health insurance premiums.

C. House Staff working in Washington, DC are also eligible for coverage under the D.C. Family & Medical Leave Act, which provides up to sixteen weeks of family and/or medical leave in a twenty-four month period.

D. Please contact the MGUH GME HR team at guh-gmeoffice@medstar.net for more information related to FMLA.

Laundry/Call Rooms:

House staff are provided access to on-call quarters as well as scrubs and laundry service for coats. Please contact your individual GME office or department for more details.

Licensure:

House Officers are expected to obtain and maintain appropriate licensure for their state and training program requirements. You will be reimbursed for licensure expenses that are ***required*** as part of your training. Please see your GME office for further details.

Loan Deferment/Forgiveness:

All applications for loan deferment/forgiveness may be submitted directly to your respective Graduate Medical Education (GME) office. Applications will be completed by GME and forwarded to the appropriate institution.

Meal Allowance:

A meal allowance is provided to house staff officers. Please contact your local GME office for more information.

Physician Concierge:

The Physician Concierge program provides you with personalized care planning, access and navigation to well-being and convenience resources. We are here when you need help with work or life challenges or when you just need to talk with someone. Whether you need emotional, social, physical, financial or career-related support, the Physician Concierge program is here to help.

Through the Physician Concierge program, you may receive confidential and unlimited support from Guide Care Concierges, Master's-level clinicians dedicated to helping you feel your best. Guide Care Concierges have received training on the benefits and resources available to you, so they may seamlessly connect you to what you need.

Your dedicated concierge will identify appropriate support resources, connect you to those you prefer, facilitate scheduling, when applicable, and check in on your progress. Services are available Monday through Friday, 8a.m. – 8p.m. Reach Physician Concierge by calling 800-554-1399, visit www.medstarhealth.org/well-being or via the MedStar ConciergeeConnect mobile app. The app can be downloaded in the App Store or Google Play Store.

Smoking:

In keeping with MedStar Health's intent to provide a safe and healthful environment, smoking is prohibited on all MedStar campuses. This policy applies equally to all employees, patients, and visitors.

Stipends:

House Staff are paid biweekly on every other Friday. Each paycheck will include earnings for all work performed through the end of the previous payroll period. In the event that a regularly scheduled payday falls on a day off such as a holiday, employees will receive pay on the last day of work before the regularly scheduled payday.

Employees are encouraged to have pay directly deposited into their bank accounts. This can be established through the Employee Self-Serve (ESS) feature in PeopleSoft.

The current academic year stipends are below:

PGY-Level	2024-2025 Annual Stipend
PGY-1	$71,000
PGY-2	$73,500
PGY-3	$75,500
PGY-4	$79,000
PGY-5	$82,000
PGY-6	$85,000
PGY-7	$88,000
PGY-8	$91,500

HOUSE STAFF REIMBURSEMENT FUND

I. Purpose

To establish a policy to provide trainees currently enrolled in MedStar Washington Hospital Center (MWHC) graduate medical education (GME) programs with guidelines related to reimbursement for invited research travel and funding for educational expenses.

II. Scope

This policy will apply to all trainees enrolled in GME programs at MedStar Washington Hospital Center.

III. Definitions

A. **House Staff or House Officer** — refers to all interns, residents and fellows participating in a graduate medical education program.

B. **Post-Graduate Training Program** — refers to a residency or fellowship educational program.

IV. Responsibilities/Requirements

A. House Staff will accrue $833 on July 1 of each year of training, to be used for educational expenses including:

- Books directly related to current training
- Educational travel
- Smart phone
- Surgical loops
- Stethoscopes
- Computer (one-time purchase at $750 maximum)
- Pager replacement fees
- DC licensure fees
- Board review courses

B. All requests for funds will be allocated at the discretion of the program director, and must be approved by the program director prior to submission to the GME Office.

C. Funds cannot be used until they are accrued.

D. In order to be reimbursed for expenses, house staff must complete the *Request for House Staff Reimbursement Form*, attach original receipts or a credit card statement (***NO Venmo, Google Pay or Apple Pay receipts are accepted by Accounts Payable***) and submit them to their program director. Once the program director has approved the expense, it should be submitted to the GME Office for processing. If funds are available, the GME Office will process the reimbursement, and will submit a check request voucher to Accounts Payable within 24 hours of receipt.

E. Invited Research Travel Reimbursement:

1. A *Request for House Staff Reimbursement Form* must be completed with the original receipts attached.
2. **GME will reimburse the following travel expenses:**
   - Registration, poster printing and abstract submission fees
   - Roundtrip coach airfare and baggage fees
   - Hotel accommodations not to exceed $250 per night. Excess expense is responsibility of the house officer.
   - Meal allowance at a maximum of $75 per day with an ***itemized receipt*** showing items purchased, no alcohol.
   - Reasonable roundtrip transportation to and from the airport
   - Airport parking fees (for personal car)
   - Personal mileage (if applicable; must include a map showing start and end points with distance in miles)
   - **Rental cars will *not* be reimbursed.**

G. The GME Office will be responsible for tracking house staff reimbursement funds. Program directors and house staff may contact the GME Office at any time to determine remaining balances.

H. Additional funds for research presentations may be granted at the discretion of the program director. Documentation of the resident/fellow presentation must be provided.