CENTRO MÉDICO EPISCOPAL
SAN LUCAS
PONCE

GRADUATE MEDICAL EDUCATION

HOUSE STAFF MANUAL
POLICIES AND PROCEDURES

2025-2026

Updated and approved by the GMEC in August 2024

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PREFACE

CENTRO MEDICO EPISCOPAL SAN LUCAS

GRADUATE MEDICAL EDUCATION

Graduate Medical Education is a crucial step in the physician's professional development between medical school and autonomous practice. Through this period of medical education, residents will learn to provide optimal patient care, under the supervision of faculty members, who not only instruct, but will serve as role models of excellence, compassion, professionalism, and scholarships.

Graduate Medical Education transforms medical students into physicians and scholars, who are competent to care for the patient, the family, and a diverse community. They will be trained to create and integrate new knowledge into practice; and to educate future generations of physicians to serve the public health sector. Practice patterns established during graduate medical education will continue for many years, establishing a constant quality improvement and long-learning approach.

The core tenet of Graduate Medical Education includes graded authority and responsibility for patient care. The care of patients is undertaken under appropriate faculty supervision and conditional independence, allowing residents to gradually achieve their knowledge, skills, attitudes, and empathy required for the autonomous practice. This essential period of training will develop the physician's professional potential, focusing on excellence in the delivery of safe, equitable, affordable, quality care for the populations they serve. Graduate medical education values the strength that a diverse group of physicians can bring to medical care provided by interprofessional teams.

Postgraduate education occurs in clinical settings that establishes the foundation for practice-based and lifetime education approaches. The professional development of the physician, which begun in medical school, will continue to grow through faculty modeling professionalism and competencies within a humanistic environment, that emphasizes a continuous culture of adherence to ethical principles, self-reflection, problem-solving, patient safety, quality improvement, and scholarly endeavors. This transformation may be often physically, emotionally, and intellectually demanding for the physician in training, within an academic and clinical environment that should protect the safety and well-being of patients, residents, fellows, faculty members, medical students, and other members of the healthcare team."

WELCOME LETTER FROM THE DIO

Dear Residents/Fellows, thank you for choosing Hospital Episcopal San Lucas (Centro Medico Episcopal San Lucas) for your postgraduate medical training. The sponsoring institution is committed to provide our learners with high quality learning experiences in compliance with the ACGME Requirements, and specialty boards requirements.

The Centro Medico Episcopal San Lucas at Ponce, located at Ponce, Puerto Rico; provides secondary and tertiary health care services to a large and diverse population from Ponce and other regions from the southwestern of the island of Puerto Rico. The hospital is a 450-bed facility, equipped with state- of-the-art medical technology. The institution is accredited by the ACGME and provides graduate medical training to over 120 physicians. Our institution also delivers education to medical students from all Puerto Rico accredited schools of medicine and several foreign schools of medicine. We are committed to retaining a diverse workforce and environment, which is also reflected in the patients that we serve.

Graduate Medical Education is a significant period of progressive learning and supervised practice, that will prepare you with the required knowledge and skills to be prepared for your independent practice and for eligibility for specialty board certification. Residents and fellows will be trained within an educational environment that facilitates the success of their clinical assignments, milestones, and the achievement of their programs' goals and objectives. Our educational programs have been designed in agreement with the ACGME Requirements. The GME office works to ensure that the institution and its programs, meet and exceed all accreditation requirements; advocating for residents, fellows, and programs; advancing GME throughout our healthcare system; and ensuring the adequate institutional resources for all programs.

This manual will provide residents, faculty and the GME staff with information concerning the structure of the GME Division, as well as with essential policies and procedures. This manual will be distributed to the house staff, faculty and all GME parties at the beginning of each academic year. As Designated Institutional Official (DIO), I oversee all activities operated by the Graduate Medical Education Division, in collaboration with the Graduate Medical Education Committee (GMEC). If you have additional concerns or questions, please contact our GME staff, who will be happy to support you at each step of through your years of training. We hope the best wishes for your postgraduate medical training at our institution and affiliated training sites. Welcome on board!

Sincerely,

María Valentín-Mari, MD, FACP
Designated Institutional Official CMESL
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GLOSSARY OF TERMS

Residents, Fellows, Trainees, or Learners are often/collectively referred as "residents".
CMESL: Centro Médico Episcopal San Lucas, is also called Hospital Episcopal San Lucas (HESL)
GME: Graduate Medical Education or period of postgraduate education for residents or fellows.
ACGME: Accreditation Council for Graduate Medical Education. Accreditation system in the USA, which makes official decision by a Review Committee based on its review and assessment of a Sponsoring Institution's or program's compliance with the applicable requirements.
Accreditation Data System (ADS): A web-based software system to collect, organize, and maintain information for accreditation and recognition purposes, and a means of communication between the ACGME and Sponsoring Institutions and programs.
Sponsoring Institution: Organization that assumes the financial and academic support to provide Graduate Medical Education, in substantial compliance with the ACGME Institutional Requirements.
Primary Training Site: The primary facility designated for clinical instruction in the program.
Participating Site: An organization affiliated with the sponsoring institution through an official Program Letter of Agreement (PLA), which provides educational experiences or educational assignments/rotations for residents/fellows.
Residency Program(s): Postgraduate educational program approved by the ACGME, which provides a structured competency-based educational experience designed to conform to the Program Requirements of a particular specialty. The satisfactory completion of the program may result in eligibility for board certification.
Fellowship Program: A postgraduate program approved by the ACGME, that provides advanced training following completion of training in a core primary specialty, through a structured educational program, designed to train physicians to enter the unsupervised practice of medicine in a specific subspecialty. The satisfactory completion of the program results in eligibility for board certification.
Applicant or Candidate: An individual invited to interview with a graduate medical education program at the sponsoring institution.
Residents: Physician in training registered in a residency program at the sponsoring institution.
Fellows: Physician in training registered in a subspecialty program at the sponsoring institution.
PGY: Postgraduate Training Year.
Faculty: Individuals who have received a formal assignment to provide education, supervision, and assessment of residents/fellow's physicians.
Attending physician: The single identifiable physician ultimately responsible and accountable for an individual patient's care, who may or may not be responsible for supervising residents or fellows.
Designated Institutional Official (DIO). The individual who, in teamwork with a Graduate Medical Education Committee (GMEC), has been provided with authority and responsibility for the oversight and administration of all ACGME-accredited programs, and for ensuring compliance with the ACGME Institutional, Common, and specialty-/subspecialty-specific Program Requirements.
Governing Body: The single entity that maintains authority over and responsibility for the Sponsoring Institution and each of its ACGME-accredited programs.
GMEC: Graduate Medical Education Committee (refer to the policy of the GMEC)
Clinical Competency Committee (CCC): A required body comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents or fellows in the program
Institutional review: The process of determining whether a Sponsoring Institution offering graduate medical education programs is in substantial compliance with the Institutional Requirements.
CLER Site Visit: A visit conducted by the ACGME CLER Field Representatives that includes interviews with faculty members, program directors, residents and/or fellows, participating sites' personnel, institutional leadership, and other staff members, and the review of the institutional documentation, as needed, to assess the effectiveness of the Sponsoring Institution and its participating sites in managing the integration of GME in the six CLER Focus Areas.
Milestones: Description of performance levels residents and fellows are expected to demonstrate for skills, knowledge, and behaviors in the six Core Competency domains.

Centro Médico Episcopal San Lucas

Affiliated to Servicios de Salud Episcopales Inc.

Mission

To provide high quality medical services, which is centered in the individualized care of patients to achieve a full physical, psychological, and spiritual healing and recovery, provided by a compassionated, committed, and highly qualified interprofessional team.

Vision

Become the forefront in the healthcare system of Puerto Rico, by nurturing a culture of humanistic and ethical values, and a friendly, spiritual, professional, and safe environment.

Values

Quality improvement, Patient Safety, Integrity, Compassion, Respect, Professionalism, and Efficiency.

Centro Medico Episcopal San Lucas

STATEMENT OF COMMITMENT TO GRADUATE MEDICAL EDUCATION

The Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements states:
I.A.7. A written statement, reviewed, dated, and signed at least once every five years by the DIO, a representative of the Sponsoring Institution's senior administration, and a representative of the governing body, must document the Sponsoring Institution's:
I.A.7.a) GME mission
I.A.7.b) Commitment to GME by ensuring the provision of the necessary administrative, educational, financial, human, and clinical resources.

The following Statement of Commitment was developed in 2002 by the Consortium Committee and was reaffirmed in January 2011 and 2016. A revised Statement of Commitment between the CMESL and the PHSU School of Medicine Consortium was signed on 2020 The Statement of Commitment states:

"The mission of the Hospital Episcopal San Lucas is to offer high quality medical education leading to Board Certification of all residents in the Graduate Medical Education Program (s). Achievement of this goal will ensure the provision of highly qualified, quality physicians to practice in the PR healthcare delivery system, particularly in the southwest.

We are committed to offer graduate medical education programs, in which residents acquire the necessary knowledge, skills, and attitudes to achieve personal, clinical, and professional competence under the guidance and careful supervision of the faculty and staff. Our programs ensure safe, appropriate, and humane care of patients. As faculty of the PHSU School of Medicine, we engage in scholarly activities, including research, and will make these available to resident physicians so that they can contribute to the medical community. HESLP is the sponsoring institution for Graduate Medical Education (GME) and will guarantee that all accredited residency programs will be in substantial compliance with the programmatic and institutional requirements. We support an organized administrative system to oversee all residency programs through the activities of the GME Committee under the leadership of the Director of GME.

As the Sponsoring Institution, the commitment to GME is through the provision of the necessary financial support for administrative, educational, and clinical resources, including personnel.

Through actions of the Consortium, the CMESL-PHSU Consortium is committed to providing the necessary educational support, leadership, and other resources to enable the institution to achieve substantial compliance with the Institutional Requirements and to assure the educational programs will achieve the ethical, professional, and educational environment for the implementation of the curricular requirements, as well as the applicable requirements for scholarly activities, and that the ACGME general competencies can be met. The CMESL-PHSU School of Medicine Consortium will promote and maintain the following aspects of its graduate medical education programs:

A. Excellence in educational programs for all residents
B. A scholarly environment for the conduction of all GME programs
C. A supportive clinical and training environment for all residents and clinical fellows conducive to learning and improvement, which compares favorably with the best programs in the Island and the nation."

Centro Médico Episcopal San Lucas

Ponce Health Sciences University - School of Medicine

Consortium

Mission

The mission of the Centro Médico Episcopal San Lucas and the Ponce Health Sciences University (PHSU) School of Medicine Consortium is to support high quality medical education leading to a Medicine Doctor Degree for medical students of PHSU School of Medicine, to support existing programs, and to develop new programs that provide high quality post-graduate medical education, which prepares the physician in training to obtain eligibility for board certification and to be prepared for a safe independent practice.

Goals

This consortium supports the education and training of medical students enrolled at the PHSU School of Medicine, and the education and training of medical residents and fellows enrolled in our ACGME-accredited program(s), and in future programs to be developed under the sponsorship of the Hospital Episcopal San Lucas including, but not limited, to the following programs: Transitional Year, OB-GYN, Internal Medicine, Pediatrics, Emergency Medicine and General Surgery. The Centro Médico or Hospital Episcopal San Lucas will, as appropriate, will provide assistance and support to medical students and medical residents to develop their research endeavors, and the competencies to deliver health care in Puerto Rico and in the United States.

Centro Medico Episcopal San Lucas
GRADUATE MEDICAL EDUCATION OFFICE

The Graduate Medical Education Office is responsible for the supervision of all training programs within the sponsoring institution, Hospital Episcopal San Lucas (HESL) also known as Centro Médico Episcopal San Lucas (CMESL), and to ensure the provision of high-quality graduate medical education and the institution and program's compliance with national standards of accreditation. For the purposes of this manual, we will refer to the Sponsoring Institution as CMESL.

The Accreditation Council for Graduate Medical Education (ACGME) is the accreditation agency in charge of the development of accreditation standards and the institutions implementation of these accreditation processes. The ACGME Residency Review Committees (RRCs) are units within the organization that develop program's specific requirements, assess program's compliance with standards, supervise and monitor institutions and programs nationwide, and recommend accreditation decisions.

The GME Office is responsible for the coordination between the CMESL administration, the PHSU School of Medicine, and the PR Department of Health, in order to assure high quality training and compliance with ACGME accreditation standards.

The GME Office works in collaboration with the sponsoring institution Graduate Medical Education Committee (GMEC) and DIO, to assure the adequacy of the resources to maintain an appropriate environment and the quality of the education provided to our learners, representing the institution during accreditation site visits, including institutional reviews, programs reviews, and Clinical Learning Environment Review (CLER) visits.

The sponsoring institution had an institutional visit in March 2010, where the institution achieved full or continued accreditation. Since the implementation of the "Next Single Accreditation System" by the ACGME in 2013, the institutional visit has been on hold until the new Self-Study process has been scheduled for February 2025, and the institutional visit was rescheduled for February 2027. The institution received a CLER visit on March 2015, February 2017, May 2019 and the last one took place at April 2022.

Other responsibilities of the GME Office include the oversight of the resident/fellow selection, application and selection-appointment processes, coordination of the resident/fellow contract signing at the Department of Health and on occasions distribution of resident stipends, securement of graduates' training information and certifications, response to requests from licensing organizations, and assurance of the institutional support for the resident wellbeing and the learning environment. The GME Office coordinates orientation's activities, didactics, institutional conferences, and graduation ceremonies, and is actively involved in the support of research, scholarly activities, scientific fairs, and symposiums. Faculty development activities are available through conferences and a Faculty Development Program annual course. Residents will participate in institutional conferences, including core specialty lectures, research, teaching skills, patient safety, quality improvement, diversity and inclusion, professionalism, among other activities, that will prepare them to acquire the proper knowledge and skills for the independent practice.

GRADUATE MEDICAL EDUCATION DIRECTORY

GME Office
Location: Torre Medica San Lucas, Suite 605

GME Office

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References

ACGME
https://www.acgme.org/
https://www.acgme.org/residents-and-fellows/welcome/
https://www.acgme.org/specialties/

American Medical Association
https://www.ama-assn.org

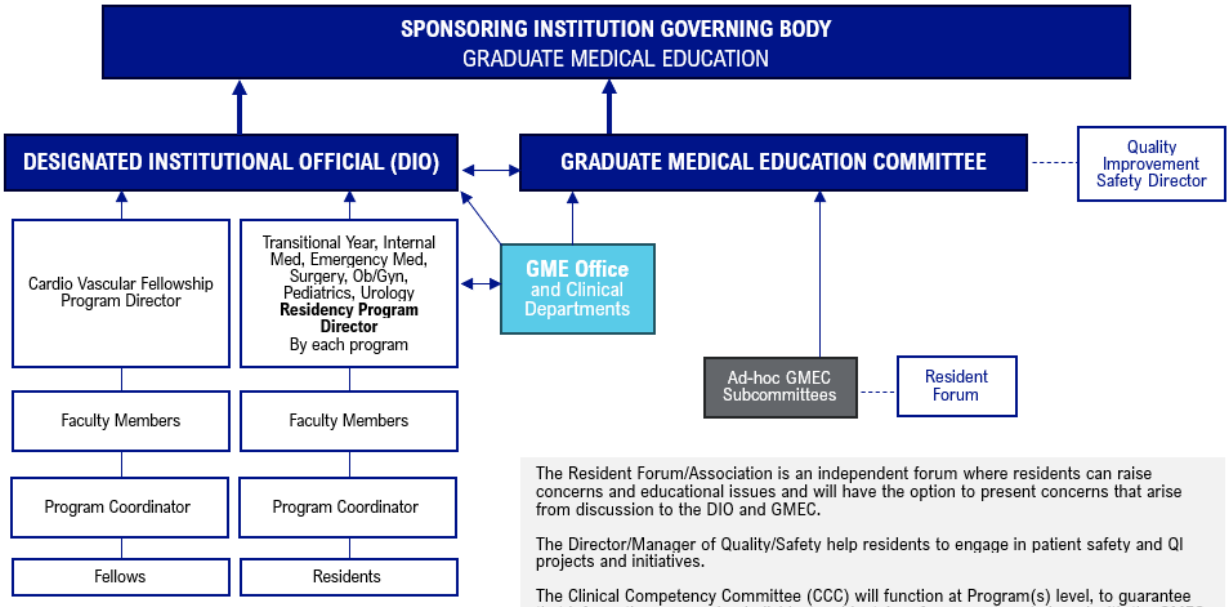
American Board of Medical Specialties
https://www.abms.org/

GME ORGANIZATIONAL CHART

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE

GRADUATE MEDICAL EDUCATION

Organizational Chart. Position of the Graduate Medical Education Committee (GMEC) in the Sponsoring Institution reporting structure, including its relationship to the Sponsoring Institution's Governing Body.



The Resident Forum/Association is an independent forum where residents can raise concerns and educational issues and will have the option to present concerns that arise from discussion to the DIO and GMEC.

The Director/Manager of Quality/Safety help residents to engage in patient safety and QI projects and initiatives.

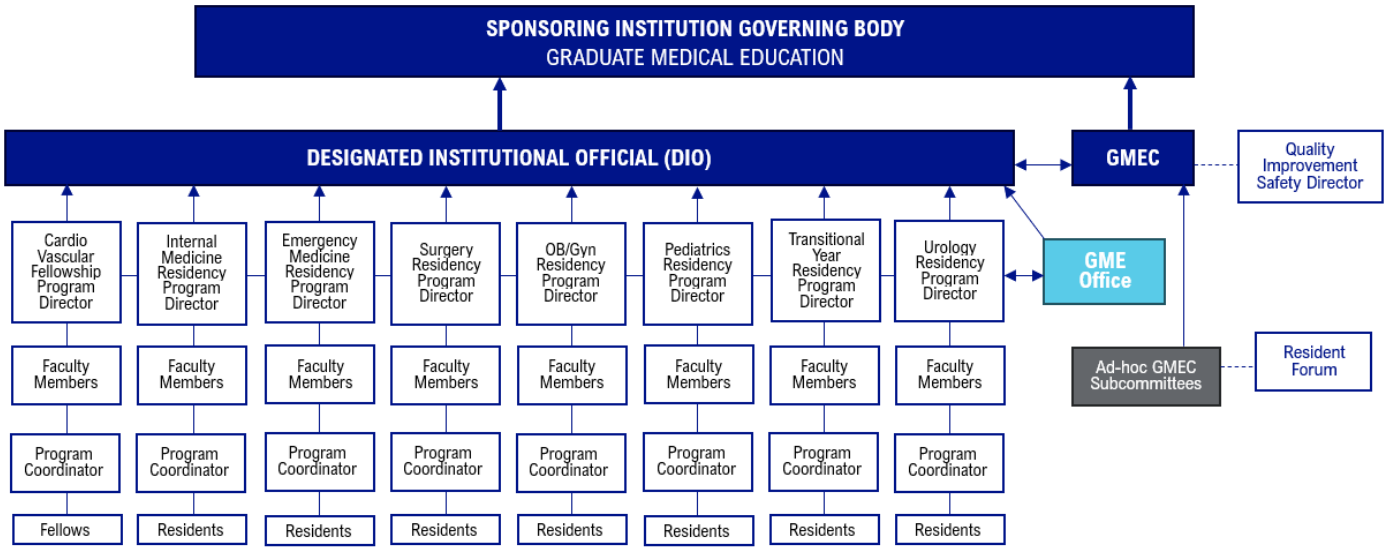
The Clinical Competency Committee (CCC) will function at Program(s) level, to guarantee that information concerning individual residents' performance is not shared with the GMEC (which includes peer selected residents).

GME ORGANIZATIONAL CHART

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE

GRADUATE MEDICAL EDUCATION

Organizational Chart. Position of the Graduate Medical Education Committee (GMEC) in the Sponsoring Institution. Reporting structure, including its relationship to the Sponsoring Institution's Governing Body.



HOSPITAL EPISCOPAL SAN LUCAS
Graduate Medical Education

HOUSE STAFF GUIDELINES

Medical Residents are physicians engaged in a graduate training program at the sponsoring institution, referring to medical residents and fellows' appointments for training, which are made by the respective residency and fellowship program, according with the Graduate Medical Education Policies, and following the Accreditation Council for Graduate Medical Education (ACGME) and its Resident Review Committee (RRC) requirements.

The term "house staff", refers to all CMESL (or HESL) residents and fellows, and may be used interchangeably with the terms of "resident, fellow, trainee or house officer". All policies and procedures remain applicable to the sponsoring institution residents and fellows regardless of the term used.

The responsibilities of the medical residents are delineated at their respective programs and by the Graduate Medical Education Committee (GMEC). Any procedure performed by them must be performed under the appropriate supervision from a faculty/staff member with privileges to perform the procedure, with the understanding that increasing responsibility in patient care management. They may serve on designated institutional committees having a non-voting capacity unless otherwise stated.

The house staff is expected to function in accordance with the Graduate Medical Education Division Rules and Regulations.

Residents will complete the medical history and physical examination and medical orders for assigned patients. Supervising senior residents and Medical Staff will countersign such orders within the next 24 hours. Medical Staff members who choose not to participate in the training program are not subject to denial or limitation of privileges for this reason.

The scope of resident's actions is determined by each Program Director and defined in the Rules and Regulations as expressed by each Program and the Graduate Medical Education Committee. The clinical competence will be evaluated by the Program Director on a regular basis.

Medical Students will be allowed to participate in patient management in such ways as the School of Medicine, in agreement with the Clinical Departments and Programs, will allow. While in the hospital they will respond to the hospital's By-Laws, Rules and Regulations.

Additional general rules related to resident-attending responsibilities include:

- All patients must be visited at least daily by the admitting faculty member or attending, or an attending designated.
- Faculty may delegate patient care activities to residents knowing that all decisions will be the faculty member's responsibility.
- All procedures performed by residents must be supervised directly or indirectly as appropriate by a faculty member and documented as such in the medical chart.
- Discharge orders will not be written by residents until discharge is approved by the patient's attending physician.
- No prescriptions will be provided by a resident until it is authorized by the attending physician.
- Residents will write daily notes and orders in the patient medical records under their care.

- Resident notes do not substitute the daily attending physician note.

It is important to understand that these rules must be followed to comply with the requirements of accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and ACGME, as well as third party payers such as Centers for Medicare & Medicaid Services (CMS).

Approved by the GMEC on 11/29/2001
Rev. 02/06
Reviewed by the GMEC: 9/18/2013/PD 10/24/2013
Approved GMEC: 12/2013:
Update Approved by GMEC January 2016
Updated and Approved by the GMEC 03/2022

	Policy # 1	GRADUATE MEDICAL EDUCATION POLICIES
CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	THE GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC) AND THE DESIGNATED INSTITUTIONAL OFFICER (DIO)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates every five years from effective date, or as needed for amendments.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To establish institutional protocols to establish and implement a Graduate Medical Education Committee (GMEC).

This policy has been established in adherence with the ACGME Institutional Requirements (I.B), which requires that the Sponsoring Institution with multiple ACGME-accredited programs have a GMEC.

POLICY. The GMEC oversees each ACGME-accredited program supported by the sponsoring institution consortium, ensuring the highest quality education of residents/fellows. The GMEC meetings' minutes must be maintained documenting required GMEC functions, actions and responsibilities.

A. GMEC VOTING MEMBERS. The Sponsoring Institution GMEC members includes the following voting members:

- The DIO / Chair of the GMEC.
- A representative sample of program directors (minimum of two) from its ACGME programs.
- A minimum of two peer-selected residents/fellows from among its ACGME programs.
- The quality improvement or patient safety officer or designee.
- In order to carry out portions of the GMEC's responsibilities, additional GMEC membership may include others as determined by the GMEC.

The peer-selected residents are identified annually at a regularly scheduled Resident Forum Meeting, typically in July of each year. Any faculty, coordinator, resident, or fellow may attend the GMEC meeting to present ideas and concerns after notifying the GME Office to provide time on the agenda. These invited guests are not voting members; however, they are expected and encouraged to discuss fully their areas of concern.

All sub-committees of the GMEC must have peer-selected residents/fellows as members. They must report to the GMEC according to a schedule established by the GMEC.

B. MEETINGS AND ATTENDANCE

a. The GMEC Must meet a minimum of once every quarter during each academic year.
b. Quorum must be meet at each meeting as describe on Institutional requirements ACGME.
c. All members of the committee may recommend agenda items and may attend the meeting.
d. Each meeting of the GMEC must include attendance by at least one resident/fellow member.
e. Minutes must be kept for all GMEC meetings with annotations representing the ACGME-required GMEC functions and responsibilities.
f. Prior to each meeting, the minutes of the prior meeting, the agenda for the upcoming meeting, along with associated reports and other documents, must be sent electronically for review by members of the GMEC prior to the scheduled meeting.
g. Confidential matters related to promotion, dismissal or disciplinary action must be redacted as appropriate.
h. All meetings are confidential, and a confidentiality agreement must be signed on an annual basis.

C. RESPONSIBILITIES OF THE GMEC

1. GMEC SUPERVION RESPONSIBILITIES.

The GMEC oversees the following tasks:

a. The ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs.
b. The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites.
c. The quality of educational experiences in each ACGME-accredited program allows a measurable achievement of educational outcomes, as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements.
d. The Annual Institutional Review and CLER visits processes, ACGME-accredited program(s)' Annual Program Evaluation(s) and Institutional Self-Study(s).
e. The institution GME policies, and its ACGME-accredited programs' implementation of institutional policy(ies), including vacation and leaves of absence, medical, parental, and caregiver leaves of absence, at least annually.
f. The processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.
g. The provision of summary information concerning patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this supervision includes verification that such summary information is being provided.

2. The GMEC REVIEWS AND APPROVALS.

The GMEC shall review and approve the following tasks:

a. All Institutional GME policies and procedures;
b. GMEC subcommittee actions that address required GMEC responsibilities;
c. Annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits;
d. Applications for ACGME accreditation of new programs;
e. Requests for permanent changes in resident/fellow complement;
f. Major changes in each of its ACGME-accredited programs' structure or duration of education, including any change in the designation of a program's primary clinical site;
g. Additions and deletions of each of its ACGME-accredited programs' participating sites;
h. Appointment of new program directors;
i. Progress reports requested by a Review Committee;
j. Responses to Clinical Learning Environment Review (CLER) reports;
k. Requests for exceptions to clinical and educational work hour requirements;
l. Voluntary withdrawal of ACGME program accreditation or recognition;
m. Requests for appeal of an adverse action by a Review Committee;
n. Appeal presentations to an ACGME Appeals Panel; and exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements.

3. **The GMEC oversees the sponsoring institution Annual Institutional Review (AIR).**

a. The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR).
   - The GMEC must identify institutional performance indicators for the AIR, to include, at a minimum: the most recent ACGME institutional letter of notification;
   - The results of ACGME surveys of residents/fellows and core faculty members;
   - Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation and recognition statuses and citations

b. The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's Governing Body. So, the DIO shall provide an annual written executive summary and verbal report on all activities of the GMEC to the Governing Body at the Hospital Episcopal San Lucas. The DIO written executive summary must include:

- Summary of institutional performance on indicators for the AIR;
- Action plans and performance monitoring procedures resulting from the AIR.

4. The GMEC oversees Underperforming Programs (Special Reviews).

a. The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process.
b. The Special Review process must include a protocol that:
   - Establishes a variety of criteria for identifying underperformance that includes, at a minimum, program accreditation statuses including: Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies;
   - Results in a timely report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes, including timelines.

D. DESIGNATED INSTITUTIONAL OFFICIAL (DIO)

The sponsoring institution GME programs shall be led by a Designated Institutional Official (DIO), who, in collaboration with a Graduate Medical Education Committee (GMEC), has authority and responsibility for the oversight and administration of the Sponsoring Institution's GME programs, to assure compliance with the ACGME Requirements.

1. THE DIO RESPONSIBILITIES.

a. Approve program letters of agreement (PLAs) that govern relationships between each program and each participating site providing a required assignment for residents/fellows in the program
b. Oversee submissions of the Annual Update for each program and the Sponsoring Institution to the ACGME/ADS.
c. After GMEC approval, oversee the submission of applications for ACGME accreditation and recognition.
d. Requests for voluntary withdrawal of accreditation and recognition, and requests for changes in residency and fellowship program complements.
e. Maintain current knowledge of and compliance with the institution GME Policies.
f. Maintain knowledge and compliance with the ACGME Institutional, Common Programs Requirements and Specific Programs' Requirements.
g. Participate as a voting member of the GMEC.
h. Engage in professional development applicable to responsibilities as an educational leader.
i. Monitor accurate and complete institutional documentation for self-study site visits.
j. Present the Annual Institutional Review Report to the governing body(s) of the Sponsoring Institution.

2. DIO DESIGNEE.

In the absence of the DIO, a DIO Designee will take over of the DIO tasks for a short period of time. In the absence of the Designated Institutional Official or DIO, a designee will achieve the duties and tasks of the DIO, as required, or requested.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 2	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ANNUAL PROGRAM EVALUATION AND IMPROVEMENT PROGRAM EVALUATION COMMITTEE (PEC)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols for each program to develop its Annual Program Evaluations (APE) which is conducted by the Program Evaluation Committee (PEC).

This policy has been established in adherence with the ACGME Common Program Requirement (V.C) V.C.1. "The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process."

BACKGROUND. In order to achieve its mission and train quality physicians, each program supported by the sponsoring institution must evaluate its performance and plan for improvement through an Annual Program Evaluation. The performance of residents and faculty members is a reflection of program quality and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

POLICY. Each Program Director must appoint its Program Evaluation Committee (PEC) to conduct and document its Annual Program Evaluation (APE), as part of the program's continuous quality improvement process.

A. PROGRAM EVALUATION COMMITTEE (PEC)

1. PURPOSE. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

2. PEC MEMBERSHIP.
The Program Evaluation Committee (PEC) must be composed of

a. Chair (Core Faculty)
b. Faculty Members (1-2)
c. One resident from each of the program's training years chosen by peers in the program.
d. Additional members (Department Chair, QI Director, Participating Site Directors, Subspecialties liaison)

3. POLICY.
a. The Program Evaluation Committee will:

- Oversee the curriculum development and program evaluations for the residency program.
- Be appointed by the Program Director who will serve as the committee Chair.

B. PEC RESPONSIBILITIES.
The Program Evaluation Committee responsibilities must include:

- **Conduct the APE**; following the parameters.
- Act as an advisor to the program director, through program oversight;
- Review the program's self-determined goals and progress toward meeting them;
- Guide ongoing program improvement, including the development of new goals, based upon outcomes;

- Review the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

Other PEC Responsibilities:
- Evaluate the program educational activities and curriculum.
- Review and make recommendations for revision concerning competency-based curriculum goals and objectives.
- Address areas of noncompliance with ACGME standards.
- Review the program annually using evaluations of faculty and residents.
- Document on behalf of the program, formal, systemic evaluations of the curriculum at least annually and render a written Annual Program Evaluation (APE) which must be submitted to the GMEC annually in the Annual Program Director update.
- Monitor and track resident performance, faculty development, graduate performance (including placement and success in future residency training), program quality, and the progress in achieving goals set forth in previous year's action plan.
- Review the program recommendations from the Clinical Competence Committee.
- Provide recommendations for changes in evaluation tools as identified during review of program.
- Review action plans from prior years to assess compliance and completion of recommendations for improvement.

Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and the program must use the results of these residents' and faculty members' assessments together with other program evaluation results to improve the program quality.

C. ANNUAL PROGRAM EVALUATION (APE) PARAMETERS OF ASSESSMENT.

1. **The Program Evaluation Committee (PEC) should consider the following elements in its assessment of the program:**
   a. Program Curriculum;
   b. Outcomes from prior Annual Program Evaluation(s);
   c. ACGME letters of notifications, including citations or adverse accreditation statuses;
   d. Areas for Improvement, and comments;
   e. Quality and Safety of patient care;
   f. Aggregate of Resident and Faculty:
      - Well-being;
      - Recruitment and retention;
      - Workforce diversity;
      - Engagement in quality improvement and patient safety;
      - Scholarly activity;
      - ACGME Resident and Faculty Surveys;
      - Written evaluations of the program.

   g. Aggregate Resident:
      - Achievement of the Residents Milestones (Report from the CCC);
      - Results of In-training Examinations;
      - Board pass and certification rates; and,
      - Graduate performance.

   h. Aggregate Faculty:
      a. Evaluation; and,
      b. Professional development.

2. **Goals and Objectives and AIMS**. The Program Evaluation Committee must evaluate the program's mission and AIMS, strengths, areas for improvement, and threats.

3. **Faculty Development Program. Overall Participation in Research.**
4. **Program Quality.**

5. **If applicable; monitor programs and action plans in case of Special Reviews for underperforming programs.**

D. ANNUAL PROGRAM EVALUATION (APE) PROCEDURES

1. The Program Director selects the Program Evaluation Committee to conduct the APE.

2. **PEC documentation**. The written work product of the PEC includes the following:
   a. APE Report.
   b. Meeting minutes - Minutes of PEC meetings should be documented.
   c. Documentation of faculty/resident review of Action Plan
   d. The PEC minutes and action plan must delineate how initiatives to improve any deficiency will be measured and monitored.
   e. The PEC minutes, report and action plan should be reviewed and approved by the teaching faculty and documented in faculty meeting minutes. It is suggested that the action plan be reviewed with the residents and appropriate staff.

3. The Program Director is ultimately responsible to monitor the process performed by the PEC according with the APE parameters.

4. The Program's Annual Evaluation Report and its Action Plan concerning the program's progress on initiatives from the previous year's action plan, will be sent to the DIO and the Office of Graduate Medical Education (GMEC). The Program Director must indicate to the DIO any deficiencies that require additional resources for resolution.

5. The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the members of the teaching faculty and the residents. The Program Director is ultimately responsible to monitor the work performed by the PEC following the APE parameters, and will ensure that the action plan is reviewed by the program's teaching faculty. This approval will be documented in the PEC meeting minutes.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 3	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	CLINICAL COMPETENCY COMMITTEE (CCC)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define the structure and responsibility of the sponsoring institution Clinical Competency Committee (CCC).

This policy has been established in adherence with the ACGME Common Program Requirements (V.A.3). A Clinical Competency Committee must be appointed by the program director. V.A.3.a) At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member".

According with the ACGME: "The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions. Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee."

BACKGROUND.
The Program Director has primary responsibility for monitoring the competencies and professionalism of residents/fellows with the purpose of recommending promotion of residents and certification for graduation, as well as for initial counseling, probation and/or other remedial or adverse actions. The CCC is responsible for providing recommendations concerning corrective actions, remediation and graduation, promotion, and disciplinary actions for residents in the training program.

POLICY.
The Clinical Competence Committee of the Residency Program must provide recommendations to the program director. At all times, the procedures and policies of the CCC will comply with the policies of the sponsoring institution and the GMEC. The Clinical Competency Committee must be assigned by the Program Director. The CCC evaluates all resident evaluations at least semi-annually; determine each resident's advancement and achievement of the specialty-specific Milestones; meeting previously to the residents' semi-annual evaluations and advising the program director regarding each resident's progress in their programs.

A. PROCEDURES.
1. Clinical Competency Committee Membership
All members of the CCC are appointed by the Program Director.

a. The CCC for any program must be composed of at least **three members of the program faculty**.
b. The Chair of the CCC is appointed by the Program Director.
c. Members of the Committee must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings.

d. Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the CCC.
e. CCC membership is reviewed and updated annually at the beginning of each academic year. Advisors should be present during discussions pertaining to their advisee.
f. Program coordinators are not members. However, they may attend and participate in discussions, but do not have a vote.

2. CCC MAIN TASKS.

a. Review all resident evaluations at least semi-annually.
b. Determine each resident's progress on achievement of the specialty-specific Milestones.
c. Meet prior to the residents' semi-annual evaluations.
d. Advise the program director regarding each resident's progress.

3. CCC RESPONSIBILITIES.

a. Residents will be evaluated using the Core Competencies and specialty-specific milestones.
b. The CCC will review all assessment data (end of rotation faculty evaluations; peer evaluations; procedural simulation; self-assessments; case logs; etc.).
c. In addition to global assessments, the CCC will review all other evaluation tools used by the program (e.g., OSCE, CEX, in-training exams, medical record audits, multisource, case logs, etc.). The CCC will take data from these evaluations and apply them to the milestones to mark the progress of a resident.
d. Residents will also be accountable for compliance with program and hospital policies, which include but are not limited to: computer ethics • sexual harassment • conflict of interest • intellectual property • Medicare compliance rules • moonlighting • infection control • drug free workplace • pre-employment drug testing • completion of medical records.
e. The CCC will provide a group narrative summary for each resident's progress and will assist in early identification of areas of needed improvement.
f. The CCC will use data from evaluation tools to prepare and assure the reporting of the milestones evaluations of each resident semi-annually to the ACGME system.
g. Under certain and warranted circumstances, the members of the committee may be required to excuse themselves to avoid a potential conflict of interest or to protect the privacy of a resident.

4. CCC MEETING. ATTENDANCE.

a. Committee members are expected to attend 75% of all meetings.
b. The sponsoring institution Office of Graduate Medical Education will provide yearly education for all members of the CCC.
c. Members are expected to attend all regularly scheduled and ad hoc meetings unless their schedule prevents them from doing so.
d. If faculty members are NOT able to attend, they are expected to contact their chair or another committee member to provide input regarding a resident's performance.

5. CCC STRUCTURE. PROTOCOLS.

a. A quorum (>50% of members) must be present in order to conduct official business and allow voting.
b. Prior to the meeting, members of the Committee may seek opinions and counsel from other program faculty regarding the performance of residents who are listed on the planned agenda. These discussions provide valuable contextual data to the Committee's deliberations.
c. A faculty member will be asked to review and present each resident. This will be followed by discussion and feedback from others.
d. All members of the Committee must keep resident, program performance data, and discussion strictly confidential and anonymous. Members of the Committee must not discuss other Committee members' opinions or comments with residents or other faculty members.
e. In addition to semi-annual performance reviews, at each meeting the Committee will review progress of residents, who are currently on a Corrective Action Plan or remediation and make recommendations to the Program Director regarding continuance or cessation.

f. Residents previously on remediation may be continually discussed to ensure maintenance of performance expectations. All praise and early concern notes received in the period between meetings will be reviewed at each meeting.
g. The coordinator will keep detailed minutes of all meetings. The minutes and decisions of the CCC must be kept in the Residency Program

6. TYPES OF PERFORMANCE REVIEWS.

a. Routine Semi-Annual Reviews. The Program must provide written summary to residents at least semi-annually. The review includes the resident's experience in the milestones, competence in performing clinical procedures, and overall progress in meeting program requirements. A review of the resident's progress in meeting board certification and program requirements must also be performed at this time. Summary performance reviews may be written by the Program Director or members of the CCC. The resident must acknowledge receipt of the summary performance review in writing.
b. Promotion Review Those residents who have achieved competency in the requirements for a specific level of training may be promoted to the next higher level of responsibility. No resident can remain at the same level of training for more than 24 months (exclusive of leave). A resident with satisfactory performance based on the milestone criteria may advance until the completion of the program/certification requirements.
c. Promotion or graduation decisions require a recommendation by the Program Director and a majority vote by the CCC. Residents Must Meet the Following Promotion Standards:
    - The resident must exhibit clinical academic performance and competence consistent with the curricular standards and the level of training undergone.
    - The resident must satisfactorily complete all assigned rotations, as supported by evaluation documentation, in each Post Graduate Year (PGY).
    - The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.

The Program Director and the CCC must certify that the resident has fulfilled all criteria, to move to the next level in the program.

Upon a resident's successful completion of the criteria listed above, the Program Director will certify by placing the semi-annual evaluations and the promotion document into the resident's file indicating that the resident has successfully met the requirements for promotion to the next educational level. If this is a graduating resident, the Program Director should place the Final Summative Assessment in the resident's file.

7. **SPECIAL REVIEWS.**

A resident may be brought up for discussion by the CCC for any of the following reasons:

a. Recommendation by the Program Director for any reason,
b. Consistently low or unsatisfactory evaluation scores,
c. Consistent lack of adherence to program requirements, or d. A specific incident that requires review by the CCC for possible probation or dismissal.

Faculty members who wish to initiate an additional review may request this from the Program Director.

8. **FOLLOW-UP REVIEWS.**

At each meeting, the Committee will review the progress of residents who are currently on a performance improvement plan, remediation, or probation, and decide to lift or continue the probation. Residents previously on probation may be reviewed for clinical and programmatic performance.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 4	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ANNUAL INSTITUTIONAL REVIEW (AIR)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To institutional protocols to perform the Annual Institutional Review (AIR).

This policy has been established in adherence with the ACGME Institutional Requirement (I.B.5). "The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR). The GMEC must identify institutional performance indicators for the AIR". I.B.5. b) "The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's Governing Body."

BACKGROUND.
As per requirement, the GMEC must demonstrate an effective oversight of the Sponsoring Institution's accreditation through the Annual Institutional Review (AIR). The GMEC must identify **institutional performance indicators** for the AIR, to include: the most recent ACGME institutional letter of notification; results of ACGME surveys of residents/fellows and core faculty members; each of its ACGME-accredited programs' ACGME accreditation information, including accreditation and recognition statuses and citations. The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's Governing Body. The written executive summary must include: a summary of institutional performance on indicators for the AIR; and, the action plans and performance monitoring procedures resulting from the AIR.

POLICY.
HESL Graduate Medical Education Committee (GMEC) must oversee all its ACGME-accredited programs sponsored by the institution, to ensure the highest quality education for our residents in training. The GMEC should supervise the Sponsoring Institution accreditation standards through an Annual Institutional Review (AIR).

A. INSTITUTIONAL PERFORMANCE INDICATORS

1. **Results of the most recent institutional self-study visit.**
   a. The action plan and outcomes to correct any citations from the most recent self-study visit.
   b. The action plan and outcomes from any findings on the most recent AIR.
   c. A review of the six areas of CLER (patient safety, quality improvement, transitions of care, supervision, well-being, professionalism) to formulate an annual plan to promote opportunities for improvement and faculty/resident engagement in CLER activities.
   d. A review of the most recent CLER visit with an action plan to correct any recommendations from the visit and their outcomes.
   e. A review of all Sponsoring Institution policies and procedures to ensure they are in substantial compliance with ACGME institutional requirements.

2. **Results of the annual ACGME resident and faculty surveys.**
   a. Institutional aggregate of the survey results to form action plan(s) to correct the areas of noncompliance or lower than average scores measured against national norms.
   b. Individual program aggregate of survey results and comparison to national norms for each accredited program.
   c. Comparison of current survey with any internal surveys, program evaluations, or other institutional assessments, which support or do not align with the ACGME survey as a means

of understanding and addressing “best practice” indicators, as well as those areas need improvement.

d. Design of an action plan for areas deemed non-compliant, below national benchmarks or changes in one standard deviation below prior survey results.

3. Notification of ACGME-accredited Program’s accreditation status and self-study visits

a. The action plan to correct any citation(s) from the program’s most recent self-study visit.
b. Program response to GMEC the domains of ACGME CLER Review.
c. Compliance with up to date, signed institutional agreements - i.e., Affiliation Agreements and Program Letters of Agreement (PLAs).
d. Results/outcome of each program’s Annual Program Evaluation.
e. ADS data and/or GME scorecard data for each program including:
    - Board pass rate
    - Resident/faculty attrition
    - Procedural volume/case mix/patient mix
    - Faculty development
    - Faculty and resident scholarly activity vi. Milestones
    - Atmosphere for residents to raise concerns/issues and make inquiries
    - ACGME cycle length
    - Match data

4. The AIR report will discuss and supervise the following (CLER) areas:

- Patient Safety.
- Number of residents recorded events.
- Training lessons and open/closed recorded events.
- Risk Management meetings.
- Residents’ ability to report without fear to retaliation.
- Quality Improvement; decreasing disparities. Institutional health disparity goals.
- Actual projects: title, residents/faculty, status, outcomes.
- Potential projects: ideas, selections.
- Didactic sessions: title, date, audience, feedback.
- Documented education, for residents/fellows and faculty, on management and mitigation
- Professionalism and Breaks of Professionalism (if available)
- Reports of resident mistreatment (if available)
- Timeliness of assignments (faculty and resident evaluations)

B. AIR Process.

1. Upon analysis of these performance indicators and other significant institutional reports, areas for development and action plans for improvement will be determined.
2. Any item or indicator listed above that is found to be out of compliance will be included within the agenda to be revised at the Graduate Medical Education Committee (GMEC) meetings, in order to monitor the progress toward resolution. (Usually during the GMEC semi-final meeting of each year).
3. Actions plans will be discussed, reviewed, followed, and approved at subsequent GMEC meetings at intervals to be determined in each action strategy.
4. These actions plan should be documented within the GMEC meeting minutes.
5. The GMEC/DIO will prepare a written, executive summary of the AIR to be presented to the sponsoring institution governing body, at the start of each year.
6. The AIR executive summary is maintained for records by the GME office.
7. Program Directors will present a report on behalf of their program with the status of the correction of deficiencies, to be documented within the GMEC minutes.
8. The time period to be reviewed during the AIR is represented by the previous academic year (July-June).

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Revised and Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To establish institutional protocols to perform the Clinical Learning Environment Review (CLER). This policy has been established in adherence with the ACGME Requirements.

POLICY.

A. General Protocols.

1. Residents on duty in the hospital will be provided with adequate and appropriate food services and sleeping quarters.
2. Support services including an intravenous team, phlebotomy services, laboratory services, and transportation services must be provided in a manner appropriate to, and consistent with, educational objectives and patient care.
3. An operative laboratory and radiologic information retrieval system must be in place to facilitate clinical duties of educational programs as well as timely, high quality patient care.
4. A medical records system that documents the course of each patent's status and care must be always available and must be adequate to support patient care, the educational needs of Residents, quality assurance activities, and provide a resource for scholarly activity.
5. Appropriate security and personal safety measures must be provided to Residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities.
6. Educational materials to support patient care in the working environment (e.g., computer with internet access, biomedical library materials, etc.) must be always accessible.
7. Patient Safety: Residents must have access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal. Residents must have opportunities to contribute to root cause analysis or other similar risk-reduction processes.
8. Quality improvement: Residents must have access to data to improve systems of care, reduce health care disparities, and improve patient outcomes. Residents must have opportunities to participate in quality improvement initiatives.

B. CLER. CLINICAL LEARNING AND EDUCATIONAL ENVIRONMENT REVIEW.

1. The CLER program measures the GME learning environment of the sponsoring institution and participating sites.
2. CLER emphasizes the quality and safety of the environment for learning and patient care.
3. Institutional accreditation standards require successful participation in the CLER program.
4. The goal of CLER is to reduce healthcare disparities among medical institutions.
5. Competency in the CLER six focus areas is required for successful clinical practice, including provider credentialing, reimbursement, and compensation.
6. Patient and health outcomes are improved with safe and high-quality care delivery.
7. The ACGME CLER team will evaluate all programs simultaneously at yearly site visits and will use the long-term data to identify trends and areas of concern within the programs.

The CLER Visits consists of the following activities:

1. The CLER site visit program: provides feedback, learning, and helping to establish baselines. The first cycle of visit findings will result in dissemination of useful practices by the Evaluation Committee.
2. The CLER Evaluation Committee: includes a comprehensive cross-section of individuals with expertise related to the aim of the CLER program. The Committee provides input to the design and implementation of CLER site visit activities and conducts evaluation review of sponsoring institutions that are visited during each cycle.
3. The ACGME distinguishes the great interest by sponsoring institutions to support faculty development in those areas on which the CLER program will focus (e.g., patient safety, health care quality, transitions of care, etc.). Therefore, as part of the CLER program, the ACGME will develop a program to support faculty development.

C. CLER 6 FOCUS AREAS.

1. **Patient Safety**: opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.
2. **Quality Improvement**: how the sponsoring institution engages residents in the use of data to improve systems of care, reduces health care disparities and improves patient outcomes.
3. **Transitions of Care**: how the sponsoring institution demonstrates effective standardization and oversight of transitions of care.
4. **Supervision:** how the sponsoring institution maintains and oversees policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
5. **Duty Hours Oversight, Fatigue Management and Mitigation**: how the sponsoring institution demonstrate effective and meaningful oversight of duty hours across residency programs; provide settings that facilitate fatigue management and mitigation; provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.
6. **Professionalism:** how the sponsoring institution educates for professionalism, monitors behavior on the part of residents and faculty and responds to issues concerning: accurate reporting of program information; integrity in fulfilling educational and professional responsibilities; and accuracy in scholarships.

D. CLER METODOLOGY.

1. The CLER does not involve the submission of information prior to the site visit.
2. The sponsoring institution must maintain current information related to the six focus areas, along with evidence of periodic reporting of this information to the CEO/governing body.
3. The site visits will be based on performance and will occur every 18 months.
4. Notification no less than 10 days prior.
5. Conduct of site visit:
    a) Interviews.
    b) Review of institutional documentation.
    c) Verbal summary to DIO at end of visit, with suggestions for improvement.
    d) Will become part of accreditation but will not result in adverse actions unless egregious violations.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 6	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	**SPECIAL REVIEWS**
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To establish institutional protocols to address underperformance programs through Special Reviews.

This policy has been established in adherence with the ACGME Institutional Requirements I.B.6. "The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process". I.B.6.a) The Special Review process must include a protocol that establishes a variety of criteria for identifying underperformance".

BACKGROUND. As per requirement, the GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process. The Special Review process must include a protocol that: establishes a variety of criteria for identifying underperformance that includes, at a minimum, program accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies; results in a timely report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes, including timelines.

INTENT. The GMEC will discuss whether a residency/fellowship program is underperforming and thereby subject to special review.

A. SPECIAL REVIEWS PERFORMANCE INDICATORS.

The GMEC will identify underperformance through the following established criteria, which must include, but are not limited to, the following:

1. **Inability to meet established ACGME common and program specific requirements**.
   a. Program accreditation Status of Initial Accreditation with Warning.
   b. Program accreditation Status of Continued Accreditation with Warning
   c. Adverse accreditation statuses as described by ACGME policies.
2. **Program Attrition**.
   a. Greater than one resident/fellow per year resident attrition (Includes withdrawal, transfer, or dismissal).
   b. Excessive program leadership or faculty turnover.
3. **Loss of major education necessities**
   a. Consistent incomplete resident complement
   b. Major program structural change.
4. **Recruitment performance**
   a. Unfilled positions over three years.
5. **Board pass rate.**
   a. Downward trend in board passage rate, or
   b. Unacceptable by ACGME specialty standards.
6. **Case logs/Clinical experience / Work Hours**
   a. Unacceptable by ACGME specialty-specific standards.
   b. Significant and repetitive non-compliance on any of these areas.
7. **Resident Survey / Complain**
   a. Compliance below the national average for any aspect of duty hour rules.

b. Downward trends in more than two categories other than duty hours.
c. Resident overall dissatisfaction with the program including but not limited to egregious single year issues and issues that extend over more than one year.

8. **Faculty Survey / Complaint**
   a. Minimum of 70% completion rate.
   b. Downward trend in more than two categories.
9. **Non-compliance with responsibilities.**
   a. Failure to submit milestones data to the ACGME and to the GMEC.
   b. Failure to submit data to requesting organizations or GMEC (ACGME/ABMS).
   c. Serious or repetitive complaints or concerns relative to program administration, functioning or the learning environment.
10. **Inability to meet established ACGME common and program specific requirements notification from RRC.**
    a. Requests for progress reports and site visits.
    b. Unresolved citations or new citations.
    c. Other actions by the ACGME resulting from annual data review or other actions.
    d. Lack of substantial compliance with ACGME Program Requirements evidence through a significant number of new or extended citatons.

B. PROCEDURES

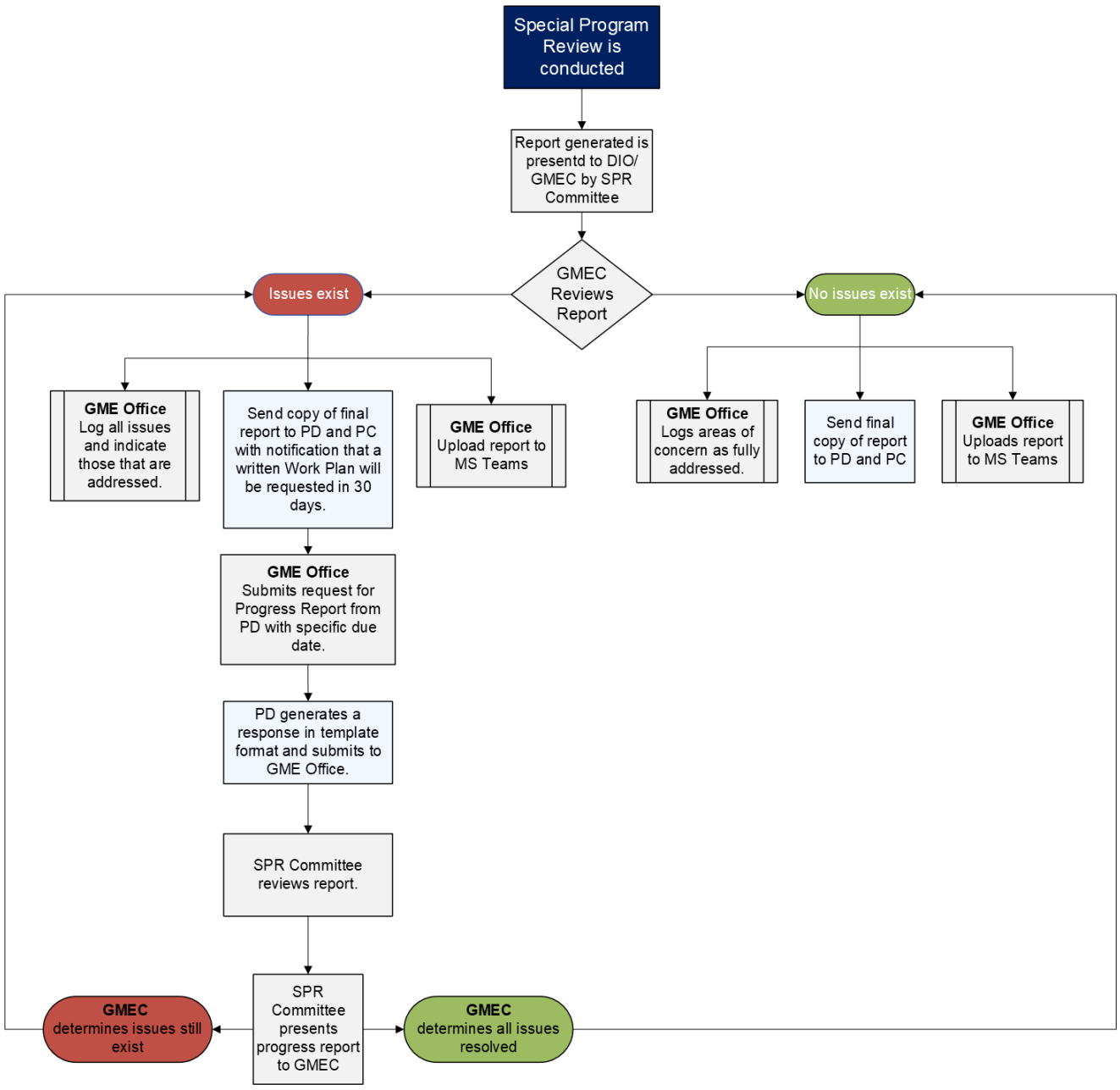
If the DIO/GMEC identifies an underperforming program must initiate a special review within 30 days of a program being identified as underperforming.

1. The special review will be conducted by a Special Review Committee (SRC).
2. The SRC will include, at minimum, the DIO, an administrative member of the GMEC, a faculty member and resident from the GMEC – though not from the program under review.
3. Additional members may be included on the SRC as determined by the DIO/GMEC.
4. The DIO will chair the SRC.
5. The SRC will determine materials and data to be used during the Special Review.
6. At minimum, the materials are to include:
   a. The ACGME common, specialty, subspecialty-specific program, and Institutional Requirements in effect at the time of the review.
   b. Accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective RRC.
   c. Previous Annual Program Evaluations (APE).
   d. Results from ACGME faculty and resident surveys,
   e. Any other materials the SRC considers necessary and appropriate.
7. The SRC will conduct interviews with the Program Director, key faculty members, at least one peer selected resident(s) from each PGY level of training in the program, and other individuals deemed appropriate by the committee.
8. The SRC will prepare a written report to be presented to the GMEC for review and approval.
9. At a minimum, the report will contain:
   a. A description of the quality improvement goals to address identified concerns.
   b. A description of the corrective actions to address identified concerns.
   c. The process for the GMEC to monitor outcomes of corrective actions taken by the program.

MONITORING OUTCOMES.

The DIO, in conjunction with the GMEC, will monitor outcomes of the Special Review. The subject program will provide quarterly progress reports to the GMEC until the deficiency is deemed remediated by the DIO/GMEC.

OFFICIAL PROCEDURE FOR THE FINAL REPORT OF A SPECIAL PROGRAM REVIEW


Special Program Review is conducted
Report generated is presentd to DIO/ GMEC by SPR Committee
GMEC Reviews Report
Issues exist
No issues exist
GME Office Log all issues and indicate those that are addressed.
Send copy of final report to PD and PC with notification that a written Work Plan will be requested in 30 days.
GME Office Upload report to MS Teams
GME Office Logs areas of concern as fully addressed.
Send final copy of report to PD and PC
GME Office Uploads report to MS Teams
GME Office Submits request for Progress Report from PD with specific due date.
PD generates a response in template format and submits to GME Office.
SPR Committee reviews report.
SPR Committee presents progress report to GMEC
GMEC determines issues still exist
GMEC determines all issues resolved

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 7	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ACGME COMMUNICATIONS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated/ Approved by the GMEC, March, 2021 Updated/ Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE.

To establish institutional protocols to maintain communications with the ACGME.

The Office of Graduate Medical Education encourages program directors to interact with their respective specialty-specific RRC for matters of guidance and advice as it pertains to their compliance with the Common and Program-specific ACGME regulations.

INTENT.

All correspondence from and to ACGME must be discussed with the DIO and the GMEC to maintain effective communication protocols and a teamwork approach.

PROCEDURES.

A. The DIO and subsequently, the GMEC, must approve all communications with the ACGME that involve the following, prior to their submission.

- All applications for ACGME accreditation of new programs
- Changes in resident complement
- Major changes in program structure or length of training
- Additions and deletions of participating sites
- Appointments of new program directors
- Progress reports requested by any Review Committee
- Responses to all proposed adverse actions
- Requests for exceptions of resident duty hours
- Voluntary withdrawal of program accreditation
- Requests for an appeal of an adverse action
- Appeal presentations to a Board of Appeal or the ACGME
- All requests for experimentation/innovation as it regards exceptions to the ACGME Common
- and Specialty-specific requirements.

B. The GME Office must receive all program information forms (PIF's) or specialty specific applications forms, one month prior to submission to the ACGME.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 8	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	GME GENERAL RULES AND REGULATIONS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See At the End of the Summary of Policies

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

A. Residents Responsibilities

1. Residents must attend all orientation activities.
2. Residents will do teaching and working rounds with the teaching faculty. During these rounds, the differential diagnosis and treatment will be discussed.
3. It is important to always maintain the confidentiality of the patient information as established by HIPAA *(Health Insurance Portability and Accountability Act).*
4. Medical procedures will be done under supervision. The resident will keep a procedure log as requested by the Residency Review Committee Program Requirements.
5. Residents will timely attend all academic activities. Academic activities include faculty meetings, conferences, departmental meetings, institutional meetings, etc. Residents may be excused during emergencies as reported to the Program Director or Chief Resident.
6. Participate in Departmental and Institutional Committees
7. Participate in the education of other residents, medical students, other healthcare professionals, or the general population as assigned by the Program Director.
8. Residents will assume all responsibilities assigned by the Program Directors, as specified in the program's resident manual.
9. **Residents' Participation on Institutional Committees**
    - Residents must have appropriate representation for institutional committees and councils whose actions affect their education and/or patient care. Residents must be aware of, and participate as appropriate, in institutional programs and medical staff activities.
    - They must be knowledgeable about and adhere to established practices, procedures, and policies of each institution participating in the educational experiences and activities of their training program.
    - During their course of training, each resident should have the opportunity to participate on committees including, but not limited to, the following: Graduate Medical Education Committee (GMEC). The GMEC must include a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs. Each meeting of the GMEC must include attendance by at least one resident/fellow member.
    - Any GME sub-committees that are created in order to carry out portions of the GMEC's responsibilities must include a peer-selected resident/fellow. Sub-committee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.
    - The Program Evaluation Committee (PEC) must have one resident to this committee and must be selected by their peers. The committee members will participate actively in evaluating educational activities of the program; reviewing and making recommendations for revision of competency-based curriculum goals and objectives; addressing areas of non-compliance with ACGME standards; and reviewing the program annually using evaluations of faculty, residents, and others.

Compliance with Rules and Regulations

All or our residency programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Residents must become familiar with and abide to the rules and regulations of the Centro Medico Episcopal San Lucas, the Sponsoring Institution, and the rules established in their contract with the Department of Health. They must also become familiar with and abide to the rules and regulations of their Program and of other affiliated training sites.

B. Resident Benefits

1. Meals

Meals will be provided by the cafeteria at CMESL during work hours and on-call days. The ID card must be presented at the moment of purchase, without exemption. Also, may use the allowance to get discounts of vendors located at the Torre Medica San Lucas' Lobby area.

2. Reimbursements

All residency /fellowship programs have a yearly budget for all academic needs, residents will receive a reimbursement for the following:

- Professional memberships
- Poster and abstracts
- External lodging or transportation expenses (gas) in compulsory rotations
- Uniforms (coat, scrubs, etc.)
- Education support
- *For Ob/Gyn and Surgery Residencies* – Travel expenses for fundamental laparoscopic and endoscopic certifications

a. In-House Lodging

Adequate sleeping and resting facilities will be provided while the resident is in service in the hospital, off regular working hours. Under no circumstances residents will sleep in patient's rooms or other areas of the hospital, other than those designated for resident's use.

b. External Lodging

Some residency programs have certain area of their training at other participating sites, as required by their program curriculum, in such cases it will be reimbursed at the end of the rotation, must be attached a copy of the contract and evidence of payment. Must contact your program coordinator to begin the process.

All requisitions must be discussed, approved, and signed by the Program Director and the DIO.

C. Occupational Health Requirements

- The Department of Health of Puerto Rico requires that house staff obtain a Health Certificate (TB screening and VDRL), within the last ninety (90) days, prior to the commencement of training and yearly.
  - Annual TB screening is required for all healthcare workers regardless of any previous results.
  - Persons with a positive result are required to have a chest x-ray and provide documentation of physician consultation regarding the positive result and/or history of treatment or prophylaxis.
- Must show proof of immunity to hepatitis B by antibodies or by three (3) doses of vaccination of hepatitis B.
  - If you have not already been vaccinated against hepatitis B, you should begin the three (3) dose series of injections as soon as possible.
  - If you choose to refuse vaccination, you are required to sign a declination form provided by CMESL.
- Must provide documentation of positive titers for measles, rubella and varicella and mumps.
- Must provide documentation of Covid 19 vaccination.
  - If you choose to refuse vaccination, you are required to sign a declination form provided by CMESL.
- Must provide documentation of influenza vaccination.
  - If you choose to refuse vaccination, you are required to sign a declination form provided by CMESL.

D. Work Related Injuries

Residents must notify all injuries and if an event requires immediate attention must be taken to the Emergency Department for their care.

All work-related injuries, including needle sticks, must be reported as follows:

1. Notify a nurse, attendings or supervisor and take care of injury as required.
2. Notify Department Nurse Supervisor, and HIV and Hepatitis (A, B, C) panel consent form will be taken from the patient and an incident report will be completed by nurse in charge.
3. Resident will be transfer to Emergency Department, a medical record will be done, full physical examination, tetanus toxoid history, pregnancy test and resident must fill consent for Post Exposure Prophylaxis (PEP)
   a. If exposure occurs during weekends the Emergency Department will prescribe the Post Exposure Prophylaxis (PEP) and on the next working day resident must present to the office of Fondo del Seguro del Estado (CFSE) to continue with the protocol.
4. The Emergency Department must notify and refer the resident to the GME office.
5. GME Office must initiate the protocol for work related injuries with the CFSE as required by law.
6. Residents have no more than 72 hours to start the protocol, if the resident does not complete the protocol as established the CSFE will not open the case and will lose all their coverage for work related injuries.

E. Certification in Cardiopulmonary Resuscitation

All residents should complete a course or demonstrate proficiency in Cardiopulmonary Resuscitation within three (3) months of the commencement of training and at least once every two (2) years thereafter. Residents must make all arrangements through your Program Coordinator for presenting the CPR during your training years. Life Support Training Center is located at the first floor of the Torre medica San Lucas at the facilities of the Universidad San Lucas.

Residents must do CPR training at the CMESL training center, Program coordinator will schedule your appointment for certification.

F. Mask Fit Test

Fit testing is done at the beginning of each academic year at Clínica del Empleado and if has any anatomical changes during their training years must do a new mask fitting.

G. Residency Mobile Phones

Each residency program has been assigned a mobile phone to optimize communication between services and all are part of the CMESL Corporation services, that will be protected during any natural disaster.

RESIDENCY PROGRAM		CALL CELLPHONE NUMBER
Internal Medicine	R1 – Admitted Patients R2 – ER Consults R3 – ICU Consults	(787) 309-9992 (787) 378-4030 (787) 903-1207
Pediatrics		(787) 624-9436
Surgery		(787) 903-1910
Obstetrics - Gynecology		(787) 903-1067
Cardiovascular Fellowship		(787) 624-3926

Urology	(787) 908-2354

H. General Behavior

Residents are medical professionals whose behavior must abide to the code of ethics of the American Medical Association and the professionalism competency requirements of the Faculty of the Centro Médico Episcopal San Lucas and those of the ACGME. It is expected that each resident be courteous, cooperative, respectful, and responsible at all moments with peers, faculty, staff, administrators, and patients. Any violation of this norm or improper behavior must be informed to the faculty, the PD or the GMED and must be subject to further evaluation and actions by the PD and corresponding Clinical Competency Committee. A critical incident report form is available to facilitate this referral.

I. Dress Code

1. All residents are expected to dress professionally during all didactic and clinical activities. All residents should wear a white coat and an identification card.
2. The use of scrubs during the day has been authorized and should be used with a white coat on all occasions. Refer to the Residency Program's Dress Code Policy. Residents must avoid using the scrub color used to identify the maternal and pediatrics units which are **ceil blue** and **pink** respectively.
3. Dressing more comfortably on weekends is not an excuse to wear shorts, sweatpants, etc.
4. Shoes must be clean and in good condition. Shoe style must be closed, flat or with comfortable heel height and of firm and fluid repellent materials that offer protection against spills and sharp objects.
5. Hair and beards should be groomed and appropriate to fit respiratory protective equipment if it is necessary its use. Must avoid wearing loose long hair or prominent jewelry that interferes with the care of patients.
6. Administrative Order # 163 or the Secretary of Health of Puerto Rico requires that all healthcare professionals follow the following rules:
    a. No artificial nails nor artificial eyelashes are allowed.
    b. Fingernails shall be no longer than 1/8 or an inch over the fingertip.
    c. Nail enamel must be changed frequently and must not be cracked.
    d. Only one ring and a watch at your hands and wrists.

J. Smoking, Drugs and Alcohol

Smoking is strictly prohibited inside the hospital. Residents must abide to the provisions of the institutional policy that prohibits the use of alcohol and drugs (Politica de Pruebas de Dopaje DOH).

H. ID Cards and Parking Permit

a. New residents will be provided with identification cards at the beginning of training. These cards must be always worn while in the hospital or at any training site. If the card is lost, it shall be immediately reported to the Program Coordinator and/or to the Office of Human Resources to make the arrangements for replacement, has a cost of $25 dollars.
b. A parking permit (barcode sticker) will be given at the beginning of training and will be used until the finalization of it. In case a permit does not allow entrance, resident must report situation to the Program Coordinator and/or to the Office of Human Resources to make the arrangements for replacement.

Medical License

- All residents must obtain a medical license that authorizes them to practice medicine in the hospital and affiliated sites. Residents must submit evidence that they have requested the license before signing the residency contract. **A copy of the license must be provided to the Program Coordinator as soon as it is received**. All residents must show evidence of

their application for license to be able to sign their contract and provide a copy of their license within 60 calendar days of initiating the resident contract. Failure to do so will result in suspension from the program.
- Residents with a provisional license are authorized to work only in the Sponsoring Institution and training sites affiliated to the institution. Residents must have a National Provider Identification Number (NPI) before or starting at the beginning of training. They must notify the Program Coordinator as soon as they have an NPI.

Research and Scholarly Activities
All Residents and Fellows must participate in research activities, such as quality improvements projects, patient safety projects, clinical trials, case studies under the direction of a faculty member, who is a qualified Principal Investigator, if the participation is disclosed to the CMESL, prior to the commencement of any project. The Research Coordinator at the GME office will assist and organize all projects.

Duty to Protect Patient Privacy
State and federal patient privacy laws include serious consequences for failing to protect patient privacy, including potential fines for Centro Medico Episcopal San Lucas and for house staff as an individual, imprisonment, and loss of one's professional license. Patients have the right to assert legal claims against both faculty, and Centro Medico Episcopal San Lucas.

Federal authorities aggressively investigate and enforce privacy and security laws against healthcare institutions and individuals when a compromise to patient information occurs, whether due to intentional wrongdoing or simply a mistake.
Additionally, violating CMESL privacy policies can lead to disciplinary actions, up to and including termination. Information that is protected under the law is often referred to as Protected Health Information (PHI) and applies to both living and deceased patients.

PHI is defined as individually identifiable health information that relates to a patient's past, present or future physical or mental health or condition, the provision of health care to a patient, or the past, present, or future payment for health care provided to a patient. You should assume that all information that you access, use or disclose – in any form, verbal, electronic or physical – about patients or their relatives is subject to the law and must be safeguarded. At a minimum the following information about a patient or a patient's relatives, employers or household members is considered PHI and must be protected:
- Names
- Social Security Numbers
- Telephone numbers
- Addresses, including ZIP Codes, and all geographic subdivisions smaller than a State
- All elements of dates (except year), including birth date, admission date, discharge date, date of death; and all ages over 89
- Fax numbers
- Electronic mail (e-mail) addresses
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) addresses
- Biometric Identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic or code

All de-identified data is used for purposes other than treatment, payment, or healthcare operations or if the data is used or disclosed outside of the hospital, permission must be obtained from the Office of Patient Safety.

All patient information, including de-identified patient information, is the property of CMESL, including medical records, images, lab results, prescriptions and other patient data and is not to be used or disclosed for non-CMESL purposes, such as publishing, presenting outside CMESL, or posting on social media or other non-CMESL websites. If de-identified data is to be used for purposes other than treatment, payment, or healthcare operations or if the data will be used or disclosed outside of the hospital, permission must first be obtained from the Office of Patient Safety.
All house staff are expected to strictly comply with all policies of CMESL, including privacy and compliance policies and procedures. Residents must be especially careful to adhere to the following patient privacy practices.

- DO NOT save patient information to non-hospital approved locations or devices. For example, do not store or transport patient data on unencrypted laptops, flash drives, smartphones, or other mobile media. No saves to the desktop or C drive.
- DO NOT use personal cloud storage accounts on any external vendor site, including Box, Dropbox, iCloud, Google Docs/Drive, Egnyte, Gmail, Facebook, Twitter, Amazon Web Service or Microsoft SkyDrive or other consumer application ("app") or Internet document, mail, and storage solutions for transferring and storing patient information. Only use CMESL approved and provided cloud vendors.
- DO NOT post patient information, photos, videos, images, even if de-identified, on social media without a written HIPAA-compliant authorization signed by the patient.
- DO NOT take photographs for upload unless using an encrypted device.
- DO NOT use your personal email account, e.g., Gmail, Hotmail, Yahoo for sending or receiving patient information; do not forward your work email to your personal email account.
- DO NOT share or disclose your user ID or password.
- DO NOT leave patient information or devices containing patient information in a
- car, a car trunk, an unlocked room, or any other area unattended (not even for a
- few minutes).
- DO NOT access patient medical records if you do not have a legitimate job related need to access the information. The hospitals' Privacy Office routinely monitors access to patients' electronic medical records.
- DO use only hospital networks, shared drives, team sites and hospital approved devices and encrypted solutions for saving patient information.
- DO use your psm.edu or ssepr.org email account for sending or receiving patient information. You must place "Secure:" in the subject line before sending emails with patient information, and the email must only be sent for legitimate business purposes. Do not put patient information in the subject line of the email.
- DO log off your computer workstations when you step away. You will be held responsible for any access to electronic medical records that occurs under your login ID.
- DO use strong passwords, i.e., eight (8) digits minimum, a combination of letters, numbers, and symbols.
- DO abide by the minimum necessary standard e.g., de-identify information.
- whenever possible. Deidentifying information means removing all the patient identifiers in the list above.
- DO report loss or suspected theft of a mobile device (laptop, tablet, smartphone), desktop, or media (CD, thumb drive, etc.) immediately.
- Do contact the Compliance and Privacy Office for approval on any hospital data requests related to research or quality improvement projects.
- DO dispose properly of any documentation that contains PHI by using one of the shredders localized in each area.

In addition, residents are required to complete Health Insurance Portability and Accountability Act (HIPAA) training at the beginning of training during orientation week.

Data Security

The security of computing devices that may handle restricted or prohibited data, including protected health information (PHI), is of utmost importance. State and Federal laws require device management, including encryption, to protect patient data. It is the resident's responsibility to ensure that all their devices are fully compliant with data security policies.

As a resident, the GME office expects that you will interact with Protected Health Information (PHI), this is considered restricted data by CMESL policy; therefore, any device you use to access email, calendar, or clinical medical records, could come into contact with restricted or prohibited data. All those devices must therefore be fully encrypted in order to comply with CMESL policies.
(If you have a personal device that is never used to access any of the above systems, and is not used on the CMESL network, then it is not required to be compliant with data security standards.).

To be granted access to the MEDITECH Software System (EHR) residents, medical students, visiting residents must fill out the form all to be done at the beginning of their training, the Program Coordinator will facilitate the form. In regard to medical students and visiting residents they must fill out the form to be granted access and this will have the specific dates(period) of the rotation, the Program Coordinator will facilitate the form. All forms must be approved by the Program Director and the DIO.

Medical Records

- All Residents, fellows, and visiting residents are required to complete computer training in order to participate in educational activities at CMESL
- All records are the property of Centro Medico Episcopal San Lucas.
- Original medical records shall not be removed from Centro Medico Episcopal San Lucas.
- Copies of medical records may be released pursuant to contractual arrangement with affiliated hospital, court order, subpoena, or other statutory requirements.
- The records may be inspected for professional purposes only by members of the Medical Record Staff, Medical Staff, and authorized hospital employees.
- Information from medical records shall not be disclosed to persons not otherwise authorized to receive this information without written permission of the patient or of the patient's legally authorized representative.
- All medical record entries and documents which are to be completed by the house staff must be completed within the guidelines as stated in the Hospital Rules and Regulations
- Residents will accurately and timely document the patient's medical record.
- Medical Record personnel will provide general orientation about the rules related to the medical record documentation during the orientation period at the beginning of training.
- In addition, training in the use of the Electronic Health Record and on HIPPA regulations
- Do not share the username nor password given for the access to the Electronic Health Record
- History and Physical examinations must be completed as soon as possible but never later than 24 hours after the patient is admitted. If the patient is critically ill on admission the History and Physical shall be done immediately.
- Write daily progress notes following the rules of the department where the resident is rotating.
- Write orders of patients under their care, recording the date and time of the order in the patient's chart.
- Use only the forms designed by the hospital and authorized by the Hospital's Medical Staff in the patient's chart. These include history and physical examination, progress notes, order forms, etc.
- Make sure that patients' charts are completed daily.
- Make sure the medical record is complete upon discharge of the patient.
- All entries must be legible (if chart is not EHR)
- Not use of abbreviations identified by the institution as a risk that may endanger patient safety.

The Guidelines for document completion are as follows:

- History & Physical within twenty-four (24) hours of admission
- Operative Report must be dictated or written immediately but in no case, later than twenty-four (24) hours after surgery or procedure.
- Discharge Summary must be completed at discharge.

- Verbal orders must be signed twenty-fours (24) hours
- All entries in the medical record are also to be timed, dated, and signed. Any errors in documentation should be reported to the medical record staff at: (787) 840-1222

Patient's or Institutional Information Release

Residents are not authorized to provide medical certificates or any information about patients or hospital's activities to journalists, lawyers, insurance companies, or the court without prior consultation. They must inform the attending physician, Program Director or the GME Office when such requests are made. Information may only be provided to the patient or their authorized delegate following the HIPAA regulations.

These rules have been in effect since July 1, 2004 and are reviewed on a yearly basis.
Revised May 2007; Updated June 2008;
Approved by the GMEC: June 2010
Draft for 2012 Revision: July 2012
Revision Approved by the GMEC: August 2012
Revision Approved by the GMEC: June 26, 2014
Revision of Dress Code approved by GMEC: July, 2015
Update Approved by GMEC January 2016
Yearly Review by GMED June 2016,
Approved GMEC June 2016
Yearly Review by GMED June 2017

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 9	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	EDUCATIONAL PROGRAM, CURRICULUM, COMPETENCIES.
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To establish institutional protocols for each ACGME-accredited program establishes an educational program, curriculum and competency-based education in compliance with the ACGME requirements.

This policy has been established in adherence with the ACGME Common Program Requirements (IV) (IV. A) concerning "The Educational Program" and (IV B) concerning the "ACGME Competencies." -2021 and 2022.

POLICY. The sponsoring institution ACGME-accredited programs should design an educational program in compliance with the ACGME Requirements, and specialty-specific program requirements, which must support the development of knowledgeable and skillful physicians who are able to provide compassionate care. Each training program is expected to define its program aims, which should be consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves, and that our graduates will serve, as well as the distinctive capabilities of the physicians we intend to graduate. Programs may place diverse emphasis on research, leadership, public health, etc. The training program aims will reflect the nuanced program-specific goals for it and its graduates.

A. PROGRAM CURRICULUM

The curriculum optimizes the resident/fellow educational experiences, the extent of these experiences, and supervision. The curriculum is designed to meet the required six core competencies as defined by the ACGME, whereby each resident must be trained and evaluated focusing on the 6 core competencies. The core curriculum serves as the foundational guidelines for each training program in the formulation of specific curriculum objectives relevant to the nature of its specialty. All residents will acquire learning experiences in the core curriculum during their training as specified by the Program Director. The curriculum assures the teaching and assessment of these competencies.

The trajectory to autonomous practice is documented by Milestone's evaluation. The Milestones detail the progress of a resident in attaining skill in each core competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

Each program should offer a curriculum that must contain the following components:

1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; which should be made available to program applicants, residents, and faculty members.
2. Competency-based goals and objectives for each educational experience (or rotation) designed to promote progress on a trajectory to autonomous practice; which must be distributed, reviewed, and available to residents and faculty members.
3. Delineation of the resident/fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision
4. A comprehensive range of structured didactic activities (Didactic Schedule)

B. **COMPETENCY BASED CURRICULUM**

The Core Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice.

These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty. Core Competencies are specific knowledge, skills, behaviors, and attitudes in the following domains: patient care and procedural skills; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. The sponsoring institution ACGME-accredited programs must integrate the following ACGME Competencies into their curriculum:

1. Professionalism.

a. Residents must demonstrate commitment to professionalism and an adherence to ethical principles.
b. Residents must demonstrate competence in:
   - Compassion, integrity, and respect for others;
   - Responsiveness to patient needs that supersedes self-interests;
   - Respect for patient privacy and autonomy;
   - Accountability to patients, society, and the profession;
   - Respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
   - Ability to recognize and develop a plan for one's own personal and professional well-being; and,
   - Appropriately disclosing and addressing conflict or duality of interests.

2. Patient Care and Procedural Skills

a. Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
b. Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

3. Medical Knowledge

a. Residents must develop knowledge of established and evolving biomedical, clinical, epidemiological, social-behavioral sciences, and the application of this knowledge to patient care.

4. Practice-based Learning and Improvement

a. Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning
b. Residents must demonstrate competence in:
   - Identifying strengths, deficiencies, and limits in one's knowledge and expertise;
   - Setting learning and improvement goals;
   - Identifying and performing appropriate learning activities; improvement methods;
   - Implementing changes with the goal of practice improvement;
   - Incorporating feedback and formative evaluation into daily practice;
   - Locating, appraising, and assimilating evidence from scientific studies;
   - Using information technology to optimize learning.

5. Interpersonal and Communication Skills

a. Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
b. Residents must demonstrate competence in:
   - Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
   - Communicating effectively with physicians, health professionals, and health-related agencies;
   - Working effectively as a member or leader of a health care team or other professional group;
   - Educating patients, families, students, residents, and other health professionals;

- Acting in a consultative role to other physicians and health professionals;
- Maintaining comprehensive, timely, and legible medical records, if applicable.

c. Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

6. Systems-based Practice

a. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.
b. Residents must demonstrate competence in:
   - Working effectively with healthcare delivery settings and systems relevant to the specialty;
   - Coordinating patient care across the health care continuum and beyond;
   - Advocating for quality patient care and optimal patient care systems
   - Working in interprofessional teams to enhance patient safety and improve patient care quality;
   - Participating in identifying system errors and implementing potential systems solutions;
   - Incorporating considerations of value, cost awareness, delivery and payment, and risk benefit analysis in patient and/or population-based care as appropriate; and,
   - Understanding health care finances and its impact on individual patients' health decisions.
c. Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, of-life goals.

D. CURRICULUM ORGANIZATION

The curriculum optimizes the resident educational experiences, the length of these experiences, and supervisory continuity. The program must provide instruction and experience in pain management if applicable for the specific specialty, including recognition of the signs of addiction.

1. Didactic Sessions

a. Residents must be provided with protected time to participate in core didactic activities.
b. The faculty should be assigned with sufficient protected time to participate in Didactic Sessions.
c. The list of conferences must include the date, conference topic, the name of the presenter(s), and the names of the faculty members and residents present for each conference.
d. Didactic activities should include core lectures, morning reports, grand rounds, M&M conference, Tumor Board, Research lectures, Professionalism workshops/courses, and many other activities.
e. The advancement of residents' knowledge of ethical principles foundational to medical professionalism; and the advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.

2. Scholarships. Programs' Responsibilities.

a. The program must develop evidence of scholarly activities consistent with its mission(s) and aims.
b. The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.
c. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.
d. The program must demonstrate dissemination of scholarly activities within and external to the program by the following methods: faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor, and peer-reviewed publication.

	Policy # 10	GRADUATE MEDICAL EDUCATION POLICIES
	TITLE	EVALUATION SYSTEMS AND FEEDBACK

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2021 Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the application process of residents/fellows to the sponsoring institution ACGME-accredited programs.

This policy has been established in adherence with the ACGME Institutional Requirements: V.A. Resident Evaluation, V.A.1. Feedback and Evaluation, and V.A.2. Final Evaluation.

Centro Medico Episcopal San Lucas has the duty to educate our trainees in the residency or fellowship programs. Each resident's professional qualifications must be periodically evaluated by their program, providing an adequate feedback process to optimize the learning experience. Assessing the trainee performance, providing useful and timely feedback, and conducting and documenting meaningful evaluations; are essential elements of graduate medical education. The faculty, program director, chair, and trainees all have responsibility for contributing to the consistent delivery of high-quality evaluation and feedback.

INTENT

The following protocols are intended to assist Program Directors, faculty members, and staff in the evaluation process. Residents should be aware of the results of these evaluations and must receive feedback at least every two weeks during a four-week rotation. "Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designer will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan. Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures." Information from the Common Program Requirements (Residency)(Fellowship), Accreditation Council for Graduate Medical Education (ACGME) 2021.

POLICY

Formative Evaluations of the Resident: All faculty members must directly observe, evaluate, and frequently provide feedback (at least every two weeks in a four-week rotation) on resident performance during each rotation or any other longitudinal or non-longitudinal experiences.

Each faculty member must evaluate each resident at the completion of each rotation or similar educational assignment. This evaluation is to be documented and shared with both the resident and the program director.

For rotations or assignments greater than three months in duration, evaluations must be documented at least every three months, and must be accompanied by feedback from the faculty.

Milestones Evaluation: Program directors must provide the Clinical Competency Committee with objective performance evaluations based on the Competencies and the specialty-specific Milestones

that incorporate information from multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members).
Each program's Clinical Competency Committee must:

a. Review all resident evaluations at least semi-annually,
b. Determine each resident's progress on achievement of the specialty-specific Milestones,
c. Meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.

Semiannual Evaluation: Program Directors or their designees (with the input from the Clinical Competency Committee), must:

a. Meet with and review with each resident a documented semi-annual evaluation of his/her performance, including the progress along the specialty-specific Milestones,
b. Assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth,
c. Develop plans for residents failing to progress, following institutional policies and procedures.

Annual Evaluation: At least annually, program directors must complete a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. The evaluations of a resident's performance must be accessible for review by the resident.

Final Evaluation: Upon completion of the program, program directors must provide a final evaluation for each resident that includes the specialty-specific Milestones, and when applicable the specialty specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. The final evaluation must:

a. Become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident,
b. Verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice,
c. Consider recommendations from the Clinical Competency Committee, and
d. Be discussed with the resident upon completion of the program. Residents must acknowledge its receival with their signature.
e. **Final evaluation is not to be used as a recommendation letter**.

PROCEDURES

1. **Feedback.**

a. Performance Feedback is required to be routine and structured for each Resident during the Program. It includes end of rotation evaluations, performance on standardized tests or in structured patient contacts, patient satisfaction surveys, 360-degree evaluations, simulation education experiences, six-month Milestone performance assessment and semi-annual evaluations, and other Program specific evaluations. Residents are encouraged to seek out Performance Feedback, reflect, and self-assess their strengths and areas for improvement throughout their training minimum every two weeks on a four-week rotation. Performance Feedback must be timely to promote performance improvement.
b. Comments provided – verbally or in writing - to help the trainee improve performance. In-person verbal feedback from supervising faculty members is an essential element of training.
c. Each residency program must adopt an effective feedback process and must be well documented.
d. Trainees must seek formative feedback from supervising faculty and other evaluators.
e. Faculty or evaluators must provide trainees with timely, appropriate, developmental feedback during each rotation or longitudinal experience.

2. **Evaluation Procedures**

a. Each residency program shall adopt procedures which provide for regular and timely evaluation and regular verbal and written notification of the evaluation to each resident regarding performance.
b. Evaluation must be documented at the completion of the assignment.
c. Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.

d. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:
   - V.A.1.c). (1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members);
   - V.A.1.c). (2) provide that information to the Clinical Competency Committee for the synthesis of progressive resident performance and improvement toward unsupervised practice.

e. During the residency, evaluation results should be personally presented to the residents no less than every six (6) months.
f. A resident whose performance is less than satisfactory should be notified of the conclusion promptly after such a decision is made.
g. An evaluation file should be maintained for each resident.
h. Information in this file shall be accessible to the resident.
i. Supervisory faculty should use New Innovations to electronically submit evaluations of each resident after each rotation, but not less frequently than quarterly during the Post Graduate Year (PGY) I or semiannually above the PGY I level.
j. At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.
k. The Program Director should review each resident's file on a routine basis. If a resident disagrees with statements in an evaluation in the file, the resident has a right to submit a written response which shall become a part of the file.
l. Residents will participate in evaluation of the faculty and the training program.

3. Evaluations

a. **Satisfactory**: Upon receipt of satisfactory evaluations and compliance with all tasks assigned, each resident is promoted to the next level of training, as agreed when the resident was recruited,
b. **Unsatisfactory**: Upon receipt of an unsatisfactory evaluation the reasons for lack of advancement must be given to the resident both verbally and by written notification.
   a. An unsatisfactory evaluation may result in a decision adversely affecting the resident at any time and without advance notice, such as probation, no advancement, non-renewal, or immediate termination. In such an instance, the resident shall be informed of the reasons for that decision both verbally and by written notification by the Program Director.
   b. Please refer to Policy #11: Academic Deficiency and Misconduct Policy and Policy #16: Promotion, Non-Promotion and Dismissal of Residents for further explanations on this subject.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 11	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ACADEMIC DEFICIENCY, MISCONDUCT AND DUE PROCESS POLICY
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed every five years from effective date

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To establish a process to address academic performance by a Resident that fails to meet expected academic standards, and to address situations in which a Resident is alleged to have engaged in Misconduct.

INTENT
To establish a process to address academic performance by a Resident that fails to meet expected academic standards, and to address situations in which a Resident is alleged to have engaged in Misconduct.

POLICY
Program Directors are responsible for compliance with this Policy and Procedure. For Accreditation Council for Graduate Medical Education (ACGME) accredited programs, the Program Director is responsible for monitoring that the Program's Clinical Competency Committee complies with this Policy and Procedure.

DEFINITIONS

- **Resident** refers to a resident or fellow in a training program in which CMESL serves as the Sponsoring Institution.
- **Program** refers to the training programs for Residents sponsored by CMESL.
- **Program Director (PD)** refers to the specialty faculty member who supervises each Program and has the authority and accountability for the operation of that Program.
- **Graduate Medical Education Committee (GMEC)** refers to the CMESL body which is comprised of DIO as Chair, Quality Improvement/ Patient Safety Officer, PDs and peer selected residents whose responsibility is the oversight of the accreditation status of CMESL and each of its Programs, including oversight of the quality of the GME learning and working environment.
- **Faculty Advisor (Mentor)** refers to a faculty member which may be the PD and may be suggested by the Resident who provides guidance during Academic Deficiency remediation. Of note, many Programs have Faculty Advisors for each Resident regardless of a need for remediation.
- **Clinical Competency Committee (CCC)** is the committee responsible for the evaluation, monitoring, and reporting of each Resident during the proscribed curriculum of training. The CCC will advise the PD regarding Resident progress, including recommendations for promotion, remediation, and Reportable Action(s).
- **Academic Performance** includes the knowledge, skills, and attitudes necessary to achieve competence in the core areas of medical knowledge, patient care, communication, professionalism, practice-based learning, and systems-based practice. For ACGME accredited Programs, progression with specialty level Milestones is part of Academic Performance expectations.
- **Academic Deficiency** is determined by the Program's CCC and is defined as Academic Performance of a Resident that does not meet academic expectations and is identified through review of the Resident's Performance Feedback.
- **Misconduct** includes but is not limited to improper behavior; intentional wrongdoing; or violation of a law, standard of practice, or Program, clinical affiliate, CMESL, or University Policy.

Examples include dishonesty, plagiarism, false documentation, discriminatory or harassing behavior, or medication diversion or theft.

- **Performance Feedback** is required to be routine and structured for each Resident during the Program.
- **Final (Summative) Evaluation** by the PD is required for each Resident upon completion of the Program. This evaluation must become part of the Resident's permanent record maintained by the Residency program and must be accessible for review by the Resident. It must document the Resident's performance at the end of the Program and verify that the Resident has demonstrated sufficient competence to enter practice without direct supervision.
- **A Remediation Plan** will be developed if the CCC determines that a Resident is not meeting Academic Performance expectations to guide performance improvement for the Resident.
- Notice to a Resident shall be deemed to be delivered when sent to the Resident's email address.
- ***Notice of Deficiency*** will be issued by the CCC to a Resident who has failed to achieve Academic Performance.
- ***Notice of Successful Remediation*** is issued by the CCC to a Resident when the CCC determines that the Remediation Plan was successful, and thereby terminates the Remediation Plan.
- ***Notice of Failure to Remediate*** is issued by the CCC to a Resident when the CCC determines that the Remediation Plan was unsuccessful. This Notice is provided when a Reportable Action is not being considered by the CCC and a new Remediation Plan will be developed.
- **Notice of Adverse Decision** is issued by the CCC to the Resident when the CCC has determined that an Adverse Decision needs to be taken. This Notice must occur after Notice of Proposed Reportable Action as described above.
- **Adverse Decision** is an action that must be disclosed to any third party upon request including, but not limited to, future employers, hospitals, and licensing and specialty boards. An action that results in extension of training, election not to promote, probation, suspension, non-renewal of contract, or dismissal is considered an Adverse Decision.
- **Request for Review of Adverse Decision** is a Resident's right to request a review of any recommended Adverse Decision. Policy #11 - Request for Review of Adverse Decision.pdf
- **Written Warning** may be issued by the CCC to a Resident when the CCC determines that Misconduct has occurred, but no other remediation or Proposed Reportable Action has been recommended. It shall include the findings of the investigation, outline expectations of future conduct, and explain that further Misconduct may result in other discipline, including an Adverse Decision.

PROCEDURES

A. RESIDENTS DEFICIENCIES

1) Each CCC determines what skills, competencies, attitudes. and Milestones must be demonstrated by a Resident at points throughout the Program, including determining when a Resident is not meeting minimal standards of performance in that Program.

2) Deficiencies in Academic Performance by Residents will be identified and evaluated by the applicable CCC through review of resident's evaluations. Each evaluation should be considered but also viewed in the context of the entirety of the Resident's Program. The CCC will accept unsolicited and informal evaluations of Academic Performance of a Resident but should not make recommendations regarding a Resident's progress or failure to meet academic expectations without substantiation of the concerns through at least one formal evaluation mechanism or without a comprehensive assessment of the Resident's performance.

3) If a Resident's performance is deemed to be deficient by the CCC, the PD will be notified and the CCC will issue a **Notice of Deficiency** to the Resident, setting forth a detailed description of

the deficiency(ices) and describing specific examples related to the core competencies and/or Milestones. Policy #11 - Notice of Deficiency.pdf

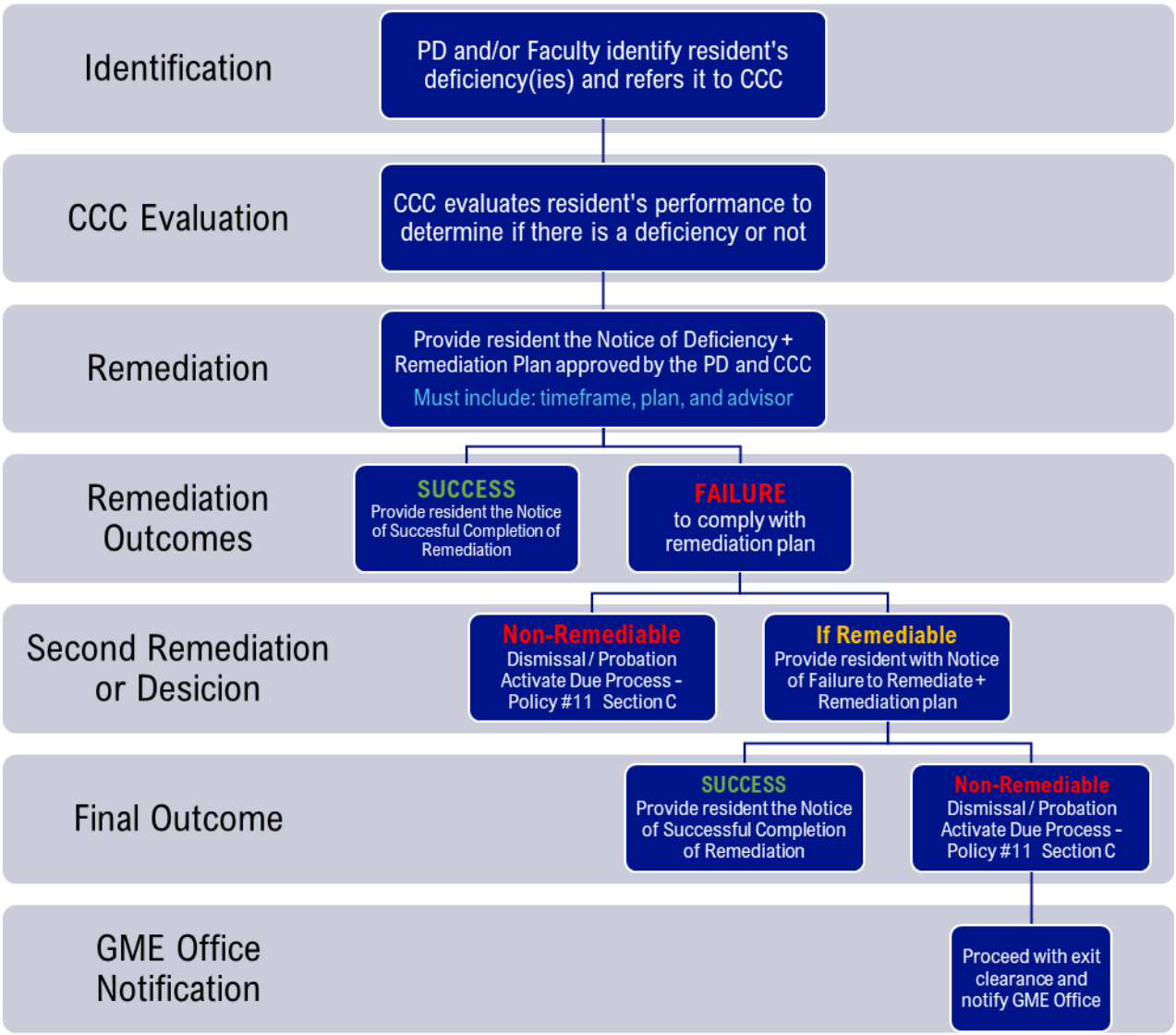
4) Following the issuance of a Notice of Deficiency, the CCC (in conjunction with the PD) must develop a Remediation Plan to address the Resident's Academic Deficiencies. Before the Remediation Plan is finalized, the PD and/or CCC may meet with the Resident so that the Resident may have input into the activities that might address the Resident's performance issues. **The Remediation Plan** shall be in writing and set forth the following elements:
    a. A timeline for the remediation; the timeline shall not be indefinite.
    b. The performance goals and expectations for the Resident; what specific knowledge, skills, attitudes, and Milestones need to improve and how.
    c. A method to assess accomplishment and what Performance Feedback will specifically measure Academic Deficiency(ices). This may be routine Performance Feedback, but may also involve more frequent feedback, simulation assessment, chart reviews, and other evaluations, depending on the deficiency(ices).
    d. The way and how often the CCC will monitor the Resident's progress; what Performance Feedback measures the CCC will use to evaluate the Resident's performance, the need for modification of the Remediation Plan, and the successful completion of remediation.
    e. The Resident's responsibilities in the Remediation Plan; these must be specified so that there is accountability of the Resident during the process.
    f. Assignment of a Faculty Advisor during the remediation period to provide the Resident with ongoing mentorship during remediation; this may be the PD or another faculty. Depending on the situation, input from the Resident regarding the assignment of the Faculty Advisor may be considered.
    g. An outline of the consequences of meeting/ not meeting the performance goals of the Remediation Plan; what determines successful completion of the remediation, and what happens if the Resident does not comply with or is unsuccessful in completing the remediation.
    h. The CCC shall have the final approval of the Remediation Plan.
    Policy #11 - Remediation Plan Revision 2024.pdf

5) **Notice of Successful Completion of Remediation:** The Resident will receive a Notice of Successful Remediation if the CCC determines that the Resident has met the performance goals of the Remediation Plan, which will thereby terminate the Remediation Plan. The Summative Evaluation of a Resident shall not reference any successful remediation for which there was no Reportable Action taken. Policy #11 - Notice of Successful Remediation.pdf

6) **Notice of Failure to Remediate:** If the Resident fails to successfully meet the goals and expectations of the Remediation Plan, the CCC will determine the next steps, including the possibility of an adverse decision. If no adverse decision is being considered, a Notice of Failure to Remediate shall be issued to the Resident by the CCC, and a new Remediation Plan shall be developed and provided to the Resident as outlined in the procedures above. Policy #11 - Notice of Failure to Remediate.pdf

7) Program Director will initiate Section C of this policy.

CMESL Graduate Medical Education
Procedure to address academic deficiencies.



B. MISCONDUCT

1) Misconduct may be identified through the Program evaluation system but may also be identified by informal or incident reports to the Program's administration.
2) Upon receipt of a complaint of Misconduct by a Resident, an investigation of the complaint shall be undertaken. The initial investigation may be directed by the PD or a CCC member. This initial investigation must include a review of the complaint and a discussion with the Resident. If there is not sufficient information to conclude that Misconduct may have occurred, no further action will be taken. If further investigation is required, the matter will be referred to the CCC.
3) If the matter involves allegations of sexual harassment and/or any Title IX or equity concern (i.e., discrimination), the PD must inform the DIO and file a report regarding the allegations to the Human Resources office, informarecursoshumano@ssepr.org.
4) If the matter involves possible medication diversion or theft, the PD must immediately notify the DIO where the incident may have occurred. The process of the Sponsoring Institution regarding this issue will be followed.
5) If the alleged Misconduct occurred at a clinical affiliate, other investigations may be required by that site or other entities. Per agreements with the participating site, they have the right to determine whether a Resident may work at their site during the investigation, or the PD may also remove the Resident from that clinical affiliate site during the investigation.
6) The Resident is expected to cooperate with all investigations of alleged Misconduct.
7) If further investigation is required, the CCC will review the complaint of Misconduct, the evidence gathered by the investigation, and will meet with the Resident regarding the complaint. The CCC may also collect additional information, independent of the initial investigation. This investigation can be independent and/or as a result of other entities' investigation findings. If a Adverse Decision is being considered by the CCC, a Notice of Adverse Decision will be sent to the Resident.
8) At any time, if new information pertaining to the alleged Misconduct is brought to the attention of the CCC, the CCC has the right to reopen the investigation.

C. REQUEST FOR REVIEW AND APPEAL OF ADVERSE DECISION

If the Graduate Medical Education Director, Program Director, or a member of the Teaching Staff, identify one of the reasons for remediation, probation, nonrenewal of contract, nonappointment or dismissal (adverse decision), a written notification must be sent to the CCC for thorough evaluation. (Step #1)

Initial Process of Adverse Decision

After evaluation, the CCC submits a recommendation to the Program Director who, in the event of an adverse decision, will send a written notification to resident during the next five (5) working days after the decision is made. The resident must be informed of the decision, its reasons, and his/her right to appeal. (Step #2)

Appeal of Adverse Decision

The resident has the right to appeal the decision within five (5) working days after receipt of the written notification. The initial appeal will be made to the Program Director.

The Program Director may submit the appeal to the CCC or to an Ad-Hoc Committee (appointed by the GME Office) as deemed necessary (Step #1); the referral of the appeal must be made within five (5) working days after the receival from the letter of appeal of the resident.

(Step #2) This process must be activated within ten (10) working days after the Program Director submits the appeal. If the appeal process is performed by the CCC a hearing with the resident will be requested. If the appeal process is performed by an Ad-Hoc Committee, a hearing with the PD, faculty and resident will be requested. A written record of the hearing will be maintained but kept confidential. The meeting must begin no later than 15 minutes after the established hour. Tardiness (15 minutes after the established hour) or unjustified non-attendance by the resident to this hearing will be interpreted as

voluntary withdrawal from the appeal process and the decision made by the Program Director is sustained.

If the CCC performs the hearing, all the documentation and the final report will be retained at the resident's record. If the Ad-Hoc Committee performs the hearing the documentation and final report will be retained by the GME Office.

The committee has five (5) working days to submit a recommendation to the Program Director who shall write a letter of notification with the final decision not more than five (5) working days after receiving the recommendation of the committee. The PD letter of notification will be sent to the GMEC, the resident, and the resident's file (Step #3).

Second Appeal of Adverse Decision
The resident has the right to appeal the results of the hearing by requesting a formal hearing with the GMEC. The request for appeal must be made on or before five (5) working days after receiving written notification about their suspension/ dismissal or other adverse action.

If the resident appeals, the GMEC must call for a hearing no later than ten (10) working days after the request is made. This will be done through an Ad-Hoc Committee appointed by the GMEC. After hearing the resident, and thorough evaluation of the case, the GMEC Ad Hoc Committee must submit the decision to the resident and Program Director. The decision of the GMEC is final.

Important information
None of the items here exposed impedes that the Director of Graduate Medical Education and/or the Program Director, suspend immediately or separate from clinical duties any resident whose professional behavior adversely affects the health or safety of the patients under his/her care or any other circumstances that place anyone at security risk. In such case, the resident also has the right for due process.

During an appeal process the contract with the Department of Health will continue and resident benefits will remain. If the resident is removed from all clinical duties due to a safety concern the contract and benefits will remain until the final decision.

Due process must be conducted within the timeframe established by this policy to be compliant.

Extension of Training Time
In the event a resident needs additional time to complete the training, it will be the responsibility of the program administration and/or the resident to:

- Request extension of provisional license to practice medicine in Puerto Rico.
- Request extension of the contract with the Department of Health
- Provide any additional information requested by the PD or GME Office
- Complete all documents requested by the PD or GME Office
- Update ACGME roster with new date expected to finish training
- Comply with all requirements from the specialty board
- Any other procedure or documentation as seemed fit

Process for disciplinary action and appeal of adverse decision.

	Reason for disciplinary action identified. Written notification shall be submitted to CCC or PD	
Initial process of adverse decision	**STEP #1** Clinical Competency Committee (CCC) evaluates written notification and submits recommendation to the Program Director (PD)	
	STEP #2 PD sends written notification of adverse decision and its reasons to resident and informs him/her of their right to appeal.	5 working days after decision
	Resident receives notification of adverse decisions and must decide if appeals or not.	
Appeal of adverse decision	**APPEAL PROCESS SUBMISSION** Resident submits written notification to PD to appeal the adverse decision.	5 working days after receipt of written notification
	STEP #1 PD submits the written notification to CCC or Ad-Hoc Committee.	5 working days after receipt of written notification
	STEP #2 Committee must start the appeal process and have a hearing with the resident. A written notification with the suggestions of the committee must be submitted to PD.	10 working days to start process and have hearing + 5 working days after hearing to submit recommendation to PD
	STEP #3 PD submits written report with the decision to the Graduate Medical Education Committee (GMEC) and the resident.	5 working days after receipt of Committees suggestions
	Resident receives a written notification with the decision of the PD and must decide if appeals or not.	
Second appeal of adverse decision	**APPEAL PROCESS SUBMISSION** Resident submits written notification to GMEC to appeal the adverse decision.	5 working days after receipt of written notification
	STEP #1 GMEC submits the written notification to a GMEC Ad-Hoc Committee.	10 working days to start process and have hearing + 5 working days after hearing to submit recommendation to PD
	STEP #2 GMEC Ad-Hoc Committee must start the appeal process and have a hearing with the resident. The final decision must be submitted to both the resident and PD.	
	Resident and PD receive final decision of the GMEC Ad-Hoc Committee.	

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 12	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RESIDENT/FELLOW APPLICATION TO PROGRAMS ELIGIBILITY, QUALIFICATIONS, SELECTION
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Revised, Approved by the GMEC, March, 2022

Scope: Applies to the ACGME accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the application to the sponsoring institution programs.

This policy has been established in adherence with the ACGME) Institutional Requirements IV.B. Resident/Fellow Appointments. IV.B.1; which states "The Sponsoring Institution must have written policies and procedures for resident/fellow recruitment, selection, eligibility, and appointment consistent with ACGME Institutional and Common Program Requirements, and Recognition Requirements (if applicable), and must monitor each of its ACGME-accredited programs for compliance. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:

- Graduation from a college of osteopathic medicine in the United States,
- Accredited by the American Osteopathic Association (AOA); or,
- Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
- Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or,
- Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty-/subspecialty program.

IV.B.3. An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of the applicant's eventual appointments. Information that is provided must include: 1) stipends, benefits, vacation, leaves of absence, professional liability coverage, and disability insurance accessible to residents/fellows; and, IV.B.3.a). (2) health insurance accessible to residents/fellows and their eligible dependents.

Visa Policy for Graduates of International Medical Schools

An International Medical School Graduate (IMG) is defined as a graduate of a medical school located outside of the United States. Centro Medico Episcopal San Lucas supports the use of the clinical (ECFMG sponsored) J-1 Visa for all trainees. Exceptions for individuals with pending green cards or individuals unable to obtain the ECFMG J-1 Visa may be granted.

Approval from the CMESL Designated Institutional Official (DIO) and CMESL Chief Operational Officer (COO) is required prior to use of an alternate visa.

CMESL uses J-1 visas sponsored ECFMG Graduates. Please allow 120 days for the processing of a J-1 visa.

For more information visit http://www.ecfmg.org.

RESIDENT AND FELLOWS' SELECTION SERVICES

National Resident Matching Program (Match) – For all residency programs except Urology Residency and Obstetrics and Gynecology Residency.

CMESL participates in the National Resident Matching Program (NRMP) for all postgraduate years (PGY) I, II and some fellowship positions. The purpose of the NRMP is to match medical students and other applicant physicians with hospitals to obtain internships, residencies, and fellowships. Applicants should submit a confidential list to the NRMP, ranking their desired position within the residency program. Participating hospitals also enter a confidential rank order list of their most desired applicants. Through a uniform date (mid-March), all applicants and hospitals are informed of the Match results.

American Urology Association Match (AUA Match) [Urology]

Annually, the Urology Residency Match provides its services to residency and fellowship matches, including pediatrics, urologic oncology, andrology, endourology and male reconstruction.

Residency Centralized Application Service (CAS) [Ob/Gyn]

Since the application cycle of 2024-2025 for all OBGYN residency programs will be participating in ResidencyCAS. OBGYN applicants will use this platform to apply to residency programs, signal OBGYN programs, request documents supporting the application, such as MSPEs, transcripts, LORs/SLOEs, and USMLE / COMLEX scores, schedule and participate in virtual interviews with programs.

INTENT

Resident/Fellow physicians must meet certain qualifications for participation and appointment in the accredited residency/fellowship programs at CMESL. These qualifications include the accreditation of the medical school, medical licensure, speaking skills, and medical licensing examinations.

The National Resident Match Program (NRMP) requires that applicants for residency positions through the NRMP who are invited to interview must be given complete and accurate information regarding the policies and procedures governing their training programs.

POLICY

A. Eligibility

Any applicant invited to interview for a resident/fellow position will be informed, in writing or by electronic means, of the terms, conditions and benefits of appointment to the ACGME- accredited program, either in effect at the time of the interview or that will be in effect at the time of his/her eventual appointment. Information that is provided must include:

- a sample contract
- financial support
- vacations, parental, sick, and other leaves of absence
- professional liability
- health, mental health, disability, and other insurance accessible to residents/fellows and their eligible dependents.

Any applicant to our programs must meet the following qualifications for appointment to an ACGME-accredited residency program:

- Have been graduated from an accredited and if graduate form a medical school outside the United States and Canada residents must present the following documentations: o a current, valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, or,
- License to practice medicine in the Commonwealth of Puerto Rico,
- The Office of Graduate Medical Education reserves the right to reject any candidate at the point it is determined that they have matriculated from an unacceptable medical school.

- Meet the requirements established by the “Junta de Licenciamiento y Disciplina Medica de Puerto Rico”
- Evidence of passing USMLE Step I and II.
- Applicants to Fellowships must provide evidence that they successfully passed USMLE Step-3.
- Ability to demonstrate spoken, auditory, reading, and writing proficiency in the Spanish and English language proficiency.

B. **Application** through the Electronic Residency Application Service (ERAS) or the applicable service is the first step in the process of joining a CMESL residency/fellowship program.

PROCEDURES
It is the responsibility of the DIO to ensure that all required information is updated and approved by the GMEC prior to the beginning of the interview season. The Office of GME will ensure that each applicant invited to the interview will be supplied with all necessary information as required by the ACGME Institutional, Common, and Program requirements.

APPLICATION
1. Only applicants who meet the Eligibility requirements for the specialty program that that they are applying for will be considered.
2. Applicants must use ERAS to submit supporting credentials directly to the program director.
3. These include:
    a. Application form
    b. Letters of recommendation
    c. Medical school performance evaluation / Dean's letter
    d. Medical school transcript
    e. Personal statement
    f. USMLE transcript
    g. ECFMG status report (for graduates of foreign medical schools)

INTERVIEWS
Only applicants who have submitted all the required credentials and documents will be invited for interviews.

RESIDENT SELECTION
In the selection process involving qualified candidates seeking an initial Graduate Medical Education position, or a position in an advanced Graduate Medical Education program that participates in one of the "specialty" matching programs, the programs will participate in and abide by the rules and regulations established by the National Resident Matching Program and/or the applicable specialty-matching program.

Applicants must submit all required documentation to the Office of the Residency Program prior to the start of residency training. Any delays in the submission of this information may result in a delay of the resident's starting date or retraction of the offered position.

- Programs will select residents from among eligible candidates based on residency related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.
- **Program Directors** must have their residency-specific criteria approved annually by the DIO and GMEC prior to the beginning of the interview process.
- **Programs will not discriminate** with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status as required by the ACGME.
- In adherence with the CMESL culture of Diversity, and the ACGME’s efforts to promote recruitment and retention of minorities underrepresented in medicine and medical leadership; all programs must document and report to the GMEC their efforts to recruit and retain a diverse workforce.

	Policy # 13	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ONBOARDING OF NEW RESIDENTS

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed every five years from effective date August 1, 2024

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the process of the residents onboarding and agreement of appointment or residents' contracts.

POLICY. The Sponsoring Institution must ensure that residents/fellows are provided with an adequate onboarding process which provides a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program. The Sponsoring Institution must monitor each of its programs regarding the onboarding process and implementation of terms and conditions of appointment.

The contract/agreement of appointment must directly contain or provide a reference to the following items: resident/fellow responsibilities; duration of appointment; financial support for residents/fellows; conditions for reappointment and promotion to a subsequent PGY level; grievance and due process; professional liability insurance, including a summary of pertinent information regarding coverage; health insurance benefits for residents/fellows and their eligible dependents, disability insurance for residents/fellows; vacation and leave(s) of absence for residents/fellows, compliant with applicable laws; timely notice of the effect of leave(s) of absence on the ability of residents/fellows to satisfy requirements for program completion; information related to eligibility for specialty board examinations; and, institutional policies and procedures; including those policies concerning the resident/fellow clinical and educational work hours and moonlighting.

INTENT.
Residents/fellows are provided with a full orientation in regard the onboarding process and an explanation of the contract with the Department of Health (DOH) of Puerto Rico to be trained at Centro Médico Episcopal San Lucas Residency Programs and its affiliated institutions.

PROCEDURES

Residents receive an email communication from their Program Coordinator that will describe all the steps for the onboarding process.

Step 1: Complete the Information Form for Contract
Step 2: Application for a Puerto Rico Medical License
Step 3: Onboarding Checklist at New Innovations
Step 4: Requirements and Documents for signing the contract with the DOH
Step 5: Complete Orientation Week
Step 6: Complete Wellbeing Orientation

All meetings and scheduled activities related to onboarding are compulsory. If for any reason a resident is not able to fulfill the schedule, the program coordinator must notify the GME Office for the pertinent arrangements for the compliance of all requirements.

	Policy # 14	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	OUTSIDE/OFF-CYCLE APPOINTMENTS

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed every five years from effective date August 1, 2024

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the process of the resident agreement of appointment or residents' contracts. To satisfy ACGME Requirements. IV.C. Agreement of Appointment/Contract.

POLICY. The Centro Médico Episcopal San Lucas (CMESL), Office of Graduate Medical Education is committed to recruiting high quality applicants who meet all ACGME eligibility requirements. To achieve this, the CMESL office will provide overside of hiring applicants outside the Match or SOAP. Approval from the CMESL office must be granted before a verbal or written offer is extended to the applicant as required below.

INTENT
Provide a complete evaluation of an off-cycle resident that serves as a standard for all our programs. This procedure listed below must be followed for any ACGME training program that accepts a trainee outside of the NRMP.

PROCEDURES

1. Must follow Policy #11 of this manual for the purpose of recruitment.
2. The Program Director and at least one another faculty member must interview the applicant.
3. The Program Director must request the **CCC minutes** of the off-cycle applicants from previous residency training (if applicable).
4. Once the program director has evaluated the candidate, prior to offering the position the Program Director **must** submit a written approval request to hire to the CMESL Office of Graduate Medical Education. This written request must include the following documentation.
    - Written justification for selecting the applicant outside the match services applicable.
    - Fill Outside Match Approval Request Form
    - Applicant's complete application including
        - CV
        - Medical School Transcript or ECFMG Certificate
        - USMLE scores (Step 1, Step 2, Step 3)
        - Personal Statement
        - Dean's Letter of Summary of Clinical Performance
        - Letters of Recommendation to include letters from any prior GME training.
        - Puerto Rico States Professional License
        - Copy of health insurances
        - ASUME Certification
        - Certificate of Good Standing – Puerto Rico
        - Immunizations
5. Once the GME Office has approved the candidate, the Program Coordinator will start the onboarding process as established on Policy #12.

	Policy # 15	GRADUATE MEDICAL EDUCATION POLICIES
CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	AGREEMENT OF APPOINTMENT. RESIDENT CONTRACT
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed every five years from effective date August 1, 2024.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the process of the resident agreement of appointment or residents' contracts. To satisfy ACGME Requirements. IV.C. Agreement of Appointment/Contract.

POLICY. The Sponsoring Institution must ensure that residents/fellows are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program. The Sponsoring Institution must monitor each of its programs with regard to implementation of terms and conditions of appointment.

The contract/agreement of appointment must directly contain or provide a reference to the following items: resident/fellow responsibilities; duration of appointment; financial support for residents/fellows; conditions for reappointment and promotion to a subsequent PGY level; grievance and due process; professional liability insurance, including a summary of pertinent information regarding coverage; health insurance benefits for residents/fellows and their eligible dependents, disability insurance for residents/fellows; vacation and leave(s) of absence for residents/fellows, compliant with applicable laws; timely notice of the effect of leave(s) of absence on the ability of residents/fellows to satisfy requirements for program completion; information related to eligibility for specialty board examinations; and, institutional policies and procedures; including those policies concerning the resident/fellow clinical and educational work hours and moonlighting.

INTENT.
Residents/fellows are contracted by the Department of Health (DOH) of Puerto Rico to be trained at Centro Médico Episcopal San Lucas Residency Programs and its affiliated institutions.

RECOMMENDATION FOR APPOINTMENT.
Recommendations of appointment for continuing residents are due in the GME office no later than the first week of February of each year. All recommendations of appointments are subject to review and final approval by the Director of the Department of Graduate Medical Education,

PROCEDURES.
1. Contracts are provided for one academic year: 12 months. All contracts require full time commitment to the training program.
2. Contract renewal is contingent to satisfactory performance as certified by the Program Director, as well as to compliance with the Institution's Rules and Regulations and the Puerto Rico Board of Medical Examiners Regulations and Code of Ethics.
3. The maximum time for contract within a specialty is the total length of training (timeframe) established for each program.
4. When an additional training period is required over and beyond the established length of training, the resident will be contracted for additional time with a nominal salary.
5. Residents who do not complete the established minimum length of training, will not be certified regardless of the reasons for non-compliance.

	Policy # 16	GRADUATE MEDICAL EDUCATION POLICIES

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	PROMOTION, NON-PROMOTION AND DISMISSAL OF RESIDENTS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed every five years from effective date, August 1, 2024. Revised, Approved by the GMEC

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address Promotion of the resident appointment at the sponsoring institution ACGME-accredited programs.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements Section (IV.D). Promotion, Appointment Renewal and Dismissal.

POLICY
The Sponsoring Institution must have a policy that requires each of its ACGME-accredited programs to determine the criteria for promotion and/or renewal of a resident's/fellow's appointment. The Sponsoring Institution must ensure that each of its programs provides a resident/fellow with a written notice of intent when that resident's/fellow's agreement will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed. The Sponsoring Institution must have a policy that provides residents/fellows with due process relating to the following actions regardless of when the action is taken during the appointment period: renewal, non-renewal, non-promotion; or dismissal.

INTENT
It is the responsibility of Program Directors to monitor the residents' performance during training and assure that they follow the institutional rules and regulations.

PROCEDURES

1. Resident or Fellow Evaluation. Each training program shall have a comprehensive resident or fellow evaluation system in place. This evaluation system shall provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. For Accreditation Council for Graduate Medical Education (ACGME) accredited programs, the assessment of Milestones for the specialty's trainees every six months by the Clinical Competency Committee (CCC) of the program is required. A component of this evaluation system will be criteria that document progressive resident performance improvement appropriate for each resident's level of training. The resident or fellow must have access to each program's evaluation/promotion criteria and policies.

2. Promotion. Each ACGME accredited program must have a policy that determines the criteria for promotion, graduation, and/or renewal of a resident's/fellow's appointment. The CCC/Education Committee will make decisions regarding each resident or fellow's promotion to the next year of training. Those decisions will be based upon the evaluation criteria developed by the program. While it is expected that trainees will promote to the next level of responsibility on a yearly basis, residents or fellows that fail to meet the program's criteria for promotion will not be advanced solely on the basis of time served.

- **To be eligible for consideration of promotion to PGY-3, a resident must have successfully completed the examination requirements necessary for permanent medical licensure (Steps I, II, and III of USMLE). In the event that a resident or fellow is accepted into a training program at CMESL at a more advanced level and has not yet met this requirement, they will have one year to successfully complete the examinations. For further details, consult policy #38.**

- A resident/fellow will be required to show documentation of examination status at the time of signature of employment contracts for PGY-2 to PGY-6. If all examination requirements have not been met by the beginning of the PGY-2 year, the program director will be notified and asked to refer the resident to the program's CCC/ Education Committee for development of a remediation plan. If all examination requirements have not been met by the beginning of the PGY-3 year, the contract for continued employment will not be offered and the resident will again be referred to the program's CCC/ Education Committee for review and recommendation.

3. Failure to Promote. If the program's CCC/Education Committee determines that the resident/fellow has not satisfied the criteria for promotion, graduation, and/or renewal, the program must then follow the procedures outlined in the CMESL Graduate Medical Education (GME) Academic Deficiency, Misconduct and Due Process Policy and Procedure (Policy #11), which includes requiring written notice of Adverse Decisions. (Adverse Decisions include any decision that results in extension of training, non-promotion, probation, suspension, non-renewal of contract, or dismissal).

Reasons for failure to promote

- Consistent failure to comply with the resident's responsibilities.
- Consistent failure to demonstrate appropriate medical knowledge or skill as determined by the program's supervising faculty.
- Failure to abide by the terms of the resident's contract of employment.
- Conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal, noncompliant with the GME or CMESL policies, procedures, and Code of Conduct, federal health care program requirements.
- Conduct threatening to the well-being of patients, other residents, faculty, staff, or the resident.

As with all actions adversely affecting a resident's or fellow's training course, the trainee has the right to appeal this decision, as outlined in the CMESL Graduate Medical Education (GME) Academic Deficiency, Misconduct and Due Process Policy and Procedure (Policy #11).

4. Contract Renewal. Prior to issuing a contract for the next period of training, the CMESL Graduate Medical Education Office must receive written direction from the program director or their designee to proceed with the contracting process for each resident or fellow.

5. Non-renewal of Contract.
In situations where a resident/fellow is not making adequate progress towards advancement to the next level of training, the program faculty may decide against renewal of the trainee's contract. In this situation, it is expected that the resident or fellow will receive at least four months advance written notice.

If the reason for non-renewal of contract occurs within the four months prior to the end of the current contract, it is expected that the program will provide the resident or fellow with as much written notice of its intent not to renew as the circumstances will reasonably allow.

Reasons for non-renewal

- Consistent failure to comply with the resident's responsibilities.
- Consistent failure to demonstrate appropriate medical knowledge or skill as determined by the program's supervising faculty.
- Failure to abide by the terms of the resident's contract of employment.
- Conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal, noncompliant with the GME or CMESL policies, procedures, and Code of Conduct, federal health care program requirements.
- Conduct threatening to the well-being of patients, other residents, faculty, staff, or the resident.

As with all actions adversely affecting a resident's or fellow's training course, the trainee has the right to appeal this decision, as outlined in the CMESL Graduate Medical Education (GME) Academic Deficiency, Misconduct and Due Process Policy and Procedure (Policy #11).

6. Automatic Dismissal. from the program may occur for a variety of serious acts. In this case the resident does not need to be on academic remediation or probation for this action to be taken. Dismissal without warning may be justified in response to specific examples of misconduct. Examples include (but are not limited to) the following:

a. lying
b. falsification of a medical record
c. violation of medical record privacy
d. being under the influence of intoxicants or drugs,
e. disorderly conduct,
f. harassment of other employees (including sexual harassment)
g. the use of abusive language on the premises (hospital or affiliated sites)
h. fighting, encouraging a fight, or threatening, attempting, or causing injury to another person on the premises.
i. If the resident is convicted of a crime as defined in Puerto Rico and/or Federal laws.
j. If the resident is listed as an excluded individual by any of the following:
    - Department of Health and Human Services Office of the Inspector General's *List of Excluded Individuals/Entities (*1)*
    - Convicted of a crime related to the provision of health care items or services for which one may be excluded under US Code, Title 42: 1320a (*2)
    - Exclusion of certain individuals and entities from participation in Medicare and State health care programs.

*1 http://oig.hhs.gov/fraud/exclusion s/exclusions list.asp: The Office of Inspector General's (OIG)
List of Excluded Individuals/Entities (LEIE) database provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

*2 https ://www.epls.gov/: The purpose of EPLS is to provide a single comprehensive list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits. The EPLS is used to keep agencies abreast of administrative, as well as statutory exclusions taken throughout the Federal Government. Actions may be taken under the Federal Acquisition Regulation (FAR) or supplements thereto, under specific agency regulations or under the Government-wide No procurement Suspension and Debarment Common Rule [68 FR 66533) or other specific statutory authority.

As with all actions adversely affecting a resident's or fellow's training course, the trainee has the right to appeal this decision, as outlined in the CMESL Graduate Medical Education (GME) Academic Deficiency, Misconduct and Due Process Policy and Procedure (Policy #11)

7. **Due Process.** A resident/fellow that receives notice of adverse decision has the right to appeal that decision as outlined in the CMESL Graduate Medical Education (GME) Academic Deficiency, Misconduct and Due Process Policy and Procedure (Policy #11).

	Policy # 17	GRADUATE MEDICAL EDUCATION POLICIES
CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	ADVERSE ACCREDITATION DECISIONS. PROGRAM CLOSURE AND REDUCTION.
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Approval GMEC: 12/2013 Update Approved by GMEC March 2021 Revised, Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address Adverse Accreditation Decisions and program closure reduction.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (IV.O.) Closures and Reductions. The Sponsoring Institution must maintain a policy that addresses GMEC oversight of reductions in size or closure of each of its ACGME-accredited programs or closure of the Sponsoring Institution that includes the following:
IV.O.1. The Sponsoring Institution must inform the GMEC, DIO, and affected residents/fellows as soon as possible when it intends to reduce the size of or close one or more ACGME-accredited programs, or when the Sponsoring Institution intends to close; and,
IV.O.2. The Sponsoring Institution must allow residents/fellows already in an affected ACGME-accredited program(s) to complete their education at the Sponsoring Institution or assist them in enrolling in (an) other ACGME accredited program(s) in which they can continue their education. (Core) July 2021/2022.

All residency programs in the CMESL are accredited by the ACGME and follow all program requirements to maintain a continued accreditation status.

If any of the programs supported by the sponsoring institution is notified of an adverse decision on accreditation status, the Program Director and/or the Graduate Medical Education Director/designated Institutional Official (DIO) have the responsibility to inform the residents and faculty of the program about the decision.

INTENT
The Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine Consortium (CMESL-PHSU SOM Consortium) abides by the ACGME institutional requirements. This policy was established to define how to proceed in the event of an adverse decision on accreditation status for any program or institution.

POLICY
Centro Medico Episcopal San Lucas, as the Sponsoring Institution, through the Designated Institutional Official (DIO), will inform the Graduate Medical Education Committee, Program Directors, Graduate Medical Education staff, and residents as soon as time permits, or no later than ten (10) days of any adverse decision on accreditation status. Every effort will be made to allow residents currently in the program to complete their education or assist the residents in enrolling in a different Accreditation Council for Graduate Medical Education (ACGME) program in which they can continue their education. Residents accepted to the program will also be informed.

Once the determination is made to reduce or close the residency program, the Sponsoring Institution must notify the Accreditation Council for Graduate Medical Education (ACGME), and the National Residency Match Program (NRMP). The Sponsoring Institution must inform these entities of the method in which the institution will assist the residents in securing a position in another accredited program. Failure to notify these entities will be viewed as an egregious violation.

If the decision of the ACGME is non accreditation of the program, and after all appealing mechanisms are used, the Program Director will do all possible arrangements to relocate in other programs all the residents that will not be able to complete their training in the program.
The Program Director shall promptly provide all the information the resident needs/request, so that the transfer is facilitated.

Any reduction in the number of residents will be done prospectively and not retrospectively to ensure that all residents already enrolled in the program complete their training, or it will assist residents in enrolling in an ACGME accredited program(s).

All recruitment commitments already made will be honored. The resident is responsible for complying with the necessary application process in the institution where he/she will be relocated. The resident must understand that the possibility of being relocated greatly depends on his/her individual qualifications and performance. This includes results in licensing examinations, In-training examinations, residency outcomes, or any other admission requirement of the program where he/she is applying to complete training. It will also depend on availability of positions in the receiving program. Evidence of arrangements made for the transfer of residents must be provided by the GME Director/DIO.

PROCEDURES.

1. All residents will be informed orally and by writing within 10 labor days of the receipt of the notification.
2. Written evidence that the residents received this information will be obtained.
3. The ACGME will be informed according to the instructions in the accreditation letter.
4. No new residents will be selected if the accreditation is withdrawn.
5. Candidates for the program will be informed about the accreditation status.
6. Results will be thoroughly discussed in the Graduate Medical Education and Consortium Committees.
7. Every effort will be made to permit trainees to finish their program with CMESL during a “train out” process. Only, when necessary, will residents already in CMESL programs be transferred to programs at other institutions to complete their training.
8. Administrative assistance will be provided to assist residents in finding a new position for a minimum of ninety (90) days from trainee notification of program closure or reduction.
9. Monetary relocation assistance, up to $2,000 per resident based on submitted expense receipts.
10. Once residency closure is achieved, all resident's files must be sent to the GME Office.
11. It is the responsibility of GME Director to oversee that this is accomplished.

Approved by the GMEC on 11-3-2003
Rev. 06/06
Closure and adverse decisions policy
Reviewed GMEC 09/2013/PD 10/24/2013/PD 10/24/2013
Approval GMEC: 12/2013
Update Approved by GMEC March 2021
Revised, Approved by the GMEC, March, 2022

	Policy # 18	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	ADJUDICATION OF RESIDENT COMPLAINTS. GRIEVANCES.
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE		Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	March 2021/2022

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

Purpose: To define institutional protocols to address residents' complaints and grievances.

This policy has been established in adherence with ACGME Institutional Requirements (IV.E), which states: "The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest".

PURPOSE
The Accreditation Council for Graduate Medical Education has established in its Institutional Requirements Section IV.E. Grievances, that the Sponsoring Institution must have a policy that summaries the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest.

INTENT
The Centro Médico Episcopal San Lucas fosters an educational environment in which a resident may raise and resolve issues without fear of intimidation or retaliation within each of the residency programs. The Residents Association serves as a forum to address issues and exchange information related to working conditions and the quality of the educational programs. CMESL-PHSU SOM Consortium also allows individual residents to present their concerns in a confidential and protected manner, implements fair policies for disciplinary actions taken against the residents and establishes fair policy for the adjudication of resident complaints and grievances.

POLICY
All GME programs at CMESL will promote fair, reasonable, efficient, and equitable resolution of concerns that may arise in the course of residency or fellowship training. CMESL prohibits retaliation against any individual who, in good faith, reports a concern or participates in the review or resolution of a concern under this policy.

Formal Grievances
Formal grievances cover extension of training, dismissal, suspension, demotion, nonrenewal, non-promotion, or any other adverse decision.

Residents are entitled to a Due Process or Grievance Hearing to appeal any adverse action taken that could result in:

- Extension of their training
- Dismissal.
- Suspension
- Demotion
- Non-renewal of a contract
- Non promotion
- Also, an individual resident or group of residents may make a written complaint with a complete description of the problem to be addressed by the Graduate Medical Education Director/DIO.

PROCEDURES.

If the resident (s) has a formal grievance or formal complaint needs to do a written statement and proceed with the following:

Step 1
- Send a written statement to the Office of the GME Director/DIO.

Step 2
- The GME Director/DIO will meet with the resident(s) within 10 (ten) working days after receiving the complaint to fully discuss it.
- The GMEC will evaluate and according to the merits of the complaint, individual meetings will be arranged with involved parties to try to resolve the issue that originates from the complaint.
- The whole process shall take not more than 15 (fifteen) labor days.
- The DIO as chair of the GMEC will send a written summary indicating how the complaint has been or will be resolved and will be sent to the resident(s) presenting the complaint within 10 (ten) working days of the last meeting with the parties.

Step 3
- If the resident(s) is(are) not satisfied with the recommendations or resolution of the complaint, they may request a Hearing (Ad Hoc committee).
- Within 10 (ten) working days after the GME Director/DIO receives the request for a hearing they (DIO and GMEC) will designate three to five members for the Hearing Panel; there must be at least one or two residents.
- No member of the panel shall have participated in the decision or action that the resident (or faculty member) is grieving about.
- In addition, if the resident requests, no member of the panel shall have previously been substantially involved in any other decision or action directly involving the resident.
- The GME Director/DIO shall designate the Panel chairperson from one of the faculty members.

Step 4
- The GME Director will schedule the Hearing to occur within 30 calendar days after they receives the request for a hearing.
- Following the hearing, the Panel will make a recommendation to the Graduate Medical Education Committee (GMEC) based on a majority vote.
- The Panel forwards its decision, which includes findings of fact and conclusions, with all documentary evidence within 15 (fifteen) calendar days after the termination of the hearing.
- After review of the Hearing Panel's recommendation in an extraordinary GMEC Meeting, the GMEC, through the GME Director/DIO will advise the resident and faculty member of the decision no later than twenty-one (21) calendar days the following the hearing.
- The GME Director provides the resident, the Program Director, and the faculty member, when applicable, with a copy of the Panel's recommendation.
- The decision of the Hearing Panel is final.

Non-Formal Grievances
In order to provide a mechanism for communicating substantive issues and concerns between residents, the administration of Graduate Medical Education programs, and CMSEL, without fear of retaliation.

PROCEDURES

- Program Directors have the primary responsibility for receiving, evaluating, and addressing concerns and complaints about any aspect of their program.

- Residents should raise issues related to their working environment and educational programs through the programs' Chief Resident(s) and Program Director.

- When residents wish to communicate concerns without disclosure of names and do not wish to speak directly to their Program Directors, they should make use of the Residents' Forum or the Institutional Virtual Suggestion Box:
  https://redcap.ssepr.org:3443/surveys/?s=AKNKCCMAX3HLWKF9

- For concerns that resist resolution via these mechanisms, residents should request a confidential meeting with the Designated Institutional Official who will try to resolve the issue in an appropriately confidential manner.

- If such concerns are not appropriate for resolution in the manner set forth in items above, the Designated Institutional Official may appoint a Grievance Subcommittee of the Graduate Medical Education Committee (GMEC):

    - one faculty member designated as chair by the DIO
    - at least one faculty member
    - at least one peer-selected resident or fellow from a different program and not associated with the grievance in any way,
    - and one member of administration.

  This grievance subcommittee will make recommendations for review and final decision by GMEC.

- The resident may present a written or oral concern to the leadership of the Resident's Association. If the Association understands it is a reasonable complaint it may present it in the next GMEC meeting or request an extraordinary meeting of the Committee. The Association representative does not need to identify the resident or residents that originated the complaint.

- If a non-formal grievance transforms to a formal grievance or is not fully resolved shall follow the procedure of a formal grievance.

Policy for the adjudication of residents' complaints
Submitted to the GMEC on 1/2004
Approved by the GMEC on 3/2004
Ratified by the CEC on *412712004*
Wording review 6/2005
Rev 06/06
Reviewed GMEC 9/2013/PD 10/24/2013
Approved GMEC 12/2013
Update approved by GMEC March 2021/2022

	Policy # 19	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	SUBSTANTIAL DISRUPTION IN PATIENT CARE OR EDUCATION.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address a substantial disruption in patient care or education, or in case of a disaster.

This policy has been established in adherence with the ACGME Requirements (IV.N.) (IV.N.1) concerning "Substantial Disruptions in Patient Care or Education: The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses administrative support for each of its ACGME-accredited programs and residents/ fellows in the event of a disaster or interruption in patient care. IV.N.1. This policy should include information about assistance for continuation of salary, benefits, and resident/fellow assignments. (July 2021/2022).

INTENT.
Following the ACGME IRs, the Graduate Medical Education Committee (GMEC) of the Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine (CMESL-PUSU SOM) Consortium has developed guidelines on how to proceed in the event of a natural disaster or catastrophic event that may adversely affect the continuation of graduate medical education programs in our institution.

POLICY.
1. The sponsoring institution residents/fellows are salaried/paid by the Department of Health of Puerto Rico. The Department of Health has communicated to us that in the event of a disaster; they will continue to pay the scholarships and stipends of the residents in order to ensure their financial support and all resident benefits.
2. The Sponsoring Institution will continue to provide all benefits and assignments for each residency program and in case of unable to provide them will do all arrangements to preserve the continuity of all benefits and provide a safe place for all residents. The designated Institutional Official (DIO) and the Programs Directors will stablish the procedure for residents to continue with all their assignments.
3. The CMESL will provide all necessary administrative and/or financial support; so that the resident may continue training in our institution or in another institution that accepts them for temporary or complete training in an ACGME accredited program. The priority will be to relocate the residents in accredited programs in Puerto Rico. If the disaster affects the whole Island, the Graduate Medical Education Director, with the collaboration of the corresponding Program Directors, will contact the ACGME and the corresponding professional organizations to seek for national support that may facilitate the accommodation of affected residents. Residents' preferences will be strongly considered in the relocation of the residents.
4. Provisional transfers may occur following ACGME policies and procedures that are in place at the time of the disaster, and after the corresponding authorization of this organization. The transfer may be permanent depending on the nature of the disaster. Once the situation is under control arrangements will be made to return the residents to their programs of origin.
5. Residents will have the responsibility to collaborate with the Program Director on the relocation arrangements. This includes the submission of the required paperwork, attendance to required interviews or compliance with other requirements that may arise to allow the temporary or permanent transfer.

   The Program Director will be responsible for submitting, with the authorization of the resident, the documents in the residents' files by the receiving Program Director and/or the performance summary reports/letters of recommendation that may be needed.

6. It will be the responsibility of the GMEC in consensus with the Consortium Committee, to determine what the best is for the residents may be able to complete their training as timely as possible but ensuring compliance with the corresponding RRC requirements.

Centro Medico Episcopal San Lucas, as Sponsoring Institution, with the direct supervision of the designated Institutional Official (DIO) has assigned responsibilities to efficiently and effectively reconstitute and restructure resident training experiences in the event of a disaster.

A. The Designated Institutional Official (DIO)/Director Graduate Medical Education should:

1. Maintain primary responsibility as the liaison between the sponsoring institution, training sites and the ACGME.
2. Coordinate all residents' clinical and educational activities during a disaster.
3. Coordinate with CMESL Human Resources, Department of Health and the consortium, in order to ensure that information is provided to residents about assistance for continuation of salary and benefits.
4. Ensure that all hospital or site-specific disaster/emergency management policies are communicated to the trainees annually.
5. Verify, with the Program Directors, the health and safety of all staff and trainees assigned to their site(s), in accordance with the hospital or site-specific emergency management policies.

B. Program Directors should:

1. Demonstrate responsibility to verify the health and safety of all trainees in their program and relay this information to the DIO.
2. Coordinate with the DIO and training sites to ensure patient care is maintained.
3. Will notify the DIO of any Work Hour exceptions that occur just prior, during and immediately after a disaster situation.
4. If needed, Program Directors, with assistance from the DIO, will arrange temporary transfers to other institutions, until the original training site is able to resume providing adequate educational experience. Program Directors will make their best efforts to ensure that each transferred trainee receives a quality educational experience at their new training site. The program director will regularly confer with the trainees and program director(s) at the site to make sure that educational needs are being met.

C. Trainees (Residents/Fellows)

1. May be needed to stay at the hospital to ensure patient care is maintained.
2. Should contact their Program Director, Supervising Faculty or Chief Residents for information regarding emergency coverage.
3. Work hours, fatigue and wellbeing will be monitored in such situations. However, trainees may be required to stay in the hospital beyond their work hour limit to maintain patient care or because it is unsafe to travel outside of the hospital.

PROCEDURES.

The responsibility of ACGME-accredited programs is that program directors should first and foremost consult and coordinate with the DIO concerning the impact of extreme emergent situations (e.g., epidemics) on resident/fellow education and work environment in accordance with institutional disaster policies. Extreme emergent situations are localized to one sponsoring institution, a participating institution, or another clinical setting. If an extreme emergent situation causes serious, extended disruption to resident assignments, educational infrastructure, or clinical operations that might affect the sponsoring institution's or its programs' ability to conduct resident education in substantial compliance with ACGME standards, the DIO will report these events to the Executive Director for the Institutional Review Committee to document the event and explain any significant variations in house staff clinical experience, case volume, or educational assignments identified in future program or institutional accreditation reviews.

A. **Designated Institutional Officer**:

1. The DIO, or designee, will immediately notify the ACGME of the occurrence of a disaster at a training site. Upon notification from the DIO or designee, the ACGME Chief Executive Officer will make a

declaration of a disaster. A notice of such will be posted on the ACGME website with information relating to the ACGME response to the disaster.

2. The DIO will convene the Graduate Medical Education Committee (GMEC) as soon as is safely possible and other appropriate institutional leadership to ascertain the status and operating capabilities of all training programs. If training facilities are damaged and unable to continue operations, the GMEC will make a recommendation as to continuation of training.
3. Within ten days after the declaration of a disaster, the DIO will contact the ACGME to discuss the due dates that the ACGME will establish for programs to:
    a. Submit program reconfigurations to the ACGME; and,
    b. Inform each trainee of any transfer decisions. The due dates for submission shall be no later than thirty days after the disaster unless otherwise approved by the ACGME.
4. The DIO may contact the Executive Director of the ACGME Institutional Review Committee with information and/or requests for information.

B. **Program Directors with assistance from the DIO**:

1. Assist trainees in obtaining permanent transfers to other institutions, if needed, in order to continue and complete their training.
2. If a transfer to another institution is necessary and if more than one institution is available, the Program Director will consider the educational needs and preferences of each trainee and make their best efforts to find an appropriate training site. Programs must make these transfer decisions expeditiously to maximize the likelihood that each trainee will finish their training in a timely fashion.
3. At the onset of a temporary resident transfer, the program must inform each transferred trainee of the minimum duration, and the estimated duration of their temporary transfer and continue to keep each trainee informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a training year, it must inform each such transferred trainee. Transferred trainees are allowed to return as soon as the institution is operational, or they may stay at the transferred institution for a reasonable length of time, to maintain a continuum of education.
4. The Program Director should call or email the appropriate Review Committee Executive Director with information and/or requests.

C. Trainees.

1. Trainees should contact their program director as soon as reasonably possible to verify their safety, current/anticipated location, and any changes to their contact information.
2. Trainees shall follow hospital and departmental protocols to ensure that adequate provisions are made for patient care.
3. All transferred trainees should refer to instructions on the ACGME Web Accreditation System to change trainee email information

Prior to the Event.

1. A list of all residents and faculty member with their names, physical address, two phone numbers with the purpose of contacting them post disaster and to be able to bring them to the hospital. Programs are required to keep an updated electronic and hard copy contact information list for their faculty and House staff to be reviewed annually or as necessary updates are made.
2. Document Storage: Maintain backup copies of the database on an independent server
3. If resident place of living is not safe, transfer him/her to a safe place and notify family.
4. Help resident with his/her immediate family to make sure he can continue with his education without worrying about their safety.
5. Each residency program will have an attending in-house every day and night, a schedule must be done and given also to the Hospital Staff and Medical Director.
6. Evaluate rest areas.

7. Each residency program will bring three teams to stay-in as a back-up plan the day prior to a natural event. This will provide enough residents per shift and maintain their work hours no more than 24 hours every third day.
8. In regard to their meals and water, the hospital provided them. But still food, snacks and water should be collected in each residency program for at least five days.

9. Residents that were on rotations out of CMESL will be notified and instructed in regard to safety and to report to the hospital as soon as roads and weather allow them in a safe manner.
10. Parking lot will be evaluated, and cars will be transferred to safer areas.
11. If communication lines are down, residents will be instructed to report to the hospital as soon as the weather and roads allow them to get in a safe manner.
12. Every Morning report and ward rounds will be done with a faculty member in charge to avoid education interruption.
13. Daily evaluation of the necessities, fears and well-being of residents and faculty.
14. Psychological/spiritual support will be available as needed and will be provided by the Sponsoring Institution or any other facility.

During the Event

1. Each resident will have the appropriate rest and meal.
2. Ward rounds will continue operative.
3. Urgencies will be prioritized.
4. Assist the Intensive Care Unit and the code team as necessary
5. Do not go out of hospital during the event
6. Hospital Staff, Medical Director, GME Director and representative of each department will have meetings at 8 am, 5:30 pm and 11 pm every day for at least the first two weeks post event and then daily until all services are reestablished.

After the Event

1. The DIO will call a meeting with the Chief Residents and Program Directors to determine if interruption of house staff training is necessary due to disaster. The meeting will include consideration of expanding resident responsibilities/duties as appropriate to assist in the event of a disaster.
2. Stipends: In case their payroll from the Department of Health is affected, CMESL will provide stipends to ensure resident/fellow benefits.
3. Benefits: All benefits should continue.
4. Reporting: All residents will continue their daily report during disaster response and recovery. Master rotation program schedules will be reassessed as needed.
5. DIO and program directors will work to provide the necessary elements for residency/fellowship education as provide alternatives rotations and electives, sufficient faculty, adequate patient volume appropriate faculty supervision, attention to resident safety and comfort, and but to limited to work hours in conformance with ACGME requirements.
6. If necessary, Program Directors will arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows. Program Directors will be responsible for ensuring pertinent information from each resident/fellow file is supplied to the Program Director of the receiving institution.
7. If determined to be a long interruption, Program Directors will cooperate in and facilitate permanent transfers to other programs/institutions. Programs/institutions will make the keep/transfer decision expeditiously to maximize the likelihood that each house staff will timely complete the academic year.
6. Inform each transferred house staff of the minimum duration of his/her temporary transfer and continue to keep everyone informed of the minimum duration. If a program decides that a temporary transfer will continue to and/or through the end of an academic year, the resident must be informed.

Reviewed and approved GMEC: June 19,207
Reviewed GMEC: September 18, 2013/
PD 10/24/2013
Approved GMEC; 12/2013
Update approved by GMEC March 2021

	Policy # 20	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	PROFESSIONAL MEDICAL LIABILITY COVERAGE
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Effective Dates & Updates**	Reviewed and translated 10/2013/PD 10/24/2013 Approved GMEC: 12/2013 Update approved by GMEC March 2021/2022 Updated August 2023

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution . Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to ensure the provision of professional liability for residents/fellows.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education Institutional Requirements (ACGME) (IV.F.) Professional Liability Insurance Institutional Requirements. IV.F.1. The Sponsoring Institution must ensure that residents/fellows are provided with professional liability coverage, including legal defense and protection against awards from claims reported or filed during participation in each of its ACGME-accredited programs, or after completion of the program(s) if the alleged acts or omissions of a resident/fellow are within the scope of the program(s).
IV.F.2. The Sponsoring Institution must ensure that residents/fellows are provided with:
IV.F.2.a) official documentation of the details of their professional liability coverage before the start date of resident/fellow appointments; and,
IV.F.2.b) written advance notice of any substantial change to the details of their professional liability coverage. July 2021/2022.

BACKGROUND
Residents enrolled at the Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine Consortium are employed by the Department of Health of the Commonwealth of Puerto Rico. As such, they are covered by the state Law #94-2023, which provides medical liability immunity to all physicians employed by the Government of Puerto Rico. It has been established by the legal advisors of the Department of Health of Puerto Rico that this coverage applies to physicians in training working in private institutions as part of their training. To access the official documents of mentioned law click the following link: Law #94-2023.

PROCEDURES
In the event of receiving a medical liability claim, the resident will receive legal assistance from the Department of Justice of Puerto Rico. When a notification for a claim is received the resident shall proceed as follows:

- As soon as the resident receives the legal claim, the GME Office must immediately notify them with a copy of the legal claim.
- The GME Office will contact the Legal Department of CMESL and the Department of Justice of Puerto Rico.
- If the Department of Justices and/or the Legal Department of CMESL require further information they shall contact the GME Office.
- **Under any circumstances the resident shall meet by themselves with any legal counselor or legal firm without the acknowledge, presence and/or consent of the Legal Department of CMESL and/or the Department of Justice**.

The Graduate Medical Education Director will notify the Centro Médico Episcopal San Lucas Legal Counselors and administrative officers of any legal action notification to residents to facilitate communication between all parties. This coverage is provided by law and is not a liability insurance purchased by a private entity. Therefore, residents are covered for any event that may occur during their training, regardless of the length of training or the date when the claim is received. Therefore, is no need for "tail" coverage.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 21	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	PATIENT TRANSFER OF CARE TO ANOTHER INSTITUTION BY RESIDENTS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Aprobado CEMG 4/10/2003 Ratificado par el Comité Ejecutivo 5/2003 Translation and Modifications Approved by the GMEC on June 8, 2006 Revised and Approved by the GMEC in November 2011 Update approved by GMEC March 2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address patient transfers of care provided by residents to another institution.

Residents are defined as any intern, transitional year resident or categorical resident affiliated to a Graduate Medical Education Program. This policy refers to residents in the programs of the Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine Consortium.

Types of Patient Transfer:
• Among hospitals, either at a short or long distance (admitted patients, bed to bed transfer).
• From the Emergency Department to other institutions (not admitted patients).

Conditions for Transfer:
• Patient with minimal conditions.
• Non-surgical patients.
• Patient needing intensive care: with mechanical ventilation and/or hemodynamic instability.
• Trauma or Surgical patient.

Responsibilities:
- Patient's primary physician is responsible for patient transfer. Adequate medical equipment and supporting staff must be used, commensurate with the patient's medical condition.
- The authorization to use residents for a transfer will be given by the Chief Resident or the Chief of the on-duty resident team only after consultation with the Residency Program Director and upon request from the primary physician. It will be subject to the resident's level of training and availability.
- The qualifications (skills, PGY level of training) required for transfer will be determined by the Program Director based on the patient's medical condition, including its hemodynamic stability, the use of supportive equipment, or other, for example, a critically ill patient in mechanical ventilation and using inotropic agents, must be transferred by a PGY-2 or higher level, with ACLS training.
- Non-Surgical Patients: Selection of residents must be based on the residents training area. For example, pediatric residents must transfer pediatric patients; obstetrics-gynecology residents must transfer Obstetrics and Gynecology patients, etc.)
- Trauma or Surgical Patients: must be transferred by the Surgery resident after consultation with the corresponding faculty or primary care physician (attending).
- Patients in the Emergency Room Department (not hospitalized patients):
  - These patients are the responsibility of the Emergency Medicine Department and not of the residents from any specific program.
  - If a resident is a trainee from the Emergency Medicine Program, or is rotating in the Emergency Medicine Department, and the transfer occurs within the resident's working shift, the resident may transfer the patient within the resident's working shift. The resident may transfer the patient provided so the rest of this regulation is fulfilled.
  - The transfer by the resident must be authorized by the Emergency Medicine specialist in charge at the time of the transfer, or by the Emergency Medicine Program Director, who must ensure that the resident has developed the competencies to assume the transfer safely and effectively.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 22	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RELATIONS WITH PHAMACEUTICAL INDUSTRY/MEDICAL DEVICES VENDORS. ACCEPTANCE OF GIFTS. GRANTS.
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address relations with vendors from Pharmaceutical Industry and Medical Devices companies.

This policy has been established in adherence with the ACGME Institutional Requirements Section (IV.L.) concerning "Vendors: The Sponsoring Institution must maintain a policy that addresses interactions between vendor representatives/corporations and residents/fellows and each of its ACGME-accredited programs. (Core) July 2021/2022.

INTENT

Due to concerns about potential conflicts of interests between medication/medical devices companies and physicians, the AMA has set-up specific guidelines about appropriate acceptance of gifts. Specifically, pharmaceutical drug companies want physicians to prescribe their products while physicians should be most interested in what is best for their patients. As a teaching institution we do work with pharmaceutical companies to provide residents educational opportunities, for example through textbooks or lunches at noon conference.

However, this interaction is regulated by the following guidelines.

A. Policy for Accepting Gifts:

The guidelines for accepting gifts from pharmaceutical industries are based on the American Medical Association Policy for accepting gifts. An overview of the guidelines is as follows:

1. Any gift accepted by physicians individually should primarily be of benefit to patients and should not be of substantial value (under $100). Gift should not be in the form of cash and any meals should be modest. Individual gifts of minimal value are permissible if they are related to the physician's work (e.g., pens, notepads).
2. Direct or indirect subsidies to cover the costs of travel, lodging or personal expenses to attend conferences or meetings are not appropriate. However, an exception is made for funds for resident attendance at carefully selected educational conferences with moneys controlled and disbursed through an educational grant to the program.
3. No gifts should be accepted with strings attached (e.g., tied to prescribing practices)
4. Social events should be of modest value, education should account for most of the total time, and the event should facilitate discussion among attendees and/or discussion between attendees and faculty.

RULES FOR SPONSORED ACTIVITIES

1. Journal Clubs, lectures, conferences, or any educational activity will be regulated by the Pharma-code and its content will not be influenced by industry.
2. Industry representative presentations may be allowed at these events, in a manner that it does not influence the content of the educational activity or speaker selection. The presentation must not be longer than ten minutes. No products advertisements for company posters will be located inside the conference room.
3. Resident and medical students will not act as lecturers for activities sponsored by the industry.
4. It is possible to accept audio-visual materials from pharmaceutical companies for personal use only.
5. It is possible to accept samples of medicines for personal use but following the institutional handling of medical samples policy.

6. **All educational grants**: designated for residents and residency programs will be received through the Graduate Medical Education (GME) Office. The funding will be deposited in a special account administered by the GME Office and will be used only for the benefit of the residents, and faculty, following the purpose for each grant. Usual expenses from moneys from these grants include payment of board review courses, attendance of specialty national meetings, participation in activities that foster scholarly activities, research activities, educational materials, book, subscriptions, etc.

Educational Strategies:
To ensure that residents know how to appropriately relate with the pharmaceutical industry the following has been established:
1. Lectures related to the relationship between physicians and the pharmaceutical industry will be provided to new residents during the annual institutional new resident's orientation period. Faculty members and/or personnel from the Pharmacy Department will participate as resources.
2. Residency library computers will have information related to this topic, including AMA code of ethics related to Gifts to Physicians from Industry, and the Pharm Code.
3. Other topics related to Relationship between the Industry and Physicians shall be offered by the residency programs. These shall include topics that cover:

a. cost/benefits or medication prescription
b. suitable use of medications
c. differentiation of educational material from promotional material
d. handling an encounter with pharmaceutical representatives
e. handling patient's request for medications after propaganda by the industry
f. others

Discussed in CEMG 4/10/2003
Ratified by the Committee Executive 5/2003
Translated 5/2006
Translated, modified and approved by the GMEC June 8, 2006
Reviewed GMEC 9/2013/PD 10/24/2013
Approved GMEC 12/2013
Update Approved by GMEC March, 2021

	Policy # 23	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	GUIDELINES FOR THE RECEIPT AND DISTRIBUTION OF MEDICAL SAMPLES

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed for amendments.
	Effective Dates & Updates	See at the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address guidelines for the receipt and distribution of medication samples.

The Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine Consortium has developed these guidelines to manage the receipt and distribution of medication samples that residents and faculty members that are part of the teaching staff receive from representatives of the pharmaceutical industry. The adequate handling of these medications is necessary to protect the safety of our patients, personnel, and the residents themselves. It also abides to the requirements of regulatory agencies and the corresponding organizational norm (2013).

The guidelines are as follows:

1. The receipt of medication samples from pharmaceutical representatives by the faculty members and residents is not prohibited, but medical students must not receive medicine samples at any time.
2. An educational activity orienting new residents on this policy and the relationship with the pharmaceutical industry and its representatives will be offered at the beginning of each Academic Year as part of the New Resident's Orientation Week.
3. Each Program Director must review the guidelines on the use of medical samples with the residents at least once a year.
4. Each Program Director will provide guidelines to their residents and faculty members as to the handling of medication samples within their respective departments.
   The following general guidelines must be followed:
   a. Establish mechanisms to assure that no medication sample gets to patient service areas.
   b. Residents and faculty members must take samples for personal use at home and may not keep them in the resident room or any clinical area.
   c. Medication samples that are destined for patient use must be stored and dispensed by the Hospital's Pharmaceutical Services Department according to their rules and regulations.

5. Distribution of medication samples:
   a. Medication samples must not be distributed to patients by pharmaceutical industry representatives.
   b. Only faculty members or residents under their supervision can recommend the use of medication samples on their patients in the following ways:
      i. Medication samples to be distributed to patients under a faculty members care: These samples should be sent to the Pharmaceutical Services Department accompanied by a letter informing the pharmacist of their intended future use.
      ii. Medication samples to be used by a particular patient under the faculty member's care. These samples must be sent accompanied by a physician prescription that includes:
         - Name and age of the patient Date
         - Diagnosis
         - Quantity
         - Duration of treatment
         - Dosing instructions
         - Physician name and signature
      iii. Medication samples to be used in a hospitalized patient under the faculty member's care in special circumstances. These samples will be handled according to the Pharmaceutical Services Department Policy on Out of Formulary Medications.

6. **Dispensing**

a. The hospital pharmacist will dispense the samples to the patient after verifying identity and quality of the product.

b. The hospital pharmacist will dispense the medication following all applicable norms and at no cost to the patient.

7. Regarding In-service activities by pharmaceutical representatives, where medication samples are distributed to residents and other physicians, the following procedures apply:

a. These activities must be approved by the Program Director. A Chief Resident or a Program Director designee must coordinate the activity.

b. In-service activities must not interrupt teaching or patient service activities.

8. Activities will be done in an area identified by the Program Director as the most appropriate so that day-to-day responsibilities in patient care are not interrupted.

9. All CMESL residents, teaching staff, personnel, medical students, and pharmaceutical representatives will be oriented about this policy.

Reviewed GMEC: 9/18/2013
PD 10/24/2013
Approved GMEC: 12/2013
Update approved by GMEC March 2021

	Policy # 24	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	NON-COMPETITION – NON-RESTRICTIVE COVENANTS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Effective Dates & Updates**	Updates performed as per institutional policies March 2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE.
To define institutional protocols to address non-competition or non-restrictive covenants.

This policy has been established in adherence with the ACGME Institutional Requirements (IV.M.) Non-competition: The Sponsoring Institution must maintain a policy; which states that "neither the Sponsoring Institution nor any of its ACGME accredited programs will require a resident/fellow to sign a noncompetition guarantee or restrictive covenant. (Core) July 2021

BACKGROUND

The ACGME prohibits any sponsoring institution from requiring residents or fellows to sign a noncompetition clause or restrictive covenant as part of their employment contract.

POLICY

Centro Medico Episcopal San Lucas, as the Sponsoring Institution, nor any of its ACGME-accredited programs, will require a trainee to sign a restrictive covenant or non-competition guarantee as part of his or her resident contract.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	RESIDENT ASSIGNMENT TO CORE AND NON-CORE TEACHING STAFF (VOLUNTARY) FACULTY
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies Update approved by GMEC March 2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE.

To define institutional protocols to address residents' assignments to non-core teaching staff – faculty.

POLICY.

Resident assignment to Core Faculty
CMESL has faculty members that serve as Core Faculty to the residents; all of them **receive financial compensation** from the Sponsoring Institution. These faculty members are committed to the education of residents and dedicate specific amount hours per week to the teaching activities and administration of the program according to the applicable ACGME Program Requirements.

The Program Director has the responsibility of identification, assignment of core teaching staff faculty members and provision of information about their roles and responsibilities, as well as the objectives to the education of residents. Core Faculty (Voluntary) must serve as role model to the residents and must abide by the Program Director guidance and ACGME Program Requirements.

Resident assignment to Non-Core Faculty (Voluntary)
CMESL has several faculty members that serve as Non-Core Faculty (Voluntary) to the residents, **none of them receive financial compensation** from the Sponsoring Institution. These faculty members are committed to the education of residents and dedicate several hours per month to the teaching activities of the program.

The Program Director has the responsibility of identification, assignment of non-core teaching staff faculty members and provision of information about their roles and responsibilities, as well as the objectives to the education of residents. Non-Core Faculty (Voluntary) must serve as role model to the residents and must abide by the Program Director guidance.

Residents will evaluate and follow up patients of the selected faculty in the same manner as patients of the core teaching staff. All faculty involved in the teaching, including the non-core teaching staff, will be evaluated by the residents and the Program Director at least annually.

Approved by the GMEC on 11-3-2003 Policy on resident assignment to non-core teaching staff
Reviewed 6/07
Reviewed GMEC: 9/18/2013/PD 10/24/2013
Approved GMEC:12/2013
Update approved by GMEC March 2021

	Policy # 26	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	FATIGUE MITIGATION AND MONITORING

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of the policy

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address fatigue mitigation guidelines and to monitor fatigue.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (III.B.5.) Clinical Experience and Education.
III.B.5.a) The Sponsoring Institution must oversee:
III.B.5.a). (1) resident/fellow clinical and educational work hours, consistent with the Common and specialty-/subspecialty specific Program Requirements across all programs, addressing areas of non-compliance in a timely manner;
III.B.5.a). (2) systems of care and learning and working environments that facilitate fatigue mitigation for residents/fellows; and,
III.B.5.a). (3) an educational program for residents/fellows and faculty members in fatigue mitigation. (Core) July 2021

INTENT
The Centro Medico Episcopal San Lucas, as Sponsoring Institution has the duty with the faculty and residents to be educated and recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

POLICY
The GME Office has developed an educational program common to all residency programs in monitoring fatigue and sleep deprivation. Lectures are offered every academic year. Residents and faculty members are educated in the monitoring and recognition of fatigue and sleep deprivation.

They are also instructed in the available procedures to report any signs of either fatigue or sleep deprivation to the Program Director or Graduate Medical Education administrators.

PROCEDURES
- Work hours must be monitored at GMEC Meetings and deficiencies identified and attended by the Program Director as they occur. The GME Director will collate the results of the Resident Surveys regarding work hour compliance for the presentation to the GME Committee and the Consortium Committee.
- The GME Director will make general recommendations for correction of all problems.
- It is the responsibility of the Program Director for final specific corrective policies for all problems detected by the Resident Survey.
- Each of the residency programs must:
  - Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.
  - Educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
  - Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
  - Must have a process to ensure continuity of patient care if a resident may be unable to perform his/her patient care duties.

• Residents are strongly encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 PM and 8:00 AM, is strongly recommended.

Resident lounges
Residents' lounges are accessible and located within the hospital. Lounges are equipped with microwaves, refrigerators, coffee makers, and water supplies, utensils, sitting and snacks.

Residents resting rooms / on-call rooms
Resting facilities are located within the hospital. Resting rooms equipped with beds, lockers to keep their belongings and desks.

Fatigue Mitigation transportation – in the event a resident is too fatigue to drive home safely at the end of shift, the resident has the following options:

1. Sleep in an available resting room until able to drive safely.
2. Notify the program coordinator or GME Office to get a taxi or any other transportation.
3. Access an app-based transportation service for round trip transportation to their verifiable home address from a rotation site. Use of these transportation services and/or reimbursements for any other purpose may result in discipline and an obligation of repayment by the resident to CMESL.

Lactation accommodation
Please consult the Policy #43 of this House Staff Manual.

After hours food
The cafeteria provides its services from Monday to Sunday from 6:00am to 7:00pm. Snacks and water are available in the pantry of each residency program.

Policy on monitoring fatigue
Submitted to the GMEC on 1/2004
Revised:6/06
Reviewed GMEC:
9/18/2003/PD 10/24/2013
Approved GMEC: 12/2013
Update approved by GMEC March 2021/2022

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	MOONLIGHTING FOR RESIDENCY PROGRAMS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of the policy

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

Purpose: To define institutional protocols related to moonlighting for residency programs.

This policy has been established in adherence with the ACGME Institutional Requirements (IV.K.) Clinical and Educational Work Hours: The Sponsoring Institution must maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements."
IV.K.1. Moonlighting: The Sponsoring Institution must maintain a policy on moonlighting that includes the following: IV.K.1.a) residents/fellows must not be required to engage in moonlighting;
IV K.1.b) residents/fellows must have written permission from their program director to moonlight;
IV.K.1.c) an ACGME-accredited program will monitor the effect of moonlighting activities on a resident's/fellow's performance in the program, including those adverse effects may lead to withdrawal of permission to moonlight; and, IV.K.1.d) the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows.

BACKGROUND
Moonlighting is defined as working at another job, often at night, in addition to one's fulltime job. In residency programs, Moonlighting refers to on duty work, outside regular working hours, not related to the regular on duty hours assigned by the residency program, that are done in or out or the hospital, for which a resident receives compensation mostly, financial.

POLICY
The Graduate Medical Education Committee (GMEC) of the Centro Médico Episcopal San Lucas-Ponce Health Sciences University School of Medicine (CMESLPHSU SOM) Consortium does not foster any activity that may affect the academic or clinical performance of the residents including moonlighting. Participation in moonlighting, especially without authorization, may endanger residents and their patients. For this reason, moonlighting by the residents **is not authorized** for categorical and transitional residents. This is only allowed for the Cardiovascular Disease Fellowship Program (Refer to the Moonlight Policy for Fellows).

Residents must inform the Program Director and the Graduate Medical Education Director about any employment outside the hospital and the time spent in such duties. Violation of these rules will lead to suspension from the program, for one month, and is subject to the sanctions established by law in Puerto Rico. Repetition of the violation will lead to dismissal from the program.

Revisado y aprobado pro CEMG, 7 de mayo de 2001
Segunda revisión junio 2002
Revisado y enmendado por el CEMG 4/10/2003
Ratificado por el Comité Ejecutivo 5/2003
Translation to English and modifications approved by the GMEC on 6/9/2006
Moonlighting Policy 2006
Reviewed CEMG: 9/18/2013/PD 10/24/2013
Approved GMEC: 12/2013
Update approved by GMEC March 2021

	Policy # 28	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	MOONLIGHTING FOR FELLOWSHIP PROGRAMS

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address Moonlighting for Fellowship Programs.

The Graduate Medical Education (GME) Office maintains a policy regarding professional activities outside the educational program, in adherence with the following Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements.
IV.K. Clinical and Educational Work Hours: The Sponsoring Institution must maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements.
IV.K.1. Moonlighting: The Sponsoring Institution must maintain a policy on moonlighting that includes the following: IV.K.1.a) residents/fellows must not be required to engage in moonlighting;
IV K.1.b) residents/fellows must have written permission from their program
director to moonlight;
IV.K.1.c) an ACGME-accredited program will monitor the effect of moonlighting activities on a resident's/fellow's performance in the program, including those adverse effects may lead to withdrawal of permission to moonlight; and,
IV.K.1.d) the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows.

POLICY

- This policy applies to the ACGME-accredited Fellowships Program (s) at Centro Medico Episcopal San Lucas.
- The Sponsoring Institution, Centro Medico Episcopal San Lucas, neither encourages nor discourages moonlighting.
- Our Graduate Medical Education Policy in regard Moonlighting states that is prohibited to all residents except for the Fellowships Program.
- Moonlighting is not permitted under a J-1 VISA.
- All fellows participating in moonlighting must first complete a Moonlighting Request form and obtain approval and signature by their Program Director and the Director of GME prior to undertaking such activity. Moonlighting Request forms are available at the GME office.
- Internal moonlighting is defined as any moonlighting that occurs the Centro Medico Episcopal San Lucas (CMESL)
- External moonlighting is prohibited. External moonlighting is defined as any moonlighting that occurs outside CMESL.
- A Fellow must have the following to participate in internal moonlighting:
    - An unrestricted, permanent license to practice medicine in Puerto Rico.
    - A permanent license is different from a training license and residents are not legally allowed to moonlight under a training license.
    - A federal DEA #. A federal DEA # is different from a training DEA # and resident are not legally allowed to moonlight under a training DEA #.
    - Fellows who moonlight within CMESL (internal moonlighting) are not covered by the Professional Liability Insurance Policy provided by the Department of Health. They must provide adequate professional liability coverage.
    - It is the Fellow responsibility to determine what level of coverage is "adequate."

All approvals for Moonlighting.

- Shall remain in force for the current academic year unless terminated by the Program Director.

- Shall automatically expire on June 30 of a given academic year.
- Renewal requests for the next academic year must be processed and approved before undertaking additional moonlighting activities.

Program Director Responsibilities.

- A prospective written approval from the Program Director and the Director of GME is required for any moonlighting activity.
- The Program must maintain a copy of the completed Moonlighting Request form, as part of the Fellow's personal file.
- The Program Director is ultimately responsible for assuring that all moonlighting activities do not interfere with the ability of the fellow to meet the goals, objectives, assigned duties, and responsibilities of the educational program. They are expected to monitor all moonlighting activities in their program on an ongoing basis.
- The Program Director may withdraw permission to moonlight if, at any time, moonlighting activities are seen as producing adverse effects on the resident's performance in the program.

Fellows' Responsibilities

- All Fellows participating in moonlighting must first complete a Moonlighting Request form and obtain approval and signature by their Program Director and the Director of GME prior to undertaking such activity.
- It is the sole responsibility of the resident to:
    - Apply for and obtain a permanent license to practice medicine to support any moonlighting activities.
    - Apply for and obtain their own Federal DEA # to support any moonlighting activities.

Work Hour Reporting

- All moonlighting activities must be reported by the resident as duty hours within the Residency work hours log in New Innovations using the appropriate task identifier:
    - Moonlighting-in-House.
- All moonlighting must be counted toward the 80-hour weekly limit on duty hours.
- Preliminary and categorical residents may not moonlight.
- Only Fellows are candidates to do moonlighting.
- Fellows employed under a J-1 visa are strictly prohibited by law from participating in moonlighting activities.
- Residents employed under an H1-B visa may be able to moonlight under specific, very limited circumstances.

Violation of these moonlighting rules and procedures by the Fellow may lead to disciplinary actions.

GME Office Responsibilities

- The GME Office must maintain a copy of the completed Moonlighting Request form as part of the resident's personnel file.

Appendix GMEC Approved March 2021

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #29	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	HEALTH AND DISABILITY INSURANCE
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	See at the end of this policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

Purpose: To define institutional protocols to ensure the provision of health and disability insurance.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (IV.G.) Health and Disability Insurance.
IV.G.1. The Sponsoring Institution must ensure that residents/fellows are provided with health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. IV.G.1.a) If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired.
IV.G.2. The Sponsoring Institution must ensure that residents/fellows are provided with disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. IV G 2. A. If the first day of disability insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired.

POLICY
The acquisition of Health Insurance coverage is required of all residents on admission to the Program and is fully subsidized through the Department of Health contract.

The CMESL as the Sponsoring Institution complies with the Americans with Disabilities Act (ADA) of 1990, as amended, which protects qualified applicants with disabilities from discrimination in hiring, promotion, discharge, pay, training, fringe benefits and other aspects of employment based on disability. The Department of Health provides disability insurance as part of their annual contract.

PROCEDURE – HEALTH INSURANCE
1. All residents must provide evidence of the health insurance prior to admission to the residency program.
2. The Department of Health will be subsidized with $150 (this will cover the acquisition, monthly payment of private health insurance).
3. If the resident does not want private health insurance, they can request public health insurance for free.

PROCEDURES – DISABILITY INSURANCE
Every year, when a resident signs a new contract, the disability insurance is automatically renewed as part of their benefits.

Resident with Disabilities Policy
Approved by the Graduate Medical Education Committee
June 19, 2007
Revised August 21, 2007
Reviewed GMEC: 9/2013/PD 10/24/2013
Approved GMEC:12/2013
Update approved by GMEC March 2021

	Policy #30	**GRADUATE MEDICAL EDUCATION POLICIES**

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	ACCOMODATIONS FOR RESIDENT WITH DISABILITIES
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated and approved as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address accommodations for residents with disabilities.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements: IV.I.4. Accommodation for Disabilities: The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations.

POLICY

Centro Médico Episcopal San Lucas and its Office of Graduate Medical Education is committed to a policy that ensures that persons with disabilities are not unlawfully discriminated against, and is committed to guaranteeing equal opportunities, and equal access to all the rights and privileges enjoyed by those who are not disabled.

CMESL will comply with all provisions of the Americans with Disabilities Act of 1990 and will provide, upon request, reasonable accommodations to qualified individuals with a disability.

PROCEDURE

Resident must require reasonable accommodations by submitting a written request to the Program Director and DIO. This request will be evaluated and confidentially discussed with the Human Resources Department and the GMEC for the adequate procedure to be conducted.

	Policy #31	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	PHYSICIAN IMPAIRMENT

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address physician impairment.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (IV.I.2.) Physician Impairment: The Sponsoring Institution must have a policy, not necessarily GME-specific, which addresses physician impairment.

BACKGROUND. Physician impairment has the potential to be injurious to patients and harmful to the trainee's education and future career plans. To address impairment, as well as to ensure the safety of the patients and trainees, this policy outlines and describes the roles and responsibilities expected from Program Directors, Trainees, Faculty, and Staff, and the procedures for identification, assessment, treatment, and potential reintegration of impaired trainees (residents/fellows).

DEFINITIONS
Physician Impairment: As defined by the American Medical Association (AMA), physician impairment is any physical, mental, or behavioral disorder that interferes with the ability to engage safely in professional activities.

POLICY
Confidentiality: The Office of Graduate Medical Education, the DIO and the program staff and faculty will confidentially maintain all records, files and other information related to issues of impairment.

Documentation: All activities related to impairment are conducted pursuant to Peer Review.

Reporting Responsibilities: Any CMESL employee, medical staff member, or resident who has reasonable concerns or significant information that patient care is currently being affected or could be affected by a possible trainee's impairment, he/she has the responsibility to report those concerns to the program leadership.

PROCEDURES

1. Faculty, staff, peers, or other individuals who suspect a House staff may be impaired are obligated to report their concern.
2. Individuals may report these concerns to the Program Director, Department Chair or the Designated Institutional Official.
3. If there is concern regarding patient safety, the resident should be immediately removed from the clinical setting and the program must follow their internal policies on adequate transition of care to ensure patient safety. Resident benefits will remain.
4. House staff are required to submit to reasonable suspicion drug and/or alcohol testing.
5. Resumption of patient care and residency program activities may be contingent upon approval and continued compliance with treatment.
6. Programs may refer the resident for a fitness for duty assessment before return to work is granted.

	Policy #32	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	NON-DISCRIMINATION

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updated Approved by the GMEC, March, 2022

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address non-discrimination protocols.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirement (IV.I.5.). Discrimination. The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. 2021/2022

INTENT
Centro Medico Episcopal San Lucas is committed to providing an Equal Employment Opportunity (EEO) to all its employees, including its residents/fellows.

POLICY
Discrimination on the basis of race, religion, national origin, age, disability, veteran status, marital status, sex, sexual orientation, gender identification or any other basis protected by federal, state or local law, including verbal or physical harassment on the basis of any of the above characteristics, is prohibited and will not be tolerated. Such prohibited harassment includes unwelcome sexual advances or comments; ethnic jokes; ethnic, racial, religious, or age-related slurs; and other similar conducts/behaviors.

Please refer to the CMESL Policy on Discrimination

	Policy #33	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	CLINICAL AND EDUCATIONAL WORK HOURS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Effective Dates & Updates**	Updates performed as per institutional policies Updated/Approved March, 2021/2022

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address clinical and educational work hours off residents/fellows.

This policy has been established in compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (IV.K.) Clinical and Educational Work Hours. The Sponsoring Institution must maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements. July 2021/2022.

CPR. (VI.F.) Clinical Experience and Education. Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities. Including (IV.F.1.) Maximum Hours of Clinical and Educational Work per Week. (IV.F.2.) Mandatory Time Free of Clinical Work and Education. IV.F.3. Maximum Clinical Work and Education Period Length. (IV.F.4.) Clinical and Educational Work Hour Exceptions. 2021/2022.

This policy addresses the ACGME Institutional and CPR. Specialty-Specific Review Committees could implement additional work hour limits or standards for their specialty-specific programs' requirements.

Definition. Clinical Experience and Educational Work Hours: Clinical and academic activities, patient care, administrative responsibilities related to clinical care, transfer of patient care, time spent in-house during call activities, attendance to academic activities and conferences.

INTENT

The Centro Médico Episcopal San Lucas is committed to protect the well-being of our residents and is aware of the need to regulate and monitor their work hours. The results will include less fatigue of residents, and more effectiveness to deliver safe patient care; minimizing the possibility of medical errors, and providing residents with an adequate time for self-studying and leisure activities. The learning objectives of the program should not be compromised by excessive reliance on residents to fulfill services' duties. Didactics and clinical education put special emphasis on the allocation of the resident time and energy. The work hour guidelines recognize that either, faculty and residents, must hold responsibility for the safety and welfare of patients.

The CMESL abides to the recommendations provided by the ACGME, AMA and the Puerto Rico Legislature related to Residents Work Hours. These policies have been updated in concordance with the ACGME up-to-date work hour standards effective on July 1, 2021, and through the revision of the CPR/work hours standards to be effective in July, 2022.

POLICY

- Each ACGME-accredited program leadership at the sponsoring institution should be familiar and fully compliant with these requirements, procedures and monitoring process of work hours.

- If one program identifies residents' non-compliance with the requirements, the leadership is required to submit a report to the GMEC, accompanied by an action plan addressing the areas of non-compliance (remediation).
- The GMEC will continue the monitoring for a period of time until remediation. The GMEC will also investigate and monitor complaints concerning work hours from surveys or other sources.
- The recurrency of non-compliance by a program, concerning clinical and educational work hours, may meet criteria to be supervised through the Special Review Protocol.
- Each program leadership is responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours; ensuring that assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

A. PROCEDURES. GUIDELINES.
The sponsoring institution ACGME-accredited programs should adhere to the following guidelines to monitor the residents/fellows' work hours.

1. **MAXIMUM HOURS OF CLINICAL AND EDUCATIONAL WORK HOURS. CPR VI.F.1.**
a. As per Requirement: Maximum Hours of Clinical and Educational Work per Week Clinical and educational 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, clinical work done from home, and all moonlighting. So, the intern/resident/fellow shall not be assigned to work physically on duty in excess of eighty hours (80) per week averaged over a four (4) week period, inclusive of all in-house call activities and all moonlighting. VI.F.1.
b. In case that a program is authorized to Moonlighting, this activity must not interfere with the ability of the resident to achieve the goals outlined by the program. Time spent by trainees in Internal and External Moonlighting must be counted towards the 80-Hour Maximum Weekly Limit. **(Please, refer to the Sponsoring Institution Moonlighting Policies for Residency and Fellowship Programs).**

2. MANDATORY TIME FREE OF CLINICAL WORK AND EDUCATION. **CPR VI.F.2.**
The program must design an effective program structure that is configured to provide residents/fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
a. Residents/Fellows should have **eight (8) hours OFF between** scheduled clinical work and education periods. VI.F.2.b.
b. 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. VI.F.2.b).(1)

3. MINIMUM TIME OFF BETWEEN SCHEDULED DUTY PERIODS
a. Residents must have at least **14 hours FREE** of clinical work and education after 24 hours of in-house call. VI.F.2.c)
c. Residents must be scheduled for a minimum of **one day in seven FREE** of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. VI.F.2.d)
*A Day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities).

4. MAXIMUM WORK HOURS PERIOD LENGTH. VI.F.3.
a. Clinical and educational work periods for residents **must NOT exceed 24 hours** of continuous scheduled clinical assignments. VI.F.3.a).
b. Up to **four (4) hours of additional time** may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. VI.F.3.a). (1)
c. Additional patient care responsibilities must not be assigned to a resident during this time. VI.F.3.a). (1). (a)

Specific Guidelines for ACGME Programs at the Sponsoring Institution:

a. Duty periods of all residents may be scheduled to a maximum of twenty-four (24) hours of continuous duty in the hospital. Residents shall not assume responsibility for a new patient or any new clinical activity after working twenty-four (24) hours of continuous in-house duty.
b. On rare circumstances, residents, of their own initiative, will be allowed to remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extension of duty are limited to reasons of required continuity for a severely ill or unstable patient, to attend unique educational activities, or humanistic attention to the needs of a patient or family.
c. Under these circumstances, the resident must:
    - Appropriately hand over the care of all other patients to the team responsible for their continuing care.
    - Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director and the office of GME.
    - The Program Director will review the submission of each additional service and track both individual and program-wide episodes of additional duty and report this to the GMEC.
    - 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.

d. All residents must have as a minimum one (1) day OFF every seven days to protect their free time and avoid fatigue. VI.F.2.d)

5. CLINICAL AND EDUCATIONAL WORK HOURS EXCEPTIONS. VI. F. 4.

a. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
    - 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.
b. These additional hours of care or education will be counted toward the **80-hour weekly limit**.
c. A Review Committee may grant rotation-specific exceptions for up to 10% percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. (VI.f.4.c).)
d. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. (IV.F.4.c).(1)).
e. Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. VI.F.4.c).(2)

6. MOONLIGHTING REQUIREMENTS/WORK HOURS GUIDELINES. VI.F.5.

a. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. VI.F.5.a)
b. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. VI.F.5.b)
c. PGY-1 residents are not permitted to moonlight. VI.F.5.c)

*Please, refer to the Sponsoring Institution Moonlighting Policies for Residency and Fellowship Programs.

7. IN HOUSE NIGHT FLOAT/WORK HOURS GUIDELINES. VI.F.6.

a. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
b. 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 of that Specialty or Subspecialty (Fellowship) program.
c. The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

Specific for the sponsoring institution:

Frequency PGY-5 Residents and above must be scheduled for in-house call no more frequently than every-third night. In-house call must not be averaged over a 4-week period.

Under certain circumstances, residents/fellows may be assigned in-house call every third night with prior approval of the program director and DME. If this occurs, it must be reported by the resident/fellow in writing and reviewed by the GMEC for monitoring individual residents and program.

8. MAXIMUM OF IN-HOUSE CALL FREQUENCY. VI.F.7.

a. Residents/Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). VI.F.7.

9. AT HOME CALL / WORK HOURS GUIDELINES. VI.F.8.

a. Time spent on patient care activities by residents/fellows on at home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to 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.
b. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. VI.F.8.a). (1)
c. When a resident returns to the hospital while on at-home call to care for new or established patients, this time is included in the 80-hour weekly maximum. However, this does not initiate a new “off-duty period.” VI.F.8.b).

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #34	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	WELLBEING POLICY
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies. Reviewed & Approved by the GMEC in 04/03/2024. Revision effective July 2024.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to ensure the wellbeing of residents and faculty.

This policy has been established in adherence with the ACGME Requirements. III.B.7. Well-Being:
III.B.7.a) The Sponsoring Institution must oversee its ACGME accredited program's fulfillment of responsibility to address well-being of residents/fellows and faculty members, consistent with the Common and specialty-/subspecialty-specific Program Requirements, addressing areas of noncompliance in a timely manner.
III.B.7.b) The Sponsoring Institution, in partnership with its ACGME accredited program(s), must educate faculty members and residents/fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents/fellows and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care.
III.B.7.c) The Sponsoring Institution, in partnership with its ACGME accredited program(s), must:
III.B.7.c). (1) encourage residents/fellows and faculty members to alert their program director, DIO, or other designated personnel or programs when they are concerned that another resident/fellow or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
(2) provide access to appropriate tools for self-screening; and,
(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
III.B.7.d) The Sponsoring Institution must ensure a healthy and safe clinical and educational environment that provides for:
(1) access to food during clinical and educational assignments;
(2) sleep/rest facilities that are safe, quiet, clean, and private, and that must be available and accessible for residents/fellows, with proximity appropriate for safe patient care;
(3) safe transportation options for residents/fellows who may be too fatigued to safely return home on their own;
(4) clean and private facilities for lactation with proximity appropriate for safe patient care, and clean and safe refrigeration resources for the storage of breast milk;
(5) safety and security measures appropriate to the clinical learning environment site; and,
(6) accommodations for residents/fellows with disabilities, consistent with the Sponsoring Institution's policy.

DEFINITIONS

Burnout: Long-term or chronic sense of exhaustion and diminished interest to work. Dimensions of burnout include emotional exhaustion, chronic fatigue, depersonalization, and feelings of inadequacy or lack of competence or success in one's work. Burnout can lead to depression, anxiety, and substance use disorders.

Resilience: Ability to withstand and recover quickly from difficult conditions or situations. During training, residents may face difficult situations during the delivery of patient care, and through educational or personal events, which can negatively affect their wellbeing and emotional stability. Decompressing after such situations, through conversation with peers, mentors or family, and self-care activities, can increase Resilience.

Well-being: State of being healthy, happy, and successful. Well-being may be positively increased by interacting with patients and colleagues at work, being intellectually stimulated and by feeling that one is making a difference/helping. In addition, it is beneficial for ourselves, to emphasize self-care activities, including exercise, getting plenty of rest and connecting with others.

INTENT

The Wellbeing Policy identifies the ways in which residents and faculty shall be supported by the Sponsoring Institution and by their program's leadership, in their efforts to become competent, caring, and resilient physicians while completing their ACGME education.

In the health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of a competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

This policy applies to Residents, Faculty, Program Directors, Program Coordinators, and Graduate Medical Education (GME) staff at HESL. This policy is implemented without fear of negative consequences for the resident who is unable to deliver patient care and will ensure the coverage of patient care in the event that a resident may be unable to perform their responsibilities.

PROCEDURE FOR GENERAL WELL-BEING ASSISTANCE

1. Residents who desire counseling, medical or mental health support services may bring it to the attention of the chief residents, faculty, program coordinators, program directors, or the Graduate Medical Education Office.
2. Faculty and program directors may also refer a resident in need of counseling. HIPAA regulations and confidentiality will always be observed. Referrals can be made either to Hospital Episcopal San Lucas Resident Counseling Services at the Behavioral Unit, the Ponce Health Sciences University Wellness Clinics and/or other community providers. Residents can access services on their own at any time using their health insurance provider list.
3. Counseling may be provided through Centro Médico Episcopal San Lucas, by providers who are not the resident's faculty, except in emergency situations, as required by law. The purpose of this counseling service is to provide and maintain a positive work environment and to provide short-term assistance to residents about several concerns that may impact on their training performance: stress, relationship difficulties, parenting issues, family illness, anger, burnout, anxiety, depression, and others. Residents must be referred to counseling services by their training program director or faculty, or the GME director.
4. Residents can confidentially discuss personal and workplace challenges in up to two (2) counseling services per issue that will be provided at no charge. Additional needed sessions may be coordinated through the residents' health insurance, as applicable.
5. Counseling discussions and records are confidential and not included in the residency training files.
6. Graduate Medical Education provides a list of appropriate counseling and mental health resources, which the resident can use at any time according to their health insurance coverage. Residents can also access services through the providers list of their health insurance company.
7. All these arrangements will be assisted by the Program Coordinator, Program Directors, or GME office to preserve and provide confidential counselling.

PROCEDURES FOR MENTAL HEALTH ASSISTANCE

1. Faculty and program directors may also refer a resident in need of counseling. HIPAA regulations and confidentiality will always be observed. Referrals can be made either to Hospital Episcopal San Lucas Resident Counseling Services. For referral to urgent and emergent care services 24 hours a day, 7 days a week, contact (787) 307-4706.
2. Please identify yourself as a CMESL resident or resident's dependent.
3. This service is entirely confidential.
4. There is no reporting to either the hospital or the department regarding individuals seeking care.
5. This service does not provide calls for emergencies. If you are presenting an emergency call 911 or go directly to our Emergency Room for an urgent referral for our Behavioral Unit evaluation.
6. Residents can access services on their own at any time using their health insurance provider list.

A. SPONSORING INSTITUTION RESPONSIBILITIES

a. Oversee its ACGME accredited program's fulfillment of their responsibility to address the well-being of residents/fellows and faculty members, in adherence with the ACGME Requirements.
b. The Graduate Medical Education Office is a safe place, where residents can ask for and receive help that support their wellbeing, including academic counseling, coaching, and mentoring.
c. Education: The Sponsoring Institution, in partnership with its ACGME accredited program(s), educates faculty members and residents/fellows in wellbeing/fatigue mitigation, counting the identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents/fellows and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care.
d. The GME Division sponsors orientations sessions for new residents and fellows, who will receive education regarding policies, access to resources and services, lectures on wellbeing, fatigue mitigation, and etiquette-based medicine.
e. Guarantee a satisfactory clinical experience, learning environment, educational work hours, and adequate clinical-academic schedules, and supports the faculty to have adequate time for teaching and supervision and for residents can achieve their assignments.
f. The consortium and the PR DOH ensure adequate benefits, vacation, time off, leave, attendance to personal appointments/PTO, maternity, health and dental insurance, accommodation for disabilities, a program for physician impairment.
g. Provide support systems and residents services, and confidential counseling services, including access to urgent and emergent care 24 hours a day, seven days a week.
h. Ensure access to resources such as wellness programs, Health Risk and Well-being Assessments, mindfulness training, health coaching, diet, and nutritional support.
i. Provide access to healthy food and beverage options, parking options, transportation options, and resting rooms.
j. Provide meal support for residents taking overnight call activity and for residents who return to the hospital to provide care.
k. Supervise that its programs and clinical departments have sufficient back-up plans to provide patient care in the event that a resident is unable to perform their patient care responsibilities.

INSTITUTIONAL RESOURCES.

The sponsoring institution provides the following resources and strategies to support the health, well-being, and resilience of our residents, fellows and faculty.
1. Provide faculty and resident/fellow employees and their families with resources and services that motivate, encourage, and promote healthy lifestyle choices while taking a proactive approach to personal well-being as well as fostering resilience.
2. Provide a variety of educational opportunities and resources, to facilitate the integration of physical, mental, and spiritual well-being; since social, emotional, spiritual, environmental, occupational, intellectual, and physical welfare are essential components of our holistic approach to wellness.
3. **The institution provide specific services to support wellbeing, including**:

a. Services provided by the Behavioral Health Division ("Salud Conductual"). The Behavioral Health Department and the Behavioral Health Unit offers psychological evaluation, counseling and lifestyle coaching.
b. Support by "Clínica de Salud del Empleado". This department provides its medical and mental health services at all residents and fellows.
c. The GME Office service to advice residents, including academic counseling, coaching, and mentoring, and resolutions of complaints.
d. Residents' Forum: "Association de Residents del Hospital Episcopal San Lucas" (ARHESL), is a group of peer-elected representatives of all residency and fellowship programs, which comes together to discuss issues affecting resident life. Promoting a harmonious and collaborative relationship amongst residents, faculty and staff, enhances the resident community through advocacy, volunteer work, and social and educational activities.
e. Residents may take advantage of reimbursed taxi/Uber/any service from the training site to home and back to the training site in the event that they are too fatigued to drive home after a clinical shift. Their program will reimburse the cost of the ride both ways.
f. All residents and core faculty must complete an annual learning module on sleep alertness and fatigue mitigation.
g. All residents and core faculty are encouraged to complete the Mayo Clinic Well-Being Index found at https://app.mywellbeingindex.org/assess. Please write *Hospital San Lucas*.
h. Residents and their spouses/significant others may obtain up to **12** hours of free mental/behavioral health counseling through a panel of community psychiatrists and psychologists.
i. Personal day per semester - As approved by the GMEC on April 3, 2024, each resident in our eight residency programs is eligible for one personal day every six months (two per academic year) to support their wellbeing. Program directors and coordinators are responsible for ensuring that this benefit is properly implemented. Residents must submit their personal day requests to their chief resident during the first month (July) and the seventh month (January) of the academic year. Approval of personal days will be granted based on availability on a first-come-first-served basis.

B. PROGRAMS RESPONSIBILITIES.

1. Education. The program should educate residents concerning Wellbeing and Fatigue Mitigation through didactics and encourage them to identify and report any burnout and wellness issues through self-screening tools, including institutional questionnaires and surveys. The program will monitor the resident's attendance to the Practice and Professionalism lectures in an annual basis.
2. Alertness Systems. Each program must ensure that any sign of impairment affecting wellbeing is alerted to the Program Director, faculty, or Chief Resident; when they have concern for themselves, or when a resident colleague or a faculty member, are displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
3. Facilitate the formal and informal discussion with residents regarding issues that may affect wellness; such as personal wellness issues; in a confidential, setting meetings with their Program Directors, Faculty or through resources available within the institution.
4. Schedules and Backup Systems. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, checkups, and emergencies. Each program must ensure coverage of patient care in the event that a resident is unable to perform their patient care responsibilities. These polices must be implemented without fear to retaliation.
5. Attendance to Appointments. Each program must ensure that residents have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Residents must follow the program's procedures for scheduling and notification of these appointments.
6. The Program Director and Program Coordinator will use administrative support for residents to minimize non-physician obligations.
7. The Program Director shall review the program achievement of wellbeing guidelines during the Annual Program Evaluation, and should review semiannually the recommendations concerning the resident's wellbeing, provided by the CCC, faculty or multiple evaluators.

8. Implement supportive and remediation plans available for residents who are burned out, depressed, or those suffering from substance abuse issues, who any resident presenting with suicidal ideations or other serious signs of mental or health issues.
9. Use Resources: Inform residents about availability and access to sponsorship programs or events concerning wellness, on a regular basis. These events must be reported to the GMEC. The programs should support retreats and activities outside the work area that will be programmed for the enjoyment of residents and staff, and to reinforce teamwork.
10. **Information to be provided by the program to the residents/fellows**:

The program will provide residents written info concerning the following:

- Access to food, meals, beverages during clinical and educational assignments.
- Access and location of sleep/rest facilities for each clinical learning site.
- Safe transportation options available and how to access them and how to be reimbursed for their use.
- Access to lactation facilities with safe refrigeration resources for the storage of breast mile for each clinical learning site.
- Safety and security measures available at each clinical learning site or participating sites.

C. RESIDENTS/FELLOWS/FACULTY RESPONSIBILITIES

- Report to their respective ACGME accredited training program, appropriately fitted for duty, and able to perform clinical duties in a safe, appropriate, and effective manner, free from the adverse effects of physical mental, and emotional impairment, including exhaustion and fatigue.

- Watch for subtle signs in themselves and other colleagues and intervene or report as needed.

- If the resident is experiencing problems, he/she is encouraged to voluntarily seek assistance before start any clinical, educational, and professional performance. Residents who voluntarily seek assistance will not jeopardize their status as a resident by seeking assistance.

- Residents are encouraged to maintain their health through routine, and necessary medical, dental, and mental health care. Residents should develop a plan for one's own personal and professional well-being. Non-urgent appointments may be scheduled in advance with appropriate permission in accordance with the GME relevant leave policy.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy # 35	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	PROFESSIONALISM
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from an effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols that ensure the implementation of the highest standards of Professionalism at the sponsoring institution and participating sites.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements III.B.6. Professionalism. The Sponsoring Institution, in partnership with the program director(s) of its ACGME-accredited program(s), must provide a culture of professionalism that supports patient safety and personal responsibility. July 2021/2022.

POLICY

1. The CMESL-PHSU SOM Consortium in partnership with its ACGME accredited Residency/Fellowship programs shall educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by patient care.
2. **Education and Monitoring**. The Sponsoring Institution must provide systems for education in and monitoring of:
   a. Residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits.
   b. Accurate achievement of required documentation by residents/fellows.
3. **Environment and Culture of Professionalism.** The Sponsoring Institution shall guarantee that its ACGME-accredited program(s) provides a professional, equitable, respectful and civil environment that is free from unprofessional behavior, including discrimination, sexual, and other forms of harassment, mistreatment, abuse, and/or coercion of residents/fellows, other learners, faculty members, and staff members.
4. **Unprofessional Behaviors Procedures**. The Sponsoring Institution, in partnership with its ACGME-accredited program(s), should maintain procedures and activities to achieve the education of residents/fellows and faculty members regarding unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns in a timely manner.

PROCEDURES

The sponsoring institution and Program Directors will ensure a culture of professionalism that supports patient safety and personal responsibility.

1. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
   a. Assurance of the safety and welfare of patients entrusted to their care.
   b. Provision of patient-and family-centered care.
   c. Assurance of their fitness for duty.
   d. Management of their time before, during, and after clinical assignments.
   e. Recognition of impairment, including illness and fatigue, in themselves and in their peers.
   f. Attention to lifelong learning.
   g. Monitor their patient care performance and improvement indicators.
   h. Truthful and accurate reporting of duty hours, patient outcomes, and clinical experience data.

2. All residents/fellows and faculty must demonstrate the following values and responsibilities:
   a. Responsiveness to patient needs that supersede self-interests.
   b. Compassion, empathy, and respect for patients, patients' families, and health team members.

c. Honesty and integrity in all interactions with patients, patients' families, staff, faculty, and administrators, as well as in any written documentation.
d. Respect and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, ethnicity, religion, disabilities, and sexual orientation.
e. Protection of patient privacy and autonomy.
f. Recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care into another qualified and rested provider. Recognize any gap in knowledge or skills that has not been still developed.

3. Teamwork

a. Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty.

VIOLATIONS OF PROFESSIONALISM

Applicable for resident/fellows, other learners, faculty, and staff members
Violations include but are not limited to:

1. Discrimination
2. Sexual Harassment
3. Other forms of harassment
4. Mistreatment
5. Abuse
6. Coercion
7. Failure to demonstrate professionalism and adherence to ethical principles.
8. Failure to be truthful in all circumstances.
9. Violation of state and federal rules/laws as standards of practice.
10. Chronic tardiness and/or failure to complete tasks in a timely manner.
11. Demonstration of unethical behavior, being offensive or rude.
12. Disregarding other team members and disrespecting authority.
13. Inappropriate behaviors with patients, families, or other members of the health care team.
14. Public or physical displays of impulsiveness and anger.
15. Failure to follow up on clinical activities and abuse of power.
16. Failure to respect policies of the sponsoring institution and participating sites.
17. Inappropriate use of property, email, and social media.
18. Unexplained absences and failure to adhere to standards and to the code of dress.

MECHANISMS AVAILABLE TO REPORT UNPROFESSIONAL BEHAVIOR

The house staff, faculty, and personnel count on several mechanisms to notify non-compliance with this policy.

1. **Program Level** – must use one or more of the following mechanisms.
   a. Notify the Chief Residents
   b. Notify Faculty Members
   c. Notify the Program Coordinator
   d. Notify the Program Director
   e. Or submit the complaint anonymously using the QR Code for the Program Virtual Suggestions Box located in each common area (resting rooms, didactics room, halls, etc.) of the program.

2. **GME Office Level** – must use one or more of the following mechanisms.
   a. Request a meeting with the Institutional Coordinator and/or the DIO.
      i. Email address: gmesanlucas@ssepr.org
   b. Or submit the complaint anonymously using the QR Code for the GME Institutional Virtual Suggestions Box. Or the following link which is also available in the Resources area at New Innovations.
      https://redcap.ssepr.org:3443/surveys/?s=AKNKCCMAX3HLWKF9

3. **Sponsoring Institution**

a. For cases of discrimination, harassment, abuse, sexual harassment, or any other situation please submit a confidential report to the Human Resources Department: Informarecursoshumano@ssepr.org
b. For cases of HIPAA, fraud and other situations related to protection of patient health information please submit a confidential report via email to: cumplimiento@ssepr.org. o assist our residents/fellows in creating a workplace that is free of retaliation when communicating inadequate supervision. Please, refer to Policy #19: Adjudication of Resident Complaints. Grievances.

PROCEDURES TO ADDRESS COMPLAINTS OF UNPROFESSIONAL BEHAVIORS

1. The sponsoring institution maintains confidential processes for reporting, investigating, monitoring, and addressing concerns related to Professionalism in a timely manner. This procedure includes participation in forums, surveys, and anonymous complaints means respecting privacy, and without any fear to retaliation.
2. Program Directors will review complaints of any source, and will follow institutional procedures to investigate, and to perform the plan of actions and remediation, with periodic reports to the GMEC.
3. Thoughtful unprofessional behaviors that may affect patient or individuals' safety, will be addressed immediately by the program and by the GME Division/Sponsoring Institution leadership.
4. Persistent problems concerning behaviors will be brought before the programs' specific evaluation group for recommendations and additional corrections.
5. If unprofessional behaviors continue and fail to be remediate at informal or previous levels, residents/fellows will be assessed by the GMEC for potential disciplinary actions.

Approved by the Graduate Medical Education Committee November 17, 2010
Effective July 1, 2011
Approved Revision March 28, 2012
Update approved by GMEC March 2021
Update approved by GMEC March 2021
Updated in May 2024

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #36	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RESIDENT SUPERVISION
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Update Approved by GMEC October 2019 Updated / Approved March, 2021 Updated / Approved March, 2022

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional procedures to address the Supervision of Residents/Fellows.

This policy has been established in adherence with the ACGME Institutional Requirements.
IV.J.1. The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows. The Sponsoring Institution must ensure that each of its ACGME-accredited programs establishes a written program-specific supervision policy consistent with the institutional policy and the respective ACGME Common and specialty-specific Program Requirements.
This policy has been established in adherence with the ACGME Common Program Requirements. VI.A.2. Supervision and Accountability.

INTENT.
All medical care of patients admitted to Centro Medico (Hospital) Episcopal San Lucas is assisted by Attendings/faculty members selected by or assigned to the patient following the Centro Medico Episcopal San Lucas Rules and Regulations and the Medical Staff By-Laws. This process implies that the Attending Physician is ultimately responsible for the care of the patient, and every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. The graded process of direct or indirect supervision develops the resident's autonomy during their training years. This will provide them with the confidence, clinical judgment, skills and maturity necessary for independent practice.

POLICY.
Supervision in the setting of Graduate Medical Education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. As part of their training experience the resident will participate with the Teaching Physician (TP) and Voluntary Faculty in the development of diagnostic strategies, planning, record keeping, order or prescription writing, management, discharge summary preparation, and decision making at a level that is commensurate with the resident's abilities, and with appropriate supervision by the teaching physician.

PROCEDURES.
SUPERVISION GENERAL PROCEDURES. (All programs)

1. Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable specialty-specific Review Committee) who is responsible and accountable for the patient's care. VI.A.2.a).(1). This information must be available to residents, faculty members, other members of the health care team, and patients.
2. **Roles**: Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. VI.A.2.a).(1).(b)
3. **Methods:** Supervision may be exercised through a variety of methods. For many features of patient care, the supervising physician may be a more advanced resident or fellow.

Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology.

4. Some activities will require the physical presence of the faculty member. In some conditions, supervision may include post-hoc review of resident-delivered care with feedback. VI.A.2.b)
5. **Supervision Level**. The program must demonstrate that the proper level of supervision is being provided for all residents, based on each resident's level of training and ability, as well as on the patient complexity and acuity. VI.A.2.b).(1)
6. **Supervision Methods**. Supervision may be exercised through a variety of methods, as appropriate to the situation. VI.A.2.b).(1). The Program Specialty Specific Review Committee may specify which activities require different levels of supervision.]
7. **Special Circumstances**: The programs are responsible for including in their supervision policy, the Special Circumstances when the physical presence of a supervising physician is required. VI.A.2.b).(2)
8. **Progressive Authority**: The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care, is delegated to each resident, and must be assigned by the program director and faculty members. VI.A.2.d)
9. **Milestones**: The Program Director must evaluate each resident's abilities based on specific criteria, guided by the **Milestones**, in a semiannual basis. VI.A.2.d).(1)
10. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. VI.A.2.d). (2)
11. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. VI.A.2.d). (3)
12. **Communications**. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). VI.A.2.e)
13. **Limits**. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. VI.A.2.e). (1)
14. The ACGME Glossary of Terms defines conditional independence as a "Graded, progressive responsibility for patient care with defined oversight."
15. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. VI.A.2.f)
16. **Services: During all in-patient rotations** there must be a resident schedule, including defined sign-in and sign-out procedures, so residents will learn to work in teams to ensure proper care and welfare of the patients. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
    The on-call system must include a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. On-call schedules for supervising physicians (teaching staff) must be structured to ensure that supervision is readily available to residents on duty.

LEVELS OF SUPERVISION. VI.A.2.c)

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

A. **Direct Supervision**

1. The supervising physician is physically present with the resident during the key portions of the patient interaction. Specialty RC may further specify.
    - PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c). (1). (a).
    - The program specialty specific Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly.
2. The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate **telecommunication technology**. VI.A.2.c). (1). (b). The Specialty RC may further specify and may choose not to permit VI.A.2.c). (1). (b).

*The Specialty Review Committee may further specify and may choose not to permit VI.A.2.c). (1). (b). *Each program is required to revise the "Specialty-Specific Program Requirements for Direct Supervision Using Telecommunication Technology". Effective as of July 1, 2021.

B. Indirect Supervision.
The supervising physician does not provide physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. VI.A.2.c). (2).

C. Oversight
The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

DETERMINATION OF PROGRESSIVE RESPONSIBILITY

1. There are multiple aspects related to the supervision of the trainee educational and patient care activities, including supervision by an advanced-level trainee, in recognition of progress towards independence and demonstration of graded authority and responsibility. The final level of supervision is the responsibility of the responsible Program Faculty and Program Director.
2. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and to delegate the appropriate level of patient care authority and responsibility.
3. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each trainee must be assigned by the program director and faculty members. The program director must evaluate each trainee's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
4. Faculty members functioning as supervising physicians should delegate portions of care to trainees based on the needs of the patient and the skills of the trainees.
5. Each trainee must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

COMMUNICATIONS WITH THE SUPERVIGING PHYSICIAN

1. Each ACGME program at the sponsoring institution must set its guidelines for circumstances in which the trainees must communicate with appropriate supervising faculty members.
2. An integral part of the supervision of the trainee educational and patient care activities includes the availability and access to communication with Program Faculty (24 hours per day, 365 days annually).

GENERAL SPECIAL CIRCUMSTANCES REQUIRING IMMEDIATE FACULTY INTERVENTION.

Residents, regardless of level of training and experience, must verbally communicate with the supervising faculty during certain circumstances, which will include, **but are not limited to**:

1. New Admissions to the hospital (including ER, clinic or same day area.)
2. Consultations on urgent conditions.
3. Transfer of patient to a higher level of care and ICU.
4. Code blue team activation, rapid response.
5. End of Life decisions and change in DNR orders.
6. Patient or family dissatisfaction.
7. patient requesting discharge AMA.
8. Patient death.
9. Patient needing urgent or emergent procedure by our service or another service.
10. Patient discharged against medical advice (AMA) or not officially discharged.
11. Urgent patient status should be discussed immediately with the supervising attending.
12. Unexpected deterioration in the patient's medical status.
13. Patient experiences an adverse outcome regardless of the reason.
14. Family, legal or systems urgent issues.
15. Sentinel Event. Medication/treatment error requiring intervention.
16. When a life-threatening medical error has been made.
17. Clinical problem deteriorates requiring invasive medical procedure or surgery.
18. When the resident feels uncertainty about the patient's care plans or goals or feels uncomfortable of their ability to perform patient care with the level of supervision required.
19. Situations in which safety is threatened. Patient presents are acutely suicidal or homicidal.

20. Resident/staff observes that patient safety is at risk.
21. When the resident feels impaired or witnesses that others are working while impaired.

Each program may further specify its circumstances.

FEEDBACK

1. The formative evaluation of trainee activities as dictated by the ACGME Program Requirements is an important component of appropriate trainee supervision.
2. The review of trainee documentation of patient care is an important aspect of trainee supervision.
3. Any concerns about inadequate or inappropriate levels of supervision should be addressed by the Program Leadership, with involvement of the GME Office and GMEC if the issues are not appropriately addressed locally. Any individual can bring concerns about trainee supervision to the attention of the GME Leadership.

SPECIFIC GUIDELINES AT THE SPONSORING INSTITUTION

This policy requires the following from every supervising(attending) physician:

- *The attending physician at the primary service will personally see all hospitalized patients **at least once daily.***
- *The attending physician at consultative services, will personally see patients for initial consultation within the specified time frame (usually 24 hours), and thereafter frequently enough to ensure safe and appropriate patient care, until the time of signoff. When patients are acutely unwell, and/or the trainees are junior or off-service learners, this may necessitate daily attending visits.*

The supervising (attending) physician will, at a minimum:

- *Examine the patient within 24 hours of admission, when there is a significant change in patient condition or as required by good patient care.*
- *Review the patient's history, the record of examinations and tests, and make appropriate reviews of the patient's progress.*
- *Confirm or revise the diagnosis made by the trainee and determine major changes in the course of treatment to be followed.*
- *Either personally perform the services required by the patient or supervise the treatment to assure the services provided by trainees and that the care meets the proper quality level.*
- *For surgical or other complex, high risk medical procedures, the attending physician must be immediately available to assist the trainee who is under the attending physician's direction.*
- *Make decisions to authorize or deny any admissions, discharges, or transfers.*
- *Sign all DNR orders, or document appropriate involvement in the decision.*
- *Assure that a properly completed, signed, and witnessed consent form is obtained and placed in the patient's record prior to the performance of any operative or invasive procedure.*
- *Assure that supervision of care for inpatients is documented in the patient record. It is the attending physician's responsibility to see that all documentation must be in accordance with appropriate regulations and the standards of good patient care and must provide evidence in writing of supervisor concurrence with the admission, history, physical examination, assessment, treatment plan and orders.*
- *Document appropriate attestation and/or sign all residents' notes in EHR.*

B. General Documentation Instructions and Common Scenarios

All teaching physicians (supervising, teaching staff) and residents may document physician services in the patient's medical record.

The documentation must be dated and contain a legible signature or identity and may be completed using one of these methods:

- *Dictated and transcribed*
- *Typed*
- *Hand-written or*

- *Computer-generated*

Macro, which is a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user, may be used as the required personal documentation if you personally add it in a secured or password-protected system. In addition to macro, the teaching physician and the resident must provide customized information that is sufficient to support a medical necessity determination.
The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. The only use only macros is not considered sufficient documentation.

Evaluation and Management (E/M Service) - For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:
a. The teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
b. The participation of the teaching physician in the management of the patient. When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. The teaching physician must document their own presence and participation for E/M services.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. The teaching physician should reference the resident by name in his/her personal note.

The timeframe to compete documentation may vary according to the clinical scenario but most of them should document supervision within 24 hours of furnished service.
• Admission Note: will document supervision within 24 hours of admission
• Progress Note (daily): will document supervision according to the clinical scenario.
• Discharge Summary: will document review within the timelines required by Medical Staff By-Laws.
• Operative Notes: will document supervision within 24 hours.
• Consultations: will document supervision within 24 hours of inpatient consultation.

The following are four common scenarios for teaching physicians providing E/M services:

Scenario 1
The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario, the resident may or may not have performed the E/M service independently. In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting. Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Example Scenario 1
Admitting Note -- "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agreed with the documented findings and plan of care."

Follow-Up Visit -- "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."
Follow-Up Visit -- "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."
SIGN and DATE

Scenario 2
The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Example Scenario 2
Initial or Follow-Up Visit -- "I was present with the resident (Dr. XXX) during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."
Follow-Up Visit -- "I saw the patient with the resident (Dr. XXX) and agree with the resident's findings and plan."
SIGN and DATE

Scenario 3
The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service.
The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 4
When a medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day: The teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may reference the resident's note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided that the patient's condition has not changed, and the teaching physician agrees with the resident's note. The teaching physician's note must reflect changes in the patient's condition and clinical course that require that the resident's note be amended with further information to address the patient's condition and course at the time the patient is seen personally by the teaching physician.

The teaching physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the teaching physician's and resident's documentation satisfies criteria for a higher level of service. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician. Note: It must be emphasized that the TP note be directly tied to the resident's note, especially when the resident's note is written at the time of service and the TP note is dictated and placed in the chart later.

Example Scenarios 3 and 4:
Initial Visit -- "I saw and evaluated the patient. I reviewed the resident's (Dr. XXX) note and agreed, except that the picture is more consistent with pericarditis than myocardial ischemia.

Will begin NSAIDs." Initial or Follow-up Visit -- "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."
Follow-Up Visit -- "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."
Follow-Up Visit -- "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."
SIGN and DATE

The Following are examples of unacceptable documentation:

- *"Agree with above.", followed by legible countersignature or identity.*
- *"Rounded, Reviewed, Agree.", followed by legible countersignature or identity;*
- *"Discussed with resident. Agree.", followed by legible countersignature or identity.*
- *"Seen and agree.", followed by legible countersignature or identity.*
- *"Patient seen and evaluated.", followed by legible countersignature or identity; and,*
- *A legible countersignature or identity alone.*

Such documentation is not acceptable because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

General Documentation Instructions for Surgical Procedures and Common Surgical Scenarios
Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. The teaching physician must document their own presence and participation for E/M services.

- *the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.*
- *the teaching physician presence and/or participation be documented in the patient's medical record for any surgical, high-risk, or other complex procedure.*
- *the attending physician must be present in the operating room for the key or critical portion of all cases and must remain in immediate proximity and available to return to the procedure immediately if needed. ("Immediate proximity" is generally defined as within the OR Suite and immediately available to return to the operating room if needed). If the attending physician leaves the OR Suite after the completion of the key portion of the procedure or another case would prohibit him/her from returning to the original case, the attending physician must make arrangements with another physician to be immediately available for the original case.*
- *It is the attending surgeon's responsibility to obtain written informed consent or document involvement (if resident obtain the written informed consent) that is in compliance with all CMS, the Joint Commission and hospital regulations, including the role of the resident/fellow in the surgery or procedure.*
- *In all surgeries including endoscopic procedures the teaching surgeon is responsible for the pre-operative, operative, and post-operative care of the patient.*
- *the teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are key or critical portions of the procedure.*
- *the teaching surgeon determines which post-operative visits are considered key or critical and require his/her presence.*
- *During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he/she must be immediately available to return to the procedure (i.e., he/she cannot be performing another procedure). If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.*

Surgical Scenarios

1. Single Surgery – When the teaching surgeon is present for the entire surgery, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

- *Teaching physician must be present during all critical and key portions of the procedure.*
- *Teaching physician must be immediately available to return to the procedure (i.e., cannot be performing another procedure)*
- *Documentation must include a statement regarding the Teaching physician's presence. The statement can be made personally by the TP, or by the resident or nurse.*
- *Teaching physician and resident must sign and date the report.*
- *Acceptable Single Surgery Attestation*
- *Teaching physician is present for entire surgery:*
- *"I was present for the entire surgery."*
- *"The attending physician, Dr. (full name of TP) was present for the entire procedure."*
- *Teaching physician is present for critical and key portions of surgery:*

  "I was present during the critical and key portions of the surgery and I was immediately available to provide assistance."
  "The attending physician, Dr. (full name of TP) was present for all critical and key portions of this case and was immediately available during the remainder of the case."

2. Two Overlapping Surgeries – the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure.

The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portions of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

- *The teaching physician must be present during the critical or key portions of both operations.*
- *The critical or key portions may not take place at the same time.*
- *When all the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure.*
- *The TP must personally document presence for both procedures.*
- *When a teaching physician is not present during non-critical or non-key portions of the procedure, the TP must arrange for another qualified surgeon to immediately assist the resident.*
- *TP and resident must sign and date the report.*

Acceptable Overlapping Surgery Attestation

- *Teaching physician is present for the critical/key portion of two overlapping surgeries:*
  "I was present during the key and critical portions of the surgery and another attending surgeon was immediately available throughout the procedure."

3.Minor Procedures

- *For a minor procedure, the TP must be present in same room as the resident and patient for the entire time the procedure is being performed in order to bill for the service.*

- *Documentation must state the TP's presence. The statement can be made personally by the TP, or by the resident or nurse. Whoever makes the statement, they must explicitly state that the TP was present for the entire procedure.*
- *TP and resident must sign and date the report.*
- *Avoid using the word "supervised" or phrases "directly supervised" or "personally supervised" as these statements do not necessarily convey that the TP was present for the entire procedure.*
- *Acceptable Minor Procedure Attestation*
- *Procedure only with resident:*
    - *"I was present for the entire procedure."*
    - *"The attending physician, Dr. (full name of TP) was present for the entire procedure."*
    - *Minor procedure and E/M with the resident*
    - *"I saw and examined the patient and discussed with resident, agree with the resident's note and was present for the entire procedure."*

4. Procedures Performed in Treatment Room or on Unit/Floor by Resident Alone

- *Residents and fellows are under the direction and supervision of a faculty member.*
- *Residents are only permitted to perform those procedures approved by their overseeing faculty member and those listed on the training program protocols as acceptable to be performed absent the direct personal supervision of a faculty member*
- *The TP must place an attestation on the documentation stating they discussed the case with the resident and agree with the plan and content as written.*
- *The TP and resident must sign and date the documentation.*

Acceptable Attestations for procedures performed in Treatment Room or on Unit/Floor by Resident Alone:

- *Resident sees patient alone and the case was discussed with the resident.*
  "I reviewed the progress note and agree with the resident's findings and plans as written. Case discussed with the resident."
- *Resident sees patient and performs an approved training program protocol procedure alone (i.e., chest tubes, arterial lines, etc.) and the case was discussed with resident.*

"I discussed the case with the resident, and we determined the performed procedure was medically necessary. I reviewed the progress note and procedure details and agree with the resident's findings and plans as written. Case discussed with resident."

Teaching Physicians must follow Medicare guidelines when supervising residents and fellows who in conjunction with the TP, are rendering service to a patient covered by Medicare and/or third-party payer. The TP will write or dictate a personal note for each billed event. This note must contain the TP's statement of services, summary of findings and documentation of his/her presence during key portion(s) of the encounter or procedure performed by the resident.

For residents, the residency training is a full-time responsibility. Activities outside the training program should not interfere with the resident's educational performance. It is important that the residents have a keen sense of personal responsibility for patient care.

Residents should be taught that their obligation to patients is not automatically discharged at any given hour of the day or any particular day of the week. The resident should not be relieved of duty until the proper care and welfare of the patients have been ensured by the presence of a suitable professional replacement.

E/M Service Documentation Provided by Medical Students

In 2018 the Centers for Medicare and Medicaid Services revised the provider manual as follows:

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements described in the abovementioned Supervision and Documentation Policy. Students may document services in the medical record and the teaching physician may use any student documentation but:

- *the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making.*
- *the teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed but may verify any student documentation of them in the medical record, rather than re-documenting this work.*
- *The teaching physician or resident must be physically present for any contribution and participation of a student to the performance of a billable service other than history.*

The medical student's documentation rule does not apply to other diagnostic or therapeutic services it only applies for evaluation and management services. Only the teaching physician may use the student documentation. Residents may not use or incorporate (copy and paste) student documentation into their notes. Residents may write an addendum at the bottom of a medical student note, but the teaching physician must attest to the medical student documentation. Only the teaching physician can verify student documentation, this cannot be delegated to a resident.

Example Scenarios

Without a resident:
"A student assisted me with documenting this service. I saw the patient and reviewed and verified all information documented by the student and made modifications to such information, when appropriate."

With a resident:
"A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the student and resident, and made modifications to such information, when appropriate.

The Hospital Episcopal San Lucas has allowed the medical students to use the Electronic Health Record (EHR) using the following categories:
• Third-year Medical Student (MS3): only access to read the EHR
• Fourth-year Medical Student (MS4): access to read and write(document) on HER Medical Student Documentation During the Public Health Emergency: CMS Rules.

In the final Calendar Year 2020 Physician Fee Schedule Rule CMS further expanded student documentation requirement to allow a physician, PA, or advanced practice registered nurse (i.e., NPS, CNSs, CNMs, and certified registered nurse anesthetists) to review and verify, rather than r e-document, information in the medial record by physicians, residents, nurses, students, or other members of the medical team.

Medical Student Documentation During the PHE In the current public health emergency, the only student documentation change that CMS has made is to allow anyone who bills under Medicare, whether or not they are in a teaching role, to review and verify (sign and date) rather than redocument, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines).

In a communication from CMS to the AAMC the Agency stated the following: During the PHE, the medical records must include documentation regarding whether the teaching physician was physically present or if present through audio/video real-time communications technology at the time the service is furnished. However, furnishing the service via telehealth does not change our flexibilities regarding who can document.

The billing practitioner will still need to review/verify the notes made by others on the medical team but does not need to re-document the service. (Emphasis added) CMS agreed with the following scenarios that were sent by the AAMC. If the teaching physician or resident sees the patient in person and provides an E/M service but the medical student is participating in the service via interactive telecommunications technology, the teaching physician can review and verify the medical student's documentation. If both the teaching physician and the medical student are participating in the E/M service through interactive telecommunications technology, and the resident or another clinician is in the room with the patient, the teaching physician must review and verify the medical student's documentation.

MECHANISMS AVAILABLE TO REPORT INADEQUATE SUPERVISION

The house staff, faculty, and personnel count with several mechanisms to notify non-compliance with this policy.

4. **Program Level** – must use one or more of the following mechanisms.
   a. Notify the Chief Residents
   b. Notify Faculty Members
   c. Notify the Program Coordinator
   d. Notify the Program Director
   e. Or submit the complaint anonymously using the QR Code for the Program Virtual Suggestions Box located in each common area (resting rooms, didactics room, halls, etc.) of the program.

5. **GME Office Level** – must use one or more of the following mechanisms.
   a. Request a meeting with the Institutional Coordinator and/or the DIO.
      i. Email address: gmesanlucas@ssepr.org
   b. Or submit the complaint anonymously using the QR Code for the GME Institutional Virtual Suggestions Box. Or the following link which is also available at the Resources area at New Innovations.
      https://redcap.ssepr.org:3443/surveys/?s=AKNKCCMAX3HLWKF9

To assist our resident/fellows in creating a workplace that is free of retaliation when communicating inadequate supervision. Please, refer to Policy #19: Adjudication of Resident Complaints. Grievances.

Resident Supervision and Documentation Policy Reviewed and approved by
the GMEC on May 7, 2001
Revision June/2006
Approved Revision March/28/2012
Approved Revision July 31, 2014
Update Approved by GMEC January 2016
Update Approved by GMEC October 2019
Update March 2021
Update May 2024

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #37	GRADUATE MEDICAL EDUCATION POLICIES
	TITLE	USMLE STEP-3 POLICY
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Sponsoring Institution Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective & Updates	Revised/approved March, 2022 Please refer to the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols concerning the USMLE Step-3. CMESL recognizes the importance for medical residents to pass the USMLE Step-3 in order to qualify for the state medical

licensure. A full and unrestricted medical license is required for both, to practice medicine, as well as to qualify for specialty boards. However, it has been identified that many residents postpone fulfilling this requirement until the end of training, risking the successful completion of their training program, and the start of their independent clinical practice. In addition, this delay affects their preparation for their specialty board examination. Advocating for the best interest of our residents, the Graduate Medical Education Committee has developed the following policy to ensure that all our graduates qualify for full and unrestricted medical license before completing their training.

POLICY. All residents, excluding Transitional Year (TY) residents, must have the ability to obtain a full and unrestricted license at the completion of their specialty training. To achieve this, all residents of categorical programs (non-TY residents) must take all USMLE components by the end of their first year of training. It is required that they pass all USMLE components by the end of their second year of training. All TY residents must take the USMLE 3 examination during their training year.

PROCEDURES AND MONITORING

• All residents of categorical programs must notify their Program Director of their plans, including the date they will take the USMLE 3 examination. This must be done by the end of their sixth month after commencing the first year of residency training; for most residents this will be before December 31 of their first year of training. The resident is required to inform the Program Director as soon as the results of the exam are available.

• The Program Director will send a list of residents who have completed the USMLE 3 requirement to the GME Director by January 31 of each academic year.

• The CCC will develop a remedial plan for residents of categorical programs that have not passed the USMLE 3 at the beginning of their last year of training. The remedial plan must include the expectations, a timeline, a reporting structure, and outcomes in case of non-compliance, and must be approved by the PD.

- TY Residents will not receive certificate of completion of their residency requirements until they take the USMLE 3.

- Residents of categorical programs will not be certified as completing their residency training until they pass the USMLE 3.

- Due process applies to these adverse decisions. After the residents from categorical programs pass the USMLE 3 they may request a full, unrestricted license in Puerto Rico while in training, with the corresponding responsibilities and fees.

Ratified by GMEC
4/27/2004
Revised and ratified by GMEC 5/2008
Revised and ratified by GMEC 11/2011
Revised and ratified by GMEC August 22, 2012
Revised and approved: June 26, 2014
Revised and approved by GMEC: January 15, 2015
Update approved by GMEC January 2016
Policy on USMLE 3
Approved by the GMEC on 6/29/2019

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #38	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	SOCIAL MEDIA
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Reviewed and approved by GMEC 06/05/2013 Update Approved by GMEC March 2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address social media guidelines.

The Internet provides residents with considerable benefits and new opportunities for education and sources of communication. However, the use of the Internet and social media communication sites may

also involve issues related to ethics and professionalism. The purpose of this policy is to provide institutional guidelines for the appropriate use of social media, and to emphasize the resident's responsibilities to maintain appropriate ethical and professional behaviors.

DEFINITIONS
Social Media includes any form of electronic communications, including but not limited to, blogs, wikis, virtual worlds, social networks, or other tools hosted outside Centro Médico Episcopal San Lucas. Social Media includes numerous links; such as Facebook, Twitter, Linkedin, You Tube, Flikr, Google+, My Space and other similar sites that may be developed in the future.

POLICY
Residents are not allowed to release, disclose, post, display or communicate the following information:

- Identifiable, confidential protected health information (PHI) regarding any patient associated with Hospital Episcopal San Lucas, its affiliated hospitals and clinics, or other external affiliated health care organization. This includes, but is not limited to, any information, such as initials, personal activities, room numbers, pictures, or other information that might enable external parties to identify patients. Disclosure of PHI may constitute a serious HIPAA violation and may have personal and/or institutional liability consequences.
- Confidential information regarding policies and operations, including financial information, regarding the Centro Médico Episcopal San Lucas, its affiliated hospitals and clinics, or other external affiliated health care organization.
- Residents must also adhere to the following:
    - Residents must not accept as "friends" any active patients or their families through any social media site.
    - Residents must not offer medical advice on any social media site.
    - Residents must not post information that might be considered offensive; or that may reflect negatively on the resident, colleagues, patients, or the Centro Médico Episcopal San Lucas (HESL-P), its affiliated hospitals and clinics, or other external affiliated health care organization.
    - Residents should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites, and the extent possible, content posted about them by others, is accurate and appropriate.
    - Residents should always be aware of their association with the CMESL when posting to a CMESL-sponsored or any other social networking site.
    - Personal profiles and content should always be consistent with the professional manner in which residents are expected to present themselves to colleagues, patients and others in all settings.
    - Residents are personally responsible for the content they post on CMESL sponsored social media properties - from blogs, to social networks, list serves, wikis, websites, forums, and other social media platforms.
    - Residents should have no expectation of privacy when using the Internet at work and are reminded that any time spent posting and viewing social media sites or other Internet sites must not interfere with the performance of their duties.
    - Residents must recognize that their actions online may negatively affect their reputations with patients, colleagues, and others, and may have long-term consequences for their careers.
    - Residents should consider that everything they post online may contribute to a lifetime record that is readily accessible by others. Potential employers may use social media to access this record to evaluate applicants. Posting distasteful, immature, or offensive content may negatively affect jobs or other professional opportunities. Residents must represent a professional and ethical personal image and behaviors to all who might view their online information through social medica communications.

Violations of this policy will be considered a break in professionalism as competency, which may jeopardize the resident's good standing status in his/her residency program, and may result in disciplinary actions such as a written warning, probation, or dismissal from the program.

Lapses in professionalism may also jeopardize the resident qualifications for eligibility to apply for the specialty board certification process.

Residents should realize the serious consequences of posting or promoting content that substantially disrupts, or materially may interfere with CMESL activities, or that might lead CMESL authorities to reasonable foresee substantial disruptions, or material interference with Hospital activities. This may result in disciplinary actions, including termination.

Reviewed and approved by GMEC 06/05/2013
Update Approved by GMEC March 2021

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #39	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	TRANSITIONS OF CARE AND HANDS OFF SYSTEMS
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Approved by GMEC March 2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address Transitions of Care and Hands Off.

This policy has been established in adherence with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements III.B.3. Transitions of Care. July 2021

INTENT. This policy establishes the protocol and standards to be followed at Centro Médico Episcopal San Lucas and Ponce Health Sciences University School of Medicine residency/fellowship programs to ensure the quality and safety of patient care, and to monitor effective, structured hand-over processes; in order to facilitate both, continuity of care, and patient safety when the transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another team. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another provider. Transitions of care occurs regularly under the following conditions:

- Change in the patient care level, including inpatient admissions from an outpatient facility, (procedures or diagnostic or ER), and transfers to/from the critical care unit.
- Temporary transfer of care to other healthcare team within procedures or diagnostic areas.
- Discharge, including discharge to home or another facility such as skilled nursing care.
- Change in provider or service change, including resident sign-out, and rotation changes for residents.

POLICY

- Residency programs must design clinical assignments to minimize the number of transitions in patient care.
- Programs must ensure that residents are competent in communicating with team members in the hand-over process.
- The Sponsoring Institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.
- Transitions of Care is critical to patient safety and resident education.
- Residents may remain on-site four (4) additional hours in order to accomplish these tasks. This must be reported by the resident physician in writing with rationale to the Program Director and reviewed by the GMEC for monitoring individual residents and program.
- Programs must design clinical assignments to minimize the number of transitions in patient care.
- The sponsoring institution and its programs must ensure and monitor an effective, structured hand-over processes, in order to facilitate both continuity of care and patient safety.

PROCEDURES

- The transition/hand-off process must involve face-to-face interactions in a quiet area, including both verbal and written/computerized communications, with opportunity for the receiver of the information to ask questions and clarify specific issues.
- Use Ward Manager HIPPA-certified digital platform use on transition of care by all residency programs
- The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:
    - Identification of patient, including name, medical record number, and age.
    - Identification of admitting/primary/supervising physician and contact information.
    - Diagnosis and current status/condition (level of acuity) of patient.

- Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken.

Outstanding Tasks - what needs to be completed in the immediate future.

- Outstanding laboratories/studies - what needs follow up during the shift.
- Changes in the patient condition that may occur requiring interventions or a contingency plan.

Each residency/fellowship program must develop components that integrate the specifics required by their specialty field. Programs are required to develop the scheduling and transitions of care/hand-off procedures to ensure that:

- Residents comply with specialty specific/institutional duty hour requirements.
- The faculty is scheduled and become available to achieve appropriate supervision levels, according with the requirements for scheduled residents.
- All parties (including the nursing team) involved in a particular program and/or transition process, should have access to one another's schedules and contact information.
- All call schedules should be available on department specific billboards.
- Patients should not be inconvenienced or endangered due to frequent transitions in their care.
- All parties directly involved in the patient's care before, during, and after the transition, should have opportunities for communication, consultation, and clarification of the information.
- Safeguards/backup systems are available for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.
- Programs provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their handoff skills.
- Each program must include the specifics of its transition of care process in its curriculum.
- Didactic sessions are provided focused on communication skills, including in person lectures, web-based training, review of curricular materials and/or knowledge assessment.
- Residents must demonstrate competency in performance of this task.
- Direct observation of a handoff session by faculty, peer or by a more senior trainee
- Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment.
- Programs develop and utilize a method of monitoring the transition of care process and update as necessary.
- The Monitoring of handoffs by the program should ensure the following:
    - Ensure a standardized process, which is routinely followed by the staff.
    - Provision of consistent opportunity for questions and clarifications.
    - The necessary materials are available to support the handoff (Including, for instance, written sign-out materials, access to electronic clinical information)
    - A quiet setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
    - Ensure patient confidentiality and privacy.

Approved by the Graduate Medical Education Committee November 17, 2010
Effective July 1, 2011
Approved Revision March 28, 2012 Update
Approved by GMEC March 2021

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #40	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	VACATIONS, LEAVES OF ABSENCE (LOA)
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Discussion PD: December 4, 2014 Approval CEMG: January 15, 2015 Update approved by GMEC March2021

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

INTENT. To define institutional protocols to address Vacations and Leaves of Absence.

This policy has been established in adherence with the ACGME Institutional Requirements. IV.H. Vacation and Leaves of Absence IV.H.1. The Sponsoring Institution must have a policy for vacation and leaves of absence, consistent with applicable laws. IV.H.2. This policy must ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s). II.F.1.c

BACKGROUND

Board requirements for a residency may include minimums of training time and competency level for completion of training. When a resident takes a prolonged leave of absence, a program may not be able to certify that the resident has met these requirements. Approval of a personal leave of absence during a training year DOES NOT automatically result in an extension of the resident's training period and does not require CMESL or the residency program to provide another training contract for the resident to meet these minimum requirements. The resident's Program Director determines if and how much additional residency training time is required to complete training. Centro Médico Episcopal San Lucas is not obliged to provide the requisite extra training time to a resident.

Board requirements override CMESL GME permitted LOA with the exception of federally protected time.

Program	Length Training
Transitional	12 months
Emergency Medicine	36 months
Internal Medicine	36 months
Cardiovascular Diseases	36 months
Obstetrics Gynecology	48 months
Pediatrics	36 months
General Surgery	60 months
Urology	60 months

In consistency with the rules and regulations of GME: residents are responsible to make up any training period missed more than the allowed for vacation leave. The makeup period must be determined by the corresponding Clinical Competency Committee and approved by the PD. When an additional training period is required over and beyond the established length of training, the resident will be contracted for additional time with a nominal salary.

Residents who do not complete the established minimum length of training **will not be certified** regardless of the reasons for non-compliance.

LOA in excess of board allowance will cause the training period to be extended. Extension of training is at the discretion of the Program Director, based on achievement of competency level, case logs, clinical competency committee ("CCC") feedback, board requirements, and subject to availability of funding and approved complement. Residents are encouraged to refer to the specialty board for specific details. Programs should refer to Policy #16.

Paid Vacation/Holiday Leave
Residents /fellows are allowed 4 week-period equals to 28 workdays. A resident's unused vacation/holiday leave during one annual contract period does not transfer to the following appointment year nor will they be paid out upon the end of their contract. A resident shall not be compensated for unused vacation/holiday leave if the resident voluntarily or involuntarily leaves the program either during a contract period or at the end of the contract period. Residents must follow the policies of their training program in requesting and scheduling vacation/holiday leave. Failure to follow departmental policies may result in the request being rejected. In general, each resident must submit a leave request in writing to his/her Program Director with as much advanced notice as possible for planning purposes. Program Directors, or their designee, have the final authority to approve vacation/holiday leave time requests.

Paid Sick Days
This paid sick time is intended for residents who are unable to complete their duties for typically a week or less due to health-related issues, but who do not require medical leave. Most programs have specific times by which residents are required to notify the Program Director or Chief Resident of a sick day absence or tardiness. It is the responsibility of each resident to know and understand their program's notification procedures.

Full time residents have twelve (12) calendar paid sick days during the annual academic contract period. Unused paid sick days for a resident in a particular training year do not transfer to the resident's appointment for any additional training year(s) nor will they be paid out upon the end of their contract. Residents shall not be compensated for unused sick day balances upon voluntary or involuntary removal from the program, either during a contract period or at the end of the contract period. It is the responsibility of the resident to follow the policies of their department in using sick days. The resident will be expected to provide evidence of the need to utilize each paid sick day, as required by his/her Program Director.

Bereavement Leave
Paid bereavement leave is provided to residents to attend funeral services for relatives or close personal friends. A resident's Program Director may approve up to five (5) days of paid bereavement leave per occurrence. A resident should notify their Program Director as soon as possible of the need for bereavement leave so that appropriate scheduling may occur. During individual departmental orientation, each resident will be informed of any other departmental requirements in completing the bereavement leave request.

Conference Leave
A Program Director may authorize paid leave for a Resident in good standing to present at local, regional, or national educational meetings. Such paid leave is limited to five (5) days each contract year, is not considered part of the Resident's annual leave, and may not be carried forward to subsequent years. Conference leave must be preapproved at least four (4) weeks in advance with additional approval from the Program Director.

Domestic Violence Leave
Residents may be provided up to three (3) days in a twelve-month period except in cases of imminent danger to the health or safety of the Resident or to the health or safety of a family or household member, Residents seeking Domestic Violence leave must provide the program

advanced notice of the leave. Domestic Violence leave does not require written approval or documentation.

Paid Medical Leave
Paid Medical Leave is to be used by residents who are unable to complete their residency responsibilities for a prolonged period of time due to a qualifying serious health condition.

In the event of a qualifying serious health condition that results in the resident being unable to perform the essential functions of the residency, an eligible resident may receive up to three weeks (21 calendar days) of paid medical leave.

Upon the expiration of the paid three-week medical leave entitlement, qualifying residents who continue to be unable to perform the essential functions of the residency due to the qualifying health condition may choose to extend the paid medical leave to a maximum of four weeks.

If leave time taken results in a resident not achieving specialty board requirements for length of residency, the resident may be required to extend training beyond the anticipated completion date. If the resident continues to need time away from the residency after the expiration of seven weeks, such leave may be subject to continuation pursuant to the unpaid personal leave of absence.

A medical leave request must be approved through the CMESL Housestaff Leave Request process. All forms are available in the Resources area of the New Innovation platform.

1) *Leave Request Form*: To be eligible for paid medical leave, a resident must complete the Leave Request Form as soon as practical prior to the start of the leave period (unless not possible to provide such documentation until after the need for leave occurred, in which case the form must be completed as soon as practical thereafter). Policy #41 - Leave Request Form.pdf

2) *Medical Leave Certification form*: To be eligible for paid medical leave, a resident must have their healthcare provider complete the Medical Leave Certification form.

3) *Return to Program Readiness*: Any resident on a paid medical leave must have their healthcare provider complete the Return-to-Work certification and resolve resulting return-to-work questions prior to GME Office and program clearing the resident to safely return to work and residency training.

Paid Caregiver Leave
Paid Caregiver Leave is to be used by residents who are unable to complete their residency responsibilities for a prolonged period because they are caring for a family member with a serious health condition.

To qualify for Caregiver Leave pursuant to this section, the resident's family member in need of qualifying care must be the resident's spouse, child, or parent. A qualifying resident may utilize up to 7 unused weeks of paid caregiver leave described in this section throughout the duration of the resident's training years regardless of whether such training lasts one year or longer. Caregiver Leave is intended for use when care is medically required for a prolonged period. If less than three consecutive days are required, no caregiver leave is needed.

In the event of a qualifying serious health condition that results in the resident being unable to perform the essential functions of the residency, an eligible resident may receive up to three weeks (21 calendar days) of paid medical leave.

Upon the expiration of the paid three-week medical leave entitlement, qualifying residents who continue to be unable to perform the essential functions of the residency due to the qualifying health condition may choose to extend the paid medical leave to a maximum of four weeks.

If leave time taken results in a resident not achieving specialty board requirements for length of residency, the resident may be required to extend training beyond the anticipated completion date. If the resident continues to need time away from the residency after the expiration of seven weeks, such leave may be subject to continuation pursuant to the unpaid personal leave of absence.

A medical leave request must be approved through the CMESL Housestaff Leave Request process. All forms are available in the Resources area of the New Innovation platform.

1) *Leave Request Form:* To be eligible for paid medical leave, a resident must complete the Leave Request Form as soon as practical prior to the start of the leave period (unless not possible to provide such documentation until after the need for leave occurred, in which case the form must be completed as soon as practical thereafter).

2) *Family Medical Certification form:* To be eligible for paid caregiver leave, a resident must have their family member's healthcare provider complete the Family Medical Certification form.

Parental Leave - Applies to birth/adoption.
CMELS provides seven weeks of paid parental leave to residents who are enrolled in training programs. Parental leave is available per occurrence (birth or adoption). If both parents are eligible residents, each parent is eligible for parental leave. Note that the provision of paid leave does not mean that academic requirements are relaxed, and time may need to be added to the end of training.

Paid parental leave may be taken at any time within the first 12 months after the birth or adoption event. Parental leave can only be taken on or after the date of birth or adoption. If leave time taken results in a resident not achieving specialty board requirements for length of residency, the resident may be required to extend training beyond the anticipated completion date.

A parental leave request must be approved through the CMESL House staff Leave Request process. All forms are available in the Resources area of the New Innovation platform.

4) *Leave Request Form:* To be eligible for paid parental leave, a resident must complete the Leave Request Form as soon as practical prior to the start of the leave period (unless not possible to provide such documentation until after the need for leave occurred, in which case the form must be completed as soon as practical thereafter).

5) *Medical (birth mother) or Family (non-birth parent) Medical Certification form:* To be eligible for paid parental leave, a resident must provide either the Medical Certification or Family Medical Certification form.

If any of the required documentation is not received in a timely manner, or the resident does not have sufficient sick and/or vacation time to cover the leave that was taken during the academic year in which the leave was initiated, the time will be considered unpaid leave.

Leave For Jury/Witness Duty
Paid Jury/Witness duty leave is provided to residents who are subpoenaed to serve on a jury or as a witness in a litigation proceeding. Each resident must notify his/her Program Director of jury/witness duty by submitting a copy of the subpoena as soon as possible upon receiving it. Jury/witness fees received by the resident for jury/witness duty may be retained by the resident. Time served on jury/witness duty will not count against the resident's paid vacation/holiday leave entitlement.

Leave For Military Duty

For Military Duty Leave the resident must submit a request form to the Program Director.

Annual Leave
All Residents will receive up to ten (10) workdays of annual leave per contract year. Annual leave must be used for any time away from the program not covered by other leave benefits below, including board exams, Step 3, and interviews. Program in-training exams do not require leave time.

Unpaid Personal Leave of Absence
A leave of absence without compensation is intended for those residents that require to be unpaid during their leave. A letter must be submitted to the GME Office to make the arrangements with the Department of Health.

Holiday Schedules
Each GME resident follows the holiday schedule of the training site where the resident currently rotates at that time. It does not require a leave of absence.

Religious/Cultural Holidays and Activities
CMESL recognizes that some religious holidays may fall on a regularly scheduled workday. This policy is intended to set guidelines and to provide reasonable accommodation for residents/fellows to practice their religious beliefs. Does not require a leave of absence.

CMESL will reasonably accommodate the religious observance, practice, and belief of residents with regard to attendance and scheduling of work. Residents wishing to observe a holy day of their religious faith shall, upon notifying their Program Director, be allowed to take unused leave or, in its absence, leave without pay to observe a religious holy day of their faith. Each resident is responsible for the work missed and will be permitted a reasonable amount of time to make up the work.

BENEFITS

Residents will continue with all benefits established in their contract during the leave period.

PROCEDURE

1) **Request and approvals for leave of absence.**
   a) The Resident submits a Leave Request Form to the Residency Program Director.
   b) Residency Program Director, in consultation with the Clinical Competency Committee (CCC), reviews the request for approval. Approval of leaves of absence must be in accordance with this policy.
   c) The residency program must notify the GME Office of leaves greater than five (5) days or of unpaid leaves for applicable processing.
   d) Once the LOA is approved and schedule, the Program Coordinator will withhold the resident's ID, and will hold access to the Electronic Health Record (EHR) until his/her return is approved
   e) The GME Office will notify the Department of Health if the leave of absence is unpaid and/or more than one month.

2) **During the leave of absence**
   a) The Residency Program Director and Resident/fellow should communicate on a regular basis, for a minimum of two weeks.
   b) Residents must notify their Residency Program Director of any change requests to the previously approved leave of absence. The Clinical Competency Committee (CCC) will consider such changes and give approval.
   c) Any changes with respect to the status of the leave of absence will require the program to notify the GME Office.

d) A leave of absence approved for medical reasons is accompanied by the expectation that the Resident must receive care and support.

Residents requesting a medical leave of absence must produce a medical certificate to verify that medical care is being received. The Resident's privacy is respected and information on the medical certificate will not disclose the reason for medical leave. The medical certificate will, however, include the anticipated duration of the leave of absence.

In the event of an extended medical leave, monthly medical certificates are to be provided by the treating physician and must be submitted to the Residency Program Director. The Program will then report updates on the medical leave status to the GME Office.

CMESL, at its own expense, may require second and third opinions if there is a reason to doubt the validity of the health care provider's statement of certification for leaves taken to care for a spouse, child, parent, or for the resident's illness. Medical Certification Form and Family Medical Certification form will not be acceptable if completed by a physician who is either a
family member or has a personal relationship with the resident.

3) Returning from a leave of absence

a) Residents must provide adequate notice of their return to the Residency Program Director as required by the program and/or the GME Office.
b) The Residency Program Director must notify the GME Office of the resumption of training with as much notice as possible but at least one week prior to the date of return.
c) Residents should not return from a leave of absence until they are ready.
d) Medical leave of absence: The Residency Program Director requires from the physician involved in the Resident's care a written medical certificate or declaration of readiness to return as a condition of returning to work.
The Residency Program Director, Clinical Competency Committee (CCC), and/or the Director of Graduate Medical Education, may request an additional independent medical opinion to ensure the Resident's medical fitness to return from the leave of absence.
    i) Residents returning after a prolonged non-parental leave of absence may require a modified educational program and may be assigned to a less advanced training level than that prior to the interruption of training. In order to determine the appropriate training level and program structure The Residency Program Director in consultation with the Clinical Competency Committee (CCC) and educational resources will develop the individualized educational plan for the resident.
    ii) All Resident assessments during the time the education plan period will be reviewed by the Residency Program Director in consultation with the Clinical Competency Committee (CCC). A recommendation regarding the Resident's re-entry to training should be submitted to the DIO/Director Graduate Medical Education later than two (2) weeks after the end of the educational plan period. Possible outcomes of an educational plan period include unconditional re-entry into the program or re-entry with a modified structure/training level.
    iii) An educational plan period may be credited towards residency training time, if recommended by the program.
g) In exceptional circumstances, the Clinical Competency Committee (CCC) may determine that it is not appropriate for the Resident on a leave of absence to return to the program. This decision must be submitted to and must be approved by the DIO. The Resident will be notified by the Program director and DIO of a program's decision against re-entry to the training program. Appeals of this decision follow the House Staff Manual policies/procedures for appeals.

Summary

Responsible Party	Action
Resident	Agrees to abide by the LOA procedures set forth in this policy, in the House staff Handbook, in the House Officer Contract, and by the programs as applicable. Know and follow program's approval and notification procedures and board eligibility requirements. Submits the appropriate LOA Form requesting leave to the Program Director in a timely manner. A LOA for medical reasons may require documentation from a physician stating that the resident has a serious medical condition that will impact training and the estimated amount of time away from the training program.
Program Director	Develops procedures for LOA approval and documents when and how annual leave can be taken in ACGME block schedule, as applicable. Advises Resident and GME Office of approval or disapproval. Maintains accurate records of the amount of all LOA Residents have used and reports use of leave accurately in New Innovation. Knows and ensures Residents are meeting board eligibility requirements Follows disciplinary process for Residents who have unexcused leaves or misuse of sick leave. Follow ABMS requirements and procedures for any preapprovals required by the ABMS as applicable. Program directors will need to report availability (or lack thereof) of resources resulting from leaves of absences to Dept Chair, GME Director and DIO when approving leave.
Office of GME	Obtains GME Director signature and returns completed LOA form to Resident and Program Administrator if the request is not for annual or sick leave.

Total Time of LOA:
Total time spent on LOA will never exceed 6 months. If there were exceptional circumstances, for a LOA with a duration longer than 6 months its authorization will require consultation and approval by the corresponding certification board and the Director of GME.

Discussion PD: December 4, 2014
Approval CEMG: January 15, 2015
Update approved by GMEC March2021

	Policy #41	GRADUATE MEDICAL EDUCATION POLICIES
CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**TITLE**	LACTATION
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Please, refer to the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address requirements to ensure access to Lactation facilities. The Accreditation Council for Graduate Medical Education requires that the sponsoring institution provides facility for lactation, with separate storage for breast milk and protected time in their program requirements for residency/fellowship training programs.

This policy has been established in adherence with the ACGME Requirements. I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care. I.D.2.c)

The purpose of this policy is to permit and encourage residents/fellows to directly breastfeed their infants, and to use protected time for expressing milk breaks. This is necessary for the breastfeeding mother to maintain her milk supply, avoid pain, discomfort, and health issues, and provide milk for her infant for the time they are separated. In addition, in situations in which direct breastfeeding is not possible, residents/fellows should have access to a private, comfortable, and sanitary space for expression of breast milk.

INTENT. Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be near clinical responsibilities. It would be helpful to have additional support within these locations that may assist the residents with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the wellbeing of the resident and the resident's family.

PROCEDURES

- The lactation room should be in close proximity to the trainees' work area or study area.
- One lactating room is available at our institution, since one space for milk expression is needed for every 50-100 female employees aged 18-45.
- Trainees should not be expected to share lactation rooms with patients or hospital guests.
- The use of a private office or other private space is sufficient if it's comfortable, sanitary, private, and convenient for the trainee.
- Do not use a restroom or bathroom as an appropriate space for the expression of milk.
- Trainee should be able to have privacy, should be able to lock the door from the inside.
- The room should include a comfortable chair, an electrical outlet, comfortable temperature, and appropriate lighting.
- The room should have a table or desk to place breast pump and supplies.
- The room should be clean, with access to a sink for handwashing, and to pump supplies.
- Trainees should have access to a secure place to store expressed breastmilk.
- Trainees should have access to a secure place to store their personal breast pump and supplies.
- Trainee will have access to professional breastfeeding support, or lactation consultants.

- In the situation that lactating trainees are performing prolonged procedures in the operating room, the trainee may scrub out to directly breastfeed/express breast milk or remain in the operating/procedure room and utilize a wearable breast pump as the human breast milk is not

recognized as a bodily fluid requiring universal precautions. This decision will be taken in accordance with the hospital policy and the trainee's preference. The lactating trainee should inform her team of her specific needs for lactation accommodations. All the decisions in determining the suitable time to breastfeed or express milk should be in good faith, to ensure patient safety and to minimize impacts on the lactating trainee education, or in teammates.
- The trainee should work with her supervisor to assure the protected time to express milk and do an appropriate schedule and do arrangements for patient coverage.

MONITORING

The GME office has the following responsibilities:

- Ensure regular education and promotion of the breastfeeding policy.
- Conducting or delegating training to program directors, program coordinators and other GME staff members.
- Ensure that each residency program will supervise the accomplishment of this policy.
- In case of complains, the process will include the following timelines:
    - Prepare a written complaint and report to your immediate supervisor.
    - The trainee will obtain a letter of acknowledgement within three days of receipt.
    - A committee will be created to evaluate the complaint, do interviews, invite the trainee to discuss and resolve the situation.
    - A notification will be sent to the trainee with the resolution of his/her complaint.
    - If the complaint is not resolved, an AD-HOC committee will be established to resolve the complaint, and to ensure that evaluations should not be impacted negatively by any accommodations needed to support breastfeeding.
    - Ensure that the program maintains a culture that support breastfeeding.

Program Directors Responsibilities

- Become familiar with and aware of the lactation policy and its implementation.
- Create a culture that supports breastfeeding and promotes the trainee's wellbeing.
- Inform pregnant and breastfeeding trainees about their options for expressing breast milk, including the lactation policy, lactation rooms availability and location, and provide contacts to report any concerns.
- Work with the trainee to determine an appropriate lactation schedule
- Communicate with the faculty, residents/fellows who will be affected by this schedule.
- Communicate support for the trainee, ensuring a plan for patient care coverage.

Trainees' Responsibilities

- Inform to their supervisor that she will require accommodations to express milk or breastfeed, this will occur during pregnancy and prior to maternity leave
- Meet with her supervisor and work together to determine a schedule that meets the trainee lactation needs while maintaining patient care responsibilities and/or classroom requirements. The schedule may need to be modified to ensure that the rotation schedule is conducive to continued breastfeeding and breast milk expression
- Clean up the lactation space after each session and reports any issues within the facilities to the program coordinator.
- Meet with a lactation consultant prior to delivery and during breastfeeding. This will help the trainee to be prepared for breastfeeding habits and to manage any related issue.

Approval CEMG: December 6, 2019
Update /Approved by GMEC on March 2021

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address retention of the resident's files.

The files of residents and fellows are an essential part of the postgraduate education process. This will contain all documentation specific to the curricular components of each resident or fellow. This policy will describe the process of retention of the files; with the purpose of allocating all the documentation in a precise manner.

PROCEDURES

1. Each graduate medical education program sponsored by the institution will maintain a file concerning each resident or subspecialty resident/fellow (trainee).
2. The file will contain a record of the trainee's specific rotations, and other training experiences (including required procedures), written evaluations from the faculty and other evaluators, periodic summative evaluations by the program director and evaluation committee, any institutional disciplinary actions, and other information concerning the trainee, and data that the program director judges appropriate to maintain in the file for purposes of evaluation and training, including records required to be maintained by applicable institutional and program requirements of the ACGME.
3. The resident file should be kept confidential, saved in a secure location, and will be available only to the program director, the Director of Graduate Medical Education, and located in the applicable residency program offices. The following will be printed on the exterior of each file: "This File Contains Confidential Information. Access to this File and the Information Contained Therein is Governed by the Content, Access, and Retention Policy for Files of Residents and Subspecialty Residents/Fellows".
4. The Program Director and the Director of Graduate Medical Education may disclose the file, or portions thereof, to others whom they judge have a legitimate need for the information (e.g., for matters relating to the education of the trainee, the quality of education in the program, or the quality of patient care in the program). The program director and the Director of Graduate Medical Education may also disclose the file, or portions thereof, to others as authorized in writing by the trainee.
5. On reasonable request, the trainee shall have access to his or her file under direct supervision of a designated staff member of the department of Graduate Medical Education. Only upon written request, copies of monthly evaluations and summative evaluations will be distributed to the requesting resident.
6. Upon completion of a training program, when the trainee will recommend for board certification, only the final summative evaluation of the trainee, the record of the trainee's specific rotations and other training experiences (including training procedures), and a record of any disciplinary actions will be retained in the file. The file will then be maintained for at least a period of seven (7) years, due to more digital clouds the retention record for a prolonged time as affordable. The Program Director may exercise his or her discretion to retain other records for which there may be a need.
7. For residents who do not complete the training program, who complete the training program but had a period of probation or who complete the training program but will not be recommended for board certification, the entire file will be maintained as a permanent record.

	Policy #43	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RESIDENT FORUM AND BY-LAWS

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	**Reviews Approvals**	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Please refer to the end of the policy.

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Resident and fellows are referred collectively as residents.

PURPOSE. To define institutional protocols to address the matter of Resident Forum.

The Centro Médico (Hospital) Episcopal San Lucas (HESLP)- School of Medicine of the Ponce Health Sciences University Consortium support a Residents' Association that represents all residents of the Residency Programs of the Consortium. The Association initiated in the year 2000, the same year that the CMESL assumed the responsibilities of the programs of the former Ponce University Hospital, later Ponce Regional Hospital (PRH). The now CMESL-School of Medicine of the PHSU Residents' Association provided continuity to the Resident's Association of the former PRH.

This policy has been established in adherence with the Accreditation Council for graduate Medical Education (ACGME) Requirements. July 1, 2021. *II.C. Resident/Fellow Forum: The Sponsoring Institution with more than one program must ensure availability of an organization, council, town hall, or other platform that allows all residents/fellows from within and across the Sponsoring Institution's ACGME-accredited programs to communicate and exchange information with other residents/fellows relevant to their ACGME-accredited programs and their learning and working environment.*
II.C.1. Any resident/fellow from one of the Sponsoring Institution's ACGME accredited programs must have the opportunity to directly raise a concern to the forum. II.C.2. Residents/fellows must have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present. II.C.3. Residents/fellows must have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.

POLICY.
To foster and ensure a forum where issues can be brought by residents and fellows and will provide confidential space for evaluation without the presence of any GME personnel.

PROCEDURES.
The Residents' Association follow the By-laws created by the residents, and they follow all articles that describe the functionality and process for all their procedures.

Approved by GMEC on March 2016
Revised by GMEC March 2021

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #44	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RESIDENT TRAVEL EXPENSES AND REIMBURSEMENT
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. The Sponsoring Institution, Centro Medico Episcopal San Lucas, provides each department with professional development funds to support Resident education during training in our Graduate Medical Education (GME) Programs. These funds are intended to educationally benefit Residents during our GME Programs and not something to be purchased in the final months of training for use at another institution or in your next practice.

POLICY

CMESL encourages Residents to attend national, US and non-US, educational conferences each year. If available funding, the amount available for each Resident is left to the discretion of Program Director and must be approved by the DIO. It is the responsibility of each Program Director to communicate amounts available to each trainee and monitor that residency program totals are not exceeded. Reimbursement must be within the CMESL policies and guidelines.

PROCEDURES

1. To be eligible for reimbursement of travel expenses the resident must have their record up to date in documentation, Work Hour Logs, Procedures or Case Logs, Evaluation Completion, no reports of misconduct or unprofessionalism, no checklists due at New Innovations and scholarly activities adequately added to the platform. The Program Coordinator must evaluate the resident's New Innovation record and ensure everything is complete. To certify the completion of this step the Program Coordinator must fill up the Travel Pre-Approval Checklist and submit it to the DIO with all required documentation.
   Click to access the form: Policy #44 - Pre-Approval Checklist Form (002).pdf
2. Prior to attending a conference or traveling on behalf of CMESL, the Resident must have the conference and travel pre-approved by the Program Director, and the DIO.
3. A copy of the conference brochure must be submitted with the GME Travel Authorization Request and Reimbursement Form.
   Click to access the form: Policy #44 - Travel Authorization Request and Reimbursement Form.pdf
4. Travel should be approved at least one month prior to traveling so the Resident may obtain the best airfare or hotel rates.
5. If approved or not, the form will be returned to the Residency Program Coordinator after the DIO signs it.
6. Once the Resident has returned from the conference, they must submit original receipts to the Residency Program Coordinator as soon as possible but no later than 2 weeks from their return.
7. All documentation should be submitted within 30 days of the end of the conference, or the Resident and the Coordinator will be required to submit a written explanation as to why this requirement was not followed.
8. Failure to complete the procedure as explained above has the risk of the reimbursement not to be approved.

The CMESL Finance Department, not the Graduate Medical Education or the Program Director, makes the final determination as to interpretation of the GME Travel Policy and what is acceptable.

Maximum Reimbursement per Category

Region	Puerto Rico	USA	International (non-USA)
Registration fee	$100	$500	$500
Transportation	$20	$40 per day	$40 per day
Meals	$25	$40 per day	$40 per day
Hotel	Not Applicable	$250 per night	$250 per night
Airfare	Not Applicable	$350	$350

Approval of reimbursement will be subject to the funding available.

Registration Fee
A copy of the conference brochure must be submitted with the Travel Authorization Form.

Transportation
Car rentals are NOT reimbursable. You must state where you went (ex. airport to hotel or conference center and vice versa) and the receipt of payment.

Meals
You must include your receipts. Meals listed as provided on the agenda or conference brochure will be deducted from the reimbursement amount, whether or not you choose to eat the conference meal. For this reason, **an agenda or conference brochure must be provided** with your trip receipts. Moreover, alcohol will not be covered in meal expenses, therefore these will be deducted from the total reimbursement.

Hotel Reimbursement

- A hotel receipt when a Resident has attended a conference must show a zero balance. If you stay at the Conference Hotel, you may be reimbursed up to the conference rate plus taxes, given you have available funds, but you must include the brochure or web page that details the conference hotel rate.
    - If the room block at the conference rate is full or if you waited until after the deadline to reserve your room, you WILL NOT be reimbursed more than the conference rate to stay at an alternative location.
- The hotel receipt must be in your name.
    - If you share a room with another Resident, only one resident (whose name is on the final receipt) will be reimbursed.
- If you do not stay at the conference hotel, you will only be reimbursed up to the federal per diem plus taxes for that city and state and corresponding dates of travel (US GSA Federal Conus Rates at www.gsa.gov/perdiem) or the conference hotel.

NOTE: Please understand we do not recommend that you book Airbnb or Vacation Rentals by Owner (VRBO) rentals to stay as a **group of Residents** since securing receipts acceptable to the CMESL Finance Department may be difficult. Receipts must be separated for each Resident and the costs should be paid separately by each Resident traveler. Please make sure that your Coordinator as well as the GME Office is aware of your intentions for an Airbnb or VRBO rental before making your reservations. You must adhere to the CMESL travel policy to be reimbursed the fullest amount possible (no greater than the conference rate for each Resident registered for the conference) for lodging. The GME Office cannot guarantee that your receipts from these entities will be acceptable to the Finance Department who ultimately makes decisions about reimbursement.

Airfare
You must attach a copy of your receipt that includes your itinerary, the cost of the ticket with a zero balance, and the designation or code for coach fare. You WILL NOT be reimbursed for seat upgrades, in-flight purchases, etc. An original receipt is required for baggage fee reimbursement.

Other
You must attach original receipts and an explanation for any other individual expenses related to the travel that you feel should be reimbursed. Keep in mind that it is subject to approval.

CODE OF CONDUCT
All travel activities are considered academic, and all our residents must abide by the professionalism and code of conduct of the sponsoring institution, and GME policies applicable. Any misconduct or failure to properly represent the vision and mission of the CMESL will be processed as established in the House Staff Manual. Refer to Policy #8 GME Rules for further details on this aspect.

CENTRO MÉDICO EPISCOPAL SAN LUCAS PONCE	Policy #45	**GRADUATE MEDICAL EDUCATION POLICIES**
	TITLE	RESIDENT TRAVEL EXPENSES AND REIMBURSEMENT
	Reviews Approvals	Reviewed & Approved by the DIO and GMEC. Responsible Office. Graduate Medical Education Office. Updates performed every five years from effective date, or as needed.
	Effective Dates & Updates	Updates performed as per institutional policies

SCOPE. Applies to the ACGME-accredited training programs supported by the sponsoring institution. Residents and fellows are referred collectively as residents.

PURPOSE. The Sponsoring Institution, Centro Medico Episcopal San Lucas, provides each department with professional development funds to support Resident education during training in our Graduate Medical Education (GME) Programs. These funds are intended to educationally benefit Residents during our GME Programs and not something to be purchased in the final months of training for use at another institution or in your next practice.

POLICY

CMESL encourages Residents to contribute to academic knowledge by publishing research in peer-reviewed journals. If funding is available, the amount allocated for each Resident's publication expenses is left to the discretion of the Program Director and must be approved by the DIO. It is the responsibility of each Program Director to communicate the available amounts to each trainee and monitor that residency program totals are not exceeded. Reimbursement must be within the CMESL policies and guidelines.

PROCEDURES

1. Before submitting a manuscript to a journal, the Resident must have the publication and associated expenses (e.g., submission fees, open-access charges) pre-approved by the Program Director and the DIO.
2. Research Coordinator of CMESL must have knowledge of the publication process, even if their aid is not required for publishing.
3. A copy of the journal's submission guidelines and fee structure must be submitted along with the CMESL Publication Expense Authorization Form.
4. Publication expenses should be approved at least one month prior to submission to allow sufficient time for processing and to ensure that available funding is used appropriately.
5. After review by the DIO, the form will be returned to the Residency Program Coordinator, indicating whether the publication expenses have been approved or denied.
6. Once the manuscript has been accepted for publication, the Resident must submit original receipts (e.g., journal submission fees) to the Residency Program Coordinator as soon as possible, but no later than two weeks from the date of acceptance.
7. All documentation must be submitted within 30 days of the manuscript's acceptance. Failure to do so will require the Resident and the Coordinator to submit a written explanation for non-compliance.
8. Failure to complete the procedure as outlined may result in the denial of reimbursement.

The CMESL Finance Department, not the Graduate Medical Education or the Program Director, will make the final determination regarding the interpretation of the CMESL Publication Expense Policy and the acceptability of the expenses.

Maximum Reimbursement per Category

Expense Category	Reimbursement Rate
Journal Submission Fee	$1,100.00 per publication

Reimbursement Guidelines

Journal Submission Fee

- A maximum of $1,100.00 of the journal submission fee will be reimbursed, up to the maximum allowable based on funding availability. A total of 4 publications are reimbursed per residency. This might be adjusted as funding availability is evaluated. These costs are used to include Open-access fees, editing services and/or other publication-related expenses. A copy of the journal's submission guidelines and a receipt showing the total fee must be provided, as well as all the services utilized. Approval of reimbursement is subject to funding availability and adherence to CMESL policies.